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Primary Care Advisory Committee

Jennifer DaPolito, Senior Health Policy Analyst, GMCB
Susan Barrett, Executive Director, GMCB
Pat Jones, Interim Director of Health Care Reform, AHS
Robin Lunge, GMCB Board Member
Julia Boles, Health Policy Advisor, GMCB

6/21/23

Agenda

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- Upcoming GMCB Regulatory Processes
  - Health Insurance Premium Rate Review
  - Hospital Budgets
- Vermont All-Payer Model
- Hospital Global Budgets
- Legislative Session: Prior Authorization

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HEALTH INSURANCE PREMIUM RATE REVIEW

GMCB Rate Review

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- Large Group Filings
  - 101 or more employees
- Small Group and Individual Filings
  - 100 employees or less & individuals and families
  - The small group and individual markets were unmerged in 2022 and will remain unmerged in 2023

Large Group Rate Review

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Rate Review Process:

- Insurers file rates with GMCB, typically 4-6 months before rates will be effective
- The GMCB has 90 days to review and approve, modify or deny a rate:
  - Insurers provide an actuarial analysis to support the proposed rates
  - GMCB's actuary reviews the proposed rates and provides its analysis
  - DFR provides an analysis of the insurer's solvency
  - Hearings are typically waived, but the parties (insurers and the HCA) provide memorandums in support of their recommendations on the proposed rates
  - Board issues its decision around Day 90
- Some items of note:
  - Large group rates affect approximately 11,000 covered lives
  - The GMCB only approves a manual rate for large group filings

Small Group & Individual Rate Review

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Rate Review Process:

- Insurers file rates with GMCB in early May
- The GMCB has 90 days to review and approve, modify or deny a rate:
  - Insurers provide an actuarial analysis to support the proposed rates
  - GMCB's actuary reviews the proposed rates and provides its analysis
  - DFR provides an analysis of the insurer's solvency
  - Hearings are typically held toward the end of July
  - Board issues its decision around Day 90 (early August)
- Some items of note:
  - These rates usually affect approximately 72,000 lives
  - Unlike the approval of only a manual rate during the large group rate filings, the rates approved for small groups/individuals will show the premiums paid by enrollees

GMCB Rate Review

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	Large Group	Small Group & Individual
Definition	101 or more employees	100 employees or less & individuals
Approval Timeline	Throughout the year (number of filings vary year to year)	Rates filed in early May to ensure compliance with federal regulations for open enrollment in November
Rate Effective Date	Varies by filing	January 1st
Plans Offered	Outside Vermont Health Connect	Qualified Health Plans (QHP) through VHC, including reflective silver plans
Subsidies Available	No	Yes, for QHPs offered through VHC (not for small group, off exchange QHPs, or reflective plans)
Covered Lives	~11,000	~72,000

Rate Review 2024 QHP Timeline

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- **May 9, 2023** – Small Group and Individual Filings submitted
- **July 5, 2023** – Actuarial Analysis and DFR Solvency Opinion
- **July 17, 2023** – MVP Hearing
  - 8am-5pm
- **July 19, 2023** – BCBSVT Hearing
  - 8am-5pm
- **July 24, 2023** – Public Comment Forum
  - 4pm-5pm
- **August 7, 2023** – GMCB Decision and Order

Rate Review Home Page | Rate Review (vermont.gov)

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HOSPITAL BUDGETS

Hospital Budgets

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Annually by October 1, the Green Mountain Care Board (GMCB) has the responsibility to review and establish budgets for Vermont's 14 community hospitals.

In its review, the Board considers local health care needs and resources, utilization and quality data, hospital administrative costs, and other data, as well as presentations from hospitals and comments from members of the public.

18 V.S.A. § 9375(b)(7); 18 V.S.A. § 9456

Brief History of Hospital Budget Oversight

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1992

Vermont Health Care Authority

Merged Health Policy Council, Health Data Council, and Certificate of Need Review Board

1995

Banking, Insurance, Securities, and Health Care Administration (BISCHA)

Established authority to limit hospital budgets

2011

Green Mountain Care Board

BISHCA renamed to Dept of Financial Regulation

Hospital Budgets

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- Each year, the GMCB establishes guidance and reporting requirements. The GMCB is in the process of updating its regulatory process and is working toward stable, predictable guidance.
- Two major benchmarks for FY24 Hospital Budgets are Net Patient Revenue Growth and Commercial Rate Increase.
- GMCB considers many factors when reviewing budgets, including labor expenses, utilization, pharmaceutical expenses, cost inflation, commercial price changes, financial indicators, Medicare/Medicaid price changes, and uncompensated care.
- GMCB has held several roundtable discussions on primary care, price discrimination, and travelling Board meeting to understand impact of hospital budget decisions on the broader clinical community.

Hospital Budgets Timeline

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- **March 31:** GMCB issues written guidance
- **July 1:** Hospitals submit budget requests approved by their local hospital board to GMCB.
- **August 9 - 23, 2023:** GMCB holds hearings for each hospital's budget.
- **Aug 23 - Sept. 15:** GMCB holds public deliberations and must establish budgets for each hospital on or before September 15th (with written decisions by Oct 1st).
- **October 1**: Hospital fiscal year begins.

Public comment encouraged July – early September.

