Hospital Global Budget Technical Advisory Group

JANUARY 24, 2023
MEETING #1

Meeting Agenda

1. Introductions and context
2. Background on hospital global budget design and use
3. Goals for hospital global budgets
4. Overview of the Technical Advisory Group design process
5. Health equity implications of global budgets

Introductions

Hospital Global Budget Technical Advisory Group members

Co-Chairs: Robin Lunge, GMCB and AHS Co-Chair TBD

Alicia Cooper, *DVHA*

Pat Jones, *DVHA*

Jordan Estey, *MVP Health Care*

Matt MacKinnon, *MVP Health Care*

Andrew Garland, *BCBSVT*

Martine Brisson-Lemieux, *BCBSVT*

Diane Raymond, *BCBSVT*

Dave Murman, *GMCB Member and practicing physician*

Jenn Bertrand, *Gifford Medical Center*

Judi Fox, *Rutland Regional Medical Center*

Rick Vincent, *UVM Health Network*

Dave Sanville, *Mt. Ascutney Hospital*

Mike Fisher, *Office of Health Care Advocate*

Eric Schultheis, *Office of Health Care Advocate*

Derek Raynes, *OneCare Vermont*

Tom Borys, *OneCare Vermont*

Context: APM, Act 159, & Act 167

- Vermont is currently participating in an All-Payer Model (APM) agreement with CMS. The agreement was customized to Vermont, and confers multiple benefits on Vermont, including patients and the health care delivery system.
  - The APM agreement has been extended, but it will be expiring in 2024.
  - CMS has been in active discussions with Vermont on a possible new agreement. The new APM agreement will not be customized to Vermont, although it may permit Vermont flexibilities. It will include hospital global budgets.
  - CMS will announce the new APM model details by the fall of 2023.
- Act 159 (2020) tasked the GMCB to "*consider ways to increase the financial sustainability of Vermont hospitals in order to achieve population-based health improvements while maintaining community access to services.*"
- Act 167 (2022) directed the GMCB, in collaboration with AHS, to "*develop value-based payments for hospitals and to develop and conduct a stakeholder engagement process for Vermont's hospitals that will reduce inefficiencies, lower costs, improve population health outcomes, reduce health inequities, and increase access to essential services.*"

Technical Advisory Group Purpose and Meeting Structure

This body builds on and expands discussions during Fall 2023 by the former Global Budget Subgroup to identify important topics to raise with CMMI team.

Technical Advisory Group charge: Make recommendations for conceptual and technical specifications for a Vermont hospital global budget program by the time CMMI introduces its new APM program.

Technical Advisory Group deliverable: Specifications outlining a Vermont hospital global budget design and implementation approach

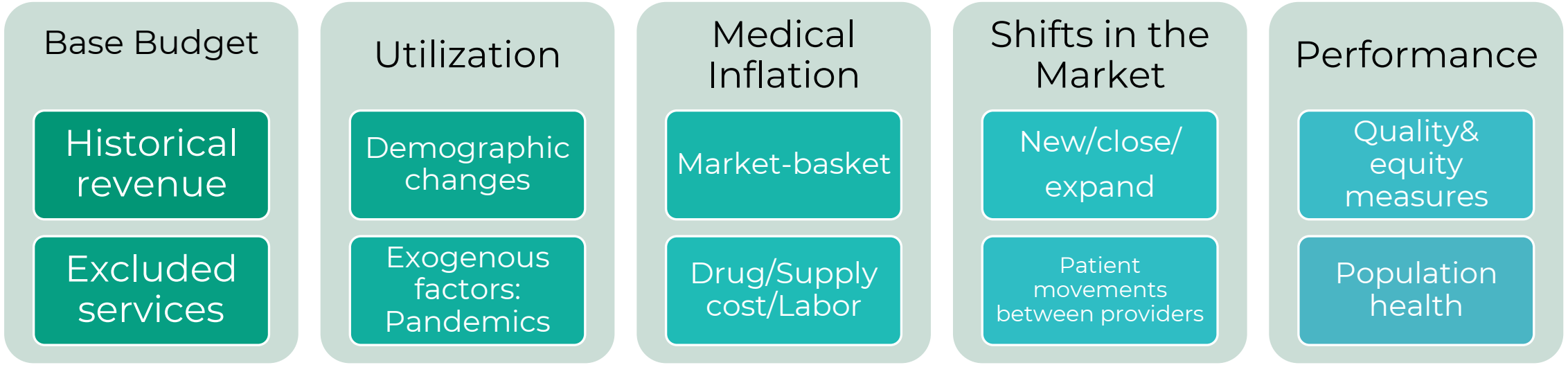
Technical Advisory Group meeting period: January-November

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

Background on Hospital Global Budget Design and Use in the U.S.

