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GMCB Response to COVID-19 and Implementation of H.742

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GMCB's response to COVID-19

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1. GMCB Implementation of Sec. 5 of H.742 (Act 91)

   Notwithstanding any provision of 18 V.S.A. chapter 220 or 221, 8 V.S.A. § 4062, 33 V.S.A. chapter 18, subchapter 1, or the Green Mountain Care Board's administrative rules, guidance, or standards to the contrary, during a declared state of emergency in Vermont as a result of COVID-19 and for a period of six months following the termination of the state of emergency, the Green Mountain Care Board may waive or permit variances from State laws, guidance, and standards with respect to the following regulatory activities, to the extent permitted under federal law, as necessary to prioritize and maximize direct patient care, safeguard the stability of health care providers, and allow for orderly regulatory processes that are responsive to evolving needs related to the COVID-19 pandemic: (1) hospital budget review; (2) certificates of need; (3) health insurance rate review; and (4) accountable care organization certification and budget review.

2. Improving the financial stability of Vermont's Health Care System in the near and long term

GMCB Implementation of H.742: Hospital Budgets

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- Worked with OCV/VAHHS/AHS/Federal Delegation to understand seemingly low grants to hospitals pursuant to the CARES ACT
- Closely monitoring hospital financial health
  - Tracking COVID-19 financial relief
  - Leveraging hospital reporting to other agencies and their own boards to understand impact of COVID-19 (# cases etc.)
- Paused non-financial reporting in budget process to free up provider capacity to fight pandemic
- Revising hospital budget guidance and process
- Hospital sustainability planning
  - Now even more important, continuing internal development until stakeholders have more bandwidth

GMCB Implementation of H.742: Certificate of Need

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- CON Bulletin 002: Procedure and Guidance for Emergency Certificate of Need Applications to Respond to the COVID-19 Pandemic
  - Streamlines CON process for new health care projects which enhance/support the State's ability to respond to COVID-19.
- CON Bulletin 003: Temporary Waiver of the Requirement for a Certificate of Need for Certain COVID-19 Pandemic-Related Projects
  - Waives requirement for health care facilities to obtain a CON for temporary health care projects related to COVID-19 where:
    - Facility has obtained a 1135 Waiver from CMS or the project falls under CMS' COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers or;
    - Project is part of the State's coordinated response to the COVID-19 pandemic and is directed by VPS or AHS, or;
    - Project is for the development of a hospital constructed or operated by the U.S. government in response to the COVID-19 pandemic.

GMCB Implementation of H.742: All Payer Model

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A letter was sent to CMMI requesting flexibility and additional funding to be directed to providers for Vermont's COVID-19 response:

- GMCB staff presented a draft of the letter at a public GMCB meeting on April 8th
- The letter was sent on April 29th and was signed by all three APM signatories (Governor, AHS, GMCB)
- Content of the request
  - Ensure providers participating in Medicare ACO Initiative can access all available resources now, and are not harmed as they look forward to financial recovery, for example:
    - Allow Vermont to keep 2019 reconciliation due to CMS for difference between FPP and FFS equivalent
    - True capitation for 2020 if FFS < FPP
    - Quality metrics to continue to be required under the APM and tracked by providers, but requesting any potential financial penalties to be waived to allow all available resources to be redirected to COVID-19 response

GMCB Implementation of H.742: ACO Oversight

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Due to Board concerns around **hospital solvency** and OneCare's letter requesting operational relief the Board reviewed OCV's 2020 Budget Order

- GMCB staff presented an analysis of OCV's request on April 1st and the board voted to amend OCV's 2020 budget order to **postpone reporting deadlines** and to **release funding requirements** for VBIF so OCV could **direct the dollars** immediately back **to providers.**
- As specified in OCV's 2020 Budget Order Amendment #1, OCV came before the board on April 22nd to provide an update on their **role in the response to COVID-19.**
- OneCare will be coming before the Board again on **June 3rd** to present its **revised 2020 budget.**
- As the situation evolves, the Board will continue to seek updates from OCV and will make budget order adjustments as necessary.

GMCB Implementation of H.742: Rate Review

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The 2021 QHP review timeline has so far remained unchanged (includes form review with DFR, rate review with GMCB and certification with DVHA).

- Issuers have indicated they plan to file on time (May 8th).
- Federal deadlines related to QHP certification and the Exchange have not changed.
- GMCB staff remain in contact with issuers, DFR, and DVHA regarding any logistical issues that may come up as a result of the COVID-19 response, including the possibility that rate review hearings and public comment may be conducted remotely.
- Insurers came before the board on April 29th to discuss their response to COVID-19.

GMCB Implementation of H.742: GMCB Operations

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- GMCB Contingency Planning
  - Preparing for potential staffing shortages due to illness and closure of school/childcare
- GMCB Budget
  - Working closely with Finance and Management representative to stay on top of all budgetary issues
  - Closely monitoring budget and looking for opportunities for cost savings (e.g. contractors offering discounts) and providing flexibility on bill back
- GMCB resources offered for COVID-19 response across state government
  - Used VCHURES to identify populations at higher risk for COVID-19
  - GMCB staff have skills that can be leveraged during this time of emergency (e.g. data, analysis, program management)

Stability of Vermont's Health Care System

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The **predictable payments** that are a part of our state's health reform model are proving an important line of **defense** in battling the **COVID-19** pandemic, especially those that are *truly fixed in nature* and not reconciled against fee-for-service equivalents.

