

**Green Mountain Care Board**  
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*Susan Barrett, JD, Executive Director*

**To:** Health Reform Oversight Committee, House Health Care Committee, Senate Committees on Health and Welfare, and on Finance

**From:** Susan Barrett, Executive Director

**Date:** December 1, 2016

**Re:** Act 143 of 2016, Section 5. Reducing Payment Differentials; Guidance and Implementation; Report

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## Statutory Charge

Under Act 54 of 2015, Section 23(b), each health insurer with more than 5,000 covered lives for major medical insurance was required to develop and submit to the Green Mountain Care Board (GMCB or Board) “an implementation plan for providing fair and equitable reimbursement for professional services provided by academic medical centers and other professionals.” The plans had to ensure that proposed changes to reimbursement would not increase health insurance premiums or public funding of health care.

Blue Cross and Blue Shield of Vermont (BCBSVT)<sup>[1]</sup> and MVP Health Care (MVP)<sup>[2]</sup> submitted implementation plans to the Board on July 1, 2016. The Board provided these plans to the committees of jurisdiction on July 15, 2016. Both plans are available on the Legislature’s website. As stated in Act 54, the Board may require BCBSVT and MVP “to submit modifications” to their plans and must “approve, modify, or reject” each plan.

Act 143 of 2016, Section 5(b) requires the Board to provide an update to the committees of jurisdiction no later than December 1, 2016 on the Board’s “progress toward fair and equitable reimbursement amounts for professional services provided by academic medical centers and by other professionals, without increasing health insurance premiums or public funding of health care, as required by [Section 23(b) of Act 54].” The Board submits this memorandum to comply with this reporting requirement.

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<sup>[1]</sup> *Implementation Plan for Providing Fair and Equitable Reimbursement Amounts for Professional Services Provided by Academic Medical Centers and Other Professionals*, July 1, 2016, available at <http://legislature.vermont.gov/assets/Legislative-Reports/BCBSVT-Act-54-Implementation-Plan.pdf>.

<sup>[2]</sup> *An implementation plan for providing fair and equitable reimbursement amounts for professional services in Vermont*, July 1, 2016, available at <http://legislature.vermont.gov/assets/Legislative-Reports/MVP-VT-ACT54-Implementation-Plan.pdf>.



## **Stakeholder Input and Board Review Process**

To evaluate the carriers' plans, the Board and staff met with stakeholders including MVP, BCBSVT, University of Vermont Medical Center, Vermont Care Organization (VCO), Health First, Bi-State Primary Care Association, the Vermont Medical Society, and the Vermont Association of Hospitals and Health Systems (VAHHS). In addition, the Board and staff reviewed reports on price and total cost of care variation in Vermont and surveyed the relevant policy literature.

## **Progress Update**

As discussed above, the Board has reviewed the implementation plans, policy materials and reports, and has met with stakeholders. It is the current thinking of the Board that a payment system based on Medicare rate-setting methodology, with an adjustment factor for academic medical center education and research, and consideration of Medicare's recent ruling on site-neutral payments, will present a transparent remedy to the problem presented in Act 54. To be clear, the Board is not proposing to reduce commercial rates to Medicare rates. Although both BCBSVT and MVP state that in developing their plans, they have analyzed Medicare rates and academic medical center differentials, the Board will request that each modify its plan and provide its underlying data and analysis. Doing so will allow the Board to confirm the stated impacts on total revenue and budget, effect on member cost-share, and premium neutrality.

In addition, the Board is considering the potential impact of implementation of the All-Payer ACO Model Agreement, which moves the state away from fee-for-service and towards value-based capitated payments. Todd Moore of Vermont Care Organization has made clear in our discussions that the VCO intends to support fair and equitable payment models across different professional services providers, including FQHCs, hospital-based physician practices, and independent private physician practices, and has provided a letter on behalf of the VCO, which is attached to this memo.

Accordingly, the Board will also request that the carriers further modify their plans to reflect potential changes in reimbursement as a result of the All-Payer ACO Model Agreement.





