Presentation: Options for Regulating Provider Reimbursement – Part 3

Impact on Provider Sustainability and Equity in Reimbursement

Act 159 of 2020 Sec. 5

Green Mountain Care Board

April 8, 2021

Executive Summary

Act 159 of 2020, Section 5

"GMCB, in collaboration with DFR, DVHA, and Director of Health Care Reform, shall identify processes for improving provider sustainability and increasing equity in reimbursement amounts among providers. The Board's consideration to include: (1) care settings; (2) value-based payment methodologies, such as capitation; (3) Medicare payment methodologies; (4) public and private reimbursement amounts; and (5) variations in payer mix among different types of providers."

- **Legislative Context:** Build on prior reports on pay parity/equity by outlining options for regulating provider reimbursements, including cost estimates and implementation issues. For summary of prior reports on pay parity/equity, see Appendix.

Executive Summary

Key Questions for the General Assembly

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What is the key problem Vermont is trying to solve?

- **Cost containment** and **value-based care** are central to Vermont's health reform strategy.
  - How should Vermont prioritize **sustainability** and **reimbursement equity** while balancing **consumer affordability** and **access**?
- How should Vermont **define sustainability and reimbursement equity**?
  - How to prioritize where policy options have varied benefits and challenges for different provider types (e.g., hospitals vs. primary care providers; health systems vs. independent providers)?
  - Act 159 of 2020 Section 4 report (due in Fall 2021) will significantly expand on the concept of sustainability and provide more information about hospital sustainability.
- How should Vermont **balance provider-led reform vs. mandatory regulation**?
  - How to support continued provider transformation and avoid change fatigue?

Options for Regulating Provider Reimbursement

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Option 1: Health System Budgets
Option 1A: Provider Entity Budgets with Population-Based Payments
Option 1B: Evolve ACO Regulatory Process to Set Provider Payment Methodologies and Amounts
Option 1C: Require Insurers to Use Population-Based Payments

Option 2: Setting Reimbursement Parameters
Option 2A: Entity-Based Growth Caps and Floors
Option 2B: Service-Based Growth Caps and Floors
Option 2C: Growth Parameters in Payer-Provider Contracts

Option 3: Fee-for-Service Rate Setting
Option 3A: FFS Rate Setting via Provider Regulation
Option 3B: FFS Rate Setting via Insurance Regulation

Option 1: Health System Budgets

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Definition: Health system budgets are caps on spending for some portion of the health care system (a provider organization, facility, or a network of providers), generally set prospectively with a defined total budget amount, prescribed enforcement mechanism, and/or payment methodology. Budgets can be all-payer or payer-specific. This option is intended to impact the *total spending*.

- Options: 3 potential regulatory approaches (provider; ACO; insurer)

What issues could this approach highlight?

- Unit cost & utilization & value-based payments
- Conflict between sustainability and cost containment/affordability in regulated sector
- Impact of minimal reimbursement increases in public payers

What issues are hard to address with this approach?

- Lack of market power for smaller, currently unregulated providers due to high administrative burden for these providers & GMCB

Cost Estimate Ranges:

- Implementation: $1.275 - $1.650 (one-time)
- On-going Operations: $375k - $1M (annual)

Option 1: Health System Budgets

Implementation Options

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Implementation via Provider Regulation

- **Option 1A: Evolve Hospital Budget Review into Provider Entity Budgets with Population-Based Payments:** The GMCB would evolve the hospital budget review to set charges based on a required payment methodology, which, after factoring in expected utilization, would total the approved budget for each entity. The payment method and amounts could be payer specific or payer agnostic. The goal would be to ensure that regulated provider entity revenues are charged and paid in a standard manner. The payment methodology could also include adjustments for unanticipated utilization, market shifts, out-of-state patients, payer mix, and other factors.

Implementation via ACO Regulation

- **Option 1B: Evolve ACO Regulatory Process to include State-Set Provider Payment Methodologies and Amounts:** The GMCB would evolve the ACO oversight process to establish a budget, payment methodology, and amounts charged by a network of providers for an attributed population based on State-developed criteria. The payment method and amounts could be payer-agnostic, but ideally would be aligned across multiple (all) payers. Requires payer and provider participation for attribution.

