Global Budget Subgroup

OCTOBER 11, 2022, MEETING #2

Meeting Agenda

1. Context & Goals
2. Flexibility for a "Hospital-Plus" Approach
3. Payment Approach: Fixed, Prospective Payment vs. FFS
4. Next Steps

Reminder: Subgroup Purpose

- Solicit input and recommend "asks" of CMS regarding global budget parameters over the next couple of months to inform CMMI's new multi-state All-Payer Model release in late 2023.

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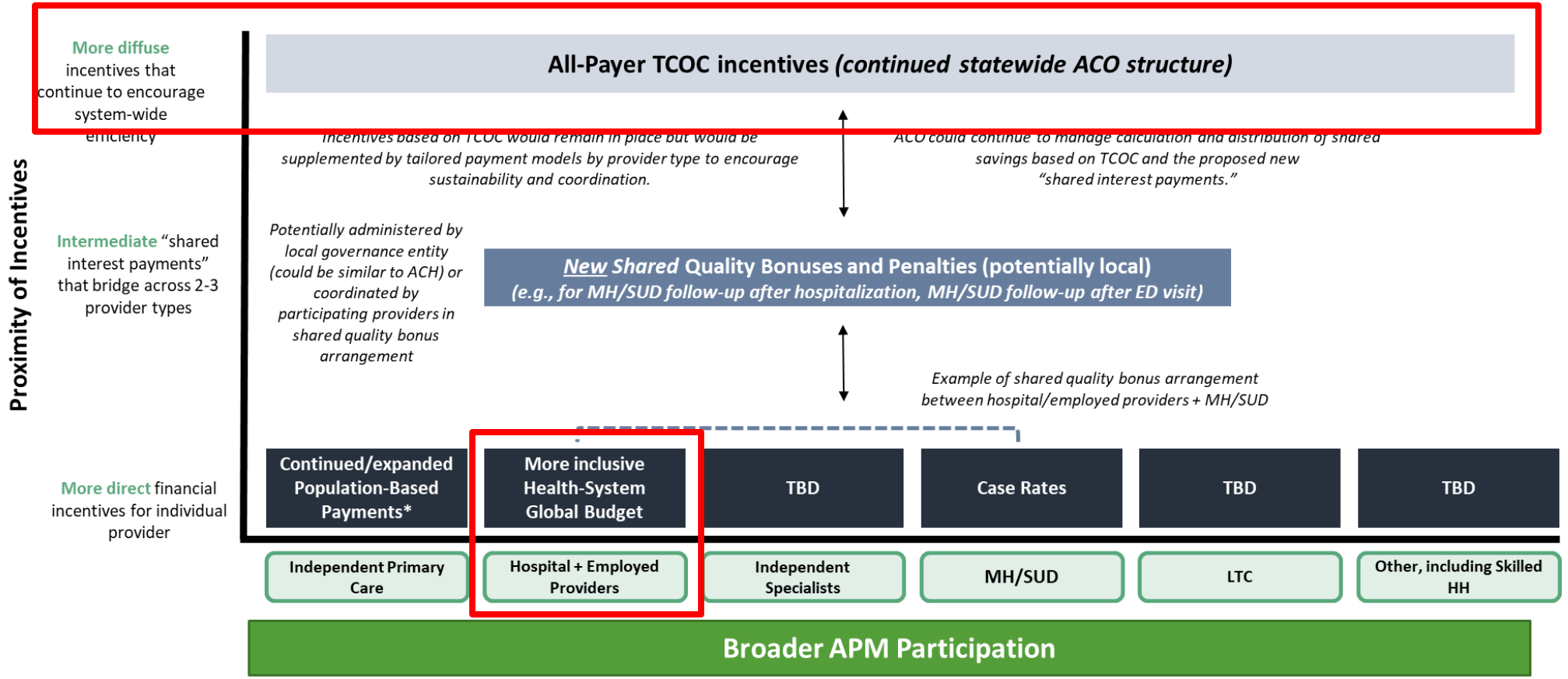
What is a Global Budget & Why Pursue One?

- CMMI global budget models share common features: **Prospective budget** established for a **facility**, implemented with **multi-payer participation** and with a focus on **population health**
- What are the problems we are trying to solve?
  - Provider stability
  - Rural sustainability
  - "Right care, right place, right time"
  - Affordability

  There is a tension across these objectives.

Where Global Budget Fits in the "Portfolio Approach"

There is much devil in the detail. High priorities for discussion with CMS are Vermont's desired parameters of the health system global budget and the TCOC design.



