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GREEN MOUNTAIN CARE BOARD

Provider Sustainability & Reimbursements

Act 159 of 2020, Sec. 4 & 5

GMCB update to Health Reform Oversight Committee

November 13, 2020

Kevin Mullin, Chair GMCB

Robin Lunge, GMCB

Alena Berube, Director of Health Systems Policy

Agenda

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1. Hospital Sustainability (Sec 4)
2. Provider Sustainability & Reimbursement (Sec 5)

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Act 159, Sec. 4: Hospital Sustainability

H.795 Sec 4

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"The Green Mountain Care Board shall consider ways to increase the financial sustainability of Vermont hospitals in order to achieve population-based health improvements while maintaining community access to services."

Background

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Why engage in this work?

1. Rates of **rural hospital closures** continue to rise across the U.S., and Vermont hospitals are not immune.
2. In Vermont, **commercial charge increases** are the primary lever to remediate challenges to hospital financial sustainability, but simultaneously threaten **health care affordability for Vermonters**.
3. The Centers for Medicare and Medicaid Services (CMS) continues to solidify its commitment to abandoning fee for service (FFS) and advocates instead for **value-based care (VBC)**.

Hospital Closures

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- Since 2005, 170 rural hospitals have closed nationally, with 2019 closure rates higher than any previous year.
- In a recent study published in Health Affairs, rural hospitals that closed during the study period had a **median overall profit margin of -3.2% in their final year before closure**.
- Vermont experienced its own hospital bankruptcy, alarming the Board, Legislators, and hospitals across the state. This was not an anomaly; margins continue to decline.
    1. April 3rd, 2019 GMCB Panel on Rural Health Care
    2. Act 26 of 2019 – Rural Health Services Task Force
    3. The GMCB memorialized their concern for hospital sustainability in FY 2020 Hospital Budget Orders with the requirement for **6** of **14** hospitals to submit a sustainability plan.

Vermont Hospitals (pre-COVID-19)

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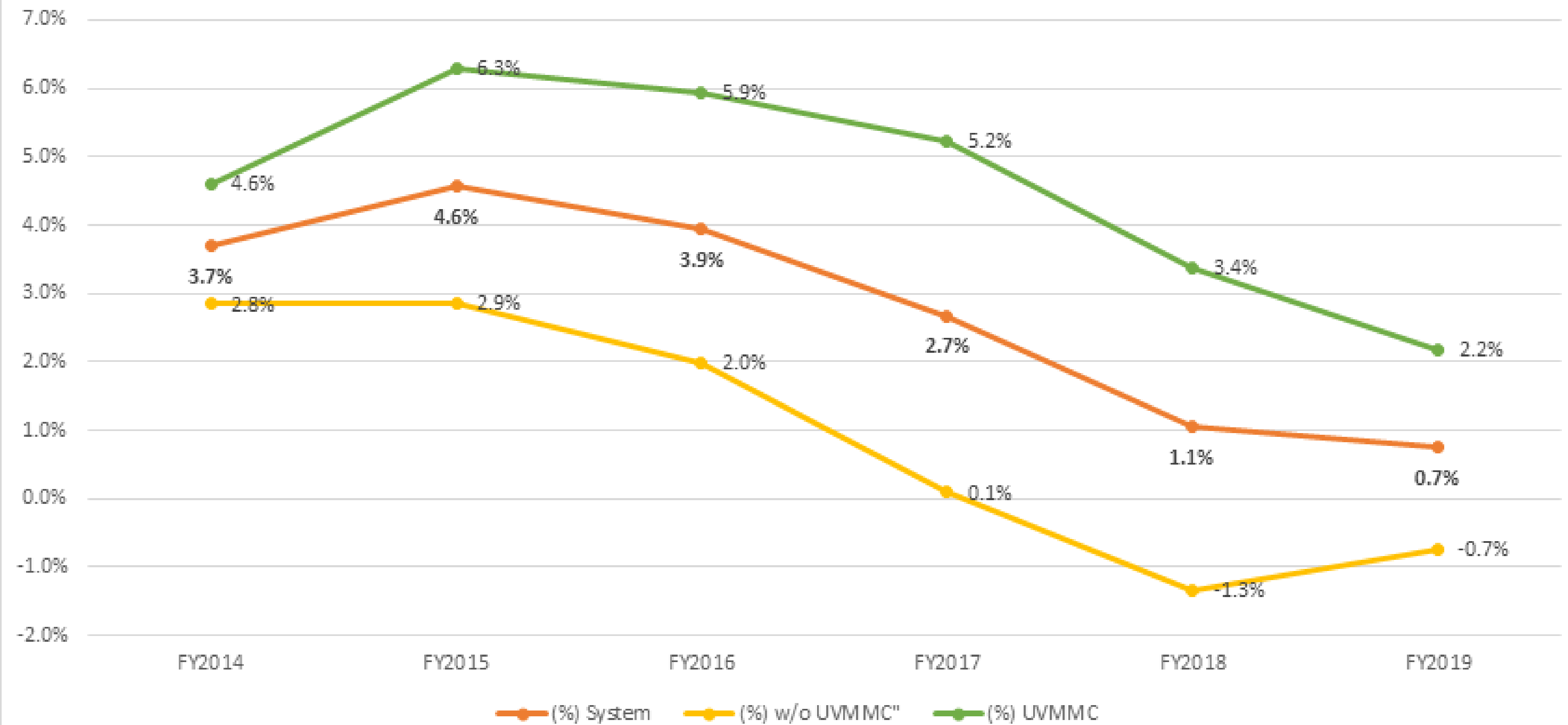

