Health Care Reform Work Group

SEPTEMBER 20, 2022 MEETING

Meeting Agenda

1. Recap of highest priority problems to be solved in Vermont's All-Payer Model (APM) 2.0 and "Design Wishlist"
2. Total Cost of Care, continued:
   - Presentation by Sarah Lindberg, GMCB
   - Discussion
3. Revisiting the Work Group's Decisions to Date
4. Next Steps

Recap of Last Week’s Discussion

Recap of Problems to Address Through Vermont's All-Payer Model

- During last week's discussion, Work Group participants noted that the top problems to address through the next All-Payer Model are:
  - Provider stability
  - Rural sustainability
  - Improving the pipeline through transitions of care ("getting people the right care at the right place at the right time")
  - Affordability for Vermonters
- The Work Group acknowledged that all problems are interconnected (e.g., improving provider stability and rural sustainability will improve access to care).
- Regarding payment, there was agreement among Work Group members that APM 2.0 should focus on prioritizing predictability of payments and aligning incentives and rewards.
- In general, the Work Group expressed that current challenges (e.g., COVID-19, inflation, workforce) impacted planning for the longer-term.

Translating Priorities to a High Level "Vermont Design Wishlist" for CMMI

Based on last week's discussion, updates have been made in red.

Medicare APM Structure	Tailoring to Vermont's Delivery System	Other Possible Asks
✓ Increase predictability of revenue for hospitals ✓ Consider expanding global budget design beyond facility fees into professional services *(subject to details of design)* ✓ Provide more direct mechanisms to promote collaboration across provider types ("shared incentives") ✓ Keep or increase Medicare funding available for primary care population- based payments and Blueprint for Health and SASH programs	✓ Account for Vermont's longstanding culture of medical conservativism – baseline utilization is lower than other states ✓ Build on existing DVHA VMNG model for Medicaid population ✓ Design for largely rural environment – current workforce and inflation pressures on costs are especially acute ✓ Design for aging population ✓ Consider border issues – can APM be based on care to Vermonters rather than care in Vermont?	✓ Keep SNF three-day waiver ✓ Telehealth flexibility including specific provider types (e.g., SNF, HH, hospice, primary care) ✓ Increase funds flow for practice transformation and learning ✓ Help Vermont structure incentives or mandates for other payers to participate, including MA plans? ✓ Allow for Medicare reimbursement for MH/SUD providers (e.g., licensed alcohol and drug counselors, psychologists, etc.) ✓ Consider how APM 2.0 will align with other Medicare value-based payment models

Recap of Context: CMS Innovation Center's 7 Design Criteria

CMMI is signaling it will produce a design to span multiple states from 2025 that will address seven priorities.

1. Include global budgets for hospitals.
2. **Include TCOC target/approach.** ★ ***Continued focus of today's discussion***
3. Be All-Payer.
4. Minimum Investment in Primary Care
5. Include safety net providers from the start.
6. Address mental health, substance use disorder and social determinants of health.
7. Address health equity.

Total Cost of Care

Objectives for Today's Discussion

- Understand TCOC design under Vermont's current All-Payer Model
- Discuss pros and cons of the current TCOC approach to inform future design

AHS and GMCB will engage with the Work Group on the technical aspects of TCOC in future discussions in a separate subgroup. Today's meeting will be focused on the role of TCOC in Vermont's current model.

Overview

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- The APM ACO Agreement includes targets for per capita growth in the CMS-agreed Statewide TCOC.
- Statewide TCOC design matters because:
  - The trend rate has been applied by GMCB to hospital budgets; and
  - If targets are missed, CMS can take back Medicare target setting authority from GMCB.
    - Medicare trend parameters are preferential to other Medicare ACO models in CMMI portfolio

What is Statewide TCOC?

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$$\frac{\text{Claims-based + Nonclaims expenditures}}{\text{Vermont resident member months}}$$

- Calculated for each payer type and then combined.

