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GREEN MOUNTAIN CARE BOARD

S.290 - GMCB Testimony

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Act 48 of 2011: Creation of GMCB

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- Act 48 of 2011 established the GMCB in order to **contain health care costs** through regulation, innovation, and evaluation.
  - Despite common misperception, the GMCB was not created to establish a single-payer health care system.

- The GMCB's work on containing health care costs has been successful, but there is still work to do.
  - GMCB has a key role in regulating ACOs and implementing the All Payer Model (APM) Agreement with the Centers for Medicare and Medicaid Services (CMS) with the aim of curbing the total cost of care, while maintaining quality and improving health outcomes of Vermonters.

GMCB Value Proposition

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1. **Holistic:** GMCB's regulatory authority encompasses health care spending, health care delivery, and health insurance premiums; it has a unique charge to consider the health care system as a whole
2. **Transparent:** GMCB conducts its business at public meetings and invites additional stakeholder participation through advisory committees and public comment opportunities
3. **Independent:** GMCB is an independent agency, with members appointed to 6-year terms

Mission: The GMCB seeks to improve the health of Vermonters through a high-quality, accessible, and sustainable health care system.

All-Payer ACO Model & ACO Regulation

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APM/ACO Activity	GMCB	AHS
ACO Oversight (Certification, Budget Review, and Monitoring)	✓	
Medicare ACO Benchmark Setting	✓	
Medicaid ACO Rate Case Review (Advisory)	✓	
Medicaid Rate Setting		✓
Commercial & QHP Rate Review	✓	
Vermont Medicare ACO Initiative Development	✓	
Operate Medicaid NextGen		✓
Implement APM Start-up Funding		✓
Planning for integration of additional Mental Health Services into APM		✓
Regulatory Alignment (Hospital x ACO x Payer)	✓	
Public health planning and implementation		✓
APM Performance Reporting	✓	
Propose APM 2.0	✓	✓

All-Payer ACO Model & ACO Regulation

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- GMCB regulates ACOs according to the criteria outlined in 18 V.S.A.§9382 and GMCB Rule 5.000 and measures and tracks ACOs' performance relative to the goals of the APM agreement; This includes the review and analysis of ACOs':
  - Governance Structure and Leadership
  - Financial Statements (income, balance sheet, and cash flow)
    - Includes metrics measuring administrative costs relative to program size
  - Network Development Strategy
  - Risk Mitigation Plan
  - Model of Care and Care Coordination Program
  - Population Health Investments
  - Collaboration with Community Providers
  - Payment Structure
  - Quality Improvement Plan
  - Payer Contracts
  - And more…

S.290: APM and ACO Regulation (Sections 1 through 3)

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- Criteria for ACO Oversight that are expected to measure ACO activity would fit more appropriately in the **"budget" section** than the "certification" section of statute, due to annual review;
- Any requirements to monitor the ACO's efforts to collaborate with other parties may be better implemented through their **existing contracts**, otherwise, criteria for collaboration needs to be clear and measurable for GMCB to be able to verify;
- Much of the **annual reporting** outlined in section 2 is **already collected** through the budget process, either at time of the ACO's budget submission or subsequently through the ACO's Budget Order;
- A **two-year budget** and reporting cycle for ACOs may be **premature** before we get to scale as much changes year over year and we still have annual obligations to CMS that require ACO regulation and reporting.

S.290: Hospital/Insurer Pricing Transparency (Section 4)

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- GMCB would like more discretion to require a greater number of health care services, and to determine which health care services may be of interest to the board given other regulatory levers, across all payers
  - Supports GMCB regulatory integration (e.g. monitoring and evaluation of APM would benefit from data on rates of primary care services vs specialist services overtime)
- GMCB recommending study to understand impact of a 0.5% commercial rate increase reporting requirement, on administrative burden to state and providers

S.290: Designated Agency Budget Review (Section 5)

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There are a range of possible approaches…

Depth of Regulatory Oversight	Resource Needs
Based on Hospital Budget Review (bill as introduced (Budget Approval)	High – 2 FTEs
Based on Brattleboro Retreat, limited financial oversight (Financial and Health System Analysis)	Low – 0.5 to 1 FTE

S.290: Board Membership (Section 6)

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- Neutral

S.290: Rate Setting (Provider/Payer) (Sections 7 through 10)

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General Recommendation

GMCB recommends a study to identify the resources necessary to implement fee-for-service (FFS) rate setting at the provider level, but also what potential rate setting could hasten a transition away from FFS toward capitation (e.g. global budgets), given the direction of health care reform. *GMCB would need the authority to require confidential information from providers and payers with the ability to maintain the confidentiality.*

The study could include:

- Volume of insurers, their programs, and rates that they set
  - Include frequency analysis of rate changes greater than 0.5% (Section 4)
- Extent of impact on TCOC under APM
- Impact on sustainability of rural health care institutions
- Number of legal FTEs required to review contracts

New

For the on-going collection and setting of reimbursement rates in the hospital budget process (18 V.S.A. § 9375(b)(7)), all information must be public. The existing language limits our ability to collect actual reimbursements information. We suggest language to allow for this collection.

