Hospital Global Budget Technical Advisory Group

OCTOBER 10, 2023
MEETING #12

Meeting Agenda

1. Recap of prior meeting discussion
2. Medicare FFS global payment straw model (continued)
3. Terms of hospital participation
4. Hospital variation
5. Hospital care transformation and resource redeployment

Recap of September 26th Meeting

September 26th Meeting Recap (1 of 2)

During Meeting #11, the TAG discussed design decisions for the Medicare FFS straw model. TAG members conveyed the following:

- Concern about the percentage of excluded revenue growing over time, with particular concern about pharmacy costs moving from outpatient to retail (and from the medical benefit to the pharmacy benefit)
- Questions about the role of Medigap payments in the model
- Concern regarding inconsistencies in provider-based billing practices, given the potential complication with separating physician payments from hospital payments
- Support for performing a hospital needs assessment to determine capacity to transition to, and operate under, a hospital global budget
- Request for analysis of whether growth in chemotherapy spending was due to utilization or price

September 26th Meeting Recap (1 of 2)

TAG member input (continued):

- Feedback that it's too early to decide how to handle changes in HSA catchment areas, anticipating that changes will occur prior to 2026 as more hospital service move to UVMMC from smaller hospitals
- Concern with accountability for how added payments resulting from an equity adjustment will be used, and request for clarity on the purpose of the equity adjustments, i.e., to cover the higher care delivery costs of high social need patients or investment in social supports

Meeting Objectives

1. Medicare FFS global payment straw model: Discuss methodology for developing total cost of care accountability.
2. Terms of hospital participation: Discuss whether the model should have voluntary or mandatory hospital participation.
3. Hospital variation: Identify whether, and if so how, the model should allow for any variation across hospitals.
4. Hospital care transformation and resource redeployment:
   a) Identify supports hospitals will need to succeed under global budgets by transforming business models and care delivery.
   b) Identify strategies for payers to support hospitals in care transformation.
   c) Discuss requirements for hospitals to demonstrate effective transformation of business models and care delivery, including through resource redeployment.

Medicare Fee-for-Service Global Payment Straw Model

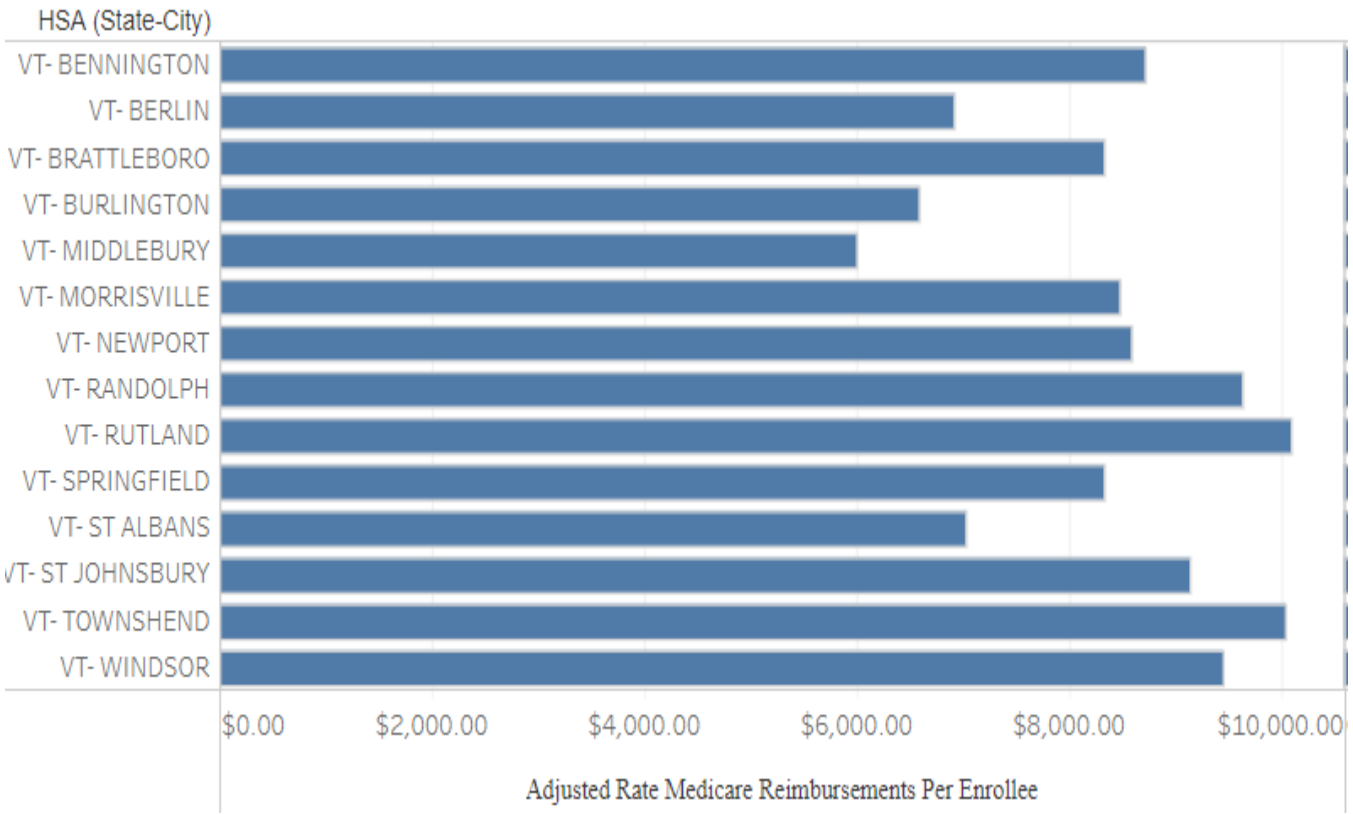
TAG Meeting 8: Rationale for TCOC Accountability

