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Update:
Hospital Sustainability
Global Payment Model Development

June 28, 2023

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LEGISLATIVE HISTORY (2019-2022)

Background on Hospital Sustainability Planning

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2019	• Per Act 26 of 2019, the Rural Health Services Task Force was created "to evaluate the current state of rural health care in Vermont and identify ways to sustain the system and to ensure it provides access to affordable, high-quality health care services"; Green Mountain Care Board (GMCB) convened the Task Force and produced a report in early 2020: Rural Health Services Task Force Report, Act 26 of 2019 • GMCB requires hospitals to develop sustainability plans due to persistently low and declining margins, Springfield bankruptcy, and rural hospital closures nationally; initially, 6 of 14 hospitals are required to provide sustainability plans
2020	• Requirement for Sustainability Plans expanded to all 14 hospitals following COVID-19 Public Health Emergency • Legislature passes Act 159 of 2020 requiring GMCB to provide recommendations for improving hospital sustainability
2021	• Report: Options for Regulating Provider Reimbursement (Act 159 of 2020, Section 5) • Work on GMCB Hospital Sustainability Report (Act 159 of 2020, Section 4) – analysis and stakeholder engagement

2022	• In response to findings of GMCB Hospital Sustainability Report, Legislature passes Act 167 of 2022 (formerly S.285), which in Sections 1-3 provides GMCB and AHS with funding for:
	  • Section 1(a): Development of a proposal for a subsequent All-Payer Model Agreement (led by AHS in collaboration with GMCB)
	  • Section 1(b)(1): Development of value-based payments for hospitals, accountable care organizations, or both (led by GMCB in collaboration with AHS)
	  • Section 1(b)(2)-(3): Alignment of GMCB regulatory processes with value-based payment models; recommend a methodology for determining the allowable rate of growth in Vermont hospital budgets (GMCB)
	  • Section 2: Lead a community engagement process to drive hospital system transformation, including data/analyses and engagement with Vermont communities and hospitals (led by GMCB in collaboration with AHS)

Source: 2023 Legislative Testimony – Act 167 Update (January 2023)

Hospitals in Vermont Health Care System

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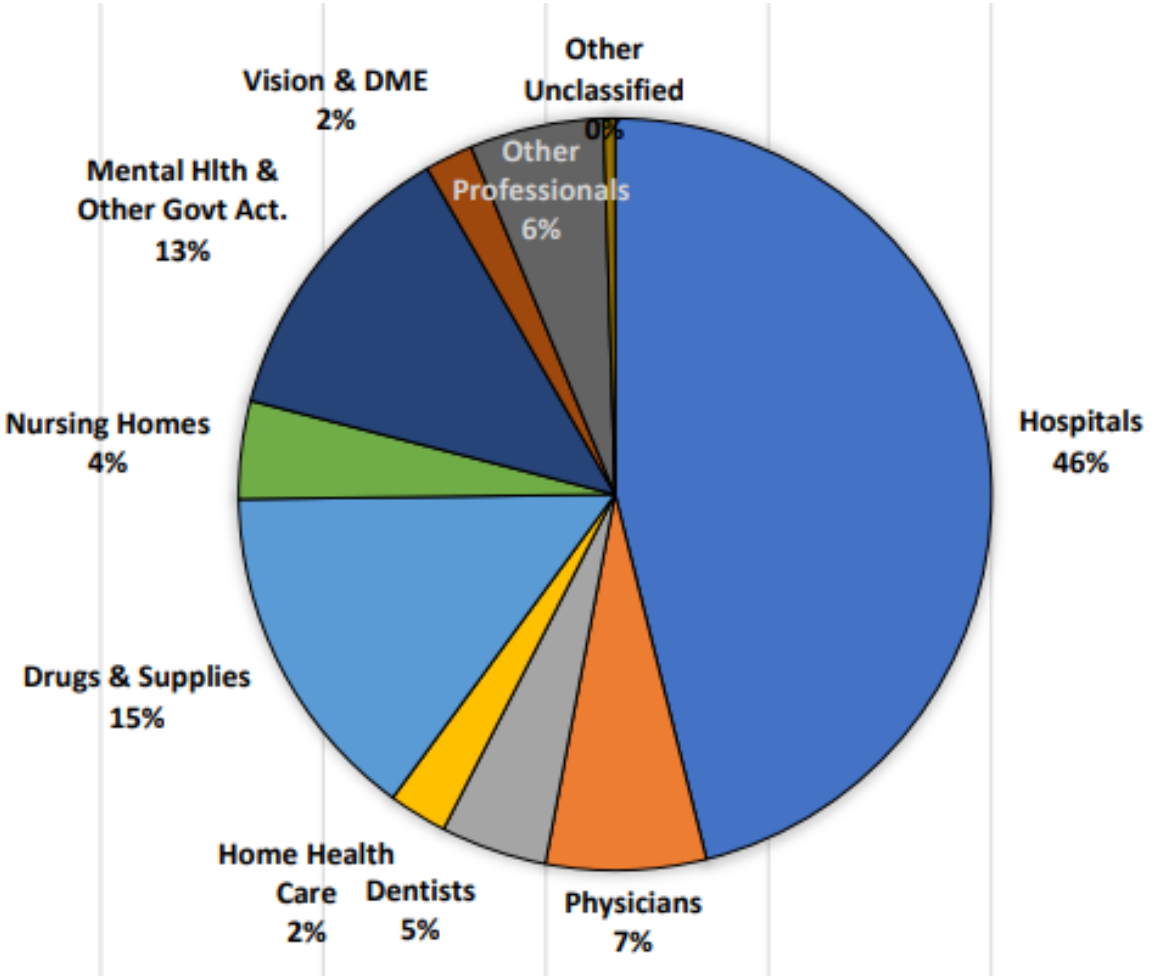
- Hospitals are the largest part of Vermont's health care system
  - 46% of total Vermont provider expenditures
  - 83% of Vermont physicians are employed by community hospitals