APM Agreement Targets

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- Expenditure growth is measured as in the Total Cost of Care (TCOC) per person for 2 groups:

	Population	Financial Target (2017 Baseline to 2022)
1) All-Payer	All Vermont residents with available claims	3.5% to 4.3% average annual growth
2) Medicare	• ACO-attributed Medicare FFS beneficiaries (2018 - 2020) • All Vermont beneficiaries in Medicare FFS (2021 - 2022)	Growth from -0.2 to +0.1 of national projections

APM Consequences

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- CMS has discretion to determine whether the state is on track to meet its 5-year *both* financial targets each year.
- They may also determine that it's a Triggering Event, which may result in a Corrective Action Plan (CAP).
- If the CAP is not approved or if the CAP fails to bring the state back on track, **CMS may directly establish the Medicare Financial Benchmarks for ACOs.**
  - Normally, the GMCB proposes these Benchmarks for CMS approval.

APM TCOC

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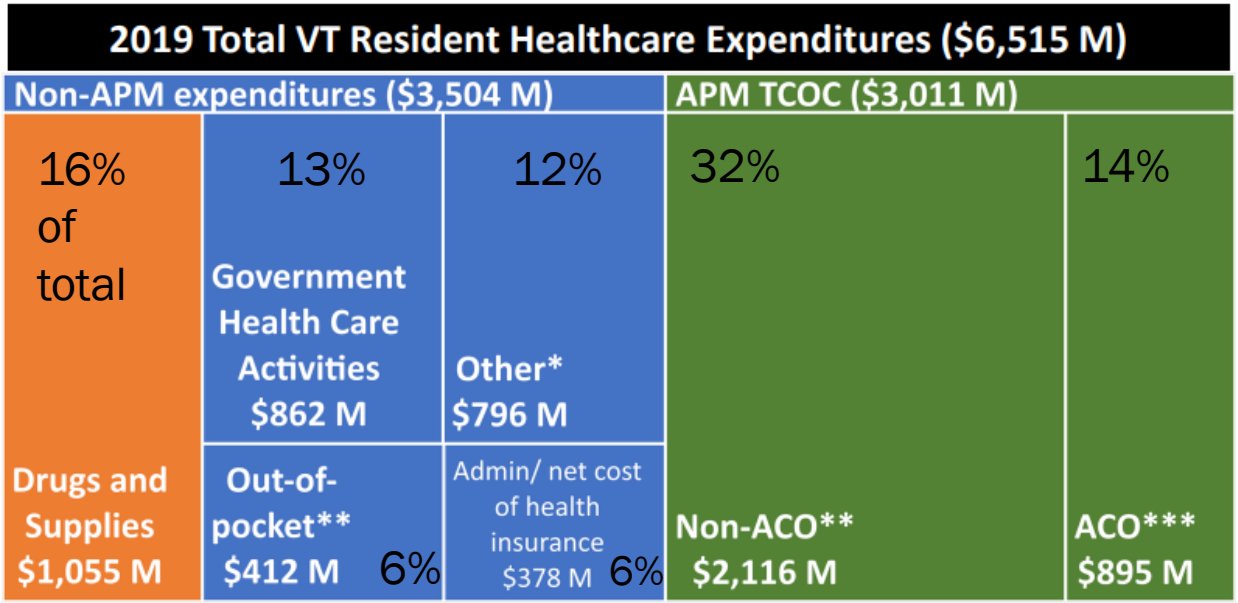

SOURCE: GMCB staff, derives from VHCEA, 2019 (Also see Appendix pages 34, 38, 39), totals may not add up due to rounding
*Other includes dental, vision, unclassified services, expenditures not paid through claims, and care costs for commercial ASO spending not captured in VHCURES.
**Out-of-pocket for APM members and services shown under APM. The remainder is under "out-of-pocket", which includes uninsured residents
***For 2021, the estimated expenditures under the ACO have increased to ~$1.2 billion.
APM TCOC = All-Payer Accountable Care Model Total Cost of Care

Source: Kinzer report to HROC (Dec 2021)