- Provides financial accountability for services outside of global budget payments, and protects against shifting hospital costs to community providers
- Incentivizes improvements in population health
- Can align incentives across provider types & payment models
- Results in APM incentive payment & exclusions from MIPS

- Hospitals would be held accountable for costs they cannot fully control
- Could add further complexity to the model

5d. Total Cost of Care Accountability

Total Medicare Reimbursements per Enrollee, Parts A and B, by HAS, 2019
(Price, Age, Sex, and Race adjusted)



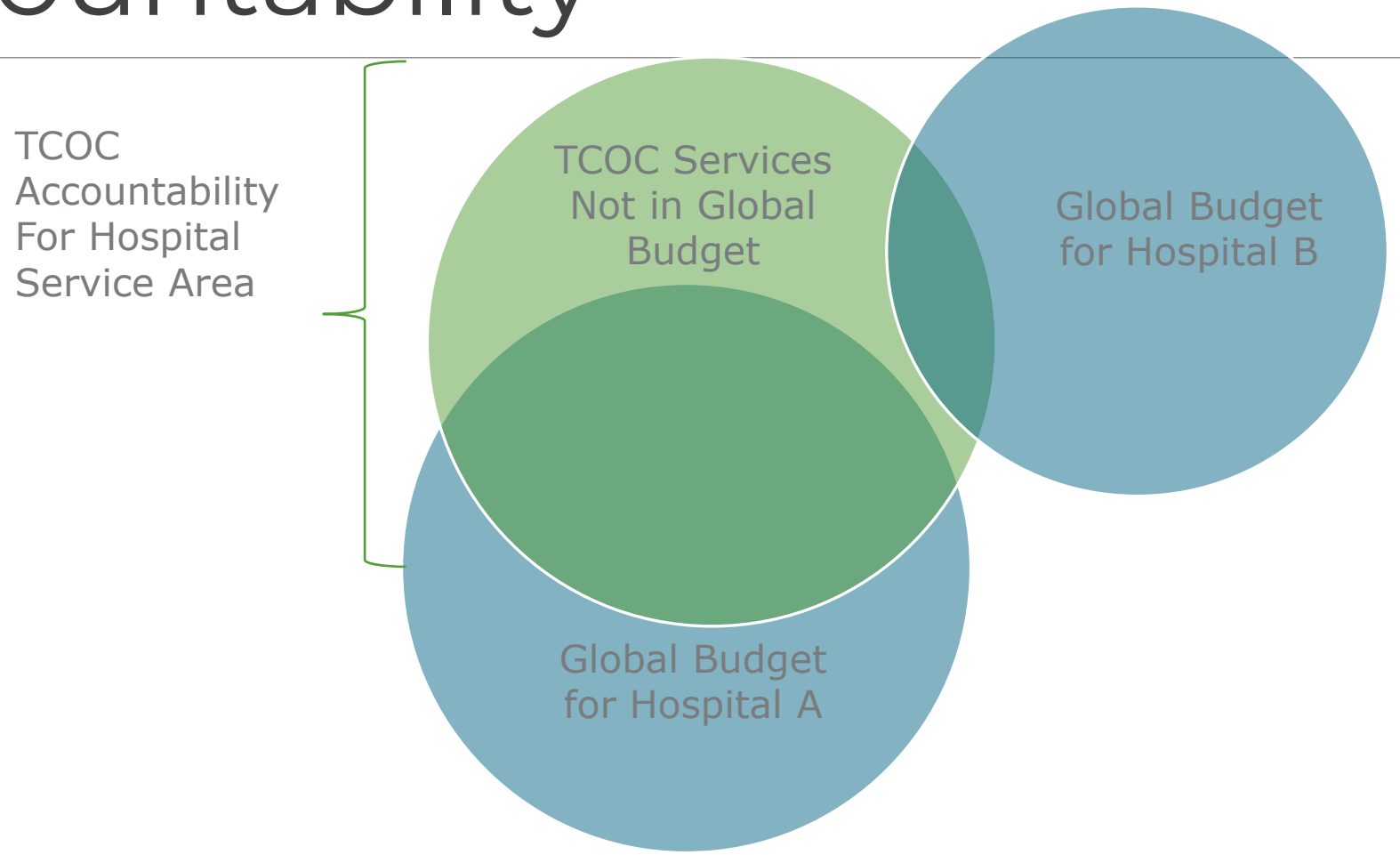
- State level accountability - Budget neutrality discussions with CMMI
- Hospital level accountability - Area-based total cost growth benchmarking

