HAP Comments—Centers for Medicare & Medicaid Services
Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Early this year, the Commonwealth of Pennsylvania announced a proposal to develop and implement a multi-payer global budget initiative in rural Pennsylvania. Many early discussions have occurred across the provider and payer communities, and it is anticipated that a small number of pilot hospitals will be selected to move forward to test this program design.

The release of this Request for Information (RFI) signals CMS’ interest and general support to explore this promising model, and HAP is supportive of efforts to test reimbursement models that align incentives, promote wellness and preventive medicine, and offer rural hospitals a stable and predictable revenue stream.

That said, it is important to note the differences in the health care marketplace between Maryland—which is often identified as a “model state” for global budgeting—and Pennsylvania. Maryland currently runs the country’s only all-payer hospital rate-setting system, under which facilities in the state are paid the same amount by all government and private health insurers. Since the Maryland state legislature established the all-payer model, the Maryland Health Services Cost Review Commission, the state agency tasked with setting hospital rates, has directed hospital reimbursement.

While there are lessons to be learned from the early successes in Maryland, this model is not one that lends itself to being simply copied and started anew in a different state. For example, Pennsylvania also has a unique payer market that includes, for example, “Blues-on-Blues” competition and statewide Medicaid managed care. Obtaining payer buy-in to this model will likely be a challenge in this state.

While it is difficult to provide detailed feedback without a comprehensive understanding of the proposed model, HAP has identified a number of general observations and questions for CMS’ consideration as it develops this program model. Our comments:

- Provide general observations relating to the prospective budget methodology
- Identify ways to encourage the participation of providers, private payers, and states in a regional prospective budget model
- Discuss specific thoughts about how to encourage the inclusion of rural and critical care hospitals in a proposed program
- Identify a number of other general observations, questions, and concerns that should be addressed in the final program design

PROSPECTIVE BUDGET METHODOLOGY

The RFI requested information about how to define and calculate prospective budgets, which components of Medicare and/or Medicaid will be included, and the type of geographic areas where a prospective budget could be applied. Calculating prospective budgets at a regional level is important to account for cost differentials across areas of a state and provide some level of protection for participating providers. For
example, there are vast differences in costs across the state of Pennsylvania. Specifically, the 2014 Medicare Shared Savings Program (MSSP) results show that Delaware Valley Accountable Care Organization (ACO), located in Philadelphia, spent $11,449 per member per year (PMPM). In contrast, RiverHealth ACO, located in Harrisburg, spent $8,529. Defining how a budget will be set will be a crucial step in developing this program.

Other considerations for developing the prospective budget methodology include:

- **Inclusion of Costly Medications.** Under current CMS programs, such as the MSSP ACO program, Part D costs are excluded from the program, as beneficiaries have alternative options for medication payment (e.g., low-cost medications at large retailers, private insurance, Medicare). Additionally, Medicare Part A and Part B include payments for injectable medications and office-administered medications. The majority of these medications are very costly and used to treat cancer, vision loss, rheumatoid arthritis, and other complex diseases. CMS should consider how the global payment structure accounts for these costly medications and evaluate any potential restrictions or exceptions for their use.

- **Transition Period and Risk.** While holding participating providers accountable for the total cost of care is the general goal of the program, it is essential that the program be flexible enough to adapt to unexpected cost drivers during any given year. The intent of this model should not risk the viability of the participants, but rather strengthen their ability to provide high-quality, accessible care to the Medicare beneficiaries they serve. To this end, any model should include a transition period of no downside risk before slowly phasing it in over time. This is particularly important in rural communities where financial sustainability of facilities has been challenging.

- **Access to Payer Claim Information.** In order to be successful in managing total cost, participating providers must have access to timely information, including a list of the patients attributed to them, real-time claims information, and the tools to manage such information.

- **Payer Contract Terms.** Participating payers should be required to execute contracts related to their responsibilities in a global budget program. The contract should stipulate how their portion of the global budget will be developed each year, including a reasonable initial term with a decision point that allows approximately two years to unwind the contract so that a transition to a different model can be accomplished, in the event that a payer/provider participant chooses to terminate its participation. The contract should also set clear expectations related to data and information exchange.

