Hospital Global Budget Technical Advisory Group

MARCH 28, 2023
MEETING #4

Meeting Agenda

1. Recap of prior meeting discussion
2. Calculation of baseline budgets

Recap of March 14th Meeting

Services to be Included in a Hospital Global Budget (1 of 3)

Hospital-owned non-hospital services

- Group members supported initial inclusion of at least some hospital-owned services, with potential for phased inclusion of additional services over time.
- Members discussed how including only some hospital-owned could create undesirable dynamics (e.g., incentivizing hospitals to acquire previously independent services or divest from owned services).
- One member conveyed that when only one hospital/health system owns or operates a particular type of service (e.g., UVMHN ownership of dialysis centers), that service should be excluded as the owning hospital does not have control over utilization when referrals come from entities across the state.
- Another member expressed support for including costly services that have wide variability in utilization (e.g., dialysis and pharmacy), as inclusion could help to address opportunities for cost reduction.

Services to be Included in a Hospital Global Budget (2 of 3)

Hospital-owned non-hospital services (continued)

- As next steps, the state will 1) conduct an inventory of all hospital-owned and corporate parent-owned services to inform continued discussion of which of these services to include in global budgets, including which should be prioritized for inclusion at the outset and which should be phased in over time, and 2) further consider the implications of including services for which there are also independent providers.

Corporate parent-owned non-hospital services

- Members discussed that some corporate parent entities do not provide health care services, and should therefore not be subject to a global budget.
- For corporate parent entities that own health care services directly (e.g., UVMHN ownership of home health and hospice), services could be included in a hospital's global budget if those services can be appropriately allocated to a specific hospital based on geography or other factors.

Services to be Included in a Hospital Global Budget (3 of 3)

Corporate parent-owned non-hospital services (continued)

- Members noted corporate ownership structures change, so budgets may need to.
- The model should not contain a blanket inclusion/exclusion for these services.
- The group will revisit which corporate parent-owned entities to include on a case-by-case basis following completion of the ownership inventory.

Blueprint Community Health Teams (CHTs)

- Most members who commented conveyed support/neutrality regarding the inclusion of CHTs. Those supporting cited ease of administration with no separate payment stream.
- Several members emphasized if CHTs are included, the model should incorporate continued – and potentially additional – transparency and tracking to ensure that funding is being maintained and used for the intended purpose.
- A co-chair expressed concern with inclusion, citing that the CHT construct has served as an important mechanism for care delivery innovation.
- Hospitals are not always the health service area administrative entity that receives and administers CHT funds.

Potential Flexibilities and Waivers Needed for Non-Hospital Services Inclusion

- The group discussed that some components of the global budget model may require changes to or waivers of existing state and federal laws and/or regulations.
- Several members cited existing federal waivers under the current APM that should be continued, including waivers of the Stark law (physician self-referral) so that clinicians can collaborate to impact the global budget, and maintaining the SNF 3-day rule waiver. One member expressed interest in exploring waivers specific to CAH payments.
- One member acknowledged that contractual barriers could exist, in addition to statutory or regulatory barriers. The state invited members to confidentially identify any such barriers.
- Throughout the group's process, the state will continually solicit input from members regarding any potential barriers that could limit or inhibit global budget implementation, and any recommended waivers or other flexibilities that may be needed.

Populations to be Included in a Hospital Global Budget (1 of 2)

- Group members supported including only VT Medicaid members in global budgets (i.e., not members of other state Medicaid programs).
- Members largely supported including all Medicare FFS beneficiaries (VT residents and non-VT residents) in the model.
- A few group members shared slight concerns with including non-residents, citing 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.
- Members supported, for modeling purposes, including commercial self-insured, fully-insured, and Medicare Advantage, including both VT and non-VT residents with commercial insurance.

