Hospital Global Budget Technical Advisory Group

FEBRUARY 28, 2023
MEETING #2

Meeting Agenda

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

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

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 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

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

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

Objectives

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

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

- 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

MD All-Payer

Included

Inpatient services

ED services

Hospital outpatient department services

Excluded/FFS

For academic medical centers, services provided to non-residents receive FFS reconciliation

PA Rural

Included

Inpatient services

ED services

Hospital outpatient department services

Excluded/FFS

Provider-based clinics receive FFS reconciliation

Inpatient distinct-unit beds (psych and rehab)

Supplemental payments

DVHA Global Payment Program

Included

Hospital and physician revenue for services included in current VMNG ACO TCOC (inpatient, outpatient, ED, and professional services)

Excluded/FFS

Services outside of current VMNG ACO TCOC (ex: dental, prescription pharmacy, services paid for by other AHS depts)

Supplemental payments

GMCB Hospital Budget Review

Included

Hospital and physician revenue

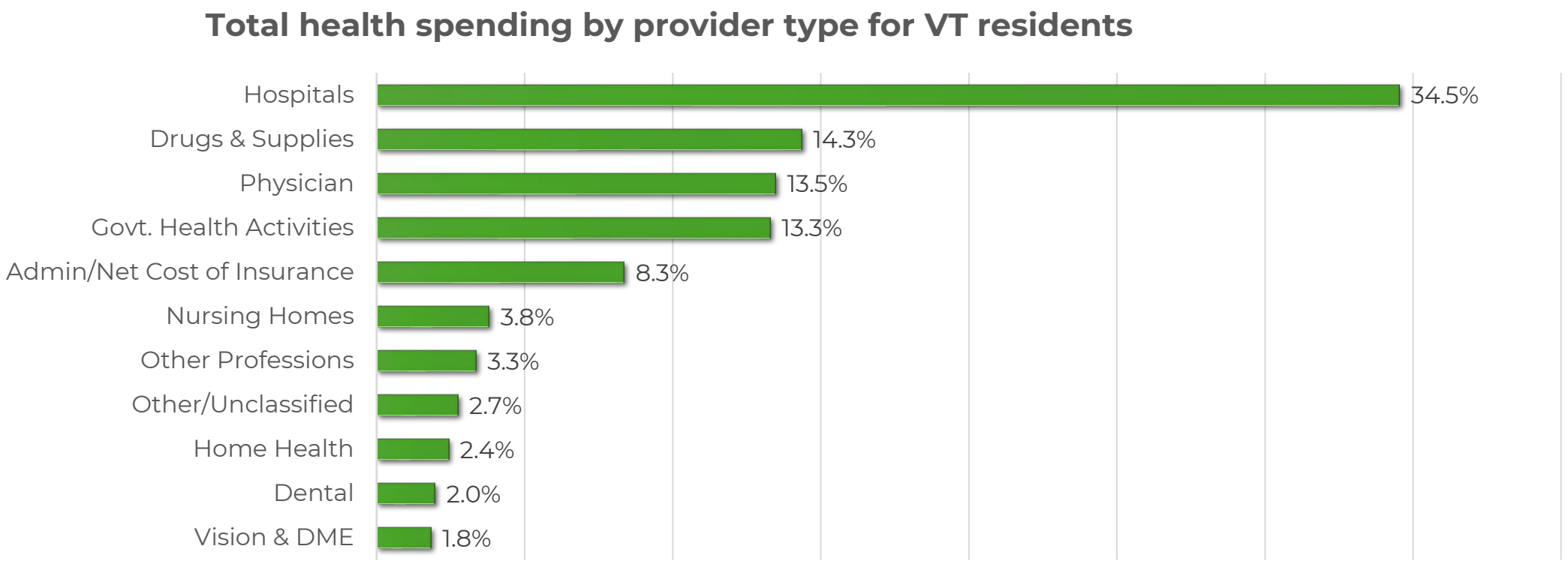
Hospital inpatient and outpatient services

Variable

Professional services and affiliated entities, such as FQHCs and SNFs

Source: Maryland All-Payer Model Evaluation Final Report; The Pennsylvania Rural Health Model (PARHM) Second Annual Evaluation Report

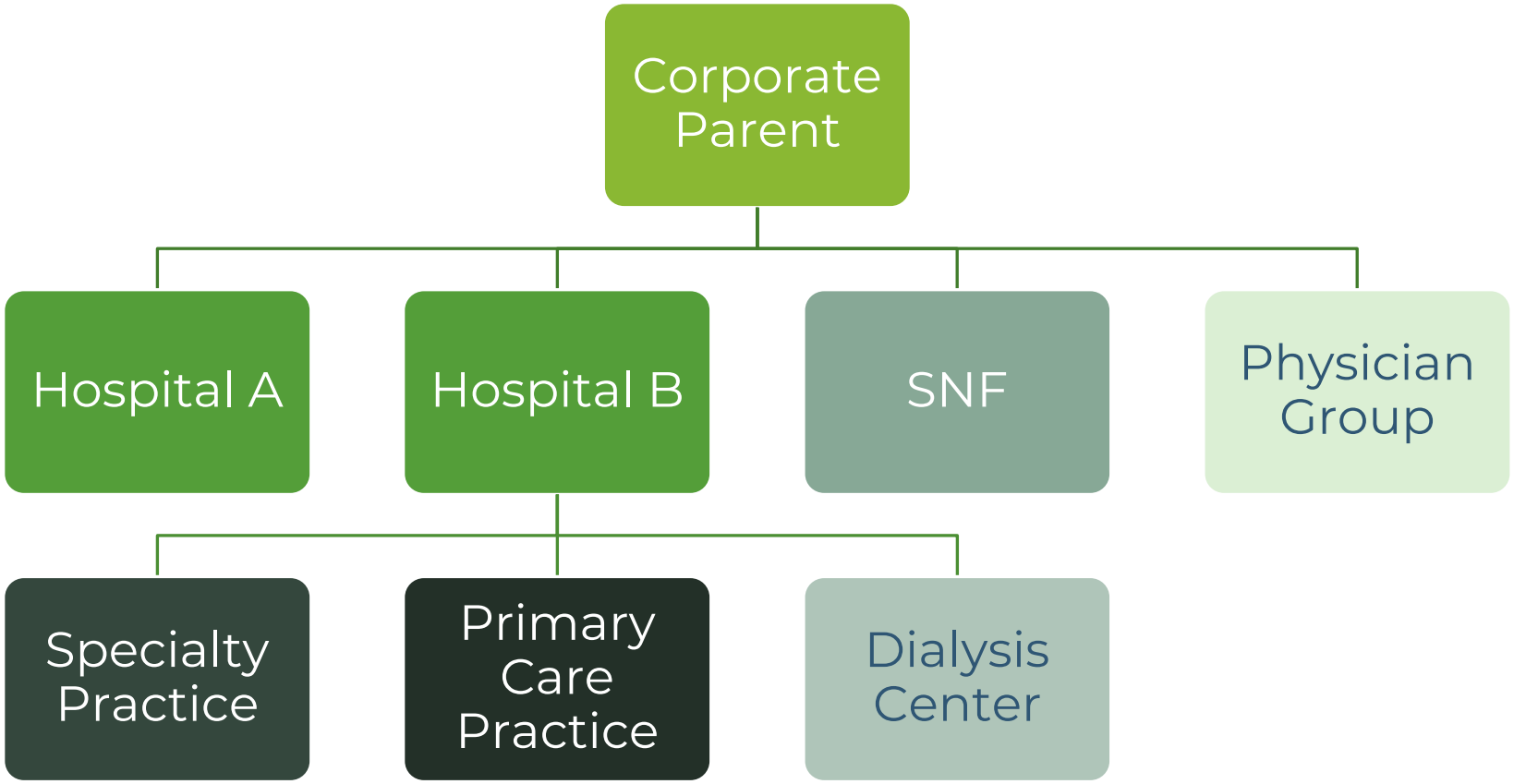
~35% of Vermonters' Total Health Spending is Hospital Spending; Physicians add 14%



