GMCB Regulatory Alignment White Paper

PART 2: OPTIONS FOR REGULATORY TIMELINE AND LOGISTICS

July 2021

Final White Paper

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

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Introduction: Part 2, Options for GMCB Regulatory Timeline and Logistics

The Green Mountain Care 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 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). The first paper lays out each of the regulatory processes in its current state. This second paper considers possible changes to the GMCB regulatory timeline to improve alignment. A forthcoming third and final paper proposes recommendations for policy alignment.

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, Board members and staff surveyed and solicited comments from 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. A discussion draft of this paper was released in July 2020 for public comment. This final version incorporates those comments, available on the GMCB website.

GMCB Regulatory Timeline and Logistics

Part 2 of this white paper series describes the Board's current annual regulatory timeline, timeline constraints, and options for change.

A Note on the Impact of COVID-19

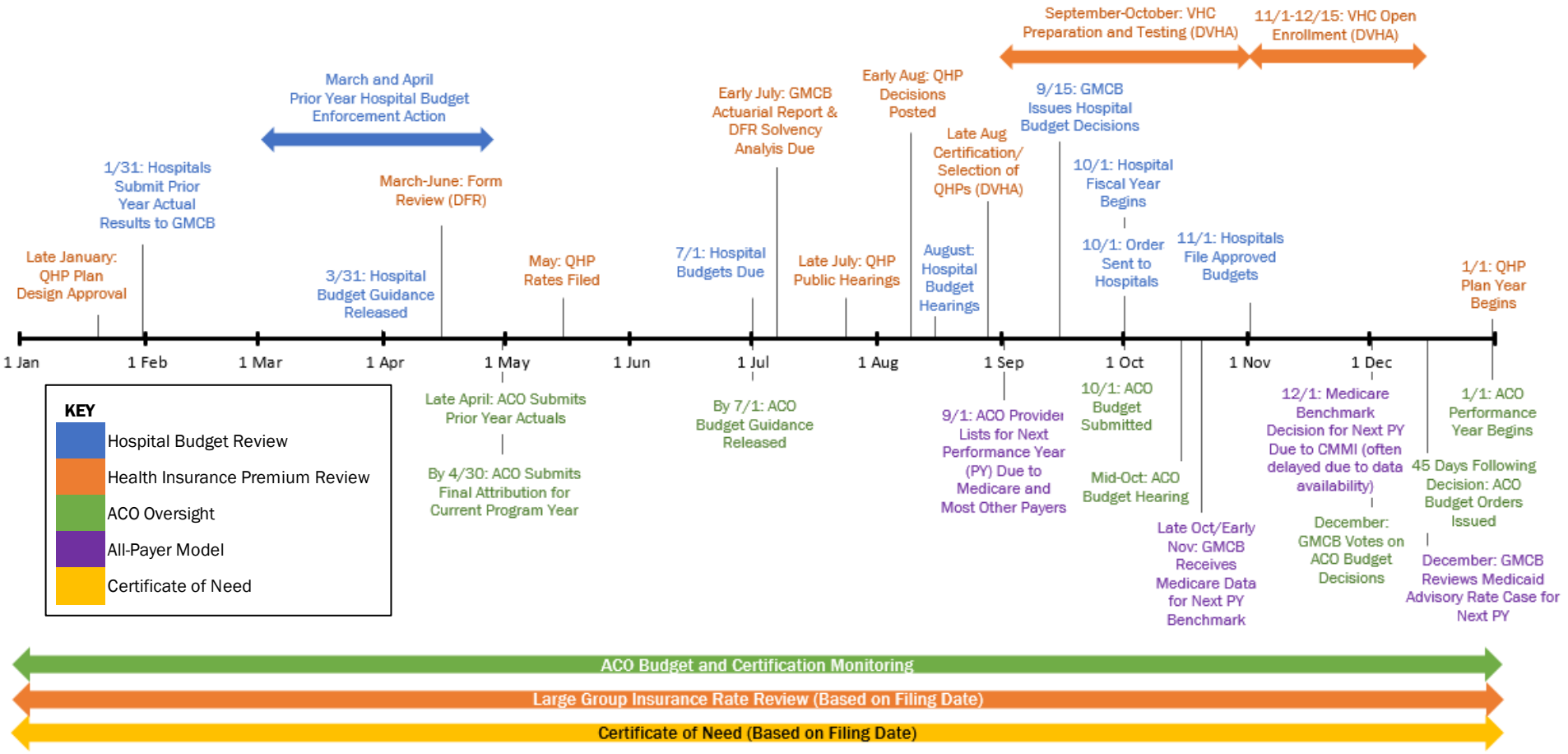
The COVID-19 pandemic and public health emergency has had enormous impacts on Vermonters and Vermont's health care system. Act 91 of 2020 has offered the GMCB and GMCB-regulated entities temporary flexibility in response to the pandemic. The Board's response has included:

- 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; and
- Transitioning all public meetings and hearings to remote meetings.