- **Identification of Accountable Third Party.** In order to implement a global payment model, it is necessary for a third party to be accountable for setting the budget. There is also a need to provide a clearly defined public comment process and appeal rights for providers.

- **Ongoing Program Flexibility.** The ability to make adjustments to the prospective budget in a timely fashion is crucial to the success of this model. As the health care market is in a state of unprecedented change, the global payment program would need the flexibility to adjust for market share shifts, population size changes, consolidations, and other changes outside the control of providers.
• **Accommodation of Beneficiary Choice.** While commercial payers have some flexibility in the design of their products and can institute products that limit choice, freedom of choice is a central tenet of the Medicare program. The model will need to accommodate Medicare beneficiaries that seek care outside of the global payment participating providers, as CMS has historically been unwilling to limit choice for the Medicare population.

• **Aligned Quality and Performance Measures.** CMS and America’s Health Insurance Plans (AHIP), as part of a broad Core Quality Measures Collaborative of health care system participants, recently released seven sets of clinical quality measures. These measure sets were created in an effort to streamline the proliferation of quality metrics developed by payers related to value-based programs, and will likely evolve to be included in the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM). CMS should encourage the utilization of aligned measures in any future multi-payer prospective budget model.

• **Monitoring Access and Utilization.** Monitoring access and delays in services will be difficult. As providers become increasing efficient with care coordination, it is reasonable to expect that lower volumes of procedures will occur. As a result, CMS should be cautious as it seeks to differentiate reductions in duplication through better care coordination versus reductions in services that could be seen as limiting access to needed health care.

**POTENTIAL PARTICIPANTS AND POPULATION HEALTH ACTIVITIES**

The RFI requested information about ways to encourage the participation of providers, private payers, and states in a regional prospective budget. Below are some general observations relating to this topic:

• **Likely Hospital Participants.** From the provider perspective, in the state of Pennsylvania, small, rural hospitals are the most likely to be interested in moving towards a global payment system. This interest exists because the majority of rural hospitals are experiencing funding challenges as the cost to provide care outpaces payment from federal, state, and some commercial payers. As health care is transforming, and more care is shifting from the inpatient to the outpatient setting, many rural hospitals now are investigating how to alleviate the expense of facilities that were built for an inpatient demand that no longer exists.

• **Voluntary Participation.** While it is most desirable to have most if not all providers participating in a given region, if the prospective budget methodology is set appropriately, the level of participation for any given region should be able to be accommodated. As provider participants are at varying levels of readiness, it is critically important for participation in this program to be voluntary in nature.

• **Administrative Burden and Up-front Costs.** As in all payment models, CMS could encourage participation by minimizing the administrative burden associated with participating in this model. This would include streamlining performance measures and reducing/eliminating authorizations. Likewise, during discussions with providers in Pennsylvania who are interested in the state pilot, providers have expressed concern about the infrastructure investment (e.g., electronic health records, disease registries,
population management tools, data sharing, and reporting requirements) necessary to be successful under such model. CMS needs to consider how these upfront costs will be recognized and supported.

- **Waiver of fraud and abuse laws, as well as certain Medicare payment rules.** In order to be successful in a global budget model, hospitals will need to form collaborative financial relationships across the care continuum. CMS should waive the applicable fraud and abuse laws that inhibit these relationships. These laws include the Physician Self-Referral Law and the Anti-kickback Statute.

Other waivers necessary specific to Medicare payment rules include, but are not limited to, the waiver of discharge planning requirements that prohibit hospitals from specifying or otherwise limiting the information provided on post-hospital services, the skilled nursing facility “three-day rule,” and the inpatient rehabilitation facility “60% Rule.” CMS has acknowledged the need to waive these rules in other value programs.

- **State Participation.** Global budget models will pose significant challenges for Medicaid agencies that are operating fee-for-service claims processing for a portion of their business which rely fully on managed care strategies. Supplemental payments (for disproportionate share and medical/health professional training) by the Medicaid agency or Medicaid managed care plans also will need to be accommodated in any new model. In order to encourage state participation, CMS will have to provide appropriate flexibility to state Medicaid agencies to implement necessary changes under their State Plan.