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November 14, 2016

Dr. Jessica Holmes  
Green Mountain Care Board  
3rd Floor City Center  
89 Main Street  
Montpelier, Vermont 05620

Dear Dr. Holmes:

I am writing on the topic of payment reform and pay parity for professional services in the context of the All Payer Accountable Care Organization Model (APM) and the plans of the Vermont Care Organization (VCO). The VCO was created to be a unified statewide ACO network and population health management organization for Vermont, and initially will hold program and provider contracts through its partner ACOs OneCare Vermont and Community Health Accountable Care. The network already includes a strong combination of hospital-based, Federally Qualified Health Center (FQHC), and independent private physician practices delivering professional services.

First, let me assure you that the VCO was formed with a philosophy of fair and equitable payment models for professional services including different types of physician practices. The VCO's population-based, multi-payer plan will include an approach to provider payment equity which focuses on experience across the full payer mix served (beyond just commercial payers), and encompassing per person costs which include both utilization and reimbursement per service components.

As VCO works to establish and expand the population-based economic approach which allows redesign of underlying provider payment models, we expect VCO and its governing bodies to be the leaders in designing these payment programs under GMCB oversight. One of the important draws of APM to providers is the ability to directly influence economic models, incentives, measurements, and rules across payers. Our vision includes provider payment models where we will increasingly be redesigning revenue to *eliminate or deemphasize fee-for-service altogether and/or blend payment streams across Medicare, Medicaid, and Commercial sources.*

Our current plans for professional services originated with the multi-stakeholder APM Payment Models sub-group facilitated by the GMCB in 2015, and were further developed in the VCO Business Plan developed during the first six months of 2016. The key payment reform elements affecting professional services include the following for ACO-attributed populations:

- For hospitals and their employed physicians, we will shift payment for services delivered to ACO-attributed populations into a fixed pre-payment model, to be piloted under the 2017 Vermont Medicaid Next Generation program and to be applied to Medicare and Commercial insured Next Generation programs in 2018. This will mean that for members of the ACO-attributed population, participating hospitals and their employed physician practices will not receive FFS payments for either professional services claims or hospital services claims.



- The hospital fixed payments will initially be based on existing aggregate revenue levels for all services delivered by the hospital and its employed physicians to the ACO-attributed population, but will be adjusted over time to reflect assessments of overall revenue adequacy which reflect the range and level of services provided as well as factors for hospital size and role, community and patient mix challenges, and ensuring access to services.
- For independent Primary Care Physicians, we plan to design and offer in 2018 a single multi-payer blended capitation amount for delivering primary care services to an attributed panel and designed to reflect the medical home model and its needed resources under advanced alternative payment models. In addition, we will develop a common "companion" fee schedule based on the targeted per-person revenue level as an optional path for primary care practices less suited for the true capitation option.
- For FQHCs, we will offer an annual option for them to "opt in" to the payer-blended ACO payment model and surrender the FQHC revenue model for professional services. However, this option does not preclude us from offering FQHCs supplemental add-on payments or allowing FQHCs to participate in the ACO-based model for individual payer programs.
- For independent specialist physicians, we plan to design and offer in 2018 a single fee schedule across ACO-attributed Medicaid, Medicare, and Commercial insured populations designed to ensure adequate financial resources for Vermont's independent specialist practices. Over time we hope to apply such a model across all specialist practice types as the underlying basis for specialist payment. This will provide for both transparent analysis of equity among specialty physician practices and more uniform patient out-of-pocket payments for comparable services.

We believe the ideas above will shift Vermont to a more comprehensive approach to assessing provider payment levels as we enter a reformed future under APM. These approaches will better match the cost model as defined in APM as the total growth in per person costs, and the ACO-based total-cost-of-care target accountability. In addition, we will be adding an increasingly significant value-based quality element of provider payments designed to reward high performance on top of an adequate base revenue model, but which will further alter significantly the traditional fee-for-service world of today.

We stand ready for additional engagement with the GMCB and others as we enter the period of true payment reform, and its impact on existing approaches and initiatives which are designed around a fee-for-service system. Please do not hesitate to contact me with questions.

Sincerely,



Todd B. Moore

CEO, OneCare Vermont Accountable Care Organization

CEO, Vermont Care Organization

SVP, Accountable Care and Revenue Strategy, University of Vermont Health Network