- This is why our regulatory system focuses on hospitals, and why hospitals must be part of current & future reforms



Source: Vermont Health Care Expenditure Analysis, 2019 (May 2021)

Source: Legislative Testimony related to Hospital Sustainability Report (Act 159 of 2020 Sec. 4) (Spring 2022)

Cost Coverage

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Cost coverage varies across hospitals, payers, services, and settings (in- vs. outpatient)

Example: Hospital Cost Coverage by Payer			
Hospital	Medicare	Medicaid	Commercial
Example A			
Example B			
Example C			
Example D			
Example E			

Cost coverage above 105% (Profit)

Cost coverage 95-105% (Break-Even)

Cost coverage below 95% (Loss)

WHY DOES COST COVERAGE VARY?

(1) Revenue

- Better able to negotiate higher commercial rates than others (e.g., higher bargaining power)
- Preferential reimbursement rates to ensure access in certain communities (e.g., CAH Medicare reimbursement)

(2) Costs

- A hospital's smaller size may limit economies of scale for the delivery of certain services
- Human capital/labor (e.g., market/ability to negotiate)
- More/less efficient operations (e.g., supply chain management, staffing efficiencies etc.)

(3) Both Revenues & Costs: Some hospitals prioritize essential (low-margin) services because of their community needs; others may prioritize higher margin services for various reasons

Hospital Charge Growth

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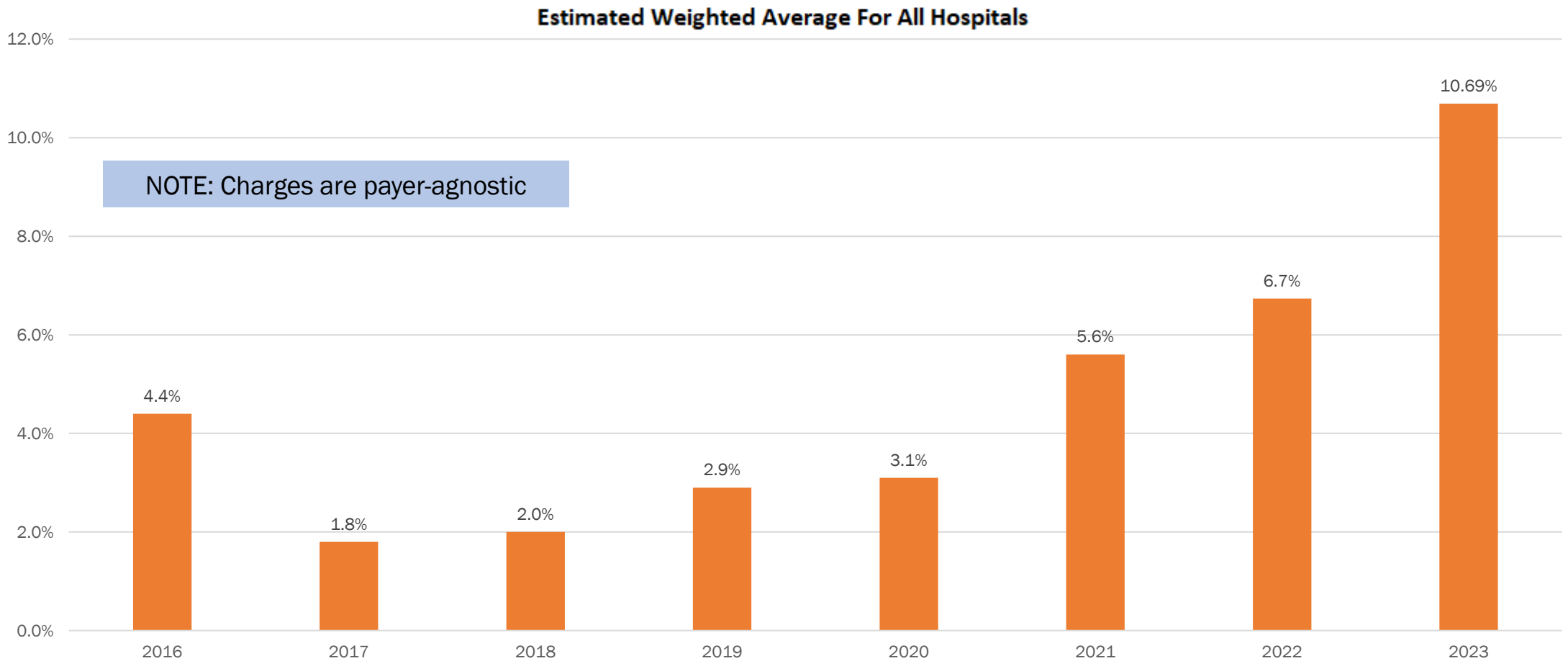

