Total Cost of Care (TCOC) Subgroup #4

OCTOBER 18, 2022 MEETING SUMMARY

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:
   – Already large proportion of fixed payment models
   – Older and aging state
   – Rural and Critical Access Hospitals
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.

- The State aims to provide as many different options/straw models as possible for CMS to consider while they design the TCOC component of the new state model.
- The goal of the TCOC subgroup is to identify any options/straw models that lack support and should *not* be raised with CMS during negotiations.
- The primary focus of this subgroup is on traditional Medicare per capita spending targets, which is within CMMI's authority and control.
- 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.

1. Feedback Heard from this TCOC Subgroup So Far

Recap of Feedback on Addressing Evolving Medicare Advantage Landscape

Option 1: Request that CMS use risk adjustment tools (HCC scores) to analyze MA v. traditional Medicare risk and increase Original Medicare per capita spending targets to reflect less healthy risk profile of remaining Original Medicare population in Vermont.

- ✓ The subgroup agreed that this option appears to be operationally feasible. The methodology for calculating Medicare per capita spending targets will need to be updated.
- ◆ More broadly, the subgroup raised questions around whether per capita spending targets need to address MA given the relatively small scale of MA enrollees. GMCB noted that this was important issue to consider given that the increasing MA penetration rate may undermine Vermont's status as a low spending state for Medicare.

Option 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."

- ✓ Similar to option 1, the subgroup agreed that this option appears to be operationally feasible. The methodology for calculating Medicare per capita spending targets will need to be updated.
- ✓ One subgroup member noted that incorporating MA when calculating Medicare per capita spending targets allows for a more holistic approach since a larger number of people are included in the calculations.
- ✓ Vermont has MA data readily available in VHCURES that can be used to implement this option.
- ✗ One subgroup member flagged that MA plans have their own priorities that may conflict with the State's overarching TCOC goals. These dynamics may be challenging to navigate.

Option 3: Request that CMS require MA Plans' participation in the APM 2.0 payment models to help control per capita spending.

- ✗ The subgroup agreed that this option may present significant legal and operational hurdles. AHS understands these challenges but aims to understand CMMI's perspective given the proliferation of MA.

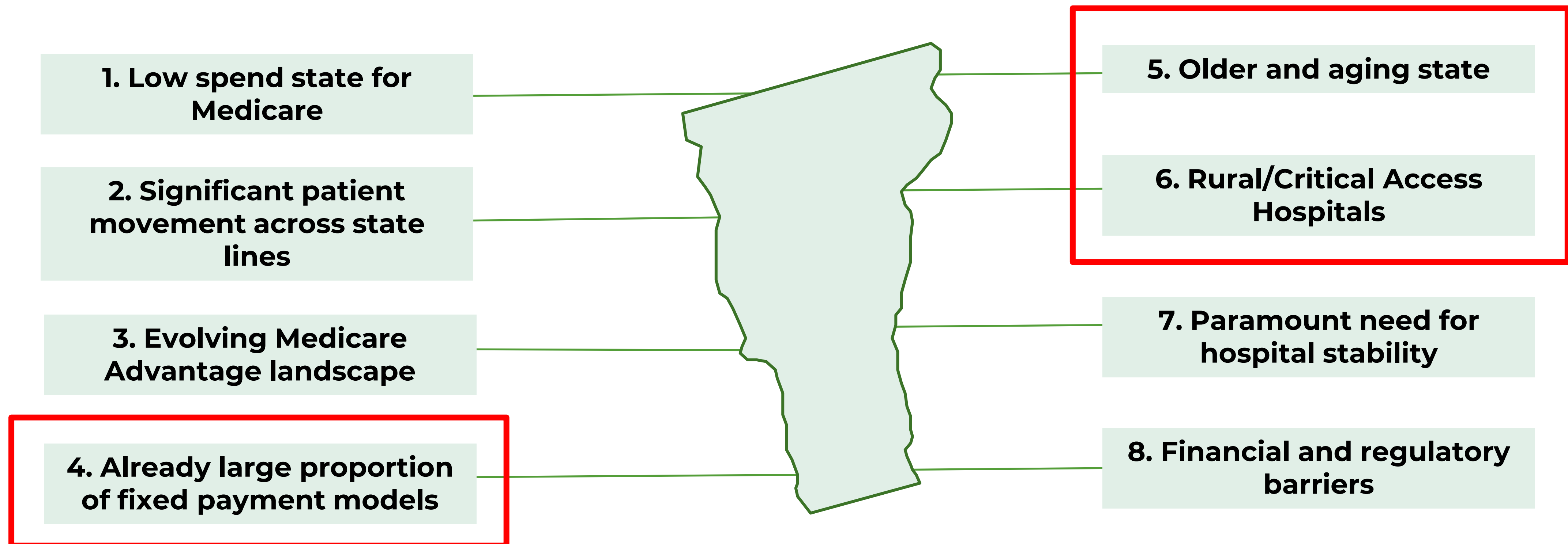
Subgroup Member Discussion on Recap of Feedback on Addressing Evolving Medicare Advantage Landscape