Context for Examples from Other States

- **Existing global budget models in other states are a starting point, not the destination.**
  - Existing models are very limited in number and in scope.
    - The three CMMI models to date have focused exclusively on hospitals.
  - Our discussion should not be bound by existing examples and should take a forward-looking approach that anticipates innovation & growth.

2. Area for Flexibility: Inclusion of Services Beyond Hospital Inpatient & Outpatient Facility Services

Current CMMI Global Budget Models Include Inpatient & Outpatient

- Current CMMI models (MD, PA, CHART) include inpatient hospital facility services and outpatient hospital facility services.
- Current CMMI models exclude professional services from the model. They also exclude services provided by owned entities

Included:	Excluded:
• Hospital inpatient • Hospital outpatient	• Professional Services • Owned entity services

Services included in the GMCB's Hospital Budget Review

- The Hospital Budget Review process examines a number of financial, clinical and community factors.
- The Hospital Budget Review may include employed professional services. Hospitals may also include information for affiliated entities in their budgets.

Included:	Variable:
• Hospital inpatient • Hospital outpatient	• Employed professional services • Affiliated entities, such as FQHCs and SNFs

Services included in Vermont APM Fixed Prospective Payment

- Fixed prospective payments in the All-Payer Model encompass a broad set of services. Payments from the ACO to participating hospitals include both facility and employed professional services.

Included:
• Hospital inpatient • Hospital outpatient • Employed professional services

Potential Rationale for CMMI Flexibility for "Hospital Plus" Approaches

1. Already implemented under the existing Vermont All-Payer Model
2. Take a more comprehensive approach to hospital global budgets, i.e., captures more of hospitals' services and spending
3. Increase incentives to integrate hospital and professional care
   - Exclusion of professional services as a barrier to care transformation in both PA & MD
4. Reduce financial incentive for hospitals to steer care to owned facilities that are not part of the global budget
5. Ensure an ability to evolve over the next decade

Parking Lot: Issues Still to be Resolved for "Hospital Plus" Approaches

At this point we are *only* trying to determine whether to ask for the ability to pursue a “Hospital Plus” approach, and not whether, and if so, how to do so.

- If Vermont were to pursue such an approach, we would want to consider additional questions such as:
  - Which specific services & affiliation arrangements should be included in the model? (at the outset, and possibly added over time)
  - Should the included services vary by hospital?
  - Should the included services vary by payer?

Discussion

- Is this an important area of flexibility for Vermont?
  - Are there compelling advantages to having only hospital inpatient and outpatient facility services as part of the global budget?
- If this is an important area for flexibility, are there additional arguments for the State to raise with CMMI to advocate for such flexibility beyond those cited on slide 11?
- Should we ask CMMI for flexibility to add additional non-hospital services to the model over time (the next 8-10 years) if so desired by Vermont?
- Should we ask CMMI for flexibility to have Medicare pay other, non-hospital entities via global payments (either directly or via an ACO)?

3. Area for Flexibility: Prospective versus FFS Payment

Context

In a global budget model, a defined budget is set in advance for the year.

However, a decision needs to be made about how hospitals are paid against that budget. They can be paid:

- **Prospectively,** meaning that each hospital receives a fixed payment at regular intervals, such as biweekly or monthly; OR
- **Fee-for-service,** meaning that each hospital bills for services rendered at a prescribed amount per service.

There can also be combinations of these payment methodologies within the same model.

Payment Methodologies in PA's Model

Payers in PA's program can choose one of two payment methodologies:

- **Fixed Global Budget Payment.** Regular payments are made throughout the course of the year. For Critical Access Hospitals, these are reconciled back to cost-based reimbursements. For Rural Prospective Payment System Hospitals, these are not reconciled back to cost or FFS but are adjusted for factors including volume shifts, payer shifts, and service line changes. This methodology is used by Medicare.
- **Virtual Global Budget Payment.** Payers make three types of payments to participating hospitals:
  1. an upfront float payment equivalent to one month's global budget at the beginning of the first global budget year
  2. FFS payments for services rendered
  3. additional lump sum payments to keep hospitals whole to the global budget

  Payers conduct an end-of-year settlement to the prospective global budget to account for market shifts that may have occurred during the year. This methodology is used by commercial payers.