Vermont Hospitals (pre-COVID-19)

Growth in Operating Expenes Outpaces Growth in Operating Revenue

6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%

$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$0

$110,367,890
$99,475,201
$69,754,205
$28,466,441
$21,101,087

FY2015 FY2016 FY2017 FY2018 FY2019

% Growth Operating Expenses
% Growth Operating Revenue
Operating Margin ($)

Source: Green Mountain Care Board

Commercial Charge Increases

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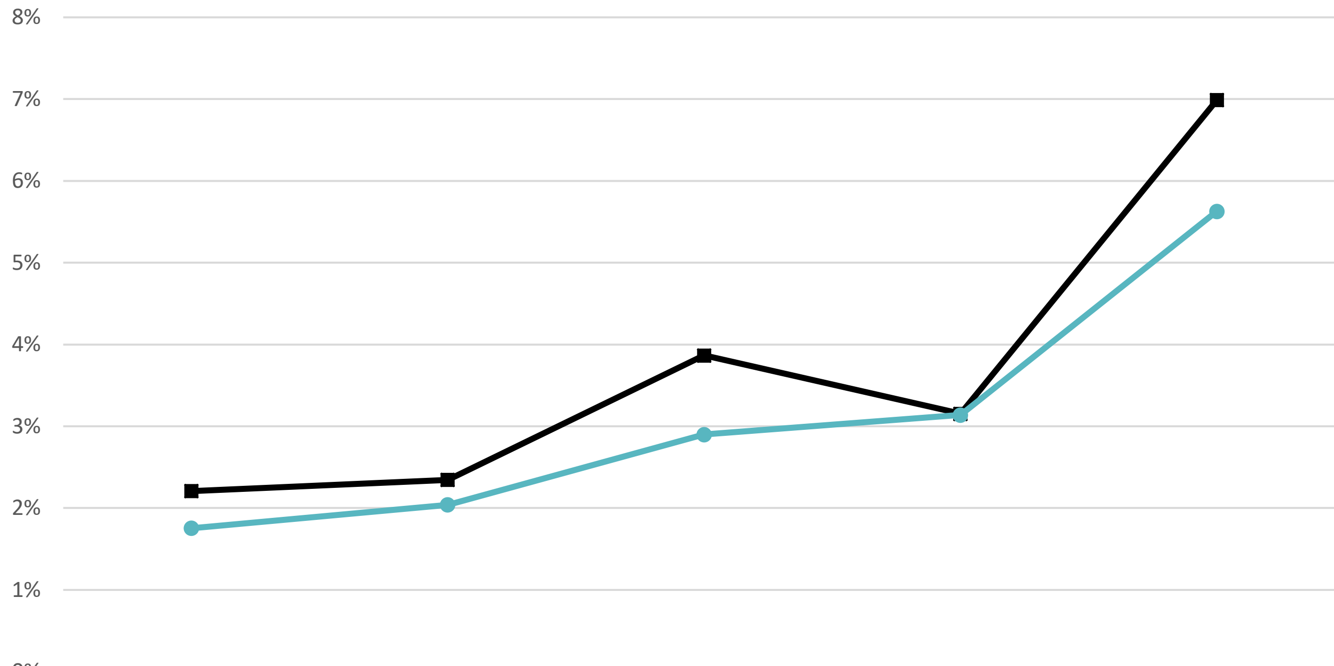

	2017	2018	2019	2020	2021
Submitted Rate	2.2%	2.3%	3.9%	3.2%	7.0%
Approved Rate	1.8%	2.0%	2.9%	3.1%	5.6%

Estimated Weighted Average for all hospitals is calculated by factoring in each hospital's proportion of gross revenue to the change in charges (rate).