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.

Current State

Figure 1: GMCB Regulatory Timeline, Current State



Why Change the GMCB Regulatory Timeline?

GMCB's major regulatory processes are timed based on the independent needs and constraints of each individual process. Currently, GMCB-regulated entities (hospitals, insurers, the ACO) use different fiscal years, plan years, and performance years.

- Hospital budgets are set in September, prior to the start of hospitals' fiscal year (October 1-September 30, as specified in Vermont law).
- Health insurance premium rate decisions for Vermont's merged individual and small group market are issued in August for the coming plan year (January 1-December 31, as required by federal law).
- ACO budgets and the APM Medicare benchmark are set in December for the coming performance year (generally January 1-December 31) and finalized in spring when commercial contracts and attribution are known.

GMCB has long recognized that these regulatory processes do not exist in a vacuum; they inform one another, and these interactions will only increase as the All-Payer Model (APM) continues to drive Vermont's health care system from fee-for-service (FFS) payment to value-based models.

One way to improve process alignment may be to adjust the Board's regulatory timeline. GMCB's current regulatory timeline creates two key challenges to holistic, system-wide regulation:

- Timing of hospital budget review and small group and individual market health insurance premium rate review: Ideally, the GMCB would work with hospitals during the budget process to set appropriate and justifiable caps on commercial charge increases. Assuming that carriers negotiate with each hospital to set actual reimbursement rates, knowledge of these caps would provide an upper limit on unit cost increases for regulated hospitals and better inform health insurance premium filings for the upcoming year. In the current system, the process is reversed: the GMCB issues small group and individual market health insurance premium decisions in July/August, prior to its review of hospital commercial rate requests during the hospital budget process in August/September. The insurers and the Board's actuary try to estimate the impact of the hospitals' submitted (but not approved) charge requests to the medical trend component of the premium rate.
- Timing of hospital budget review and ACO budget review: Hospitals would ideally develop budgets that reflect their plans for ACO participation in the coming fiscal year with the most up-to-date information on the associated costs, benefits, and risks. Tighter alignment of hospitals' budget years with the ACO performance cycle would increase the accuracy of hospital budgets and strengthen the connection between the hospital and ACO budget processes. Currently, hospitals' October-September fiscal year and summer budget approval cycle do not coincide with the January-December ACO fiscal year and ACO-payer contracts, or the late fall ACO budget approval cycle, and ACO program and incentive details are not finalized until payer contracts are executed late in the calendar year (or, in some cases, early during the performance year).

Timeline Constraints

Despite the challenges caused by GMCB's current regulatory timeline, potential changes are limited by Vermont law and regulation; federal law and regulation; interaction with non-GMCB regulatory partners, particularly other State of Vermont agencies and departments; and data availability and comparability.

Figure 2: Regulatory Timeline Constraints

Regulatory Process	Regulatory Timeline Constraints	Relevant Statute
All-Payer Model Regulatory Responsibilities	*Medicare Benchmark*: The All-Payer ACO Model Agreement (APM Agreement) requires GMCB to submit to CMS for approval the benchmark (financial target) for the coming Medicare ACO program year by December 1 annually. Medicare data availability, driven by the final Medicare ACO provider list (available September 1), has proven a practical constraint in completing this responsibility on time; however, delays in benchmark approval also delay the finalized ACO budgets as the ACO's final budget must reflect the Medicare trend and Medicare attributed lives. Following receipt of Medicare data, GMCB staff and contractors must analyze the data to come to a growth trend and benchmark recommendation for Medicare.	APM Agreement; 18 V.S.A. § 9382(b)(1)(N) [impact of Medicaid rates on other payers]
	Medicaid Advisory Rate Case: GMCB is required to review any all-inclusive population-based payment arrangement between DVHA and an ACO; GMCB receives data from DVHA in mid-December for actuarial review. GMCB is required to complete its review prior to December 31 and finalization of the Medicaid ACO contract. GMCB is also required to consider the impact of Medicaid's ACO payment rates on other payer programs, including the Medicare benchmark decision.	18 V.S.A. § 9382(b)(1)(N), § 9573
ACO Oversight	The timeline for ACO oversight is defined by regulation in GMCB Rule 5.000; however, this timeline is dictated largely by data availability. The ACO finalizes its provider network (provider list) – a critical factor in developing its total budget – for Medicare and most other payers on September 1 for the coming January-December contract year. The ACO budget year begins on January 1, in alignment with Medicare ACO programs; however, the ACO budget is not finalized until after the start of the performance year when final patient attribution counts are available.[1] As the ACO approaches full scale, population volatility will decrease and early attribution and budget estimates will likely improve; however, attrition due to churn between coverage, relocation, death, and other causes mean that attribution and hence the ACO's budget will continue to be finalized in January-March for all payer programs.	18 V.S.A. § 9382
Hospital Budget Review	Vermont law requires that all hospitals begin their fiscal year on October 1. This aligns with federal Medicare reporting requirements for many hospital types, which are based on an October 1-September 30 fiscal year.	18 V.S.A. § 9454
Insurance Premium (Rate) Review[2]	*Individual and Small Group Plans (Qualified Health Plans [QHPs] and reflective plans sold off-exchange)*[3]: Individual and small group plan premiums are reviewed annually by GMCB; this review is in addition to regulatory action by DVHA and DFR. GMCB's review occurs between May, when rates for the coming plan year are filed, and August, when the Board issues its decisions. This timeline is	8 V.S.A. § 4062; 45 CFR § 155.410(e)(3); 45 CFR § 154

