Hospital Global Budget Technical Advisory Group

SEPTEMBER 5, 2023
MEETING #10

Meeting Agenda

1. Recap of prior meeting discussion
2. Terms of commercial payer participation
3. Variation for participating payers

Recap of August 1st Meeting

August 1st Meeting Recap

- We continued discussion of how quality and equity performance should be used to modify and/or supplement global budget payments.
  - Several group members supported aligning quality and equity arrangements across payers to the extent feasible, and also acknowledged that too many measures., combined with multiple platforms, can add complexity and require significant resources.
  - One member cautioned against imposing financial penalties for hospitals with lower quality scores, and another member voiced that quality and equity incentive programs should not increase costs to ratepayers.
  - Members did not convey a strong preference between whether the model should use quality and equity to adjust global budget payments, or as complementary VBP arrangements to the hospital global budgets.
- We additionally reviewed a straw model for Medicare Fee-for-Service global budget payments, which included service and revenue eligibility and inclusions/ exclusions, global budget payment calculations and adjustments, and potential data sources and processes.

Meeting Objectives

1. Terms of payer participation: Identify which commercial payers should participate in the model, for which markets, and whether participation should be voluntary or mandatory. Review implementation options for multi-payer alignment.
2. Payer variation: Identify areas where the model should allow for payers to vary, including whether and how 1) commercial plans (inclusive of MA) might differ from Medicare and Medicaid, and 2) commercial plans (inclusive of MA) might differ from each other.

Terms of Payer Participation

Overview of Commercial Payer Participation Parameters

Considerations for commercial payer participation in the global budget model include:

1. Include both VT and non-VT residents
2. Limit to commercial payers licensed in state or doing business in state (expanding to non-licensed carriers could only occur on a voluntary basis)
3. Define participation by carrier as a single entity

For discussion today:

4. Define commercial payer participation by hospital-level membership and/or revenue thresholds?
   - Voluntary or mandatory commercial payer participation?
5. Best implementation options for multi-payer alignment?

Are there other parameters we should consider for commercial payer participation?

Defining the Commercial Market Population (recap) (1 of 2)

We previously discussed how to define the commercial market population for modeling. Multiple Advisory Group members expressed supporting for including:

- commercial self-insured, fully-insured, and Medicare Advantage business
- as many commercial payers as possible, but especially those with significant market presence
- VT and non-VT residents with commercial coverage

Defining the Commercial Market Population (recap) (2 of 2)

Additional input from Advisory Group members:

- One member conveyed concern with engaging payers with whom a hospital has no contractual relationship
- Several members conveyed support for determining a revenue threshold for payer inclusion that is based on a payer's percentage of an individual hospital's budget, rather than statewide carrier revenue

Participation by Carrier as Single Entity

We propose that commercial payer participation be based on a **carrier as a single entity**:

- Threshold for participation is applied to all of the payer's members and revenue at a particular hospital (e.g., all BCBS of Vermont plans)
- Increases participation
- May complicate accounting for payers that have plans with small membership or revenues

Context for Considering Size Thresholds for Commercial Insurer Participation

Commercial Enrollment (VT residents), 2021

Carrier name	Fully insured	MA	Self-insured	Total
BlueCross BlueShield of Vermont	52,429	0	57,517	109,946
MVP (Health Plan, Inc., Health Services Corp, Select Care)	71,571	0	940	72,511
Cigna	4,909	0	52,504	57,413
UnitedHealthcare of New England	0	9,326	0	9,326
Vermont Blue Advantage, Inc.	0	5,044	0	5,044
WellCare Health Plans of Vermont, Inc.	0	1,818	0	1,818
Sierra Health and Life Insurance Company (UHC)	0	1,580	0	1,580
Other*	618	390	374	1,382
QCC Insurance Company	0	0	1,017	1,017
Not reported in ASSR**	0	13,239	0	13,239
Grand total	**129,527**	**31,397**	**112,352**	**273,276**