Commitment to Value Based Care

A commitment at CMS to move away from fee-for-service (FFS) to Value Based Care began under Obama, continued under Trump, and is expected to only be amplified under a Biden Administration.

COVID-19 only further demonstrated the failure of FFS; providers already facing revenue challenges dealt with dramatic reductions in utilization, plunging operating margins, especially for small rural hospitals, into the negatives.

"Our fee-for-service system is consistently showing itself to be insufficient for our most vulnerable Americans."

– Seema Verma, Director CMS

Goals for the Sustainability Planning Framework

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1. Engage in a robust **conversation** on maintaining **access to essential services in our communities,** preparing for a shift to **value based care,** and understanding the threats to the **sustainability** of our rural health care system;
2. Encourage **hospital leadership, boards, and communities** to **work together** to address sustainability challenges and the shift to value based care;
3. Identify **hospital-led strategies** for sustainability, including efforts to "right-size" hospital operations, particularly in the face of Vermont's demographic challenges and making the shift to value based care;
4. Identify **"external" barriers** to sustainability and making a successful shift to value based care that are more aptly addressed by other stakeholders, policy-makers, or regulatory bodies, and generate insights to inform the state's approach to planning for- and designing a proposal for a subsequent **All-Payer Model Agreement (APM 2.0).**

Framework Development

History of Framework Development	Timeline
1. GMCB votes to require hospital sustainability plans as part of hospital budget review	Sept 2019
2. GMCB staff meet with CFO work group to discuss sustainability planning framework development	Jan/Feb 2020
3. GMCB staff propose DRAFT framework and solicit public comment	Feb 2020
DELAY DUE TO COVID-19	
4. GMCB approves spirit of the framework and designates staff to continue development	Aug 2020
5. GMCB extend sustainability planning to all hospitals	Sept 2020
6. GMCB staff meet with hospital leadership and the Health Care Advocate to solicit feedback on framework	Oct/Nov 2020

How the framework has evolved…

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The latest draft of the framework has not yet been vetted by the Board, but the “spirit” remains.

Changes following feedback from hospitals:

1. Abstract to a higher level of analysis (cost model and service mix)
2. Focus on outcomes, not just volume as a predictor of quality
3. More heavy lifting by GMCB staff in terms of up-front data analytics – hospitals will still have to weigh-in and provide commentary
4. More precise links between sustainability and the shift from fee-for-service (FFS) to value-based care (VBC)
5. Clearer recognition that there are both hospital- and community-specific challenges, as well as common statewide barriers to sustainability and the shift to VBC
6. Overt acknowledgement that this framework is intended to facilitate a collaborative conversation and not for the purpose of central resource allocation.

Revised Framework

Stage 1 – Hospital Financial Health

- Hospitals will be measured against regional and national **benchmarks** and asked to comment on **drivers of vulnerabilities** and **strategies** and **barriers** to their mitigation

Stage 2 – Hospital Financial Sustainability and the Shift to Value-Based Care (VBC)

- Integrates **HRAP** and **Community Health Needs Assessments** (CHNAs) with a **statewide capacity study** to identify gaps in needs and essential services; asks hospitals to provide details on their **cost model**, highlighting the relationship between **payment** structures and **service mix optimization** in the context of VBC

Stage 3 – Efficiency of the Vermont System of Care

- Assessing **system-wide efficiency** and highlights opportunities to **remove costs** from the system and/or to reinvest resources consistent with **value-based care** delivery in anticipation of greater returns in terms of cost or quality statewide. It is not the intent of the Board to mandate the appropriate allocation of investments, but to provide a **transparent** and **integrated** view of service delivery and costs across the system, and for hospitals to weigh in on how they can **coordinate with players outside their walls** as they are preparing for a shift to value-based care.

