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Green Mountain Care Board
144 State Street
Montpelier, VT 05620

Dear Members of the Green Mountain Care Board,

Vermont must make affordability and access the priority as we negotiate a Global Hospital Budget Methodology to participate in the AHEAD model with. Blue Cross and Blue Shield of Vermont supports health care reform efforts on behalf of our members that improve the cost, quality and access to the statewide health care system. The current outline of the proposed AHEAD model does not offer a clear benefit for the immense affordability and access issues facing families and employers utilizing commercial health insurance coverage. The Vermont health care system is nearing a crisis state, and we are concerned about overlaying a complicated reform effort that may further exacerbate these underlying issues rather than offer financial stability and improvements in the system of care.

Focus on Affordability

Affordability must be a pillar of any state reform effort with an emphasis on the commercially insured population. The premise of the Vermont Global Payment Program, "to provide Vermont hospitals with a stable and predictable cash flow", focuses too narrowly on hospital revenue cycles and not on the financial sustainability of the entire health care system. The excessive focus on increasing hospital revenue over the past 14 years has pushed hospitals forward, all the while leaving the rest of the health care system bereft of the resources it needs. The global payment methodology must allow for the reallocation of existing revenue, increase efficiencies, and lower expenses instead of continual expansion.

Baseline and Adjustments

The methodology begins with current hospital revenue; a tenuous starting point. The recent Rand 5.0 study[1] shows that prices at our state's only academic medical center are significantly higher than peers nationally, the proportion of the state health care dollars going to hospitals is higher than most states, hospital spending has grown faster than any other state in the country.[2]

The adjustments outlined in the AHEAD model are predominantly upward, leading us to believe that if the program achieves any savings, it is unlikely that the delta would be returned to consumers. While Blue Cross VT supports moving toward a value-based payment system,

structuring said payment system based on historical revenue with scant downward adjustments locks us into already high prices that are the hallmark of health care in our state.

Methodology

We understand that the draft methodology is currently only specific to Medicare, but we must tread forward carefully as this will have a profound impact on Vermont's other insured populations. We have several specific concerns:

Pharmaceutical revenue, less the actual acquisition cost of the drugs, must be included in the Global Hospital Budget methodology. The exclusion of pharmacy, when this is a lead factor driving up health care in Vermont and nationally, is a glaring omission. This policy choice gives us pause about whether a Medicare-centric health care reform model can address the myriad of health care issues impacting this state. Pharmacy specifically is an unnecessarily opaque area within hospital budgets that is costing Vermonters dearly.

Medicare FFS GPP adjustments, Table 3 of the draft methodology shows fifteen different types of adjustments, with only eight of them possibly—and only slightly—reducing the global payments. The financial incentives must align with the priorities and outcomes that are the purpose of our participation in the model. Many of these adjustments reward hospitals for positive and negative outcomes simultaneously and ensure that savings achieved by the model will never be realized by Vermonters who pay commercial rates, further exacerbating the affordability crisis.

Is there any plan to consider outlier scenarios in which all adjustments are either upward or downward? Examples of potential solutions would include:

- A cap to adjustments, which could be a limiter in terms of an overall strong increase or decrease to the model based purely on adjustments.
- The overall increase that the provider would receive could be imputed to be the average of their peers' adjustments, if that value is lower than the providers initial increase.

Some scenario analysis would be good for confidence in the system if it can put undue long-term stress on the member base financially.

We have grave concerns about open-ended adjustments such as "exception-based factors" for upward adjustments on a "case-by-case basis" being an avenue for influence-driven decision-

making.[1] If these recommendations remain in the methodology, criteria must be established to manage the circumstances where undefined adjustments may be utilized.

Finally, tying funding to service line changes should incentivize an alleviation of access challenges, but just as importantly, should implement significant downward adjustments when quality declines, costs expand, or access doesn't improve. Furthermore, both the service line adjustments and beneficiary updates must be made in the same plan year as the changes occur or it will further stress the commercial risk pool as members move to government programs or out of state plans, yet still would remain the fiscal responsibility of the originating health plan's risk pool, to the detriment of those left paying the premiums.

Oversight and Participation

As we have repeatedly advocated, in order for the AHEAD model to succeed, its oversight must be transparent and timely. The GMCB is the appropriate body to provide publicly accountable oversight.

Partial participation on the part of either the hospitals or the insurers will create unintended incentives and competitive advantages. If only some hospitals are participating in the global hospital budgets there will be incentives to shift patients to hospitals that aren't under a global budget. Similarly, payers may have a competitive advantage for customers if participation increases costs and therefore premiums. None of the transformation investments accrue to payers for implementation changes forcing these costs onto premium payers.

As we have stated from the beginning, participation in federally driven health care reform models is proving problematic because of the focus on Medicare savings over the health of the statewide system and in particular, affordability for those with commercial health insurance coverage. The model must benefit all participants and increase access and affordability for consumers.

Sincerely,

Sara Teachout, Corporate Director
Government and Media Relation

[1] Rate Regulation Revisited: Managing Regulatory Failure and Regulatory Capture in Health Care by Robert Murray.