

# Hospital Global Budget Technical Advisory Group

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FEBRUARY 28, 2023  
MEETING #2

# Meeting Agenda

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1. Updates
2. Recap January meeting and revisit goals
3. Services to be included in a global budget
4. Populations to be included in a global budget

# Updates: Currently Participating Organizations

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

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

# Recap of January Meeting

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# Goals for Designing a Hospital Global Budget

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# Why a Hospital Global Budget?

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- 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 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 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 need to carefully balance the concerns and priorities of all parties.

# Value Proposition for Global Budgets



# Updated Hospital Global Budget Design Goals

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The following goals incorporate input during the 1/24 meeting.

1. Hospital financial predictability, flexibility and sustainability
2. Reduced low-value transaction costs
3. Hospital spending growth at an adequate rate for workforce and capital needs, and at an affordable rate for Vermonters served by the commercial, Medicaid and Medicare markets
4. Increased hospital investment in population health
5. Access to the right care, in the right place, and at the right time
6. Improved quality and equity of care and improved outcomes
7. A process to measure results and make necessary adjustments



# Updated Hospital Global Budget Design Goals – Feedback Received

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The following goals incorporate additional feedback received on 2/24.

1. Hospital financial predictability, flexibility and sustainability.
2. Reduced low-value transaction costs.
3. Hospital spending levels growth that balance and address affordability, access to care, and system sustainability, with at an adequate rates that are adequate for workforce and capital needs, and at an affordable rate for Vermonters served by the commercial, Medicaid and Medicare markets.
4. Increased hospital investment in population health.
5. Access to the right care, in the right place, and at the right time, and whenever appropriate, community-based care (e.g., preventive care, primary care, and mental health services).
6. Improved quality and equity of care and improved outcomes.
7. A process to measure results and make necessary adjustments.

# Services to be Included in a Hospital Global Budget

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# Objectives

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1. Consider options for including different service types within the model.
2. Identify opportunities and potential challenges with including specific hospital and hospital-owned services
3. Consider approaches taken by other states and historical spending associated with some options
4. Identify areas where additional information is needed
5. Obtain input from the TAG about what services should and should not be included in the global budget
6. Begin discussion of member/patient populations for inclusion

# Services to Consider for a Hospital Global Budget

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## Hospital Facility Services

Inpatient Hospital Facility Services

Outpatient Hospital Facility Services

## Professional Services

Employed Prof., Billed Under Hospital's TIN

Non-Employed Prof., Billed Under Hospital's TIN

Non-Employed Prof., not Billed Under Hospital's TIN

## Other Services

Hospital-Owned

System-Owned

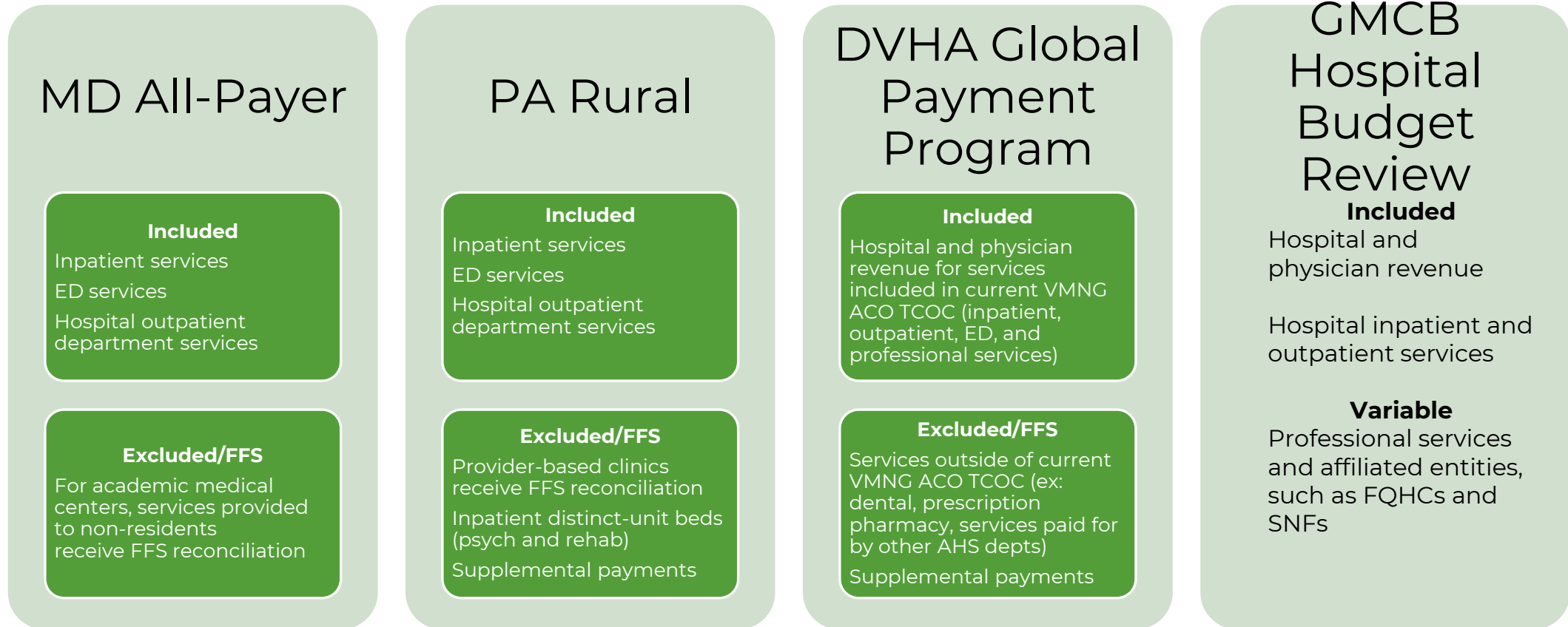
Independent

# Services Included in Hospital Global Budget Models

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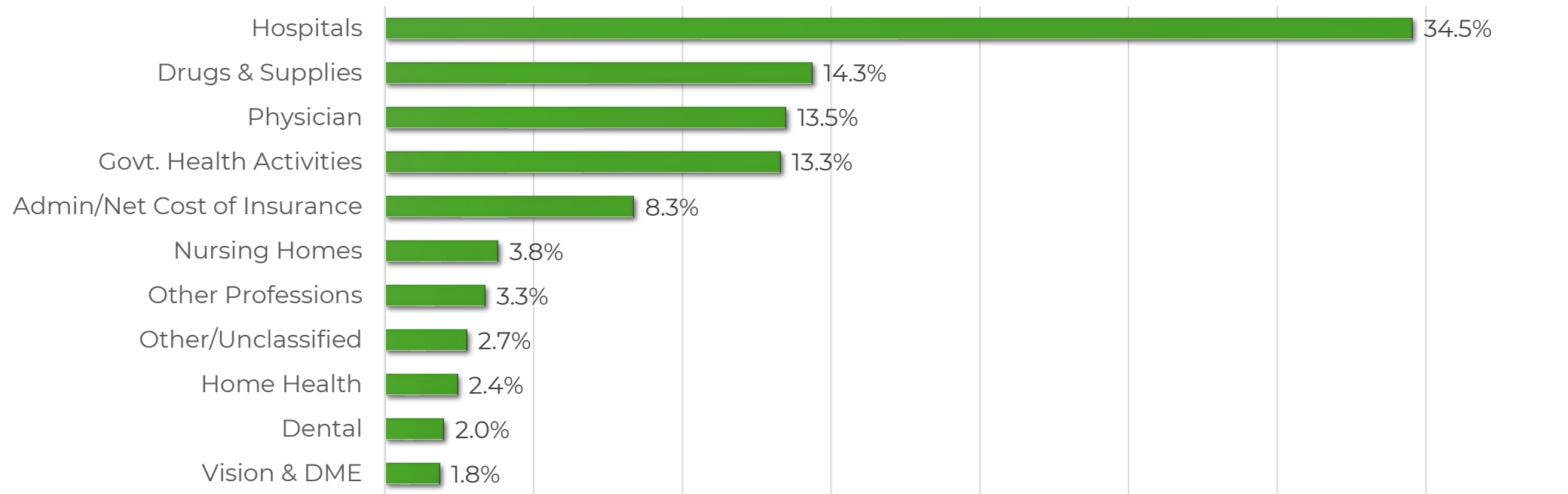
- Hospital global budgets have **included inpatient and outpatient hospital services**.
- In MD and PA **professional services** are excluded; however, some professional services are included within the Fixed Prospective Payment through OneCare Vermont.
- Hospital global budgets vary in their inclusion or exclusion of **other hospital-owned facility-based services** (e.g., home health services, hemodialysis, skilled nursing facilities).
- GMCB's hospital global budget review process encompasses a broad set of services and owned entities.
- Uniquely, Vermont has multi-payer Blueprint **community health teams** employed by hospitals in most health service areas.