Next steps :

1. Align definition of TCOC for Medicare FFS with state-wide accountability. Part A and Part B services (currently does not include Part D which pays for retail pharmacy).
2. Determine geographies to attribute to hospitals. Hospital service areas (HSAs) or smaller geographies if a hospital does not have significant market share.

Data Source: Dartmouth Data Analytics Core

Geographic definition of total cost accountability



5d. Total Cost of Care Accountability

Questions to develop the methodology:

1. Geographic level assessment of rate of growth in total cost of care
2. Adjustments (demographic and other adjustments)
3. Implementation timeline

Question for TAG:
Should we use HSAs for TCOC accountability? Should we build smaller geographies for smaller hospitals, e.g., Grace Cottage, Porter?

Proportion of Medicare Allowed Amounts by Hospital

HSA	Brattleboro	Central Vermont	Copley	Gifford	Grace Cottage	Mt. Ascutney	North Country	Northeastern	Northwestern	Porter	Rutland	Southwestern	UVMMC	Grand Total
Brattleboro	85%	0%	0%	0%	13%	0%	0%	0%	0%	0%	1%	1%	0%	100%
Bennington	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	11%	85%	0%	100%
Springfield	10%	0%	0%	0%	10%	39%	0%	0%	0%	0%	38%	3%	0%	100%
Rutland	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	87%	0%	11%	100%
Burlington	0%	0%	5%	0%	0%	0%	0%	0%	3%	1%	0%	0%	91%	100%
White River Jct	0%	3%	0%	16%	0%	69%	0%	6%	0%	0%	3%	0%	3%	100%
Middlebury	0%	0%	0%	0%	0%	0%	0%	0%	0%	50%	7%	0%	43%	100%
Barre	0%	65%	3%	4%	0%	0%	0%	1%	0%	0%	0%	0%	26%	100%
Randolph	0%	11%	0%	82%	0%	1%	0%	0%	0%	1%	3%	0%	3%	100%
St. Albans	0%	0%	1%	0%	0%	0%	0%	0%	64%	0%	0%	0%	35%	100%
St. Johnsbury	0%	2%	0%	0%	0%	0%	1%	93%	0%	0%	0%	0%	3%	100%
Morrisville	0%	4%	65%	0%	0%	0%	1%	1%	0%	0%	0%	0%	28%	100%
Newport	0%	0%	3%	0%	0%	0%	81%	8%	0%	0%	0%	0%	7%	100%

Terms of Hospital Participation

Options for Hospital Participation

Options for hospital participation in the global budget payment model include the following:

1. *Voluntary approach*: Hospitals could choose to participate in the model and have an option to leave the model.
2. *Mandatory approach*: The State would use its regulatory authority to mandate use of a hospital global payments across all Vermont hospitals.
3. *Phased-in approach*: Participation would be voluntary initially but then required in the future.
4. *Hybrid approach*: Participation would initially be mandatory for some hospitals (e.g., non-CAHs) and voluntary for others (e.g., CAHs).

