Thoughts on Vermont Payment Reform Strategies

Presentation to:
Green Mountain Care Board

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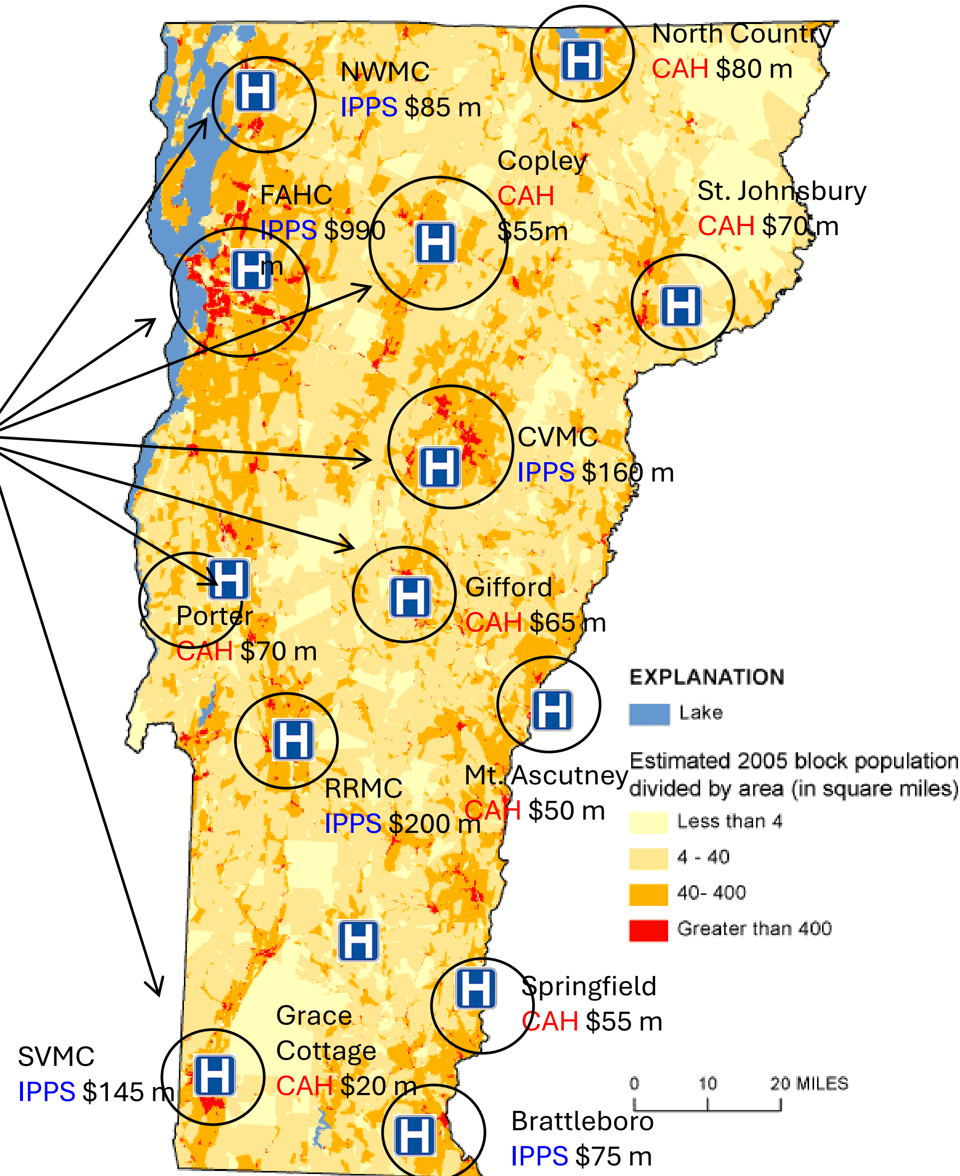
My Biases Regarding Payment Reform

- It's still the Prices!
- Runaway health care spending is driven by rapid price growth
- Caused by profound Market Failures in health care
  - Market Failure requires government intervention
  - In Maryland, in enacting the HSCRC statute, the legislature realized there was a role for government
  - But limited the intervention to correcting for market failure, but avoid other unnecessary interventions
- Voluntary rate setting models <u>don't work</u>
- Population-based payment is the ultimate goal, but ACOs won't get you there
- States have the best opportunity establish <u>mandatory rate setting</u> systems to address key health care issues
- Key is to change the incentives, but helpful to initially preserve some of the existing system
- Regional systems have an advantage of meeting the unique needs of populations
- Two good demonstrations to follow: Rochester/Finger Lakes Demos