What is a hospital global budget?

- It is a payment model in which hospitals are paid a prospectively established amount for a defined set of services over the course of a year.
- Payment is to a significant degree fixed, regardless of the quantity of services delivered.



State Implementation of Hospital Global Budgets

- 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's All-Payer Model also includes some characteristics of hospital global budgets; we will review Vermont's model as well.

State Models Have Varied

- State models vary across a number of design considerations, such as:
  - Which hospitals are included?
  - Which payers are included?
  - How are baseline budgets calculated?
  - What adjustments are made to those baseline budgets?
  - How are payments administered?
- The model that emerges from this design process will likely be different from any preceding state hospital global budget model.

Current Global Budget Models

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

Findings from State Experiences

New York (1980-87)

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

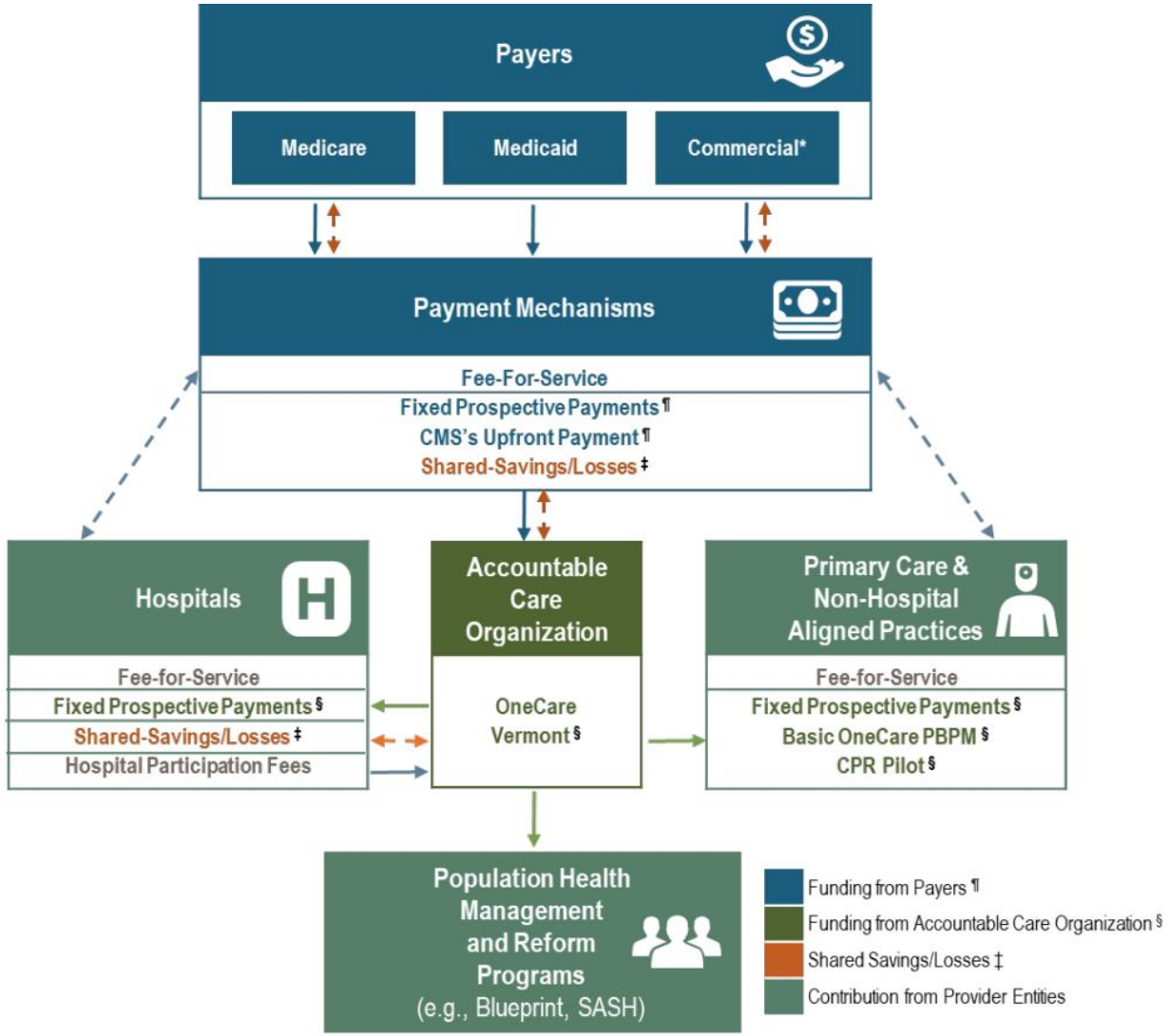
Maryland (2010 to date)

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

Pennsylvania (2019 to date)

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

VT's All-Payer Model Includes Fixed Hospital Prospective Payments



- Payment methods vary by payer
- Fixed prospective payments are one type of payment within the All-Payer Model. They currently comprise a small percentage of hospital revenue.

