GMCB Regulatory Alignment White Paper

PART 1: CURRENT STATE

July 2020

The Green Mountain Care Board seeks to improve the health of Vermonters through a high-quality, accessible, and sustainable health care system.

DRAFT FOR DISCUSSION

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Introduction: Part 1, Current State

The Green Mountain Care Board ("GMCB" or "Board") was created as an independent board to promote the general welfare of the State by:

(1) improving the health of the population;
(2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
(3) enhancing the patient and health care professional experience of care;
(4) recruiting and retaining high-quality health care professionals; and
(5) achieving administrative simplification in health care financing and delivery.

18 V.S.A. § 9372

As Vermont moves forward with health system transformation, the Board has begun reviewing its regulatory processes with the goal of aligning them more fully with each other and with the Board's statutory purpose, in particular improving the health of the population and reducing the per-capita rate of cost growth while ensuring access to and quality of health care.

This series of three white papers considers five core GMCB regulatory processes: (1) All-Payer Model (APM) Regulatory Responsibilities (Medicare ACO Program Design and Benchmark Rate Setting); (2) Accountable Care Organization (ACO) Oversight; (3) Hospital Budget Review; (4) Health Insurance Premium (Rate) Review; and (5) Certificate of Need (CON). This first paper lays out each of the regulatory processes in its current state. The second paper considers possible changes to the GMCB regulatory timeline to improve alignment. The third and final paper (to be released in early 2021) reviews four key areas for policy alignment: (1) financial measures, (2) quality measurement, (3) delivery system roles and responsibilities, and (4) risk and reserves.

Goals

This white paper series aims to improve the Board's ability to make decisions consistently across regulatory processes and ensure appropriate assessment of regulated entities in a reformed payment and delivery system environment. Below are specific GMCB alignment goals:

- Streamline GMCB oversight to ensure regulatory processes inform one another where appropriate and achieve alignment on key policy issues (e.g., aligning health care cost growth with overall economic growth and connecting hospital budget decisions to both health insurance premium rate review and ACO oversight);
- Develop measures, where feasible, to allow for comparisons across GMCB regulatory processes; and
- Envision future GMCB regulatory structures as Vermont continues to shift from fee-for-service to population-based payment models.

Methods

In developing this series, GMCB surveyed regulated entities and other stakeholders; held a stakeholder focus group; and gathered data about current processes, challenges, and considerations for future regulatory refinements or changes. GMCB is soliciting comment on Parts 1 and 2 of this white paper series from stakeholders and the public during Summer 2020.

Current State: GMCB Regulatory Processes

In what follows, we offer a brief description of the Green Mountain Care Board's key regulatory processes:

- Vermont's All-Payer Model (APM)
- Accountable Care Organization (ACO) Oversight
- Hospital Budget Review
- Health Insurance Premium Rate Review
- Certificate of Need (CON)

Where relevant, we describe the Board's statutory authority, scope or magnitude of influence, relevant timeline, and note other state entities who share regulatory authority.

A Note on the Impact of COVID-19

The COVID-19 pandemic and public health emergency has had enormous impacts on Vermonters and Vermont's health care system. Act 91 of 2020 has offered the GMCB and GMCB-regulated entities temporary flexibility in response to the pandemic. The Board's response has included:

- Providing new guidance for emergency certificate of need applications related to the COVID-19 response
- Continuing to monitor hospital solvency and issuing new hospital budget process guidance intended to reduce the regulatory burden on hospitals, including delaying hospital budget submission due dates
- Working with federal partners at the Center for Medicare and Medicaid Innovations to request monitoring flexibility and additional funding for providers participating in Vermont's All-Payer Model
- Amending OneCare Vermont's 2020 Budget Order to allow the redirection of resources toward front-line providers and to extend the reporting timeline to allow for revisions in light of COVID-19 and account for delays in the availability of information
- Delayed GMCB's insurance rate review decisions by one week (allowable under existing authority)
- Data analysis to support the State's response

Given the uncertainty caused by COVID-19 and temporary nature of regulatory changes in response to the public health emergency, this white paper focuses on GMCB regulatory processes as they would occur in a normal year.

Vermont's All-Payer Model

Relevant Statute/Authority: 18 V.S.A. § 9551; 18 V.S.A. § 9573; 2 U.S.C. § 1315a; All-Payer ACO Model Agreement.

Overview: The Vermont All-Payer Accountable Care Organization Model (APM) Agreement was signed on October 26, 2016, by Vermont's Governor, Secretary of Human Services, and GMCB Chair, and the Centers for Medicare and Medicaid Services (CMS) to advance health care reform in the state of Vermont. The All-Payer Model holds participating providers accountable for the cost and quality of the care they provide, and assumes that payment reform will incentivize delivery reform to improve care management, invest in population health improvement, and shift utilization to primary care settings. Simultaneously, participating providers should benefit from more predictable income streams and the opportunity to share in any savings they generate for payers.

The All-Payer Model aims to reduce health care cost growth by moving away from fee-for-service reimbursement to a value-based model; these arrangements are tied to quality and health outcomes, including three population-wide health outcome goals defined in the APM Agreement:

1. Improve access to primary care;
2. Reduce deaths due to suicide and drug overdose; and
3. Reduce prevalence and morbidity of chronic disease.

Impact of Transition to New Payment Models

The All-Payer Model facilitates Vermont's transition away from fee-for-service toward value-based payment models by enabling Vermont providers to join a Vermont-tailored Medicare ACO model.

As more Vermont providers and payers engage in All-Payer Model reforms, the scale of the model will continue to grow.

In addition to the APM signatories' role in supporting progress toward these targets and the Board's extensive data and reporting functions, the Board has the authority to request modifications to Medicare's national Next Generation ACO Model to create a Vermont-specific Medicare ACO program in Years 2-5 of the APM. This includes the ability to request programmatic changes and the obligation to propose the Medicare ACO benchmark (spending target) for federal approval.

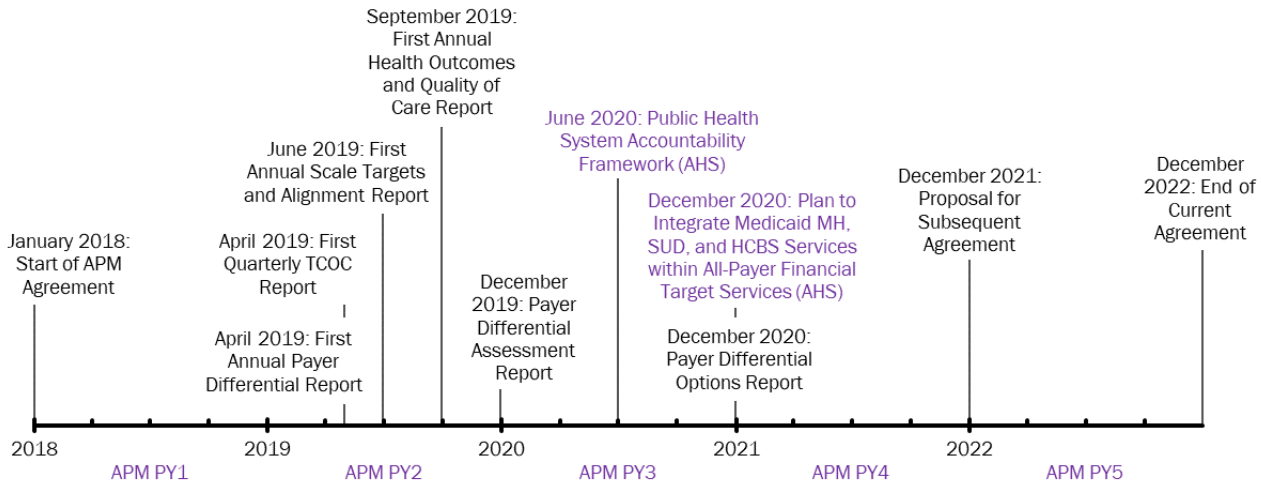
Scope:

- *Population:* While some of Vermont's APM goals are limited to Vermont residents attributed to an ACO (approximately 220,000 in 2020, see pg. 8), Vermont is also accountable for reaching population health improvement targets for most Vermonters, not just those attributed to the ACO (see Key Measures and Policy Themes, below).
- *Providers*: All Vermont providers can contribute to the achievement of overall population health goals. The APM uses the Medicare Next Generation ACO Model as a chassis for health care reform. For a summary of ACO-participating providers in 2020, see pg. 8.
- *Payers*: The APM Agreement focuses on Medicare's participation in the Vermont model, and holds Vermont accountable to Medicare for cost, quality, scale, and payer alignment. In addition to its contract with Medicare, in 2020 the ACO is also contracted with Medicaid, and commercial payers (BCBSVT and MVP on behalf of QHP lives; BCBSVT self-insured).
- *Services*: APM total cost of care (APM TCOC) includes Medicare Part A- and Part B-equivalent services, such as inpatient, outpatient, and professional services; it excludes retail pharmacy, long-term services and supports, and non-DVHA Medicaid services (e.g., specialized mental health, substance abuse or services for seniors paid for through other departments within the Agency of Human Services). Note that included services may vary in contracts between the ACO and payers.
- *Proportion of Health Care Spending:* In 2018 (most recent data available), approx. 46% of total health care expenditures on behalf of Vermont residents were included in APM TCOC.[1]

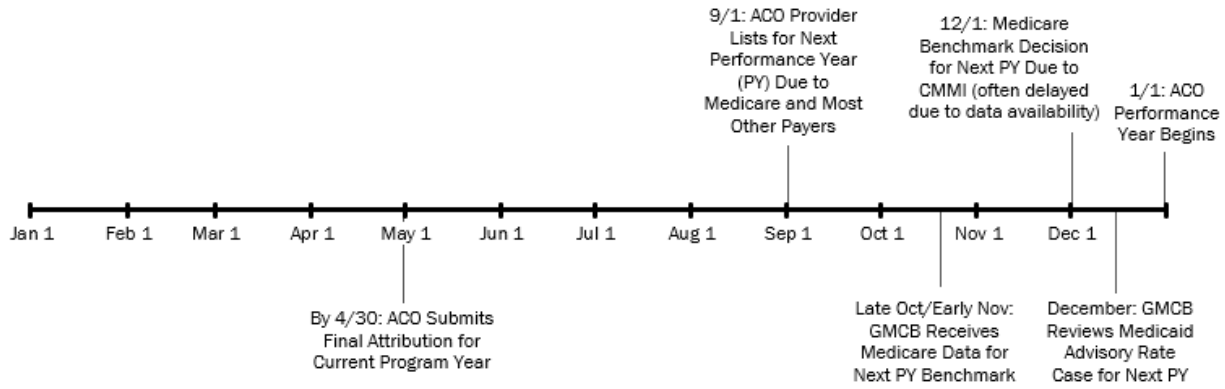
[1] $2,870,039,124 (2018 All-Payer Total Cost of Care, see APM TCOC Annual Report, PY 1 (2018)) divided by $6,259,671,000 (2018 Vermont resident expenditures, see 2018 Vermont Expenditure Analysis, pg. 9).

Current Timeline:

All-Payer Model Agreement 5-Year Timeline:



Annual Medicare Benchmark Approval Timeline:



Key Measures and Policy Themes:

Financial: The APM Agreement requires Vermont to control per capita spending growth for included services, as measured by Medicare and All-Payer TCOC metrics. Growth for Vermont's traditional Medicare beneficiaries is targeted to be at least 0.2 percentage points below the projected growth rate for beneficiaries nationwide. The All-Payer TCOC is targeted to be within or below 3.5% growth statewide (with a corrective action plan triggered at 4.3% growth). This latter growth range was developed by calculating Vermont's economic growth over 10-15 years prior to the agreement, at the time of the negotiation.[2]

Quality: The APM Agreement includes a quality framework with over 20 measures for which Vermont is accountable. These measures are centered around 6 population-wide health outcome measures, tied to the three population health outcomes listed on pg. 5; the quality framework also includes health care delivery system quality measures which evaluate ACO performance and quality of care, and process milestones which ensure that the State and ACO are striving towards improvement on prevention and disease management. These measures generally align across payers in the ACO program, with some adjustments for population and covered services.

[2] See All Payer Model FAQ (2016), pg. 10, Q49.

Delivery System Roles and Responsibilities: The All-Payer Model assumes that payment reform will incentivize delivery system changes to improve care management, invest in population health improvement, and increase primary care utilization.

Other: The All-Payer Model assumes that providers will be more likely to change the delivery of care when there are sufficient patients and payers participating in the new payment models. The Agreement sets targets for "scale" – the percentage of Vermonters attributed to the ACO – over the life of the Agreement:

	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
All-Payer Scale Target	36%	50%	58%	62%	70%
Medicare Scale Target	60%	75%	79%	83%	90%

In order to be attributed to an ACO, a Vermonter must be insured by an ACO-participating payer and meet other criteria: In most cases, attribution is based on past or current primary care relationship with an ACO-participating provider; however, DVHA is testing a geographic attribution methodology that attributes Vermonters to the ACO based on residence if they do not have a past or current primary care relationship.

Regulatory Partner Alignment:

- *Agency of Human Services (AHS)*: AHS is a co-signatory on the APM Agreement and is jointly responsible for achieving the goals of the Model. In addition, AHS is responsible for significant reporting under the Agreement, including a Collaboration with Public Health report (submitted June 2020) and a plan to integrate Medicaid behavioral health and home- and community-based services into model financial targets (due December 2020).
- *Department of Vermont Health Access (DVHA)*: DVHA participates in the APM as a payer, contracting with the ACO through the Vermont Medicaid Next Generation ACO Program. Through a process known as the Medicaid Advisory Rate Case GMCB also reviews Medicaid's actuarial range for the Medicaid ACO benchmark (spending target) and provides advice to DVHA prior to the finalization of the Medicaid ACO contract – typically in the last quarter of the year prior to the start of a new Performance Year. The purpose of this review is to ensure that the Board has insight into Medicaid's financial arrangement with the ACO when determining its budget and to provide DVHA with suggestions regarding the financial terms of its contract. Per 18 V.S.A. § 9382(b)(1)(N), GMCB is also required to consider the impact of Medicaid's ACO payment rates on other payer programs, including the Medicare benchmark decision.

Accountable Care Organization (ACO) Oversight

Relevant Statute/Authority: 18 V.S.A. § 9382; GMCB Rule 5.000.

Overview: GMCB oversees Vermont ACOs through ACO certification, and budget and programmatic review. There is currently one ACO operating in Vermont, OneCare Vermont.

- *Certification*: An ACO must be certified by the GMCB to be eligible to receive payments from Medicaid or a commercial insurer through a payment reform initiative such as the All-Payer Model. Certification ensures that an ACO's policies and procedures meet statutory requirements. After initial certification is granted, GMCB verifies continued eligibility for certification annually.
- *Budget and Programmatic Review*: GMCB performs an annual financial and programmatic review of the budget for each Vermont ACO. GMCB also monitors the ACO's budget and performance throughout the year to ensure compliance with any budget approval conditions. Under statute, the Office of the Health Care Advocate receives budget materials and has the opportunity to provide input to and participate in the ACO budget process. GMCB's decision on OneCare's 2019 budget required that "over the duration of the agreement, OneCare's administrative expenses should be less than the health care savings, including cost avoidance and the value of improved health, projected to be generated through the Model."[3]

Impact of Transition to New Payment Models

As more Vermont providers and payers engage in ACO-based reform, more Vermonters will become part of ACO oversight, and the total ACO budget will grow.

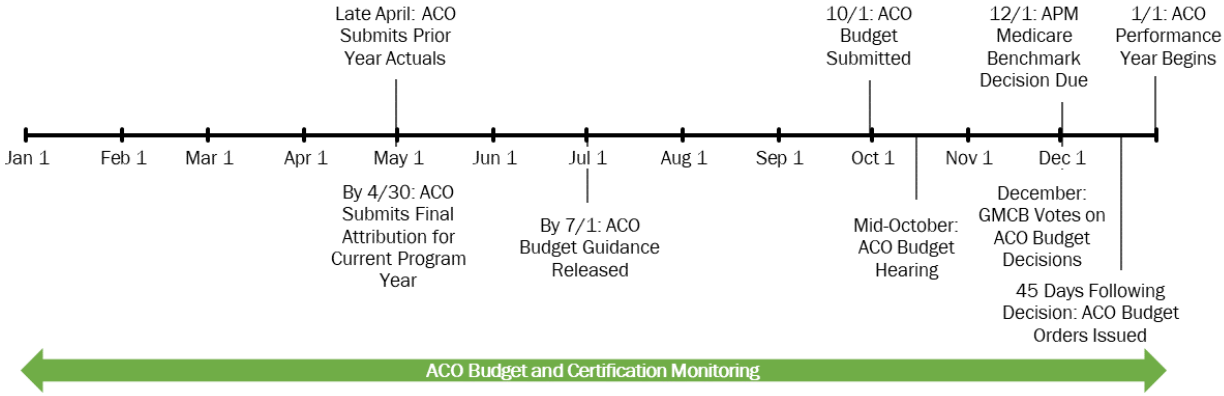
Scope:

- *Population*: Typically, in order to be attributed to an ACO, a Vermonter must be insured by an ACO-participating payer and have a past or current primary care relationship with an ACO-participating provider; DVHA is also testing a geographic attribution methodology that attributes Vermonters to the ACO based on residence if they do not have a past or current primary care relationship. In 2020, approximately 220,000 Vermonters are attributed.
- *Providers*: Providers who volunteer to participate in an ACO network. In 2020, the following providers participated in OneCare's network for one or more payer programs[4]:
  - 13 of 14 Vermont hospitals, plus Dartmouth-Hitchcock Medical Center
  - 9 of 12 Vermont FQHCs, representing 49 locations
  - ~76 hospital-owned practices, ~29 independent, and 49 FQHC locations, of ~267 total primary care practices
  - 25 independent specialists, 4 physical therapy practices
  - 9 of 9 home health and hospice agencies, 27 of 38 skilled nursing facilities
  - 10 of 16 designated mental health agencies & specialized service agencies
  - 1 ambulatory surgical center
- *Payers*: For 2020, Medicare, Medicaid, commercial (QHP; some self-insured).
- *Services*: Generally includes Medicare Part A- and Part B-like services, such as inpatient, outpatient, and professional services; excludes pharmacy, long-term services and supports, and non-DVHA Medicaid services (e.g., services paid for through other departments within AHS). Included services may vary in contracts between the ACO and payers.
- *Proportion of Health Care Spending:* The 2020 ACO oversight process reviewed approximately 19% of projected 2020 total expenditures by Vermont residents.[5]

[3] To be measured following the end of the 5-year APM Agreement (2018-2022); measure in development.
[4] See GMCB ACO Oversight FY2020 Preliminary Recommendations presentation (December 11, 2019), pg. 46.
[5] $1,255,590,792 (see Updated OneCare Vermont FY20 Budget provided June 19, 2020, pg. 9) divided by $6,658,548,000 (2018 Vermont Expenditure Analysis (Vermont Resident Analysis Projections, 2020, pg. 37). Total expenditures include expenditures for services excluded from ACO programs.

Current Timeline:

Budget and Programmatic Review:



Certification: Initial review occurs when an ACO requests certification. An annual review is performed at the same time as the ACO budget process to verify the ACO's continued eligibility for certification.

Key Measures and Policy Themes:

- *Financial*: In ACO Budget and Programmatic Review, the Board approves a budget framework, including trends, administrative cost ratios, and investments. In addition, GMCB reviews administrative costs, population health investments, prior year and projected budget year ACO total cost of care (TCOC) for each of the ACO's payer programs and the ACO's total risk distribution and reserves.
- *Quality*: GMCB reviews the ACO's quality performance on payer-developed measure sets when results are available, usually in September following the end of the performance year. GMCB reviews programs to ensure resource allocation supports population health goals.
- *Delivery System Roles and Responsibilities*: The ACO's care model includes care management and utilization management responsibilities that may overlap with payer, provider, or Blueprint for Health activities; the ACO, payers, and the Blueprint collaborate to align care management and reduce duplication.
- *Risk and Reserves*: ACO Budget and Programmatic Review includes review of the ACO's payer contracts, including risk and the potential for savings at the ACO level and between the ACO and participating providers. The Board also considers minimum reserve requirements and other risk mitigation strategies to ensure the ACO and participating providers have the ability to cover any potential losses. Rule 5.000 also requires GMCB to establish a "risk cap" for the ACO; however, availability of final attribution data at the time GMCB reviews the ACO's budget makes establishing a total dollar amount impossible, so the Board approves the terms of the ACO's total risk (e.g., 4% of the total Medicare benchmark, which is a product of 5% risk corridor with 80% risk- and gain-sharing).

Regulatory Partner Alignment:

- *Department of Financial Regulation (DFR)*: DFR regulates insurer solvency and sets surplus ranges for Vermont insurers periodically.
- *Department of Vermont Health Access (DVHA)*: The ACO contracts with DVHA as a participating payer through the Vermont Medicaid Next Generation ACO Program. As noted above, GMCB performs an advisory rate review of the financial arrangement. In addition, under statute GMCB reviews the ACO's integration with the Blueprint for Health.

Hospital Budget Review

Relevant Statute/Authority: 18 V.S.A. § 9375(b)(7); 18 V.S.A. § 9456; GMCB Rule 3.000.

Overview: By September 15, the Board has the annual responsibility to review and establish community hospital budgets for their fiscal year beginning October 1. Through this process, the Board aims to reduce the rate of per capita health care cost growth while ensuring access to care, quality of care, and process transparency. In its orders, the Board typically establishes upper limits on both hospital charge growth and net patient revenue/fixed prospective payments (NPR/FPP) growth for the year. The Board has the authority to establish guidance on other metrics as well. Enforcement hearings related to the hospitals' performance in the prior budget year are held in late winter or early spring for hospitals with significant NPR/FPP budget variances. In specific circumstances, the Board may modify a hospital's approved budget. Under statute, the Office of the Health Care Advocate receives budget materials and has the opportunity to provide input to and participate in the hospital budget process.

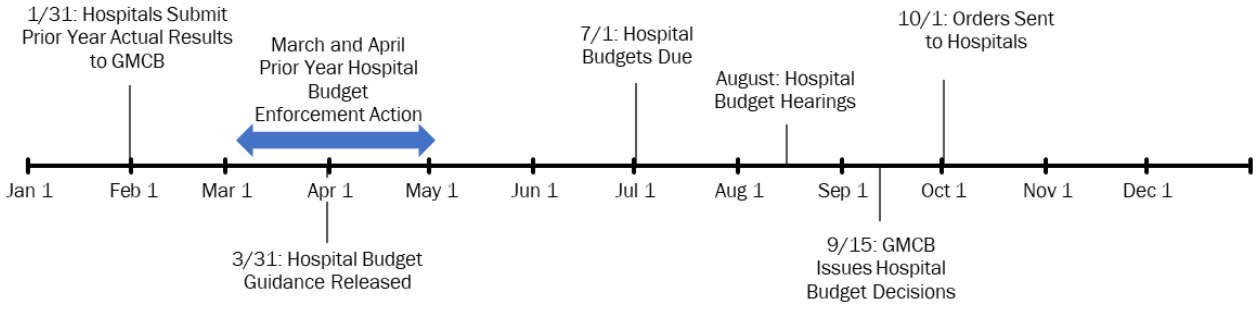
Impact of Transition to New Payment Models

As more Vermont providers engage in ACO-based payment and delivery reform, hospital budget review may need to be modified to reflect the assumption of risk by hospitals, allow for financial metrics that translate to the All-Payer Model Total Cost of Care, and increase the monitoring of quality of care and population health investments.

Scope:

- *Population*: Anyone receiving services from a regulated Vermont hospital or a hospital-affiliated provider (e.g. primary care office).
- *Providers*: Vermont hospitals and affiliated providers. The GMCB regulates Vermont's 14 community hospitals, including medical practices owned by regulated hospitals in the state.[6]
- *Payers*: Medicare, Medicaid, Commercial (in- and out-of-state), self-insured employers (in- and out-of-state), and self-pay/uninsured.
- *Services*: Hospital inpatient, hospital outpatient, and some primary care and specialty services.
- *Proportion of Health Care Spending:* In 2018 (most recent data available), approximately 42% of total health care expenditures by Vermont health care providers flowed through Vermont hospitals and affiliated practices.[7]

Current Timeline:



[6] Act 140 of 2020 directs the Board to begin budget reviews for the Brattleboro Retreat and to collect and review data from the Designated Mental Health and Specialized Service Agencies, which may include financial data as well as data on scope of service, volume, utilization, discharges, payer mix, quality, coordination with other health care providers.

[7] See 2018 Vermont Expenditure Analysis (Vermont Provider Health Care Revenues, pg. 30).

