S.290 Draft No. 1.1 Unedited Draft for Discussion Purposes – GMCB Response

General Feedback

Currently, the studies in the draft appear to overlap in content to some degree. The studies should work in concert and should not be duplicative, because you risk generating recommendations that are in conflict or inconsistent with each other.

Section 1 – Oversight of Accountable Care Organizations

OK. (Q) & (R) will be hard to measure effectiveness in a regulatory process, but GMCB currently collects information on these efforts.

Section 2 – Agency of Human Services; Accountable Care Organizations; Public and Population Health

Neutral

Section 3 – Regulation of Accountable Care Organizations; All-Payer ACO Model Future Planning; Report

GMCB understands that the goal of this report is to provide recommendations in two primary areas: 1. Structure of ACO regulation and 2. Modifications to APM 1.0 for APM 2.0 development. However, the language is focused on ACO regulation and ACO payer program development, not APM 2.0 issues. It will be more costly and less effective to have a broad scope of work in this RFP. Contractors who have expertise in designing regulatory systems may not necessarily be experts on ACO programs and vice versa.

- As it relates to work stream #2, APM 2.0 development, please keep in mind the timeline already shared with the committee, which illustrates that planning is already under way, with little to no buffer time for rework. If the committee wants to impact the development of APM 2.0 the best way to do so is at the level of setting of goals and policy priorities as was set out in Act 113 of 2016. A starting place may be for the committee to revisit these goals, which continue to guide the development of subsequent models (i.e. APM 2.0) and determine if these priorities continue to reflect the needs of Vermonters.
- Streamlining the study approach to focus on one area would be more effective. Currently, the recommendations touch on both regulatory design and ACO payer programs:
    - ACO regulation model – Regulation
    - Increasing ACO transparency – Regulation
    - Fostering ACO collaboration – ACO payer program (not Regulation, not APM 2.0)
    - ACO multi-year relationships – ACO payer program (not Regulation, not APM 2.0)
    - Provider solvency and shared savings distribution – ACO payer programs/Regulation
    - Multi-year ACO budgets – Regulation

Section 4 – High-cost Health Care Services; Hospitals; Report

Please define “services that the hospital provides at the highest cost” as this could be defined a number of ways: hospital expenses or price (which could be reimbursement or charge)

Section 5 – 18 VSA 9453(a)

OK

Section 6 – Hospital Duties

OK

Section 7 – 18 VSA 9457

OK

Section 8 – Health Care Provider on the Board

The board maintains the same concerns previously shared in testimony about what to do if no qualified individual applies, and appreciates the continuation of the language in the effective date section from the prior version that permits renewal of existing board membership.

Section 9 – DA Budgets

Neutral, prefer new version of the language

Section 10 - GMCB Rate Setting/Payment Reform Report

There appear to be multiple workstreams (and studies) in this section:

1. Rate setting: would include (a)(1) and (a)(2);
    - (a)(2): It is premature to project the impact of rate-setting on the APM total cost of care. This analysis should be incorporated into the rate-setting process when it is implemented. We recommend a modification of (a)(2) to read:
        - (a)(2) *how* rate setting could impact the total cost of care under the APM and how it could be used to increase the sustainability of rural health care facilities.
2. APM/ACO Program
    - (a)(3) specialty care is already included in the APM Total Cost of Care and quality measures. What is the intent of this language?
3. Rate Review
    - (a)(4) we are happy to include this work in the results of a study, but would like to inform the committee that this analysis is already under way and is unrelated to rate-setting or payment reform. Insurer administrative costs are included in premium rate review for QHP and large group markets.
4. New regulation
    - (a)(5) Please define "preferred provider organizations"; this is a term of art used in the ACO payer programs to mean providers who join the ACO, but do not take on risk. It is not, therefore, a description of a provider type that can be regulated through a separate budget process. For example, some FQHCs have joined the ACO, but not all of these organizations have joined. Section 11 – Neutral.

As mentioned previously, GMCB's hope is that this study would align with other studies required under this bill and would produce recommendations that could be taken together.

Section 11 – Role and Structure of State Government in Health Care Regulation and Reform

Neutral, but (b)(2) seems unrelated to (b)(1). Hospital commercial charges are currently capped in the hospital budget process, which limits the ability of hospitals to negotiate increased commercial reimbursements.

Section 10 – Health Insurers

Pending language.

Section 12 – Fair Contract Standards

Neutral, but here are some considerations:

- (c)(1) – If the Board is raising the cap on a commercial charge for a hospital due to financial solvency and sustainability issues or reducing a commercial charge to enforce a budget, the 120 day provision may be problematic and delay implementation. This reduces the effectiveness of the budget process.
- (c)(2) – The Board adjusts charges annually and sometimes more frequently in cases of urgent issues. This provision, for example, may have been problematic for Springfield Hospital's midyear charge increase request.

Section 13 – Workgroup on regulation and oversight of provider rates and contracts

How is the purpose of this work group different than the studies outlined in earlier sections?

Section 14 – Public Employee Attribution and ACO Study

GMCB will provide scale target performance and ACO scale strategy submitted via ACO oversight processes; GMCB recommends delivering this report as soon as possible to continue scale momentum.