# Comparison of Service Inclusion



# ~35% of Vermonters' Total Health Spending is Hospital Spending; Physicians add 14%

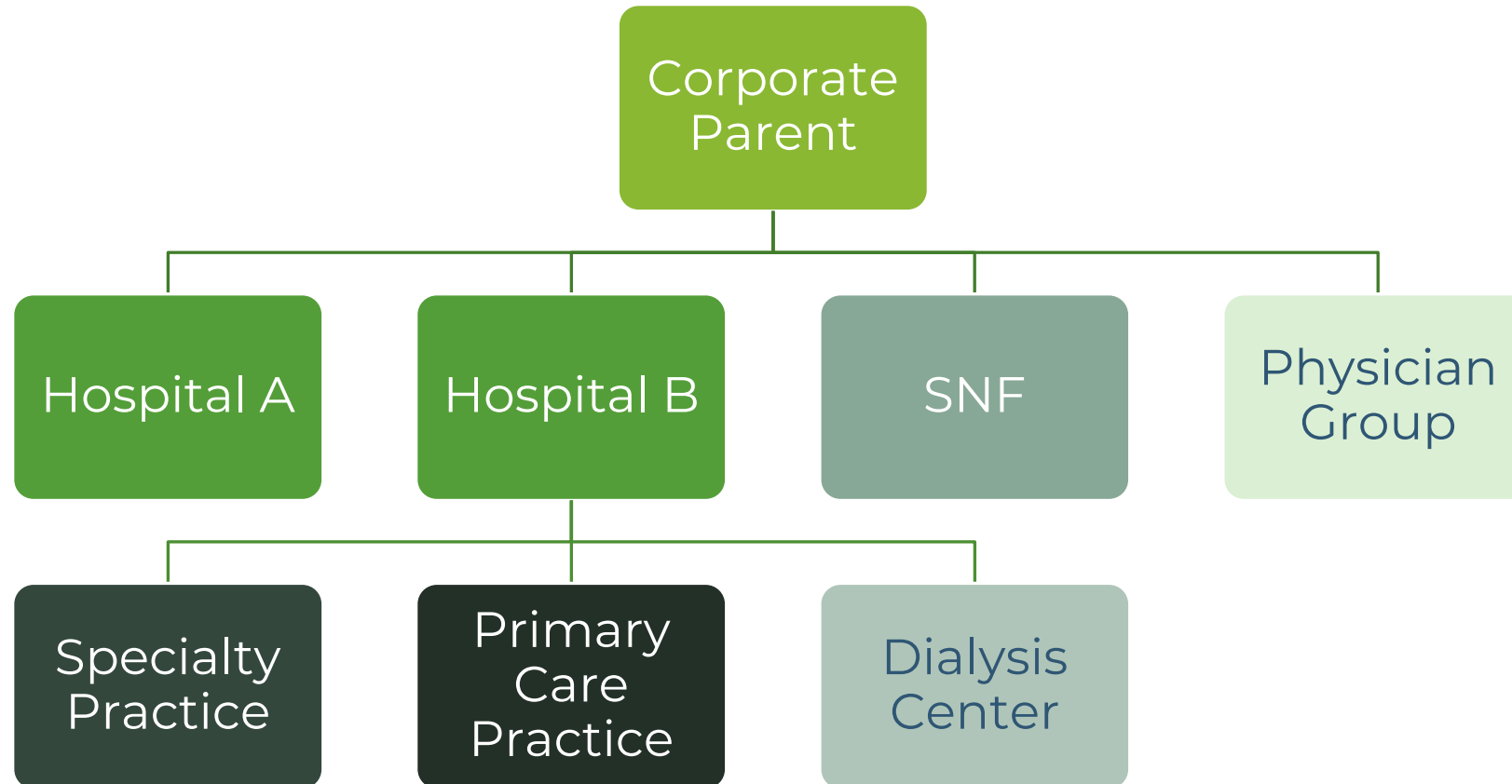
**Total health spending by provider type for VT residents**



Data reported is a blend of FY and CY 2020

# Hospitals' Owned Assets Could Reside within an Individual Hospital or within a System

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# Prior Stakeholder Group Discussion

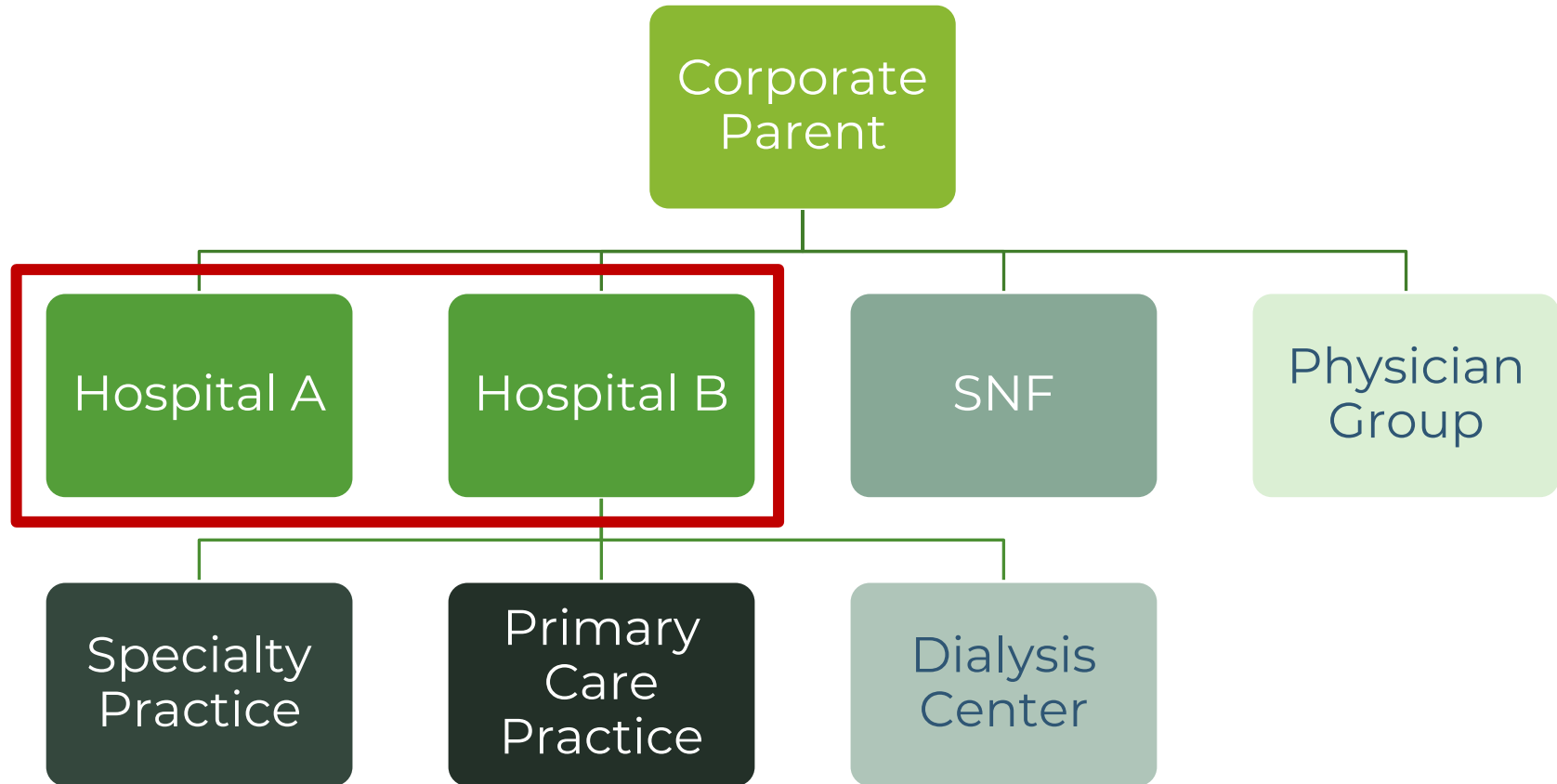
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- Service inclusion was discussed by the AHS/GMCCB Global Budget Subgroup during its meetings in Fall 2022.
- The Subgroup identified flexibility for including services beyond hospital inpatient and outpatient as important for the state to request CMMI include in its program design.
- Considerations informing the recommendation included:
  - A sizeable amount of spending is going to hospital-employed professional services.
  - A sizeable percentage of physicians are hospital-employed.
  - There was a desire to align incentives across a broader set of services to avoid the adverse consequences of misalignment.

# Hospital Inpatient and Outpatient Services

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We are considering IP & OP services delivered at these facilities



# Definition of Hospital Inpatient and Outpatient Services

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All states with hospital global budget experience have included spending for hospital facility inpatient and outpatient services in their models, with some variation.

- **Hospital facility inpatient services** includes room and board, procedures, treatments, and ancillary services (e.g., diagnostic tests, pharmaceuticals, ER services) when a member is admitted to a hospital (including med/surg units, behavioral health units and rehab/swing beds).
- **Hospital facility outpatient services** includes non-inpatient procedures, treatments, or testing provided in the hospital setting (including HOPD) billed as a hospital service

## **Discussion:**

- For the purposes of operationalizing the hospital global budget, how should these categories of services be captured?
  - One option is to identify services billed via the UB-04 claim form, excluding residential facility services and other non-hospital claims.
- Are there any clarifications or changes that should be considered for these definitions?

