Hospital Global Budget Technical Advisory Group

JUNE 13, 2023
MEETING #8

Meeting Agenda

1. Recap of prior meeting discussion
2. Hospital risk mitigation strategies and adjustments
3. Total cost of care accountability
4. Quality and equity performance

Recap of May 23rd Meeting

May 23rd Meeting Recap (1 of 2)

Baseline budget construction (revisited)

Workgroup members in attendance supported the following:

Revenue for Inclusion	Revenue for Exclusion
• Claims-based payments for commercial payers and Medicaid (including pharmacy billed through medical claims) • Fixed prospective payments under current ACO program CMMI will specify Medicare's approach regarding included revenue.	• Disproportionate Share Payments • Graduate Medical Education • Other reform payments • Revenue streams billed under the pharmacy benefit (e.g., retail pharmacy) • Other non-Net Patient Revenue

- Following the meeting, BCBSVT shared concerns about excluding the pharmacy-related revenue streams.

May 23rd Meeting Recap (2 of 2)

Inflation adjustments (continued)

- Members in attendance conveyed preliminary support for annual inflation adjustments based on the CMS Market Basket Index (50%) and VT median household income (50%).
- Members requested further information on how the Market Basket Index has compared to VT health care spending growth over time, and data showing the projected inflation factor trends using the proposed formula.

May 23rd Meeting Recap (3 of 3)

Utilization adjustments (continued)

- During Meeting #6, some members cited a preference for the market shift adjustment approach over volume adjustments, given the specificity of how the market shift adjustment can be tailored to specific service lines.
- During Meeting #7, some members conveyed support for the volume adjustment approach over a market shift adjustment combined with other specific utilization adjustments, stating that the volume adjustment approach appeared to be less complicated to administer.
- The State is reviewing these options and will come back to the Technical Advisory Group with a recommendation.

Meeting Objectives

1. Develop recommendations for ongoing monitoring and both routine and ad hoc adjustments for **hospital risk mitigation**, including whether such adjustments should differ by hospital type.
2. Develop a recommendation for how **total cost of care accountability** should be incorporated in the model.
3. Begin to identify potential domains and measures for assessing **quality and equity performance for payment**, including how performance should be used to modify and/or supplement global budget payments.

