Total Cost of Care (TCOC) Subgroup #3

OCTOBER 11, 2022 MEETING

Meeting Agenda

1. Feedback heard from this TCOC subgroup so far
2. Discuss potential TCOC approaches to address the following key issues and features of Vermont:
   - Evolving Medicare Advantage landscape
   - Already large proportion of fixed payment models
3. Next meeting and next steps

Reminder: Purpose of TCOC Subgroup

Vermont seeks to develop a list of concrete "asks" on TCOC to share with CMS to inform the design of the new state model.

- AHS and GMCB seek to collect feedback from subgroup members on TCOC to inform conversations with CMS.
- TCOC subgroup meetings will serve as a mechanism for AHS and GMCB to solicit input and gauge providers' reactions to potential straw models.
- The primary focus of this subgroup is on traditional Medicare per capita spending targets, which is within CMMI's authority and control.

1. Feedback Heard from this TCOC Subgroup So Far

Recap of Feedback on Addressing Low Spend State for Medicare FFS: Medicare Per Capita Spending Targets

Option 1: Require Vermont to keep absolute PBPY Medicare FFS costs below the national average or hold the % by which Vermont is below national PBPY steady, but no obligation to <u>further</u> bend the cost curve.

- ◆ The subgroup noted that Medicare spending targets need to be high enough to encourage investments and create better incentives for providers, with fair participation by Medicare in that effort.
- ✘ One subgroup member did not prefer this option since the State would be benchmarking against a variable—national PBPY is unpredictable, which is further exacerbated since the new state model will be in effect for longer (8+ years).

Option 2: Allow Vermont to capture back a portion of gap between Vermont's per capita Medicare spend and national per capita Medicare spend for reinvestment in health system.

- ✓ One subgroup member mentioned that this option creates opportunities to invest in initiatives that improve health, which has not been afforded under the current agreement due to the low trend rate.
- ✓ One subgroup member noted this option provides the State with more control as compared to option 1.
- ◆ Several subgroup members highlighted the need to be thoughtful when making investments in the health system, i.e., it is not just the availability of the funds that is important, but how they are distributed. If this is done incorrectly, care could be pushed to other provider types that may not be financially supported.

Recap of Feedback on Addressing Low Spend State for Medicare FFS: All-Payer Per Capita Spending Targets

Option 1: Request higher rates in traditional Medicare as part of the APM (similar to Maryland) to offset pressure on commercial rates *(low likelihood but high impact)*.

- ✓ The subgroup agreed on the need for increased investment from Medicare.
- ◆ The subgroup had questions about how this option would be operationalized—how would rates be increased, who would set those rates, etc.
- ◆ The subgroup also wondered if a lump sum from Medicare to enable investment in the State's priority areas would be easier to operationalize; if going this route, careful thought is needed not just on the lump sum but how it would be distributed within Vermont.

Option 2: Create sub-per capita spending targets by payer that are reported alongside All-Payer per capita spending targets to enable monitoring of differential cost growth by payer type.

- ✘ The subgroup noted that this option does not reflect that spending is starting from a different base and some payers (Medicaid) have invested heavily in the health care system.

Recap of Feedback on Addressing Significant Patient Movement Across State Lines

Option 1: Per capita spending targets could be based on care provided in Vermont rather than care to Vermonters; would move completely away from attribution-based models CMS has used to date.

- ◆ The subgroup acknowledged that shifting to a non-attribution-based model of measuring "care in Vermont" is attractive but operationally daunting and a big shift for both CMS and the State. The implications of this option may be clearer as global budget work proceeds.
- ✓ One subgroup member noted that the global budgets concept more closely aligns with this option since it is based on geography.
- ✗ Determining spending in Vermont is especially challenging for professional claims.

New

Option 1a: Per capita spending targets could be based on care provided **to Vermonters** but only by providers **in Vermont**.

- ✓ Easy to implement, since it is a subset of care provided to Vermonters.
- ✓ Does not hold Vermont accountable for care it cannot influence (e.g., care in Florida).
- ✗ May create incentives to refer out of state.

Option 2: Medicare TCOC could still be based on care provided to Vermonters but could be supplemented by a separate trend analysis that compares in-state v. out-of-state care and includes some type of risk corridor around out-of-state spending.

- ✓ One subgroup member noted that it could make sense to include some providers who are out-of-state in the "in-state" group (e.g., DHMC)

2. Continued Discussion of Vermont's Key Issues and Features informing TCOC

Today's Topics

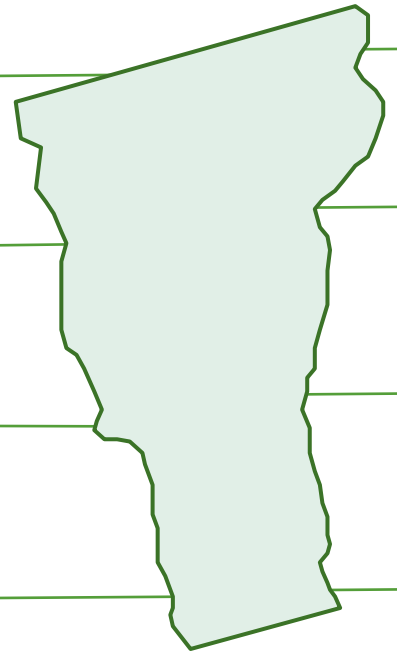
The main workgroup and this TCOC subgroup have identified the following features in Vermont that must be accounted for in a new model

