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Act 159 Interactive Price Transparency Dashboard Recommendations

Green Mountain Care Board

February 2022

Outline

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1. Background on Price Transparency
   a) Review previous reports
      - Act 53: Price Transparency Report from November 2019
      - Act 54: Consumer Information and Price Transparency Report (2015)
   b) Available data and limitations
2. Reimbursement Variation Report
   a) Validation efforts
   b) Overview of approach
   c) Demonstration
3. Recommendations for future development

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Background: History of transparency initiatives

FINDINGS: Consumer Information and Price Transparency Report (2015)

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Resources

- Best-practice transparency website are expensive to create and costly to maintain.

VHCURES

- Primarily a tool to analyze broader trends in utilization and spending, there is limited ability to adapt data for a consumer-facing site that compares costs for specific procedures.

Health insurance landscape in Vermont

- Vermont's large group insurance market is dominated by one very large health insurer (Blue Cross & Blue Shield of Vermont) which holds almost 80% market share.

CONSIDERATIONS:
Price Transparency and Billing Processes Report (2019)

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- Conduct a needs assessment
- Define goals and objectives
- Evaluate funding and resources
- Select website features
- Implement best practices

CMS Price Transparency Rules

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- Hospitals
  - Required to post machine-readable files with negotiated rates for all items and services and subset of shoppable services in a consumer-friendly format.
  - Providers must provide uninsured or self-pay patients good faith estimates prior to all scheduled care (No Surprises Act).
- Health plans
  - Starting in July 2022, many health plans will be required to post pricing information for covered items and services.

NOTE: These rules do not provide standard formats, limiting the ability to make comparisons.

GMCB Data Availability

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- Full reimbursement amounts are available in Vermont's All-Payer Claims Database, VHCURES (Vermont Health Care Uniform and Reporting and Evaluation System).
- VHCURES started in 2009 and contains data for Medicare, Medicaid, and most commercial health plans for Vermont residents.
- Includes care delivered to Vermont residents by out-of-state providers.

Limitations on VHCURES Data

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- Does not include:
  - Care delivered in Vermont to non-Vermont residents
  - Care that is paid outside of insurance (e.g. self pay)
  - Approximately 75,000 Vermonters with coverage through a self-funded employer group
- Lagged by ~ 9 months
- Lacking information about plan design (e.g., metal level tier for Qualified Health Plans)

Enhanced Data Validation Work

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- A voluntary group of 20 stakeholders assisted the GMCB in identifying a subset of procedure codes for validation with providers and payers.
- Stakeholders represented hospitals, independent practices, FQHCs, insurers, consumer advocates, and vendors.
- Ultimately, the group identified 22 common procedures. Insurers provided their data, which was compared with VHCURES.

VHCURES vs Insurer Data

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- Of the 22 procedures, median reimbursements per procedure per provider were compared.
  - 17 procedures (77%) matched within the dollar
    - 5 evaluation and management office visits
    - 2 vaccine administration codes
    - Physical therapy
    - Standard lipid panel
    - Diagnostic colonoscopy
    - Removal of benign lesion
    - Vaginal delivery
    - Drain/injection without ultrasound guidance
    - Arthroplasty of the knee
    - Laryngoscopy
    - Psychotherapy
    - Eye exam