Hospital Risk Mitigation

Topics

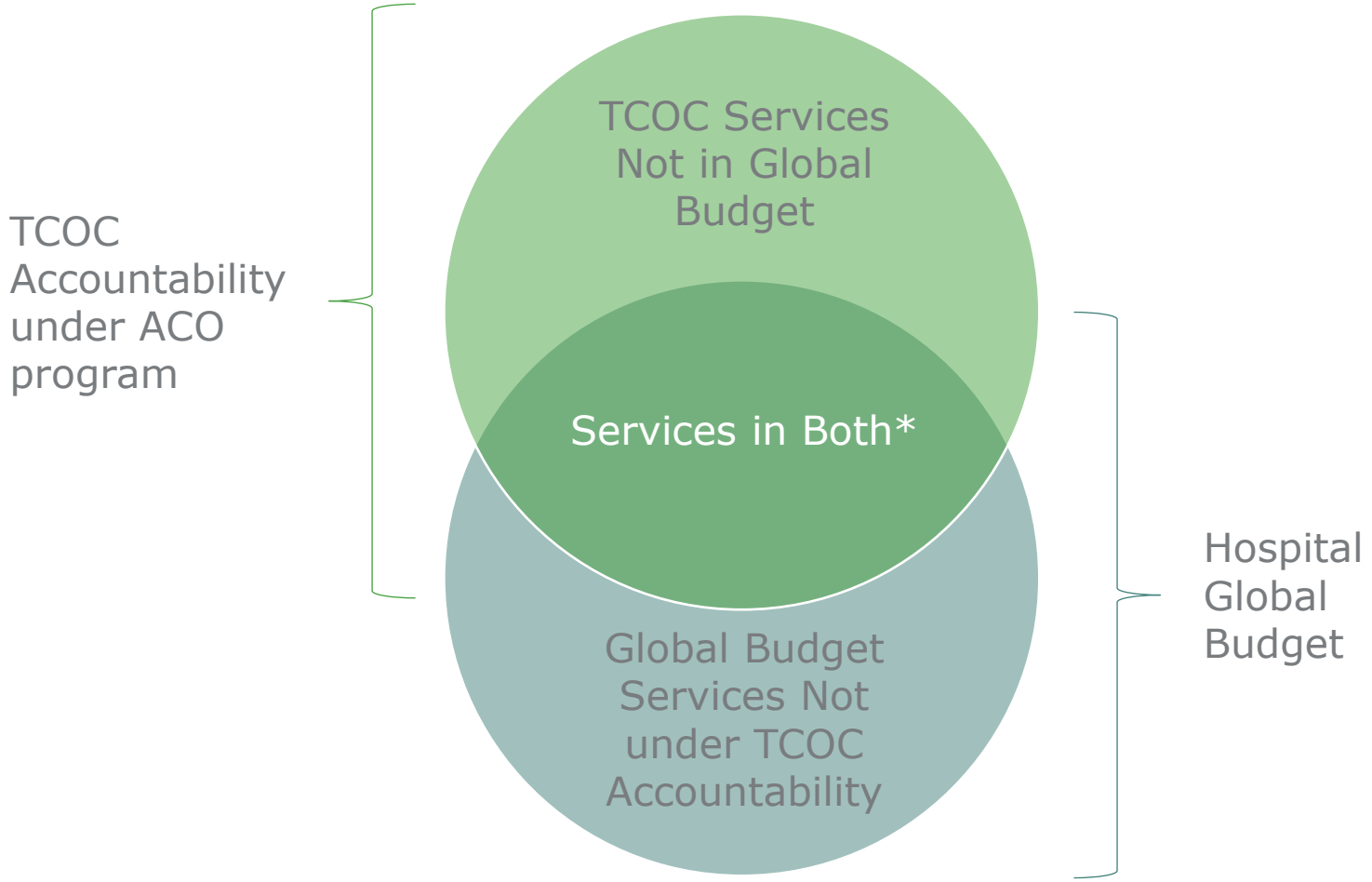
- Framing
- Total Cost of Care (TCOC) risk vs. global budget risk
- Comparison to fee-for-service
- Reframing risk under a global budget
- Other risks worth consideration

Disclaimer: The thoughts and opinions expressed herein are my own and do not represent those of OneCare Vermont, the University of Vermont Health Network, or any related entities.

Framing

- Risk is a word used often but has many connotations (and rarely comes with a definition)
- There are technical and conceptual angles related to risk
  - Because the technical specs of the global budget model are still in development, this presentation focuses on the conceptual angles
- Consider this information "food for thought"
  - Not a proposal or recommendation
  - Content represents observations and learnings
- The perspective is primarily from the provider/hospital entity side
  - Payers/insurers will have their own assessment of risks
- This is not easy – the challenges are significant and many will take years to address
- When it relates to a Medicare global budget, Critical Access Hospitals are different…just need to say that up front

Total Cost of Care (TCOC) Risk vs. Global Budget Risk



* Likely not for this group, but work needs to be done to ensure alignment of the "Services in Both" section between ACO arrangements and global budgets

Total Cost of Care (TCOC) Risk vs. Global Budget Risk

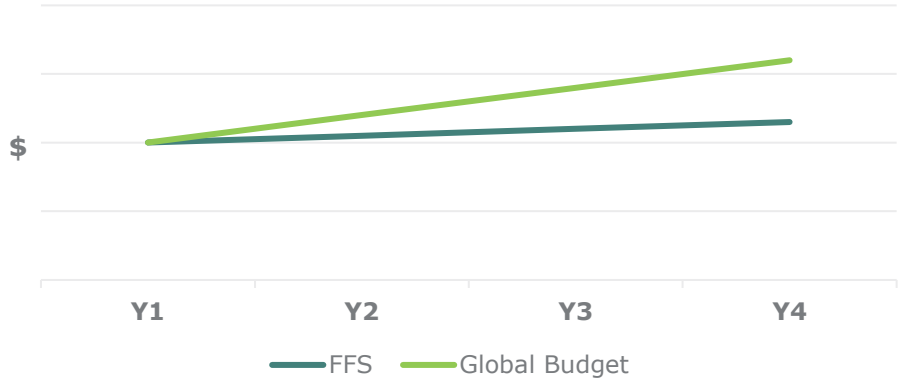
TCOC Risk	Global Budget Risk

• Relative to total healthcare expenditures for the attributed population
  • Not all services are delivered by the hospital entity
• TCOC risk relative to hospital entity services (revenue) is variable
  • Ranges from 4% to 10% in OneCare in 2022
  • Depends on the proportion of services delivered by the hospital entity
• Results impacted by coordination of care across provider entities (i.e. not isolated to the hospital entities)
	• Relative only to services (revenue) delivered by the hospital entity
	• Typically involves a comparison to fee-for-service (FFS) potential
	• Results impacted by hospital entity cost and utilization
	  • Some components a hospital entity can control
	  • Some components a hospital entity cannot control