**POTENTIAL RURAL SPECIFIC OPTION**

The RFI requested information about how to encourage inclusion of rural and critical care hospitals in a prospective budget program. Below are a series of observations relating to the program design, which could promote the participation of rural and critical care hospitals.

- **Critical Access Hospital (CAH) Issues.** With the appropriate structuring, CAHs could and should be included in the prospective budgeting concept. However, there are unique questions that would need to be addressed for CAH inclusions. For example, will the global budget include all the special CAH payment arrangements that currently exist in Medicare and Medicaid programs? In addition, will the global budget include funding for capital expenditures and medical education? Will it incorporate necessary regulatory relief (e.g., 96-hour rule)? Any model associated with CAHs must also ensure that future funding will not be less than it is today.

- **Downside Risk.** Thirty-four percent of rural Pennsylvania hospitals currently are operating with negative total margins and many more have dangerously narrow margins. Regardless of their classification, these hospitals would not be candidates for managing downside risk at the onset of this model. Medicare savings should be measured by the reduction in the overall trend in health care expenditures, not by an absolute decrease in cost over the prior year.

- **Availability of Payment for Telehealth.** One “low-hanging” opportunity for rural acute care hospitals and CAHs to partner with larger institutions is through telehealth. Pennsylvania currently is considering telehealth payment parity legislation that would require payment across payers for telehealth services. The passage of this legislation is
critical in ensuring that Pennsylvania providers can invest in the technology and relationships to provide access to specialty care remotely, while reducing the costs to both CMS as well as the patients by assuring proper treatment and greater efficiency. Likewise, Medicare’s payment policies related to telehealth should be expanded and enhanced. This initiative can be an important driver for CMS to advance the adoption of telehealth.

- **Appropriate Quality Measures.** Measuring the cost of care and quality outcomes for rural acute care hospitals and CAHs becomes more difficult in the absence of a critical mass of beneficiaries. Each measure should be considered independently and excluded if there are too few individuals, as determined by CMS, in the denominator of the measure. Additionally, CMS should give appropriate consideration for socio-economic adjustments.

**OBSERVATIONS/OUTSTANDING QUESTIONS**

After evaluating Pennsylvania’s rural global budget initiative and responding to CMS about this related RFI, HAP has a number of outstanding questions and/or observations.

**Observations**

- Pennsylvania hospitals’ main goal is to provide the right care, at the right time, in the right setting. While the concern of ensuring appropriate transfers and services is indeed a safety precaution the prospective budget program will need to address, the resolution should include collaboration among the provider community and both private and public payers.

- Provider participants must be assured that there is a “safety valve” that allows them to return to serving their community in the manner they were accustomed to prior to their participation in the model.

- Specific detail relating to the patient population, services, geographic area, rate setting (e.g., acuity and socio-economic adjustments), trend development, and other issues are necessary to fully evaluate a rural global budget proposal.

- Existing state and federal hospital licensing regulations must be revised to permit the innovative reforms necessary to ensure that this model is a success.

- Updating the regulatory/legislative structure governing the assumption of risk will be necessary. It is important to note that the level of downside risk that some/most rural providers may be able to assume is minimal at best.

- The issue of physician recruitment and retention (especially related to primary care providers) will require additional discussions and support.

- It will be important to evaluate the necessity and feasibility of a state or independent organization to negotiate and set the global budgets for participating providers. This will need to include how public and stakeholder comments will be addressed.

- Securing hospital board approval for a move like this likely will require significant time, communications, and education.
Questions

- What are the long-term implications for hospitals agreeing to this model?
- Will the prospective budget program replace all other value-based programs, e.g., MIPS, APMs, for a given provider participant?
- Are there unintended implications for the continued trend toward hospital mergers and acquisitions in regards to rural hospitals participating in these programs?
- What is the oversight or public accountability model that CMS envisions for global budgets—regulatory or waivers?

HAP is supportive of continuing to investigate the feasibly of implementing global payment in the state of Pennsylvania, but strongly urges both states and CMS to fully vet the intricacies related to such programs as the implications for a failed initiative could be catastrophic, particularly for rural communities in the state.

HAP
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