As stated by Dr. Stephen Leffler, the President of Vermont's Academic Medical Center during recent testimony, "those payments are actually now our *most secure dollars* in this situation."

Stability of Vermont's Health Care System

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Variation exists across providers in terms of the **proportion of their revenues that are fixed**, depending on the programs in which they elected to participate, and the number of attributed lives that fall within that program

- Of those hospitals participating in ACO programs in 2020, **0.1%** to **23.1%** of revenue are made of fixed prospective payments (FPP). However, a smaller portion of these payments are true FPP, meaning unreconciled at year end (i.e. Medicaid).
- Of the **35** participating independent providers only **7** are taking a true FPP, but all program participants will receive supplement payments (approx. $1 million in total);

Under our current model, maximum scale is ~85% of Vermonters; and both participation in the model as well as electing FPP is *voluntary*.

Stability of Vermont's Health Care System

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How do we continue improving the financial stability of Vermont's Health Care System in the near and long term?

Stability of Vermont's Health Care System:

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Short Term (Current Fiscal Year)

- Analyze opportunities to modify the Medicare ACO Initiative to increase FPP available to providers.
- A GMCB board meeting was held on April 29th to understand how insurers are supporting our state's response to COVID-19.
  - OCV currently piloting fixed payment with BCBS
- Continue collaborating with AHS to ensure hospital solvency.
- Understand OCV's response to COVID-19 including impact on participating independent providers.
  - June 3rd presentation on revised 2020 budget
- Support of Telemedicine expansion to health care workforce and access to care.

Stability of Vermont's Health Care System:

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Medium Term

- Hospital Sustainability Planning
  - Now more important than ever to refocus on financial stability of Community health systems
- Communicate benefits to providers of FPP program that is already in operation under the ACO (voluntary program)
- Increase scale
  - GMCB to continue following-up on scale survey
  - How to motivate self-insured to join the model?
    - State employees/teachers
- Explore possible changes to Medicare ACO Initiative under APM*
  - **Geographic Attribution Methodology**: based on residency, instead of claims history; will increase scale, which provides more opportunity for FPP
  - **True Capitation Payment**: Right now FPP is reconciled against FFS equivalent at year end and poses a financial risk to participating providers; true capitation mirror's Medicaid's FPP program
- Coordinate with DFR to ensure system-wide equity in cost-sharing.

**Timeline:* Changes of this magnitude would take 18+ months for CMS to operationalize

Stability of Vermont's Health Care System

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Long Term

- APM 2.0 – continuing concept development, but also considering request for extension to current model
  - We expect COVID-19 to impact our health system now and into the future, not just in terms of financials, but also in terms of scale and quality; it will take time for these effects to be known, quantified, and analyzed
- Explore methods to increase FPP
  - Consider building on Hospital Budget Process to establish global budgets and invoke provider rate setting authority
  - Leverage lessons learned from other models (e.g. MD All payer global budgets, PA rural health model and global budgets)

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Questions?

Appendix I: Learning From Others

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Pennsylvania All Payer Rural Health Model and Global Budgets

- **Hypothesis:** predictability of global budgets → investment in quality and preventive care by rural hospitals and tailoring of services to better meet the needs of local communities.
- **How:** Facility-based global budgets with FPP from all participating payers (includes CMS), based on historical spend, requires rural hospitals to a Transformation Plan to the state/CMS for approval
- **Status:** This model is still relatively new but is experiencing implementation challenges, as PA was unable to establish an independent regulatory authority

Maryland All Payer Global Budgets

- **Hypothesis:** Predictability of hospital rate-setting through an All-Payer Model → investments in improving patients' health and reducing costs to better
- **How:** State regulatory authority sets rates for all hospitals and participating payers (includes CMS) based on inflation, payer mix changes, population and demographics, and the impact of value-based reimbursement programs
- **Status:** This model has proven successful in achieving savings through increasing access and reducing hospital readmission rates

Appendix II: Other Resources

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- The case for FPP, especially during COVID-19
  - https://www.chcs.org/addressing-provider-viability-the-case-for-prospective-payments-during-covid-19/
  - https://www.milbank.org/publications/how-payment-reform-could-enable-primary-care-to-respond-to-covid-19/
- Global Budgets 101
  - https://www.urban.org/sites/default/files/05_global_budgets_for_hospitals.pdf
- State Considerations on Global Budgets
  - https://www.shvs.org/wp-content/uploads/2018/05/SHVS_-Global-Hospital-Budgets_FINAL.pdf
- AHA on global budgets for vulnerable communities
  - https://www.aha.org/global-budgets-pathway-ensuring-access
  - https://www.aha.org/system/files/content/16/ensuring-access-taskforce-exec-summary.pdf
- Telemedicine
  - https://www.vpqhc.org/statewide-telehealth-events