QHP Premium Increases: 2020-2022

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- Within the individual and small group market (for small business and people without employer-based coverage):
  - Cost of Health Care: Increased by 20% between 2020-2022
    - **Medical Services = Approx. 82% of the overall trend**
      - **Primary driver was unit cost (e.g., price), not utilization**
    - Rx = Approx. 18% of overall trend
      - Primary driver was specialty pharmacy
  - Administrative Costs = <1%

Source: L&E Analysis of rate filings

Source: Legislative Testimony related to Hospital Sustainability Report (Act 159 of 2020 Sec. 4) (Spring 2022)

Declining Operating Margin (%) is a System-Wide Issue

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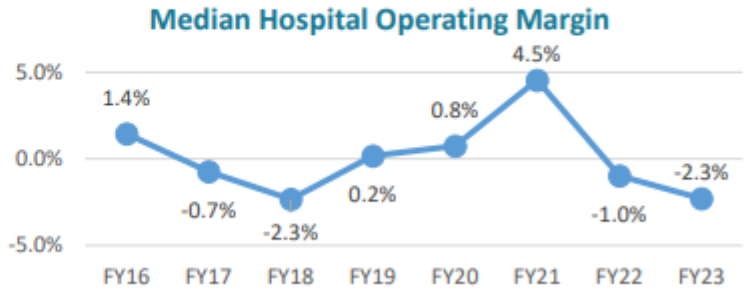
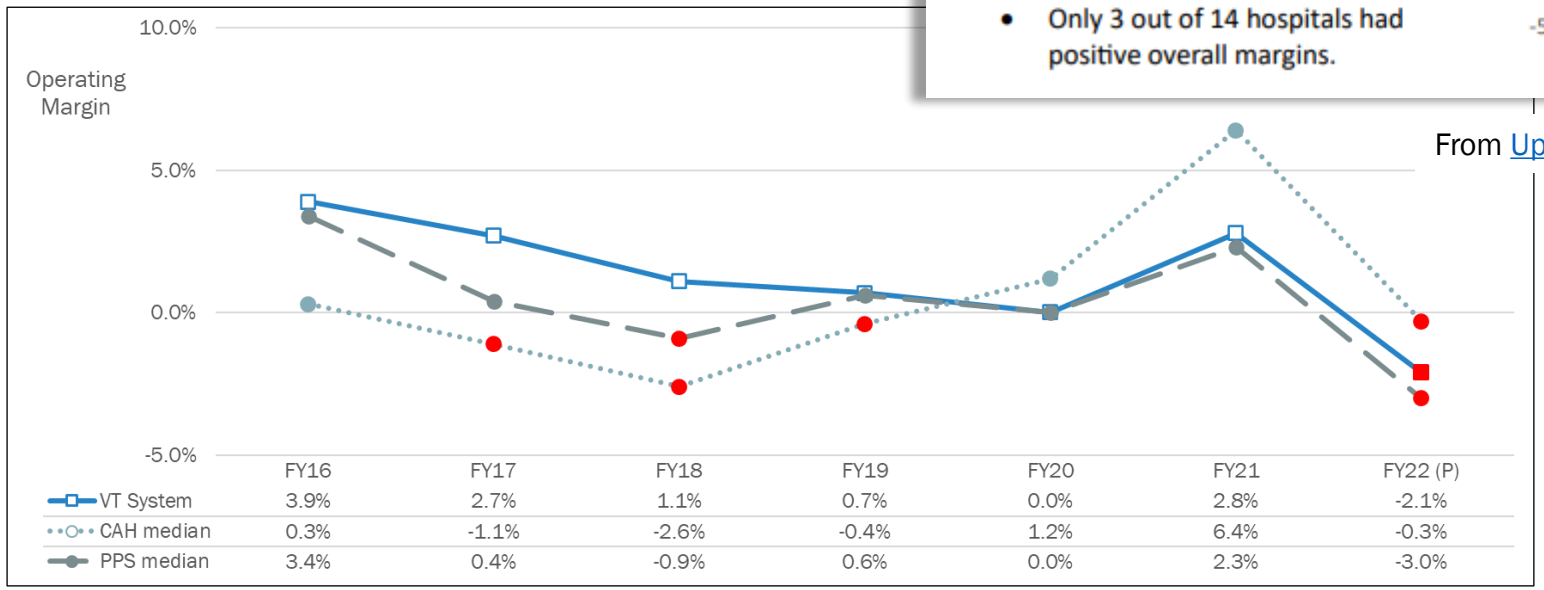
Vermont Hospitals Face Negative Operating Margins