Building on Medicaid's Fixed Payments

- Medicaid and OneCare are planning for an expansion of the Medicaid fixed prospective payments in the Vermont Medicaid Next Generation ACO model.
- This approach begins to separate the provider payment methodology from an attribution-based payment methodology.
- For Medicaid, it will support the goal of transitioning more FFS payments into fixed payments and create more predictability in budgeting.
- For hospitals (& OneCare's Comprehensive Payment Reform practices), it will make Medicaid revenue more predictable, and reduce having "feet in two canoes" for a single payer.
- Learnings from this model expansion may be informative for future planning.

GMCB's Hospital Budget Review

Aspects of the GMCB hospital budget review process resemble a global budget.

- The GMCB establishes revenue growth rates and caps price growth for Vermont's hospitals. It has used the APM TCOC target to inform its regulatory work.
  - Hospitals "back into" the commercial revenue need based on assumptions for reimbursement by public payers (Medicare and Medicaid).
  - Pre-COVID, commercial price growth was the driver of increasing budgets, not utilization, due to low rates of growth in public payer rates.
  - Payers and hospitals report that the growth cap affects commercial price growth.
  - Enforcement occurs after the fiscal year ends, so it does not have an immediate impact.
- This process is intended to constrain cost growth, but, unlike a global budget, it does not create a "floor" for sustainable and predictable revenue for hospitals.

Goals for Designing a Hospital Global Budget

Why a Hospital Global Budget?

- Hospital global budgets 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 witness 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**,
  - **control growth** in hospital spending at an affordable level.
- Hospital global budgets also have risks, particularly related to over-incentivizing reductions in care, which need to be carefully mitigated.
- Global budgets can create "win-win" alignment for hospitals, payers, consumers and the state, but will need to carefully balance the concerns and priorities of all parties.

What should our goals be for the model we design?

- Previously, stakeholders have identified the following goals:
  - Provider financial stability
  - Rural sustainability
  - Improve transitions of care
  - The right care, in the right place, at the right time
  - Improve equity of care and outcomes
  - Affordability for Vermonters
- Are these the right goals?
- Which goals do you prioritize?