Data reported is a blend of FY and CY 2020

Source: Expenditure Analysis - Resident Perspective | Green Mountain Care Board (vermont.gov)

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

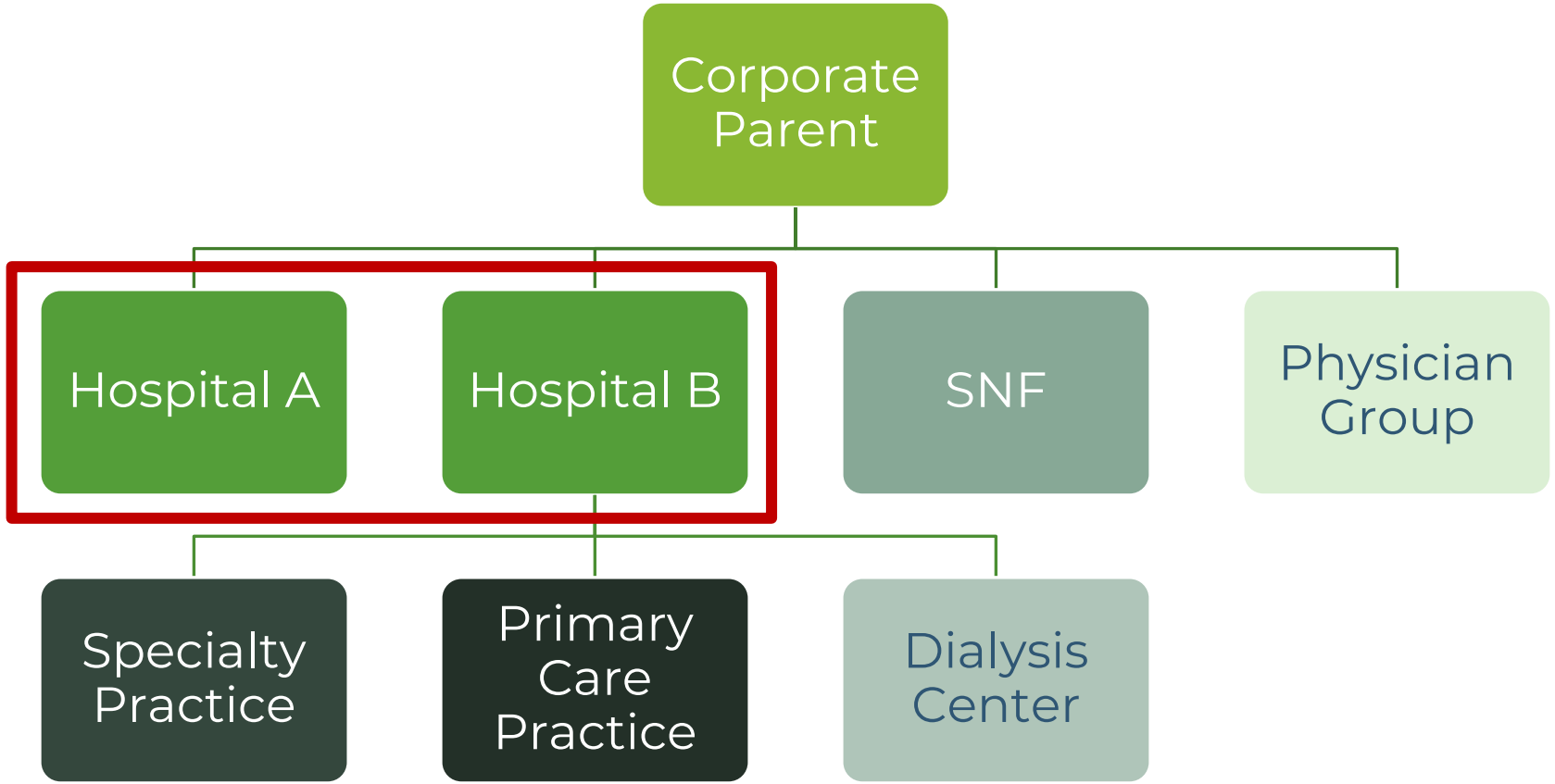


Prior Stakeholder Group Discussion

- Service inclusion was discussed by the AHS/GMCB 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

We are considering IP & OP services delivered at these facilities



Definition of Hospital Inpatient and Outpatient Services

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?

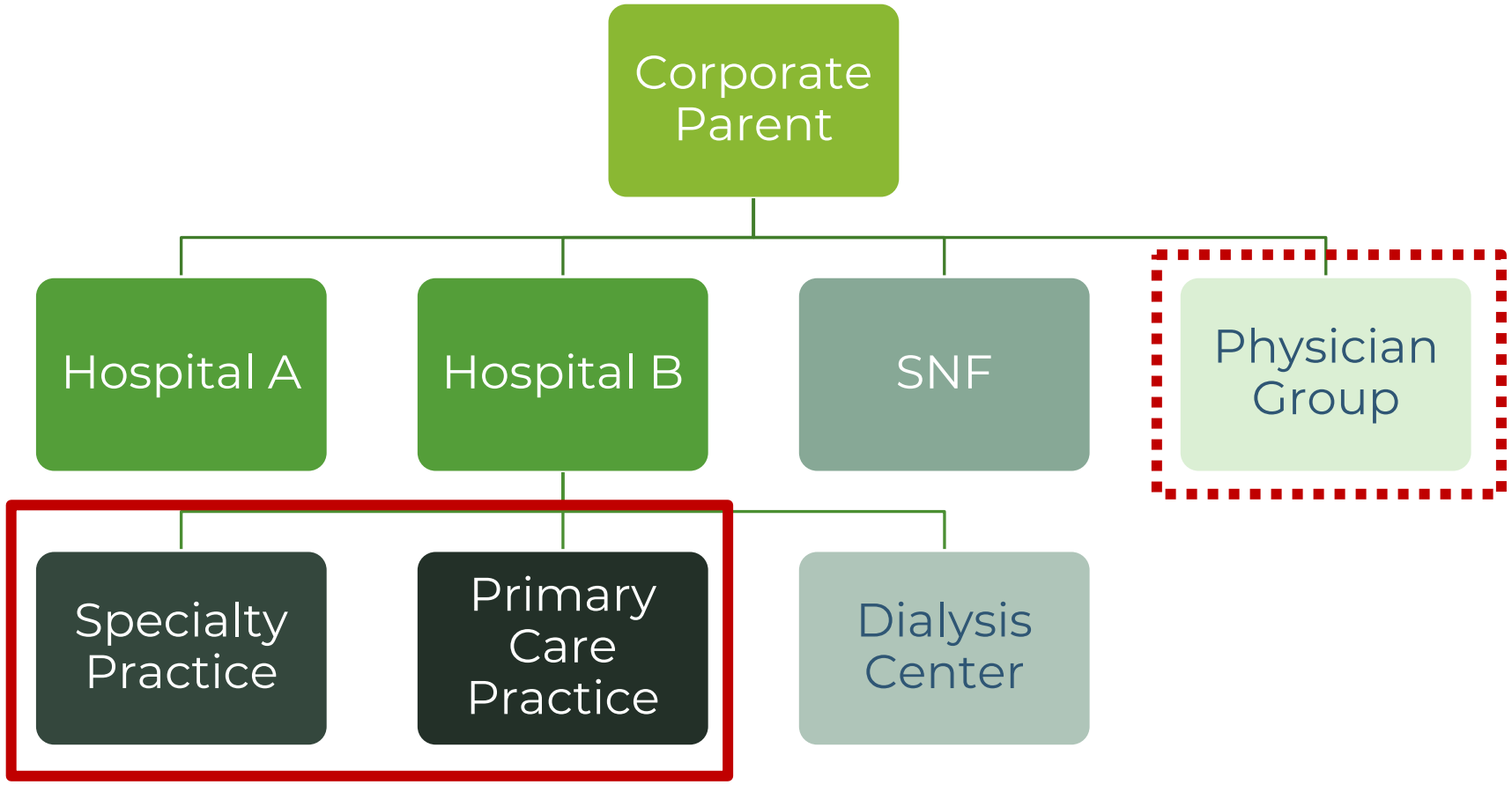
Definition of Hospital Inpatient and Outpatient Services (cont'd)