# Definition of Hospital Inpatient and Outpatient Services (cont'd)

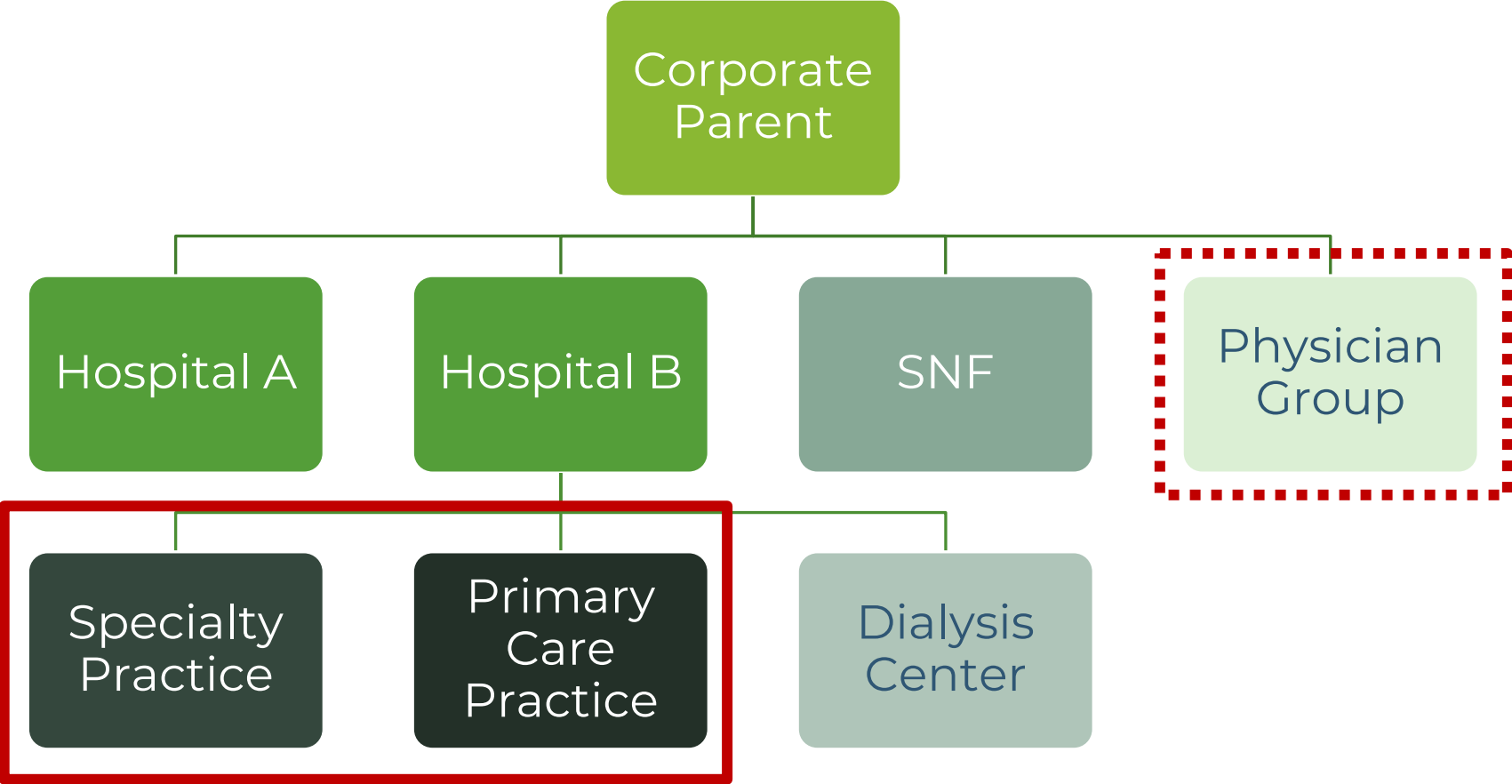
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Are there certain services that should be *excluded* from the global budget? For example:

- Low frequency, high-cost services (such as quaternary care services)
- Services where there is public policy interest in higher levels of spending growth (e.g., mental health and substance use? primary care?)?

# Professional Services

We are considering professional services billed by the hospital



# Rationale for Considering Inclusion of Professional Services

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1. Already implemented under the existing Vermont All-Payer Model as an ACO fixed prospective payment
2. Takes a more comprehensive approach to hospital global budgets, i.e., captures more of hospitals' services and spending
3. Creates aligned incentives across hospital and professional care
  - Exclusion of professional services has been cited as a barrier to care transformation in PA & MD because incentives not aligned
4. Reduces financial incentive for hospitals to steer care to owned facilities that are not part of the global budget

# Physician Gross Revenue Comprised 16% of Hospital Total Gross Revenue in FY2020 (Hospital Financial Data)

Data reported is FY 2020

Source: Hospital Financial Data – Payer Revenue Sheet

## HOSPITAL AND PHYSICIAN GROSS REVENUE BY HOSPITAL

Hospital name	Hospital total gross revenue	Physician care total gross revenue	Hospital and physician total gross revenue	Physician gross revenue as a % of total gross revenue
UVMHC	\$2,184,664,886	\$534,405,279	\$2,719,070,165	19.7%
Northwestern	\$155,671,665	\$37,380,281	\$193,051,946	19.4%
Mt. Ascutney	\$82,006,626	\$19,519,152	\$101,525,778	19.2%
Grace Cottage	\$25,474,011	\$4,520,897	\$29,994,908	15.1%
Gifford	\$91,713,907	\$16,053,582	\$107,767,489	14.9%
Central Vermont	\$338,189,055	\$57,803,573	\$395,992,628	14.6%
Southwestern	\$297,028,884	\$50,739,677	\$347,768,561	14.6%
Porter	\$132,672,878	\$22,639,358	\$155,312,236	14.6%
North Country	\$160,540,102	\$23,399,655	\$183,939,757	12.7%
Springfield	\$83,602,392	\$9,528,139	\$93,130,531	10.2%
Rutland	\$484,537,740	\$54,903,250	\$539,440,990	10.2%
Northeastern	\$152,317,392	\$16,904,689	\$169,222,081	10.0%
Brattleboro	\$156,305,806	\$16,211,490	\$172,517,296	9.4%
Copley	\$117,975,109	\$5,227,181	\$123,202,290	4.2%
<b>Totals</b>	<b>\$4,462,700,453</b>	<b>\$869,236,203</b>	<b>\$5,331,936,656</b>	<b>16.3%</b>

# Definition of Professional Services

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Here, we are only considering the costs associated with a professional fee and *not* any clinical or personnel costs that may be included in a facility fee.

## Discussion:

- What framework(s) could be used to define "professional services"?
- Are there specific services that should be excluded from the global budget?
  - Low frequency, high-cost services?
  - Medical pharmacy?
  - Services where there is public policy interest in higher levels of spending growth (e.g., mental health? primary care?)?



# Professional Services: What Should be Included?

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## Employed Professionals Billed Under Hospital's TIN

- Would this capture enough revenue to align incentives for transformation?
- How should services billed under the TIN of a related entity be handled?

## Non-Employed Professionals\* Billed Under Hospital's TIN

- Is there value in including these professionals?
- Are there barriers to doing so?

## Non-Employed Professionals\* Not Billed Under Hospital's TIN

- Is it valuable to include these professionals?
- Is it feasible?

\* These could be contracted professionals or non-contracted professionals.

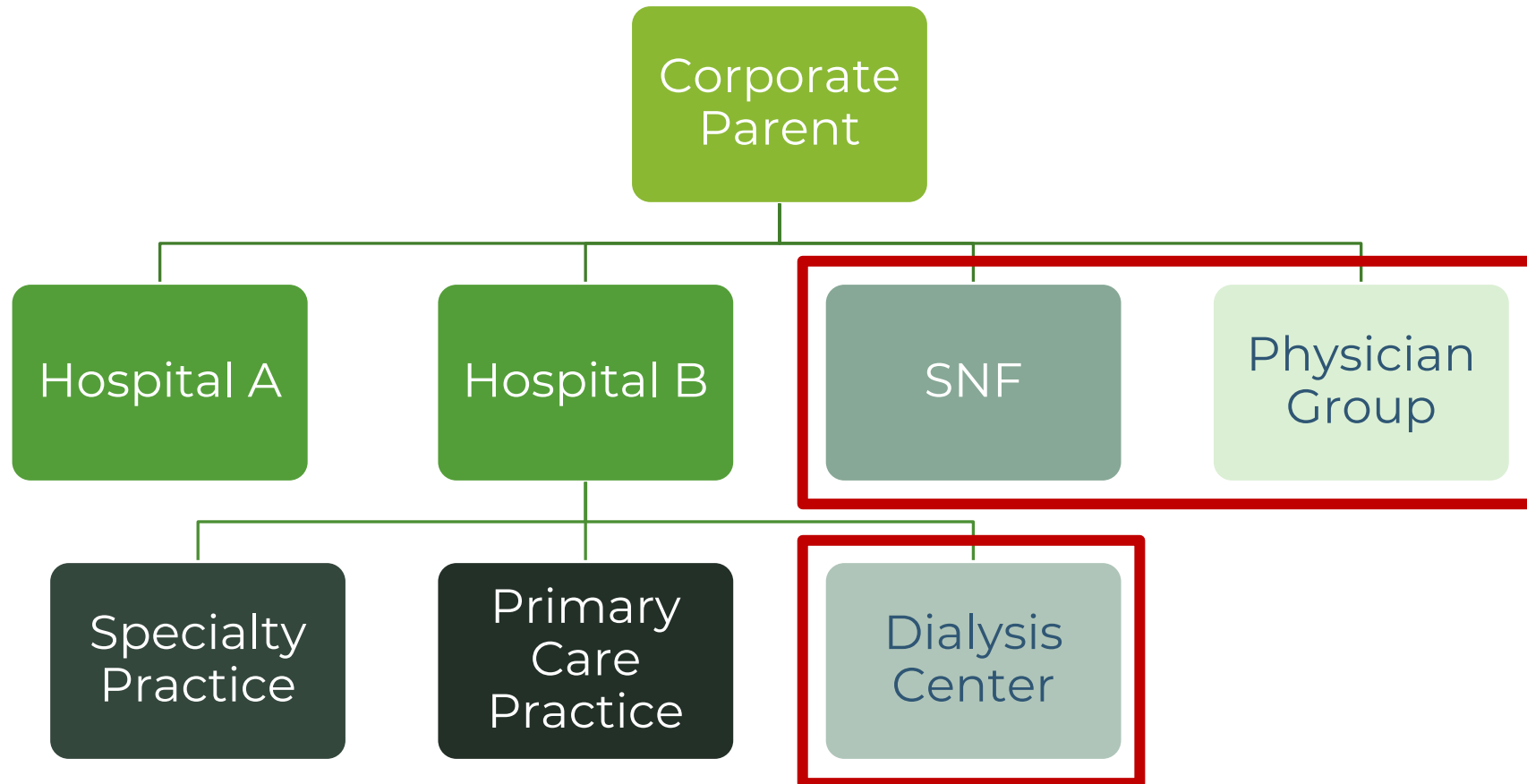
# Professional Services: Additional Considerations