Voluntary / Phased-in Approach: Pros and Cons

- Allows for a more incremental approach which can include more hospitals over time
- Would be more appealing to hospitals that feel they need more time to prepare for a global budget payment methodology

- If participation is low, the model will have limited impact
  - Could also impact sustainability
- Could create administrative complications for commercial payers
- Participation from a subset of hospitals could mean differing payment incentives
  - Hospitals paid under a global budget arrangement may “shed” patients to other hospitals paid on a FFS basis in an attempt to maximize savings

Mandatory Approach: Pros and Cons

- Increases incentives for providers & payers to work together across settings to reduce costs and transform care → universal hospital participation can yield strong outcomes
- Greater hospital participation makes learning collaboratives across hospitals more robust
- Easier for commercial payers to administer
- Easier for the State to oversee and administer the model effectively

- Not all hospitals may be ready to implement hospital global budget payments at the same time

Hospital Participation Examples

Maryland All-Payer and TCOC Models	Pennsylvania Rural Health Model

• While hospital participation is voluntary, all-payer rate-setting authority compels participation from all payers, impacting payments to all hospitals
• All 47 general acute care hospitals participate in the model
• Excludes psychiatric hospitals and specialty hospitals
	• Voluntary participation; eligible hospitals (67) include all rural CAHs (15) + acute care hospitals that receive reimbursement under IPPS & OPPS
	• 18 hospitals currently participate
	• Hospital participation minimum scale targets (amended in 2020 & 2021):
	  • PY1 (2019): 5 hospitals; PY2 (2020): 13 hospitals; PY3 (2021): 18 hospitals
	  • PY4-6 (2022-2024): 18 hospitals (amended from 30)

Discussion (1 of 2)

- Should participation in the hospital global budget model be:
  1) Mandatory for all hospitals (PPS hospitals, AMCs, and CAHs)?
  2) Voluntary for all hospitals (PPS hospitals, AMCs, and CAHs)?
     - Should the model have increasing participation targets over time?
       - If so, how should those targets be defined?
       - If targets are not met, should that trigger mandatory participation?
  3) Voluntary participation initially with phased-in mandatory participation?
     - If so, what should be the timeline for mandatory participation?
  4) Hybrid participation that is mandatory for some hospital types and voluntary for others?

Discussion (2 of 2)

- If voluntary participation, either initially or with a phased-in approach, how can the State help to ensure maximum participation?
  - What would make the program more appealing for hospitals to join on a voluntary basis?
  - What information and modeling do hospitals need?

Hospital Variation

Variation by Hospital Type

- The hospital global budget model could allow for variation in the model for the different types of Vermont hospitals.
- Potential areas for hospital variation include:
  1) Timeline for mandatory participation (as previously discussed)
  2) Level of inflation adjustments
  3) Thresholds for planned service line changes impact
  4) Risk mitigation (e.g., risk corridors, potential thresholds for revisiting the baseline budget or adjustment if those are included in the model)
  5) Thresholds for payer participation - payer/hospital dyad
  6) Accountability framework/transformation requirements (to be discussed)

➢ *Which of these areas for variation do you support, and for which hospital type(s)?*