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

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
UVMMC	$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%
Totals	**$4,462,700,453**	**$869,236,203**	**$5,331,936,656**	**16.3%**

Definition of Professional Services

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.

<u>Discussion:</u>

- 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?

Employed Professionals Billed Under Hospital's TIN	Non-Employed Professionals* Billed Under Hospital's TIN	Non-Employed Professionals* Not 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?	• Is there value in including these professionals? • Are there barriers to doing so?	• Is it valuable to include these professionals? • Is it feasible?

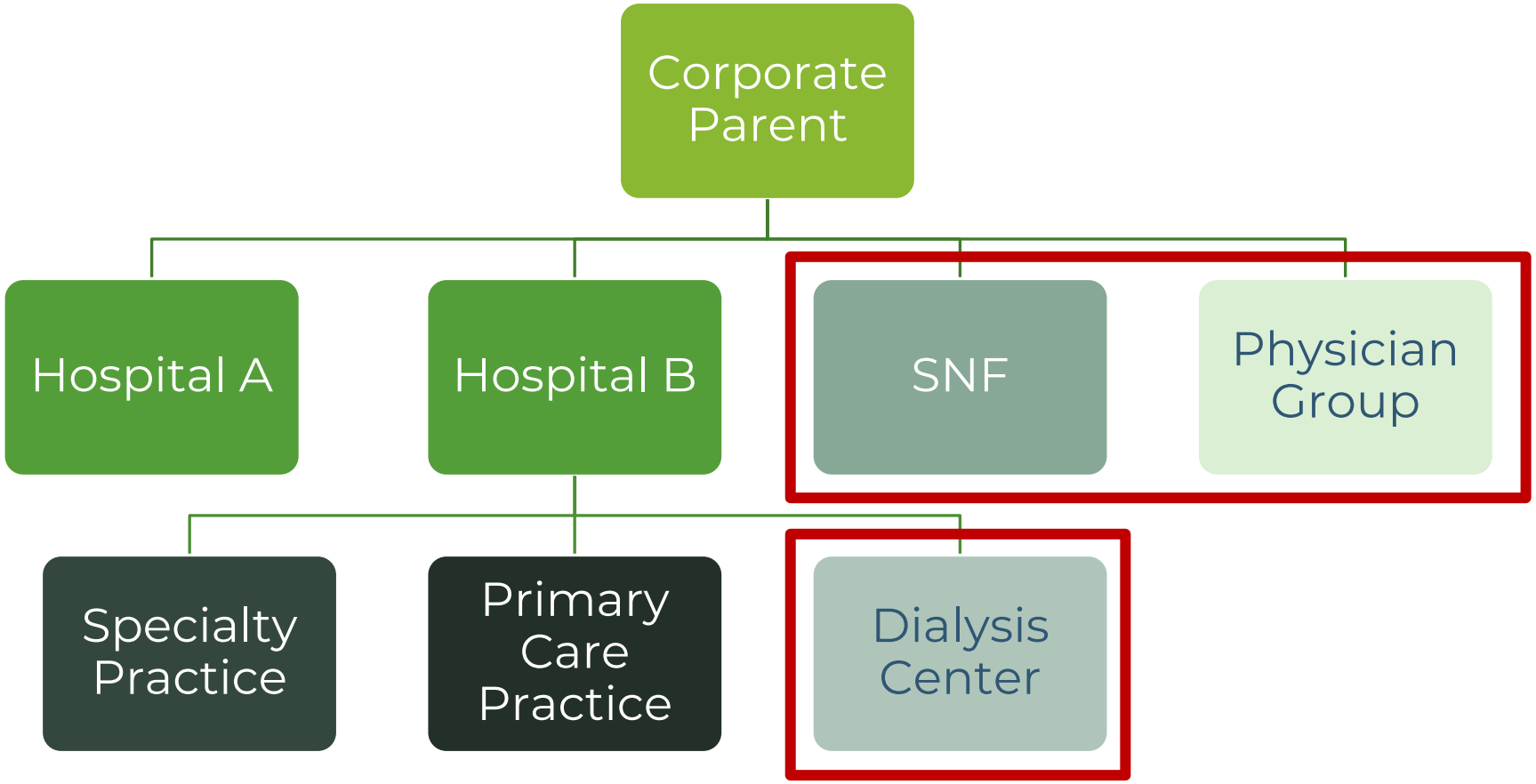
* These could be contracted professionals or non-contracted professionals.