Source: VT Annual Market Share Report

Total insurer paid amounts by carrier (VT residents, VT hospitals), 2021

Carrier Name	Insurer Paid reported to VHCURES total*
BCBS of VT**	$400,703,763
MVP Health Plan	$126,372,138
UnitedHealthcare	$78,516,532
Cigna	$28,340,772
Aetna	$5,898,735
Point 32***	$5,838,935
Blue Cross Blue Shield of FL	$5,582,737
Wellpoint	$2,985,529
Blue Shield of California	$2,163,347
USAble Mutual Insurance Co	$1,428,259
Excellus Health Plan	$906,263
Humana Insurance Co	$172,954
Grand Total	**$658,909,964**

Data reported are from CY 2021
*VHCURES includes all fully-insured and 63% of self-insured
**Includes BCBS of VT and The Vermont Health Plan
***Includes Harvard Pilgrim, Tufts, and Health Plans, Inc.

Source: Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

Discussion

We recommend setting a threshold for commercial payer participation in the hospital global budget payment model using one of the following approaches, or a combination of the two:

1) statewide hospital payments were at or above a specific amount, and/or
2) the payer accounts for a minimum percentage of the hospital's total net patient revenue.

- Which approach do you recommend, and why?
- Should commercial payers that meet the threshold(s) be required to participate, or should participation be voluntary?
  - If voluntary, what parameters would make the payment model attractive? What parameters would make it less attractive?

Implementation Options for Multi-Payer Alignment

During prior meetings, hospitals and insurers have expressed interest in a hospital global budget approach that minimizes administrative requirements, including the need for negotiation.

In order to reduce administrative demands and obtain maximum alignment across payers, the global budget model could use one of the following approaches:

1) Provider rate setting
2) Requirements for state-regulated insurers

Provider Rate Setting

The GMCB has statutory authority to implement provider rate setting but has not yet exercised this authority

- When passed, not funded or staffed by General Assembly
- Requires rulemaking and stakeholder engagement
- GMCB sets hospital charges in the hospital budget process.

Authority includes the ability to establish payment methodologies and payment amounts.

Comprehensive review of possible provider rate setting options:

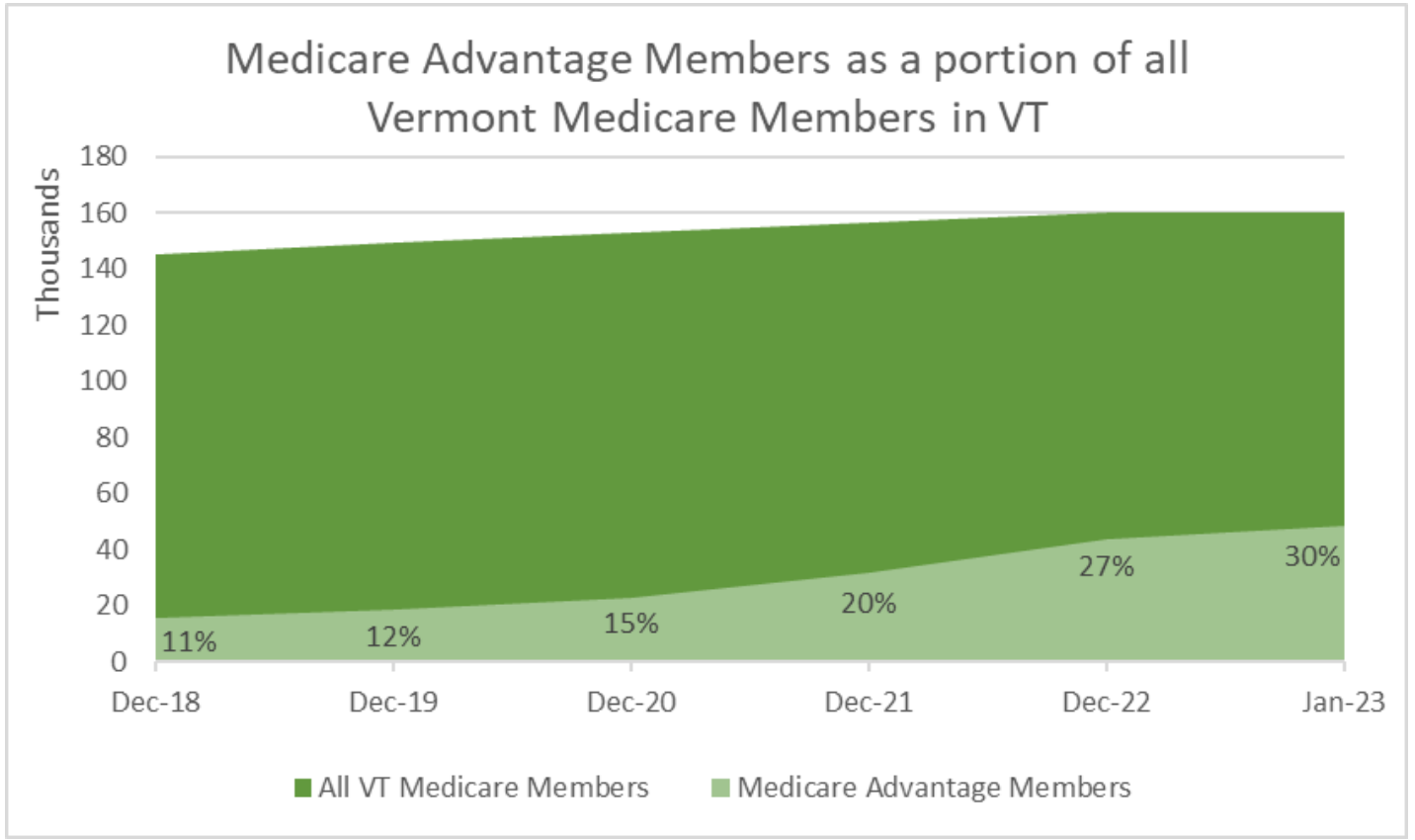
- Provider Reimbursement Report (2021)