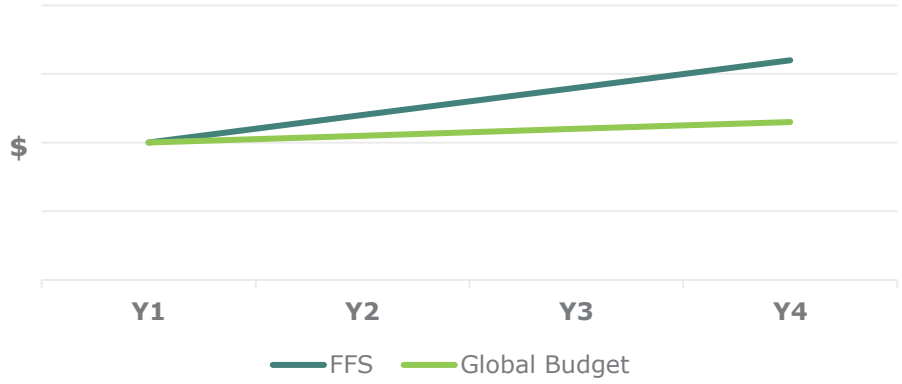
Comparison to FFS

- In OneCare's experience, the most common assessment of risk under a global budget (or fixed payment) to relative to FFS
- Material variation between FFS and the global budget amounts grows creates a winner/loser dynamic
  - Risk to sustainability of the initiative or continued provider participation
- But…resetting to FFS every year doesn't solve the problems either…

If Global Budgets levels begin to materially exceed FFS levels, the payer has a motivation to exit the arrangement



If FFS levels begin to materially exceed Global Budget levels, the hospital entity has a motivation to exit the arrangement



Reframing Global Budget Risk

If the comparison to FFS issue can be solved…

- Global Budget risk should be evaluated against:
  - Ability to cover the cost/expense to deliver the care
  - Ability to affect/control the outcome
  - Ability to fulfill community need

If the hospital entity believes the global budget revenue will cover expenses, they can control the outcome, and they can fulfill community need, the **perceived risk should be low.**	If the hospital entity believes the global budget revenue will not covers expenses, they cannot control the outcome, and/or they cannot fulfill community need, the **perceived risk will be high.**

(Food for Thought: One can argue the Critical Access Hospital cost-based reimbursement model already checks these three boxes.)

Financial and Other Risk Tolerance Angles

- Financial risk tolerance is linked to underlying financial health
  - If the entity is financial stable, and adequately reserved, their willingness to take on additional risk should be higher
  - Else, their willingness to take on additional risk will be lower
- Hospital entity boards are a key stakeholder group
  - Recommending a risk-arrangement to a board can be perceived as a professional risk for the executive team
- Trust and transparency (or lack thereof) is a risk
- Administrative burden is a risk
  - This risk can be alleviated if the benefit (financial, care delivery, etc.) is clear

Questions & Thoughts

Defining Financial Risk (1 of 2)

- A hospital global budget model using fixed prospective payments will inherently entail some level of increased financial risk for hospitals.
- We previously discussed how **utilization adjustments** can ensure a level of financial protection for hospitals due to unforeseen circumstances or changes outside of a hospital's control impacting utilization.

Defining Financial Risk (2 of 2)

We propose two types of supplemental strategies for risk mitigation under rare and extreme circumstances:

1) Budget exceptions or carve-outs for **certain high-cost services** (*to be discussed at a future meeting*)
2) Budget adjustments for rare and extreme circumstances when hospitals have **much-higher-than-anticipated input costs.**
   - Inflation adjustments will account for some of these costs, but input cost growth could theoretically greatly exceed inflation forecasts.