Professional Services: Additional Considerations

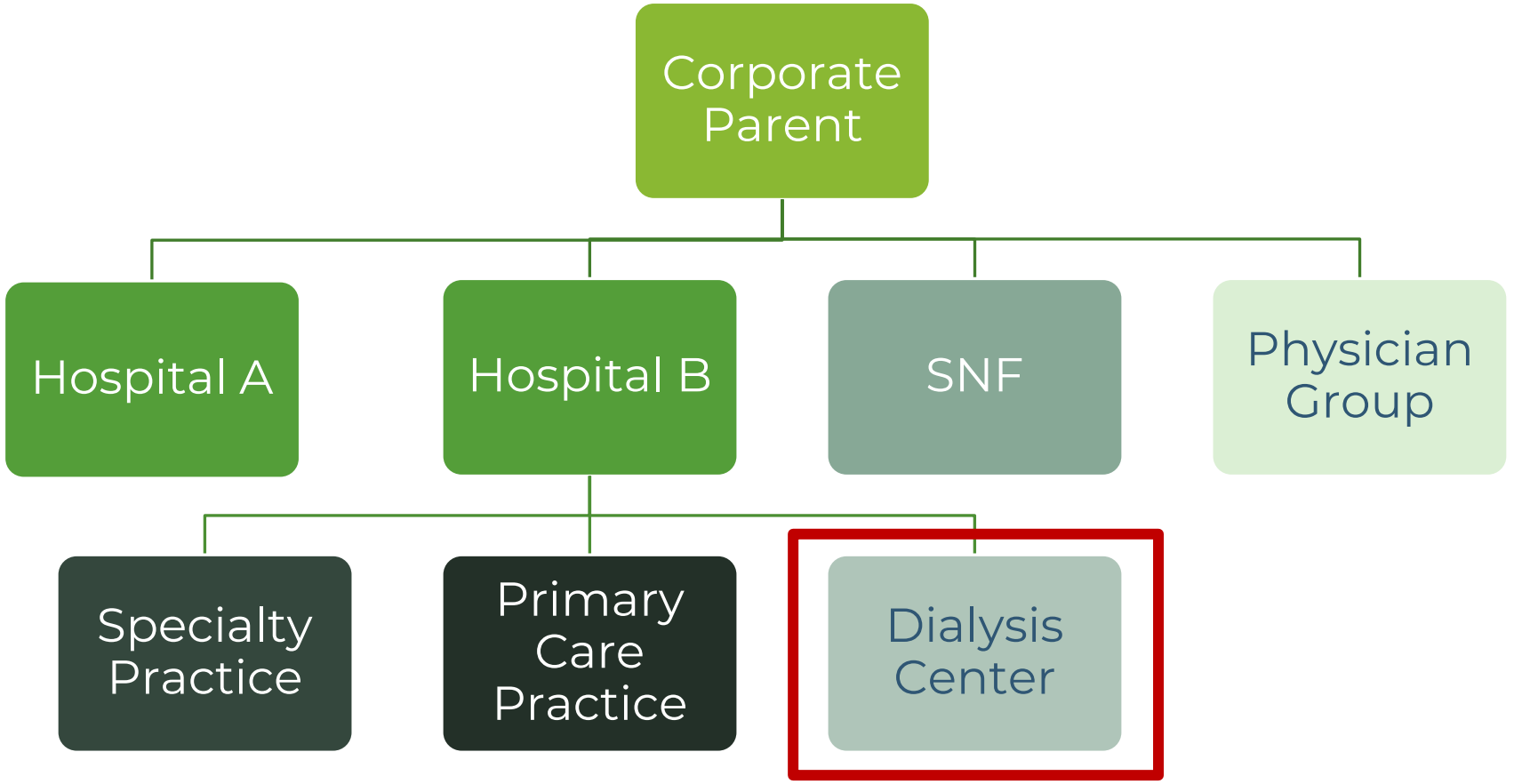
- Are there any potential adverse implications if hospital professional services are in the budget and services provided by non-hospital-owned practices are not?
  - If so, how might we mitigate those adverse consequences?

- 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



Other Services Owned by Hospitals



Hospital Ownership of Non-Hospital Services

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

- 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

- 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

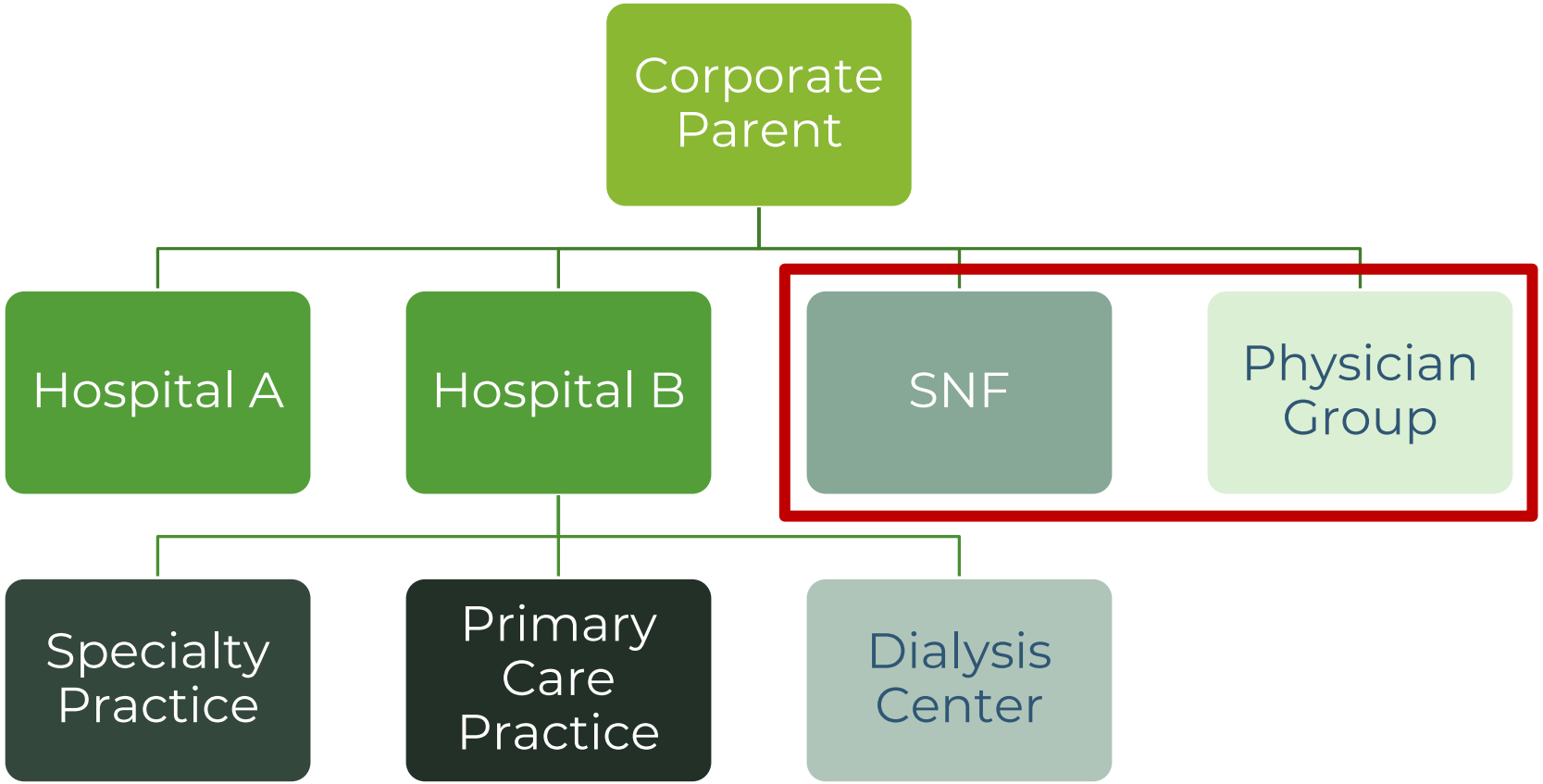
Current VT Hospital Ownership Arrangements: Form 990 Limitations

