



Center for Medicare and Medicaid Innovation

Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for Information (RFI)

SUMMARY

The Centers for Medicare & Medicaid Services (CMS) is seeking input on a concept that promotes accountability for the health of the population in a geographically defined community. Under the Maryland All-Payer Model, CMS and the State of Maryland are testing a new hospital global budget payment program in which all payers in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. CMS is seeking input on the feasibility of similar approaches for other geographical areas, which could include areas smaller than a state. In this concept, providers could receive a prospective budget for the care of the population of a community, and would be accountable for the total cost of care across the entire continuum of care and health outcomes for the entire population. The purpose of this approach would be to support better management of cost and quality for a community's population, by providing clear revenue expectations and connecting services across outpatient and inpatient sectors. The concept could also incentivize collaboration of provider systems with community-based services outside the traditional health system. Lastly, this concept could encourage the inclusion of rural providers through providing incentives tailored to the unique needs and opportunities presented in rural areas.

DATES: *Comment Date:* To be assured consideration, comments must be received by Friday May 13, 2016

ADDRESS: Comments should be submitted electronically to: RegionalBudgetConcept@cms.hhs.gov.

FOR FURTHER INFORMATION, CONTACT: RegionalBudgetConcept@cms.hhs.gov with "RFI" in the subject line.

BACKGROUND

Section 1115A of the Social Security Act authorizes the Secretary of Health and Human Services to test innovative models of payment and service delivery that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.

CMS is issuing this Request for Information (RFI) to obtain input on the design of multi-payer, regionally- based payment approaches. CMS seeks to build upon lessons learned from the [Maryland All-Payer Model](#) (click hyperlink for more information). Under the Maryland All-Payer Model, certain provisions of the Medicare fee-for-service (FFS) Inpatient Prospective Payment System and Outpatient Prospective Payment System are waived, and the State of Maryland, through its Health Services Cost Review Commission, sets rates for hospital inpatient and outpatient services for all payers in the State. Over the course of this model, Maryland has had to facilitate the shift of its hospital revenue to population-based payment such as hospital global budgets, providing hospitals with the responsibility for managing cost of care for inpatient and outpatient hospital services. In its first year, Maryland shifted more than 95 percent of its acute care hospitals, both urban and rural, into prospectively set annual global budgets and achieved \$116 million in Medicare savings while simultaneously reducing hospital acquired conditions by 26 percent. We note that prior to the beginning of Performance Year 4 of the Maryland All-Payer Model, Maryland will submit a proposal to CMS for a new model that will limit, at minimum, the Medicare per beneficiary total cost of care growth rate.

Despite Maryland's early promising results, an all-payer statewide approach may not necessarily be feasible for every state, particularly for states with diverse landscapes with different markets and provider communities. CMS is currently testing some provider-based models that engage communities to improve health and reduce costs for Medicare and/or Medicaid beneficiaries (e.g. [Community-based Care Transitions Program](#), [Comprehensive Primary Care Initiative](#), [Next Generation ACO Model](#)). However, some of these models may be limited in scope and alignment across payers in a community. As a result, CMS is interested in learning whether a multi-payer concept similar to the Maryland All-Payer Model could be implemented at a regional level and is seeking information on stakeholders' interest in this concept.

CMS is seeking input on a concept that improves the delivery of patient-centered care and population health, reduces expenditures, and includes a global budget. A global budget prospectively establishes an annual budget for the health care services delivered to patients by each participating provider, such as hospitals or integrated care networks. CMS is interested in understanding whether this predictable revenue stream could improve quality of care and cost efficiency. Participating providers would be accountable for spending associated with all or most health care services received by the population in a given geographic area and for quality improvement at the individual and population levels. To be most effective, CMS would work with states and private health insurers to achieve multi-payer participation. The overall goals of this concept would be to improve quality, including population health outcomes, and decrease cost by providing participating providers with clear revenue expectations so that they could emphasize value-driven, rather than volume-driven, care and focus on transforming their health care system.

CMS is interested in seeking information on how to set global budgets, including the feasibility, necessity, and potential role of a state or independent organization to negotiate and set the multi-payer prospective global budgets for multiple provider systems within a defined geographic area. Additionally, CMS is interested in seeking information on how to ensure (1) sufficient support for providers for

strategies that prioritize population health outcomes defined by local communities, and (2) that a broad range of stakeholders will be represented in the process of setting priorities.

