Global Budget Subgroup

NOVEMBER 8, 2022, MEETING #6 SUMMARY

Meeting Agenda

1. Recap of Prior Meeting Discussion
2. Potential Flexibility for Interaction with Other Models via Shared Incentives
3. Potential Flexibility for Global Budgets for Other Provider Types
4. Potential Flexibility for Requiring Medicare Advantage Participation
5. Next Steps

1. Recap of Prior Meeting Discussion

Recap of 11/1 Meeting (1 of 2)

Flexibility in Establishing Baseline Budgets

- Two members voiced support for flexibility; additional comments advocated for transparency about the methodology that is selected.

Flexibility to include Specialty Hospitals:

- Members expressed the opinion that the Brattleboro Retreat should be asked for its view.
- One member opined that this was not a central issue in the design of the global budget model.

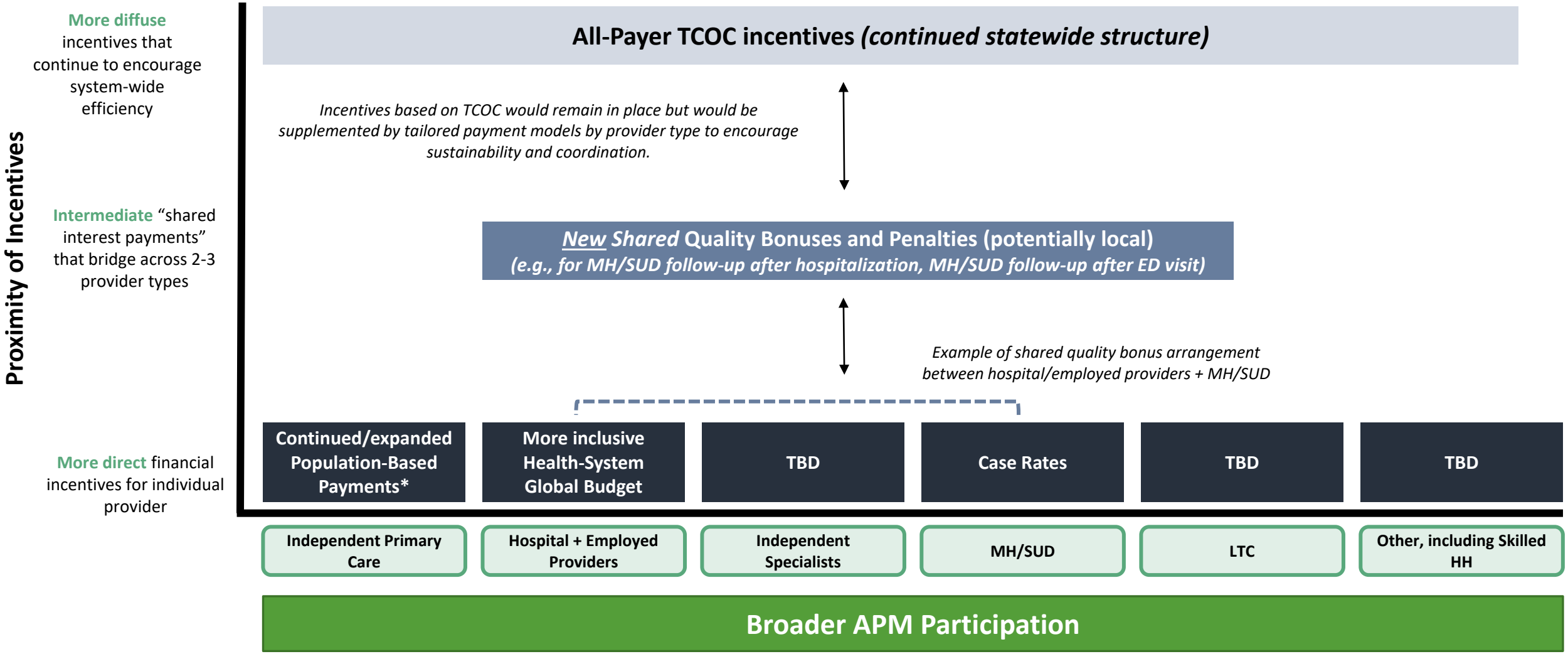
Recap of 11/1 Meeting (2 of 2)

Flexibility for Global Payments to Critical Access Hospitals

- Two members conveyed that moving away from a cost-reconciled model could create high risk for CAHs, with one member stating that a bridge strategy would be necessary if it were to be pursued and another suggesting a glide path.
- Another member suggested that relooking at how fixed expenses are defined for CAHs and moving away from a focus on Net Patient Revenue might be necessary if CAHs are to adopt a global budget without cost reconciliation.
- In response to a question about what CAHs would seek, a CAH representative identified a) predictable payment, and b) updated CMS cost audits.
- One member recommended pursuing this flexibility to ensure consistency of payment method across hospitals.