- 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



Corporate Parent-Owned Entities

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

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

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

Overall Approach to Population-Inclusion

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

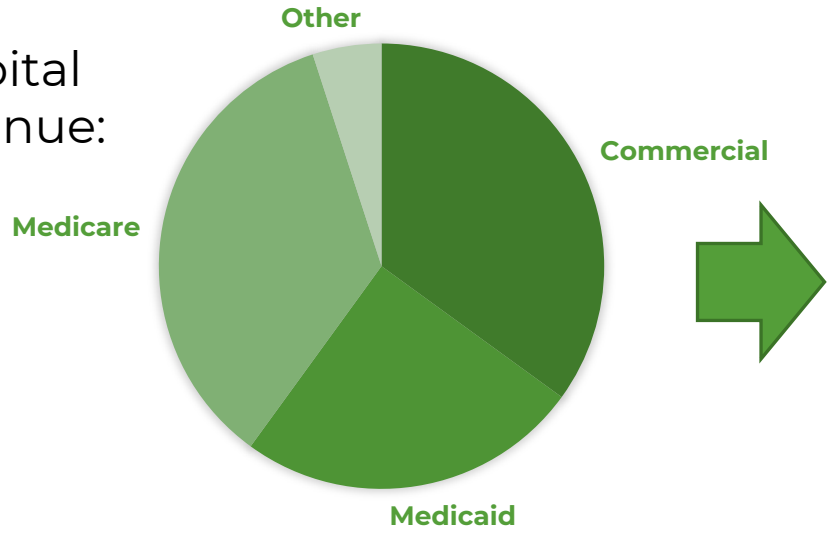
Hospital-based approach:

- 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.

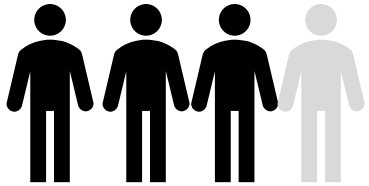
We propose to model budgets with a hospital-based approach.

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

Hospital Revenue:



Carrier A:



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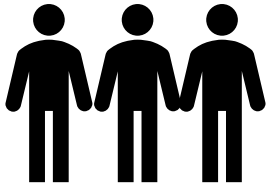
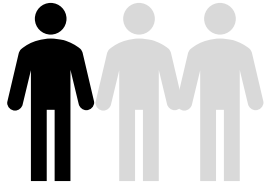


Carrier C:



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?

VT resident

Non-resident

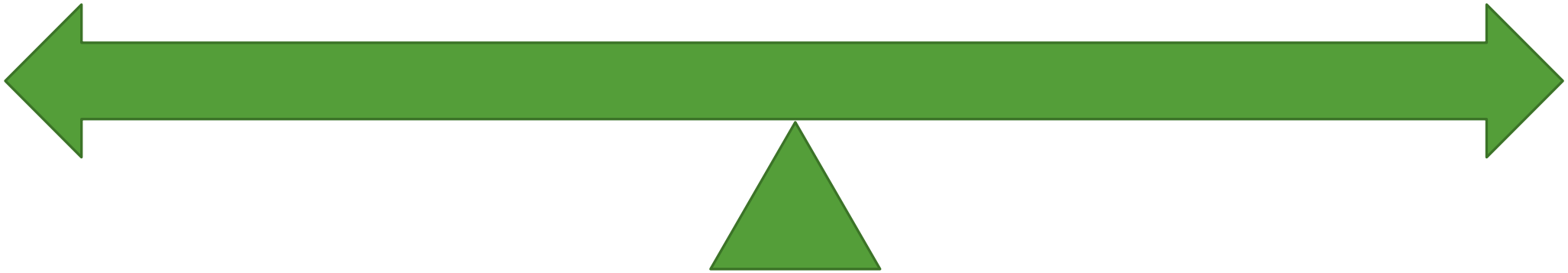
Defining the Population: General Considerations

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



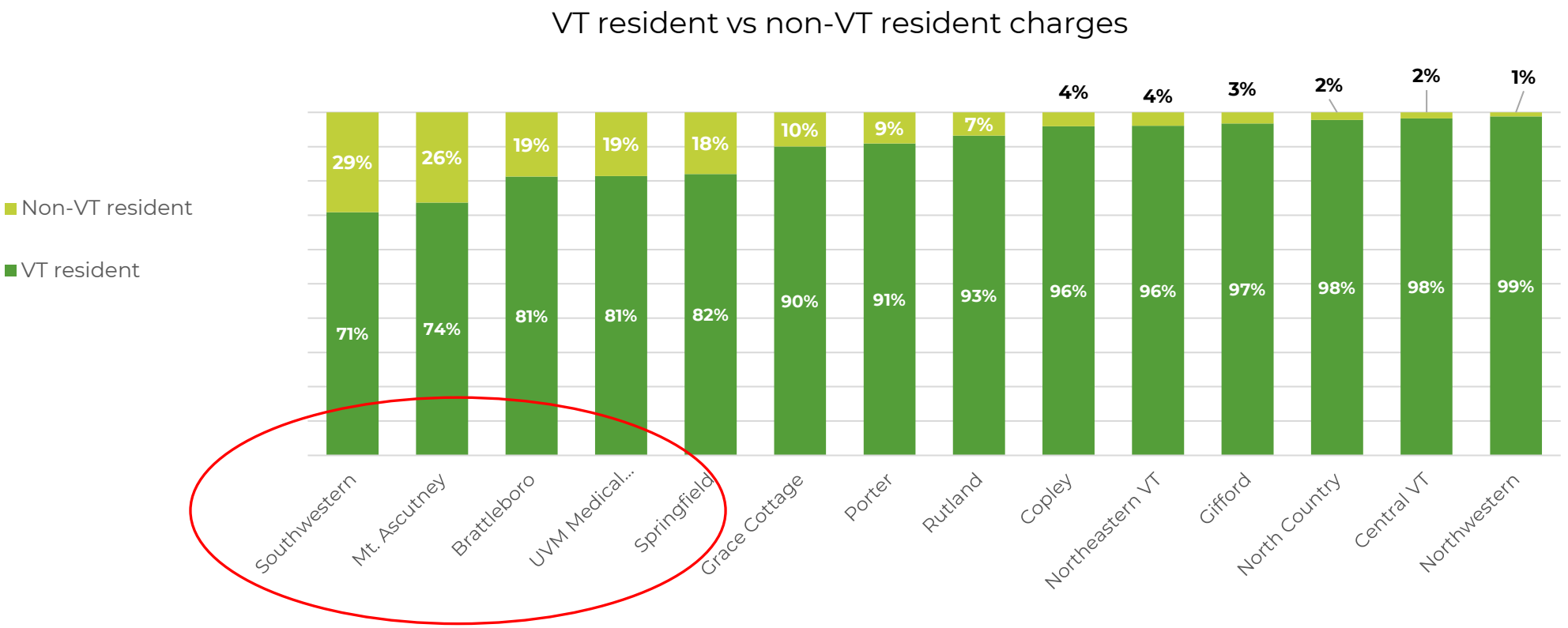
Total Hospital Spending for VT Residents by Payer Type

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
Totals	**100%**	**$ 2,361,358,250**

Data reported is a blend of FY and CY 2019

Source: Expenditure Analysis - Resident Perspective | Green Mountain Care Board (vermont.gov)

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



Data reported is CY 2020

Source: Vermont Uniform Hospital Discharge Data System (VUHDDS)