Populations to be Included in a Hospital Global Budget (2 of 2)

- Several members voiced support for including as many commercial payers as possible.
- One group member expressed concern from the hospital perspective with engaging payers with whom the hospital has no contractual relationship.
- Several members recommended that, for the purposes of determining a revenue threshold for including commercial payers in the modeling, the threshold should be based on a percentage of a hospital's budget, rather than a dollar amount for revenue.

Calculating Baseline Budgets

Meeting Objectives

1. Discuss the key components for constructing baseline budgets and develop recommendations, including for:
   - Selecting a “top-down” or “bottom-up” approach
   - Defining baseline revenue
   - Determining the base year
   - Calculating budgets at the hospital (rather than system) level
2. Discuss the implications of a fiscal year versus calendar year approach and develop a recommendation.
3. Discuss the planned approach to discussing adjustments with the TAG and obtain input on the topics for the next several meetings.

Establishing Baseline Budgets

Identify baseline revenue

- How is revenue defined?
- Which revenues are *included*?
- Which revenues are *excluded*?
- Which base year is used?

Apply any adjustments

- We will discuss this in meeting #5

Trend forward to performance year

- We will discuss this in meeting #5

Note that our conversation today will focus on identifying the information that goes into the **base budget**. We will discuss adjustments and trends in meeting #5 and beyond.

What Approach Should We Use to Calculate Budgets? (1 of 4)

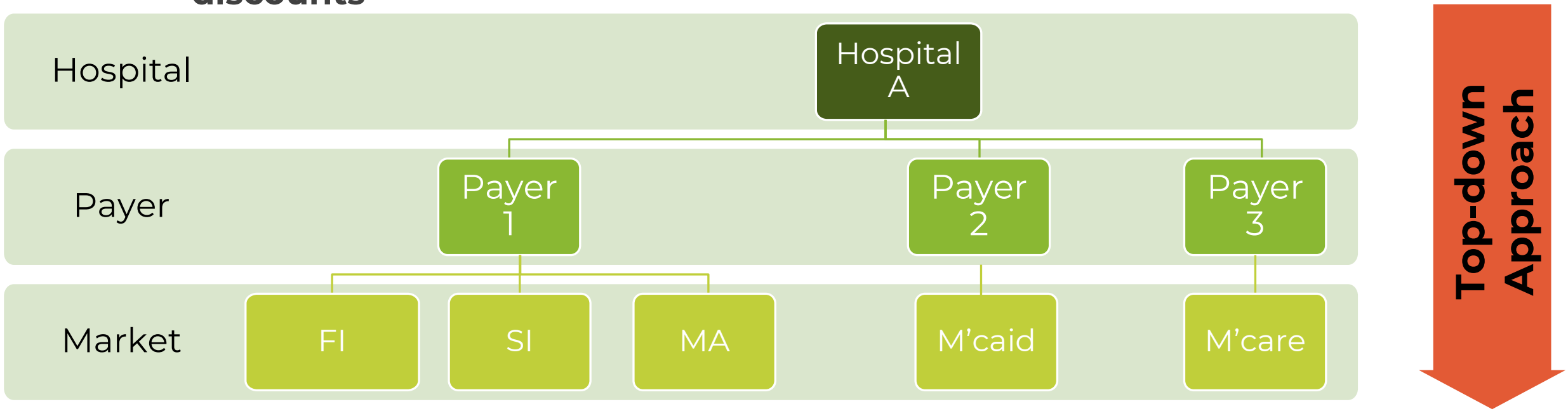
There are two primary approaches for calculating budgets.

1. **Top Down (MD)**
2. **Bottom Up (PA)**

What Approach Should We Use to Calculate Budgets? (2 of 4)

In a **top-down approach**, the hospital would have **one primary budget** across all payers and markets.

- Begin with **total hospital revenue**
- Calculate **payer-specific budgets** based on **market share** and **payer discounts**



What Approach Should We Use to Calculate Budgets? (3 of 4)

Hospital global budgets can also be calculated using a **bottom-up approach**.