2. Potential Flexibility for Interaction with Other Models via Shared Incentives

“Portfolio” Approach Revisited



What Do We Mean by “Shared Incentives”?

Aligned quality measures

- Performance of different provider types assessed using aligned measures
- Payment, including for performance incentives, is handled separately for different provider types

Shared interest payments

- Shared interest payments across different provider types for performance on selected measures
- Base payment is handled separately for different provider types

What are the Goals of Shared Interest Payments?

Building in shared interest payments across multiple provider types can help to:

1. Ensure alignment for all providers to work toward the same goals (better population health, higher quality care, lower costs, health equity)
2. Promote accountability across provider settings for a patient population
3. Support a "buy not build" approach to promote community-based care
4. Ensure better coordination across provider types and settings
   - Improve data sharing
   - Promote development of cross-provider operating protocols to "meet patients where they are"
   - Reduce unnecessary duplication of care and care management

Potential Approaches for Shared Incentive Payments

- Shared incentives can take different forms and may not need to be shared across all providers for every measure of desired performance, e.g.,
  - Hospital + PCP
  - Hospital + DA
  - Hospital + PCP + home health + SNF
- As hospitals in Vermont are geographically separated, Vermont could consider shared performance incentives across hospital and specific types of non-hospital providers in a given geographic region
- Shared incentives could focus on the care for specific populations, such as individuals with mental illness and/or substance use disorder
- Alignment of incentives across provider types is most important when multiple provider types in different settings contribute to the quality of care and outcomes for a given person/population
  - e.g., receipt of preventive care for a population with SPMI

Examples of Performance Measures and Domains

- The following performance measures and domains could be employed for shared incentives across hospital and non-hospital settings:
  - Information exchange between the hospital and other care settings, e.g., race, ethnicity, language and/or other SDOH data
  - Engagement of hard-to-reach populations/populations experiencing health disparities
  - Patient engagement after discharge, including for behavioral health (e.g., timely follow-up visits, timely medication reconciliation after discharge)
  - Potentially avoidable hospital utilization (e.g., preventable admissions, readmissions , ED visits)
  - TCOC growth, for an entire population or for populations with specific conditions
  - Population health improvement (e.g., lower rates of certain chronic conditions; better outcomes for people with certain chronic conditions)

Aligned Incentives in Vermont's All-Payer Model and ACO

All-Payer Model:

- Incentives to ACO based on six population health targets, along with care delivery measures and process milestones

OneCare Vermont

- OneCare assesses performance on certain measures at the network level.
- Performance incentives are distributed to providers within the network.
- Hospitals and primary care practices are the primary holders of risk. Risk is two-sided.

