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GREEN MOUNTAIN CARE BOARD

Report: Options for Regulating Provider Reimbursement – Part 1

Impact on Provider Sustainability and Equity in Reimbursement

Act 159 of 2020 Sec. 5

Presentation to Senate Committee on Health and Welfare

March 26, 2021

Executive Summary

Act 159 of 2020, Section 5

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"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?

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BACKGROUND

Background
Value-Based Care

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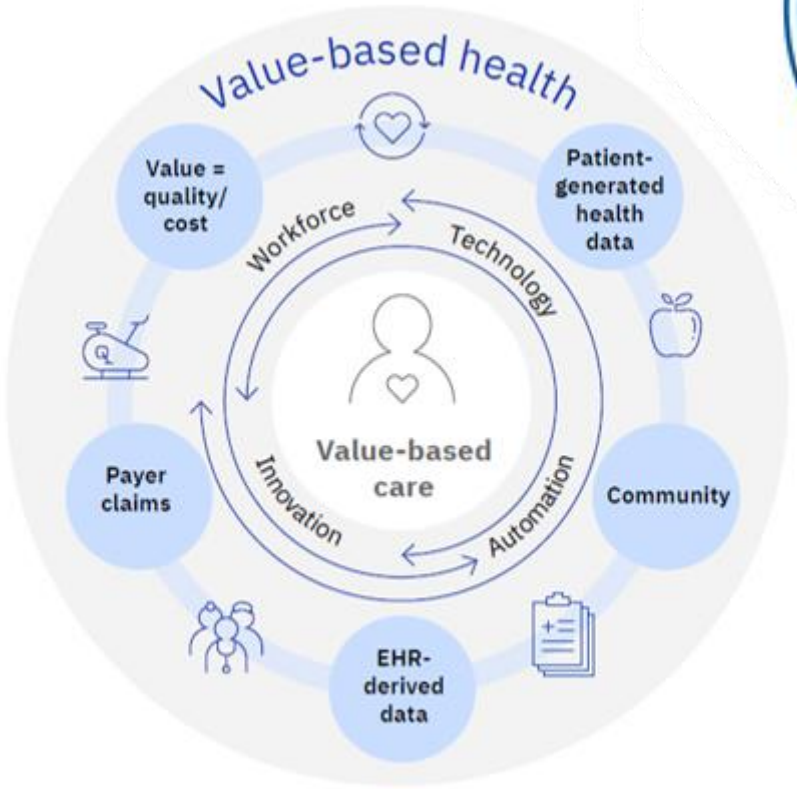

VALUE BASED CARE

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Background
Federal Shift from FFS to Value-Based Care

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The federal government has been committed to moving away from fee-for-service (FFS) provider reimbursement for over a decade, and that commitment remains.

2010:
Affordable Care Act (ACA)

- Created CMS Innovation Center (CMMI) to test new payment and care delivery models to further value-based care.
- ACA specifically identified accountable care organizations (ACOs) as a promising model, and CMMI launched multiple Medicare ACO models through 2017.

2015:
Medicare and CHIP Reauthorization Act (MACRA)

- Accelerated shift to value-based models by creating an incentive program (Quality Payment Program) for providers participating in Medicare.
- Providers can either elect to participate in the Merit-Based Incentive Payment System (MIPS) and report on quality and have a performance-based payment adjustment; or they can participate in Advanced Alternative Payment Methodologies (APMs), innovative payment models that tie payment to value.

2020:
State Medicaid Director's Letter #20-004

- Discusses Value-Based Care Opportunities in Medicaid.
- Describes the benefits of multi-payer models that align incentives across Medicare and Medicaid.
- Also highlights challenges inherent in models that are voluntary for providers in reaching critical mass, and in avoiding adverse provider selection.

2021 and Beyond:
Biden Administration

- Biden Administration approach remains to be seen.
- Given past bipartisan support for value-based models, expect this push to continue and evolve.