TCOC vs Resident Expenditures

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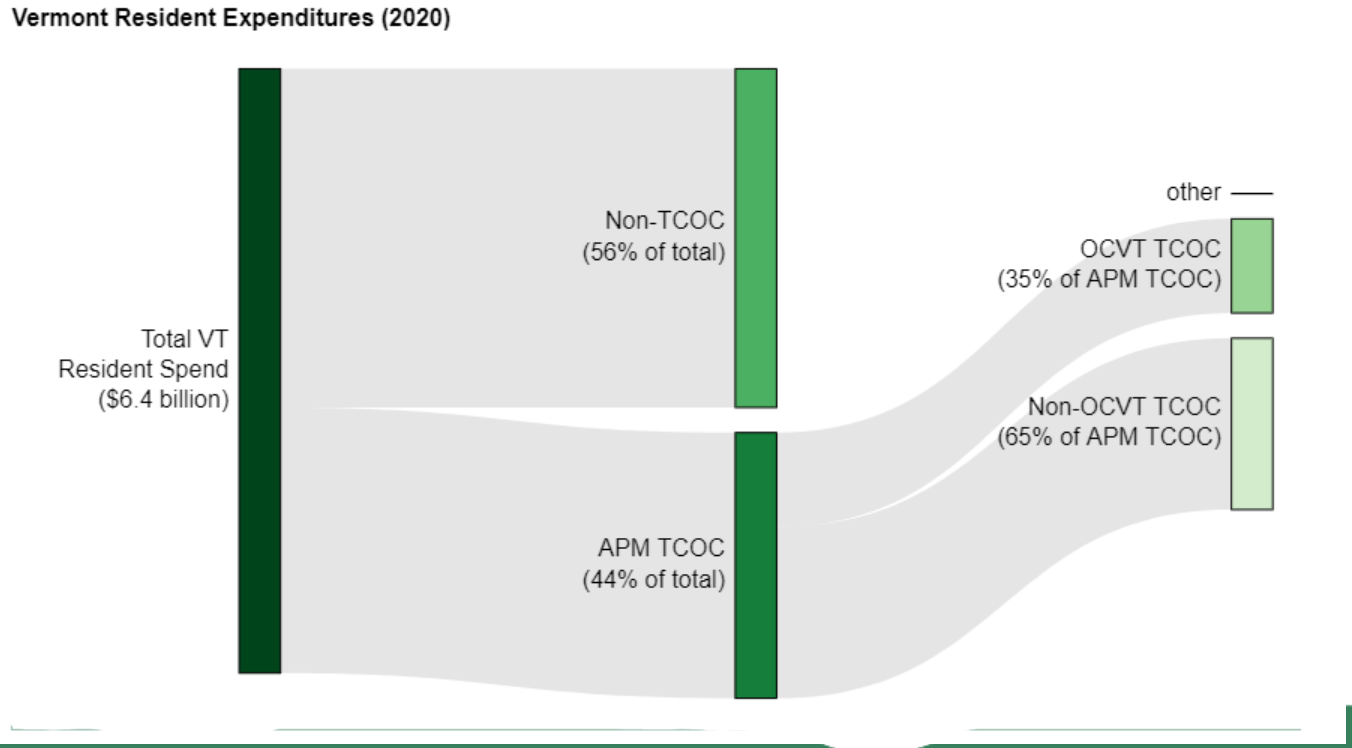
- Due to excluded services and payers under current APM, the All-Payer Model Total Cost of Care (APM TCOC) represents less than half of all spending on behalf of Vermont residents (44% in 2020).



All-Payer TCOC Per Beneficiary Growth

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Table 7a: All-Payer Total Cost of Care Results, Prior Four Quarters and Year-to-Date (including reduction for excludable Medicaid costs)[5]

		Q1	Q2	Q3	Q4	TCOC Growth YTD (Q1+Q2+Q3+Q4)*
Baseline (CY 2017)	TCOC/Beneficiary (PMPM)[6]	$495.10	$502.84	$485.16	$502.92	$496.51
	Numerator ($)[7]	*$679,450,246*	*$692,235,152*	*$665,677,087*	*$687,931,668*	*$2,725,294,153*
	Denominator (Members)[7]	*457,447*	*458,884*	*457,361*	*455,958*	*457,412*
PY 1 (2018)	TCOC/Beneficiary (PMPM)[7]	$518.53	$519.47	$500.29	$524.14	$515.61
	Numerator ($)[7]	*$718,106,830*	*$717,781,247*	*$688,079,090*	*$719,432,612*	*$2,843,399,779*
	Denominator (Members)[8]	*461,629*	*460,590*	*458,455*	*457,529*	*459,551*
PY 2 (2019)	TCOC/Beneficiary (PMPM)[7]	$546.86	$552.47	$530.19	$541.81	$542.85
	Numerator ($)[7]	*$752,008,634*	*$756,276,259*	*$722,854,974*	*$736,790,761*	*$2,967,930,628*
	Denominator (Members)[8]	*458,383*	*456,300*	*454,463*	*453,292*	*455,609*
PY 3 (2020)	TCOC/Beneficiary (PMPM)[7]	*$523.41*	*$427.80*	*$540.61*	*$519.04*	*$502.79*
	Numerator ($)[7]	*$715,609,207*	*$590,806,580*	*$751,512,670*	*$727,305,533*	*$2,785,233,989*
	Denominator (Members)[8]	*455,731*	*460,346*	*463,374*	*467,078*	*461,632*
	Per Beneficiary Growth Rate	***1.9%***	***-5.2%***	***3.7%***	***1.1%***	***0.4%***

*Quarters may not sum due to rounding and different amounts of time for claims runout.