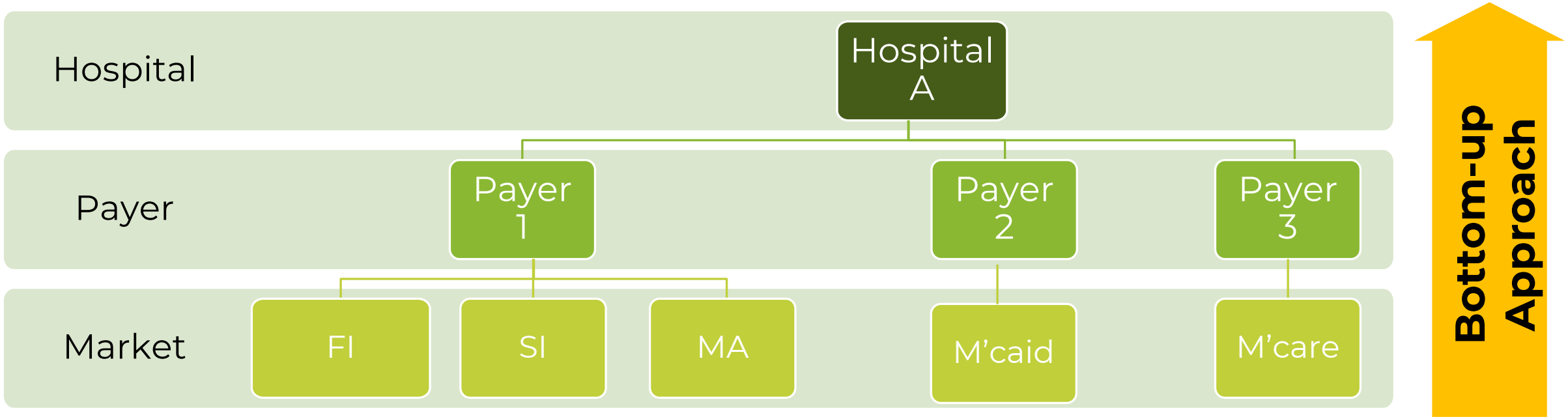
- This approach relies on payers and hospitals establishing **individual payer budgets** for each hospital.
- For each hospital, this approach could generate:

  (a) one budget for each payer across markets, or

  (b) individual budgets for each payer/market dyad

What Approach Should We Use to Calculate Budgets? (4 of 4)

In this example, a hospital would have **at least three budgets** (one for each payer) and **possibly five budgets** (one for each payer/market dyad).



Top-Down vs. Bottom-Up Approach: Comparison

Top-Down (One Budget, Apportioned to Payers) Budget Calculation	Bottom-Up (Payer-Specific) Budget Calculation
• Calculated consistently across all payers, could promote more consistency and equity across payers. • Does require a third party to take on this task. • Would need to account for differing baseline payment rates across payers.	• Leaves room for payers and hospitals to negotiate and for variation between payers. • Payers and hospitals could take on these calculations themselves, or a third party could play this role (as in PA). • Small payer-specific budgets can be challenging.

- Are there other additional advantages or disadvantages to choosing a top-down or bottom-up approach?

Top-Down vs. Bottom-Up Approach: Discussion

- Which do you recommend adopting and why?
- If a bottom-up approach is used, would you recommend adopting:
  - (a) one budget for each payer across markets, or
  - (b) individual budgets for each payer/market dyad?

Defining Hospital Revenue

- We've previously discussed whether the global budget baseline should be based on revenue or cost.
  - MD and PA use hospital revenue (really, claim-based payments) as the primary data source to define baseline budgets.
- **We recommend using actual revenue** for the following reasons:
  - Revenue reflects the dollars that payers currently pay into the system.
  - There is no established mechanism for determining "optimal" costs.
- If desired, actual hospital expenses could be reflected in:
  - Baseline budget adjustments
  - Other performance and budget adjustments considered as part of the annual update process
- We will begin the discussion of adjustments in meeting #5.
- Are there any questions or concerns about this approach?

Which Commercial Payer Revenues Should be Included?