Background
Vermont's Move Toward Value-Based Payment

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Vermont has also been on the path away from FFS and toward value-based care for many years, in alignment with (and often ahead of) the federal government

2003-present:
Blueprint for Health

- Major investment in Vermont's primary care practices
- Began to tie payment to value through quality incentives
- Medicare has participated in the Blueprint and Support and Services at Home (SASH) since 2011 through the federal MAPCP Demonstration (2011-2016) and through the All-Payer Model ($7.5M+ annually since 2017)

2013-2017:
State Innovation Models (SIM) Grant

- $45M in federal funding to accelerate the transition to value-based care in Vermont
- Launched Vermont's Medicaid and commercial ACO Shared Savings Programs (SSPs) which laid the groundwork for Vermont Medicaid Next Generation ACO Program (VMNG)
- Supported All-Payer Model development, major investments in practice transformation and health information technology

2017-2022:
All-Payer Model and other Value-Based Arrangements

- Aims to test payment changes, transform care delivery, and improve health outcomes while controlling health care cost growth
- Medicare participates in Vermont-specific program through federal All-Payer Model Agreement signed in 2016; 2017 = Year 0
- Supports continued Medicare participation in Blueprint for Health and SASH

2005-current: Global Commitment to Health 1115 Waiver. Provides flexibility and funding for State priorities within the Medicaid program, including flexibility to pursue value-based payment models.

Background
Controlling Health Care Spending

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To control total spending, we must address both unit cost and utilization

- Unit cost is the reimbursement amount paid to a health care provider for a particular service or set of services
- Many provider reimbursement regulatory options seek to impact **unit cost**. Other regulatory options do not address unit cost directly, but rather the **growth rate** (the rate at which unit cost can allowed to increase over time)

Provider Sustainability & Reimbursement
Act 159 of 2020, Section 5

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Background

Considering Value-Based Care, Sustainability, and Reimbursement Equity

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Value-Based Care	Definition: The efficient and economic delivery of high-quality care. • Does the option move away from fee-for-service, address utilization issues, promote services where increased spending improves health (e.g., prevention), or avoid spending on care that does not improve health (e.g., preventable care, episodic care)? • This could include incentive structures or payments that are tied to quality performance.[1]
Provider Financial Sustainability	Definition: The ability of a provider to consistently cover expenditures with revenues. • Does the option include a provider-level look for solvency, consider payer mix, promote predictable and flexible revenue to providers, allow for necessary capital investments in technology or facility, or decouple reimbursement from volume? • Requires ongoing detailed data to determine whether and when provider reimbursements are sufficient to cover the cost of delivering services; it is also important to consider questions of access and quality when assessing financial sustainability (e.g., HRAP/Act 159 Sec. 4 report on Hospital Financial Sustainability).
Reimbursement Equity	Definition: Equitable payment within and across provider types for care delivery. • Does the option address underlying FFS differentials within provider types or move away from site-specific reimbursement? Does the option address underlying FFS differentials across provider types? • Requires a nuanced understanding of providers' current FFS reimbursements relative to each other and periodic analysis to develop an "equitable" methodology that can be trended forward for a specified group of providers/particular services over-time.

[1] For more information on value-based payment models, see the Health Care Payment Learning & Action Network (LAN) Alternative Payment Model Framework.

Background

Increasing Sustainability & Equity

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- In practice, there may be tension between the goals of provider sustainability and reimbursement equity:
  - No single option maximizes both sustainability and equity
  - This tension could be addressed by implementing multiple policy options simultaneously; however this adds complexity, expense, and potentially regulatory burden
- This report contemplates the ability of each option to address these two statutory goals within the context of value-based care
  - Would require more direction on policy priorities (which providers/which services/which payers?) to explore and evaluate payment methodologies in more detail for their impact on provider sustainability and equitable reimbursement

Background

Implications for Access & Consumer Affordability

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Especially in rural settings, there may be tension between provider sustainability, consumer affordability, and access.