Implementation via Insurance Regulation

- **Option 1C: Require Insurers to Use Population-Based Payments:** The GMCB would require insurers to adopt population-based payment methodologies (e.g., predictable, flexible, stable, value-based payments paid to providers or an ACO) and other reimbursement parameters to establish a budget for the population purchasing an insurance product. This would correlate to a portion of providers' budgets associated with these populations. Self-insured employer plans could voluntarily participate.

Health System Budgets

Example: Maryland All-Payer Model (2014-current)

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- Maryland evolved its all-payer rate setting model (see slide 78), transitioning to a global budget model starting in 2014 and then to a Total Cost of Care model in 2019.
- Under Maryland's All-Payer Model, Maryland Health Services Cost Review Commission (HSCRC) established an annual health system budget for each hospital and then set hospital rates for all payers, including Medicare and Medicaid.
  - Hospital budget built from allowed revenues during a base period and adjusted for future years using a number of factors, both hospital specific and industry wide, and updated each year
  - Payers are billed on FFS basis using rates set by HSCRC and are then increased or decreased systematically to achieve a fixed budget
- Maryland APM aims to improve quality through two of the waiver requirements:
  - Reductions in the Medicare 30-day hospital readmission rate to the national rate over 5 years
  - Reductions in the state's all-payer aggregate rate of 65 potentially preventable conditions by 30% over the 5 years of the waiver
- So far, Maryland has saved over $45 billion and lowered the rate of cost growth from 25% above the U.S. average to 3% above the average

Health System Budgets

Example: Pennsylvania Rural Health Model (2019-current)

- Pennsylvania's Rural Health Model, an All-Payer Model with the Center for Medicare and Medicaid Innovation (CMMI), is testing a multi-payer global budget model with rural hospitals in the state. The model tests whether the predictable nature of global budgets will enable participating rural hospitals to invest in quality and preventive care, and to tailor their services to better meet the needs of their local communities. CMS is making $25M available to PA to implement the model. The Agreement required Pennsylvania to create a new regulatory body to support this effort.
- Rural hospitals are paid fixed amounts by CMS and other participating payers. These amounts are set in advance and intended to cover all inpatient and hospital-based outpatient care. The Model does not set a fixed all-payer budget; rather, budgets are set payer-by-payer for their members. Participating payers include Medicare, Medicaid, and some commercial payers.
- Participating rural hospitals prepare Rural Hospital Transformation Plans, outlining their proposed care delivery transformation, which must be approved by Pennsylvania and CMS.
- Metrics: Under the Model Agreement, Pennsylvania has committed to the following:
    - $35M in Medicare hospital savings; the growth rate for rural PA total Medicare expenditures per beneficiary must not exceed the growth rate of the rural National total Medicare expenditures per beneficiary by more than a certain percentage; Increase access to primary and specialty care, reduce rural health disparities through improved chronic disease management, decrease deaths from substance use
- Benefits to this model include predictable payments and stable cash flow; a payment model that enables hospitals to move towards financial sustainability; and budget neutrality for payers across the portfolio of participating hospitals
- Challenges include the voluntary nature of this model; a small (but growing) number of hospitals has elected to participate, and PA has not achieved full commercial payer participation.

Option 2: Setting Reimbursement Parameters

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Definition: Regulatory entity limits provider reimbursement to a particular growth rate; growth caps can be combined with growth floors for particular services or provider types to align with state policy goals. Vermont's hospital budget process (see example, slide 67), already acts as a cap on cost-per-service growth for Vermont's 14 community hospitals; the GMCB only regulates growth over time in the current process, and does not review data on actual charges or paid amounts annually. Targets *growth in unit cost;* does not prescribe *unit cost*. • Options: 3 regulatory approaches (provider; high-level service parameters; insurer) • Hypothetical example: Payments for primary care services must increase by X% in 2022. An offsetting limitation must be made in other services if cost neutrality to premiums is desired.
What issues could this approach highlight? • Prioritize growth for certain types of providers or services (e.g., primary care) & limit growth for other types of care; highlights winners and losers in provider sector • Could counterbalance lack of market power to some degree over time (not completely)
What issues are hard to address with this approach? • Total spending (not targeted at utilization) • Sustainability of unregulated providers
Cost Estimate Ranges: • Implementation: $70-425k (one-time; range depending on option chosen) • On-going Operations: $10k-270k (annual)