- For each payer type, we will need to consider which revenues should be included in calculating the baseline budget.
- For **commercial payers**, we propose that revenues should include *claims-based payments*.
- Should *non-claims-based payments*, such as incentive payments and care coordination payments, be included?
- Are there other specific Commercial payment types that should be considered for inclusion?

Which Medicaid Revenues Should be Included?

- For **Medicaid**, we propose that revenues should include claims-based payments.
- Should non-claims-based payments also be included?
- We propose to exclude all supplemental payments (e.g., DSH and GME payments) from the global budget model.
- Are there other payment types that should be discussed?
- What feedback do you have for this proposed approach?

Which Medicare Revenues Should be Included?

- For Medicare FFS in the CHART program, baseline budgets took into consideration the following:
  - Hospital Part A and Facility Part B CMS paid amounts
  - Adjustments related to national Medicare quality hospital programs
  - No change to medical education payments, Low Volume Adjustments, bad debt payment amounts etc.
- We anticipate that CMMI will specify Medicare's approach later this year. We are not yet clear on how much flexibility states will have.

Considerations for Including Services Beyond Hospital & Professional Services

- In prior meetings, this group has considered possibly including the following additional hospital-owned service types:
  - Hemodialysis
  - Home health & hospice
  - SNF, nursing home
  - Mental health/SUD
  - Pharmacy
  - Rehab/PT
  - Other specialty care
  - Urgent care clinics
- For each of these services, we would like to understand whether there are specific sources of revenue that should be excluded or that might need special consideration. For example:
  - Are there specific types of bundled payments that might make it challenging to calculate baseline revenue?
  - Are there certain types of services where there might be marked variation in billing practices across facilities, making it difficult to consistently calculate baseline revenue?

What Year(s) of Data Should We Use to Determine the Baseline Budget? (1 of 2)

States typically use historical financial data from one or more prior years to establish baseline expenditures.

MD All-Payer and TCOC Model	PA Rural Health Model
Most recent prior year	Average across three most recent prior years

What Year(s) of Data Should We Use to Determine the Baseline Budget? (2 of 2)

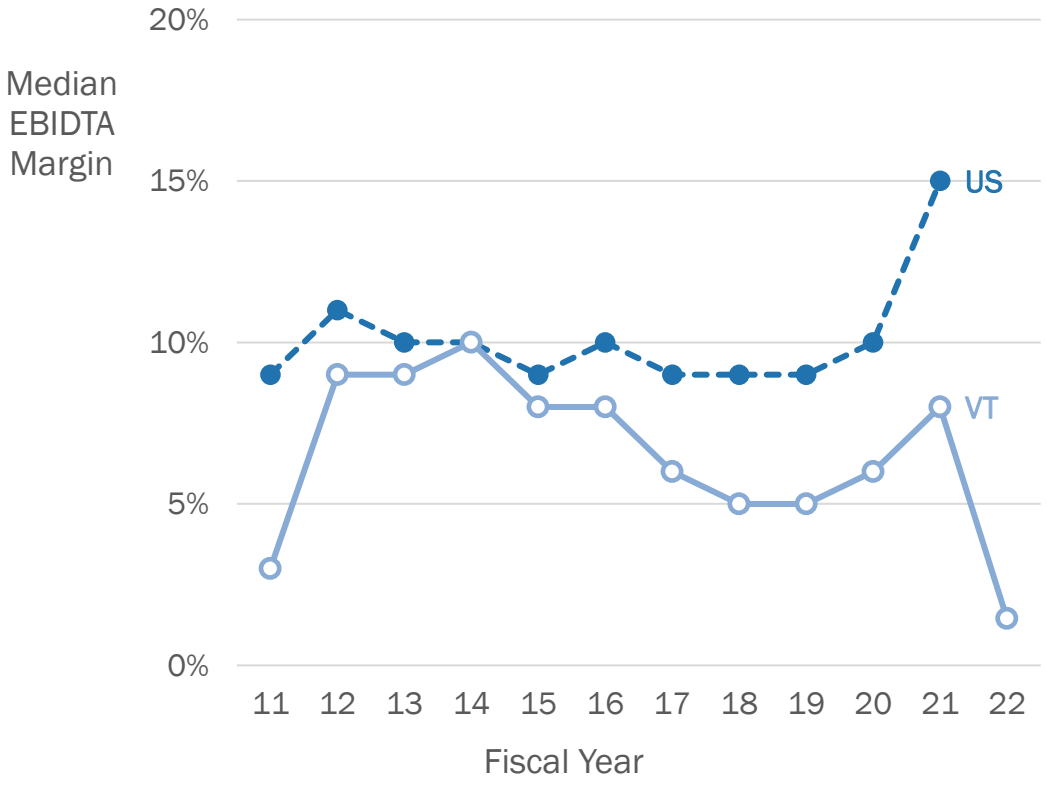
Depending on when the first program performance year is, Vermont may wish to consider different options for calculating its base year.