Advantages to Regional Approaches

Vermont's regional system of hospitals makes it well-suited for hospital Global Budgets

Populations are naturally mapped to individual Hospitals



Regionally organized delivery systems are advantageous

Vermont is uniquely positioned to set up Such a system

This was our concept when we set up Maryland rural hospital global budgets

Rochester and the Finger Lakes hospital Global budget models were regional models

Best to leverage the cooperation of other Key actors in each region

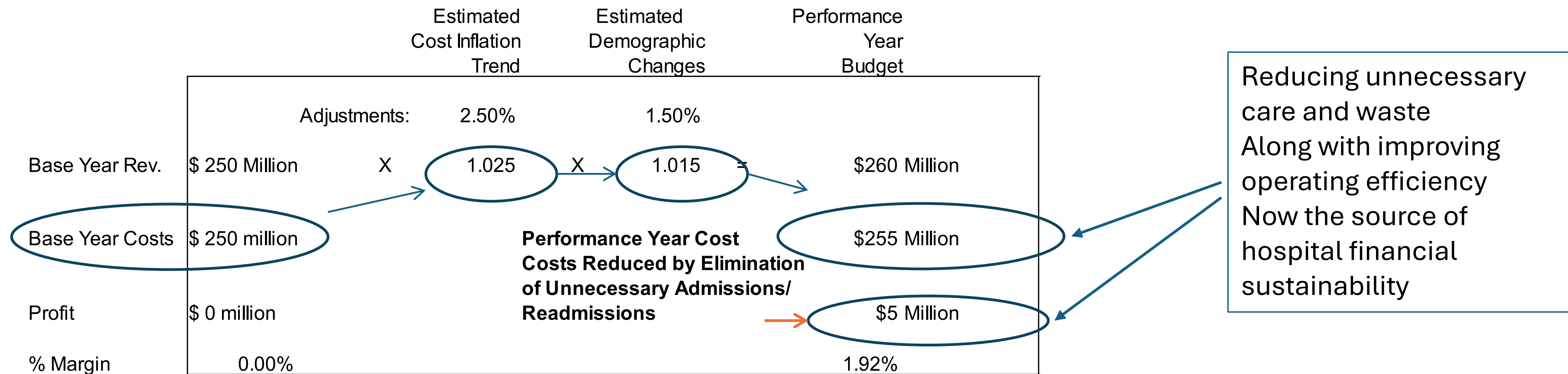
Private Payers
Primary Care Physicians
FQHCs

Key Features of an Effective Spending Control System

- Operated by a small independent agency
- Agency had broad powers to set and update provider rates & achieve other goals
- Strong enforcement authority
- Emphasis on:
  - Establishing very clear and attainable financial/cost targets
  - Formula-based rate methods that are relatively simple and well understood
  - Preserving existing payment infrastructure (claims processing systems)
  - Locus of regulatory control – at the Hospital Global Budget level
- Strong Preference for Flexible (as opposed to Fixed Global Budgets)
  - Some flexibility on how Flexible Budgets can be designed
- **<u>Mandatory participation by all hospitals and payers in the state</u>**
- Cooperation with private payers in designing incentive-based payment for physicians

Example of a "formula-based" Global Budget

- Medium Sized Rural Hospital
  - Community hospital in a rural part of the State
  - Separated by distance and mountain ranges
  - Serves 100,000 population in County
  - Limited "in-migration" from other parts of the State
  - Budget in Prior year = $250,000,000 – used as basis for Global Budget



This structure is similar to the Pilot Global Budget Hospital Arrangement proposed for Vermont in 2014