1. Low spend state for Medicare

2. Significant patient movement across state lines

3. Evolving Medicare Advantage landscape

4. Already large proportion of fixed payment models



5. Older and aging state

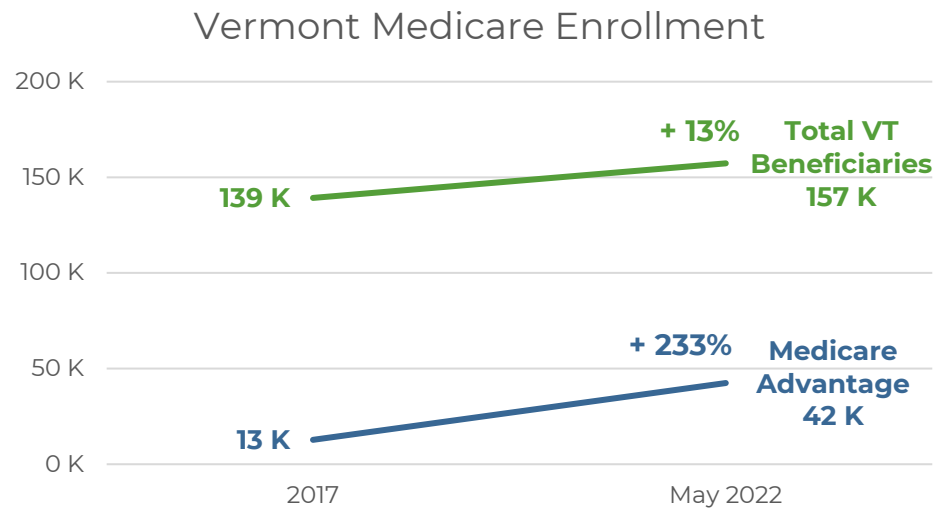
6. Rural/Critical Access Hospitals

7. Paramount need for hospital stability

8. Financial and regulatory barriers

Note: Some of these issues/features are not unique to Vermont (e.g., rural state), but are particularly salient to our State.

#3: Evolving Medicare Advantage Landscape (1 of 2)



ACO-Attributed PY2021 Medicare	TCOC PMPM (CY2020)
All Attributed	$657
After all eligibility exclusions*	$673 (+2.4%)
Attributed but not included in TCOC counts due to newly enrolling in MA	$533 (-18.9%)

*Medicare population who was attributed for PY2021 AND fulfilled all eligibility criteria (e.g., still has Part A and B FFS Medicare as of Jan 1, 2021)..

Source: GMCB

Current State

The Medicare Advantage (MA) penetration rate has increased substantially during the last several years. Under the current APM ACO Agreement, MA is categorized as a commercial health plan and spend is tracked as "commercial."

- MA enrollees tend to be healthier than those with Original Medicare Parts A and B. In Vermont, individuals enrolling in MA tend to have ~20% lower per average monthly costs compared to the attributed Medicare population at large.
- The difference in risk profiles among these two groups has implications on per capita cost for those left in Original Medicare.

#3: Evolving Medicare Advantage Landscape (2 of 2)

Options for Consideration

1. Request that CMS use risk adjustment tools (HCC scores) to analyze MA vs traditional Medicare risk and increase Original Medicare per capita spending targets to reflect less healthy risk profile of remaining Original Medicare population in Vermont.
2. Request that CMS adds spending by MA Plans in Vermont back into Medicare for Medicare per capita spending targets, rather than counting MA as "Commercial."
3. Request that CMS require MA Plans' participation in the APM 2.0 payment models to help control per capita spending.

#4: Already Large Proportion of Payments within Vermont's Health Care System are Fixed (1 of 2)

Current State

- Vermont is in the middle of this spectrum. Today, many provider types including hospitals and primary care practices already receive fixed PMPM payments; however, as noted in our discussions, some of these payments (Medicare prospective payments to hospitals in particular) are heavily "trued up" to FFS, and non ACO attributed patients are not included.
- If the new model includes global budgets that also include professional services ("hospital global budget plus"), Vermont will move further along the spectrum with more fixed payments relative to FFS.
- The **function** of per capita spending targets changes with movement along the spectrum: when most payments to providers are fixed prospectively, provider behavior does not impact per capita spending. Instead, the **target informs the aggregate budget** that shapes the dollars available to providers. In other words, TCOC methodology and global budget methodologies are strongly linked.

#4: Already Large Proportion of Payments within Vermont's Health Care System are Fixed (2 of 2)

Options for Consideration

1. Take out payments under global budgets and other forms of prospective payment from both Medicare and All-Payer per capita spending targets and measure only per capita spending that is not covered by these forms of payment (i.e., the remaining spend that is FFS).
2. Still factor in global payments into per capita per spending targets, but weight them lighter in the methodology than remaining FFS payments.
3. If there were bonuses/penalties tied to hitting target (*unclear from CMS description*), narrow risk corridor. For example, if 50% of the payments are fixed and 50% can vary, then it is twice as hard for any 1% increase or decrease in spending, since only half of the budget has to do all of the "work" to generate the savings.

Alternative solutions *(mutually exclusive)*

Question for Discussion

Is there really a CMS "ask" here? Or is the bigger issue that the part of the budget that is fixed becomes the primary tool for hitting the target, meaning that providers who take risk by agreeing to fixed payments ***also*** have to bear most of the burden of staying within the target?

3. Next Meeting and Next Steps

Next Meeting and Next Steps

- The next TCOC subgroup meeting is on **Tuesday, 10/18** from **9-10am**. We will focus on the following topics as they relate to TCOC:
  - Older and aging state
  - Rural state
- If you have suggestions for other TCOC-related topics, please send them to Edith (estowe@manatt.com) and Lora (lykim@manatt.com).