Payment Methodologies in PA's model: Example

Example: Hospital with a budget of $120M per year, $10M per month

Fixed Model	Jan	Feb	Mar	Apr	May	June
Monthly Payment	$10	$10	$10	$10	$10	$10

Virtual Model	Jan	Feb	Mar	Apr	May	June
Upfront lump sum	$10					
FFS (*lagged payment)	$8	$10	$12	$8	$9	$10
Additional lump sum (*lagged payment)	*Made if total payments (including upfront payment) are less than projected budget*					

*For simplicity, lagged payments are shown in the month in which they are incurred, not the month in which they are paid

Payment Methodology in MD's model

In Maryland, hospitals are paid retrospectively on a FFS basis; rates are adjusted up and down to meet the budget.

For simplicity, consider the same hospital with a budget of $120M per year, which provides only one type of "service." In setting the budget, the hospital is expected to have 1200 units of service per year, so the initial rate is set at $0.1M per unit.

Retrospective FFS model	Jan	Feb	Mar	Apr	May	June
Units of service	100	120	120	120	100	100
Rate per Unit	$0.1	$0.1	$0.1	$0.096	$0.096	$0.096
Revenue (*lagged payment)	$10	$12	$12	$11.5	$9.6	$9.6

Rate change

*For simplicity, lagged payments are shown in the month in which they are incurred, not the month in which they are paid

Current Vermont All-Payer Model Hospital Payment Approaches Vary

- **Medicaid** makes fixed, prospective, unreconciled payments to OneCare for a portion of its spend; OneCare makes fixed, prospective, unreconciled payments to participating hospitals.
- **Medicare** (for beneficiaries in Original Medicare) makes a fixed payment to OneCare; OneCare makes fixed prospective payments to participating hospitals. These payments are reconciled to fee-for-service at year-end.
- **BCBSVT** makes a fixed payment to one hospital. The payment is reconciled to fee-for-service.
- Remaining payments are largely fee-for-service

Rationale for Flexibility for Payment Methodology

1. Prospective payments provide upfront funding and predictability.
2. Vermont's current model includes prospective payment approaches; these have been cited by hospitals as being valuable.
3. Flexibility around payment methodology may facilitate the inclusion of a broader array of provider types/ services over time.

Parking Lot: Payment Issues

At this point we are *only* trying to determine whether to ask for the ability to pursue a prospective payment approach, and not whether, and if so, how to do so.

If Vermont were to pursue such an approach, we would want to consider additional questions such as:

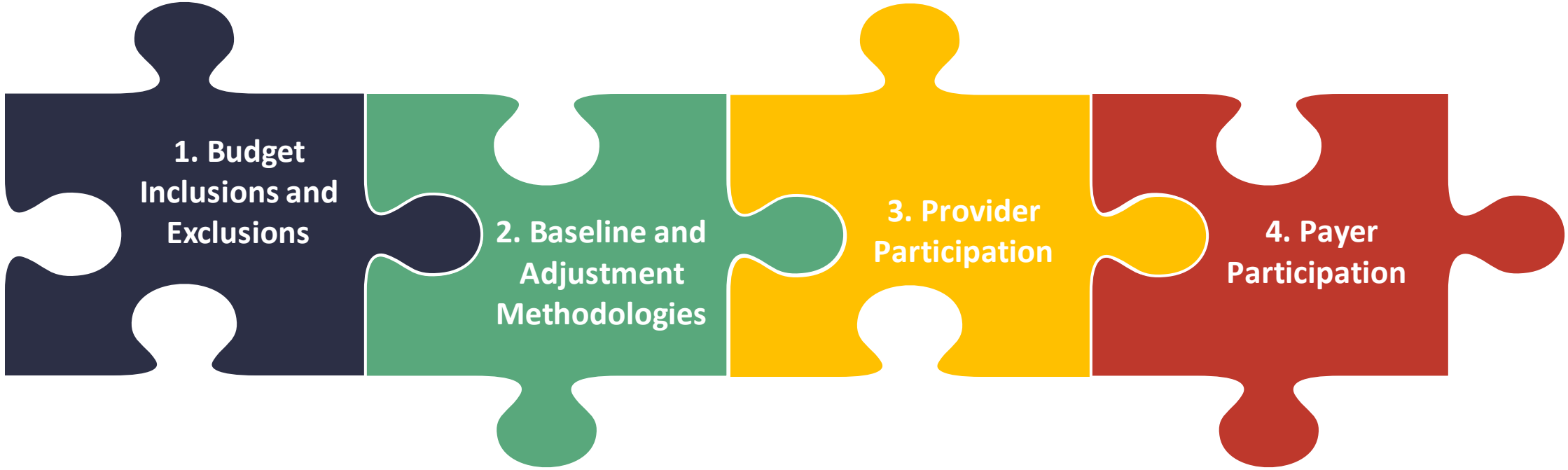
- Should there be a reconciliation and if so, how it should be set up?
- Could different payers have different approaches?