Overview of the Technical Advisory Group Design Process

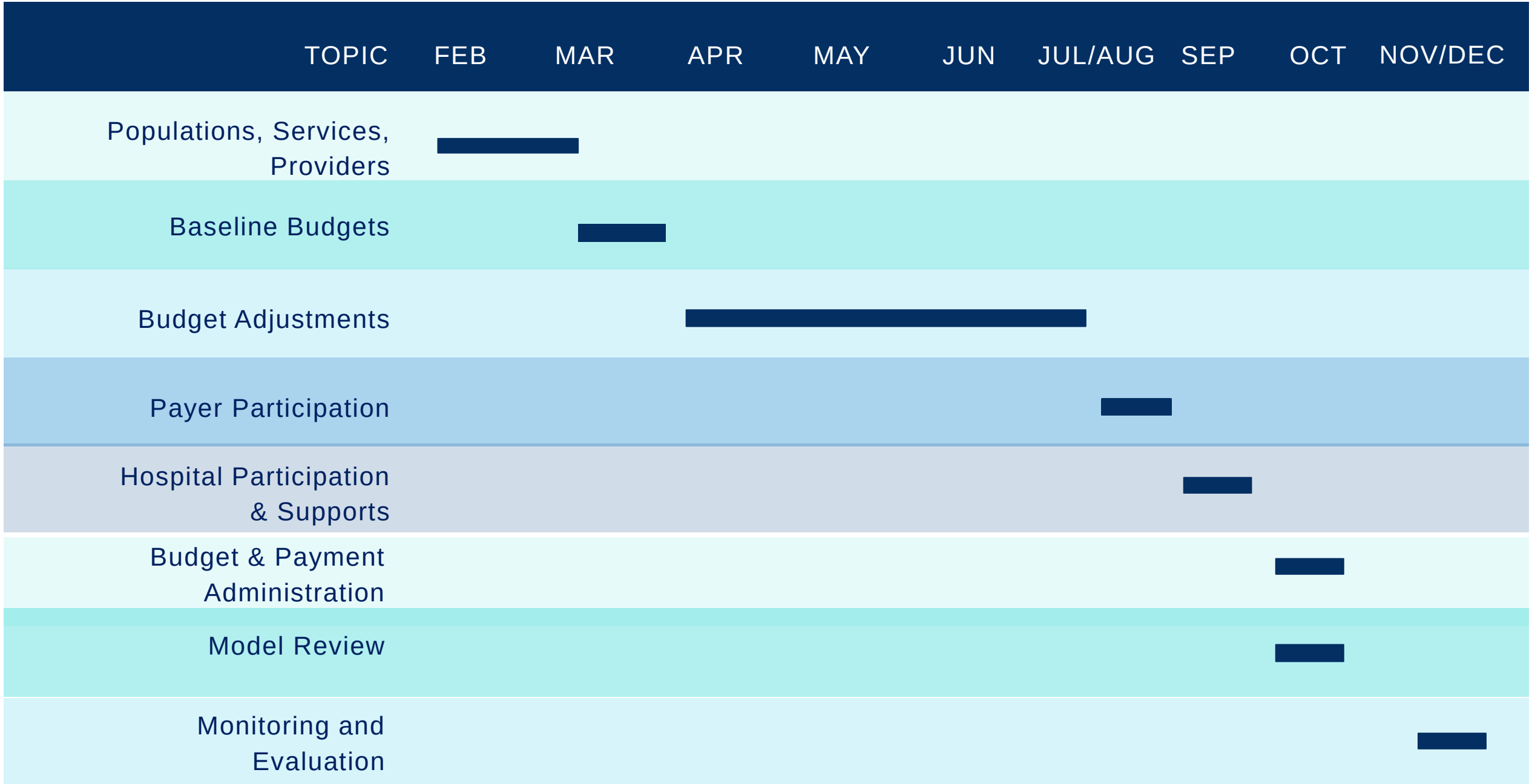
Considerations in Developing the Advisory Group Workplan

1. Discuss key design decisions to inform an assessment of CMS' hospital global budget design once announced.
2. Recognize that issues are interwoven, i.e., certain topics may surface in multiple meetings, even if a decision on that topic is only listed for one specific meeting.

Considerations in Developing the Workplan (continued)

- Propose certain assumptions upfront, to guide design discussions and support data analysis and modeling:
  1. Assume full participation by payers and hospitals at the outset of the design process, but include explicit discussion of participation later in the process. (Fall 2023)
  2. Assume the global budget model is fully standardized, but include explicit discussion of important areas of possible variation later in the process. (Fall 2023)
  3. Assume no reconciliation to FFS based on previous stakeholder input. Propose to discuss a range of other payment strategies, but not reconciliation to FFS.

Workplan Overview



Technical Advisory Group Workplan

Identifying Populations, Services and Providers

Meetings 2 & 3 (February 28 & March 14)

- Identify populations to include
- Identify services to include
- Determine how providers and services will be identified in the budget development process
- Identify barriers to inclusion of these providers and services and whether, and if so how, they can be addressed

Technical Advisory Group Workplan

Establishing Baseline Budgets

Meeting 4 (March 28)

- Develop methodology for establishing baseline budgets:
  - Net Patient Revenue, insurance paid amounts, operational costs
  - Measures of revenues/payment for other providers
  - Exclusions
  - Supplemental payments/payer-specific considerations
- Determine whether the budget is calculated at the system level
- Discuss fiscal year versus calendar year approach

Technical Advisory Group Workplan

Developing List of Potential Adjustments, and Methods of Adjustments for General Trends and Utilization Changes

Meeting 5 (April 18)

- Summarize categories of adjustments, including prospective, retrospective, exoge-nous factors and risk mitigation
- Trends and adjustments to baseline budgets construction
- Measures of inflation
- Demographic changes

Meeting 6 (May 9)

- Adjustments for utilization changes
  - Service line changes
  - Market shifts
  - Flexible budgets

Technical Advisory Group Workplan

Developing Adjustments for Quality, Equity & Financial Performance, and Risk

Meeting 7 (May 23)

- Quality and equity
- TCOC performance
- Shared incentives with multiple provider types
- Mid-cycle check-in

Meeting 8 (June 13)