GMCB monitors the financial health of Vermont's 14 community hospitals. For FY22 (October 2021 – September 2022), which was the most financially challenging year for hospitals since the pandemic:

- Only 5 out of 14 hospitals had positive operating margins; and
- Only 3 out of 14 hospitals had positive overall margins.



From Update on Financial Status of Vermont Hospitals (May 2023)



	FY16	FY17	FY18	FY19	FY20	FY21	FY22 (P)
VT System	3.9%	2.7%	1.1%	0.7%	0.0%	2.8%	-2.1%
CAH median	0.3%	-1.1%	-2.6%	-0.4%	1.2%	6.4%	-0.3%
PPS median	3.4%	0.4%	-0.9%	0.6%	0.0%	2.3%	-3.0%

*Note FY2020 includes COVID Relief Funds and Expenses

Impact on Vermonters
Hospital Financial Distress

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Affordability

In Vermont, hospitals' primary lever to increase operating margin is commercial price, which only exacerbates the existing affordability crisis through its impact on premiums, foregone wages, and out of pocket costs.*

Quality

Hospitals in financial distress "struggle to maintain quality and patient safety and have worse patient outcomes relative to well-resourced hospitals"[1].

Access

Financial distress is a key predictive factor in determining the likelihood of hospital closure, which left unaddressed compromises communities' access to essential services, such as primary care, mental health, and maternal health etc.[2]

**Employers must often choose to invest more for the similar coverage year over year or reduce benefits.*

1. Source: Akinleye DD, McNutt LA, Lazariu V, McLaughlin CC. Correlation between hospital finances and quality and safety of patient care. *PLoS One*. 2019;14(8):e0219124. Published 2019 Aug 16. doi:10.1371/journal.pone.0219124
2. Source: Holmes GM, Kaufaman BG, Pink GH. Predicting financial distress and closure in rural hospitals. *The Journal of Rural Health* 2017;33(3): 239-249.

Source: Legislative Testimony related to Hospital Sustainability Report (Act 159 of 2020 Sec. 4) (Spring 2022)

Hospital Sustainability Report (Spring 2021) Summary of Recommendation #1

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Recommendation #1: Accelerate Shift to Value-based Payment & Delivery

Hospital Payment Reform

1. Preserves Vermonters' access to essential services by establishing a sustainable funding stream for hospitals, particularly for lower volume facilities.
2. Eliminates "two canoes" and shifts hospital focus from volume to value.
3. Allows hospitals greater flexibility to deliver cost-effective, high value care in more innovative ways.
4. Offers a glide path for transitioning to value-based payment and care delivery.

Community Engagement

1. Hospital delivery system transformation that is intentional, patient-focused, and based on a reformed payment system can ensure the efficient delivery of high-quality care (e.g., improve equitable access to high impact, essential services, promote delivery system organization around low-cost, high-quality centers of excellence).
2. Provides a real opportunity to improve health care affordability and quality, and expands Vermonters' equitable access to necessary care.

Source: Legislative Testimony related to Hospital Sustainability Report (Act 159 of 2020 Sec. 4) (Spring 2022)

2022 Legislative Process

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Simultaneous to legislative Hospital Sustainability discussion, legislative consultants also recommend shift to global payments

Donna Kinzer, Opportunities for Evolution of Vermont's Healthcare Regulatory System (December 10, 2021)

Summary of Recommendations, Advantages and Disadvantages, cont.

RECOMMENDATION	ADVANTAGES	DISADVANTAGES
#4 As providers take on more responsibility and risk for total cost of care under an ACO/APM model or other payment constructs, **consider aligning ("nested" within the ACO/APM framework) or easing some regulatory processes, while continuing consumer protections of regulation**	Avoid conflicts in incentives, improve performance, lower regulatory cost	Focus, time, resources, risk in change
#5 Consider alternative review/fixed global payment options, "nested" within the ACO/APM Model framework**, for hospitals and their employed physicians** to improve alignment (moving away from fee-for-service) & sustainability/cost containment (predictable fixed payments)	Better alignment with ACO/APM, Increased sustainability of system ***and*** improved cost containment	Cost and capabilities to implement, degree and complexity of change, CMS waivers