- One subgroup member made the point that it will be important to determine whether spending targets are set once at the beginning with a trend over the life of the model; or re-set annually relative to FFS.
  - The more the model relies on a long-term trend over time, the more important it is to account for the attrition to Medicare Advantage since this trend is likely to continue.

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



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

#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 acts as the aggregate budget*** that shapes the dollars available to providers. In other words, TCOC methodology and global budget methodologies are strongly linked.

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? Or do providers feel that the organizations remaining in FFS bear the brunt of responsibility for hitting per capita targets?

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

Options for Consideration

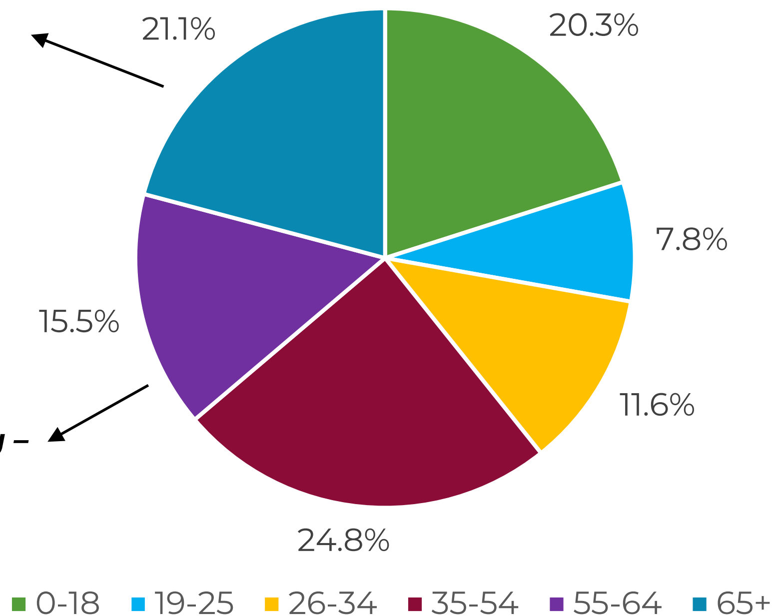
1. **Take out payments under global budgets and other forms of prospective payment from both Medicare and All-Payer per capita spending targets and measure only per capita spending that is not covered by these forms of payment (i.e., the remaining spend that is FFS).**
   - ✓ Ensures that Vermont is held accountable only for the parts of spending that can be influenced in a given year
   - ◆ Questions around availability of data on prospective payments v. FFS spending
   - ✗ May shift burden of adhering to per capita spending targets to providers in FFS
2. **Still factor in global payments into per capita per spending targets, but weight them lighter in the methodology than remaining FFS payments.**
   - ✓ Ensures all providers bear the burden of meeting TCOC targets, while acknowledging that fixed payments are not able to be reduced during the year
   - ◆ Similar questions around availability of data
   - ✗ More operationally complex and less intuitive
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.**
   - ✓ Acknowledges differential impact of fixed v. FFS payments
   - ◆ Only makes sense when there are bonuses/penalties—unclear whether CMS is imposing bonuses/penalties for statewide TCOC

Alternative solutions (mutually exclusive)

Subgroup Member Discussion on Already Large Proportion of Payments within Vermont's Health Care System are Fixed

- The subgroup agreed that it is important to consider the range of services that remain in FFS and what incentives are set up with the application of spending targets to that set of services.
  - One subgroup member made the point that if the subset of services left in FFS correlate with preventative care, it could have unintended consequences of constraining spending in areas where spend should increase to improve health outcomes.
- Another subgroup member made the point that the proposed introduction of global budgets will mean that the APM is based on care in Vermont whereas statewide spend targets will continue to be based on care to Vermonters, as today.