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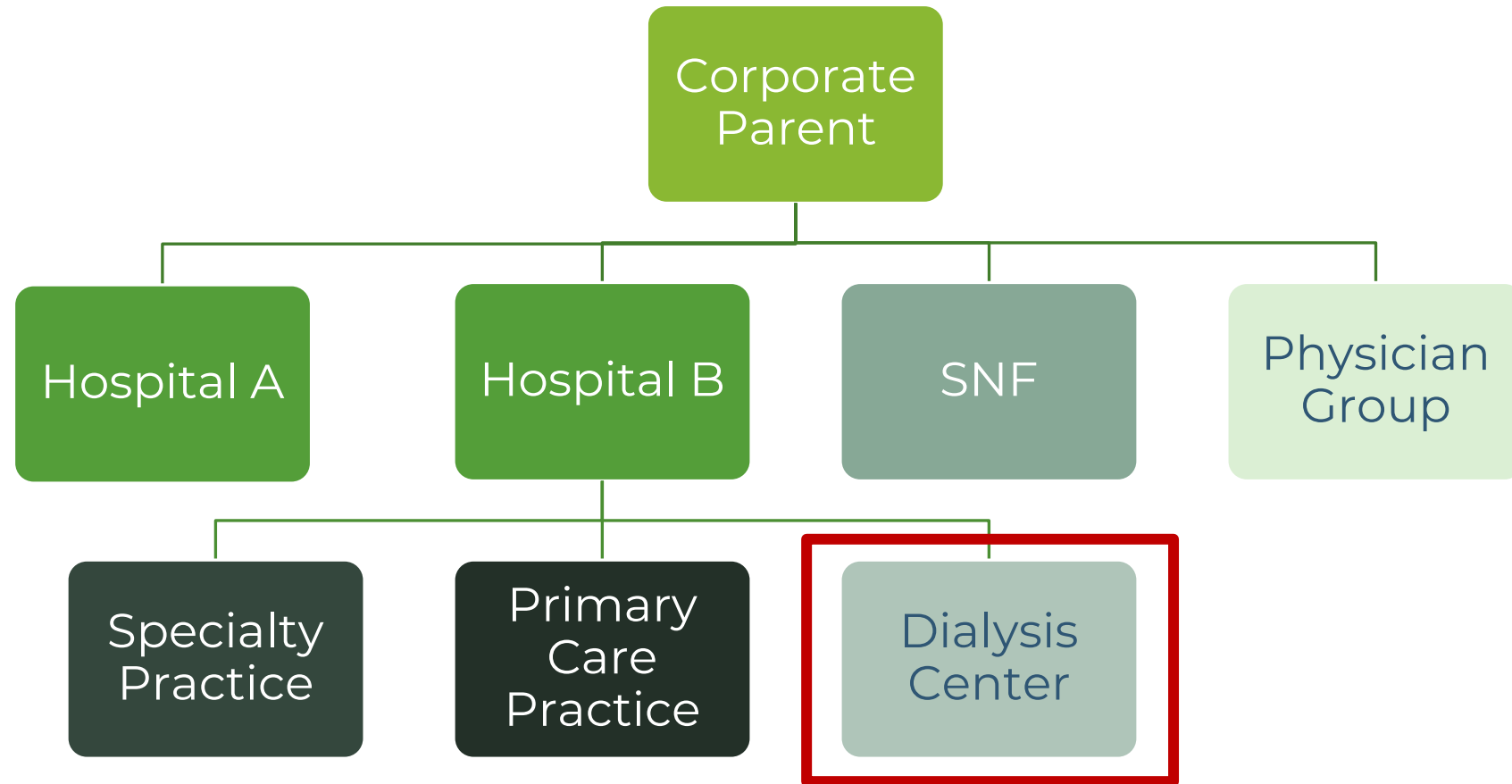
- Are there any potential adverse implications if hospital professional services are in the budget and services provided by non-hospital-owned practices are not?
  - If so, how might we mitigate those adverse consequences?
- How should the hospital global budget support the primary care reform efforts under the current OneCare Comprehensive Payment Reform (CPR) Program?

# Other Services Owned by Hospitals or Corporate Parents

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# Other Services Owned by Hospitals



# Hospital Ownership of Non-Hospital Services

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Hospitals may own other non-hospital services. These include home health agencies, imaging centers, urgent care centers, SNFs, outpatient clinics, etc.

- These may be located within or outside of the hospital's campus.
- They may or may not be part of the hospital's license.
- They may be owned by a health system (or other corporate entity), rather than by a specific hospital.

We need consider how to define and identify these hospital assets, and make a recommendation about whether the services should be included in a global budget.

# Rationale for Considering Inclusion of Other Hospital-Owned Services

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- Provides expanded revenue predictability to the hospital/hospital system
- Protects against shifting care to other hospital-owned services that do not have any budget controls
- Incentivizes better coordination across hospital-owned care settings

BUT

- Increases complexity of budget development
- Could create different incentives for hospital-owned versus non-hospital-owned services.

# Current VT Hospital Ownership Arrangements: Form 990 Data

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- The following types of entities were reported on hospitals' 2020 Form 990s, on Schedule H (non-hospital facilities) and Schedule R (related tax-exempt organizations):
  - Primary care (including one FQHC and one rural health clinic relationship) and urgent care
  - Specialty care (includes behavioral health clinics, physical therapy)
  - Dialysis
  - SNF, nursing homes and retirement communities
  - Other: inpatient psych, adult day, assisted living, pharmacy, home health & hospice, ambulance

# Current VT Hospital Ownership Arrangements: Form 990 Limitations

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- According to 2020 Form 990s, Schedules H and R do not show whether or not a particular hospital provides a given service.
- They only report whether or not a particular hospital operates (1) a non-hospital facility providing that service, or (2) is related to another organization that provides that service.
- Hospitals provide many services that are not listed on these particular schedules of the Form 990.