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VERMONT ALL-PAYER MODEL

Health Care Reform Update

GMCB Primary Care Advisory Group

June 21, 2023

Pat Jones, Interim Director of Health Care Reform

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Sustaining Medicare Participation in Multi-Payer Alternative Payment Models in Vermont

Original Vermont All-Payer ACO Model Agreement → **Amended and Restated Vermont All-Payer ACO Model Agreement** → **Future potential Vermont Medicare Multi-Payer Agreement**

Six Year Agreement (2017-2022)

- The Vermont All-Payer ACO Model Agreement is an arrangement between Vermont and the federal government that allows Medicare to join Medicaid and commercial insurers to pay for health care differently.
- The goal is to shift from paying for each service (fee-for-service) toward paying for high performance and good outcomes (value-based).
- Changing how services are paid for is intended to reduce health care cost growth, maintain quality of care, and improve the health of Vermonters.
- The current model relies on an Accountable Care Organization (OneCare Vermont) to develop a voluntary network of health care providers that agree to be accountable for the care and cost for their attributed patients.

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Sustaining Medicare Participation in Multi-Payer Alternative Payment Models in Vermont

Original Vermont All-Payer ACO Model Agreement → **Amended and Restated Vermont All-Payer ACO Model Agreement** → Future potential Vermont Medicare Multi-Payer Agreement

2023-2024
Extension of current agreement

- Vermont and the federal government have executed an extension of the Vermont All-Payer ACO Model Agreement.
- Agreement terms are similar.
- The extension is currently in place for 2023 and the State has accepted the option to extend the Agreement through 2024.
- The extension maintains Medicare investments in Vermont, such as the Blueprint for Health and OneCare's Comprehensive Payment Reform program that support primary care practices.

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Sustaining Medicare Participation in Multi-Payer Alternative Payment Models in Vermont

Original Vermont All-Payer ACO Model Agreement → Amended and Restated Vermont All-Payer ACO Model Agreement → **Future potential Vermont Medicare Multi-Payer Agreement**

2025-?

- The federal government is developing a multi-state, multi-payer model to be available in future years.
- Vermont is providing feedback on the model's design to the extent possible and will assess the model when it is released to determine if it meets the state's needs.

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Timeline for Engaging with the Center for Medicare and Medicaid Innovation (CMMI)

August-December 2022
Phase 1 Engagement

During this phase, the Agency of Human Services convened the Health Care Reform Work Group and advisory groups to provide initial feedback to CMMI on its priorities for a future multi-state, multi-payer alternative payment model.

January-Late 2023
Phase 2 Engagement

The Agency of Human Services and the Green Mountain Care Board are continuing to meet with CMMI to provide feedback on the potential model's design. The Agency is seeking broad stakeholder feedback through public comment, community engagement, and other forums designed to capture input from Vermonters.

Mid-Late 2023
Potential New Multi-State Model Opportunity

Based on current information, the Agency of Human Services expects a formal opportunity for participation in a multi-state, multi-payer model to be available at some point in 2023. The State needs to submit a proposal in response to the model offering if it wants to participate.

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What do we know about the new payment model under development by CMMI?

CMMI is signaling that it will produce a design spanning multiple states, starting in 2025, that will address 7 priorities:

1.	Include global budgets for hospitals.	**Payment Design**
2.	Include Total Cost of Care target/approach.	
3.	Be all-payer.	
4.	Include goals for minimum investment in primary care.	
5.	Include safety net providers from the start.	**Core Principles**
6.	Address mental health, substance use disorder, and social determinants of health.	
7.	Address health equity.	

Through an advisory group structure and other methods, AHS and GMCB are gathering input on a variety of topics to inform feedback to CMMI on a new multi-payer, multi-state model.

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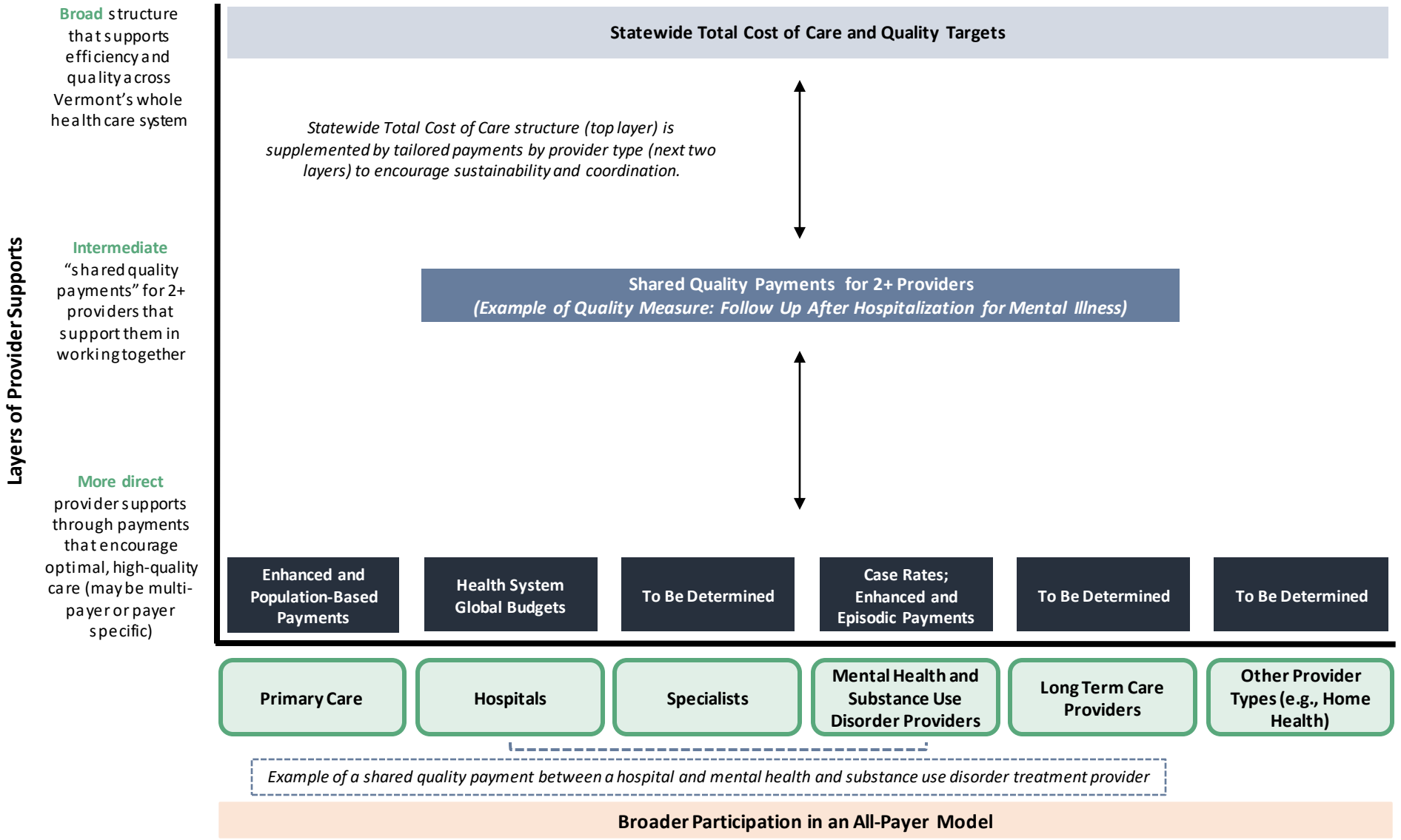
Vermont's Vision for a Statewide Approach