#5: Older and Aging State (1 of 2)



Breakdown of Senior Population (2020)

- ***Ages 65-74:*** 10.9% of state population
- ***Ages 75-85:*** 5.1% of state population
- ***Ages 85+:*** 2.2% of state population *(ranked #6 in the nation)*

Current State

- Vermont is one of the oldest states in the nation and is also rapidly aging.
- Since being older is associated with negative health outcomes, health care spending should be high, ultimately increasing total cost of care.
- However, Vermont is of one of the healthiest states in the nation. The State ranked #2 among states for overall health* ***and*** is a low-spend Medicare state (#50 for Medicare FFS).
- This can be attributed to significant investments from Medicaid, robust public health infrastructure, and other factors.
- **Vermont is overperforming and should be rewarded by CMS for these achievements.**

*The following components were considered in United Health Foundation's rankings: social and economic factors, physical environment, clinical care, behaviors, and health outcomes.

Sources: Population Distribution by Age; States with the Most Seniors; America's Health Rankings 2022 Annual Report; 2020 Profile of Older Americans; *2020 CMS Office of the Actuary (OACT) Spending Data*

#5: Older and Aging State (2 of 2)

Options for Consideration

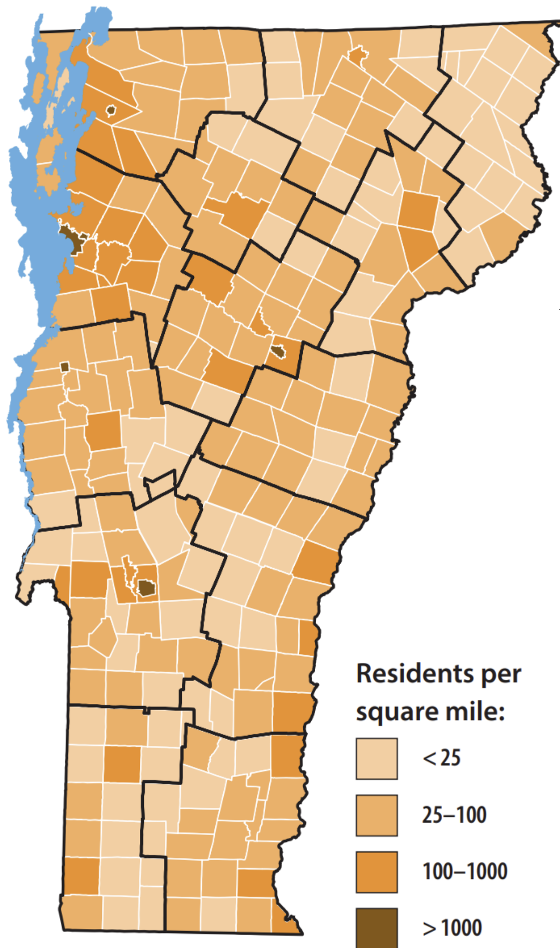
1. **Request that Vermont is not asked to bend the curve in all-payer per capita spending*.**
   - ✓ Ensures no further reduction in cost growth, allowing spending to grow closer to national averages
   - ✗ Benchmarking against a variable—national PBPY is unpredictable, which is further exacerbated since the new state model will be in effect for longer (8+ years)
   - ✗ Does not take into account historically low spend or enable any reinvestment
2. **Request "credit" for achievements by having the ability to invest savings in health-related initiatives*.**
   - ✓ Gives State control over dollars to enable reinvestment to targeted providers/geographies
   - ◆ Questions about who would decide how dollars would be allocated
3. **Request "credit" for achievements by applying discounts to and/or risk adjusting PBPY actual spending.**
   - ✓ Makes targets easier to achieve
   - ✗ Allows for higher utilization of services, but does not enable higher payments/additional investment

*Similar to option previously discussed during 10/4 discussion on low-spend Medicare state.