Source: [All-Payer 2020 Annual Report]

APM All-Payer TCOC PMPM

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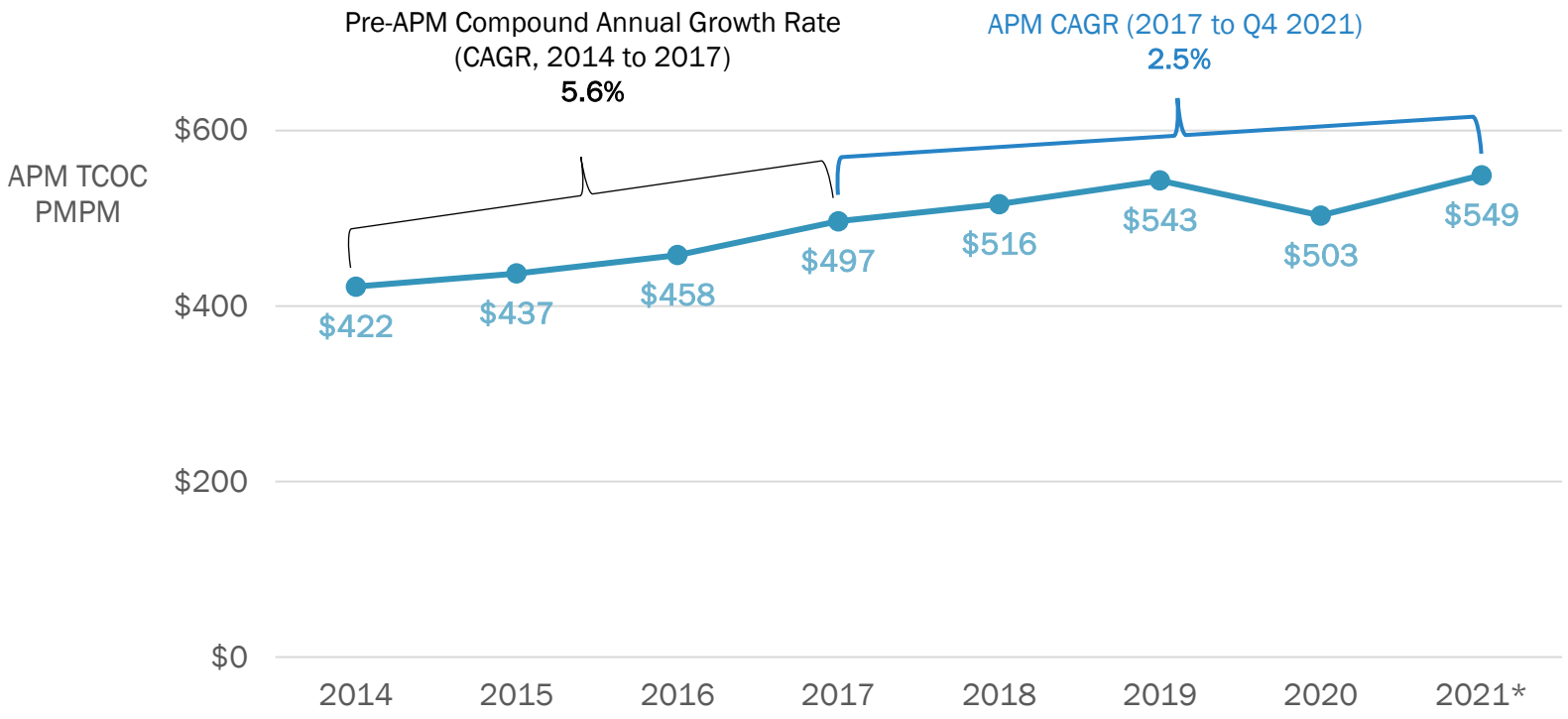