VHCURES vs Insurer Data

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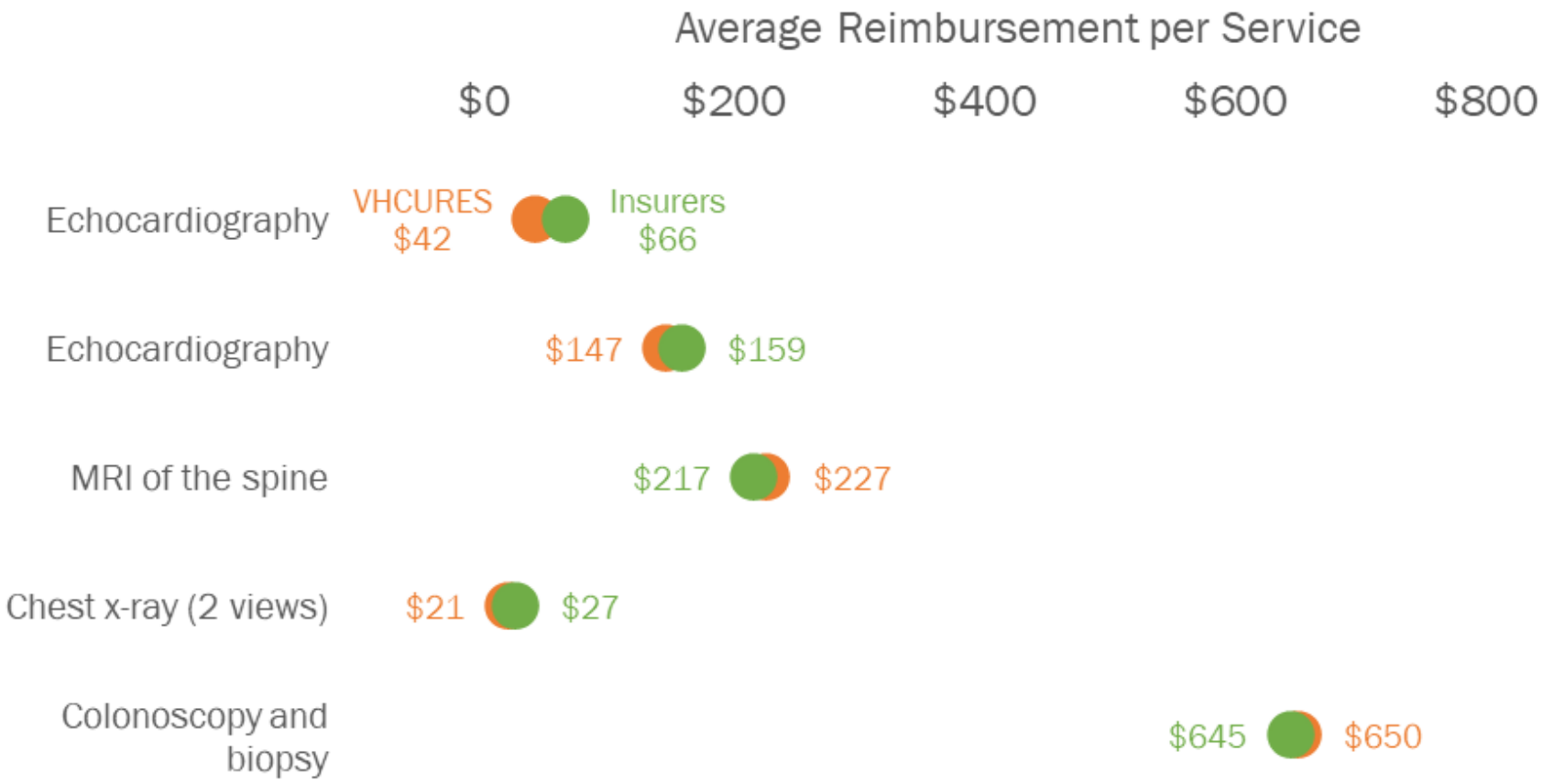

Challenges for Estimating Payments in Advance

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Patient characteristics

Patients that seem similar based on demographics may have very different treatment needs, which can be difficult to determine before the patient is seen.

Provider options

Providers may have different treatment options available.

Individual providers may have differences in their recommended treatment.

Billing complexity

Different contracts pay for services in different ways (e.g., episodic payments, bundles, capitation).

Medical coding is extremely complex and includes discretion to interpret guidance.

Services may require coordination of providers, not all of which may be under the employ of the provider.

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Dashboard: Reimbursement Variation 2017-2020

Dashboard Approach

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- Includes total reimbursements for three types of care:
  - Inpatient stays
  - Outpatient surgery
  - Outpatient diagnostic services
- The dashboard uses the **total allowed amount**, which includes:
  - Payments from the insurer and
  - Payments expected from the patient (i.e., copays, coinsurance, and deductible amounts)
- The total allowed amount is the full payment expected by the provider and *is not*
  - The charges from the provider's chargemaster
  - The cost to the provider to perform the service
- The episodes are designed to capture all the relevant payments associated with the service, including professional services.

Dashboard Approach, continued

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- Episodes are assigned to a primary provider.
- Payer types include:
  - Medicare: provided by the federal government to aged and disabled beneficiaries, including Medicare Advantage plans
  - Medicaid: provided by the State of Vermont to beneficiaries who qualify, often based on their income
  - Commercial: either purchased directly or provided through employment, including self-funded employer groups with data available in VHCURES
- Reimbursements are not adjusted for patient complexity.

Dashboard Example – Median Reimbursement by Provider

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Dashboard Example – Median Reimbursement by Provider and Payer Type

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Dashboard Example – Median Reimbursement by Provider and Payer Type

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Dashboard Example – Provider Detail

