Clear and distinct roles in Health Care Reform

In health care reform, the roles of government agencies should be clear and nonduplicative. The OECD Best Practice Principles for Regulatory Policy recommends that policy formation should be done by elected governments and that regulatory agencies advise, but not create policy. [1] VAHHS recommends retaining the GMCB's current regulatory functions of CON, hospital budgets, ACO budgets, and insurance rate review, while housing policy development at the Director of Health Care Reform. VAHHS also recommends that hospital quality measurements reside with the Vermont Program for Quality in Health Care (VPQHC).

Align to Reduce Administrative Costs

With a new payment model comes the opportunity to reduce administrative costs and provide a more aligned approach to health care.

- **Align quality measures:** Disparate quality measures come at a cost. Not only do they create confusion, but a recent study found that simply reporting on quality metrics, without implementing quality interventions, cost Johns Hopkins over $5.6 million dollars and over 100,000 person hours.[2] CMS is aligning quality measures through its Universal Foundation initiative. By aligning quality measures with CMS, Vermont can reduce costs while maintaining quality.
- **Align data collection:** As with quality measures, disparate data collection also creates confusion and costs.
- **Provider credentialing and enrollment:** Insurer credentialing should also align with the federal government. If a provider is credentialed by Medicare, commercial insurers should also credential and enroll the provider to save time and administrative costs.

Setting hospital global budgets

As Vermont moves towards hospital global budgets, it should adopt a corresponding governance model or advisory committee to determine the global budget rate, similar to Pennsylvania's model, which includes representation from all participating parties.

GMCB regulates statewide outcomes for hospitals participating in global budgets

Although the All Payer Model was represented as having a cohesive regulatory structure; in practice, regulation was fractured. The latest federal report on the All Payer Model notes that implementation challenges included commercial insurance remaining fee-for-service and lack of investment dollars.[3] For the next payment and delivery system reform model to work, the model itself should be monitored and regulated to ensure that providers, payers, and government are coordinating together. Entities that are not participating will be regulated outside the model.

[1] OECD Best Practice Principles for Regulatory Policy, 2014, pg. 37 at https://doi.org/10.1787/23116013.
[2] Saraswathula A, Merck SJ, Bai G, et al. The Volume and Cost of Quality Metric Reporting. *JAMA*. 2023;329(21):1840–1847. doi:10.1001/jama.2023.7271
[3] NORC, Third Evaluation Report, https://innovation.cms.gov/data-and-reports/2023/vtapm-3rd-eval-full-report#page=12&zoom=page-fit,-508,390

S.211: Health Care Reform

Sections	VAHHS Position
Sec. 1. Director of HCR develop and maintain a method for evaluating systemwide performance and quality	Support clarification of roles in health care reform. The Director of Health Care Reform should set the policy and measurements. The GMCB should analyze progress against measurements while not duplicating efforts (i.e. VPQHC for quality).
Sec. 2. Payer participation in payment reform	Support. Should clarify language around "alternative payment model"—AHEAD is not an alternative payment model under federal definition.
Sec. 3. Amending the purposes of GMCB.	Need clarification on definition of equitable reimbursement. Need more information on how the GMCB would reduce administrative burden, etc..
Sec. 4. Amending operations of GMCB	Would support reinstating 18 V.S.A. § 9374(d)(2) re: delegating final decisions in regulatory matters. This is a VT Supreme Court case.
Sec. 5. Amending duties of the GMCB and requiring collaboration with the Director of HCR.	Delegation of Director of Health Care Reform and GMCB duties should be clear. Need to understand definition of "equitable reimbursements." AHS has a health care workforce position, and health care workforce responsibilities should be with that position. If the GMCB is setting global budgets, they should be regulated differently than they are under the current system.
Sec. 6. Amending the authority of GMCB re: regulating payments, rates and prices, including reference-based pricing	Oppose- reference-based pricing and site neutral payments are based on fee for service and further advance the cost shift.
Sec. 7. GMCB may only engage in payment reform as directed by AHS and Leg.	Support clarifying the role of GMCB as regulator and Director of Health Care Reform and Legislature for policy.
Sec. 8. Review of ACO Budget shall be quasi-judicial; regulates Medicare ACOs	Neutral
Sec. 9. Require mediation prior to termination of contracts.	Would like more information on whether this will add to administrative costs.

Sec. 10. Alignment of credentialing, quality measures and data collection.	Support to reduce administrative costs and streamline enrollment of health care providers.
Sec. 11. Requiring hospitals to provide salary info on executives and aggregate data on provider productivity.	What is the definition of aggregate data on provider productivity? For executive and clinical leadership salaries, 990s are currently available. Concerned about usurping role of local nonprofit boards.
Sec. 12. Hospital Budget Review shall be quasi-judicial; allows consideration of "quality of, access to and affordability of services.."; spending across sectors; consider role of hospital in a system; removes revenue from a FPPA from budget consideration; restricts criteria and benchmarks to system level, requires consult prior to setting benchmarks, and prohibits changes to criteria and benchmarks after set.	Would like to see more information on how the quasi-judicial meeting will work. Which parts are not open to the public, will there be adoption of question limits, etc? How is “aggregate data on provider productivity” defined? We should clarify VPQHC’s role in quality. How will looking at the spending across different sectors be used for hospital budgets? How does budget process work with one part of the budget not considered? Ideally, the payment model is assessed. • If exempting fixed prospective payments from budget review, expenses associated with fixed prospective payments should also not be considered Support benchmarks—would need to change date if hospital year is changing.
Sec. 13. Nursing Apprenticeship Program. Allows nursing board to regulate apprenticeships.	VAHHS supports. Nursing apprenticeship supports nursing pipelines and paying nursing students for learning on the job. Also increases commitment to Vermont organizations.
Sec. 14. Training required for GMCB members	Neutral
Sec. 15. Population Based Hospital Budgeting report required.	Support

Sec. 16. Regulatory realignment	Support
Sec. 17. Review of mergers, affiliations and divestments	Should remain with the Attorney General to maintain clarity of roles.
Sec. 18. Single agency for clinical health care data	Need more information