Key Measures and Policy Themes:

- *Financial*: For FY20 and FY21, the Board set a target limit on NPR/FPP growth to 3.5% or less in alignment with the state's APM total cost of care goals.[8] With growing concerns for rural hospital financial health and sustainability, the Board monitors key financial metrics monthly for each hospital, including operating margin, total margin, days cash on hand, debt service coverage ratio, and days payable/receivable. The Board also monitors budget-to-actual and actual-to-actual variances for revenue (NPR/FPP), operating expenses, and key utilization metrics.
- *Quality*: The Board provides hospitals with statewide and Health Service Area (HSA) quality metrics using the APM quality framework. Each hospital is asked to consider and respond to the HSA's performance and its role in improving metrics, where indicated. The Board also considers each hospital's federally required Community Health Needs Assessment (CHNA), with specific focus on quality improvement priorities.[9]
- *Delivery System Roles and Responsibilities*: Most Vermont hospitals own primary care practices that engage in care coordination and care management, as well as administering the Community Health Team (CHT) for their HSA. The Board reviews hospitals' provider acquisitions and transfers, including acquisitions and transfers of primary care practices. In addition, the Board has periodic traveling Board meetings during which it visits a community to hear from the hospital, as well as the community providers, to more deeply understand the delivery system in that locality.
- *Risk and Reserves*: ACO-participating hospitals are risk-bearing entities; the impact of ACO performance and potential for risk- or gain-sharing in the ACO's payer contracts could significantly impact hospital operating performance and solvency. Under the ACO payment model, hospitals are assuming risk for the care provided to the residents in their community, regardless of where that care takes place. This is an area of ongoing analysis and work at the GMCB, including determining the right amount of risk, how that risk may be funded, and how to record risk on hospital financial statements.

Regulatory Partner Alignment:

- *Department of Vermont Health Access*: The Board requests information from DVHA regarding reimbursement changes, provider tax amounts and changes to disproportionate share hospital (DSH) payments to true up with the hospital's estimates.
- *Vermont Department of Health*: Non-profit hospitals must meet federal requirements to complete Community Health Needs Assessments (CHNAs) every three years, including identifying quality improvement priorities for their service area; this process is monitored by VDH. GMCB staff work with VDH staff to develop and issue suggested CHNA guidance in conjunction with the hospital budget review process and VDH's Hospital Report Card guidance.

[8] It should be noted that the APM financial growth targets are set on a per capita basis while the NPR/FPP growth targets do not currently adjust for changes in the size (or the underlying risk) of the population served. Additionally, the services included in the APM financial growth targets are a subset of the services and ancillary costs included in a hospital's NPR/FPP.
[9] Hospital non-financial reporting is waived in 2020 to reduce hospital regulatory burden in support of Vermont's COVID-19 response.

Health Insurance Premium (Rate) Review

Relevant Statute/Authority: 8 V.S.A. § 4062; 18 V.S.A. § 9375; 8 V.S.A. § 4515a; 8 V.S.A. § 9487; 8 V.S.A. § 5104; GMCB Rule 2.000.

Overview: There are two major types of health insurance coverage – commercial coverage (including fully-insured plans and self-insured plans), and government coverage (Medicare and Medicaid). 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 (100 employees or less) insurance markets. Generally, within 90 days of submission, the Board must determine whether a proposed rate is affordable; promotes quality care; promotes access to health care; protects insurer solvency; is not unjust, unfair, inequitable, misleading, or contrary to Vermont law; and is not excessive, inadequate, or unfairly discriminatory. The Office of the Health Care Advocate appears as a party to rate review proceedings.

Impact of Transition to New Payment Models

As more Vermont providers and payers engage in ACO-based payment and delivery reform, rate review may need to be modified to reflect transfer of risk to the ACO and how new payment methods impact medical trend and utilization patterns.

Scope:

- *Population*[10]: Vermont residents and employers purchasing major medical health insurance from an insurer licensed in Vermont; premiums are based on insurer-specific claims information. In 2018 (most recent comparable data available), about 21,000 Vermonters (3% of total state population) were insured through large employer insurance; 73,000 Vermonters (12%) were insured through small employers or purchased insurance themselves. Since 2013, Vermont has seen a movement from the insured market to other forms of coverage, including self-insured plans and government coverage:

	2013		2018		Change, 2013-2018
	Members	% Total	Members	% Total	
Total Insured Market (GMCB regulated)	**151,752**	**24%**	**94,415**	**15%**	**▼ 37.8%**
Individual & Small Group	*35,509*	*6%*	*73,064*	*12%*	*▲ 105.8%*
Large Group	*116,243*	*19%*	*21,351*	*3%*	*▼ 81.6%*
Total Self-Insured Market	**157,047**	**25%**	**208,439**	**33%**	**▲ 32.7%**
Total Other	**41,191**	**7%**	**12,135**	**2%**	**▼ 70.5%**
TOTAL COMMERCIAL MARKET	**349,990**	**56%**	**314,989**	**50%**	**▼ 10.0%**
Medicaid	**127,342**	**20%**	**150,375**	**25%**	**▲ 21.7%**
Medicare	**111,954**	**18%**	**133,915**	**22%**	**▲ 22.0%**
TOTAL GOVERNMENT COVERAGE	**239,396**	**38%**	**284,290**	**47%**	**▲ 21.8%**
TOTAL UNINSURED	**37,344**	**6%**	**19,800**	**3%**	**▼ 47.0%**
TOTAL VERMONT POPULATION	**626,630**		**626,299**		**▼ 0.1%**

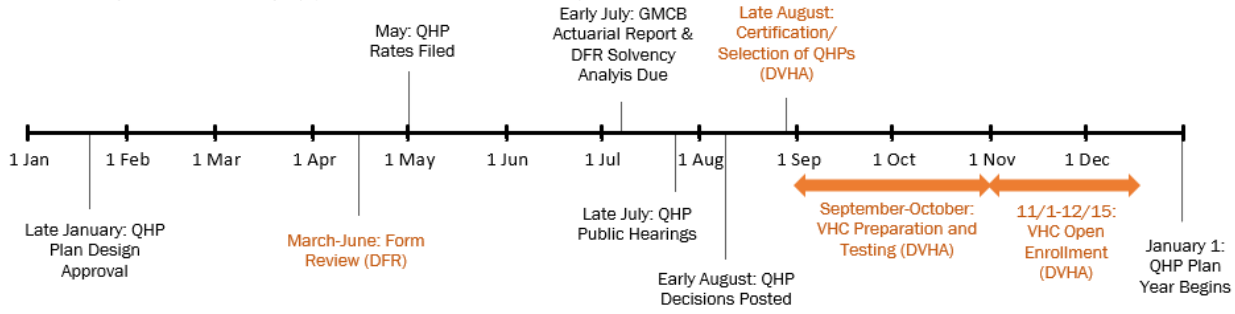
  As a result, the GMCB's premium rate review process impacted only 30% of the commercially insured market in 2018 (compared to 43% in 2013), and 15% of the total Vermont population (compared to nearly 25% in 2013).
- *Providers*: Providers contracting with a specific insurer, including both in- and out-of-state hospitals, professionals, and others.

[10] See 2017 Vermont Health Care Expenditure Analysis (Health Insurance Coverage Profile, pg. 42), and 2018 Vermont Expenditure Analysis (Health Insurance Coverage Profile, Vermont Residents, pg. 43).

- *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).

Timeline:

Individual/Small Group (Qualified Health Plans) Review Timeline:



Large Group Filing Review Timeline (4 filings annually from 3 insurers): Large group rates are reviewed and approved on a rolling basis, within 90 days of filing.

Key Measures and Policy Themes:

- *Financial*: An insurance premium represents an estimate of expected future costs based on historical data and projected changes to a variety of factors (e.g., changes in population morbidity, unit costs, and utilization of medical services). For individual/small group policies, the Board approves an overall premium (per member per month amount), which is then used to develop consumer-adjusted premium rates (e.g., single rates, couple rates, and family rates). For large group policies, the Board approves the rating methodology and a "manual rate," which is a per member per month amount that an insurer will apply to a specific employer's claims experience to develop an actual premium. For both individual/small group and large group plans, premium includes expected medical costs; taxes, fees and other administrative costs; and a contribution to reserves. Figure 1 (pg. 15) provides an overview of these premium components.
- *Quality*: Each insurer is required to maintain a quality program under Department of Financial Regulation (DFR) Rule H-2009-03. DVHA oversees federally mandated Quality Improvement Strategy (QIS) and Quality Rating System (QRS, or Star Rating) programs. QHP issuers are also required by CMS to maintain accreditation from a nationally recognized accrediting agency (e.g., NCQA), for their Vermont QHP products (CFR 156.275). The Board often asks about quality in its individual and small group hearings but does not currently have a systematic process to review quality.
- *Delivery System Roles and Responsibilities*: Each insurer has a utilization management program. Insurers participating in the ACO also contract with OneCare Vermont (OCV) to provide the ACO's care management programs to the attributed lives in individual and small group plans.
- *Risk and Reserves*: DFR is charged with ensuring insurer solvency and reviews the reserves of each payer. Generally speaking, solvency is a measurement of whether an insurer has enough funds (reserves) to cover the relevant risks and costs associated with the insurer's business, such as unexpectedly high claims cost. The Board considers DFR's solvency opinion when it approves rates submitted with each filing.