* 2021 data incurred through Dec 2021 and paid through Mar 2021

Medicare TCOC Per Beneficiary Growth

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Table 1: Vermont Medicare TCOC Per Beneficiary Growth to Date by Beneficiary Type

		Performance		National Projections		Vermont Performance Above / (Below) Target
		Annual Growth	Compounding Growth	Annual Growth	Compounding Growth Target	
Non-ESRD	PY1 (2018)	0.5%	0.5%	3.7%	3.5%	(3.0)
	PY2 (2019)	3.3%	1.9%	4.0%	3.7%	(1.8)
	PY3 (2020)	-5.9%	**-0.8%**	4.2%	**3.8%**	**(4.5)**
ESRD	PY1 (2018)	-18.4%	-18.4%	3.7%	3.5%	(21.9)
	PY2 (2019)	2.4%	-8.8%	3.3%	3.3%	(12.1)
	PY3 (2020)	-4.5%	**-7.2%**	3.1%	**3.1%**	**(10.4)**

Source: Medicare 2020 Annual Report

Four Issues for Discussion

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- Several provisions of the current agreement are worth revisiting today:
  1. Changes to traditional Medicare population due to Medicare Advantage enrollment
  2. Exclusions in services and types of care
  3. Vermont as a Low Spend State
  4. Other Adjustments

Issue 1: Medicare Advantage

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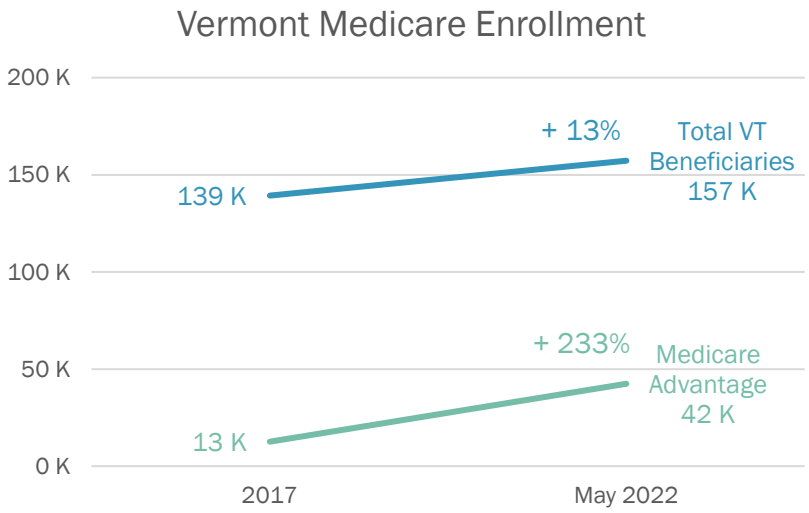
- Medicare Advantage (MA) is categorized as a commercial health plan (1.bb.)

MA enrollment increased substantially during current model.



It's changing the traditional Medicare population.

ACO-Attributed PY2021 Medicare	TCOC PMPM (CY2020)
All Attributed	$657
After all eligibility exclusions	$673 (+2.4%)
New to MA subset	$533 (-18.9%)

Issue 1: Medicare Advantage

For Discussion:

Assuming that MA penetration will continue to grow in Vermont, in common with other states:

- Departure for MA raises the risk profile of the population remaining in Traditional Medicare. How might Vermont advocate for the new model to take this into account?
- Should Vermont engage CMS on ways to improve MA Plans' participation in the model?

Issue 2: Exclusions

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Commercial	Medicaid services	Products
• Plans without a certificate of authority from DFR	• Mental Health • Home and Community-based • Long-Term Institutional (2018 – 2020)	• Dental • Vision • Supplemental • Third-party liability • Retail pharmacy

Issue 2: Exclusions

For Discussion:

- Inclusion in TCOC measurement means that CMS holds Vermont accountable for those expenditures.
- Should more of the currently-excluded services be included in TCOC in APM 2.0? Why?