Population-Based Payment: A provider or provider organization is accountable for the health of a group of patients in exchange for a set payment. This gives providers flexibility to coordinate and manage care for their patients. They accept risk for costs of care that exceed the set payment amount.
Health System Global Budget: A global budget is a budget that is established ahead for a fixed period of time (typically one year) for a specified set of services (e.g., inpatient and outpatient hospital services) for a set population.
Case Rate: A provider receives a flat rate for a patient's treatment for a specific period of time.

Vermont's Feedback to CMMI to Date

Here are some of Vermont's needs that have been communicated to CMMI:

- Support rural provider stability and sustainability (workforce and inflation are important concerns)
- Increase predictability of payments
- Ensure the right amount of revenue (recognize that Vermont is a very low-cost state for Medicare)
- Support investments in preventive and community care
- Make sure payment models and quality measures are aligned across payers as much as possible
- Allow Vermont to keep moving forward on our important health care reform efforts (care for people with complex health and social needs, support for primary care through programs such as the Blueprint and Comprehensive Payment Reform, support for community-based services)

Gathering input from Vermonters

Summer 2022 – Work focused on short-term stability

Fall 2022 – Work began to inform discussions on the multi-state, multi-payer model

February 2023 – Technical discussions began on design of global budget model and Medicare waivers that might be beneficial to Vermont

Mechanisms for public input are available on both the GMCB and AHS websites

Planned for later in 2023 – Regular updates at GMCB public board meetings and discussions at existing forums

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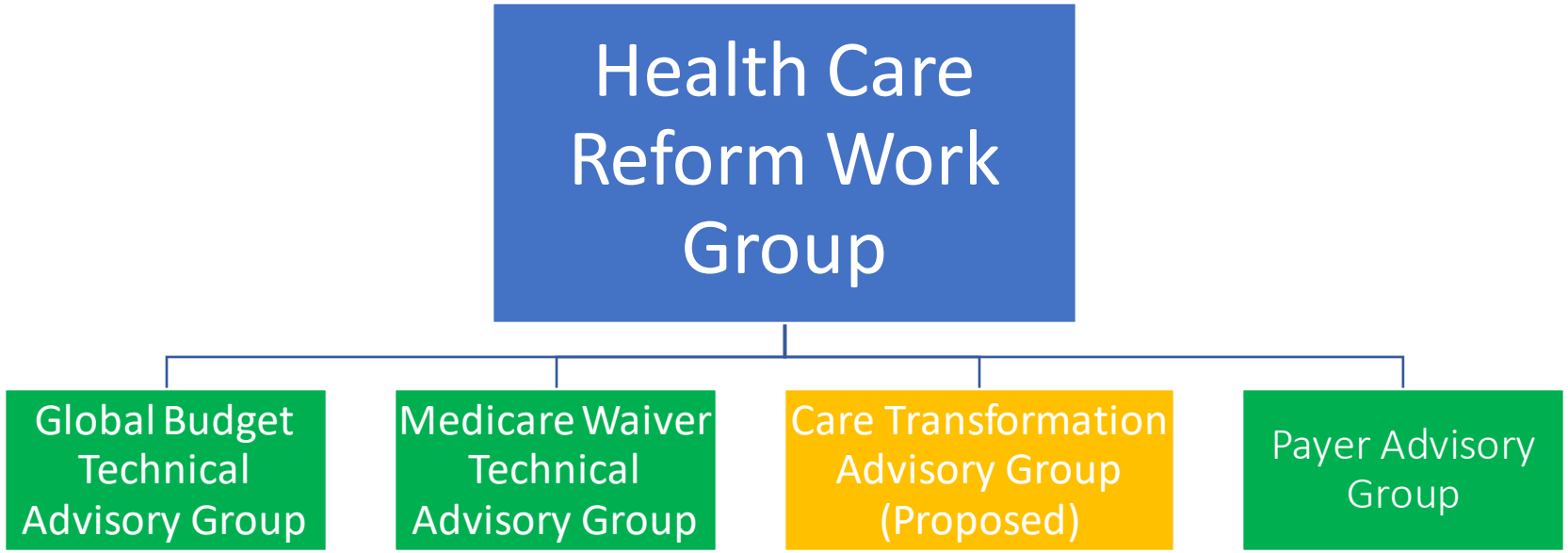
Current Work Group Structure