[1] This occurs early in the performance year for Medicare and Medicaid programs, and in early spring for QHP/reflective plan commercial ACO programs. Federal law allows for a grace period for qualified health plan premium payment, which means the enrolled population and hence the ACO-attributed population is not finalized until February. Note that the attributed population for each payer's ACO program fluctuates (generally downward) throughout the performance year; this is taken into account at settlement following the end of the performance year.

[2] Act 25 of 2021 unmerges the individual and small group markets for the 2022 plan year.

[3] For a full QHP process timeline, see 2021 Qualified Health Plan Certification Timeline.

	constrained by Vermont law, which requires GMCB to issue decisions within 90 days of filing; federal law; and the needs of other Vermont agencies: ○ *Prior to GMCB rate decisions*: Work to determine the QHP plan design and cost sharing, including stakeholder input and GMCB decision, occurs annually in November-February. This is a prerequisite for carrier form development and DFR form review. DFR completes form review for each health plan annually from March-June. Form review is extensive and cannot be shortened without reducing DFR's regulatory scrutiny. ○ *Following GMCB rate decisions*: DVHA inputs plan information into its enrollment system, and there is a comprehensive testing period for both DVHA and insurers offering QHPs prior to the start of open enrollment. The federal Center for Consumer Information & Insurance Oversight (CCIIO) requires state-based health insurance exchanges to begin open enrollment no later than November 1 for a plan year starting January 1. Federal law is the largest constraint to changing the timing of this process: ○ Federal law requires plans sold in the merged individual and small group market to be on a calendar year. ○ Rates and forms cannot be finalized by insurers and filed with DFR/GMCB until after the federal government (both CMS and IRS) issues its annual guidance, which has been shifting later into the spring. This allows QHPs to incorporate the full set of federal regulatory changes. ○ Federal law requires an open enrollment period beginning on November 1. A Vermont stakeholder group convened in 2017 with the goal of condensing the QHP premium rate review timeline and concluded that it was not possible to shorten this process without reducing regulatory responsibilities and oversight.	
	<u>*Large Group Plans*</u>: GMCB reviews and approves the formulas and factors used by major medical health insurers to develop large group premium rates on a rolling basis. Currently, this process occurs relatively independently of other GMCB regulatory processes.	8 V.S.A. § 4062
Certificate of Need	Certificate of need applications are reviewed and decided on a rolling basis; GMCB is required to issue a final decision within 120 days of notifying an applicant that its application is complete, which generally occurs within 90 days of receipt of the application (excluding time spent by the applicant responding to requests for information); extensions are taken when necessary.	18 V.S.A. § 9440(c)

Recommendations: Regulatory Timeline and Logistics

Option 1: Consider Changes to Hospital Budget Process to Improve Alignment, Data Availability, and Enforcement Ability[4,5]

A portion of GMCB's regulatory timeline misalignment could be solved by modifying the hospital fiscal year to allow for greater data alignment with the ACO program year and/or with the individual and small group market premium year. We describe pros and cons of two timeline options below, noting that either would likely cause significant disruption to hospital operations and financial reporting. Either option would require significant vetting with stakeholders prior to serious consideration by the Board; the Board and stakeholders would need to assess whether improved information flow is worthwhile given the operational challenges that would arise from a change in hospital fiscal year.