Aligned Incentives in Maryland's TCOC Model

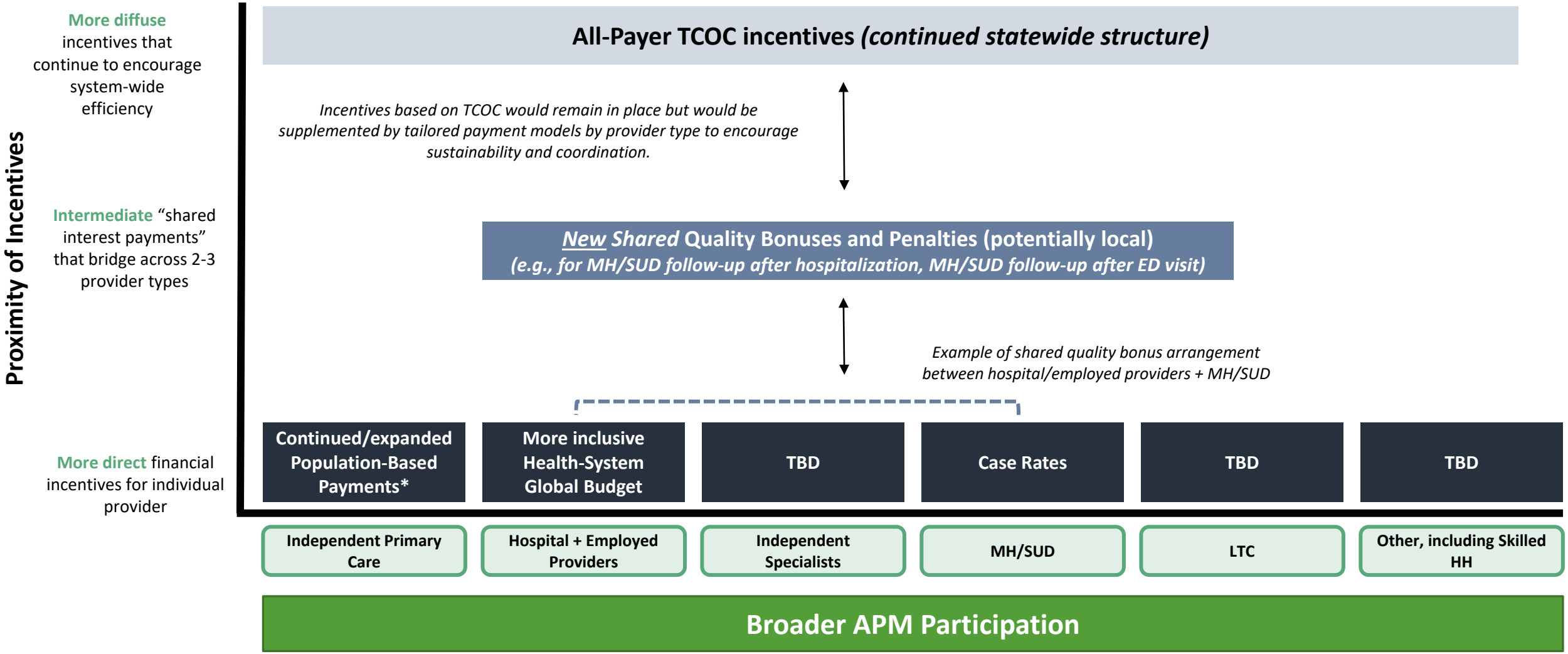
- In 2019, Maryland began implementing a Total Cost of Care (TCOC) Model, which sets a per capita limit on Medicare total cost of care in Maryland. This Model builds upon the All-Payer Model, which had set a limit on hospital expenditures only.
- The TCOC Model includes a *Care Redesign Program*, which allows hospitals to make incentive payments to non-hospital health care providers who partner and collaborate with the hospital and perform care redesign activities aimed at improving quality of care.
- The TCOC Model also established the *Maryland Primary Care Program*, which includes a performance-based incentive payment to health care providers to reduce hospitalization rates and improve the quality of care for their attributed Medicare beneficiaries, among other quality and utilization-focused improvements.

Subgroup Member Feedback

- Several members supported seeking flexibility to utilize shared interest payments across global budgets and other provider payment models.
- Members voiced the following additional comments:
  - It is preferable to utilize existing measures for which providers already hold risk.
  - It is important that providers share common incentives for performance influenced by different provider types.
  - Measures should reflect where practices have influence.
  - Incentives should get down to the practice level.

3. Potential Flexibility for Global Budgets for Other Provider Types

“Portfolio” Approach (Again!)



When should a global budget be considered and for what providers?

Goal alignment:

- Transform care delivery so that people receive "right care, in the right place, at the right time"
- Provider stability
- Rural sustainability
- Affordability for Vermonters

Reasonable accountability:

- Ability to influence a category of costs

Vermont Context: Medicaid Transformation

- DVHA is working to move more payments into a fixed, prospective payment arrangement.
- Many provider types in Vermont have experience with global budget-like arrangements, including:
  - Hospitals
  - Primary care (through Comprehensive Payment Reform – see next slide)
  - Designated Agencies/Specialized Services Agencies
- In addition to the ACO model, AHS has payment reform projects for mental health, residential SUD, applied behavioral analysis (autism), developmental disability services, children's integrated services, and hi-tech nursing

Vermont Context: Comprehensive Payment Reform

- The Comprehensive Payment Reform (CPR) program is OneCare's payer-blended fixed payment model for independent primary care practices.
- In 2022, there are 13 TINs and 16 practice sites participating.
- The fixed payments cover services for the Medicaid, Medicare, and BCBSVT QHP programs.
- Practices receive monthly Per Member Per Month (PMPM) payments for "core" primary care services, with a supplemental PMPM to support care delivery evolution and enhanced FFS reimbursement for other services offered within the primary care setting. Practices are at risk for 15% of TCOC shared savings/shared losses.