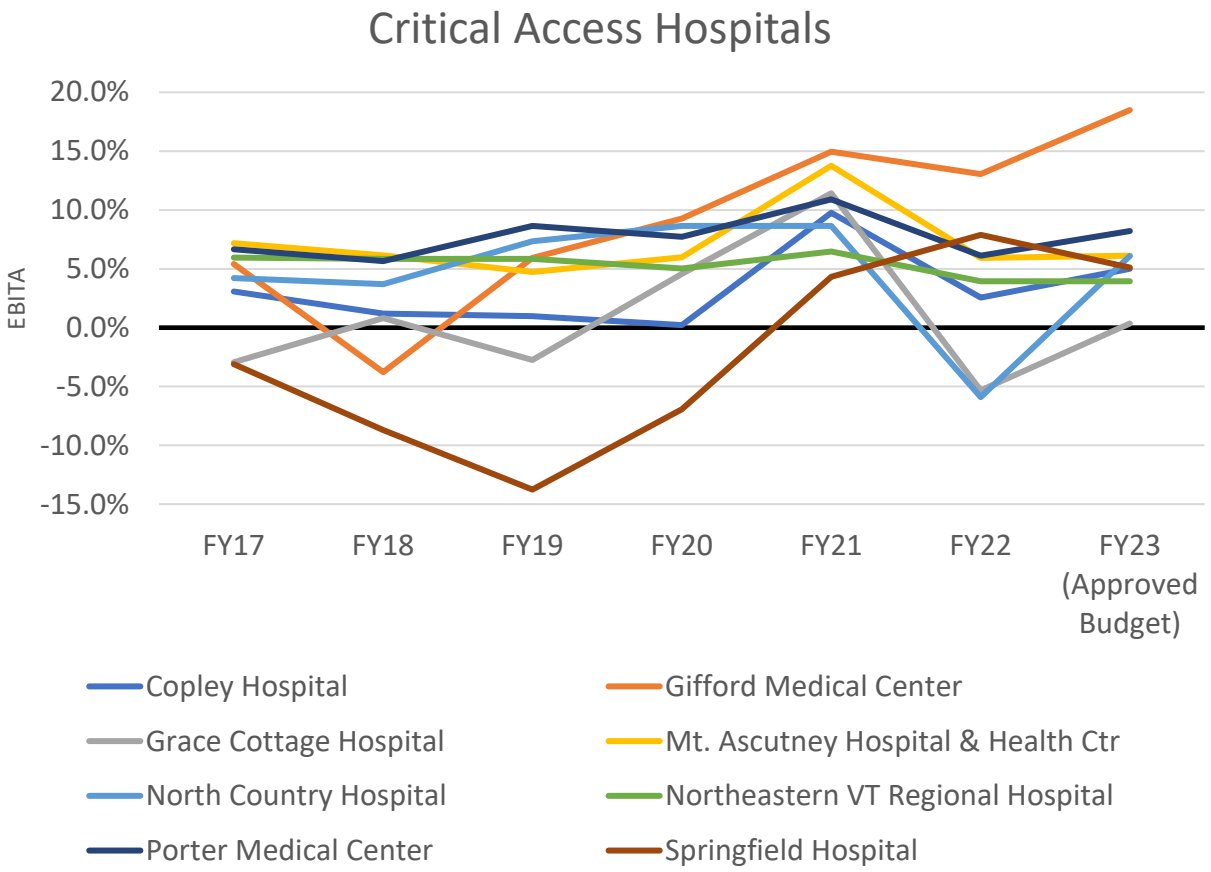
   Examples of #2 include:
   - Hospital lost large numbers of staff and had to hire contractual labor for double the cost
   - Hospital experiences the introduction of new very high-cost infusion drugs
   - Hospital experiences an unusually high level of intensive care cases