- Adjustments for risk and other factors utilization changes
  - Exogenous factor adjustments
  - Risk mitigation
  - Other (cost reports, capital improvement expenditures)

Meeting 9 (July 11)

- Recap

Technical Advisory Group Workplan

Term of Payer Participation and Payment Mechanism

Meeting 10 (August 1)

- Identify which payers should participate in the model and whether that participation should be voluntary or mandatory
- Review GMCB's rate-setting authority and discuss the necessity of its application to ensure self-funded employer participation (ERISA plans)
- Identify areas where the model should allow for different payers to vary from the model
- Determine how the budgets would be paid

Technical Advisory Group Workplan

Terms of Hospital Participation; Hospital Supports and Implications of Global Budgets for Commercial Benefits Administration

Meeting 11 (September 5)

- Participation requirements
  - Transformation Plan
  - GMCB budget review submissions
- Discuss whether the model should have voluntary or mandatory participation for providers
- Identify whether, and if so how, the model should allow for variation for hospitals

Meeting 12 (September 26)

- Discuss care transformation opportunities created by global budgets
- Identify desired supports for hospitals and strategies for payers to support care transformation
- Assess impact of global budget on commercial benefits administration, especially consumer cost-sharing

Technical Advisory Group Workplan

Budget Calculation & Payment Administration; Model Description Review

Meeting 13 (October 10)

- Determine who should calculate budgets and manage and oversee the hospital's global budget
- Discuss who should administer the payments
- Determine how a global budget and an ACO should co-exist, e.g., should the global budget operate within and/or outside of an ACO?

Meeting 14 (October 31)

- Review written model description
- Discuss CMMI All-Payer Model hospital global budget design (if available)

Technical Advisory Group Workplan

Monitoring and Evaluation

Meeting 15 & 16 (November 14 & December 5)

- Create a plan for monitoring and reporting on progress
- Include ongoing monitoring for unintended consequences on patients, hospitals and payers
- Create a plan for program evaluation

Workplan Discussion

- Questions or feedback about proposed topics and sequence?
- Is any content missing from the workplan to ensure the Technical Advisory Group discusses all key design decisions related to the program's goals?

Health Equity Implications

Addressing Health Equity

- Advancing health equity is a shared objective of AHS and the GMCB.
- Health equity should be considered throughout discussions of the hospital global budget model design, implementation, and evaluation.
- Health equity has been defined in Healthy People 2030 as "the attainment of the highest level of health for all people.“
- Incorporating the goal of improving health equity is important because hospital global budget models could potentially perpetuate and worsen existing health inequities.
  - For example, global budgets can preserve existing inequities in access to care and utilization because they typically begin with historical payment rates.

Examples of Strategies for Improving Health Equity

- Adjust budgets to account for social risk and correct existing inequities in payments.
  - Hospitals that disproportionally serve historically underserved communities (e.g., low-income communities, non-English speaking communities) could receive additional financial support based on identified needs, such as historical patterns of resource underutilization by certain populations.
  - This support could take the form of an adjustment to ongoing payments, or an up-front, one-time adjustment based on individuals' social risk factors.
  - This type of adjustment would help ensure that hospital budgets reflect their patient population's care needs, and that providers are not penalized for serving underserved populations.

Example: CMS' CHART model promoted an Area Derivation Index (ADI) positive-only adjustment for hospitals serving populations from communities with high levels of socioeconomic deprivation compared to the average national rural community..

Examples of Strategies for Improving Health Equity

- Assessing quality and equity improvements
  - In addition to evaluating absolute performance against a hospital global budget, assessments could include improvements in quality and equity.
  - For example, payments could be linked to disparities-sensitive quality measures and equity measures.
  - When assessing performance, results could be stratified using health equity data to the greatest extent possible. This can include race, ethnicity, language, disability status, sex, sexual orientation, gender identity, geography (for example, rural vs urban, zip code), income, insurance status, and other social risk factors.
  - These measurements can help to reduce inequities in performance and improve performance for specific subpopulations who experience inequities.

Example: Maryland hospitals are able to earn a reward of up to 0.5% of inpatient revenue by reducing socioeconomic disparities in readmission..

Addressing Health Equity

- We will highlight health equity implications throughout the design discussions.
- Certainly, approaches that make sense in other states might not for Vermont given the small and rural nature of Vermont's hospitals and the racial profile of the state population.
- Are there specific health equity topics or options that you are particularly interested in discussing within this Technical Advisory Group?

Wrap-up and Next Meeting

- The next Hospital Global Budget Technical Advisory Group meeting is scheduled for Tuesday, February 28 from 10 am – 12 pm