Tentative Timeline

Activity	Tentative Date*
Update #1 - HROC	November 13, 2020
Stage 1 – Hospital Financial Health	Winter 2020
Stage 2 – The Shift to Value-Based Care	Spring 2021
Update #2 - HROC	April 1, 2021
Stage 3 – Efficiency & the VT System of Care	Summer 2021
Final Recommendations to HROC	September 1, 2021 (<November 1, 2021)

1. Stakeholder Feedback
    1. Stage 1 – complete**
    2. Stages 2/3 – first round of feedback complete, will circulate next iteration
2. Board vote on revised framework – Winter 2020
3. Develop supporting analytics (GMCB/Outside experts) – Winter 2020/Spring 2021
4. Compile results and report out Summer/Fall 2021

**Proposed timeline subject to COVID-19 resurgence.*

*** GMCB staff were not able to meet virtually with UVM network due to cyber security breech but shared a draft framework, and plans to meet with UVMHN leadership in December*

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Act 159, Sec. 5: Provider Sustainability & Reimbursements

Act 159 of 2020, Sec. 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:
  - Care settings;
  - Value-based payment methodologies, such as capitation;
  - Medicare payment methodologies;
  - Public and private reimbursement amounts; and
  - Variations in payer mix among different types of providers.
- On or before November 15, 2020, the Board shall update HROC regarding its progress. On or before March 15, 2021, the Board shall provide options and identify areas that would require further study prior to implementation.

Background

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- Since 2014, the legislature requested a series of reports on reimbursement differentials among health care providers.
  - See Resource Slides for a summary of the report findings and recommendations.
  - In 2018, the Board took action in hospital budgets and rate review to address the differential.
  - View Act 54 (2015) & Act 143 (2016) Provider Reimbursement Reports and other materials here.
- Current report looks at potential implementation strategies for assessing and addressing sustainability and reimbursement issues.

Average allowed amount per primary care service*, Vermont Blueprint practices, 2015

	Total # Blueprint practices	Avg. allowed amount Commercial	Avg. allowed amount Combined public/private
FQHC/RHC	41	$95.66	**$120.39**
Academic Medical Center	10	$167.58	**$112.51**
Independent	47	$99.72	**$91.57**
Community Hospital	34	$103.31	**$80.34**

Source: Blueprint practice roster and VHCURES claims data, CY2015
*Primary care services as defined by primary care work group in 2015.

Approach to Act 159 Report

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- Review previous reports and analyses
- Research state models
- Research potential implementation issues and costs
- Submit report March 15, 2021, to the House Committee on Health Care and the Senate Committees on Health & Welfare and on Finance
  - Provide options demonstrating the greatest potential for improving provider sustainability and increasing equity in reimbursement amounts and identify areas that would require further study

Research Framework

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Model	New Statutory Authority Required (if any)	Examples	Challenges and Benefits	Implementation Costs	Data Requirements
Fee-for-Service Rate-setting					
Other Rate Setting Models (e.g. % of Medicare range)					
Global Budgets for certain entities					
All Payer Systems					

- The main goal of this research framework is to comparatively and comprehensively review models for the regulation of reimbursement in order to evaluate what the next steps for Vermont could be.

State Models Under Review

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- California
- Connecticut
- Maine
- Maryland
- Massachusetts
- Mississippi
- New Hampshire
- New York
- Oregon
- Pennsylvania
- Rhode Island
- Tennessee
- Virginia

Next Steps

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- Complete research of state models
  - Discuss information with other agencies and departments
- Begin work on the challenges and benefits of each model, required statutory changes, implementation costs, and data issues
- Continue to engage DFR, DVHA, and Director of Health Care Reform
- Stakeholder engagement around potential policy options (Q1 2021)

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RESOURCE SLIDES

Prior Reports

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Legislation	Report/Activity	Recommendation
Act 144 of 2014, Sec. 19 – Independent Physician Practices Report *(AOA with stakeholder process)*	Differentials in commercial payment rates is based on academic medical center (AMC) designation, not hospital ownership (November 2014)	VT continue to pursue payment and delivery system reform while ensuring pay differential is part of the discussion
Act 54 of 2015, Sec. 23 – Payment Reform and Differential Payments to Providers *(BCBSVT and MVP)*	Implementation plans for providing fair and equitable reimbursement (July 2016)	Reduce AMC differential by reducing rates based on a factor calculated by insurers; each carrier proposed different ways of achieving reduction
Act 143 of 2016, Sec. 4-5 – Provider Reimbursement Report *(GMCB with stakeholder process)* Reports submitted December 1, 2016 and February 1, 2017 with update at April 2017 Board meeting	Determined reimbursement differential varies across AMC, community hospitals, FQHCs and independent providers for primary care. Data is not fully available for other practice types. Multiple legislative recommendations.	Site-neutral payments (MedPAC), newly acquired practices remain on community fee schedule, work group, clinician landscape
Act 85 of 2017, Sec. E.345.1 – Fair Reimbursement Report *(GMCB with stakeholder process)*	Report to HROC October 1, 2017	Changes the GMCB have put into effect to achieve site-neutral, fair reimbursements for medical services.