Option 2: Setting Reimbursement Parameters
Implementation Options

Implementation via Provider Regulation:

- **Option 2A: Entity-Based Growth Caps and Floors.** The GMCB would evolve the hospital budget process to impact the professional fee schedule and/or regulate cost-per-service for currently unregulated providers. GMCB could evolve its current hospital budget process to refine how it caps the trend on charges (currently, the cap on charges impacts commercially reimbursed inpatient and outpatient hospital services). The process of applying a cap or floor on trend could be extended to other provider types, however, a cap on commercial reimbursement may not be applicable to all providers.
- **Option 2B: Service-Based Growth Caps and Floors.** The GMCB would set a minimum or maximum reimbursement growth trend for a *category* of codes (e.g., professional services), around which the providers and payers could negotiate. It would not do so at the level of an individual service. This option is focused on commercial reimbursements.

Implementation via Insurance Regulation:

- **Option 2C: Growth Parameters in Payer-Provider Contracts.** The GMCB would direct payers to limit growth in reimbursement in contracts negotiated with providers.

Setting Reimbursement Parameters

Example: Vermont Hospital Budget Review (1983-current)

- Since 1983, Vermont has annually reviewed and established community hospital budgets
  - Review 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
  - GMCB took on this process from BISHCA per Act 171 of 2012
- Hospitals submit budgets on July 1 for coming fiscal year (begins October 1)
- Two regulatory levers:
  1) Growth in net patient revenue (NPR) and fixed prospective payments (FPP):
     - Total charges at the hospital's established rates for providing patient care services, including FFS claims at the charged amount and services paid for under FPP arrangements
  2) Change in charge
     - Increase (or decrease) in the average gross FFS charge for all services across all payers.
     - Instead of regulating charges for particular hospital services, GMCB sets a maximum average gross charge increase per hospital for all services for all payers; however, Medicare and Medicaid do not negotiate their prices, so change in charges impact hospitals' negotiations with commercial insurers
     - GMCB cannot review net charges (gross charges minus the negotiated deductions by payers and hospitals) because negotiated prices are considered confidential, and this information is not available to the GMCB

Setting Reimbursement Parameters

Example: Rhode Island Affordability Standards (2004–current)

- 2004: Created Health Insurance Advisory Council (HIAC) to better understand health care cost drivers
- 2009: HIAC Developed Affordability Standards and Priorities for Rhode Island Commercial Health Insurers
  - Commissioner directed insurers to comply with four new criteria to have premium rates approved:
    - Expanding and improving primary care infrastructure;
    - Spreading the adoption of the patient-centered medical home model;
    - Supporting the state's health information exchange, CurrentCare;
    - Working toward comprehensive payment reform across delivery system.
- 2016: Most recent affordability standards adopted require insurers:
    - Spend at least 10.7% of their annual medical spend on primary care;
    - Limit hospital rate increases so that the average rate increase is no greater than the Urban Consumer Price Index (CPI) (less food and energy) percentage increase plus 1%.
- Affordability standards also require the inflation plus 1% cap in insurers' negotiated prices with hospitals in order to have their premium rates approved

Option 3: Fee-For-Service Rate Setting

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Definition: Regulatory entity sets reimbursement amounts, most commonly using an existing payer's reimbursement scheme as a point of reference. Medicare is the most common point of reference for fee-for-service rate setting, because Medicare's reimbursement amounts and methodologies are publicly available, national, and geographically adjusted.