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Participating Organizations: Health Care Reform Work Group

- Bi-State Primary Care Association
- BlueCross BlueShield of Vermont
- Counseling Center of Addison County
- Department of VT Health Access
- Gifford Medical Center
- Green Mountain Care Board
- HealthFirst
- MVP Health Care
- Northern Counties Health Care
- OneCare Vermont
- Rutland Regional Medical Center
- Thomas Chittenden Health Center
- University of Vermont Health Network
- Vermont Agency of Human Services
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont Department of Financial Regulation
- Vermont Health Care Association
- Vermont Medical Society
- VNAs of Vermont
- Visiting Nurse and Hospice for Vermont and New Hampshire

More than 30 individuals from these participating organizations are on the Work Group.

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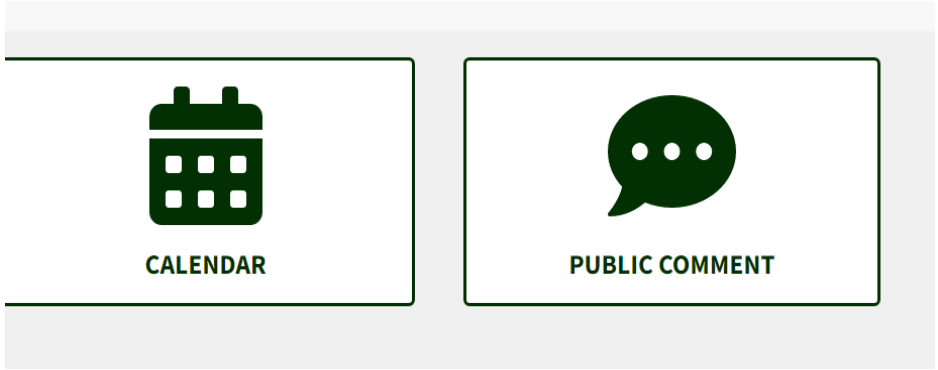
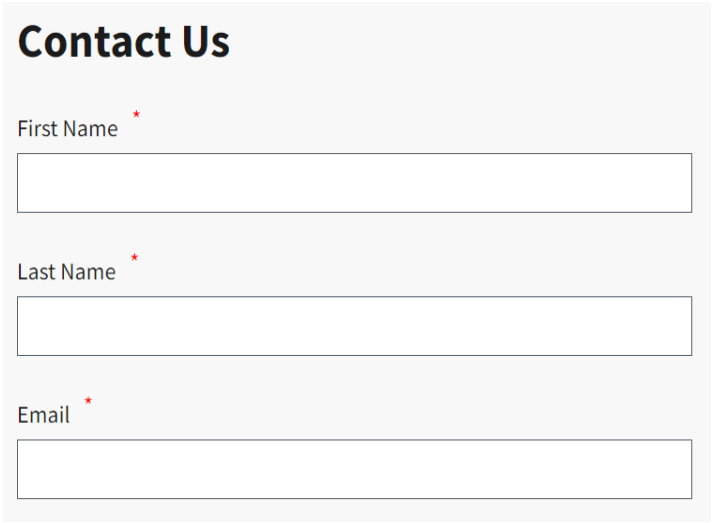
Public Information and Input: AHS and GMCB Websites

- Advisory group meeting materials and summaries posted on GMCB and AHS websites
- Mechanisms for public input:





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Summary of Next Steps

- Continue meeting with CMMI
- Continue gathering input:
  - ✓From work groups
  - ✓From AHS and GMCB advisory groups
  - ✓From presentations at Green Mountain Care Board meetings
  - ✓From public comments
- Carefully review model when CMMI releases it to see if it is good for Vermont, and continue to gather input when formulating a response

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HOSPITAL GLOBAL BUDGETS

Act 167 of 2022, Section 1(b)(1):
Developing Value-Based Payment Models

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- Act 167, Section 1 (b): "…build on successful health care delivery system reform efforts by developing value-based payments, including global payments, from all payers to Vermont hospitals or accountable care organizations, or both…"
- AHS and GMCB collaborated to host stakeholder meetings to gather input about potential payment models

Health Care Reform Work Group/Global Budget Subgroup: In Summer 2022, AHS convened a stakeholder group (Health Care Reform Work Group); GMCB has participated on some topics. In Fall 2022, members of a sub-group provided high-level input to AHS and GMCB on future Medicare alternative payment methodologies, focusing on high-level areas where Vermont would seek flexibility

Hospital Global Budget Technical Advisory Group: In January 2023, GMCB and AHS are co-convening a group of technical experts as a sub-group of the Health Care Reform Work Group to develop a methodology for a potential global budget payment model for hospitals