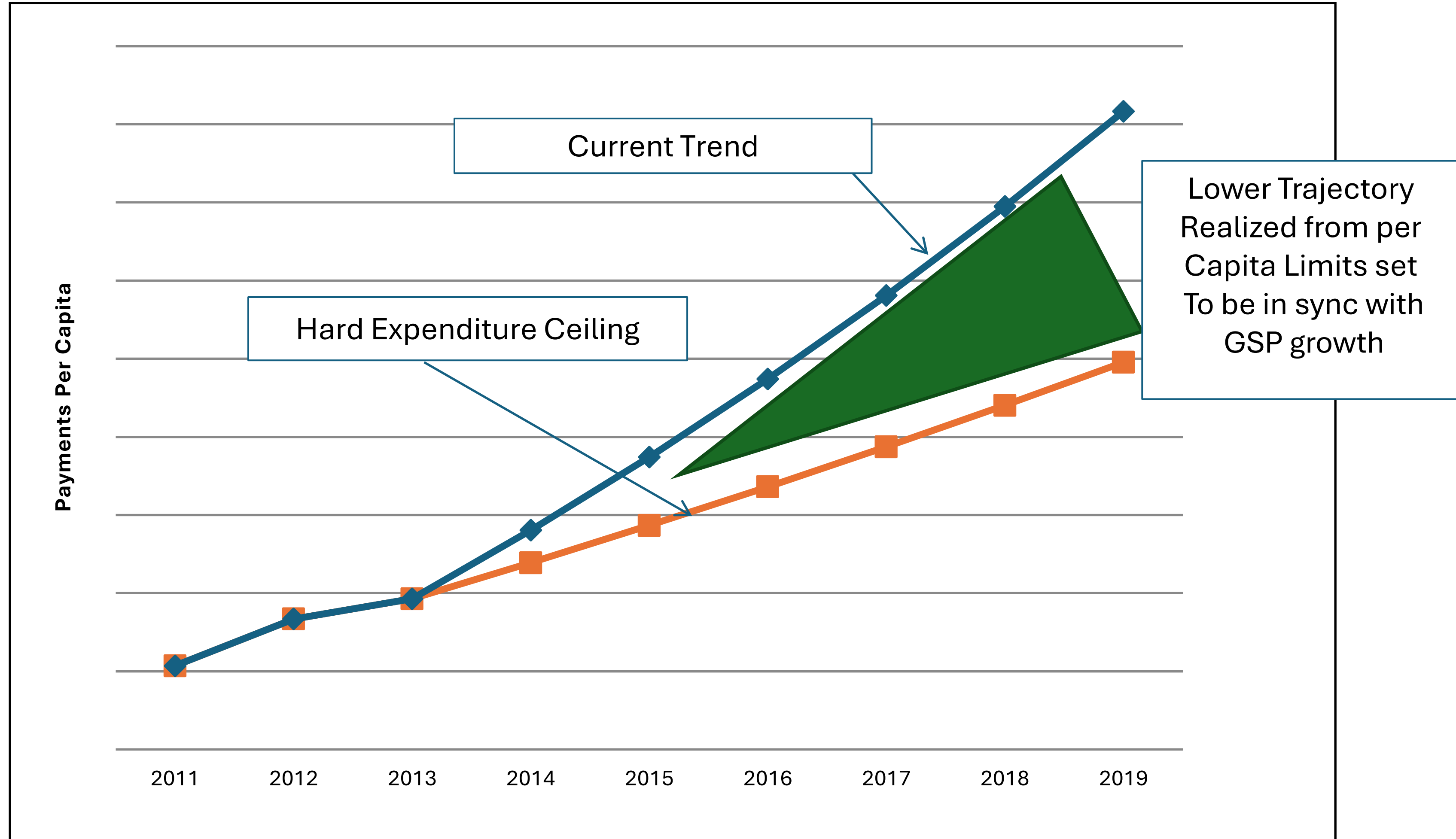
However, unlike Maryland, we proposed the use of "Flexible budgets" which paid on the basis of hospital Variable cost for volume change but preserved hospitals' fixed costs when volume declined

Overview of Three Different Approaches to Hospital Payment

FFS MODEL	Flexible Global Budget	Fixed Global Budget
Hospital marginal revenue greatly exceeds their marginal costs Provides extreme incentives for hospitals to increase volumes unnecessarily	• Hospital receives revenue for volume growth, but only for variable costs • Provides a predictable revenue source (covers fixed costs), neutralizes incentive to unnecessarily increase volume but tempers the incentive to restrict (i.e., stinting) or shift care to increase savings	• Hospitals do not receive additional revenue for volume growth • Incentivizes hospitals to reduce volume/costs and may encourage stinting and shifting of care as hospital gets paid the same regardless of volume

It's a "middle ground" approach – avoids excessively strong incentives to reduce care and embodies Manageable financial risk for smaller hospitals