Regulatory Partner Alignment:

- *Department of Financial Regulation (DFR)*: DFR is charged with ensuring insurer solvency and reviews the impact an insurer's requested rate will have on the insurer's solvency. DFR

also reviews insurer forms and contracts and considers network adequacy and other Rule 09-03 standards. DFR has approved a target Risk-Based Capital ratio range for BCBSVT, which is domiciled in Vermont. For MVP and Cigna (both domiciled out of state), DFR reviews solvency but relies on the regulator in the state of the insurer's domicile. The Board considers DFR's solvency opinion when reviewing each rate filing. DFR does not currently assess ACO solvency as part of its insurer solvency determination process. DFR's recent Risk-Based Capital Order for BCBSVT considered the transfer of risk in the ACO program but assigned minimal weight to this factor.

- *Department of Vermont Health Access (DVHA)*: Generally, DVHA proposes plan designs for GMCB approval in the individual/small group market. Following the Board's insurance rate decisions, DVHA certifies Qualified Health Plans and prepares the Vermont Health Connect system for open enrollment, required to begin by November 1 under federal law.

Figure 1, below, shows the basic components of commercial insurance premiums. Premium costs are comprised of claims costs and non-claims costs such as administrative expenses, taxes and fees, and contribution to reserves.

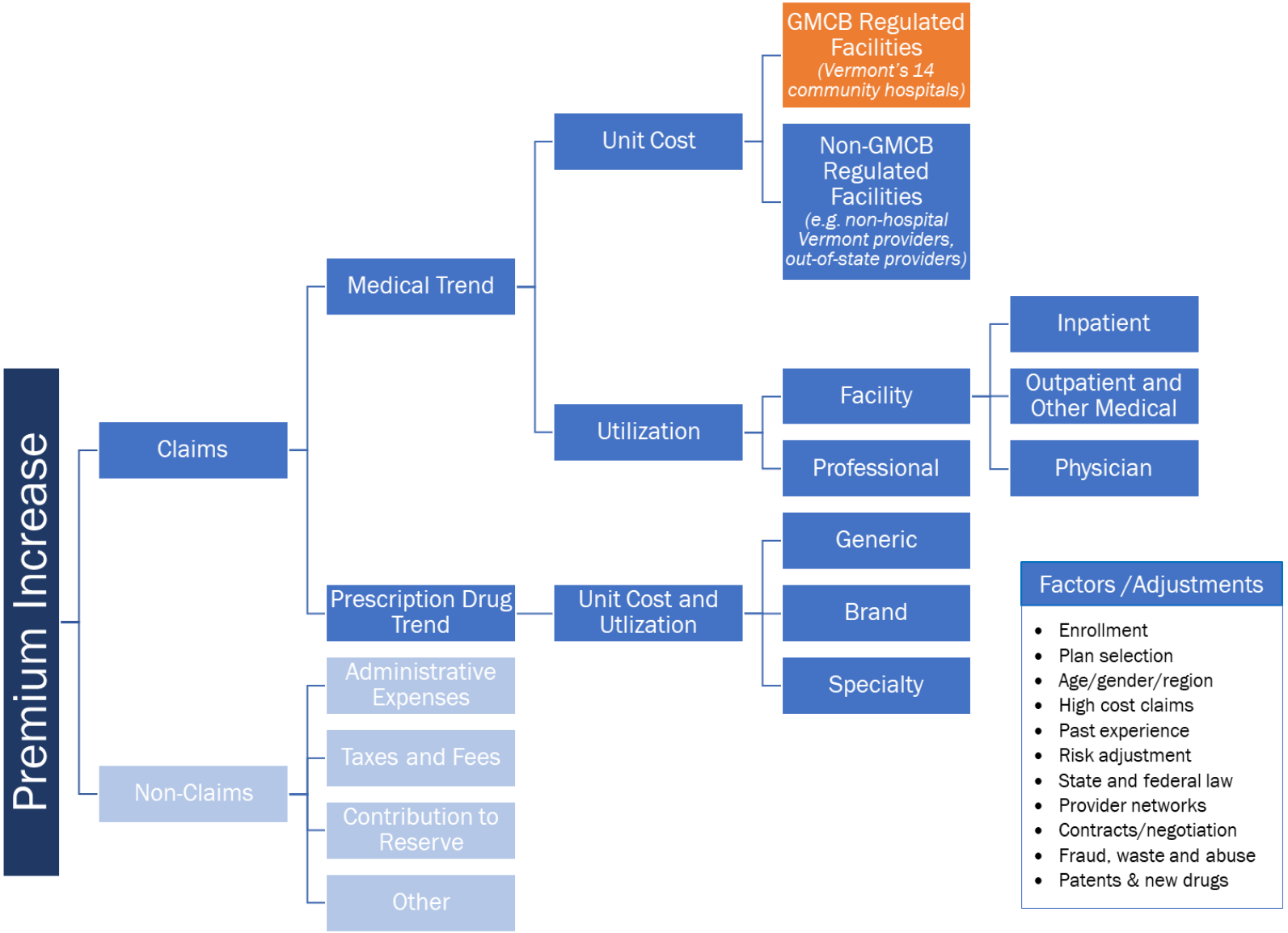
These premium components contribute unequally to premium rate increases; some components contribute to rate increases in a given year, while others may partially mitigate a premium increase.

Highlighted in orange in Figure 1 is the contribution of GMCB-regulated health care facilities – Vermont's 14 community hospitals, regulated through the Board's hospital budget review process. In the 2020 QHPs, changes in price ("Unit Cost" in Figure 1) at GMCB-regulated hospitals contributed $9.49 PMPM to the total approved premium increase of $70.89 PMPM for BCBSVT QHP customers, and $11.50 PMPM to the total approved premium increase of $51.39 PMPM for MVP QHP customers. As shown in Figure 1, unit cost is one part of a much larger component to the premium increase – Medical Trend. For 2020 QHPs, the Medical Trend component was $35.63 PMPM for BCBSVT plans and $23.66 PMPM for MVP plans. In addition to Medical Trend, Prescription Drug Trend also contributes to the ultimate anticipated claims costs; for 2020 QHPs, Prescription Drug Trend contributed $6.79 PMPM for BCBSVT plans and $4.39 PMPM for MVP plans. Lastly, changes in non-claims costs are also reflected in the premium increase. For 2020 QHPs, BCBSVT anticipated an additional non-claims cost of $14.61 PMPM (the total of an increase in taxes of $14.91 and a decrease in other administrative costs of $0.30), plus an additional $6.89 PMPM for contribution to reserves. MVP anticipated additional non-claims costs of $8.26 PMPM, including both administrative costs and contribution to reserves.[11]

Because each year's requested and approved premium increase are based on membership experience and changing circumstances (new taxes, elimination of taxes, etc.), different premium components' contribution to premium changes varies significantly by year and between carriers. The above explanation of 2020 QHPs is to provide context for the process shown in Figure 1.

[11] It is important to note that the examples provided above for the 2020 QHP PMPMs (Medical Trend, Pharmacy Trend and Non-Claims Costs) will not cleanly add to the total PMPMs for 2020 plans (BCBSVT $70.89, MVP $51.39); for ease of explanation, we have not included adjustments that were made to rate components to account for changes in plan design, changes in population, risk adjustment, etc. These adjustments are required to make the overall premium increase actuarially sound but would be more detail than is needed for purposes of this illustration.

Figure 1: Commercial Insurance Premium Components



Certificates of Need (CON)

Relevant Statute/Authority: 18 V.S.A. § 9431-9446; GMCB Rule 4.000.

Overview: Vermont law requires a hospital or health care facility to obtain a Certificate of Need before developing a new health care project as defined in 18 V.S.A. § 9434. In general, this includes expenditures of capital or annual operating expenses over $3M for hospitals and over $1.5M for other health care facilities; purchase or lease of therapeutic or diagnostic equipment or technology over $1.5M for hospitals and over $1M for other facilities; changes in the number of licensed beds; new services with operating expenses over $1M for hospitals and $500,000 for other facilities; any new home health services; health care facility ownership transfers (excluding nursing homes); and construction, development, purchase, or lease of ambulatory surgical centers.