Hospital Global Budget Technical Advisory Group

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- Co-chaired by GMCB and AHS, with support from state staff and contractors:
  - Bailit Health Purchasing: Meeting planning, materials development, facilitation; stakeholder engagement; policy research and options; national context
  - Mathematica Policy Research: Analytics and modeling to support decision-making; materials development; technical expertise
- Membership selected based on technical expertise, knowledge of current provider payment models and contracting:
  - Hospital CFOs
  - Hospital health equity representatives
  - Payer representatives with actuarial and/or provider contracting responsibilities (including DVHA)
  - OneCare Vermont payment model development staff
  - Office of the Health Care Advocate
  - Union/self-funded plan representative
  - Provider representatives
  - Staff from GMCB, AHS/DVHA, DFR staff

Hospital Global Budget Technical Advisory Group

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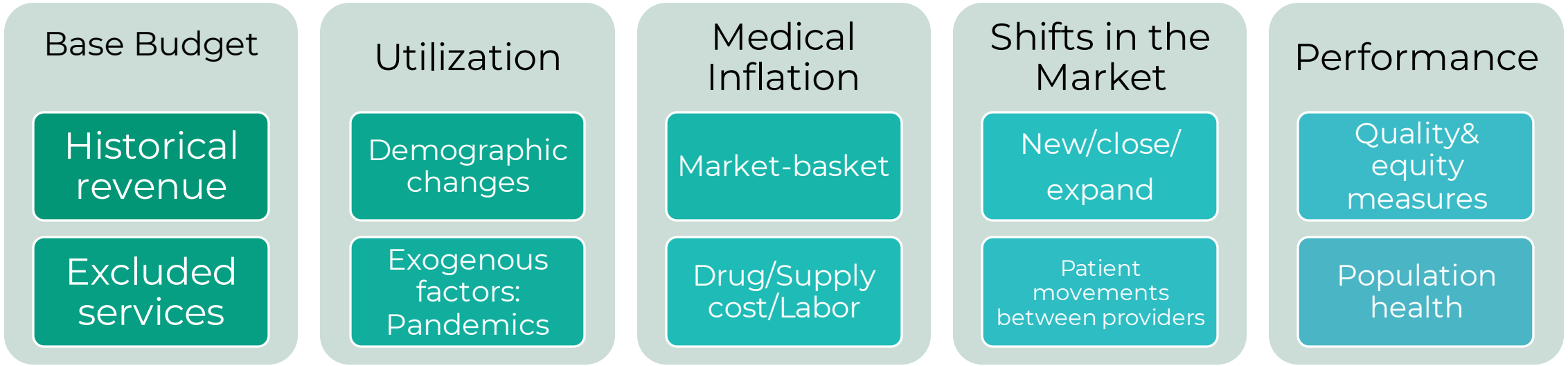
- Through Fall 2023, the Hospital Global Budget Technical Advisory Group will use data and analyses to work through key payment model design questions related to a potential hospital global payment model, including:
  - Defining scope (population, services, and included providers)
  - Calculating baseline budget
  - Defining potential necessary budget adjustments and adjustment methodologies
    - Could include adjustments for general trends (e.g., inflation); exogenous factors (e.g., a public health emergency or natural disaster); utilization changes; quality, equity, and financial performance; risk mitigation.
  - Payer participation
  - Provider participation
  - Strategies to support care transformation and quality under a global budget
  - Program administration
  - Evaluation and monitoring
- Materials are posted publicly to the GMCB webpage

What is a hospital global budget?

- It is a payment model in which hospitals are paid a prospectively established amount for a defined set of services over the course of a year.
- Payment is to a significant degree fixed, regardless of the quantity of services delivered.



From *Hospital Global Budget Technical Advisory Group Meeting #1 Slides*. GBTAG - Meeting 1 Materials - 1/24/2023 | Green Mountain Care Board (vermont.gov)

GMCB's Hospital Budget Review

Aspects of the GMCB hospital budget review process resemble a global budget.

- The GMCB establishes revenue growth rates and caps price growth for Vermont's hospitals. It has used the APM TCOC target to inform its regulatory work.
  - Hospitals "back into" the commercial revenue need based on assumptions for reimbursement by public payers (Medicare and Medicaid).
  - Pre-COVID, commercial price growth was the driver of increasing budgets, not utilization, due to low rates of growth in public payer rates.
  - Payers and hospitals report that the growth cap affects commercial price growth.
  - Enforcement occurs after the fiscal year ends, so it does not have an immediate impact.
- This process is intended to constrain cost growth, but, unlike a global budget, it does not create a "floor" for sustainable and predictable revenue for hospitals.

From *Hospital Global Budget Technical Advisory Group Meeting #1 Slides*. GBTAG - Meeting 1 Materials - 1/24/2023 | Green Mountain Care Board (vermont.gov)

State Implementation of Hospital Global Budgets

- Three examples of state hospital global budget programs:
  - NY Hospital Experimental Payment Program (1980 – 1987)
  - MD All-Payer Model and TCOC Model (2010 – present)
  - PA Rural Health Model (2019 – present)
- Each state's model has been unique and reflective of state-specific policies and market dynamics.
- Vermont's All-Payer Model also includes some characteristics of hospital global budgets; we will review Vermont's model as well.