Option 1A: Align ACO Budgets and Hospital Budgets; Move Hospital Fiscal Year to January 1

As described in Part 1, 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 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 (including risk) for the upcoming program year. Hospital budget decisions rely on a preliminary ACO provider list but the final list and attribution for the upcoming year are not available until September (provider list) and later in the fall (preliminary attribution based on provider list), after the Board's hospital budget decisions are due. In addition, hospitals do not have accurate estimates of fixed prospective payment (FPP) revenue for the following budget year at the time the Board decides their budgets because ACO-payer contracts are still in flux; this causes significant uncertainly in hospitals' budget development.

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 the ACO approaches full scale, population volatility will decrease and early attribution and budget estimates will likely improve; however, attrition due to churn between coverage, relocation, death, and other causes mean that attribution and hence the ACO's budget will continue to be finalized in January-March for all payer programs.

[4] In a letter submitted on October 30, 2020, the Vermont Association of Hospitals and Health Systems (VAHHS) indicated that it does not support this change, commenting: "Asking hospitals to shift to a different fiscal year during COVID-19, when there is so much financial uncertainty and administrative staff are already stretched thin, would be impossible. Furthermore, the advantages of changing the hospital fiscal year are limited, especially when coming at the end of this iteration of the All-Payer Model agreement. Continuing current regulatory processes and allowing for data to be collected consistently year over year should create greater predictability and achieve the goals of regulatory alignment with far less disruption. Changing the process now would create a shift in current data and cause disruption instead of alignment."

[5] In a letter submitted on October 30, 2020, the Office of the Health Care Advocate indicated that it does support this proposal: "…[W]e do not think it is sustainable for the Board to set health insurance rates in isolation from hospital budget review. The HCA therefore supports the Board staff recommendation to shift the hospital budgets to the calendar year to align with the ACO year and QHP year, only under the condition that the Board must also use its rate setting authority to set affordable hospital commercial reimbursement rates for QHPs." See pg. 15 for more information on the suggestion of setting hospital commercial charges for individual and small group market plans.

The ACO budget, filed on October 1 annually, includes estimates of the total cost of care benchmark by payer, FPP by hospital for Medicaid and Medicare, and each hospital's risk by payer program; these estimates, based on preliminary Medicare attribution data, lack accuracy due to data availability limitations caused by significant population changes between ACO program years. Better estimates are available later in the ACO budget review period (or early in the ACO performance year for the commercial ACO QHP/reflective plan population) following preliminary attribution modeling. GMCB could also alleviate some of this challenge by providing additional modeling data to the ACO regarding the entire Vermont population represented in data available to the GMCB.

In addition, the Board receives data from Medicare in late November or early December, which is used to calculate the Medicare benchmark and set a Medicare ACO program trend. The Board's decision on the Medicare trend and the analysis on the benchmark (both completed in mid-December) form the basis upon which Medicare program risk is calculated and eventually paid out to the hospitals; the Board is also required to consider the impact of Medicaid's ACO payment rates on other payer programs, including in its Medicare ACO program trend decision.[6]

Ideally, the Board would have decided the Medicare benchmark and have accurate risk levels and FPP information prior to deciding hospital budgets in order to have a predictable and accurate projection of the non-FFS components of the hospitals' net patient revenue. If the state were to achieve ACO scale, FPP would be a significant component of the hospitals' budgets, which could allow for a more nuanced analysis of the appropriate price and utilization increases.

One option to improve information flow around Medicare risk levels and FPP – and with it, the accuracy of hospital budgets and the ACO budget – is moving the hospital fiscal year later to improve data availability. Moving the hospital fiscal year to *January 1* may require an earlier provider commitment to participate in the ACO in order to have the information completed in time to make hospital budget decisions by December 15.

Shift Hospital Fiscal Year to January 1: Pros	**Shift Hospital Fiscal Year to January 1: Cons and Barriers**
• Hospitals have more certainty in the ACO-related portion of their budgets and more certainty about the ACO program • May allow risk levels and FPP amounts for Medicare and Medicaid to be known earlier and incorporated into the hospital budget process and decisions	• Hospitals would still need to submit budgets three months prior to the start of the fiscal year; this would require an October 1 submission date, based on data through August 1, and would require updating to include information based on the ACO provider list • Hospitals' following year submitted commercial rates would not be available for health insurance premium rate review process • Budget decisions would need to occur early enough to allow hospitals to negotiate contracts with commercial payers • Requires statutory change in hospital fiscal year • Operationally challenging and administratively burdensome for hospitals, especially during the transition; would require hospitals to develop either a long (12+ month) budget or a short "bridge" budget to make this change • Simultaneous ACO & hospital budget process would be challenging for the GMCB

Alternately, GMCB could review/decide the Medicare and Medicaid trends earlier, but the feasibility of this option is limited by data availability; it would require an earlier provider commitment deadline

[6] The Board typically receives the Medicaid rate case in December. The Medicaid rate case provides the Board with actuarial information used by DVHA in negotiating the Medicaid ACO benchmark and Medicaid FPP to hospitals. The rate case does not currently include FPP information.