CMS is also specifically interested in seeking information on how this concept could serve as an opportunity for rural providers to participate in alternative payment models. For example, prior to the Maryland All-Payer Model that provides global payments to all acute care hospitals in the state, Maryland operated a “Total Patient Revenue” system that established fixed global budgets for certain rural hospitals on the basis of historical trends in the cost of providing care for the specific populations they serve. The incentives under this regional multi-payer prospective budgets concept, such as clear revenue expectations, emphasis on value over volume, and focus on improvement of health at the community level, could be appealing to other rural providers who generally have defined market areas. CMS understands that rural providers may have a unique set of needs and opportunities, and is seeking information on elements that are specific to rural providers.

CMS seeks broad input from patients, consumers and consumer organizations, health care providers, associations, purchasers and health plans, Medicaid agencies and other state offices, quality review organizations, social service providers, health information technology vendors, and other stakeholders. Commenters are encouraged to provide the name of their organization and a contact person, mailing address, email address, and phone number in the following field; however, this information is not required as a condition of CMS’s full consideration of your comment.

CMS may publicly post the comments received, or a summary thereof, so commenters should not share proprietary or confidential information. The information and questions in this RFI reflect ideas that CMS is considering, but it takes no position on whether any of the concepts or options discussed here or that may be raised by commenters in response to this RFI would be feasible or permissible.

SECTION I: INFORMATION REGARDING REGIONAL MULTI-PAYER PROSPECTIVE BUDGET CONCEPT

This concept could test prospective budget setting for a defined region. Key considerations for this concept could include:

- Prospective budgets for specific geographic areas that may include Medicare and/or Medicaid savings. Participating providers could have options on the type of prospective budget, which could vary based on the scope of services included and the level of accountability for total cost of care.
- Population health activities funded under the prospective global budget., informed by the community
- A potential rural hospital track that targets the specific needs and challenges of rural communities and rural providers.

SECTION II: QUESTIONS ON PROSPECTIVE BUDGET METHODOLOGY

CMS is interested in obtaining information on how to define and calculate prospective budgets, which components (or payment systems/schedules) of Medicare and/or Medicaid will be included, and the type of geographic areas where a prospective budget could be applied (e.g., Metropolitan Statistical Areas,

hospital referral regions, or rural health service areas). CMS believes participation among all providers within an area would be important to align payment incentives among providers, minimize inappropriate shifting of care to other providers, and incentivize the improvement of population health in a region. CMS nevertheless is interested in seeking information on whether participation among all providers within a region is necessary for the concept to be successful, and how to limit and account for any inappropriate shifting of care. Additionally, CMS is seeking information on potential methodologies to calculate the prospective budget for the region, such as a methodology based on a patient or geographic attribution, or a provider's historical revenue, as well as the types of services and costs to include in a prospective budget for both Medicare and other participating payers. CMS is also interested in seeking information regarding the governance structure of how to set global budgets and who would be responsible for negotiating and calculating the multi-payer global budgets. State governments could facilitate the setting of prospective budgets in a region or have other roles, similar to the way that the State of Maryland's independent Health Services Cost Review Commission sets rates and global budgets for all acute care hospitals in Maryland. Therefore, CMS seeks information on the need or feasibility of and the potential roles of a state or independent organization in negotiating or regulating the multi-payer global budgets within a region. CMS also believes availability of health spending data is critical to develop global budgets, quality and population health measures and to measure effectiveness of this concept. Based on prior experiences in other states including Maryland, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data, generally and in light of the Supreme Court's recent decision in *Gobeille v. Liberty Mutual Insurance Co.*, 577 U.S. (Mar. 1, 2016) No. 14-181. Lastly, as discussed later in this RFI, CMS is also interested in seeking information on the inclusion of rural hospitals in this concept and is seeking responses on the budget methodology with specific consideration for rural hospitals as well.

CMS is seeking responses to the following questions:

1. Please comment on whether and how a prospective budget could be determined for a geographic area and the type of geographic area that such a budget would be suited for.
2. Please comment on possible financial arrangements, including an attribution methodology that CMS could consider for Medicare, Medicaid and other payers to determine the prospective budget; the types of services and categories of spending that could be included or excluded in a prospective budget; and provider risk sharing relationships that could be supported within this concept. Please comment on whether CMS should include or exclude spending for Medicare Parts A, B and D, as well as payment systems/schedules (for example, Inpatient Prospective Payment System and Physician Fee Schedule), and whether all or only selected Medicare beneficiaries in a defined geographic area should be included.
3. Additionally, how could participating providers be held accountable for total cost of care? How participating payers could be held accountable to the requirements of a prospective budget concept?
4. Please comment on how the prospective budget would be determined for Medicare, Medicaid and other payers and the necessity or feasibility of a state or independent organization to negotiate and set the global budgets for participating providers. What would be the roles and

responsibilities of this organization? What resources and expertise would be necessary for this organization to set prospective global budgets across multiple payers? Would this organization need to be able to set rates for services? Do states require legislative authority to establish the authority for this organization to set global budgets or rates and for the organization to hold the providers accountable for these budgets?