Subgroup Member Discussion on Older and Aging State

- The subgroup agreed that risk adjustment of spend targets would make sense. It is harder to accomplish for All-Payer than Medicare but possible (e.g., Hopkins Grouper in APCD).
  - Relating to points previously made, if the design of the spending targets is a fixed starting point with a trend, it is more important to have risk adjustment; whereas if the spend targets are re-set each year, the age of the population is more naturally taken into account.
- Subgroup members raised that exogenous factors related to constraints on the delivery system can push up total cost of care being measured in the spend targets. For example, pressure on Long Term Care and Home Health capacity can have a knock-on effect on total spending across Medicare and other payers (e.g., pressure on subacute beds pushing patients into acute care).

#6a: Rural State (1 of 2)



Approximately two-thirds of Vermonters live in rural areas. Outside of Chittenden County, no cities or towns have more than 16,000 residents.

Current State

- According to 2020 census data, approximately 19 percent of Americans live in rural areas. In Vermont, that number is 3x higher—61 percent of residents live in rural areas.
- Individuals living in rural areas are likely to experience higher rates of chronic conditions, less likely to receive preventive care, and have issues accessing care due to workforce shortages. These factors cause health to worsen and become more acute over time, leading to higher utilization of hospital services, impacting TCOC.
- However, as mentioned previously, Vermont is one of the healthiest states in the nation.
- **Vermont is overperforming and should be rewarded by CMS for these achievements.**

Sources: State Health Assessment 2018; Healthcare Access in Rural Communities

#6a: Rural State (2 of 2)

Options for Consideration

1. **Request to sustain or increase dollars in Blueprint and SASH programs “outside” of TCOC.**
   - ✓ Creates a sustainable funding source for these programs since they are not funded out of savings.
   - ✗ May not increase dollars relative to today.
2. **Request “credit” for achievements by having the ability to invest savings in health-related initiatives* *(same as prior discussion).***
3. **Request “credit” for achievements by applying discounts to PBPY actual spending *(same as prior discussion).***

*Similar to option previously discussed during 10/4 discussion on low-spend Medicare state.

#6b: Large Number of Critical Access Hospitals (1 of 2)

Current State

- 8 out of 14 hospitals in Vermont are Critical Access Hospitals (CAHS). They receive cost-based reimbursement (i.e., actual costs instead of standard Medicare fees) for hospital services furnished to Original Medicare beneficiaries.
- CAHs' operating budgets are thin. The Medicare portion of their budgets is substantial, ranging from 33 to 53 percent of their budgets.
  - This unique reimbursement structure for CAHs is critical for provider stability.
  - CAH participation in "hospital plus" global budgets presents a complex set of issues that will be contemplated in the GB subgroup.
- Currently, per capita spending targets ***only account for claims payments and not cost-based reconciliation***. CAHs do not have a negative impact on the State's performance.

Source: GMCB

Subgroup Member Discussion on Large Number of Critical Access Hospitals

- The subgroup agreed that for CAHs, the exclusion of the cost-based reimbursement in total spend targets should continue.
- One subgroup member said that generally, we would want more, not less, care diverted to CAHs since they are local to rural communities. As raised in previous parts of the discussion, care should be taken that the spend targets do not unintentionally constrain appropriate and preventive care.

#6b: Large Number of Critical Access Hospitals (2 of 2)

Options for Consideration

1. **Request no change from how CAHs are handled in per capita spending targets under the current agreement.**
   - ✓ Requires no updates to methodology or calculations; can continue the status quo, which is easy to implement.
   - ✗ Per capita spending targets will not impact CAHs—a large number of hospitals will be exempt from statewide efforts to control TCOC.
2. **Other?**

Note: CAHs present bigger challenges when thinking about how to incorporate them into global budgets than for TCOC.

3. Next Meeting and Next Steps

Next Meeting and Next Steps

- The next TCOC subgroup meeting is on **Tuesday, 10/25** from **9-10am**. We will focus on the following topics as they relate to TCOC:
  - Paramount need for hospital stability
  - Financial and regulatory barriers
- If you have suggestions for other TCOC-related topics, please send them to Edith (estowe@manatt.com) and Lora (lykim@manatt.com).