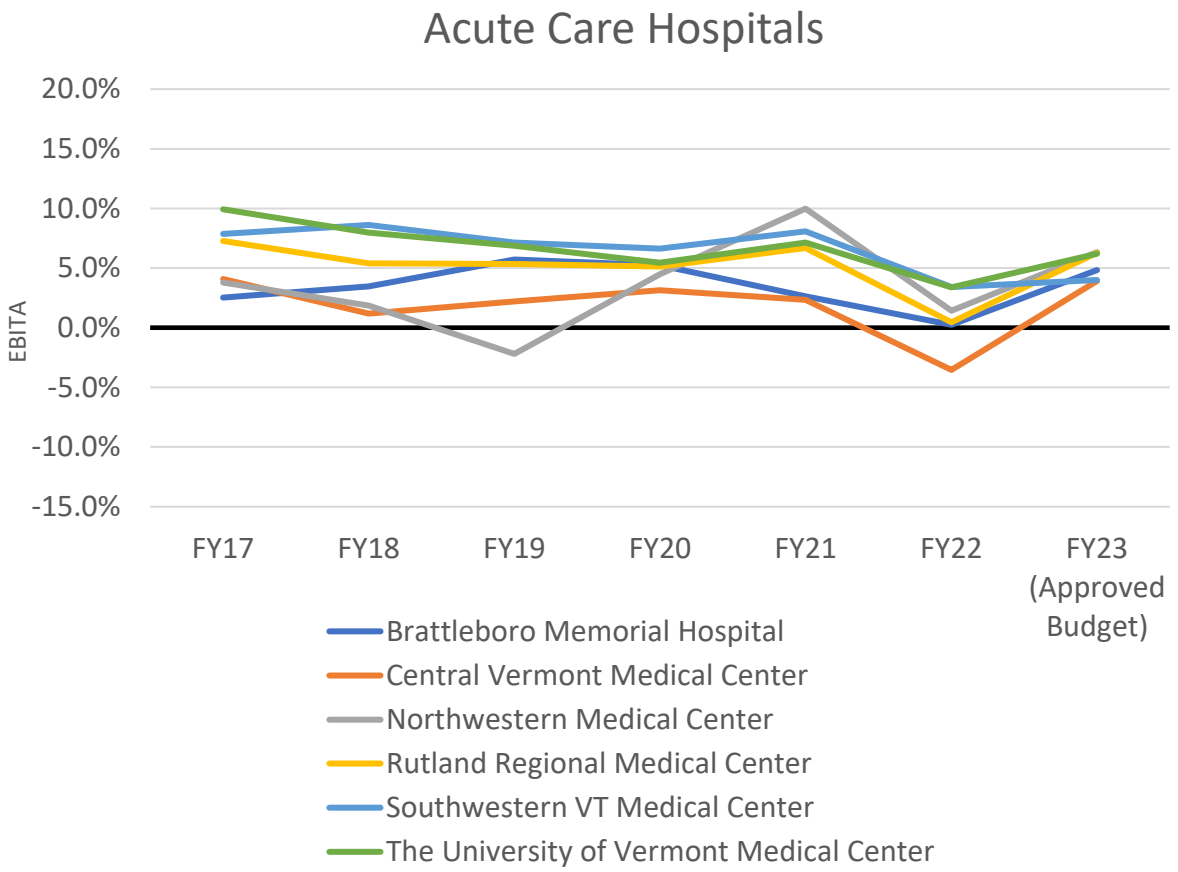
Identifying Financial Risk

- In order to determine when global budget payment adjustments for extreme circumstances are warranted, we propose adapting the GMCB hospital monitoring process in order to track:
  - if an individual hospital's utilization significantly varies from projections used in the global budget payments even after agreed upon adjustments, or
  - if an individual hospital runs a negative margin beyond a specified threshold.
- Thresholds that trigger an ad hoc adjustment for financial risk could be informed by a hospital's financial position.

Does this approach seem reasonable to you? What changes would you recommend, if any?

VT Hospital EBIDTA Margin Trends





Other Risk Mitigation Options for Hospitals

Risk mitigation strategies for hospitals could include:

- **Insurance-related policies**
  - Individual and/or aggregate stop-loss coverage/reinsurance (purchased independently or through a state-supported program, to help pay for losses above a certain limit)
- Use **secured funds in reserves**
- **Pool risk across hospitals**

Which approach(es) seem reasonable to you? Why? Are there important features to each approach?

Total Cost of Care Performance

Defining Total Cost of Care

- A global budget model could include accountability for total cost of care (TCOC) where accountability provisions differ by insurance market or payer. It could also only apply to certain insurance markets.
- For consideration of an TCOC adjustment, we propose that TCOC be defined as payments for all covered services for individuals residing in the Hospital Service Area.
  - Retail pharmacy would be excluded, as would long-term services and supports and dental for Medicaid.