Impact of Transition to New Payment Models

As hospitals move to fixed prospective payments, there will be greater incentives for cost containment through expense management. This could result in a reduced need for capital investment approvals. It would be appropriate to review the statutory criteria at a later date when the payment models are fully mature.

Each project must meet statutory criteria related to access, quality, cost, need, and appropriate allocation of resources, and must avoid unnecessary duplication of services. The general assembly amended CON law in 2018 to streamline the process for certain routine replacements and created a new process for nursing home transfers at the Department of Disabilities, Aging, and Independent Living, eliminating the need for GMCB review of these transfers. The CON process is intended to prevent unnecessary duplication of health care facilities and services, promote cost containment, and help ensure equitable allocation of high-quality services/resources to all Vermonters. Costs from capital projects may be supported through days cash on hand, borrowing, or increases in charges and revenue, depending on the project.

The Office of the Health Care Advocate can participate as an interested party during the CON process.

Scope:

- *Population*: Vermonters and out-of-state consumers using Vermont hospital or health care facility services.
- *Providers*: Vermont hospitals and health care facilities with significant capital projects.
- *Payers*: Medicare, Medicaid, Commercial (in- and out-of-state), self-insured employers (in- and out-of-state), and self-pay/uninsured.
- *Services*: Varies by project.
- *Proportion of Health Care Spending*[12]: The total project cost of CONs reviewed by GMCB varies significantly from year to year. The table below includes total approved CON project cost – cost to complete all approved projects, not the cost to the health care system of providing associated services – for the past three complete years.

Year	Approved Projects	Total Project Cost
2017	10	$47,016,372
2018	7	$217,172,169
2019	6	$17,565,189

[12] See CONs and Statements of Decision for approved projects.

Current Timeline: CONs are reviewed as they are received according to a timeline defined in statute, which provides the GMCB with 90 days for review. When an applicant receives questions from the Board, the 90-day clock is stopped until the answers are received. Applicants may also request an expedited review.

Key Measures and Policy Themes:

- *Financial*: The Board approves the total costs of each CON project and, for hospital projects, assesses impacts on NPR/FPP, costs, and charges. It has been typical for the Board to expect the hospitals to assume the capital costs within its borrowing capacity or days cash on hand unless there is a strong justification for allowing a rate increase. The Board monitors the progress of each CON and receives reports on the approved metrics.
- *Quality*: The Board reviews evidence on efficacy and quality related to CON applications where appropriate, depending on the type of project, and may continue to monitor it for an additional period of time if the CON is approved.
- *Delivery System Roles and Responsibilities*: The GMCB has required participation in delivery system reform (e.g., ACO participation) where relevant to the applicant's requested project.
- *Risk and Reserves*: Under the ACO payment model, hospitals are assuming risk for the care provided to the residents in its community, regardless of where that care takes place. This encourages hospitals to accumulate reserves to cover potential financial risk and may impact hospital willingness to embark on large capital projects, particularly those that do not reduce cost or improve quality.

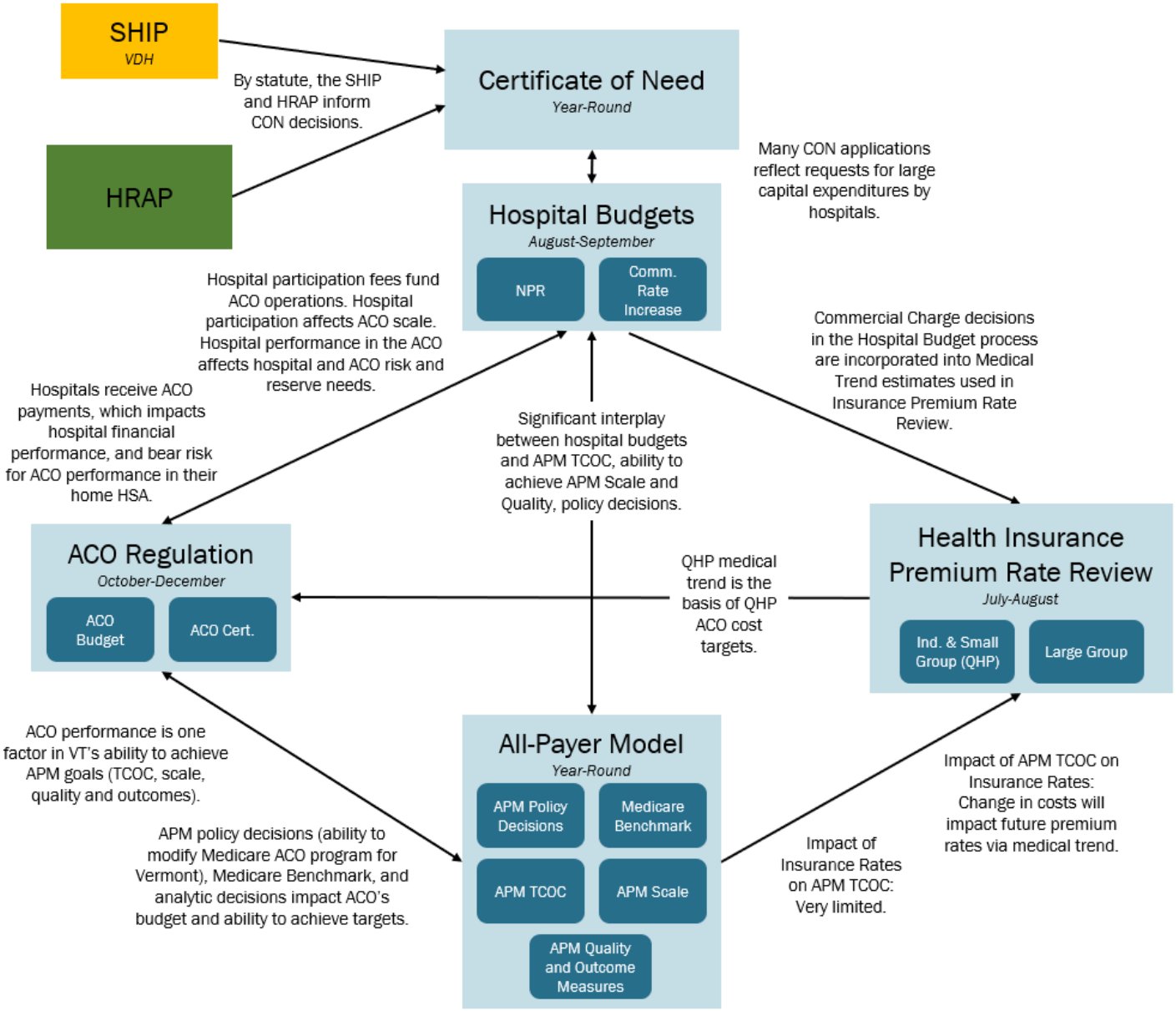
Regulatory Partner Alignment:

- *Agency of Human Services*: The Board occasionally requests information from AHS Departments to confirm assertions made by the applicant or to provide other input. This is done on an ad hoc basis depending on the project; for example, VDH may provide information related to dental care access for a CON that seeks to develop new dental services in a particular area.

Connections Between Regulatory Processes

In order to effectively move towards the goals of the All Payer Model, it is important to understand whether and how the Board's regulatory decisions impact one another and how they impact health care costs and quality more generally. Historically, each regulatory process has been designed for an individual purpose, using the data and timing that makes the most sense for that purpose. This section of the paper briefly focuses on the connections between the major GMCB regulatory processes to better understand how they interrelate and whether they might be better aligned to improve decision-making and enhance our efforts to meet the goals of the All Payer Model.

Figure 2: Current State – GMCB Regulatory Processes



ACO Oversight and APM Regulatory Responsibilities and Performance

There are two clear links between ACO Oversight and the Board's APM regulatory responsibilities and goals: the authority to modify Medicare's ACO programs and set the Medicare ACO benchmark, and the ability to oversee the ACO's performance to attain the APM goals related to quality and cost.

Authority to Modify Medicare ACO Programs:

Under the APM Agreement, the Board has the authority to propose modifications of federal ACO programs for CMMI approval. This authority was granted to improve alignment between payer programs, with the idea that delivery system reform would be more effective and less administratively burdensome if there were common incentives for providers across all major payers.