If first performance year is:	2025	2026	2027
Possible options include:	Most recent year: 2023	Most recent year: 2024	Most recent year: 2025
	Average of 2022 and 2023	Average 2022, 2023 and 2024	Average 2023, 2024 and 2025

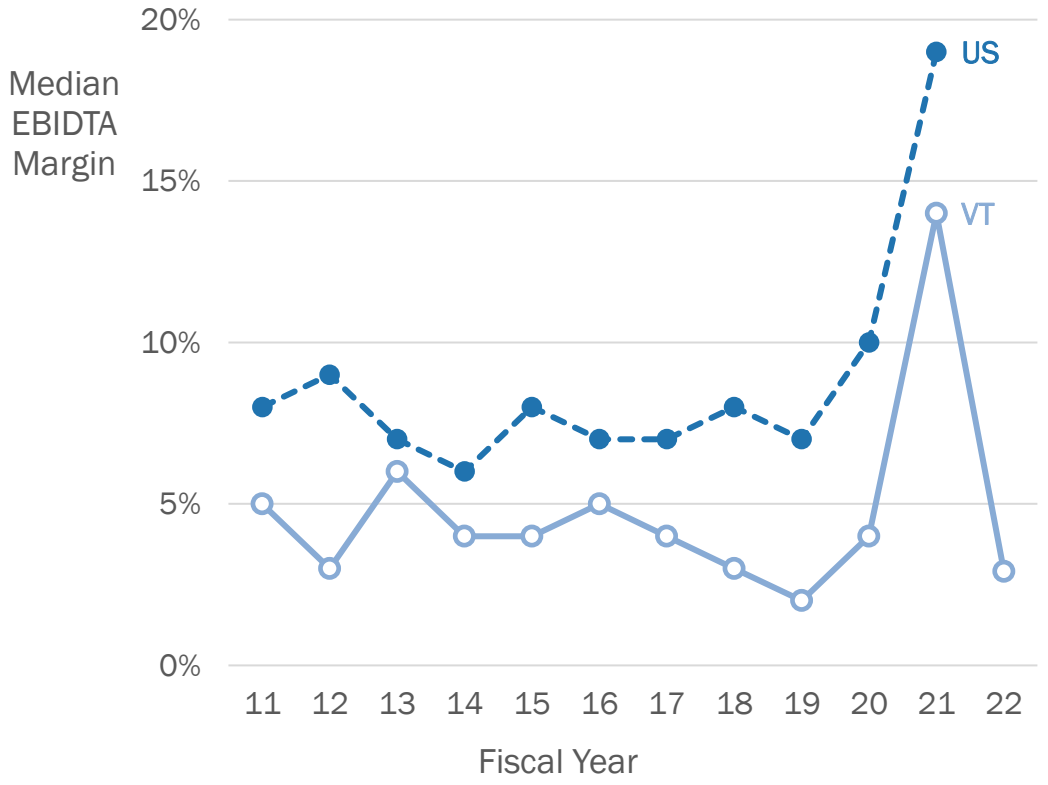
US vs VT: Median EBITDA Margins

VERMONT
GREEN MOUNTAIN CARE BOARD

Acute Care Hospitals



Critical Access Hospitals



EBIDTA = Earnings Before Interest, Taxes, Depreciation, and Amortization
US data from Healthcare Cost Report Information System for hospitals with a Federal Fiscal Year.
VT data from actuals reported to GMCB by regulated hospitals (GMCB data within +/- 1 percentage point of HCRIS)