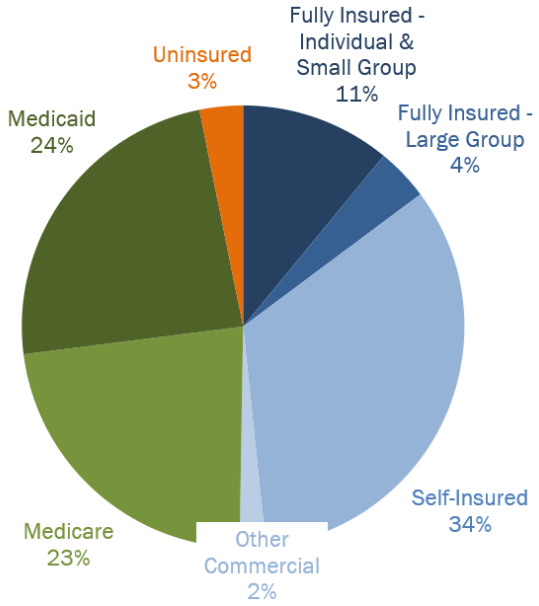
(currently September 1) because the ACO program risk levels and FPP amounts are based on the attribution and historical claims experience of participating providers' patients.

Note: This option does not improve alignment with qualified health plan premium review, and may impede alignment between this process and hospital budget review as the Board will not have hospitals' change in charge requests prior to deciding qualified health plan premium rates.

*Option 1B: Shift Hospital Fiscal Year to **July 1** to Improve Data Availability in Hospital Budget, Individual/Small Group Premium Rate Review, and ACO Oversight Processes*[7]

To improve information flow between hospital budgets, individual and small group premium rate review, and the ACO process, a July 1 hospital fiscal year might be considered. This would allow the hospital budgets to be known prior to insurance premium rate review decisions in August. With a July 1 hospital fiscal year, 6 months of hospital revenue projections could be incorporated into the individual and small group plan filings.

Figure 3: Vermont Health Insurance Enrollment



Moving the hospital fiscal year is more feasible than adjusting the individual and small group premium rate review timeline. As noted earlier, moving premium review for individual and small group insurance plans is very difficult due to the federal constraints and the roles of other state agencies in the individual and small group premium rate review process. In the best-case scenario, GMCB may be able to move its portion of the individual and small group premium rate review process by a week earlier or later, neither of which improves alignment in a significant way.

It is important to understand that the impact of moving the hospital fiscal year to better align the hospital budget process with the individual and small group health insurance premium rate review process may also be minimal. Since 2013, Vermont has seen a movement from the insured market to other forms of coverage, including self-insured plans and government coverage, as demonstrated in Figure 4, next page. As a result, in 2019 (most recent data available) the GMCB's premium rate review process impacted only 29% of the commercially insured market in 2019 (compared to 43% in 2013), and 15% of the total Vermont population (compared to 24% in 2013). Only about 68,000 people are insured by individual and small group plans (11% of the VT population and 22% of the privately insured population; see Figure 3, above),[8] so, as noted in the first white paper, this market has a small impact on APM TCOC and on hospital budgets. Furthermore, the impact of the

[7] In a letter submitted on October 30, 2020, the Office of the Health Care Advocate indicated that it does not support this proposal: "Due to the vulnerability of Vermonters and small businesses on QHPs, we have concerns about any plan that would move the Board's hospital budget review prior to the QHP rate review process. If the hospital budget review process took place before the QHP rate review process, the Board would set hospital commercial rates without knowing their impact on Vermonters with QHPs." GMCB notes that while hospital budget and health insurance premium rate review utilization trends should be directionally consistent, they will not match because they consider different populations, different providers, and different services. In addition, the QHP population is general sicker and higher risk than the general Vermont population.
[8] See 2019 Vermont Expenditure Analysis (Health Insurance Coverage Profile, Vermont Residents, pg. 46).

uncertainty created by the misalignment may be relatively small in terms of carriers' overall rate requests. For example, the FY2020 budgets submitted by hospitals, if approved by the Board as filed, would have increased the 2020 premium rates filed by the carriers by approximately 0.5%.[9]