Commercial Member Enrollment (VT Residents, 2021)

Carrier name	Fully insured	Medicare Advantage	Self-insured	Total
BlueCross BlueShield of Vermont	52,429	0	57,517	109,946
MVP (Health Plan, Inc., Health Services Corp, Select Care)	71,571	0	940	72,511
Cigna	4,909	0	52,504	57,413
UnitedHealthcare of New England	0	9,326	0	9,326
Vermont Blue Advantage, Inc.	0	5,044	0	5,044
WellCare Health Plans of Vermont, Inc.	0	1,818	0	1,818
Sierra Health and Life Insurance Company (UHC)	0	1,580	0	1,580
Other*	618	390	374	1,382
QCC Insurance Company	0	0	1,017	1,017
Not reported in ASSR**	0	13,239	0	13,239
Grand total	**129,527 (47.4%)**	**31,397 (11.5%)**	**112,352 (41.1%)**	**273,276**

Medicare Advantage Enrollment

- Medicare Advantage enrollment growth in VT has outpaced overall Medicare enrollment growth in recent years.



Commercial Payment Distribution to VT Hospitals (VT Residents, 2021)

Fully-insured paid amount as a percent of total commercial

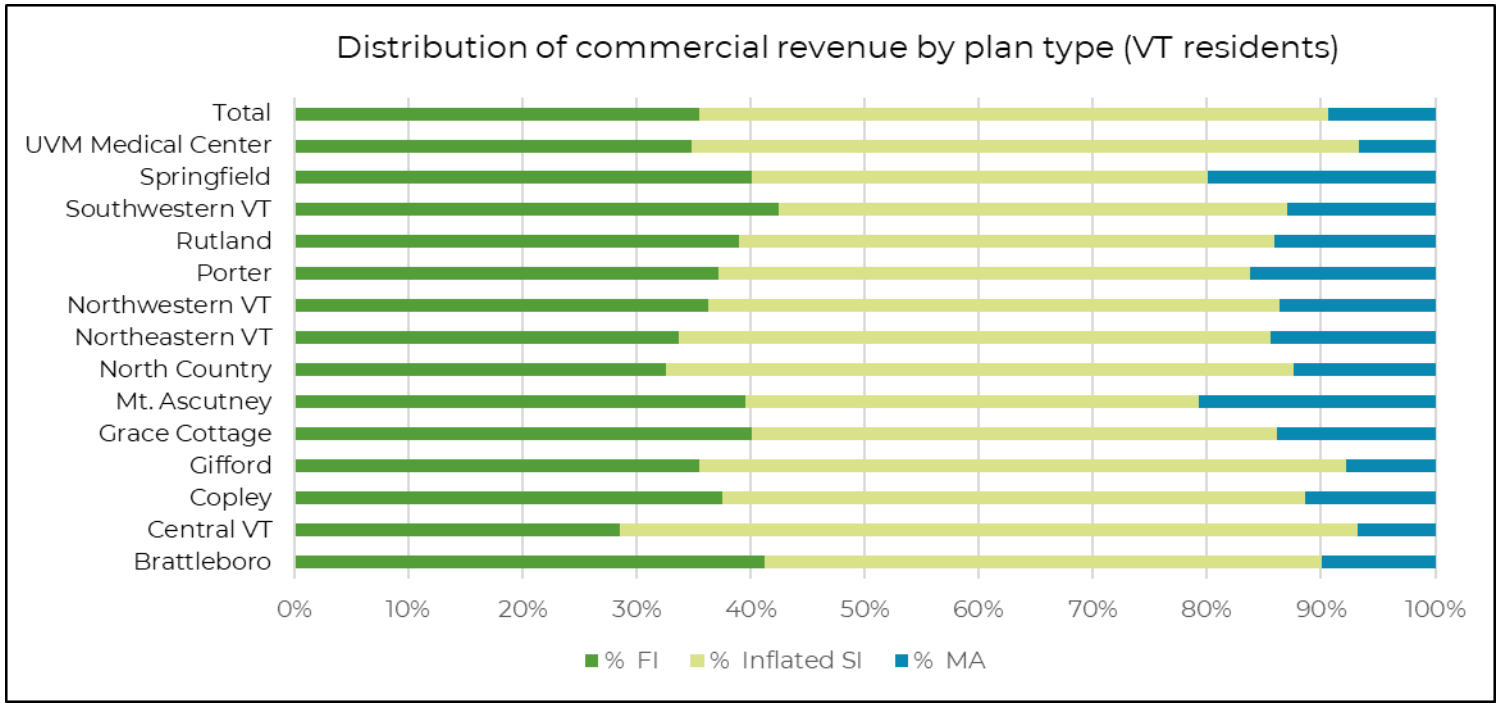
36%

Self-insured paid amount as a percent of total commercial

55%*

Medicare Advantage paid amount as a percent of total commercial

9%



Data reported are from CY 2021.
The total represents all payments from insurers and beneficiaries/members.
*The percentage of self-insured reported in VHCURES estimated to be 63% of SI payments in VT, so SI payments are inflated to total 100%.

Source: Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

Discussion

- How should we ensure enough commercial market revenue is included in the hospital global budget payment model to ensure positive impact for both payers and providers?
- Should the payment model be implemented for the commercial market through:
  1) provider rate setting?
  2) requirements of state-regulated insurers?

Payer Variation

Commercial Payer Variation from Medicare FFS

As discussed during Meeting #9, parameters for commercial payers *could* differ in the following ways from Medicare FFS:

- Prospective inflation adjustments for the commercial market could include a blend of the Medicare Market Basket Index and VT median household income, which may differ from Medicare's approach to inflation adjustment.
- Commercial payers could have different weights and proportions for adjustments based on membership changes, including commercial member growth trend by hospital service area and demographic changes with age and gender weights.
- Prospective adjustments for quality and policy could differ (e.g., if Medicare FFS were to include adjustments for CMS quality programs and CMS policy adjustments).

Discussion

We won't know for a few months what will comprise the exact Medicare model. We can, however, still consider the following two questions in abstract:

1. For each of the element of the Medicare straw model, to what extent do we want to encourage or limit variation in model design by commercial payers and Medicaid?
2. To what extent do we want to encourage or limit variation in model design among commercial plans?

Wrap-up and Next Meeting

The next Hospital Global Budget Technical Advisory Group meeting is scheduled for Tuesday, **October 10th** from 10 am – 12 pm.