Issue 3: Low Spend State

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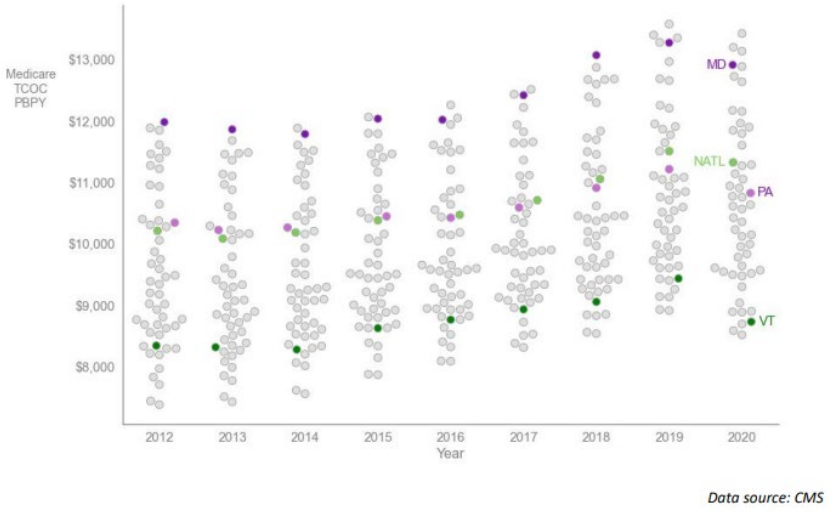
Vermont's history of relatively lower per capita expenditures often feels underacknowledged by federal partners.

The relatively low expenditures are partially due to utilization levels. Increasing access will likely increase per capita expenditures and should not necessarily be penalized.



Source: [Medicare 2020 Annual Report]

Issue 3: Low Spend State

For Discussion:

- TCOC calculations typically look back several years and apply a trend rate to growth, under which spending needs to be maintained.
    - As of 2022, rising costs are the highest concern for hospitals and other providers, leading to low or negative margins. This is a different picture from 2016.
    - Given this current picture, how should Vermont advocate for TCOC calculations that prioritize stabilization?

Issue 4 : Other Adjustments

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1. Age Bands
   - Allows adjustment for Vermont vs national population. This is not currently being applied.

2. Aged and Disabled vs ESRD
   - Allows for population differences in case there are shifts in the relative proportion of beneficiaries eligible due to End-Stage Renal Disease

3. Growth Target Floor
   - Provided a minimum growth target for the initial performance year based on criteria around the national projection. The State did utilize this adjustment for 2018.

Issue 4: Other Adjustments

For Discussion:

- What changes are needed, if any, and why?

Revisiting the Work Group's Decisions to Date

TCOC & Global Budget Intersections

All-Payer TCOC incentives *(continued statewide ACO structure)*

***TCOC overlay** on top of global budgets incentivizes providers to strive for optimal utilization*

Global Budgets

Three Options

?

Hospital Global Budgets & FFS

- ✓ Decouple hospitals from volume incentives, particularly for specialty and elective procedures that may be at low demand, and instead allow hospitals more flexibility to add service lines that are not traditional profit centers but support community population health needs
- ✓ Increase predictability of revenue for hospitals
- ✓ Considers expanding global budget design beyond facility fees into professional services (subject to details of design)
- ✓ Maintains FFS outside of the hospital global budgets

Does this align with our principle of moving away from FFS?

Portfolio Approach to Global Budgets

- ✓ Builds on existing efforts, representing a more iterative approach
- ✓ Includes hospital global budget approach + portfolio of APMs for other providers
- ✓ More inclusive of currently non-participating provider types
- ✓ Shared interest payments strengthen incentives for cross-provider collaboration within a community
- ✓ Goal is to “dial up” payment incentives inherent in each provider level Alternative Payment Model
- ✓ Includes a community-based global budget component piloted by Medicaid in 2023
- ✓ Allows providers to request reinvestment from one category of funding to another under an advanced governance structure

X

Community-Based Global Budgets

- ✓ Funding for all provider types flows through a single governance entity
- ✓ Portions of the community budget are allocated to each provider type
- ✓ Governed by an independent governance entity
- ✓ TCOC overlay on top of global budgets incentives providers to strive for optimal utilization across geographies

Reminder

- AHS/GMCB will be establishing two new subgroups:
  - Global Budgets
  - Total Cost of Care Model
- The subgroups will focus upon policy positions to raise with CMMI.
- **Please send Chris (cromero@bailit-health.com) the name(s) of an individual(s) from your organization who you would like to participate on one or both subgroups by today (9/20).**
  - Please copy Ena (Ena.Backus@vermont.gov) and Kristin (Kristin.Kellett@vermont.gov).