Discussion

What characteristics should we take into account when recommending a base year?

- Is an average preferred over a single year?
- Should we avoid using 2022 and previous years due to COVID-19 impact on utilization and hospital margins?

Calculating Global Budgets at the Hospital Level

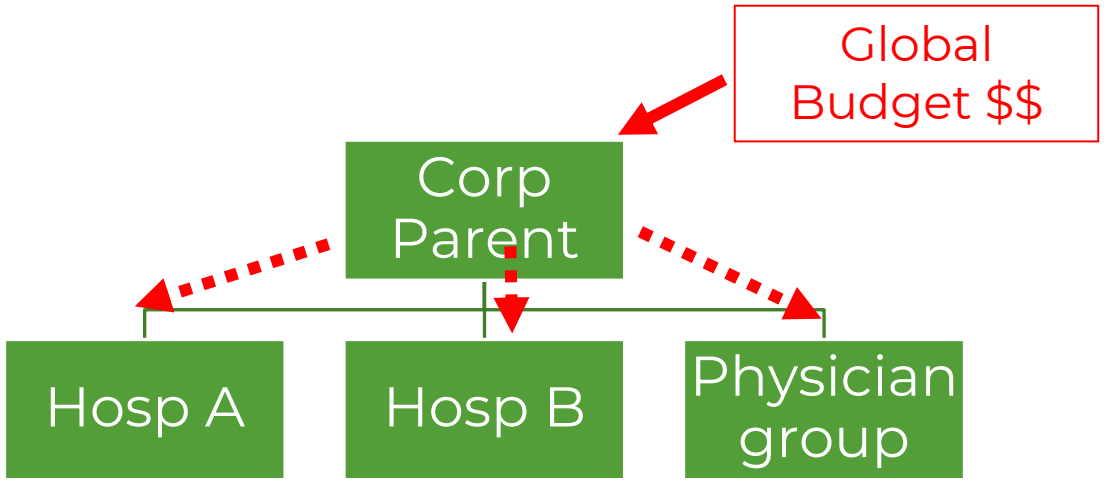
In Vermont, there are a few hospitals that are part of health systems.

This could include multi-hospital systems (two or more hospitals) or a single diversified hospital system (which in the AHA definition includes one hospital and three or more pre or post acute health care organizations). Both involve an ownership, lease, sponsorship or contract-management relationship with a central organization.

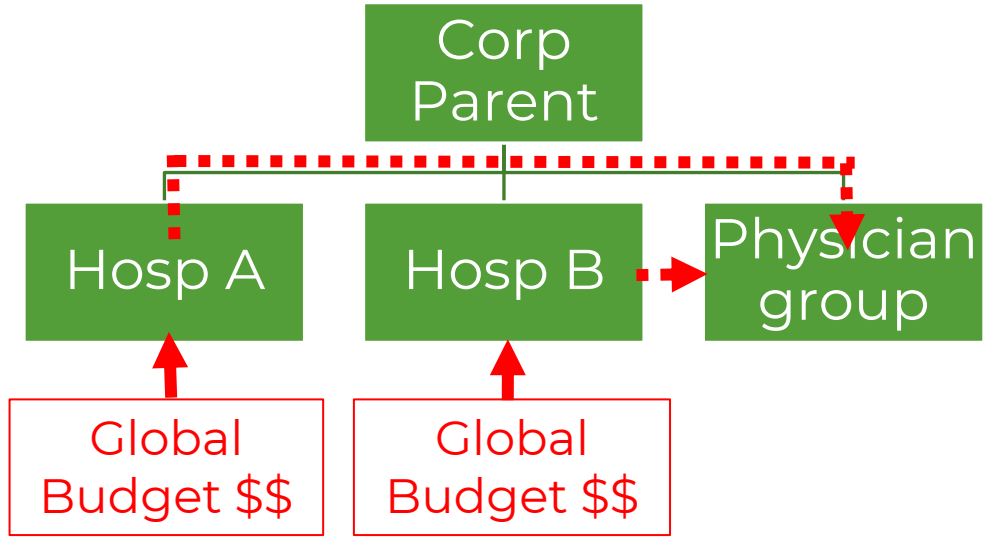
Theoretically, budgets could be calculated at the system or the hospital level, as shown on the following diagram.