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RESULT: Act 167 Sections 1 and 2

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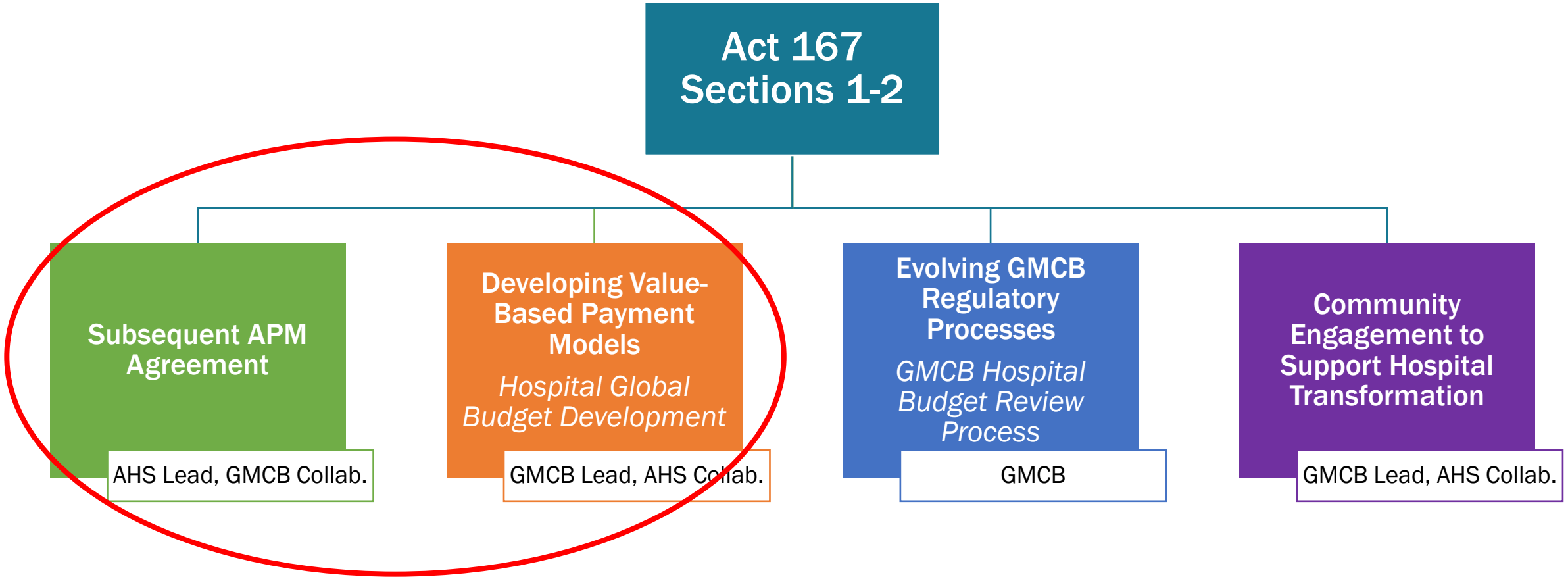

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PAYMENT MODEL DEVELOPMENT:
Global Budget Technical Advisory Group (TAG) Update

Hospital Global Payments

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- Global payments are fixed, often prepaid amounts of funding for a certain period of time for a specified population, rather than fixed rates for individual services or cases. (Adapted from Urban Institute, 2016).
- Hospital global payments can be supportive of hospitals and payers and advance state objectives to control costs and improve quality because they have the potential to:
  - Ensure **steady, predictable financing**, and protect payers and hospitals during great volume swings as witnessed at the start of COVID-19;
  - Provide **greater flexibility** to modify hospital service offerings to best meet community needs;
  - Move financial incentives away from volume and towards providing care **more efficiently** and reducing avoidable and low-value care to produce **positive health outcomes**, and
  - **Control growth in hospital spending** at an affordable level.

Hospital Global Payments

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- Like all payment models, hospital global payments also have risks which need to be carefully mitigated. Risks include:
  - Over-incentivizing reductions in care
  - Insufficient funds to cover true cost of providing care

- If risks are mitigated, global payments can create "win-win" alignment for hospitals, payers, consumers and the state, but need to carefully balance the concerns and priorities of all parties.
  - Community engagement to consider community needs, population dynamics, and care patterns is a critical part of designing a global payment model and a health care delivery system that works for Vermont and Vermonters.

Value Proposition for Global Payments

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Global payments can create "win-win" alignment for hospitals, payers, consumers and the state, but need to carefully balance the concerns and priorities of all parties

State Implementation of Hospital Global Budgets

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- Three examples of state hospital global budget programs:
  - NY Hospital Experimental Payment Program (1980 – 1987)
  - MD All-Payer Model and TCOC Model (2010 – present)
  - PA Rural Health Model (2019 – present)
- Each state's model has been unique and reflective of state-specific policies and market dynamics.
- Vermont is looking to these examples for insight.