The APM Agreement grants the Board the authority to change Medicare's national Next Generation ACO Model to create a Vermont-specific Medicare ACO program in Performance Years 2-5 of the APM (2019-2022), known as the Vermont Medicare ACO Initiative. This shapes the contract between the ACO and Medicare. Without this authority, the Board's ACO oversight would be much more limited, because the state would have no influence over the Medicare ACO program which has the greatest spending and therefore the greatest potential impact on TCOC.

In addition, GMCB sets the Vermont Medicare ACO benchmark: the ACO's spending target for its contract with Medicare, against which the total spending on ACO-attributed Medicare beneficiaries is judged. The comparison of the benchmark to actual spending determines shared savings or losses. The Medicare benchmark relies on an estimate of expected annual claims experience, an annual rate of allowable growth, and the number of prospectively aligned beneficiaries. The ACO's estimated benchmarks from each payer are used as the basis for the ACO's budget. Medicare spending is the largest component of the ACO's spending (e.g., 40% of the total 2020 ACO budget).[13] Because of the magnitude of this spending, GMCB authority to set the Medicare benchmark is important; it allows the Board to suggest methodology refinements and provides greater control over the Medicare ACO program than if Vermont was simply participating in a national model. It also allows the Board to have a deeper understanding of the ACO's Medicare spending and ensure that the budget oversight is based on up to date, accurate estimates of the next year's Medicare spending in the ACO program.

The Board's authority to set the Medicare ACO benchmark does not impact the fixed prospective payment (FPP) amount provided by a payer to the ACO and thus to hospitals and primary care providers participating in the ACO's Comprehensive Payment Reform Pilot. The benchmark decision is based on a population-based analysis which uses historical spending data for a population to estimate future costs, while fixed prospective payments are set based on historical revenue data for each participating provider entity to estimate future revenue.

ACO Oversight and APM Performance:

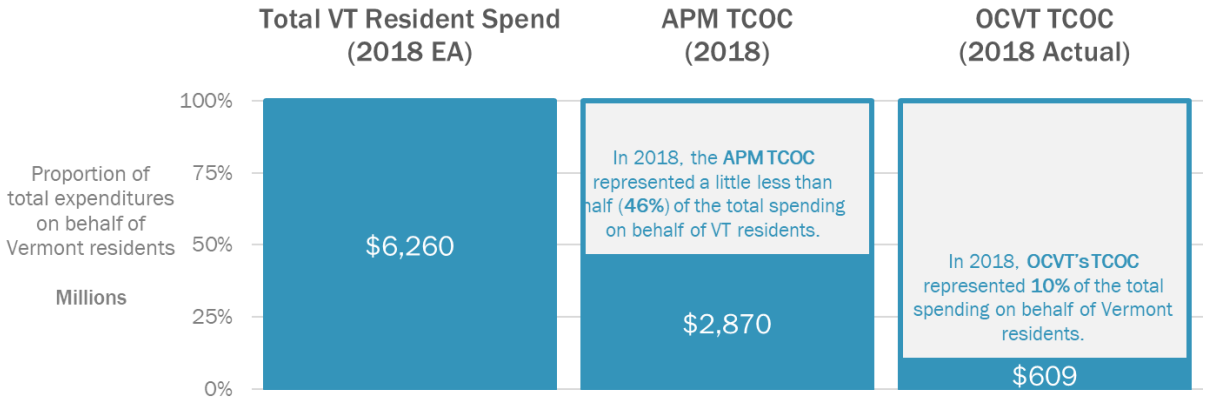
ACO Oversight and the ACO's performance on APM total cost of care, scale, and quality and population health outcomes also shapes Vermont's performance against the statewide targets included in the APM Agreement. For example, if the ACO is successful at containing APM TCOC growth, this will support Vermont in achieving the statewide TCOC goals embedded in the Agreement.

[13] To understand the impact of payer-specific trends on the ACO's budget, see GMCB staff recommendation on 2020 Medicare Benchmark recommendation, pg. 4.

Because the GMCB's ACO budget review process includes oversight of population health programs and the coordinated care model, it is likely to have a bigger impact on quality and population health than the other regulatory process, which are more financially focused. The Board's budget orders include conditions intended to ensure that the proposed ACO investments support the goals of the APM Agreement, while the review process increases transparency and acts as a vehicle for evaluating integration across the continuum of care and between health care and social services. Through this process, the ACO must demonstrate progress to date, provide details of how it measures the return on investment in the short- and long-term, and justification for the continuation, scaling up, or sunsetting of population health investment programs.

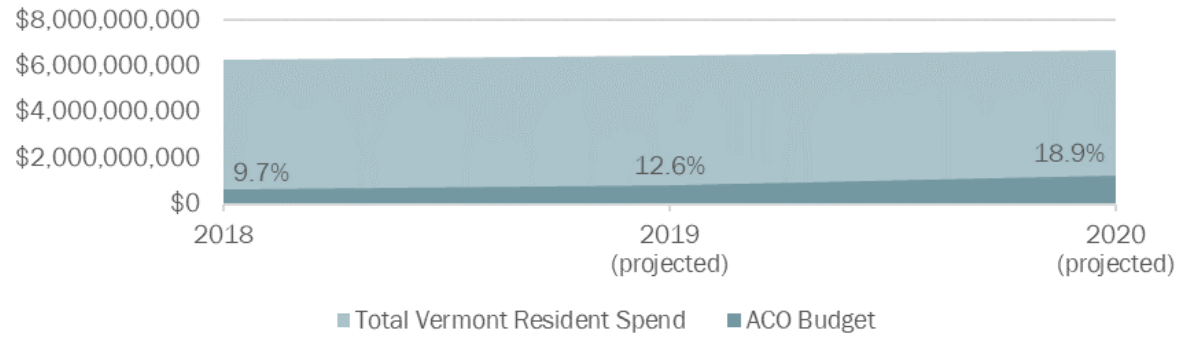
It is important to note that the impact of the ACO Oversight process on APM spending and quality of care targets also depends on the scale of the ACO program. Increasing scale means that the proportion of the APM TCOC population that is attributed to the ACO is growing, and thus the impact of the ACO oversight process on the APM TCOC population grows in parallel. Significant scale is also a necessary condition for achieving the population health goals set forth in the agreement. Until greater scale is achieved, ACO Oversight and APM TCOC populations and providers are not comparable, because the APM TCOC includes significantly more people and thus more spending ($2.87B in 2018 APM TCOC vs. $609M in OneCare's 2018 spending).

Figure 3: Total Vermont Health Care Expenditures, APM TCOC, and OneCare Vermont TCOC



ACO spending for 2019 and 2020 will include a larger share of APM TCOC and total Vermont resident health care expenditures due to ACO program growth.

Figure 4: ACO Budget as Percent of Total Vermont Resident Health Care Expenditures[14]



[14] 2018 Vermont Expenditure Analysis (2018, pg. 9, projected 2019 and 2020, pg. 37).

Hospital Budget Review and ACO Oversight

The ACO's budget and the budgets of ACO-participating hospitals are interdependent.

- ACO-participating hospitals pay participation fees to the ACO.
- ACO-participating hospitals select whether to participate in each of the ACO's payer programs, and in doing so, become risk-bearing entities; ACO performance and potential for risk- or gain-sharing in ACO payer contracts has the potential to significantly impact hospital spending and financial health, either positively if savings are achieved or negatively if costs exceed targets. Hospitals are accountable for ACO performance in each hospital's home HSA.
- In the Medicare and Medicaid ACO programs, ACO-participating hospitals receive fixed prospective payments from the ACO in exchange for providing care to their attributed population; this gives providers greater revenue predictability throughout the year.[15] Alternately, ACO-participating hospitals can choose to continue to receive fee-for-service reimbursement while still being accountable for total spending under ACO-payer contracts.[16] Participating hospitals may also receive other reform payments to support infrastructure and care coordination, among other initiatives. In its annual budget submission, the ACO details each hospital's share of participation fees, their expected fixed perspective payment, and other reform payments, each hospital's Maximum Risk Limit (total cost of care risk level), and any risk protection provided by the ACO for a specific hospital. The Board uses this information in both the ACO budget process as well as the hospital budget process. The Board also incorporates each hospital's projected revenue from fixed prospective payments (FPP), as well as projected FFS revenue, in NPR decisions in the hospital budget review process, and considers each hospital's risk and potential for gain-sharing by ACO payer program, taking into account FFS spending both within and outside of the hospital's home HSA. While the Board's Medicare ACO benchmark decision shapes the ACO's budget for its Medicare population, it does not impact the calculation of hospitals' Medicare FPP revenue (see text box on pg. 19). These and other factors impact hospitals' balance sheets and net patient revenue growth. Currently, hospitals use varied methods to record per-member payments from ACOs and ACO membership fees, as recommended by their individual auditors, which limits comparability across the system.