- This option targets unit cost but not utilization, which limits its effectiveness in impacting total cost of providing care. This option will modify the current base cost of health care, but also targets the growth trend (growth in base cost over time).
- Options: 2 regulatory approaches (provider; insurer)
- Hypothetical Example: Evaluation & Management Code XXXXX = $100

What issues could this approach highlight?

- Counterbalances market power issues

What issues are hard to address with this approach?

- Total spending (not targeted at utilization)
- Sustainability of unregulated providers
- Moving to value-based care
- Winners and losers in the provider sector

Cost Estimate Ranges:

- Implementation: $600-2,025k (one-time; range depending on option chosen)
- On-going Operations: $300-950k (annual)

Next Steps
Key Questions

What is the key problem Vermont is trying to solve?

- **Cost containment** and **value-based care** are central to Vermont's health reform strategy.
  - How should Vermont prioritize **sustainability** and **reimbursement equity** while balancing **consumer affordability** and **access**?
- How should Vermont **define sustainability and reimbursement equity**?
  - How to prioritize where policy options have varied benefits and challenges for different provider types (e.g., hospitals vs. primary care providers; health systems vs. independent providers)?
  - Act 159 of 2020 Section 4 report (due in Fall 2021) will significantly expand on the concept of sustainability and provide more information about hospital sustainability.
- How should Vermont **balance provider-led reform vs. mandatory regulation**?
  - How to support continued provider transformation and avoid change fatigue?

Next Steps
Potential Areas for Discussion

- Defining and ranking (or balancing) policy priorities
- Potential for combining policy options; pros and cons of this approach
- Potential for including public payers and challenges to doing so
- Low-hanging fruit

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DISCUSSION

Reference

Options for Regulating Provider Reimbursement - Summary

Model	Summary	Providers and Care Settings Impacted	Payers Impacted		
			Medicare	Medicaid	Comm.
Option 1: Health System Budgets. Health system budgets are caps on spending for some portion of the health care system (a provider organization, facility, or a network of providers), generally set prospectively with a defined total budget amount, prescribed enforcement mechanism, and/or payment methodology. This option targets *total spending*.					
Option 1A: Provider Entity Budgets with Population Based Payments	Evolves the hospital budget review to set charges based on a required payment methodology, which, after factoring in expected utilization, would total the approved budget for each regulated provider entity.	Vermont hospitals currently subject to the budget process; could be expanded to other provider types with new authority.	Maybe	Maybe	Y
Option 1B: Evolve ACO Regulatory Process to Set Provider Payment Methodologies and Amounts	Evolves the ACO oversight process to establish a budget, payment methodology, and amounts charged by a network of providers for an attributed population based on State-developed criteria.	Providers participating in an ACO to whom the payment method applies; ACOs operating in Vermont.	Maybe	Maybe	Y
Option 1C: Require Insurers to Use Population-Based Payments	Require insurers to adopt population-based payment methodologies and other reimbursement parameters to establish a budget for the population purchasing an insurance product.	Providers accepting payment by regulated carriers or through an ACO.	N	N	Y
Option 2: Setting Reimbursement Parameters. Regulatory entity limits provider reimbursement to a particular growth rate; growth caps can be combined with growth floors for particular services or provider types to align with state policy goals. This option targets *growth trend*.					
Option 2A: Entity-Based Growth Caps and Floors	Evolves the hospital budget process to impact the professional fee schedule and/or regulate cost-per-service for currently unregulated providers.	Hospitals; potentially additional entity types	N	N	Y
Option 2B: Service-Based Growth Caps and Floors	This option would set a minimum or maximum reimbursement growth trend for a category of codes (e.g., professional services), around which the providers and payers could negotiate. It would not do so at the level of an individual service.	Could apply to any class of services (e.g., professional services), or a subset of services or provider types.	Unlikely	Unlikely	Y
Option 2C: Growth Parameters in Payer-Provider Contracts	Directs payers to limit growth in reimbursement in contracts negotiated with providers.	Could apply to any combination of inpatient, outpatient and professional services.	N	N	Y
Option 3: FFS Rate Setting. Regulatory entity sets reimbursement amounts, using Medicare's reimbursement methodology as a point of reference. This option targets *unit cost* and *growth trend.*					
Option 3A: Implementation via Provider Regulation	Sets reimbursement methodology based on a percentage of Medicare reimbursement; providers change charge lists to match.	Most applicable to hospital and physician services	Maybe	Maybe	Y
Option 3B: Implementation via Insurance Regulation	Directs payers to negotiate with providers for reimbursement that averages a maximum percentage of Medicare reimbursement.	Most applicable to hospital and physician services	N	N	Y