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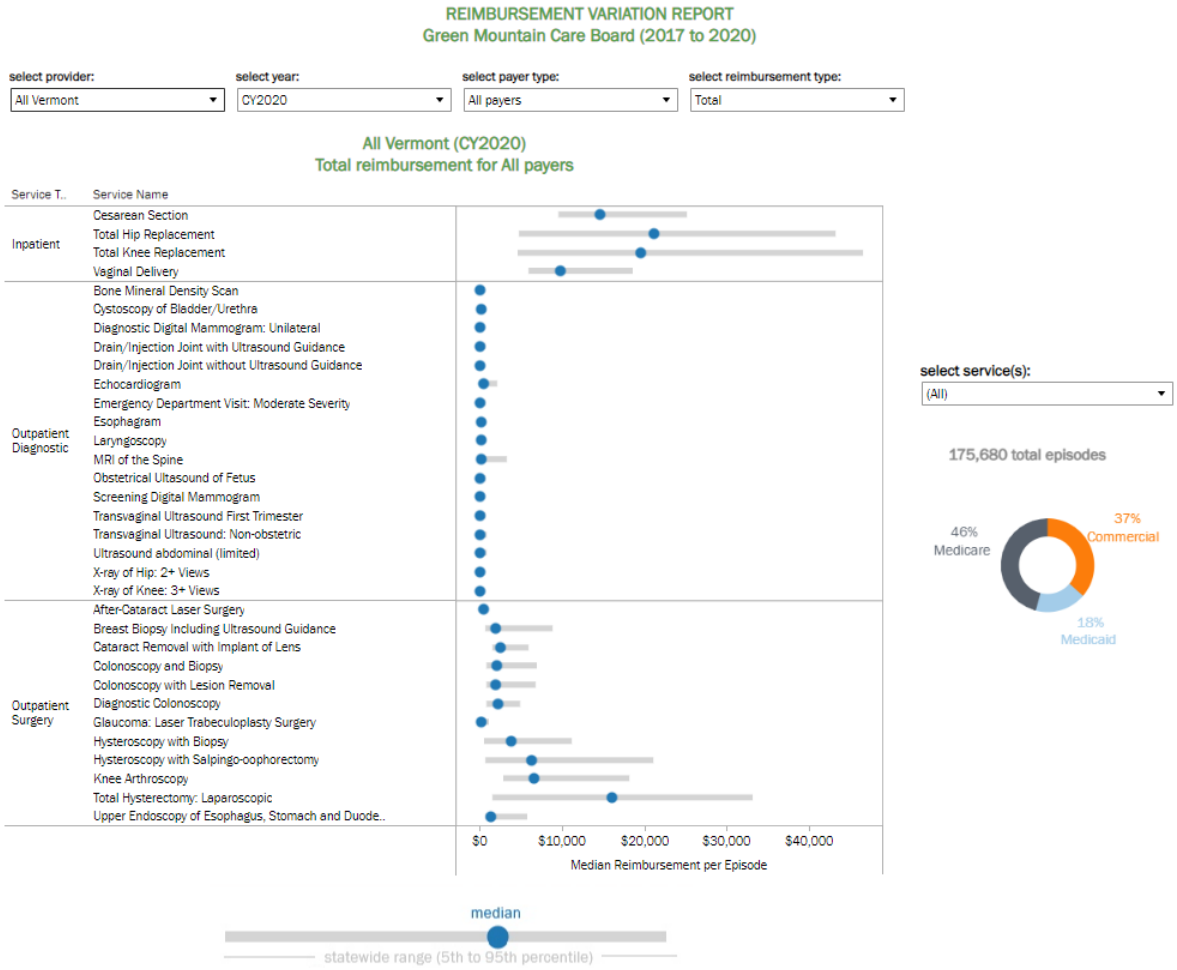

Demonstration

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- The report may be found on the GMCB website:

https://gmcboard.vermont.gov/gmcboard.vermont.gov/reimbursementvariation

- Questions and feedback may be directed to GMCB.DATA@vermont.gov.

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Recommendations and Further Development

Strategies to Improve Data

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- Improve the quality and usability of standardized provider data.
- Develop ongoing tools to offer submitters more insight about post-consolidated data.
- Encourage more self-funded employer groups to submit data to VHCURES.

Adding Quality Information

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- While a critical piece of information, meaningfully measuring quality involves considerable resources and may add burden to providers.
- Results may be limited in utility, especially due to the state's small population.
- Current provider data has limitations in connecting providers together for episodes of care – especially for professional services.

Adding Self Pay estimates

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- This task will be unlikely to yield useful estimates because:
  - Programs exist for certain conditions and situations that change frequently and are not tracked in a systematic way.
  - Patient financial responsibility is tracked at an encounter level in many financial systems.
  - The service ultimately needed may be different than what patients expects:
    - A birth is often expected to be uncomplicated but may end up requiring more intervention.
    - A patient going for a screening colonoscopy may end up needing a biopsy or removal of lesions.

Plans for Expanding Dashboard

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- The dashboard will evolve to more closely align with the Boards' work related to sustainability, which will allow inclusion of:
  - additional services
  - risk-adjustment
  - estimates of provider cost
- This will provide a more "apples-to-apples" comparison and extend the information available for monitoring the state's health delivery system.