Provider Reimbursement Reports - Summary

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- For currently affiliated practices, carriers directed to formulate plans to align fee schedules for site-neutral services
  - Carriers proposed plan for implementing site-neutral reimbursement plan, and provide analysis of plan impacts on 2018 insurance rates and plan design, and implementation of All-Payer ACO Model
  - Not acted upon by legislature
- Board directed carriers to look at Medicare's site-neutral approach
  - Carriers agreed that the Medicare site-neutral approach is rational for Medicare; however, there are complexities for the commercial market
  - Commercial insurers have multiple fee schedules and negotiated contracts, so there are contractual and administrative consequences
  - Not acted upon by legislature

Medicare and MedPAC Model

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- In 2014, MedPAC identified service categories that could have their hospital rate aligned with physician office rates
- MedPAC recommended applying site-neutral rates to E/M codes and 66 ambulatory services that:
  - Do not require emergency standby capacity
  - Do not have extra costs associated with higher patient complexity in the hospital
  - Do not need the additional overhead associated with services that must be provided in a hospital setting
- January 1, 2017 (Section 603 Bipartisan Budget Act of 2015) – Newly acquired off-campus physician practices no longer eligible for reimbursement under Medicare Outpatient Prospective Payment System (OPPS). These providers now paid under Physician Fee Schedule (PFS).

Further Action

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- After the submission of the February report and carrier responses, the Board took a step back to better understand the issues driving the legislative charge and consider new avenues towards fair and equitable reimbursement.
  - The Board analyzed data on provider employment trends in Vermont and conducted both a state-wide survey and a series of focus groups.
  - The Board also reviewed a claims-based analysis performed by Onpoint Health Data, analyzed all plans and responses provided by insurers, and convened a stakeholder workgroup.

Clinician Landscape Study

From the clinician landscape study, the Board identified the following key takeaways:

- Independent clinicians cite strong patient relationships, option to run a practice, and flexibility over scheduled as most satisfying and are most frustrated by billing, paperwork, administrative burden and uncertainty of income.
- Employed clinicians are most satisfied about not having to run their own business, not being responsible for high practice costs, and the certainty of their income. Employed clinicians are also frustrated by administrative burden and lack of control over their schedule.
- Top three cited threats to independent practices are regulatory and administrative burdens, health reform payment models (Federal and/or State) and Medicaid reimbursement. The same top three threats apply to employed clinicians.

Stakeholder Engagement

From the stakeholder workgroup discussion, the following key points emerged:

1. Nationally and in VT, more providers are choosing employment in hospitals and health systems.
2. Multiple factors explain the trend toward more hospital-based employment including growing costs, challenges and risks of running a business, ACA incentives, and provider preferences. Commercial reimbursement rates don't appear to be a factor and salaries are not likely to be higher in hospital-based settings.
3. FFS rate differentials exist between hospital-based practices and independent settings for processional services. In VT, greatest differential is between the AMC and other providers.
4. Adjusting FFS rate through regulation is complex and will have impacts on premiums and out-of-pockets costs, hospital budgets, as well as access and quality of care.

Board Actions

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- Successful implementation of the All-Payer ACO Model is the top priority, which will help address pay parity concerns.
- In the short-term, the Board exercised its regulatory authority to reduce payment differentials and move closer to fair and equitable reimbursement:
  - Hospital budget review (2018): Board voted to approve UVMMC's FY18 budget with a condition that it reduce payment differentials for a set of site-neutral services.
  - Rate review: Board ordered substantial reduction in the insurer's medical trends in 2018 VHC rate filings to encourage the insurers to negotiate rates with providers that promotes reimbursement parity.
  - Increased Transparency: The Board requested and received tax information from the 14 hospitals and published names and salaries of the hospitals' highest earners.