➢ *What other areas should be considered for variation?*

Hospital Care Transformation and Resource Redeployment

Act 167 Sections 1 and 2

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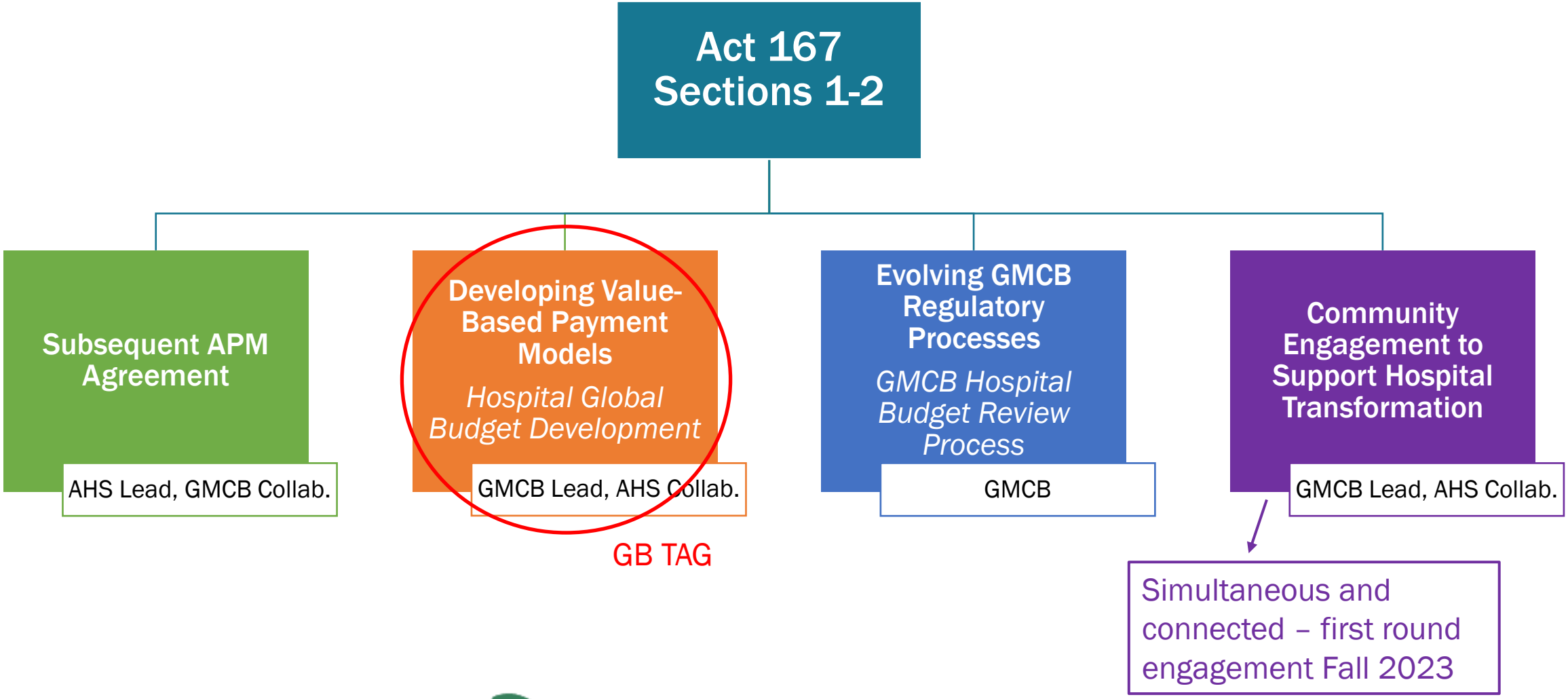

Community Engagement – Hospital Transformation

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- As directed by the Legislature in Act 167 of 2022, GMCB has retained an expert to support a “data-informed, patient-focused, community-inclusive engagement process for Vermont’s hospitals”
- Consulting firm Oliver Wyman will review data and solicit local input to develop options that ensure Vermonters have sustained access to affordable care. They will be working directly with community members, businesses, hospitals, and health care organizations to ensure a wide range of voices are represented in these discussions. A current contractor will provide data analytics support.

For more information: GMCB Community Engagement to Support Hospital Transformation

Community Engagement Progress Update

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- Community meetings are slated to begin in October
- Some TAG members may have already met with the Community and Provider Engagement contractor to provide feedback on their engagement plan or offer feedback on the current state of Vermont's health care system
- In Spring 2024, the contractor will offer hospitals data- and community-informed options to improve hospital sustainability, patient access and affordability, and quality of care

Vermonters are encouraged to sign up for emails about community meetings in their region by visiting GMCB Community Engagement to Support Hospital Transformation

Meeting details will be posted on GMCB's website as they become available.

Discussion: Supporting Hospitals in Care Transformation

- What supports will hospitals need to succeed under global budgets by transforming business models and care delivery?
- What types of investments or other changes would be helpful from payers to support hospitals in care transformation?