Figure 4: Vermont Health Insurance Enrollment, 2013-2019

	2013		2019		Change, 2013-2019
	Members	% Total	Members	% Total	
Total Insured Market (GMCB regulated)	**151,752**	**24%**	**92,321**	*15%*	**▼ 39.2%**
Individual & Small Group	*35,509*	*6%*	*68,390*	*11%*	*▲ 92.6%*
Large Group	*116,243*	*19%*	*23,931*	*4%*	*▼ 79.4%*
Total Self-Insured Market	**157,047**	**25%**	**209,347**	*34%*	**▲ 33.3%**
Total Other[10]	**41,191**	**7%**	**11,937**	*2%*	**▼ 71.0%**
TOTAL COMMERCIAL MARKET	**349,990**	**56%**	**313,605**	*50%*	**▼ 10.4%**
Medicaid	**127,342**	**20%**	**148,689**	**24%**	**▲ 16.8%**
Medicare	**111,954**	**18%**	**141,895**	**23%**	**▲ 26.7%**
TOTAL GOVERNMENT COVERAGE	**239,396**	**38%**	**290,584**	**47%**	**▲ 21.4%**
TOTAL UNINSURED	**37,344**	**6%**	**19,800**	**3%**	**▼ 47.0%**
TOTAL VERMONT POPULATION	**626,630**		**623,989**		**▼ 0.1%**

Despite limited alignment improvements between the hospital budget and individual and small group premium rate review process, a July 1 hospital fiscal year could improve data availability between the hospital budget and ACO oversight process for half the year. Moving the hospital fiscal year to July 1 would allow for the hospital budgets to reflect actual ACO attribution and FPP for the remaining six months of the calendar year (July-December). This would require an earlier estimate of the ACO budget for the second half of the new hospital fiscal year (January-June); however, hospitals could likely use prior year budget data to estimate this, since Medicare FPP is reconciled to FFS spend.

Shift Hospital Fiscal Year to July 1: Pros	Shift Hospital Fiscal Year to July 1: Cons and Barriers
• Hospital budgets could reflect 6 months of final ACO FPP, known in February/March based on final attribution • Data from two quarters of approved hospital budgets could be incorporated into individual and small group premium rate review filings	• Requires statutory change in hospital fiscal year • Operationally challenging and administratively burdensome for hospitals, especially during the transition; would require hospitals to develop either a long (12+ month) budget or a short "bridge" budget to make this change • Final ACO attribution would not be known in advance of budget decision for the following calendar year • Board may not be able to fully review individual and small group premium rate review filings before voting on hospital change in charge

[9] See Blue Cross and Blue Shield of Vermont 2020 Individual and Small Group Rate Filing Decision (August 8, 2019), Findings, ¶33; MVP Health Plan Inc. 2020 Individual and Small Group Rate Filing Decision (August 8, 2019), Findings, ¶52.
[10] Includes Catamount Health (prior to the end of that program in 2014) and Vermonters covered by insurers domiciled outside of Vermont.

Option 2: Consider Using Statewide Data for Medicare Benchmark to Reduce Data Availability Challenges[11]

GMCB currently faces significant data availability challenges in the Medicare benchmark calculation, which impacts both the Medicare benchmark approval process as well as the Board's annual decision on the Medicare ACO trend rate. Currently, both are contingent on the Medicare ACO provider list, received on September 1; this allows only a short period for staff and contractors to perform necessary analysis – including identifying a preliminary beneficiary cohort and analyzing historical spending among this cohort – and for the Board to make its decisions.

GMCB could accelerate the Medicare benchmark and Medicare ACO program trend decisions by using the statewide Medicare population in both calculations. Utilizing historical spending data for all Vermont Medicare beneficiaries in the benchmark calculations (rather than historical spending for a preliminary attributed population) would tie the benchmark to statewide Medicare spending and allow for a more stable and predictable benchmark prior to achieving ACO scale (the Medicare ACO population has historically changed significantly from year to year). If scale is achieved, the ACO-attributed Vermont Medicare population would be very close to the full Vermont Medicare population; the APM Agreement includes a Medicare scale target of 90% by 2022, though prior GMCB analysis has indicated this is not practically achievable given the current care patterns (e.g., Vermont Medicare beneficiaries who receive the predominance of their care from out-of-state providers; increasing enrollment in Medicare Advantage plans).