The Model is Designed to Contain Per Capita Cost Growth



Key Success Factors

- Regional Orientation of Model and Cooperation with Key Regional Actors
- Set clear financial incentives (backed by strong enforcement) and an emphasis on keeping rate methods, well-understood, as simple as possible & formula-based
- Otherwise, avoid interfering with hospital resource allocation and operational decision-making
- This is a Macro-regulatory model, not a Micro-management regulatory model
- Focus on aggregate revenue compliance (at the budget level) and formula-based rate setting obviates the need for a large and complex regulatory agency
- Need for a Medicare/Medicaid Waiver to cede payment control to the State
- Two key dangers to rate regulation:
  - Regulatory Failure & Regulatory Capture
- The rate setting approach advocated can help avoid regulatory failure
- Key structural protections of the rate agency can help avoid regulatory capture

Vermont Has The Key Ingredients

- Small Independent Regulatory Agency
- Public Utility Approach – public deliberations and interactions
- ACT 48 gave the GMCB provider rate setting authority – thus the state already has the authority to create a mandatory rate setting state
- Mandatory rate setting can be designed to avoid ERISA pre-emptions
- Most necessary data can be collected directly from the hospitals per the GMCB's authority
- Regional orientation of the Vermont Delivery System
- The State should study and follow the Rochester/Finger Lakes demonstration models (previously authorized by the Medicare agency HCFA)
- Involvement from the State Department of Health
- Regional Models focusing on addressing Regional Health Care needs

Questions/Answers?

Potential Issues and Risks

- Hospital might not be effective at managing down unnecessary utilization – and thus it will lose 100 cents on the dollar for expenditures above the Budget
- Under fixed revenue caps, providers will be rewarded for reducing volumes of services – outside concern is this might lead to "skimping" quality, avoiding high cost cases or shedding of cases to other hospital and non-hospital providers
- The Participating Payers will not include Medicare initially – although Medicare Revenues will be counted toward the Hospital's Budget
  - If Medicare Volumes drop precipitously, the Participating Payers will be subject to "rate" increases necessary for the hospital to meet its Target Budget
  - Other Medicare shortfalls could occur if CMS has 0% or very low annual updates
- While many payers pay "Discounted Charges" (so payment changes to the hospital will be "automatic" with charge master changes), some pay on fee-schedules and thus the hospital must wait for a settlement until Year End
- There are additional data generation, oversight and monitoring requirements
- Implementation of the Pilot will require a separate process for the GMCB staff – RRMC will still file normal Budget Submissions

Benefits for the Hospital

- The Global Budget releases the hospital from the shackles of FFS medicine and the need to generate new and additional encounters and "transactions" in order to increase revenue and profitability
- The Global Budget also provides the hospital with increased predictability (the hospital knows what its revenues will be in a particular year)
- There is additional flexibility for the hospital too because, it can use these guaranteed revenues as it sees fit to meet the unique needs of its community
- It also more fully aligns the incentives of the hospital with those of its patients, the payers and the State
- It promotes a focus on community based efforts to keep residents healthy and de-emphasizes expensive facility-based interventions – many of which are unnecessary and harmful for the patient
- As noted, Global Budgets will not mean hospitals must go bankrupt in order to save society money in a new era of more affordable health care

Benefits for Payers

- The Global Budget also provides predictability for payers – they know what their rate increase will be while over time there is on-going pressure on the hospital to reduce unnecessary utilization
- It provides an opportunity for the hospital and payer to work more cooperatively to improve efficiency and reduce unnecessary or marginal care
- There is the potential for additional Administrative savings through reduced need for denials of claims and the possible implementation of a "Level Payment System" that would reimburse the hospital periodically and not per encounter
- Improved Affordability for subscribers (Maryland's Demonstration has the potential to reduce the growth in premiums for single individuals from nearly 1.0% on a compounded basis over time)
- Most importantly, Global Budgets can greatly contribute to the overall affordability and sustainability of a State's hospital sector

Benefits for the State

- Hospital expenditure growth per capita in Vermont (while lower in recent years following the great recession) has been quite high = 7.5% over 1991-2009
- Global Budgets would cap hospital/employed expenditure growth in the State at around 3.68% - a level commensurate with GSP growth and considered "economically sustainable"
- Health care expenditures have traditionally grown at GDP + 2.4% over time
- No jurisdiction (other than Rochester) has achieved a "sustainable" growth rate like this over a sustained period of time
- At the same time, as experience in New York and Maryland show, hospitals can remain viable financially while expenditures grow much more slowly
- Project be of great interest to CMS and the Center for Medicare/Medicaid Innovation for a possible future waiver to allow Medicare participation
- Global Budgets also remove the current disconnect in incentives under FFS facing hospitals and the incentives and goals under the SSP-ACO program
- Global Budgets are also very consistent with the goals of the *BluePrint* for Health