Would you recommend any changes to this proposed TCOC definition?

Rationale for TCOC Accountability

- Provides financial accountability for services outside of global budget payments, and protects against shifting hospital costs to community providers
- Incentivizes improvements in population health
- Can align incentives across provider types & payment models
- Results in APM incentive payment & exclusions from MIPS

- Hospitals would be held accountable for costs they cannot fully control
- Could add further complexity to the model

TCOC Performance in State Global Budget Models

MD TCOC & Other Savings Targets	PA TCOC & Other Savings Targets
• Hospitals are held accountable for the TCOC for Medicare FFS patients if state TCOC savings target is not met. • If spending falls below a specific benchmark (+/-3%), hospitals receive a positive adjustment to their Medicare hospital global budget payments, and vice versa. • *Other savings targets*: $2 billion in Medicare Part A & B (2019-2026); all-payer hosp. spending growth ≤ 3.58%	• Medicare TCOC guardrails established to ensure that the PA rural Medicare TCOC growth does not exceed the national rural Medicare TCOC growth, but no explicit connection between hospital payments and TCOC performance. • *Other savings targets*: $35 million in Medicare Part A & B (2019-2024); all-payer rural hosp. spending growth ≤ 3.38%

Operational Considerations for TCOC Accountability

1. If CMMI follows the Maryland model and requires Medicare to have geographic attribution for hospital-specific TCOC accountability, should this be extended to other markets/ payers?

   If yes –

   - Should TCOC accountability be extended to all or some payers?
   - Should the TCOC accountability measure differ by payer type?

2. Should TCOC accountability be one-sided or two-sided?

Quality and Equity Adjustments

Incorporating Quality and Equity Into Hospital Global Budgets

Incorporating quality and equity into a hospital global budget can help incentivize improvements in access to care, care coordination, patient safety, clinical outcomes and/or patient engagement.

Before we consider quality and equity arrangements for a hospital global budget model, it is important to consider existing incentive programs to which Vermont hospitals are subject.

- Alignment with existing programs may improve hospital outcomes, as multiple initiatives would reinforce the same priorities.
- There should, however, be consideration of creating financial incentive to address other priorities for which financial incentives are currently lacking.

Vermont-Specific Measures

- Vermont Hospital Report Cards
- Centers for Medicare & Medicaid Services Hospital Compare
- Vermont All-Payer Accountable Care Organization Model
- “Shared Interest Measures”

Vermont Hospital Report Cards

Vermont Hospital Report Cards include the following domains:

- Survey of patients' experiences
- Readmission rates
- Death rates
- Healthcare associated infections
- Patient safety measures
- Nurse staffing information and data

https://www.healthvermont.gov/stats/systems/hospital-report-cards

The Vermont Hospital Report Cards contain a subset of the CMS Hospital Compare measures described on the next slide. Relatively easy-to-navigate format intended for a broad audience; some hospitals' results can't be reported due to small numbers.

Vermont Reporting on CMS Hospital Compare

CMS Hospital Compare domains include:

- Complications and Deaths
- Healthcare Associated Infections
- Outpatient Imaging
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Timely and Effective Care
- Unplanned Hospital Visits
- Payment and Value of Care

Extensive hospital measure set. Vermont hospital data often not available, due to small numbers of cases. When data is reported, Vermont hospital performance is almost always similar to national results (small numbers are likely a factor).

Vermont All-Payer ACO Model Agreement Quality Framework

- Overarching goals in VT All-Payer ACO Model:
  - Increase Access to Primary Care
  - Reduce Deaths from Suicide and Drug Overdose
  - Reduce Prevalence and Morbidity of Chronic Disease (Diabetes, Hypertension, COPD)
- 22 related measures

  6 Population Level Health Outcome Measures
  - Reduce deaths related to opioid overdose
  - Reduce deaths due to suicide
  - Reduce prevalence of chronic obstructive pulmonary disease, diabetes, and hypertension (3 measures)

Vermont All-Payer ACO Model Measures (continued)