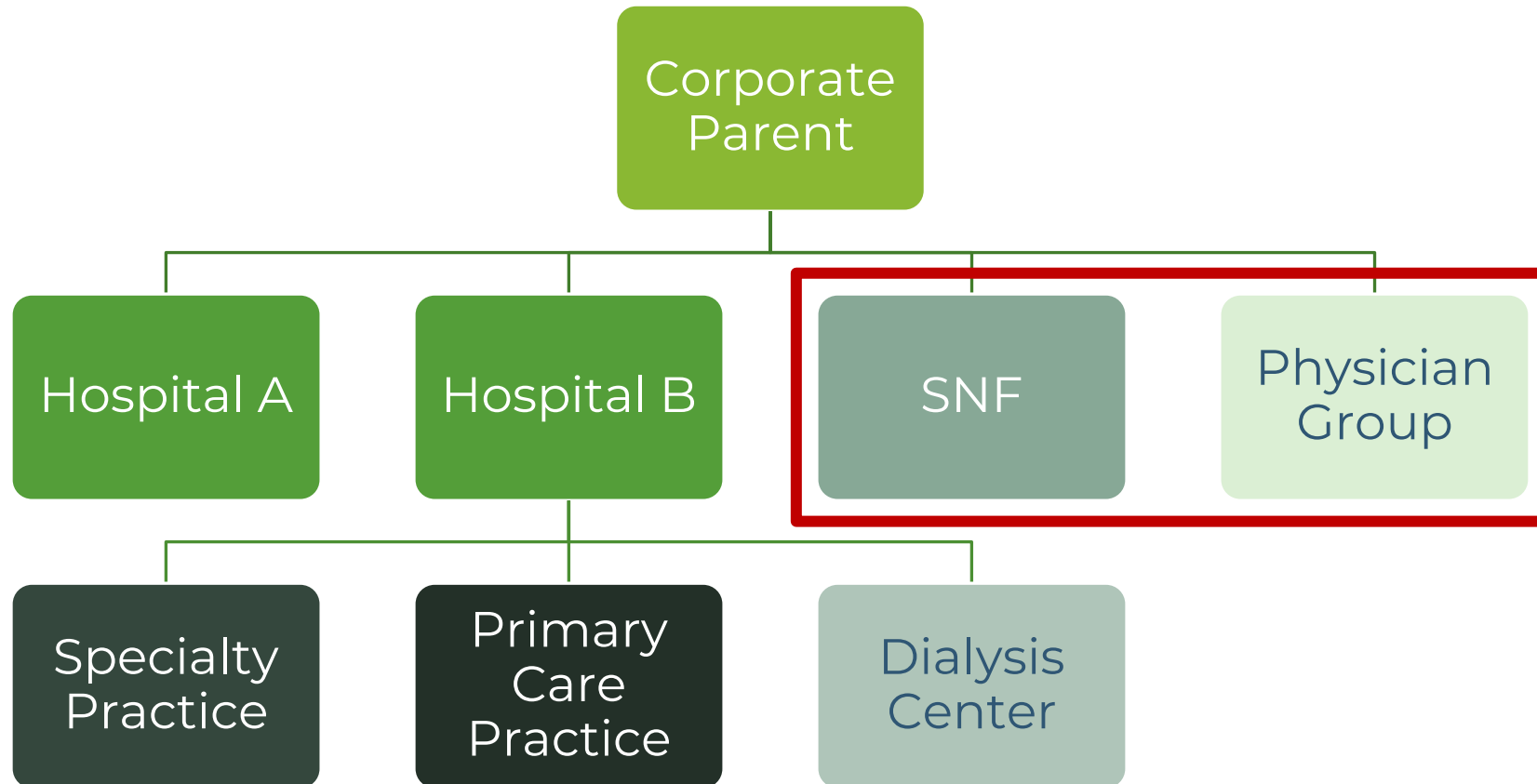
# Should Global Budgets Include All, Some, or None of These **Hospital-owned Services**?

Primary Care Clinics	Urgent Care Clinics	Specialty Care Clinics
Mental Health or Substance Use Clinics	Home Health & Hospice	Skilled Nursing Facilities
Nursing Homes	Dialysis	Other



# Corporate Parent-Owned Entities

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# Corporate Parent-Owned Entities

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We will now specifically consider questions related to whether services are provided by an entity that is owned by a corporate parent, rather than by a hospital

1. Should services provided by entities owned by a *corporate entity that sits above the hospital* be included within a global budget?
2. Should this vary for different types of services?
3. If they are not included, how should the program address "leakage" of patients/services outside of the global budget?

# Blueprint Community Health Teams

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As part of Vermont's Blueprint for Health, Community Health Teams are employed by hospitals (in most service areas) and support primary care practices within a health service area.

Community Health Teams are funded by all insurers through capacity payments, scaled by the number of attributed patients to the participating primary care practices within the health service area.

Discussion: Should Community Health Team payments be incorporated within the hospital global budget?

- What are the advantages to doing so? Disadvantages?

# Summary and Next Steps

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In this section, we discussed:

- Hospital inpatient and outpatient services
- Professional services
- Services provided at other hospital-owned facilities
- Services owned by a corporate parent versus services owned by a hospital
- Community Health Teams

# Populations to be Included

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# Overall Approach to Population-Inclusion

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Conceptually, a budget can be developed starting with a population, or starting with a hospital.

## Population-based approach:

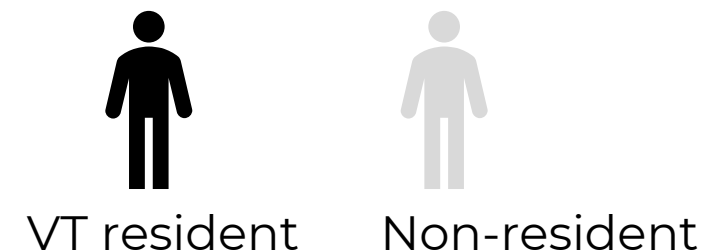
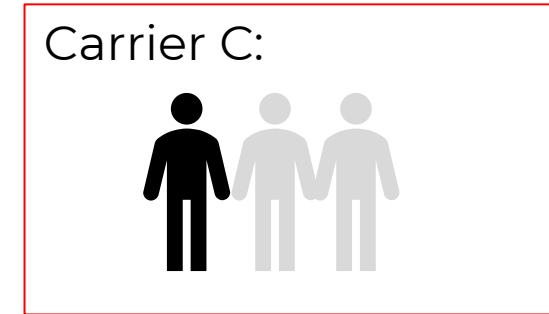
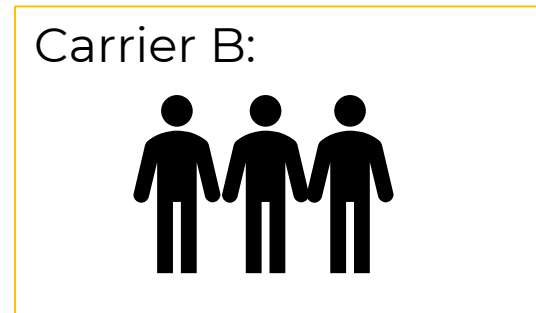
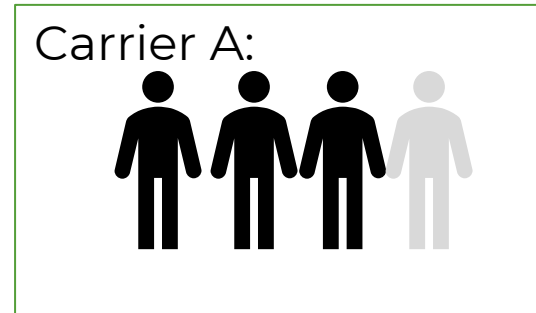
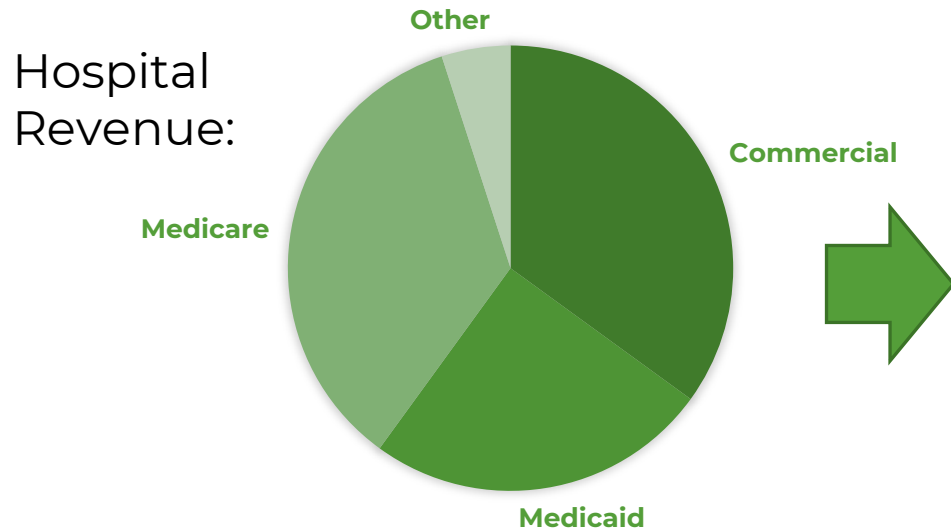
- CHART: Started from a particular population of beneficiaries residing in a particular community, then calculated the population's spending, then calculated a specific hospital's share of that spending

## Hospital-based approach:

- Maryland's Hospital Payment Program calculates budgets for each hospital, that applies to (almost) all the patients seen by that hospital (~95% of hospital revenues). The budget applies to both MD residents and non-MD residents (with some exemptions).
- Pennsylvania's Rural Hospital Model also calculates budgets for each hospital, by payer, based on the amount of historical revenue for each payer.

*We propose to model budgets with a hospital-based approach.*

# What Population Should be Covered by a Hospital's Global Budget?



A hospital receives revenue from caring for patients whose care is paid for by different payers/carriers, and who may be residents or non-residents.

- How much of this population (and its associated revenue) should we try to capture within the global budget?