Calculating Global Budgets at the System Level vs. the Hospital Level

If budgets are calculated at the **system level,** then the system would receive one payment (from a given payer) for all hospitals and would be responsible for distributing payments across participating hospitals and non-hospital entities.



If budgets are calculated at the **hospital level,** then each hospital would receive a separate global budget payment. These budgets may include some services provided by system-owned entities.



Calculating Global Budgets at the Hospital Level

- Calculating global budgets at the hospital level facilitates tailoring of budgets to meet individual hospitals' circumstances.
- Our understanding is that given organizational structures and billing practices in Vermont, there is likely not a major benefit to taking a system-level approach.
- We propose to model budgets at the hospital level. Is there a strong reason to instead focus on a system-level approach?

Aligning Program Years

Aligning Program Years

Different definitions of “year” are used by Medicare, Medicaid, GMCB for its budget review, and the State.

If CMMI sets Medicare's global budget to run on a calendar year (based on Medicare’s APM calendar), what challenges would we need to address?

	Jan.	July	Oct.
GMCB Budget Review Year			X
Medicare Cost Report Year			X
Medicare APM Performance Year	X		
OneCare Vermont Performance Year	X		
VT Medicaid Next Gen Performance Year	X		
VT Global Commitment Rate Year	X		
Commercial Plan Rate Year	X		
State Fiscal Year		X	