- 9 Healthcare Delivery System Quality Measures
  - Initiation and Engagement of substance use disorder treatment (2 measures)
  - Follow-up after discharge from the emergency department (ED) for mental health and substance use disorder (2 measures)
  - Reduce rate of growth of ED visits with a primary diagnosis of mental health or substance use disorder
  - Diabetes: hemoglobin A1c poor control
  - Controlling high blood pressure
  - All-cause unplanned admissions for patients with multiple chronic conditions
  - Patient experience survey: Getting timely care, appointments, and information

Vermont All-Payer ACO Model Measures (continued)

- 7 Process Milestones
  - Decrease rate of use of morphine milligram equivalents dispensed per 100 Vermont residents
  - Increase Vermont residents receiving medication assisted treatment for substance use disorder
  - Screening for clinical depression and follow-up plan
  - Tobacco use assessment and cessation intervention
  - Appropriate asthma medication management
  - Children and adolescents with well-care visits
  - Medicaid members aligned to scale target ACO initiative

Significant alignment across Vermont ACO programs for Healthcare Delivery System Quality Measures and Process Milestones:
10 of 16 measures in two or more payer programs.

Shared Interest Measures

- Goal is to identify measures that relate to coordination of care between multiple providers
- Examples include:
  - Readmissions
  - Follow-up after hospitalization for mental illness
  - Follow-up after discharge from the emergency department for mental health
  - Follow-up after discharge from the emergency department for substance use disorder

Quality Measurement and Improvement

- Current quality focus: Vermont has made progress in aligning measures across payers and programs (see Appendix B in this GMCB Report: FINAL Annual Quality Report_PY3_2020.pdf (vermont.gov))
- Overarching goals in VT All-Payer ACO Model:
  - Increase Access to Primary Care
  - Reduce Deaths from Suicide and Drug Overdose
  - Reduce Prevalence and Morbidity of Chronic Disease (Diabetes, Hypertension, COPD)
- Do these goals still resonate? Are there other important areas of focus?

Future Focus for Quality Measurement and Improvement

- Future areas of focus:
  - What are future priorities for quality measurement and improvement in a potential hospital global budget model?
  - Shared interest measures
  - Hospital measures
  - Measuring equity

- Are there opportunities for further alignment in quality measurement and quality improvement?

Other State Hospital-Focused Quality Programs

Maryland TCOC Model	Pennsylvania Rural Health Model

• MD Quality-Based Reimbursement Program
• Readmissions Reductions Incentive Program
• Hospital-Acquired Conditions Program
• Potentially Avoidable Utilization
	• Medicare FFS portion of hospital budgets adjusted based on quality performance
	  • Intended to establish an All-Payer Quality Program; cancelled due to the COVID-19 pandemic
	  • Now use Medicare hospital quality reporting programs
	• All-payer budget reductions based on targeted potentially avoidable utilization reductions
	• Statewide quality measures for monitoring purposes

National Hospital-Focused Quality Programs

Some examples of national programs focused on improving hospital quality include:

CMS

- Hospital Inpatient Quality Reporting Program
- Hospital Value-based Purchasing Program
- Hospital Outpatient Quality Reporting Program
- Inpatient Psychiatric Facility Quality Reporting Program

Other

- The Joint Commission Hospital Accreditation
- The Leapfrog Group Hospital Safety Grade

Other State Hospital-Focused Equity Programs

We have already discussed whether to use a measurement of social risk for routine budget adjustments. We are now considering if other equity-related adjustments should be considered.

Maryland TCOC Model	CMS ACO REACH
• Maryland's Readmissions Reduction Incentive Program: hospitals can receive up to 0.5% of their inpatient revenue by reducing socioeconomic disparities in readmission.	• Health Equity Data Reporting Adjustment: Up to a 10% positive adjustment to an ACO's quality score if the ACO submits patient-reported demographic data and up to a 5% adjustment for SDOH data

Quality and Equity Adjustments

- Current CMMI models include supplemental financial arrangements focused on improving hospital quality and promoting equity.
- Do you recommend using quality:
  - to adjust hospital global budgets?
  - as complementary VBP arrangements to the hospital global budgets?
  - for monitoring and/or public reporting purposes?
- To what extent should quality and equity arrangements be aligned across payers?

Note that CMMI may have certain requirements for the model overall, which is different than applying measures to modify hospital budgets.

Wrap-up and Next Meeting

The next Hospital Global Budget Technical Advisory Group meeting is scheduled for Tuesday, **July 11th** from 10 am – 12 pm.