# Defining the Population: General Considerations

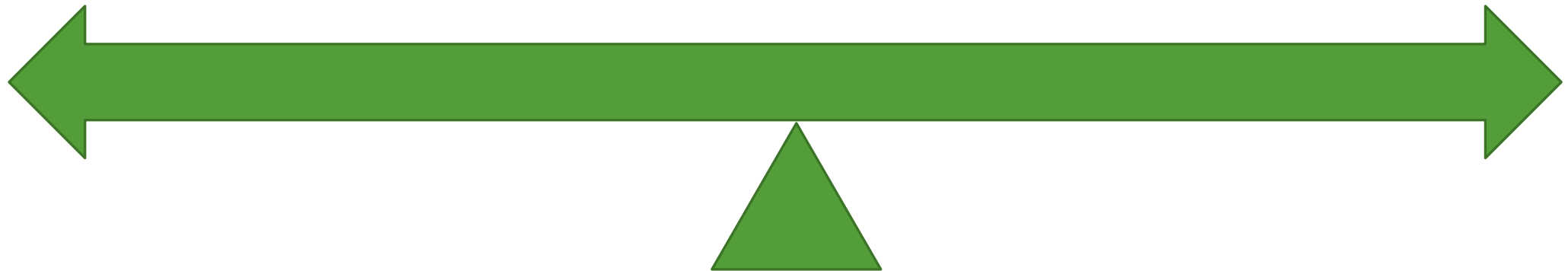
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## **Narrower definition:**

- Implementation may be easier
- But...risks not having enough critical mass to drive transformation
- Retains multiple payment systems

## **Broader definition:**

- More opportunity to align on transformation goals and simplify admin
- Requires coordinating with, and obtaining participation of, multiple payer entities



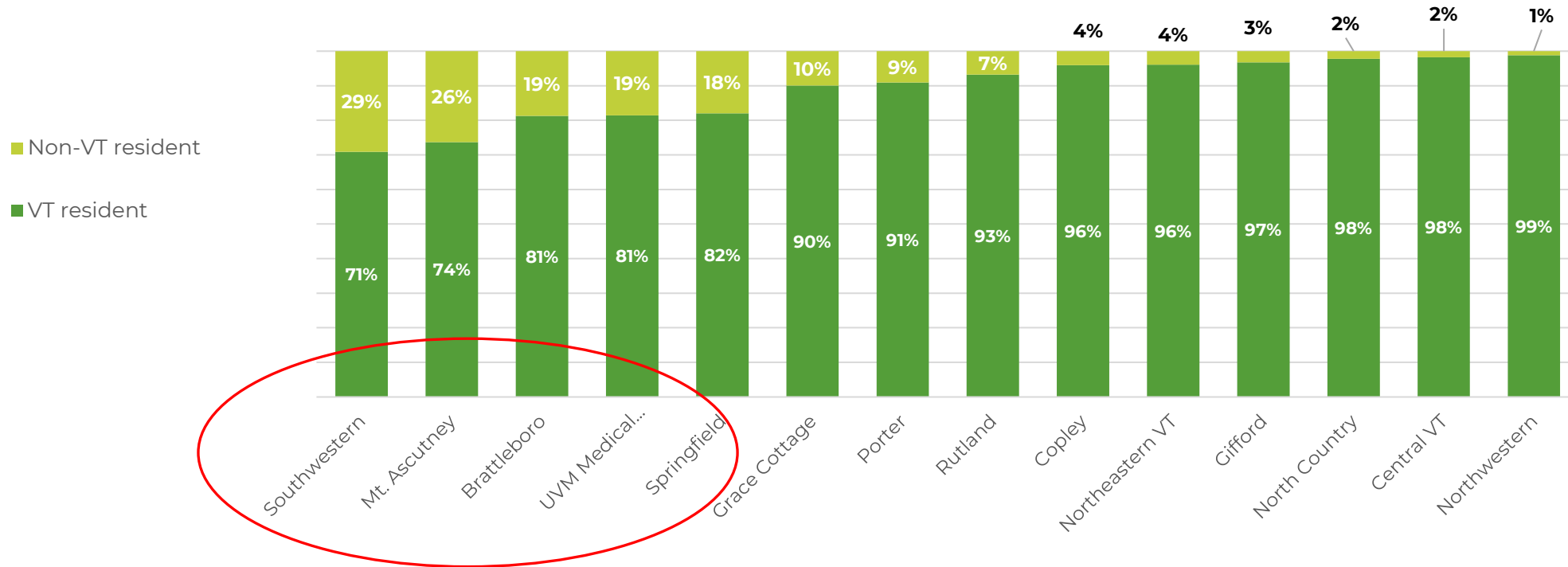
# Total Hospital Spending for VT Residents by Payer Type

Total hospital spending by payer type, 2019 (VT residents)		
Payer	% of total spend	Total Spend
Commercial	44%	\$ 1,048,869,808
Medicare	27%	\$ 643,745,499
Medicaid	13%	\$ 318,630,726
Out of Pocket	10%	\$ 232,953,511
Other Government	5%	\$ 117,158,705
<b>Totals</b>	<b>100%</b>	<b>\$ 2,361,358,250</b>

Data reported is a blend of FY and CY 2019

# Five VT hospitals have more than 10% of charges from non-VT residents

VT resident vs non-VT resident charges



Data reported is CY 2020

# Medicaid Population: VT and Non-VT Resident Charges

Medicaid charges as a percent of all hospitals total payer mix charges

**17%**

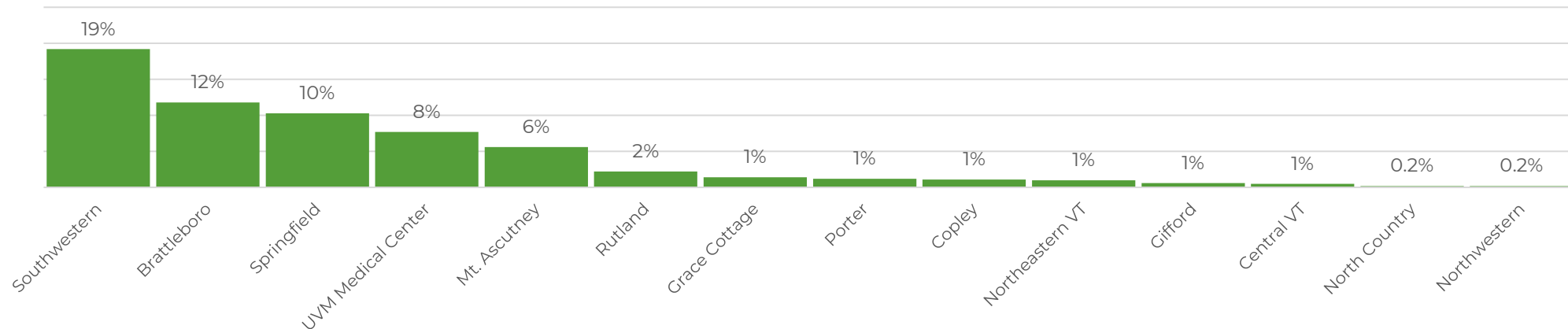
Medicaid charges for care provided to Vermont Medicaid members

**94%**

Medicaid charges for care provided to Medicaid members from other states

**6%**

% non-resident Medicaid of total hospital Medicaid



# Defining the Population: Medicaid

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## **Recommendations for Discussion:**

1. We propose to focus only on Vermont Medicaid enrollees (not enrollees of other state programs).
2. We propose to include in our modeling *all* Vermont Medicaid enrollees, regardless of whether they are currently attributed to an ACO. The reason for doing so is to increase the percent of revenue covered in the global budget model, recognizing that we will need to return to a more detailed discussion of how a global budget would intersect with the ACO model.

*Are there concerns with this approach?*

# Medicare Population: VT and Non-VT Resident Charges

Medicare FFS charges  
as a percent of  
all hospitals total payer  
mix charges

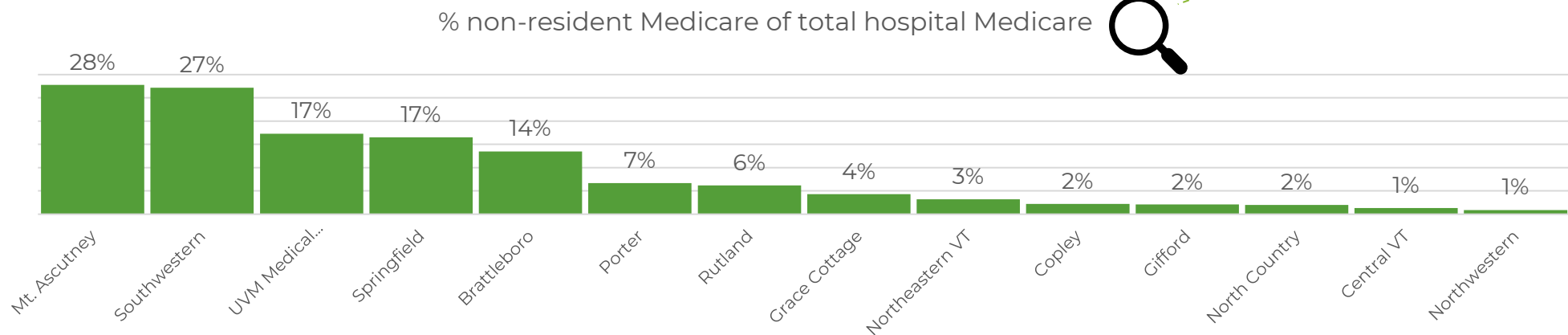
**48%**

Medicare FFS charges  
for care provided to  
Vermont Medicare FFS  
members

**87%**

Medicare FFS charges  
for care provided to  
Medicare FFS  
members from other  
states