Medicaid Population: VT and Non-VT Resident Charges

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

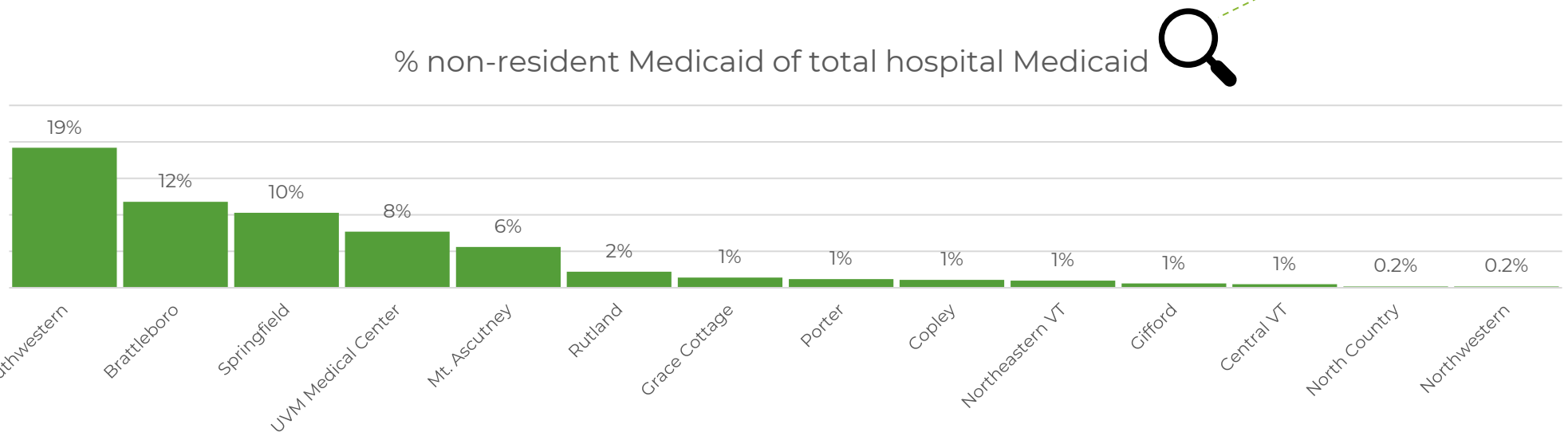
17%

Medicaid charges for care provided to Vermont Medicaid members

94%

Medicaid charges for care provided to Medicaid members from other states

6%



CY 2020 data
Source: VUHDDS

Defining the Population: Medicaid

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

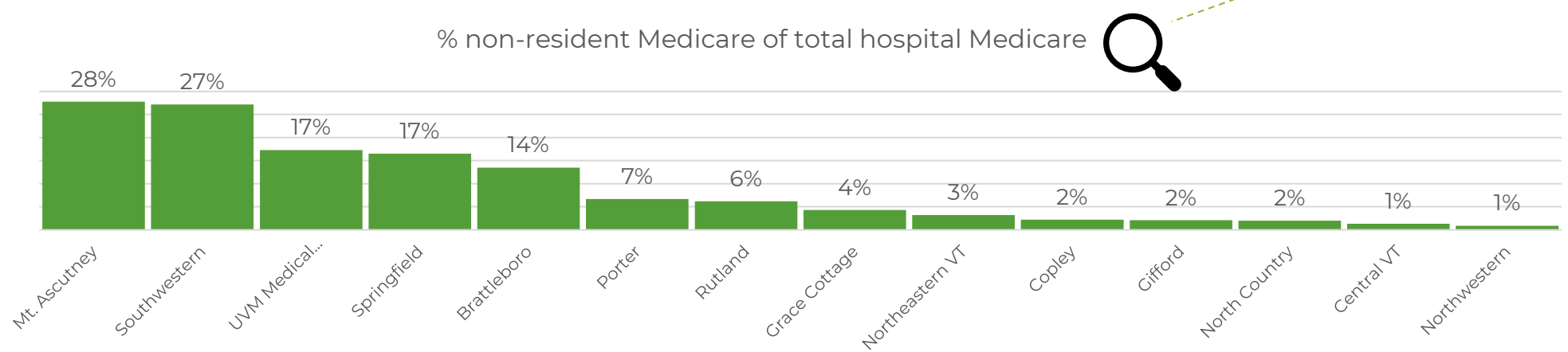
48%

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%



CY 2020
Source: VUHDDS

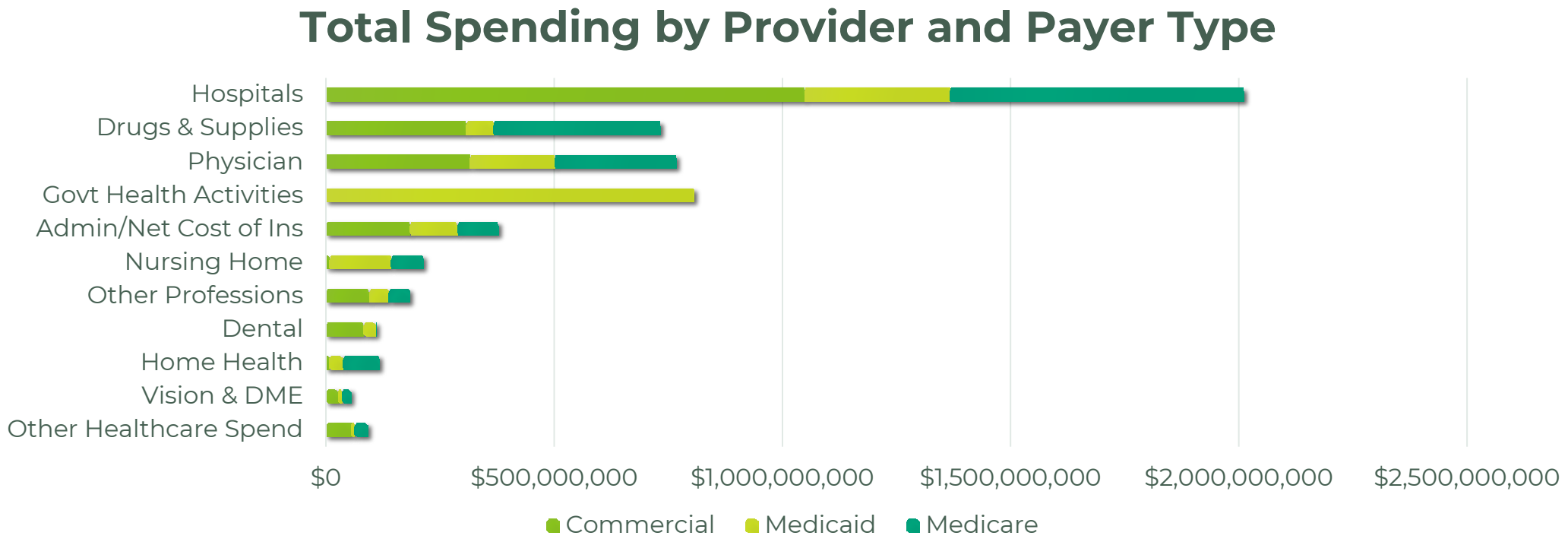
Defining the Population: Medicare

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



Data reported is a blend of FY and CY 2019

Source: Expenditure Analysis - Resident Perspective | Green Mountain Care Board (vermont.gov)