Adapted from: Hospital Global Budget TAG (TAG) – Meeting 1 Materials (1/24/23)

Global Budget TAG
Currently Participating Organizations

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Co-Chairs: Robin Lunge, GMCB and Pat Jones, AHS

- BlueCross BlueShield of Vermont
- Cigna Healthcare
- Department of Vermont Health Access
- GMCB General Advisory Committee
- Mt. Ascutney Hospital
- MVP Health Care
- Northwestern Medical Center
- Office of Health Care Advocate
- OneCare Vermont
- Rutland Regional Medical Center
- Southwestern Vermont Medical Center
- University of Vermont Health Network
- Vermont Department of Financial Regulation
- Vermont-National Education Assoc.

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Global Budget TAG
Purpose and Meeting Structure

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Charge: Make recommendations for conceptual and technical specifications for a Vermont hospital global budget program by the time CMMI introduces its new All- Payer Model program.

- Likely to be federal limits and guardrails for any state-developed methodology to ensure alignment with federal principles

Deliverable: Recommended specifications outlining a Vermont hospital global budget design and implementation approach.

Meeting Period: January-November

Meeting cadence: 120-minute meetings, approximately every three weeks.

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Global Budget TAG
Analysis and Discussion Topics

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- Through Fall 2023, the Hospital Global Budget Technical Advisory Group will use data and analyses to work through key payment model design questions related to a potential hospital global payment model, including:
  - Defining scope (population, services, and included providers)
  - Calculating baseline budget
  - Defining potential necessary budget adjustments and adjustment methodologies
  - Payer participation
  - Provider participation
  - Strategies to support care transformation and quality under a global budget
  - Program administration
  - Evaluation and monitoring

Global Budget TAG

Payment Design Topics Covered To Date

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1) Services included in hospital global budget payments
2) Populations included in hospital global budget payments
3) Calculating baseline global budget payments
4) Annual, periodic, and ad hoc global budget payment adjustments

The following slides provide a summary of input to date from TAG meeting participants for these topics.

Global Budget TAG Input to Date

1. Services Included in Hospital Global Budget Payments

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- All hospital inpatient and outpatient services, with the possible exception of infrequent and high-cost hospital services, a question which the Technical Advisory Group will revisit.
- Both employed and non-employed professional services billed under the hospital's taxpayer identification number (TIN), but not non-employed professionals not billed under the hospital's TIN.
- At least some hospital-owned facility-based services, with phased inclusion of additional services over time.
- Corporate parent-owned entities on a case-by-case basis, based on whether those services can be appropriately allocated to a specific hospital based on geography or other factors.

Global Budget TAG Input to Date

2. Populations Included in Hospital Global Budget Payments

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- Vermont Medicaid members and not members of other state Medicaid programs.
- All Medicare FFS beneficiaries (VT residents and non-VT residents receiving care at Vermont hospitals), acknowledging the importance of understanding the percentage of non-resident Medicare charges from non-border states, as those beneficiaries are more likely to receive primary care out-of-state.
- As many commercially insured people as possible, including both VT and non-VT residents receiving care at Vermont hospitals.

Global Budget TAG Input to Date

3. Calculating Baseline Budget Payments

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- Use net patient revenue from Medicaid, Medicare and participating commercial payers as the primary data source for determining baseline budget payments.
- Calculate at the facility level (not the system-level)
- One-time adjustments to the baseline budget should take into account:
  - Hospital financial condition, including hospital operating margins
  - Inflation trends
  - Demographic changes
  - Policy changes (e.g., changes in Medicare and Medicaid payment)

Global Budget TAG Input to Date

4. Annual & Ad Hoc Adjustments

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- Make annual adjustments to the global budget payments for the following:
  - Inflation trends – balancing hospital cost inflation lens with affordability lens
  - Demographic changes – methodology TBD
  - NOTE: Future meetings will include discussion about adjustments for efficiency, potentially avoidable utilization, high-value care, etc.
- Make annual and potentially mid-year adjustments for changes in utilization. Two potential approaches (mixed TAG feedback) – stay tuned!
- Include two-sided accountability for total cost of care (TCOC)
- Consider adjustments to mitigate provider financial risk <u>in extreme circumstances</u>
  - Monitoring for (1) changes in utilization beyond a selected threshold or (2) negative margins beyond a certain threshold could trigger ad hoc adjustment for financial risk, informed by a hospital's financial position

Global Budget TAG
Progress and Future Plans

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- Currently working to develop a straw model based on TAG recommendations to-date
- Looking ahead: TAG will react to straw model this summer, and see a more developed model with actual Vermont data in fall
- In the meantime, continuing to tackle key issues: strategies to support care transformation, terms of payer participation, terms of hospital participation, budget calculation and payment operations, and monitoring and evaluation

TAG materials are publicly available on the GMCB website

Key Areas of Methodology

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- In the coming months, staff will seek Board member input on critical methodology decision points. Questions may include (among many others)…

Base Budget	• Given that any global payment methodology will utilize claims, how to trend baseline to current day? • What adjustments, if any, should be made to the base budget?
Annual Trends and Adjustments	• How to balance keeping up with inflation/costs and affordability? • How to incentivize efficiency, reduce waste, and reward high-value care?
Regulatory Mechanism	• How could Vermont administer global payments? Provider rate setting vs. payer regulation approaches
Quality Framework, Monitoring, Evaluation	• What quality measures should be part of a global payment model? • What measures should be part of a monitoring framework?