From *Hospital Global Budget Technical Advisory Group Meeting #1 Slides*. GBTAG - Meeting 1 Materials - 1/24/2023 | Green Mountain Care Board (vermont.gov)

Current Global Budget Models

Model Summary	Pennsylvania Rural Health Model	Maryland Total Cost of Care (TCOC) Model
Provider participation	• 18 rural hospitals (5 Critical Access Hospitals)	• 46 rural and urban hospitals • Aligned physician and post-acute providers
Payor participation	• Medicare FFS, 6 private payers with commercial plans, Medicaid MCO, Medicare Advantage	• All-payor (through provider rate-setting approach)
Included spending	• Hospital inpatient and outpatient • Self-insured groups are excluded by some commercial plans	• Hospital inpatient and outpatient • Other types of spending aligned with different models

From *Hospital Global Budget Technical Advisory Group Meeting #1 Slides*. GBTAG - Meeting 1 Materials - 1/24/2023 | Green Mountain Care Board (vermont.gov)

Findings from State Experiences

New York (1980-87)

- Reduced growth in hospital operating revenues and expenses
- Improvements in net margins
- May have yielded stronger results with model expansion

Maryland (2010 to date)

- Reduced hospital spending for Medicare and commercial
- Reduced total expenditures for Medicare
- Reduced admissions for Medicare and commercial
- Reduced ED visits

Pennsylvania (2019 to date)

- Limited data to assess effectiveness
- Participation from many hospital types (critical access, system-owned, independent)

From *Hospital Global Budget Technical Advisory Group Meeting #1 Slides*. GBTAG - Meeting 1 Materials - 1/24/2023 | Green Mountain Care Board (vermont.gov)

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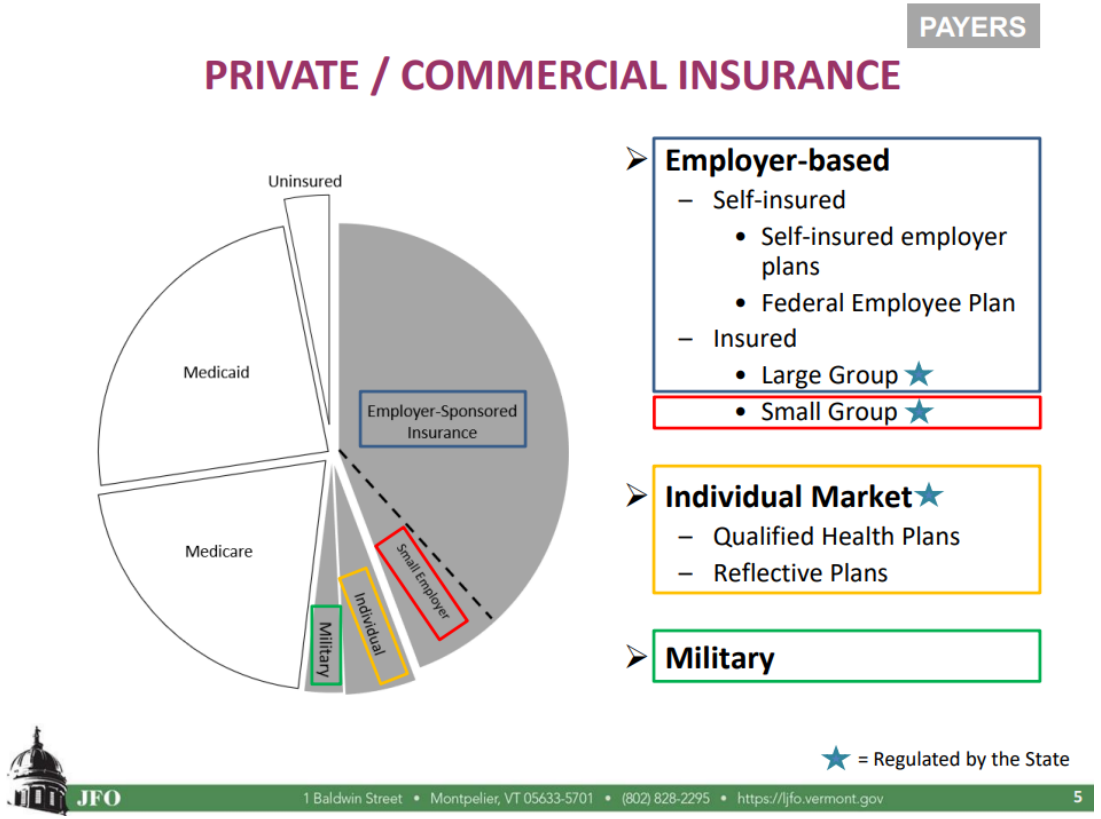
LEGISLATIVE SESSION: PRIOR AUTHORIZATION