**13%**



# Defining the Population: Medicare

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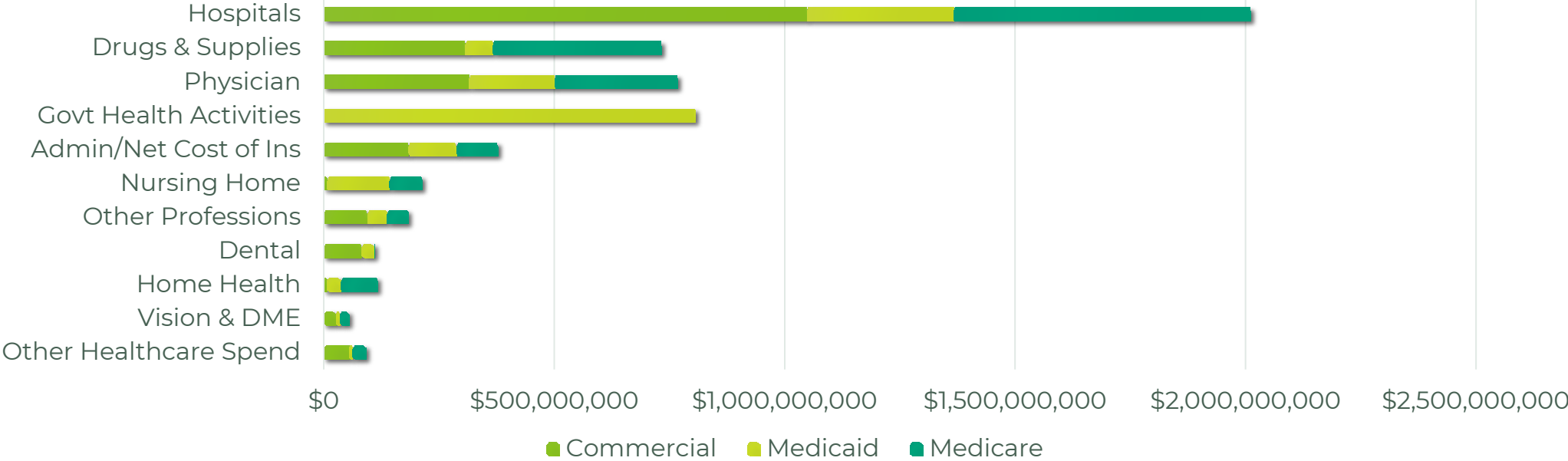
## **Recommendations for Discussion**

1. The All-Payer Model focuses on Vermont Medicare beneficiaries. We propose to include all Vermont Medicare beneficiaries in the model, regardless of whether they are attributed to an ACO or another program.

*Are there concerns with this approach or alternative proposals?*

# Commercial Spending Comprised \$2.1B of \$5.4B Total Health Spending in 2019

## Total Spending by Provider and Payer Type



Data reported is a blend of FY and CY 2019



# Commercial Population: VT and Non-VT Resident Charges

Commercial charges  
as a percent of all  
hospitals total payer  
mix charges

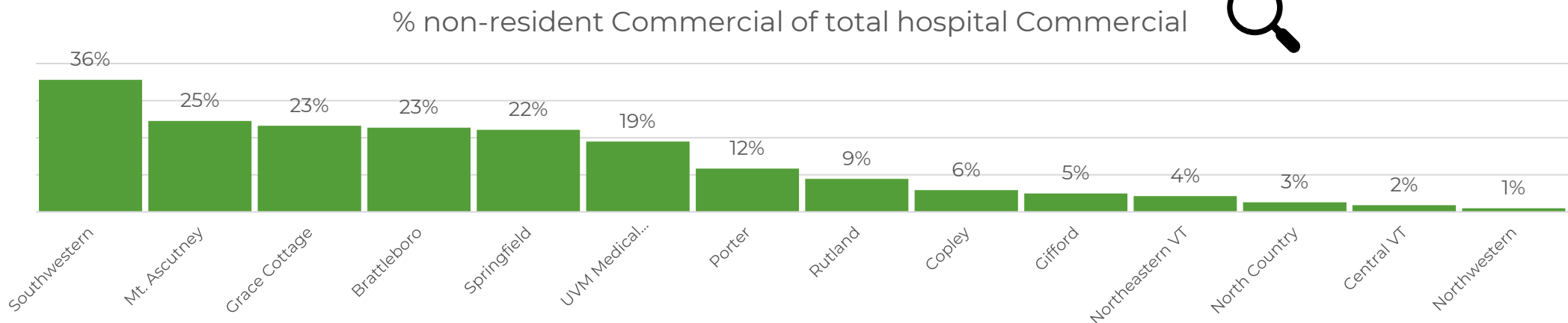
**21%**

Commercial charges  
for care provided to  
Vermont members

**84%**

Commercial charges  
for care provided to  
Commercial members  
from other states

**16%**



# Enrollment of VT Residents by Payer by Line of Business (2020)

Self-insured enrollment (VT residents)		
Payer	% of members	Total members
BCBS of VT	52%	63,913
Cigna	46%	56,042
QCC Insurance Company	1%	1,084
MVP Select Care	1%	947
Other*	1%	751
<b>Total</b>	<b>100%</b>	<b>122,737</b>

**55%** of total commercial lives

Fully insured enrollment (VT residents)		
Payer	% of members	Total members
BCBS of VT	45%	38,784
MVP Health Plan	41%	34,859
Cigna	6%	5,156
MVP Health Services	4%	3,618
Other	2%	1,339
United Healthcare	1%	1,158
The Vermont Health Plan	1%	1,074
<b>Total</b>	<b>100%</b>	<b>85,988</b>

**38%** of total commercial lives

Medicare Advantage enrollment (VT residents)		
Payer	% of members	Total members
UnitedHealthcare of New England	49%	7,658
UnitedHealthcare Insurance Company	40%	6,237
Sierra Health and Life Insurance Company	10%	1,519
Other*	2%	248
<b>Total</b>	<b>100%</b>	<b>15,662</b>

**7%** of total commercial lives

Data reported is from December 31, 2020

\*Refers to payers with less than 500 lives

# Defining the Population: Commercial

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## **Recommendations for Discussion**

1. Include all lines of business, including self-insured, fully insured and Medicare Advantage (for modeling purposes).
2. Include top three payers by market: self-insured/fully-insured combined, Medicare Advantage.
3. Include all members (Vermont and non-Vermont residents).

# Summary and Next Steps

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In this section, we discussed:

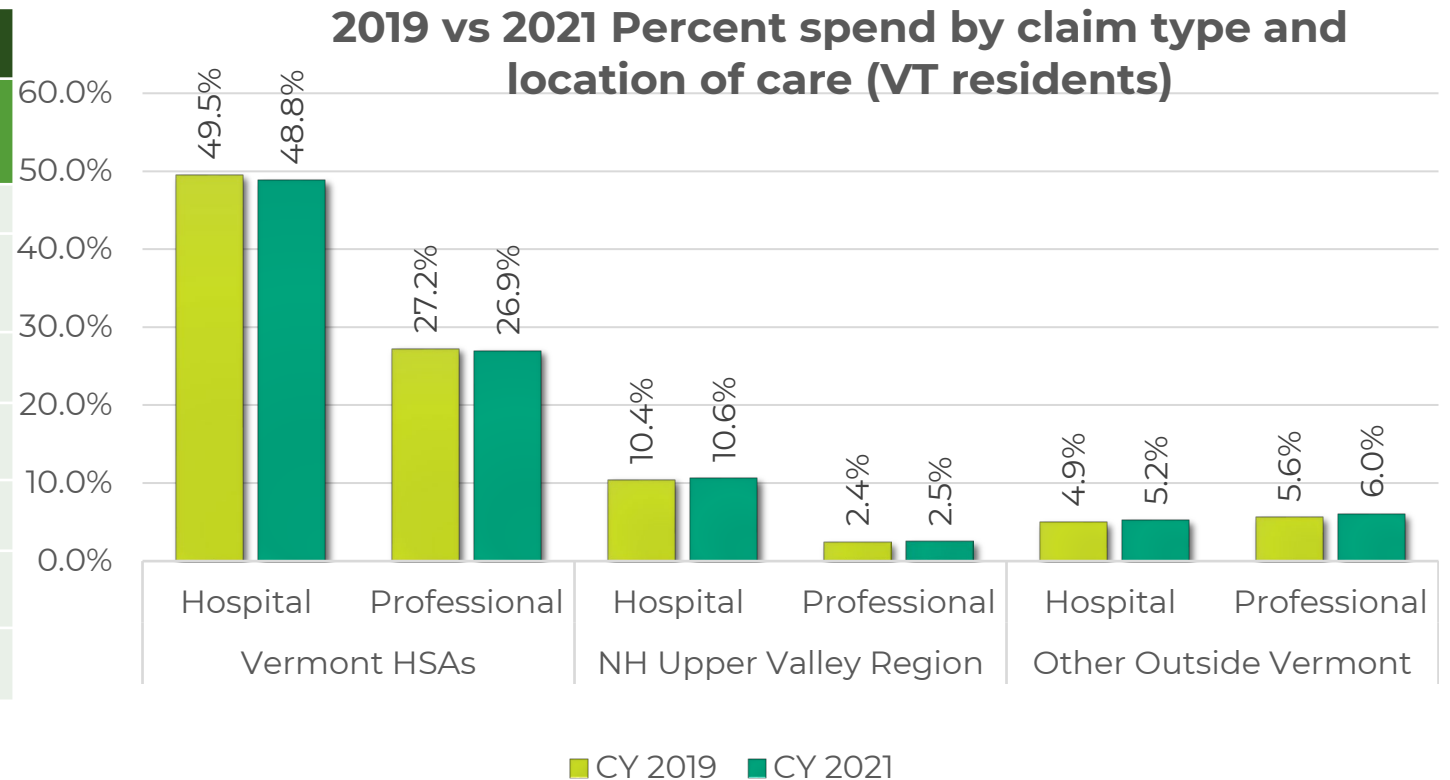
- A conceptual approach to defining the populations included within a hospital global budget
- Trade-offs involved in choosing a broader or narrower set of populations for inclusions
- Potential recommendations for inclusion of Medicaid members
- Potential recommendations for inclusion of Medicare FFS beneficiaries
- Potential recommendations for inclusion of commercially insured members