S.290: Fair Contract Standards (Section 11)

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- Neutral

S.290: Public Employee Attribution to ACO (Section 12)

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- Neutral

Preliminary Scale Estimates based on ACO 2020 Budget Submission

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	2018 Final			2019 Projected			2020 as Submitted (Budget)		
	APM Population	Population In Scale Target Initiatives	Scale Performance (Target)	APM Population	Population In Scale Target Initiatives	Scale Performance (Target)	APM Population	Population In Scale Target Initiatives	Scale Performance (Target)
Medicare	**115,029**	**39,702**	**36% (60%)**	**113,272**	**54,210**	**48% (75%)**	**~114,080**	**~53,014**	**~46% (79%)**
Medicaid	136,407	42,342		135,879	75,711		~130,025	~94,221	
Commercial Self-Funded	182,151	9,874		166,996	10,111		~171,795	~66,387	
Commercial Fully Insured	105,473	20,838		92,978	20,074		~88,083	~35,842	
Commercial Medicare Advantage	11,749	0		12,693	0		~17,776	0	
All-Payer Total	**550,809**	**112,756**	**20% (35%)**	**521,818**	**160,106**	**31% (50%)**	**~521,759**	**~249,464**	**~48% (58%)**

Resources

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GMCB Website

2020 GMCB Meeting Information

2019 GMCB Annual Report, submitted 1/15/2020

GMCB Legislative Reports webpage

GMCB Rule 5.000 – ACO Oversight

OneCare Vermont 2020 Budget Order

Appendix I: GMCB Containing Health Care Costs

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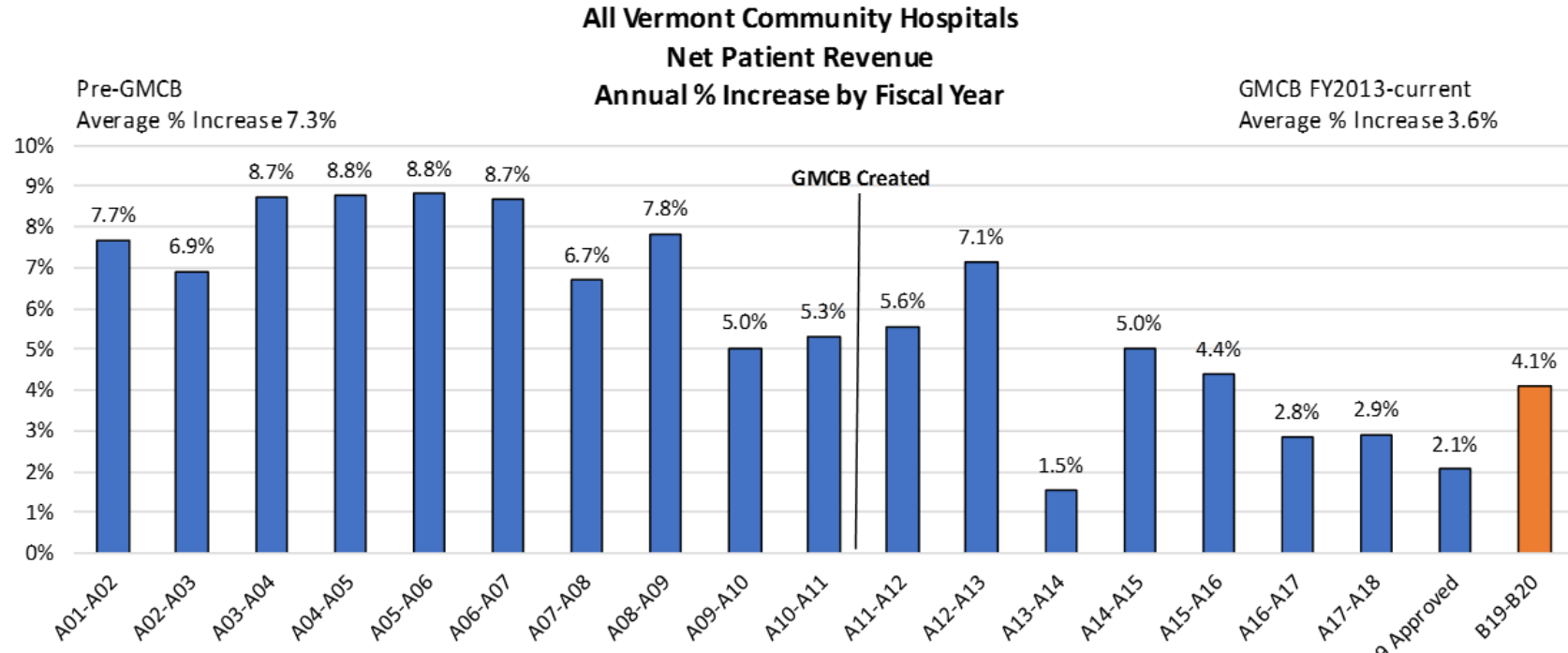

FY20 Budgets were approved with adjustments for accounting changes and provider transfers at 4.3%

Notes:
A = Actual
B=Budget
GMCB assumed responsibility for reviewing and approving hospital budgets in FY2013

Appendix II: All-Payer ACO Model & ACO Regulation

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Implementing
Provider-Led ACO

Payment Structure
- Population-based payments and system-wide investments in primary care and prevention
- Waivers (e.g. prior authorization and SNF care)
- Complex care coordination payments

Data and Information
- Tools to manage care for high-risk patients
- Analyses on variations in cost, utilization and quality to support provider-led health reform
- Data literacy and clinical improvement support

Technical Assistance
- Coordinated state/federal reporting for providers
- Partner with social services and the Blueprint for Health to address social determinants of health
- Care coordination training and clinical education

Leads to Changes in
Care Delivery

Shift to Prevention
- Fixed payments allow providers to invest in prevention activities to meet community needs (otherwise unreimbursed), eliminating incentives for volume associated with fee-for-service

Accountability
- Providers now responsible for populations' health/social needs, not only treating the sick
- Provider reimbursements are tied to high quality, person-centered care and outcomes

Collaboration
- Incentivized to increase partnerships with providers and service organizations to ensure alignment and reduce duplication of services (complex care coordination/DULCE)

Which Support Desired
Outcomes

Improved Access to Primary Care

Reduced Prevalence and Morbidity of Chronic Disease

Fewer Deaths Due to Suicide and Drug Overdose