Overview of Budget Adjustments

Budget Adjustments

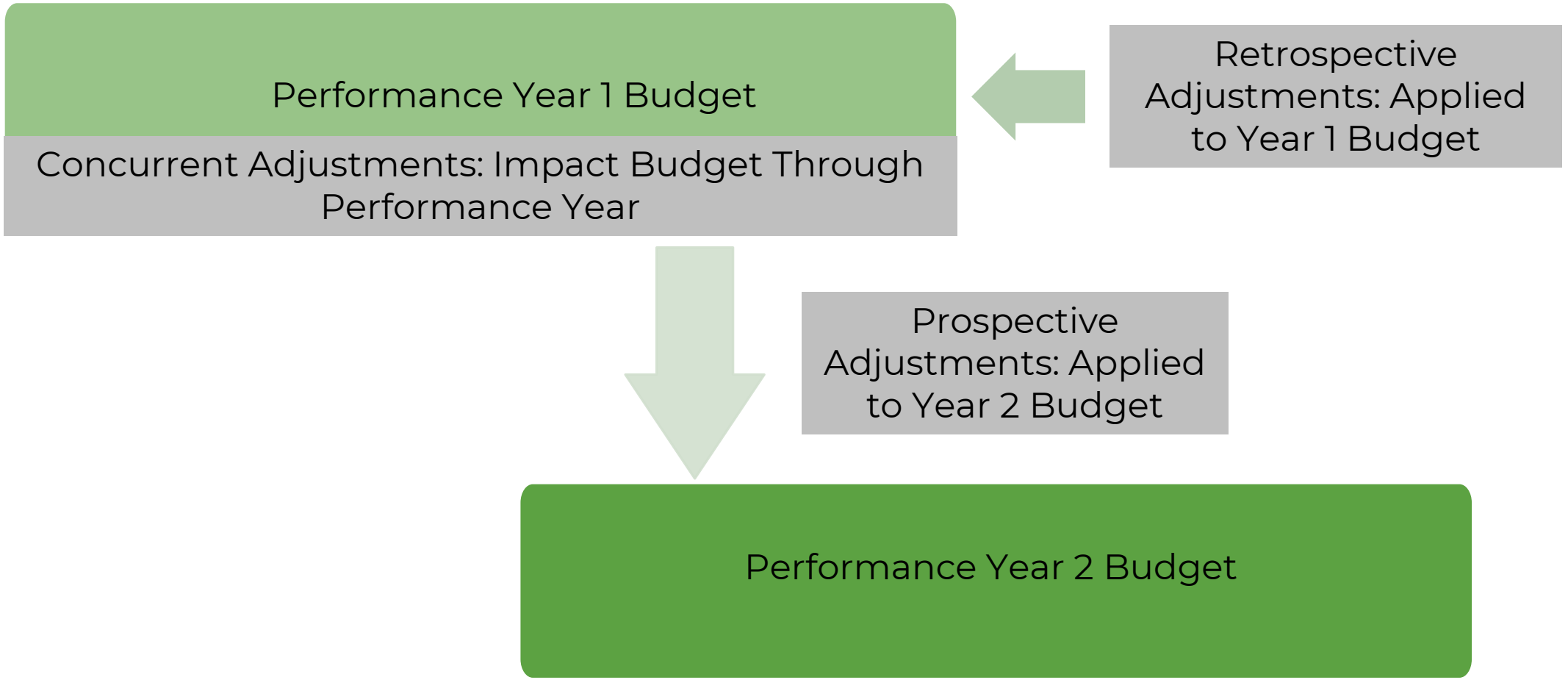
- There are many different types of adjustments that could be considered in designing a global budget, such as adjustments related to:
  - Financial performance
  - Inflation and population trends
  - Utilization
  - Quality and equity
  - Risk mitigation
- We will consider many different types of adjustments over meetings #5-9
- For each adjustment type, we will be discussing whether to adjust, and if so, how the adjustment should be applied (concurrent, retrospective, prospective)

The Pros and Cons for Adjustments

Reasons for adjusting	Reasons for not adjusting
• Account for changes in the market that hospitals may not be able to fully control • Support hospitals in managing unexpected expenses • Use adjustments to accomplish certain policy aims, such as achieving certain quality and equity benchmarks	• A primary goal of the global budget is to create more predictable revenue. The more that budgets are adjusted, the less predictable the revenue for hospitals (and payments for payers). • Adjustments for factors such as utilization dampen the effectiveness of the hospital global budget in promoting for efficient use of resources. • Adding adjustments makes the model increasingly complex.

- Are there other pros or cons to adjusting budgets?

Adjustments Can Be Applied Concurrently, Retrospectively or Prospectively



Budget Adjustments: Scheduled Topics

Baseline Budget Adjustments (Meeting 5)	Inflation & Population Trends (Meeting 5)	Utilization (Meeting 6)	Quality & Equity (Meeting 7)	Risk Mitigation & Other (Meeting 8)

• Margin
• Rates
• Services
	• Inflation
	• Population
	  • Demographics
	  • Case Mix Socioeconomic Factors
	• Other Drivers
		• Service line changes
		• Market shifts
		• Flexible budget
		• Budget reconciliation
			• Quality & equity measures
			• TCOC
			• Shared incentives across multiple provider types
				• Exogenous factors
				• Risk mitigation
				• Cost reports
				• Capital expenditure

Meeting #9: Allow additional time for additional discussion of adjustments

What other types of adjustments should be presented to the TAG for consideration?

Mid-Cycle Check-in on TAG Process

Wrap-up and Next Meeting

The next Hospital Global Budget Technical Advisory Group meeting is scheduled for Tuesday, April 18th from 10 am – 12 pm.