# Appendix

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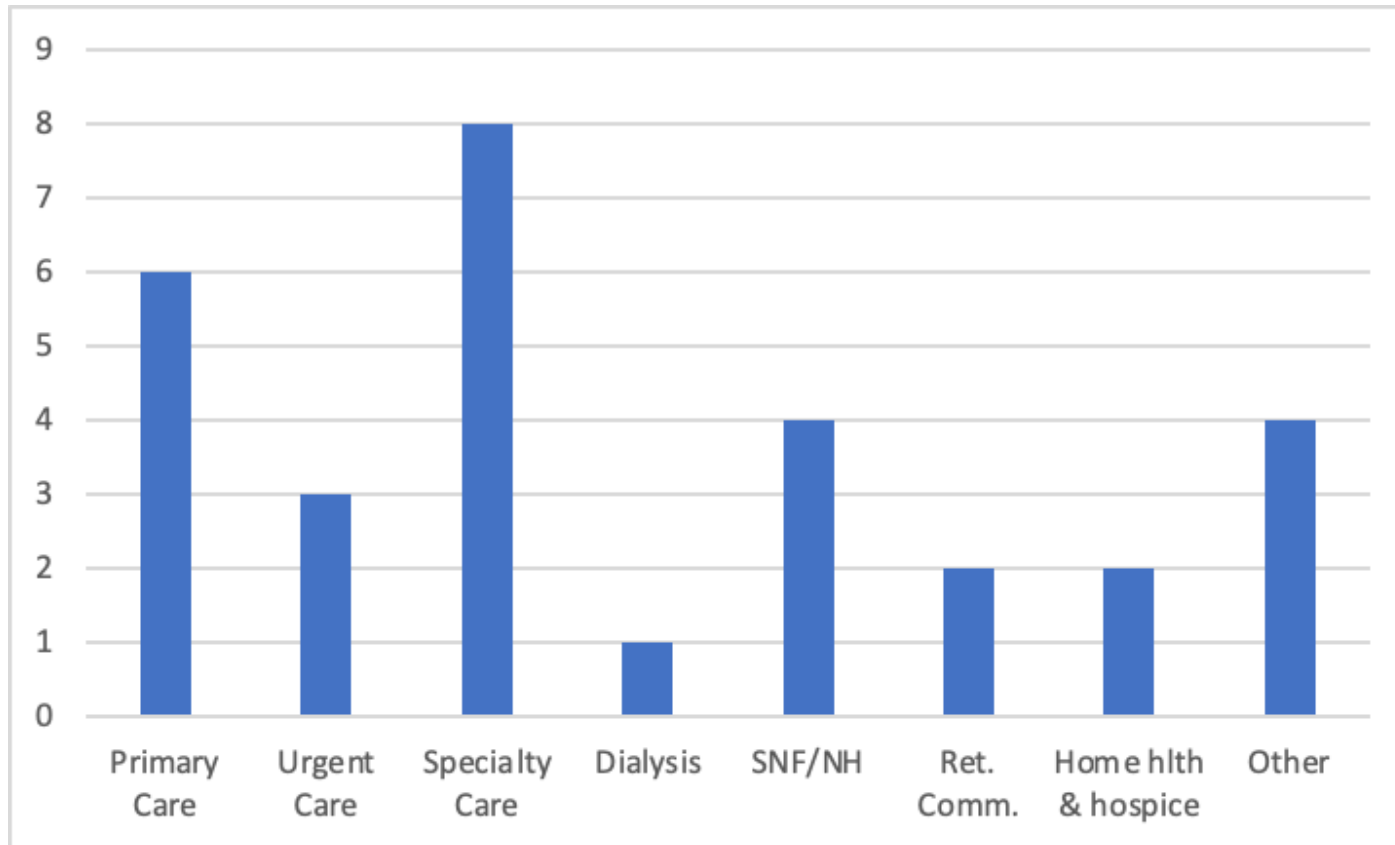
# VT Resident Spend in NH Upper Valley Region was 13% of Spend in 2021

Medical spend by location and claim type (VT residents)			
Where care was received	Claim type	2021 \$	2021 %
Vermont HSAs 76%	Hospital*	\$1,650,300,126	48.8%
	Professional	\$910,714,145	26.9%
NH Upper Valley Region 13%	Hospital	\$358,777,815	10.6%
	Professional	\$83,274,489	2.5%
Other, Outside Vermont 11%	Hospital	\$174,853,210	5.2%
	Professional	\$202,934,163	6.0%
<b>Total</b>		<b>\$3,380,853,948</b>	<b>100%</b>



Data reported is CY 2021  
\*Hospital includes IP and OP facility

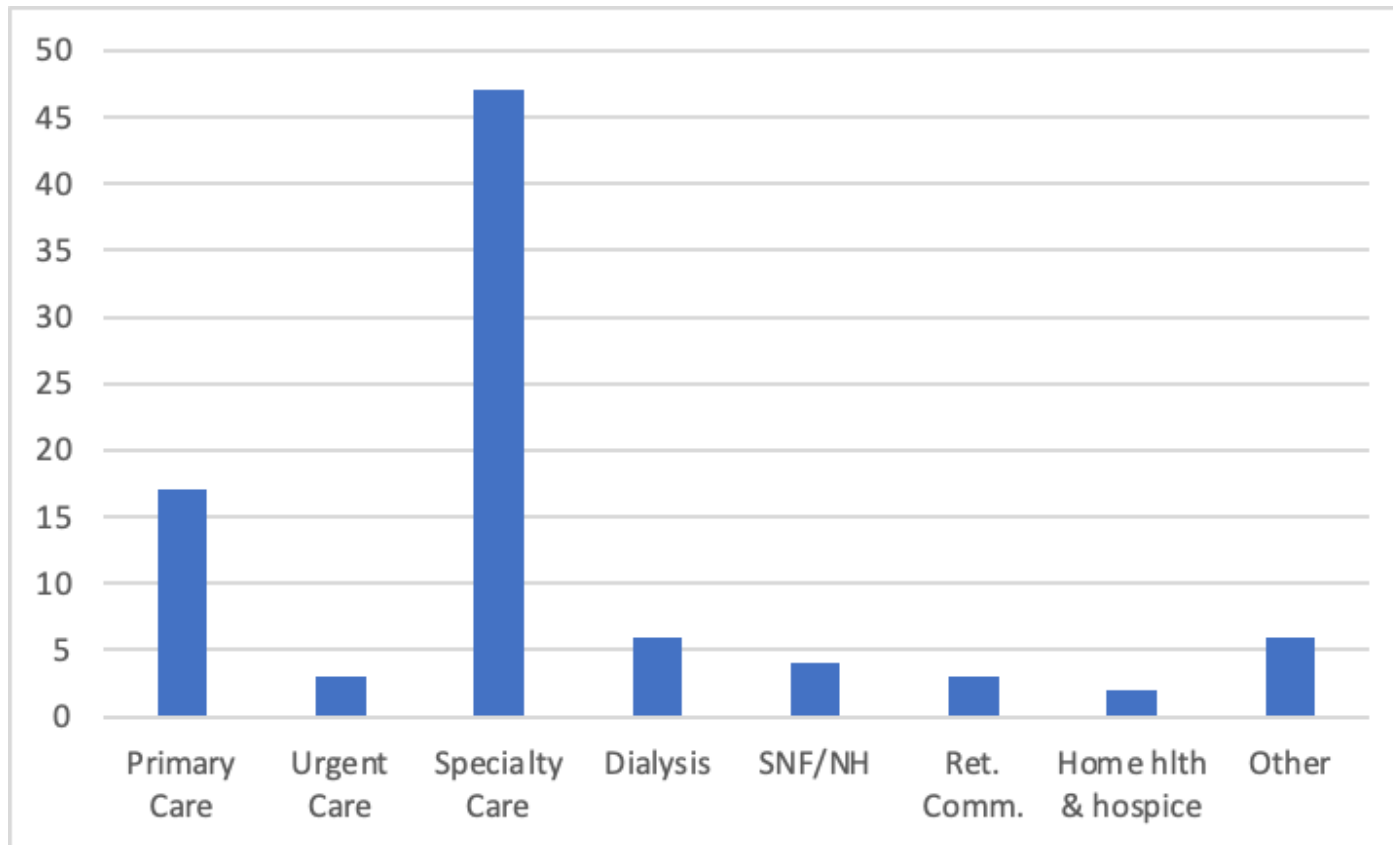
# # Hospitals Owning Each Entity Type



*Other: Pharmacy, Inpatient Psych, FQHC, Adult Day, Ambulance, Medical Group*

# # Owned Entities by Type

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*Other: Pharmacy, Inpatient Psych, FQHC, Adult Day, Ambulance, Medical Group*