Options for Care Transformation and Resource Redeployment Accountability

Hospitals could be subject to certain requirements or other accountability mechanisms to demonstrate that they are effectively transforming business models and care delivery, including:

1) Hospital-specific care transformation plans
2) Resource redeployment and care transformation initiatives across hospitals
3) Accountability through regular hospital management-State meetings and site visits
4) Other potential mechanisms

CMMI has indicated that some mechanism for hospital accountability for transformation will be important to include in the model.

Examples of Care Transformation Opportunities

Examples of care transformation opportunities created by global budgets include:

- enhanced chronic disease management
- improved care coordination (in alignment with the Blueprint for Health when related to advanced primary care)
- potentially avoidable utilization reduction
- improved population health
- increased investments in upstream services

What other care transformation and resource redeployment opportunities could be created by global budget payments?

Overview of Care Transformation Plans

- Care transformation plans are hospital-specific plans for redesigning care delivery that can be tied to overall goals of the global budget program or other specific quality and/or population health goals.
- Transformation plans can be required for participation in a global budget model (as in Pennsylvania) or be voluntary.

State Model Example of Care Transformation Plans

PA Rural Health Model

- Model requires the development and approval of hospital transformation plans by both the PA Department of Health and CMS.
- Plans specify how the hospital expects to redesign the care it provides by investing in quality and preventive care, and tailoring services to the needs of the local community.
- Stakeholder engagement plans required for obtaining support and continuous feedback from community stakeholders.
- Plans focus on areas such as investing in and improving population health and avoiding potentially avoidable ED visits and hospitalization.

Note: Hospitals reported needing more resources and ongoing technical support to implement transformation plans successfully.

Resource Redeployment and Care Transformation Initiatives

- Hospitals could also demonstrate accountability for care transformation and resource reemployment through initiatives and programs across hospitals and/or between hospitals and community-based providers.
- Participation in these programs could be voluntary or mandatory.

State Model Example of Care Transformation Initiatives (1 of 2)

Maryland TCOC Model

- Care Redesign Program (CRP)
  - *Health Care Improvement Program (HCIP):* Allows hospitals to compensate providers outside the GB for participating in improvement activities and reducing avoidable care
  - *Episode Care Improvement Program (ECIP):* Rewards hospitals for improving quality & efficiency beyond hospital stay
  - In 2021, 4 hospitals participated in HCIP (significant decline from 37 in 2019) and 21 participated in ECIP (up from 15 in 2019)
- Care Transformation Initiatives (CTIs)
  - Rewards hospitals for efficient episodes of care but gives them more flexibility (compared with ECIP) in defining the episodes and interventions.
  - In 2021, 42 (88%) hospitals participated in CTIs for one or more types of episodes of care.

State Model Example of Care Transformation Initiatives (2 of 2)

Maryland TCOC Model (continued)

- Regional Partnership Catalyst Program
  - Invests in hospital partnerships with community organizations to build sustainable programs that support the population health goals of the TCOC Model.
  - Total investment of $165.4 million over a five-year grant period (1/1/21-12/31/26)
    - $86.3 million directed to diabetes prevention and management activities
    - $79.1 million directed to fund behavioral health crisis services.

Other Accountability Mechanisms

- As another accountability option, the State could establish a process of regular meetings with each hospital's management team to review progress on expected areas of financial and service transformation, including quality and financial measure accountability.
- GMCB and DVHA could work with hospitals to identify areas that should be expected to change in how they operate, and then conduct site visits to confirm that change is indeed happening.

Discussion: Care Transformation and Resource Redeployment (1 of 2)

- Should the hospital global model include:
  1) Hospital-specific care transformation plans?
  2) Resource redeployment and care transformation initiatives across hospitals?
  3) Accountability through regular State-hospital meetings and site visits?
- Should there be other mechanisms for holding hospitals accountable for utilizing the new flexibility afforded by global budgets to redeploy resources to meet the needs of the community, strengthen community-based organizations, and engage in care transformation activities?

Discussion: Care Transformation and Resource Redeployment (2 of 2)

- How can we ensure alignment between care transformation and resource redeployment goals and statewide quality improvement and/or population health goals?
  - Note that the AHEAD model will require all participating states to develop a statewide health equity plan, which will outline strategies for improving population health and reducing identified disparities across the state or within a specific geography.
- Evaluation criteria: to whom should hospitals be accountable for care transformation and resource deployment activities?

Wrap-up and Next Meeting

The next Hospital Global Budget Technical Advisory Group meeting is scheduled for Tuesday, **October 31st** from 10 am – 12 pm.