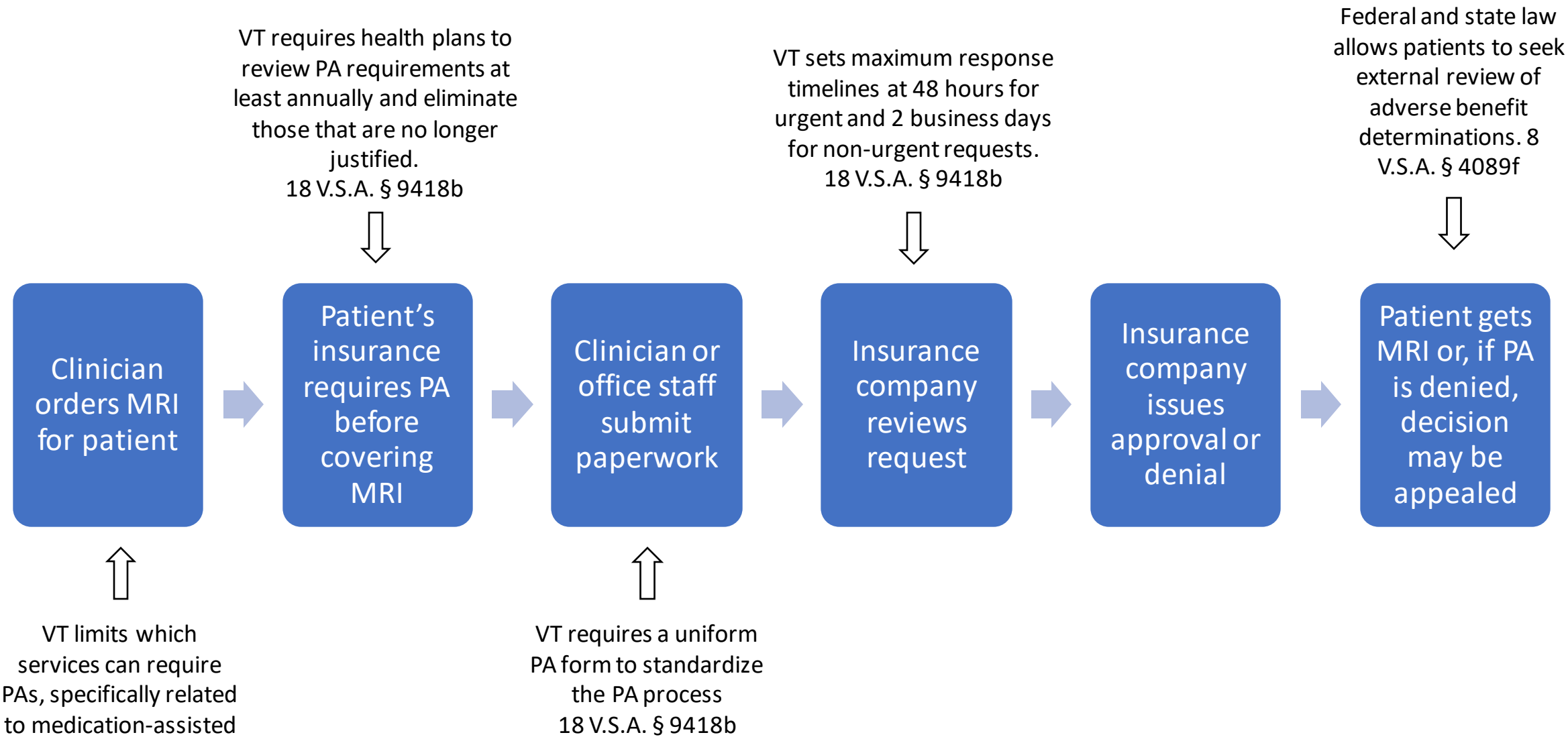
Scope of Legislative Action

- As with other policy topics considered by the committee, any legislative action will be limited to state regulated plans.
- As it relates to PAs, this means that changes to streamline processes and reduce administrative burden will not apply to all patients seen by Vermont providers.
  - For example, changes will not apply to self-insured employer plans