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Key Takeaway: *Provider reimbursement methodologies will impact access and affordability (positively or negatively) but will not alone solve these problems.*

Background
Regulating Provider Reimbursement

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Regulation of provider reimbursement (sometimes called "rate setting") is governmental action to set provider reimbursement methodologies and amounts, which can be implemented via the following regulatory mechanisms:

1) States set provider reimbursement amounts or methodologies through provider regulation
2) States set parameters for payer-provider negotiations through insurance regulation

Currently, provider reimbursement amounts and methodologies are most commonly negotiated between commercial payers and providers participating in their networks, or set by Medicare and Medicaid for providers participating in those programs.

- Left to the market, provider-insurer negotiations are likely influenced by relative bargaining power/market share of the provider and the insurer:
  - Providers with higher market share (bargaining power) will be able to negotiate higher reimbursement; insurers with higher market share (bargaining power) will be able to negotiate lower reimbursement[1]
- This can also include reimbursement amounts paid to accountable care organizations (ACOs) to cover care for attributed members and the ACO payment models
  - Vermont's ACO programs have also been used to shift funds between parts of the health care system (e.g., from hospitals to primary care) through dues and value-based payment models

[1] Roberts, Chernew, and McWilliams, Market Share Matters: Evidence of Insurer and Provider Bargaining Over Prices (Health Affairs, January 2017)

Background
Basis for Provider Reimbursement

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There are two primary bases for provider reimbursement on which payment models are built. Each can act as the foundation for multiple payment models: fee-for-service payment, per diem (daily) rates, episode-based payments, health system budgets, capitation, or others.

- **Cost-Based** – Reimbursement amounts set based on the provider's historical cost (often with adjustments), to provide a service or an aggregate set of services; most common in historical state rate setting models and for Medicare reimbursement of critical access hospitals
  - Price based on actual expenses of the provider, sometimes blended with expenditures from peer institutions or regional/national data; should provide for margin; could vary by payer
  - Would vary by provider
- **Fee-for-Service (FFS)** – Reimbursement amounts set for each service based on negotiated amounts, an average or median of historic amounts, or a reference payer.
  - Public payers' FFS payment amounts are influenced by payers' appropriated budgets.
  - Could vary by payer, or same price across payers

In addition, regulators and payers may choose to layer one or more payment strategies…

- **Growth Targets or Caps** – Limit ability of providers and payers to negotiate above or below a certain amount; impacts growth trends, not base price.
- **Value-Based Payment Models** – May reward or penalize providers based on performance and/or value (e.g., provision of high-quality care; readmission rates; demonstrated practice transformation)
- **Population-Based Payment Models** – May be based on historical FFS spending and utilization, cost to provide care, or total budget available, with some assumptions of utilization and often expectations for efficiency; may include minimum quality threshold or otherwise tie payment to quality performance.

Resource: Urban Institute, Hospital Rate Setting Revisited (November 2015), chapters 1 and 2.

Background
Regulatory Approaches

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	APPROACH 1: Entity- or Provider-Level	APPROACH 2: Service-Based	APPROACH 3: Insurer/Payer-Based
Description	Sets reimbursement policy for the provider entity based on provider characteristics	Sets reimbursement policy for a category of services or specific services across all provider sites	Sets reimbursement policy for the payer
Example	Current hospital budget review process: Looks at expected revenue and expenses for each provider organization	Hypothetical example: Payments for primary care services must increase by X% in 2022.	Hypothetical example: Require GMCB-regulated commercial insurers to increase payments for primary care services by X% in 2022.
Trade-Offs	Includes focus on provider sustainability; equity considerations include provider specific information & payer mix; captures broad population	Includes focus on equity of reimbursement regardless of provider type; provider sustainability considerations limited; captures broad population (depending on services chosen)	Captures subset of commercial population (insured only); provider sustainability considerations limited; focus on equity limited by population

Options for Regulating Provider Reimbursement

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Option 1: Health System Budgets

Option 2: Setting Reimbursement Parameters

Option 3: Fee-for-Service Rate Setting

Next Steps
Key Questions for the General Assembly

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Reference
Major GMCB Regulatory Authorities

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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.