Commercial Population: VT and Non-VT Resident Charges

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

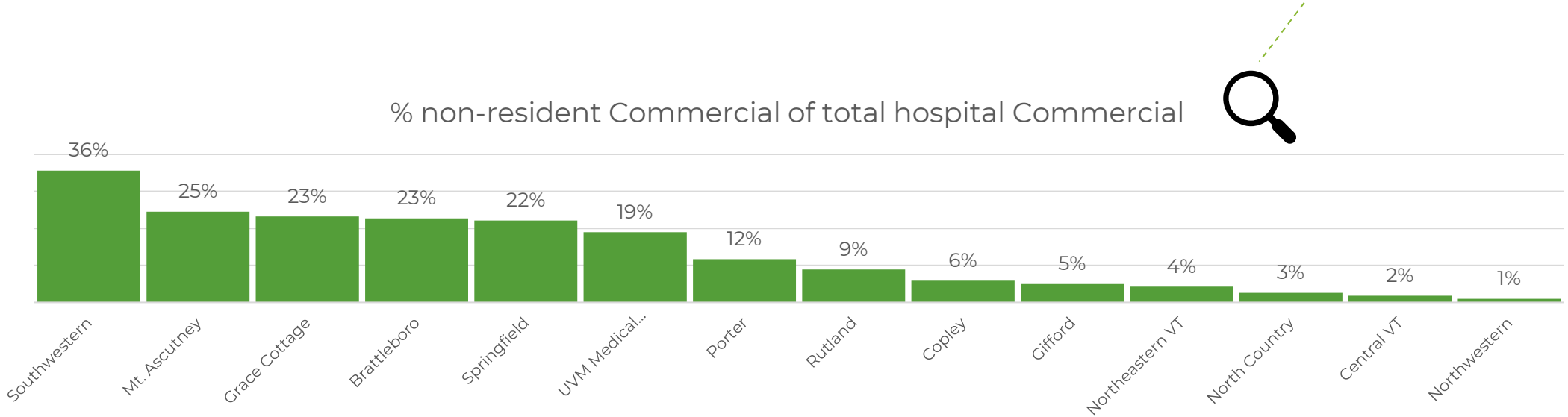
21%

Commercial charges for care provided to Vermont members

84%

Commercial charges for care provided to Commercial members from other states

16%



CY 2020 data
Source: VUHDDS

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
Total	**100%**	**122,737**

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
Total	**100%**	**85,988**

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
Total	**100%**	**15,662**

7% **of total commercial lives**

Data reported is from December 31, 2020
*Refers to payers with less than 500 lives

Source: VT Annual Market Share Report

Defining the Population: Commercial

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

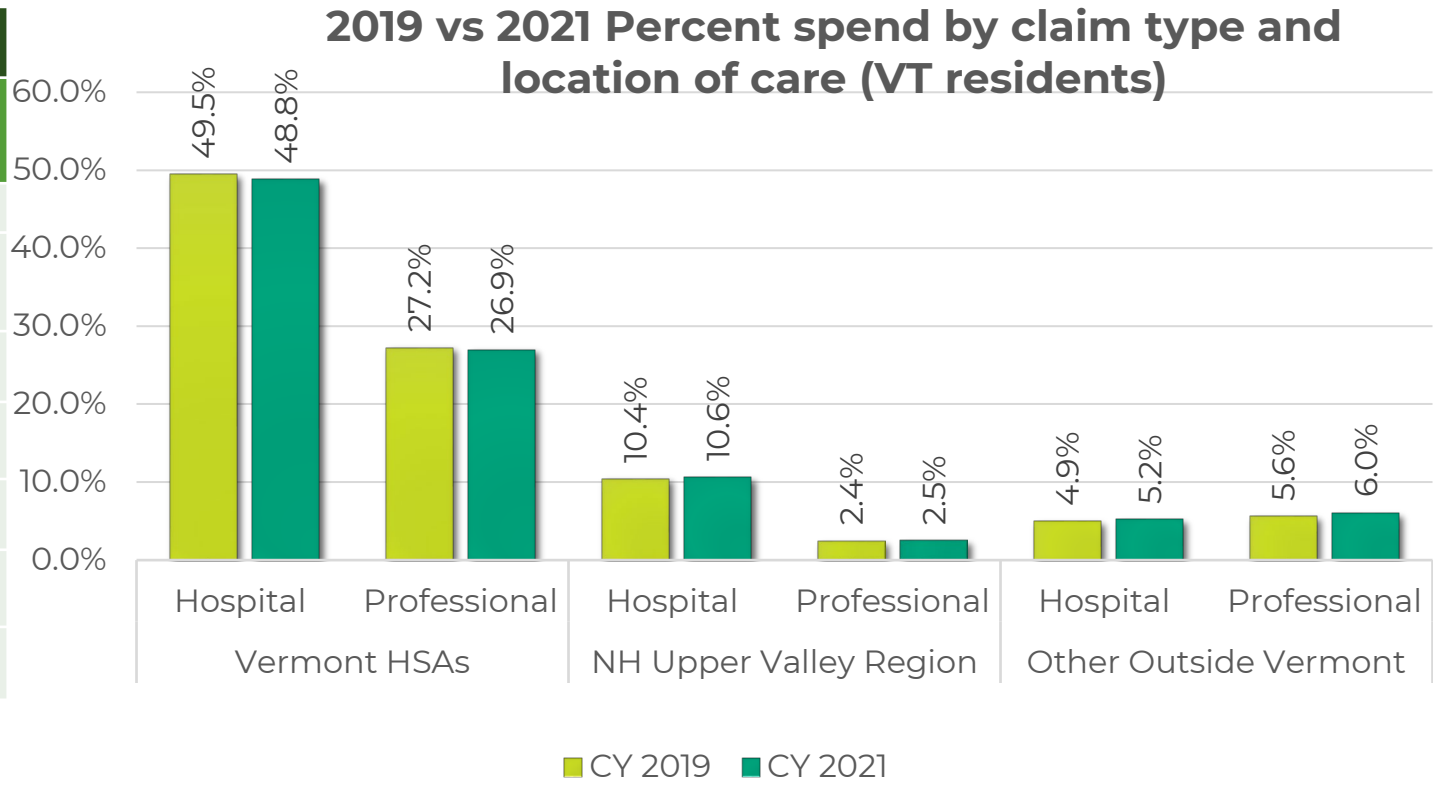
In this section, we discussed:

- 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

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

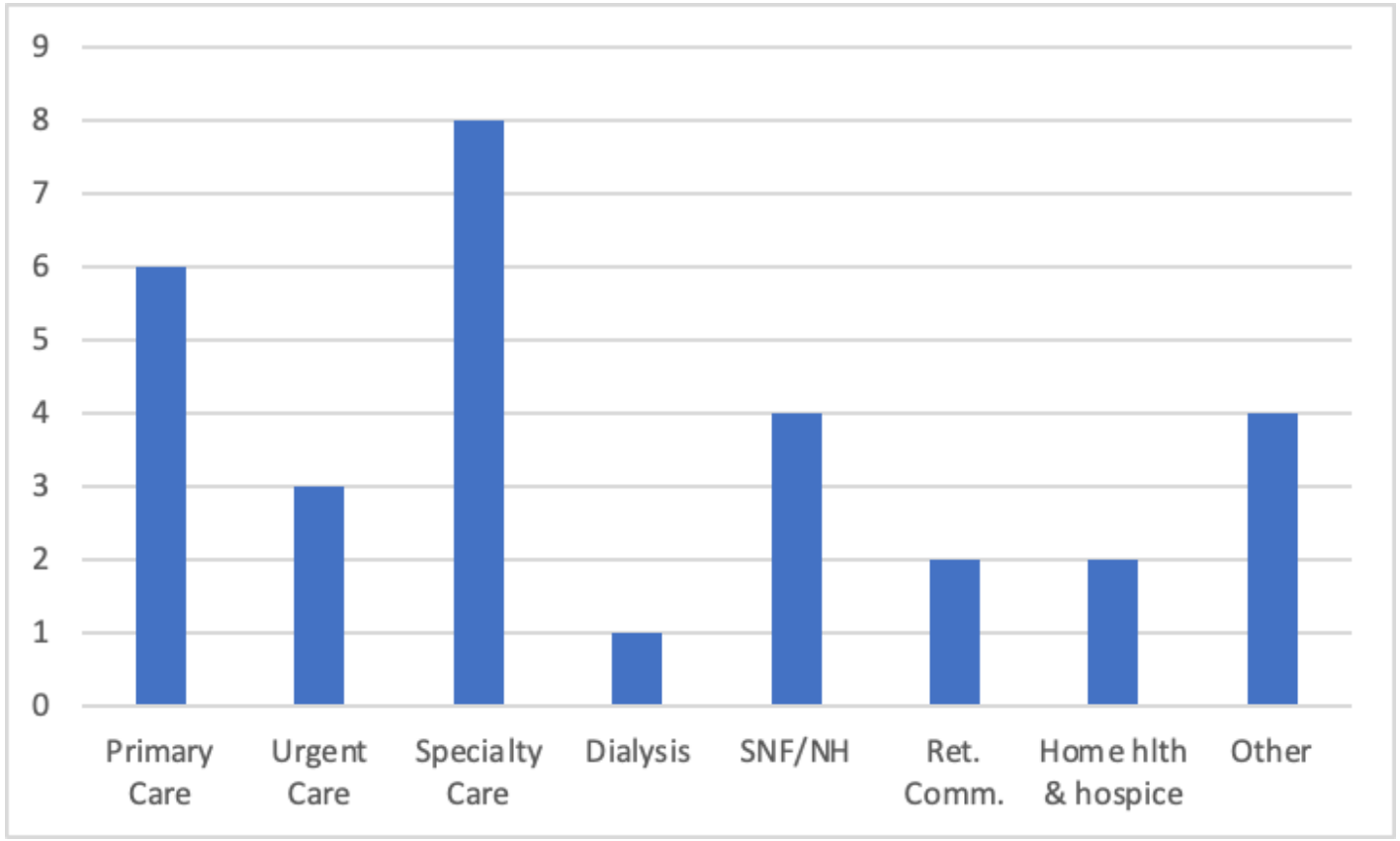
Medical spend by location and claim type (VT residents)			
Where care was received	**Claim type**	**2021 $**	**2021 %**
Vermont HSAs 76%	Hospital*	$1,650,300,126	48.8%
	Professional	$910,714,145	26.9%
NH Upper Valley Region 13%	Hospital	$358,777,815	10.6%
	Professional	$83,274,489	2.5%
Other, Outside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



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

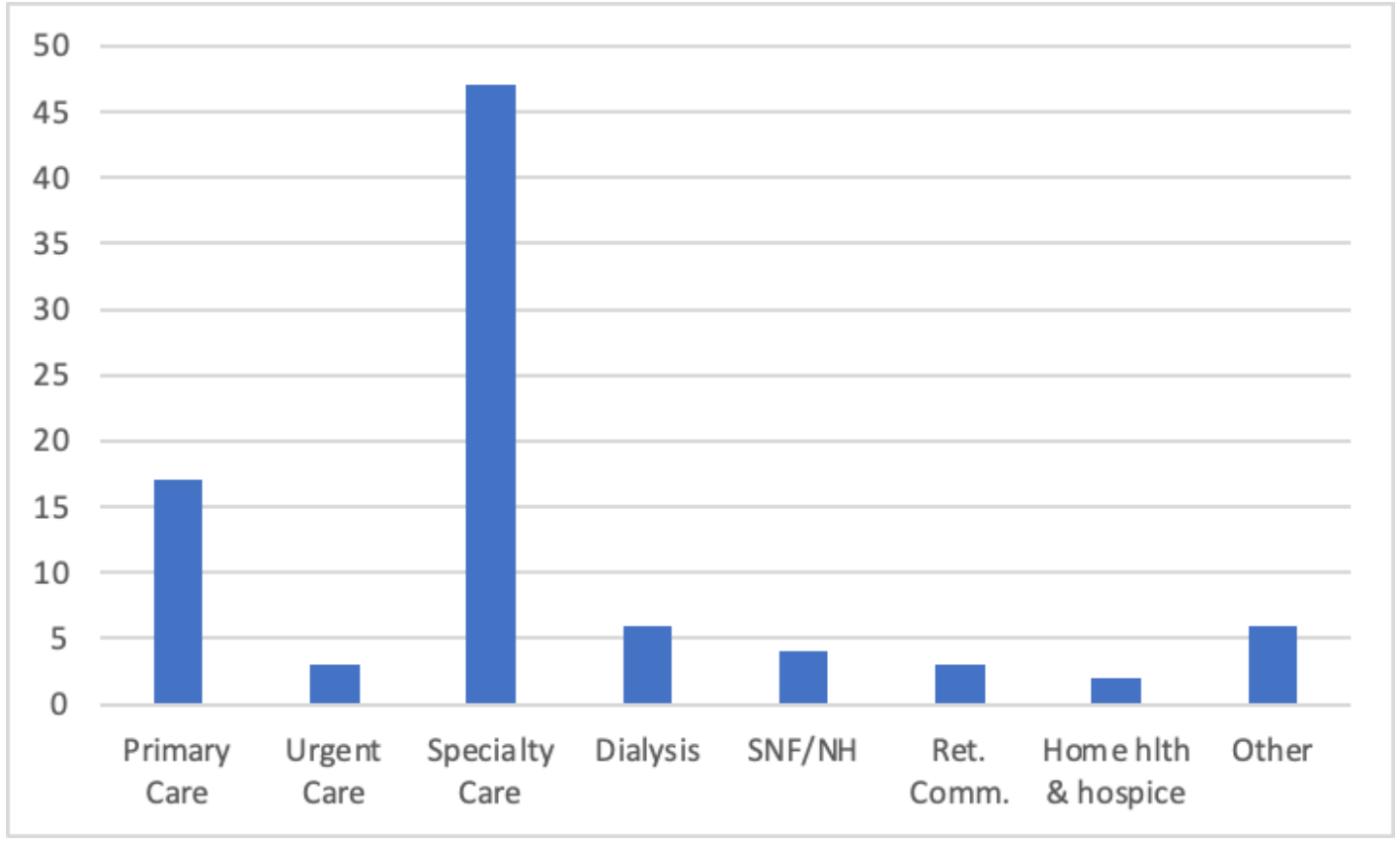
Source: Patient Migration | Green Mountain Care Board (vermont.gov)

Hospitals Owning Each Entity Type



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

Owned Entities by Type



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