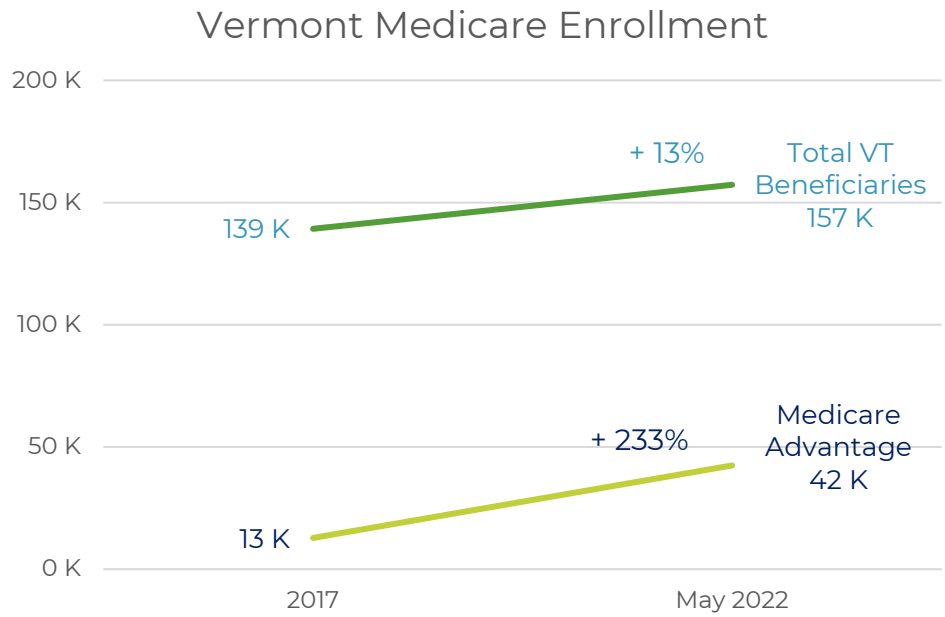
Subgroup Member Feedback

- A few members supported seeking flexibility to utilize global budgets with other provider types. No members voiced opposition.
- Members voiced the following additional comments:
  - Consider changing the language from "…flexibility for Medicare to participate…" to "…flexibility to offer the platform for…", since we want the flexibility for Vermont to administer such models as opposed to CMS doing so.
  - Commercial payers won't have sufficient volume to make global budgets feasible for some provider types, e.g., Designated Agencies and home health.

4. Potential Flexibility for Requiring Medicare Advantage Participation

Medicare Advantage Trends in Vermont

- Historically, Vermont's Medicare Advantage enrollment penetration rate had been quite low as compared with other states.
- However, in recent years, the penetration rate increased steadily and then jumped substantially in 2021, in part due to Blue Cross Blue Shield's entrance to the market.
- As of May 2022, the penetration rate had increased to almost 27%.



Given increasing penetration in Vermont, inclusion of Medicare Advantage may be important to ensure multi-payer alignment for the global budget model.

Medicare Advantage Participation in Other Global Budget Models

Maryland All-Payer Model	Pennsylvania Rural Health Model	CMMI Community Health Access and Rural Transformation Model (CHART)
• Mandated Medicare Advantage plan participation.	• CMS encourages, but does not require, commercial payers administering Medicare Advantage (MA) plans to participate in the model. Payers who *do* participate must bring in all lines of business, however, with some exceptions. • The Model has participation from five MA plans and a significant share of covered lives from MA (17.6%).	• Medicare Advantage enrollees could be included as part of multi-payer alignment with commercial payers (i.e., encouraged but not required).

Options for Medicare Advantage Participation in Global Budgets

- Medicare Advantage plans could be mandated to participate in the global budget model.
- Other *theoretically* possible CMS levers include incentives in the MA program that could be applied in the establishment of benchmarks, rebates, quality bonuses, and/or in the bidding process

Subgroup Member Feedback

- A few members supported asking CMS to require Medicare Advantage plans participation in Vermont's global budget program. One member recommended instead asking CMS to encourage participation.
- Members voiced the following additional comments:
  - Consistency of practice across payers will be important to providers.
  - Many commercial payers will have very low volume at the individual facility level.

5. Next Steps

Planned Topics for 11/15

Reconsideration of 11/8 topics

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?*

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?*

Planned Activity after 11/15

- The State will survey Subgroup members following the 11/15 meeting and request that they indicate which of the 12 discussion topics should be prioritized with CMMI. The survey will include space for comment.