Screenshot from Nolan Langweil's presentation to HHC on 1/17/2023

Existing Laws and Rules for Prior Authorization

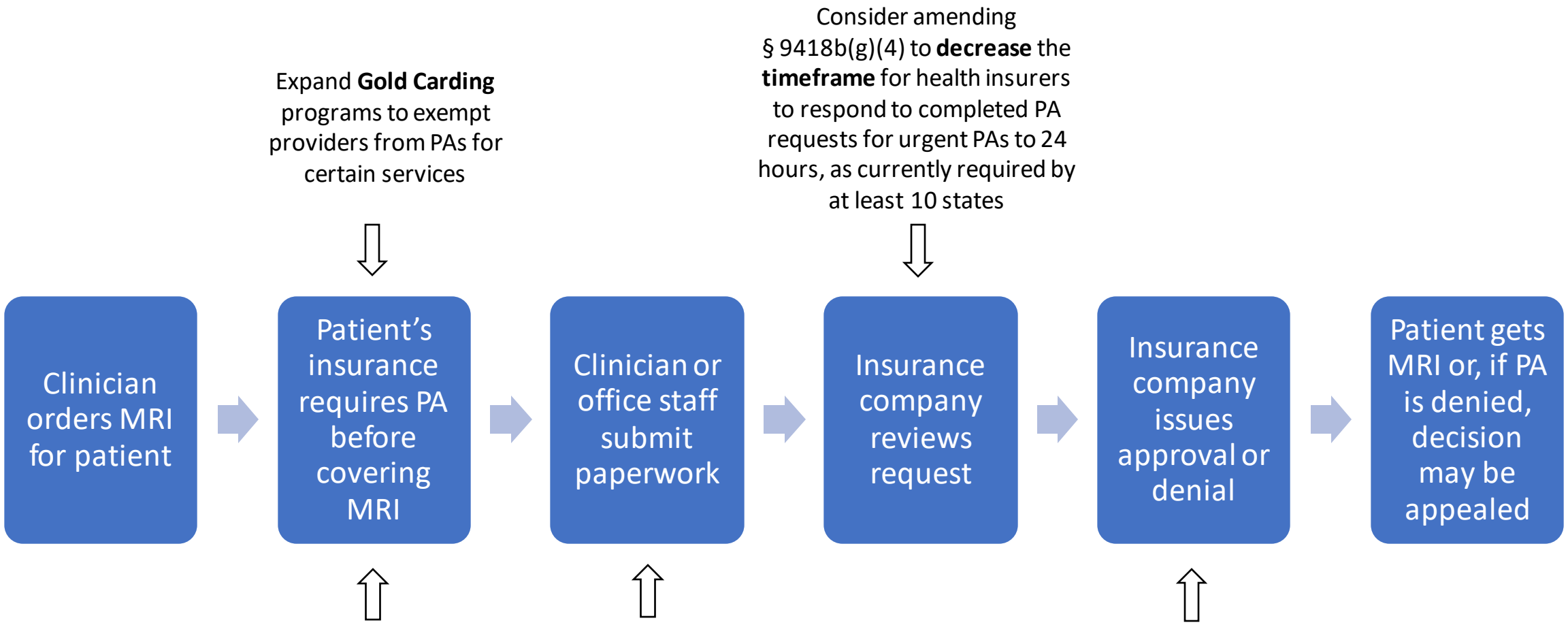


*Note applicability of VT laws is limited to state regulated plans

Past Work on Prior Authorization

Year	Action
2013	**Standard Prior Authorization Forms (Act 171 of 2013)** The Department of Financial Regulation (DFR) was tasked to work in consultation with the Department of Health Access (DVHA), the Vermont Medical Society (VMS), and health insurers to develop a "clear, uniform, and readily accessible" prior authorization form for use by all relevant Vermont providers. The uniform prior authorization form will be used for all types of medical treatment that requires prior authorization, including mental health and substance abuse. The uniform prior authorization form for medical service requests was finalized by September 1, 2013, as required.
2013-2016	**Prior Authorization Pilots** In 2013, 18 V.S.A. § 9377a was added, directing the GMCB to work with health care professionals and health care insurers to implement a prior authorization pilot program. Through a workgroup convened by GMCB, the pilot program ultimately focused on eliminating PAs for two classes of drugs (PPIs and statins) and one procedure (non-contrast MRI of the spine for low back pain). This work laid the groundwork for future Gold Carding pilots.
2017	**Medicaid ACO Prior Auth Waiver** In 2017, DVHA implemented a PA waiver through its Vermont Medicaid Next Generation ACO Program, negotiated with OneCare, for services included in TCOC. Modifications in 2018 to have waiver follow Medicaid member (not provider in VMNG) to reduce admin burden and confusion among providers (e.g. referrals). Information from DHVA Act 140 report
2018	**Primary Care Advisory Group provided recommendations to GMCB on PA** [see next slide]
2020	Legislature passes Act 140, requires gold carding pilots for insurers (with over 1,000 covered lives for major medical health insurance in VT) to exempt from or streamline certain PAs for a subset of providers (Sec. 11(a)).
2021	GMCB convened a workgroup (AHS, DVHA, DFR, BCBSVT, MVP, HCA, OCV, HealthFirst, VAHHS, and VMS) to discuss opportunities for and obstacles to aligning and reducing PAs under APM (results in GMCB Act 140 Report)
2021 Annually	Prior Auth Attestation: Annually, starting in 2021, health plans shall attest to DFR and GMCB annually that it has completed review and elimination of PAs that are no longer justified or for which requests are routinely approved.
2021-22	Reports under Act 140 about PAs: DVHA PA and Provider Exemptions Report; Opportunities for and Obstacles to Aligning and Reducing Prior Authorizations under the All-Payer ACO Model (GMCB); Opportunities to Increase the Use of Real-Time Decision Support Tools Embedded in Electronic Health Records to Complete Prior Authorization Requests for Imaging and Pharmacy Services (DFR)
2023	Insurer PA and Gold Carding Reporting from each insurer required to implement a pilot program, due to GMCB, HHC, SH&W, and Senate Finance.

Opportunities for Legislative Action on Prior Authorization



*Note applicability of VT laws is limited to state regulated plans

Act 183 Report
Opportunities for Legislative Action

- Consider amending § 9418b(g)(4) to decrease the timeframe for health insurers to respond to completed PA requests for urgent PAs to 24 hours, as currently required by at least 10 states.*
- Consider prohibiting insurers from requiring reauthorization during the current plan year when a PA has been granted for services deemed preventative by the IRS under 26 U.S.C. § 223(c)(2)(C), which includes prescription drugs for certain chronic conditions.
- Expand Gold Carding programs instituted under Act 140 of 2020.

* https://www.ama-assn.org/system/files/2021-04/pa-state-chart.pdf

Act 183 Report
Opportunities for Legislative Action

- Limit how insurers apply step therapy – protocols establishing the sequence in which prescription drugs for a specific medical condition are prescribed.
  - The Massachusetts law prohibits insurers from requiring step therapy when:
    - A medication is known to be ineffective for the patient's condition or the patient has already tried a medication in the same pharmacological class.
    - If the patient is stable on a medication and switching off it would cause harm.
  - Massachusetts also requires insurers to report to the Division of Insurance on the number and type of step therapy exception requests received and approved

Request for PCAG

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- **What:** Share examples when you encounter challenges with prior authorization (omitting patient details) and whether any of the policy proposals reviewed in these slides could alleviate the challenge.

  Details that are helpful to share:

  - Type of prior authorization requested (service/procedure vs pharmaceutical).
  - Type of insurance – different insurance plans have different rules for prior authorization and the state's ability to impact these rules depends on the plan (see scope slide).
  - Amount of time you/your office spent on the request and impact on the patient's access to care.
- **How:** Call or email Julia Boles.
- **When:** Between now and the next PCAG meeting
- **Why**: As the Legislature considers prior authorization policy, PCAG can help share information on which parts of the prior authorization process (overlapping with areas of state jurisdiction) are causing the greatest challenges for you and your patients.