Reference

Options for Regulating Provider Reimbursement - Summary

Model	Implications for... Value-Based Care	Provider Sustainability	Reimbursement Equity	Implementation and Operations Cost
Option 1: Health System Budgets				
Option 1A: Provider Entity Budgets with Population Based Payments	Supports	Supports	Could improve reimbursement equity across regulated providers, depending on design. Would not impact unrelated providers.	• Implementation: $1,275-1,650k (1x) Option 1A only: $175-250k (1x) All Options: $1,100-1,400k (1x) • Operations: $375-1,000k (annual) *NOTE: All Health System Budgets options would require significant model design to inform operational cost estimates*
Option 1B: Evolve ACO Regulatory Process to Set Provider Payment Methodologies and Amounts	Supports	Supports	Could improve reimbursement equity through special payment models.	
Option 1C: Require Insurers to Use Population-Based Payments	Supports	Could support, depending on design	Not designed to improve reimbursement equity, though could improve equity within commercial market over time depending on design.	
Option 2: Setting Reimbursement Parameters				
Option 2A: Entity-Based Growth Caps and Floors	Could potentially support	Could support or hinder, depending on design	Could improve reimbursement equity if extended to currently unregulated providers.	To evolve hospital budget process: • Implementation: $0-70k (1x) • Operations: $0-10k (annual) To expand hospital budget process: • Implementation: $285-475k (1x) • Operations: $235-270k (annual)
Option 2B: Service-Based Growth Caps and Floors	Could potentially support	Does not support	Could improve reimbursement equity, depending on design. Impacts growth, not unit cost.	• Implementation: $285-425k (1x) • Operations: $135-270k (annual)
Option 2C: Growth Parameters in Payer-Provider Contracts	Could potentially support	Does not support	Could improve reimbursement equity within commercial market, depending on design. Impacts growth, not unit cost.	• Implementation: $20-60k (1x) • Operations: $20-60k (annual)
Option 3: FFS Rate Setting				
Option 3A: Implementation via Provider Regulation	Does not promote	Does not support	Could improve reimbursement equity with modifications to Medicare reimbursement policies	• Implementation: $1,500-2,025k (1x) • Operations: $625-950k (annual)
Option 3B: Implementation via Insurance Regulation	Does not promote	Does not support	Could improve reimbursement equity within commercial market with modifications to Medicare reimbursement policies	• Implementation: $600-725k (1x) • Operations: $300-350k (annual)

Reference

Major GMCB Regulatory Authorities

Regulatory Authority	Statute and Rule	Summary
Hospital Budget Review	• 18 V.S.A. chapter 221, subchapter 7 • GMCB Rule 3.000	Establishes aggregate budget target and caps charge trend for each of Vermont's 14 community hospitals annually by October 1.
Health Insurance Premium Rate Review	• 8 V.S.A. § 4062 and 18 V.S.A. § 9375 • GMCB Rule 2.000	Tasks the GMCB to review major medical health insurance premium rates in the large group and the merged individual and small group insurance markets.
ACO Certification and Budget Review	• 18 V.S.A. § 9382 • GMCB Rule 5.000	Establishes criteria for the State's regulating authority to certify and review ACO budgets. Authority has been given to the GMCB to approve or deny the certification of ACOs, with eligibility verification annually after initial approval; and annually review and approve or deny an ACO's budget.
Rate Setting Authority	• 18 V.S.A. 9375(a)(1)	Not implemented to date. Gives authority to oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs; promote seamless care, administration, and service delivery; and maintain health care quality in Vermont. No enforcement provisions.