Use Full Vermont Medicare Population to Calculate Benchmark: Pros	Use Full Vermont Medicare Population to Calculate Benchmark: Cons and Barriers
• Increased stability and predictability • More timely benchmark calculation • Aligns with Medicare TCOC population in PY4-5	• May not accurately reflect the risk of the ACO-attributed Medicare population

Option 3: Continue to Improve Communication of Hospital Budget Impacts on Individual and Small Group Filings[12]

In the past two years, the Board has included the impacts of hospital budgets in its rate review decisions. The decisions are legal documents which are not easily understood by the public. The Board will continue to work on improving the way we communicate how these processes overlap.

Additional Options: Not Recommended

The Board also considered the following options, but determined that these options should not be considered further:

Implement a 2-Year Hospital Budget Review Process

Implementing a 2-year hospital budget review process would provide hospitals with increased regulatory certainty due to known NPR and commercial rate increases for a two-year period. However, utility is questionable at this time given the limited data on which the 2-year budget submissions would be based; 2-year budgets would likely require continued adjustments throughout

[11] In a letter submitted October 30, 2020, OneCare Vermont stated that it does not support this change: "While OneCare recognizes the pressures with the timing of the Medicare benchmark calculation, we do not support using the statewide Medicare population in order to accelerate the Medicare ACO benchmark decision. Although this option would provide a timelier benchmark calculation, the methodology would not accurately reflect the total cost of care or risk of the ACO-attributed Medicare population."

[12] This recommendation received support from VAHHS and OneCare Vermont in separate comments submitted October 30, 2020.

the budget period. The Board issued guidance with NPR targets for two years in 2019, but has maintained the same annual process to review budgets. This guidance did not include a target for commercial rate increases. This option may be feasible to reconsider if we achieve greater stability in the ACO population and more stability in the growth rates.

Shift Individual and Small Group Premium Approval Process to After Hospital Budget Approval to Better Integrate Hospital Commercial Charge Increases into Individual and Small Group Premiums

While GMCB would ideally set commercial charge increases and then integrate them into individual and small group premium filings for the upcoming plan year, state and federal constraints in the individual and small group premium approval timeline preclude a later GMCB individual and small group rate review process.

Align Large Group Insurance Premium Years and Hospital Fiscal Years; Require Large Group Plans to Operate on a January 1 Plan Year

While this option would more clearly crosswalk hospital commercial charge increases with large group premium rate review, it would be extremely burdensome and provide minimal improvements over the current process. The transition period where large group plans were moved from current plan years (throughout the year) to a January 1 plan year would cause significant consumer confusion regarding deductibles, due to either a partial year plan or a plan for over 12 months; insurers would face operational costs from a short interim plan year or premium estimation challenges for a plan that longer than year.

In addition, alignment would have a small impact: large group plans currently cover ~24,000 people, and, to the fullest extent possible, actuaries already incorporate prior year hospital budget orders and review the most up-to-date budget submissions for consideration in the premium review process (see pg. 5).

Shift Hospital Fiscal Year to April 1

Under this option, hospital accounting would shift to an April 1-March 31 fiscal year; budgets would be submitted early in the calendar year, for approval by March 15. In theory, this would allow hospital budgets to take into account the ACO's approved budget and final FPP, which is known in February/March; however, final ACO would still not be known in advance of hospitals' initial budget submissions, so budgets would need to be updated mid-process to reflect final attribution.

Public Comment

GMCB received six public comments on Parts 1 and 2 of this white paper series. Themes included:

- The potential burden to providers and payers of regulatory timeline changes, particularly in the context of COVID-19, and ensuring that alignment does not come at the cost of increased regulatory burden;
- The potential benefits and drawbacks of proposed timeline change options;
- The necessity of centering the needs of consumers, particularly affordability of health care services and of insurance coverage, in any potential changes; and
- Looking ahead to future iterations of the All-Payer Model and evolving regulatory efforts.

Where public comments stated a specific position on the policy options outlined here, they have been indicated with a footnote.

Additional recommendations suggested by these public comments include:

- Work with regulated entities to ensure data produced by regulated entities is comparable across entities and across regulatory processes, and over time (HCA, 10/30/2020). GMCB has been engaged in this ongoing exercise for a number of years and will continue to work to refine reporting templates to improve data quality and consistency, in partnership with regulated entities. As described in the Part 1 of this white paper series, differences in population, providers, and services often prevent GMCB from accurately comparing information across regulated entities and regulatory processes.
- Work to make risk and reserves more transparent across the ACO oversight, hospital budget review, health insurance premium rate review processes, and work to limit duplication of reserves across the health care system (HCA, 10/30/2020). In its comment, the HCA notes that reserves are funded by insurance premium payers and taxpayers. GMCB agrees that continued analysis of risk and reserves is critical in the context of expanding value-based payment models. As the state moves from a volume-based reimbursement system to one based on value, performance risk shifts from payers to providers. While in theory, system-wide total risk should not change (and could in fact decrease with predictable payments and the removal of waste from the delivery system), the actual ACO and insurer regulatory mechanisms across GMCB and DFR make this challenging: even after ACO scale is achieved, ACO-attributed lives are likely to make up a small proportion of the total book of business for most commercial insurers. Additionally, this system-based view of risk may not align with providers' view of their own financial risk under new payment models.[13] That said, the ACO program and risk shifted to the ACO and providers was considered in DFR's 2019 Risk-Based Capital (RBC) decision for BCBSVT.[14]
- Use provider rate setting authority to set commercial charges for individual and small group market plans (HCA, 10/30/2020). The HCA suggests this could improve affordability for QHP and reflective plan premium payers, while having a limited impact on hospital finances due to the small population enrolled in these plans. Approaches to this suggestion are considered in the GMCB's recent report on Provider Reimbursement (Act 159 of 2020, Sec. 5); moving forward with this approach would require additional funding.
- Develop a methodology for evaluating ACO population health investments (HCA, 10/30/2020). GMCB requires ACO reporting and evaluation of its own performance. GMCB's 2020 ACO budget order required OneCare to develop workplans to evaluate the effectiveness of its population health investments.[15] This requirement will continue in the GMCB's forthcoming ACO reporting manual, expected Spring 2021.
- Utilize the health insurance premium rate review process's post-decision window to ensure individual and small group premium decisions reflect approved hospital change in charge following the Board's hospital budget decisions (BCBSVT, 10/7/2020). GMCB worked with DVHA to explore this possibility and found that it would not allow time for necessary VHC testing prior to the start of open enrollment: GMCB decides hospital budgets over a month

[13] For example, provider entities may feel that population-based payments reduce their risk by providing increased certainty over a portion of their revenue, regardless of FFS volume; alternately, providers may feel that non-FFS payment models entail risk beyond the amount explicitly embedded in the payment model, as they lose some control over revenue generation. Providers' risk will also vary depending on whether non-FFS payments are reconciled or settled based on actual utilization or cost following the end of the performance period, and whether and how settlement is adjusted based on quality or other factors.
[14] See discussion at Green Mountain Care Board meeting (July 10, 2019).
[15] See OneCare Vermont FY2020 Budget Order Deliverables 11c and 18 (submitted June 30, 2020).

after health insurance premium rate decisions, and decisions are not finalized until October 1. Because final premium decisions are a key data element in VHC testing, delaying finalization of premium rates until October 1 is not workable.

- Align standards by which GMCB evaluates decisions across all regulatory processes such that affordability, access to care, quality of care, and solvency (the statutory criteria according to which health insurance premium rate requests are considered) are applied consistently across all regulated entities (BCBSVT, 10/7/2020). Currently, the standards and criteria used in the health insurance premium rate review process and other GMCB regulatory processes are defined in statute. This reflects the General Assembly's varied goals in authorizing the Board's regulatory efforts, and is likely to present a barrier to alignment. Additionally, even if standards and criteria were aligned, the standards and criteria would likely be measured differently across processes; for example, the health insurance premium rate review process uses actuarial certification, which is likely not appropriate for all other GMCB regulatory processes. Likewise, a consideration of solvency in the hospital budget process would likely be defined different from insurer solvency as it is considered within rate review. Nonetheless, the Board believes this suggestion merits further discussion.
- Ensure that timelines for new reforms, regulations, and initiatives align with annual regulatory timelines and All-Payer Model Agreement timelines (Bi-State PCA, 10/13/2020). GMCB agrees with this suggestion, and will continue to advocate for aligned timelines whenever possible.

The full text of all comments is linked in the attached Appendix.

Conclusion

While regulatory timeline changes appeared to have potential as a mechanism to increase alignment, timeline constraints (including Vermont law and regulation; federal law and regulation; interaction with other State of Vermont regulatory partners; and data availability and comparability) limit our options for change.

Feedback received from stakeholders during the public comment process have made clear that the barriers to altering the regulatory timeline – including regulatory burden and operational challenges, and the risk of increasing integration in some areas only to decrease integration between other processes – outweigh the benefits at this time. The GMCB recommends no changes to the regulatory timeline.

Appendix: Links to Public Comment

- Vermont Office of the Health Care Advocate (HCA) Public Comment
- OneCare Vermont Public Comment
- Vermont Association of Hospitals and Health Systems (VAHHS) Public Comment
- Bi-State Primary Care Association Public Comment
- BCBSVT Public Comment
- HCA Technical Comments
    - HCA Part 1 Technical Comments
    - HCA Part 2 Technical Comments