Discussion

- Is this an important area of flexibility for Vermont?
- If this is an important area for flexibility, are there additional arguments for the State to raise with CMMI to advocate for such flexibility beyond those cited on slide 20?
- Are there types of payment methodologies that are important to support inclusion of additional non-hospital services to the model over time (the next 8-10 years) if so desired by Vermont? (This could include PMPM capitation payments, case rates, or hybrid payment models).

4. Next Steps

Global Budget Design Issues

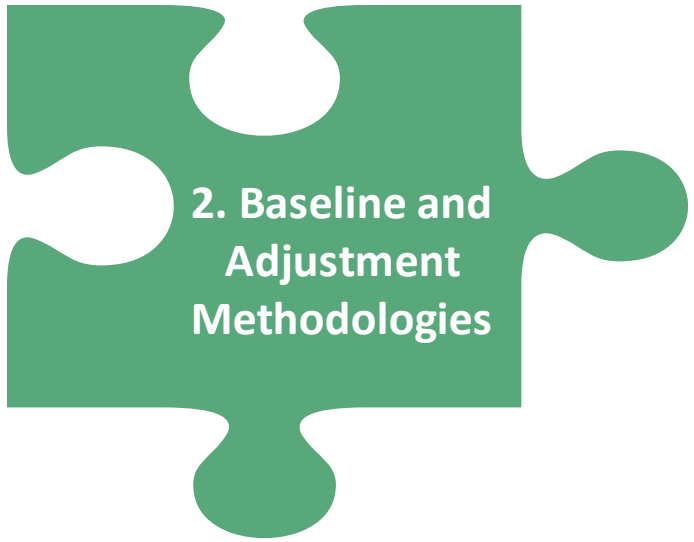


Proposed Global Budget Design Areas for Discussion

1. Hospital facility services only *vs.* "hospital +" models (10/11)

Other states' models with Medicare participation include only hospital facility services. Is this an area in which CMMI should provide flexibility to states and/or model participants to include additional services?

Proposed Global Budget Design Areas for Discussion



2. Accounting for current hospital operating losses (Proposed for 10/18)

Recognizing that many hospitals are currently experiencing losses, should CMMI gives states flexibility in identifying which year(s) are used as a baseline, and in potentially applying adjustments to account for financial hardship? Should there be other adjustments to reflect areas that need more/less utilization?

3. Fixed versus flexible budgets (Proposed for 10/18)

Maryland's model has historically been a "fixed" budget, meaning that there is no adjustment if utilization is higher than expected. An alternative is a "flexible" budget where hospital payments could be adjusted for variable costs associated with higher/lower than expected utilization. Should the CMMI model include the option for a flexible budget approach?

Proposed Global Budget Design Areas for Discussion

4. Voluntary *vs.* mandatory provider participation

Should the new CMMI model provide states the option for voluntary hospital participation (PA, CHART) and mandatory hospital participation (MD)? If so, with which payers?

5. Acute care hospitals + CAHs vs. all non-state-owned hospitals

Current CMMI models have included only acute care hospitals + CAHs. Should CMMI include an option for states to include additional hospital types?

6. Considerations specific to Critical Access Hospitals

PA's model has a different payment structure for CAHs. Is this an option CMMI should allow in the future model?

Proposed Global Budget Design Areas for Discussion

7. Medicare Advantage participation

Should CMMI encourage/incentivize/mandate Medicare Advantage participation in the new model?

8. Multi-payer participation

How should CMMI support multi-payer participation and alignment in the model? Which payers should be most closely aligned to Medicare (or vice versa) and to each other? To what degree should CMMI align Medicare to the multi-payer approach in a given state?

Proposed Global Budget Design Areas for Discussion

Underlying Payment Methodology

9. Prospective payment versus fee for service (10/11)

MD's underlying payment mechanism is fee for service. PA's model uses prospective payments. Is it important to push CMMI to include one or both of these approaches?

10. Interaction with other models via shared incentives

What flexibilities are most important in considering how the Global Budget model could share aligned incentives across different provider types in the portfolio model?

Proposed Global Budget Design Areas for Discussion

Overall program structure:

11. One common model with common administration *vs.* common parameters but separate programs by payer

MD's model has common, centralized administration of the program that calculates payment rates and monitors the program. PA's model's administration is more decentralized. In the new model, should CMMI allow for both types of programs and support their success, particularly as it relates to Medicare participation?