Timing is a challenge to alignment between hospital and ACO budget oversight. At any given point in time, hospitals are finalizing their prior year financials and ACO performance, operating within the current budget year, and planning their next budget year, including making decisions about future ACO participation; this is in part due to differing fiscal and performance years, with hospitals' fiscal year beginning October 1 and the ACO performance year beginning January 1 . This means hospitals are balancing prior year projected performance (including, if participating in the ACO, Medicare performance reconciliation and its potential impacts on current year financial performance), projections for current year performance, and budget planning for the upcoming program year. Hospital budget decisions rely on a preliminary ACO provider list but the list and attribution for the upcoming year are not available until after the statutory deadline for budget decisions. In addition,

[15] In the 2020 Medicare ACO program, fixed payments are currently reconciled at year-end against the FFS equivalent; total spending is also compared to the Medicare ACO benchmark at year-end to calculate risk- and gain-sharing amounts. In the 2020 Vermont Medicaid Next Generation ACO program, providers can elect to receive a fixed payment that includes risk, which is not reconciled to FFS equivalent spending; total spending is also compared to the VMNG ACO benchmark at year-end to calculate risk- and gain-sharing amounts. BCBSVT is piloting fixed prospective payments with one participating hospital in 2020.

[16] For example, Dartmouth-Hitchcock Medical Center in Lebanon, NH, participates in the VMNG program but has continued to receive FFS payments from Medicaid.

hospitals do not have accurate estimates of FPP for the following budget year at the time the Board decides their budgets because ACO-payer contracts are still in flux.

The ACO is also simultaneously finalizing prior year performance, operating within the current performance year, and designing and recruiting for not-yet-finalized contracts in the upcoming year.

As more hospitals and payers participate in the ACO and scale grows, the proportion of hospitals' budgets built on fixed prospective payments will grow as the proportion of fee-for-service payments decreases; this will tie hospital budgets more closely to the ACO budget. However, some portion of hospital revenue will likely always remain fee-for-service as hospitals will continue to perform services outside the scope of fixed payments and provide care to patients who cannot be attributed to the ACO (e.g., out-of-state patients); this will need to be reconciled with actual spending against ACO estimates.

In addition, the Board is considering how to account for risk taken by the ACO, and how that risk is transferred to and mitigated by hospitals, combined with the risk taken by the commercial payers (in collaboration with DFR) to provide protection for the system without maintaining too much in reserves.

Insurance Premium Rate Review and ACO Oversight

Insurance premium rate review has a direct impact on the ACO budget, because the QHP ACO program trend (with risk adjustment) is currently directly tied to the medical trend approved in the premium rate review process. Though the connection between commercial QHP ACO programs and insurance premium rate review is direct, the magnitude is limited by the size of the QHP market; the QHP ACO programs represent approximately 36,000 lives, or 14% of the anticipated 2020 ACO attributed population.[17] If the QHP population grows and more large group insured plans are added to ACO attribution, the connection between the two regulatory processes will become stronger.

CON and Hospital Budget Review

Certificates of Need (CONs) are required for hospital capital expenditures that meet statutorily defined criteria.[18] The Board's decisions to grant or deny CON applications can have a significant impact on individual hospitals' budgets, both in the moment and over time as capital plans and expenditures are accounted for in the budget process. Likewise, funding availability in each hospital's budget shapes the decision to propose capital expenditures which require a CON.

To understand this interaction, the Board reviews the impact of current and planned capital expenditures on the financial health of each hospital during its annual budget review process. This not only provides advanced notice of future certificate of need applications but also another opportunity to review the progress and financial impact of already approved CON projects. In addition, the Board generally includes a condition in certificate of need orders requiring the hospital to pay for the project without relying on net patient revenue or commercial rate increases, which are reviewed in the hospital budget process.

[17] See GMCB staff preliminary recommendation, FY2020 ACO Oversight, pg. 53.
[18] 18 V.S.A. § 9434

Insurance Premium Rate Review and Hospital Budget Review

Differences in population, services, and methodology prevent direct comparison of hospital budgets and insurance premium rate review.

Impact of insurance premium rate review on hospital budgets:

Most Vermonters are covered by Medicaid, Medicare, and self-insured plans; only a small proportion of Vermonters are covered by GMCB-regulated plans in the QHP and large group markets (see sidebar). Thus, while premium rate review provides important oversight for consumers in the large group and QHP insured markets, the impact of premium rate review on hospital budgets is limited.

Only 15% of Vermonters (under 95,000 in 2018) are covered by the QHP and large group insured markets. Overall spending by those subscribers comprises only 9% of total Vermont hospital spending. Because of this, insurance premium rate review decisions do not significantly impact hospital budgets.

Impact of hospital budgets on rate review:

Spending by providers regulated through the hospital budget process impacts about half of medical trend in the insurance premium rate review process.[19] Spending outside of the hospital budget process, however, will also have a significant impact on costs (see Figure 1, pg. 15), as it incorporates spending by independent practices, clinics, FQHCs, urgent care centers, and non-regulated hospitals both in- and out-of-state. In the 2020 QHP plans, increases in price ("Unit Cost" in Figure 1) at GMCB-regulated hospitals contributed $9.49 PMPM to the total approved rate increase of $70.89 PMPM for BCBSVT QHP customers, and $11.50 PMPM to the total approved rate increase of $51.39 PMPM for MVP QHP customers.

Spending by providers regulated through the hospital budget process impacts about half of medical trend in the insurance premium rate review process.

Because the Board reviews individual and small group (QHP) premium rate review filings in July for August approval and hospital budgets in August for September approval, the insurers and the Board's actuary work to provide information about the hospitals' submitted (but not approved) charge requests and the impact to the medical trend component of the premium rate. The Board's actuary annually reviews the charge decisions in the prior year's hospital budget decisions, mid-year charge adjustments and enforcement decisions as well as current year hospital budget submissions to validate insurer-submitted price trends. Negotiated hospital prices, taking into account GMCB-allowed charge increases, are embedded in future years' base spending as actual claims cost.

Hospital Budget Review and APM Regulatory Responsibilities and Performance

Regulated hospital spending is about 42% of all Vermont health care spending.[20] Thus hospital spending, and hence net patient revenue growth caps and commercial rate increase limits set by the Board during the hospital budget process, have potential to impact performance against APM targets. Because of this, the hospital budget review process has the potential to have a significant impact on the APM targets as well as premiums paid by Vermonters, both in the insured market and for self-insured employers and employees. In addition, the Board has begun incorporating nonfinancial reporting into the hospital budget process by asking the hospitals to comment on their HSA's performance on the APM quality framework measures. The Board also collects information on

[19] Exact percentage varies by carrier depending on their network and population.
[20] See 2018 Vermont Expenditure Analysis (Vermont provider spend, pg. 30).

how each hospital's community health needs assessment aligns with hospital investments in their communities.

Insurance Premium Rate Review and APM Regulatory Responsibilities and Performance

In 2018, the Board commissioned a study on the impact of premium rate review decisions on the All-Payer Total Cost of Care (TCOC).[21] This study, conducted by Berry Dunn in collaboration with Board staff, determined that, while insurance rate reductions result in premium reductions for Vermonters in the QHP and large group insured markets, the overall impact on TCOC growth is limited because as of 2018, 85% of the covered lives and health care spending lies in the Medicaid, Medicare, and the self-insured employer markets.[22] The study modeled the impact of keeping the medical trend for the regulated insured markets to the All-Payer Model target of 3.5% and determined this had a .04% impact on TCOC growth.

CON and Insurance Premium Rate Review, ACO Oversight, APM Regulatory Responsibilities

CON bares little connection to GMCB regulatory processes outside of hospital budgets. Since the majority of CONs are issued to hospitals for capital improvements, additional regulatory connections do not warrant further study.

Conclusion

After reviewing the regulatory processes and their connections, the Board has identified several areas of further exploration to enhance alignment between processes and further the achievement of the APM goals. The second and third papers in this series will consider possible changes to the GMCB regulatory timeline to improve alignment, and will review four key areas for policy alignment: (1) financial measures, (2) quality measurement, (3) delivery system roles and responsibilities, and (4) risk and reserves.

[21] See Issue Brief: Impact of Rate Review on APM TCOC (December 2018).
[22] See 2018 Vermont Expenditure Analysis (Health Insurance Coverage Profile, Vermont Residents, pg. 43).