5. Please comment on the appropriate data, data sources, and tools to support data aggregation and data sharing, for the purposes of setting multi-payer global budgets, assessing quality and population health metrics, and measuring effectiveness of this concept.
6. Please comment on adjustments to a prospective budget that would need to be made over time, accounting for shifts in market share, population size and other market changes that could occur. Additionally, please comment on how a budget could handle boundary issues such as patients seeking services outside of the defined region.
7. Please comment on appropriate quality measures for a prospective global budget that emphasize improvement in health outcomes and population health for Medicare and Medicaid beneficiaries and those covered by other payers. How could this concept incentivize quality improvement? How could CMS obtain multi-payer alignment on these measures? How could CMS encourage the reporting of performance measures on the most important priorities while minimizing duplication and excess burden?
8. How could CMS monitor and address unintended consequences under this concept, such as providers limiting access to care, inappropriate transfers, delay of services, or cost shifting?

SECTION III: QUESTIONS ON POTENTIAL PARTICIPANTS AND POPULATION HEALTH ACTIVITIES

CMS is interested in information on ways to encourage the participation of providers, private payers, and states in a regional multi-payer prospective budget concept. CMS is seeking information on a concept that could provide different options for participating providers to select, where the options would differ based on the types of services included in the prospective budget and the entity accountable for total cost of care. CMS is interested in understanding whether this concept could allow flexible spending by providers (e.g. hospitals or integrated care networks) with guaranteed revenue so that providers could invest in the health of their population. CMS is interested in information on how to incorporate population health activities to improve the health of the region and how to encourage community involvement in determining those activities. These activities may vary by the needs of the communities, but examples could be activities addressing health promotion or disease prevention. CMS would be interested in working with State governments to facilitate multi-payer participation, including Medicaid. CMS believes the participation of both states and providers would be essential to the success of this concept. Because CMS is also interested in information regarding the inclusion of rural hospitals in this concept, CMS is seeking responses that may pertain to rural hospitals as well.

CMS is seeking responses to the following questions:

9. Please comment on the types of providers or the provider characteristics that could be interested in participating in this prospective budget concept. Please comment on whether participation among all providers within a region would be necessary for the concept to be successful.
10. Please comment on how to incorporate population health activities in this concept. What are population health activities that could be included in a prospective budget that providers could be responsible for? How could the concept encourage collaboration among the community, including representation from patients and families, local government, non-hospital healthcare organizations, and non-healthcare organizations to determine these population health activities? How could CMS encourage participating providers to work with non-hospital providers and organizations to successfully manage the care, and the budget, for a defined population of beneficiaries?
11. Payer participation beyond Medicare FFS is critical in order to align incentives under a prospective budget and avoid cost shifting among payers. CMS is seeking input on how best to promote multi-payer participation of payment incentives and performance measurement. How could CMS encourage participation by other payers?

SECTION IV: QUESTIONS ON POTENTIAL RURAL SPECIFIC OPTION

CMS is interested in understanding how to encourage inclusion of rural hospitals (such as rural acute care hospitals and/or Critical Access Hospitals) that have defined market areas and may benefit from a prospective budget. CMS is interested in obtaining information on how to provide an option adapted to the unique needs of rural hospitals.

CMS is seeking responses to the following questions:

12. Should Critical Access Hospitals be included in a prospective budget concept and if so, how could Critical Access Hospitals be included? Please comment on whether there are special considerations for Critical Access Hospitals to be included in a prospective budget concept.
13. What are the resources, support, or other features of the model that would be necessary in order to include rural acute care hospitals or Critical Access Hospitals in this concept? Would certain types of rural hospitals be better able to manage down-side risk than others? How could risk be structured to ensure Medicare savings, but also allow the rural acute care hospitals or Critical Access Hospitals to be successful?
14. What are ways for CMS, the rural acute care hospitals, or the Critical Access Hospitals to align partnerships with larger health care institutions to provide support such as specialty care, information technology and quality improvement tools?
15. How could CMS best measure total cost of care and quality outcomes for individuals and population health for rural acute care hospitals or for Critical Access Hospitals?
16. For rural acute care hospitals and for Critical Access Hospitals, many services are appropriately referred or transferred to other facilities. How could appropriate versus inappropriate transfers or services provided be identified or monitored? How could this concept improve access to services not readily available in these rural areas?

SPECIAL NOTE TO RESPONDENTS: Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which payment would be required or sought. All submissions become Government property and will not be returned. CMS may publically post the comments received, or a summary thereof.