Opportunities for Input

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	Subsequent APM Agreement AHS Lead, GMCB Collab.	**Developing Value-Based Payment Models** *Hospital Global Budget Development* GMCB Lead, AHS Collab.
GMCB Member Input	• NOFO (State application) – GMCB input will inform application development; vote prior to submission • Final Agreement – GMCB vote required for Chair to sign	• Implementation may require use of one or more GMCB regulatory authorities; if so, GMCB would need to undertake rulemaking. GMCB would provide input on draft rule and vote on final rule.
Public / Stakeholder Input	• GB TAG input (payment model design) • AHS stakeholder engagement • GMCB public comment period	• GMCB stakeholder engagement in rule development • GMCB public comment period

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DISCUSSION

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APPENDIX

Literature on Global Budgets/Global Payments

Act 167 of 2022, Section 2 – Community and Provider Engagement

Current Global Budget Models

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Model Summary	Pennsylvania Rural Health Model	Maryland Total Cost of Care (TCOC) Model
Provider participation	• 18 rural hospitals (5 Critical Access Hospitals)	• 46 rural and urban hospitals • Aligned physician and post-acute providers
Payor participation	• Medicare FFS, 6 private payers with commercial plans, Medicaid MCO, Medicare Advantage	• All-payor (through provider rate-setting approach)
Included spending	• Hospital inpatient and outpatient • Self-insured groups are excluded by some commercial plans	• Hospital inpatient and outpatient • Other types of spending aligned with different models

Source: Hospital Global Budget TAG (TAG) – Meeting 1 Materials (1/24/23)

Findings from State Experiences

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New York (1980-87)

- Reduced growth in hospital operating revenues and expenses
- Improvements in net margins
- May have yielded stronger results with model expansion

Pennsylvania (2019 to date)

- Limited data to assess effectiveness
- Participation from many hospital types (critical access, system-owned, independent)

Maryland (2010 to date)

- Reduced hospital spending for Medicare and commercial
- Reduced total expenditures for Medicare
- Reduced admissions for Medicare and commercial
- Reduced ED visits

NOTE: In the first iteration of MD's global budget model, it saw utilization and costs shift to services outside of the global budget; the second iteration (TCOC Model) seeks to moderate this by controlling overall cost growth

Source: Hospital Global Budget TAG (TAG) – Meeting 1 Materials (1/24/23)

Literature: Global Payments

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Maryland All-Payer Model Agreement (2014-2018) and Total Cost of Care Model (2019-current):

- The State of Maryland estimates Medicare savings of $1.4 billion in the first phase of Maryland's All-Payer Model (2014-2018). (MD Health Services Cost Review Commission)
- A look at the first 3 years of the model (2014-2017) found that total expenditures declined ($25.37 PBPM), primarily attributed to a reduction in total hospital expenditures ($20.69 PBPM). These savings beyond hospital expenditures indicate that hospital savings were not offset by shifts to non-hospital services. (Beil et al, 2019)
- The Maryland Total Cost of Care model (successor to the initial MD APM) has also demonstrated early cost savings compared to national trends ($365 million reduction in TCOC in Year 1, 2019). (CMMI, 2021)
- Maryland saw improvement in hospital admission rates, 30-day unplanned readmissions, and potentially preventable admissions vs. a comparison group; in addition, measures of care coordination (follow-up after hospitalization and follow-up after an emergency department visit for an acute exacerbation of a chronic condition) improved vs. a comparison group. (CMMI, 2021)

Literature: Global Payments

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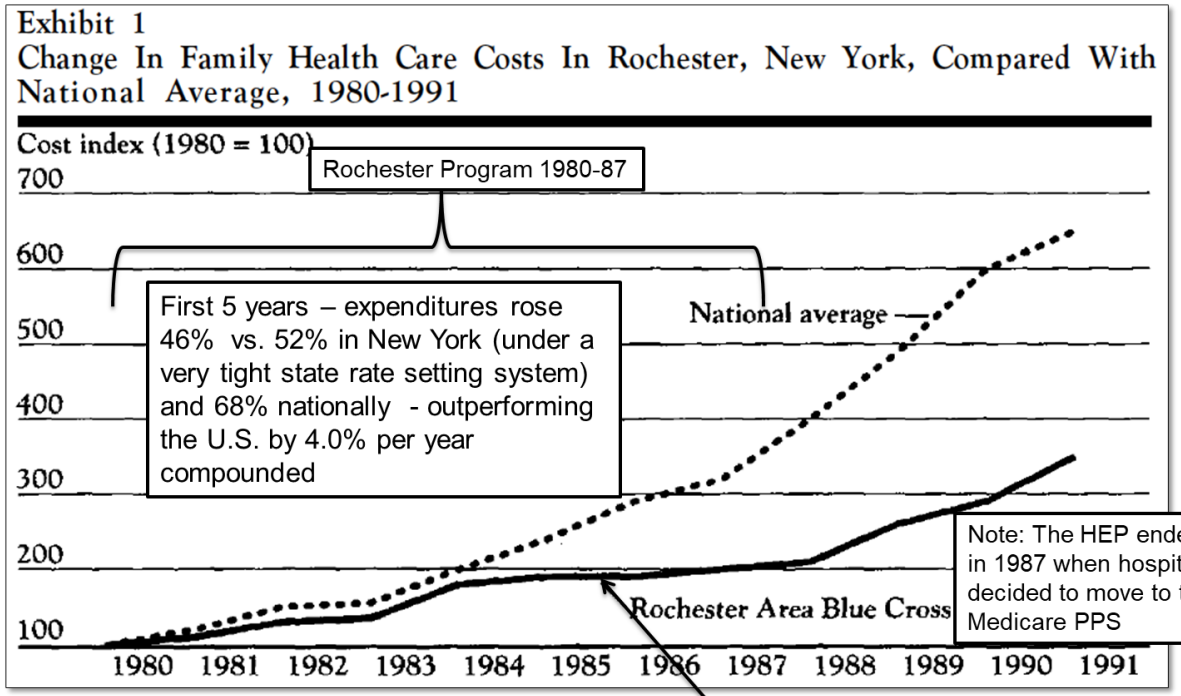
NY Hospital Experimental Payment Program (1980-1987 – "Rochester Model"):



First 5 years – expenditures rose 46% vs. 52% in New York (under a very tight state rate setting system) and 68% nationally - outperforming the U.S. by 4.0% per year compounded

Note: The HEP ended in 1987 when hospitals decided to move to the Medicare PPS

Greatly contributing to a stabilization of commercial insurance premiums in the region

Hall and Griner et al. *Health Affairs* 1993

Table 1.—Cumulative Operating Profit (Loss) of Hospitals in Various Regions of New York State, 1980 Through 1984

Region	Operating Profit/(Loss), Millions of Dollars
New York City	(693.7)
Northern metropolitan (downstate)	(150.1)
Nassau/Suffolk	(180.7)
Abany	(41.7)
Utica	(33.7)
Syracuse	(77.7)
Rochester	11.9
Buffalo	(122.3)

Table 2.—Hospital Admissions to General Hospitals in New England, New York State, and Rochester, NY

Year	Admissions/1000 New England	New York State	Rochester
1979	148	149	135
1980	149	149	133
1981	147	150	132
1982	146	149	126
1983	146	148	124
1984	141	148	124
Net change, 1979-1984	−7	−1	−11

Profitability and cash flow of these hospitals was significantly better than other New York hospitals 1980-84

System also experienced larger drops in use rates than other nearby areas (NY and New England)

Block *JAMA* 1987

Slide adapted from Bailit Health Purchasing

Act 167 of 2022, Section 2

Data Analysis and Community/Provider Engagement to Support Hospital Transformation

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- Act 167 of 2022, Sec. 2 defines a community engagement process for hospital system transformation with the goals of reducing inefficiencies, lowering costs, improving population health outcomes, reducing health inequities, and increasing access to essential services while maintaining sufficient capacity for emergency management.
- The GMCB, in collaboration with AHS, is seeking a contractor to support this process. The contractor will:
  - Conduct a system-wide data analysis and participatory community engagement process.
  - Support the development of localized transformation plans with a cohort of providers.
- Stakeholder participants will include hospitals and other health and human services providers, payers, the State of Vermont, and the public at large.

Act 167 of 2022, Section 2

Data Analysis and Community/Provider Engagement to Support Hospital Transformation

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Summer 2022	Following the passage of Act 167, GMCB worked closely with AHS to develop an RFP • GMCB and AHS engaged together with key stakeholders to seek feedback and revised the RFP scope as a result • Received feedback from hospital executives and the Vermont Association of Hospitals and Health Systems, Vermont health care provider and professional organizations, OneCare Vermont, the Office of the Health Care Advocate, Legislators, and commercial payer representatives
Fall 2022	RFP release and bid review
Winter-Spring 2022	Bidder selection and contract negotiation
Late Summer 2023	Expected contract execution
Early Fall 2023	Launch community and provider engagement