Hospital Global Budget Technical Advisory Group

AUGUST 1, 2023
MEETING #9

Meeting Agenda

1. Recap of prior meeting discussion
2. Quality and equity performance (continued)
3. Introduction to Medicare Fee-for-Service global payment straw model
4. Roadmap for remaining hospital global budget topics

Recap of June 13th Meeting

June 13th Meeting Recap (1 of 2)

Risk mitigation strategies

- In order to determine when global budget payment adjustments for extreme circumstances are warranted, group members supported 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.
- Meeting participants also voiced support for:
  - Thresholds that trigger an ad hoc adjustment for financial risk that would be informed by a hospital's financial position.
  - Additional risk mitigation strategies that hospitals can employ, such as pooling risk across hospitals, will be discussed after further details of the model are finalized.

June 13th Meeting Recap (2 of 2)

Total Cost of Care (TCOC)

- Members in attendance supported supplementing the hospital global budget payment model with two-sided accountability for TCOC.
  - Several members supported including retail pharmacy in the TCOC budget.

Quality and equity performance

- Following a review of the quality incentive programs to which Vermont hospitals are subject today, meeting participants voiced support for the overarching quality goals in the current All-Payer Model, but with a broadened lens of addressing mental health and SUD and incorporating equity as a future priority.

Meeting Objectives

1. 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.
2. Introduce a **straw model for Medicare** hospital global budgets and solicit Technical Advisory Group member input.
3. Review a roadmap of **remaining hospital global budget topics** and solicit Advisory Group member input.

Quality and Equity Performance

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.

During the last meeting, we considered existing incentive programs to which Vermont hospitals are subject (see Appendix) to help inform consideration of quality and equity arrangements for a hospital global budget model.

- 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.

Other State Global Budget Hospital-Focused Quality Incentive Programs

Maryland TCOC Model	PA Rural Health Model
• Quality-Based Reimbursement - 17 measures across 3 domains: person and community engagement, safety & clinical care - Max penalty/reward = +/- 2% of inpatient all-payer revenue • Readmissions Reductions - Reduce all-cause 30-day readmissions - Max penalty -2% & max reward 1% • Hospital-Acquired Conditions - 14 preventable complications developed during hospital stay - Max penalty/reward = +/- 2% • Potentially Avoidable Utilization - Adult & pediatric unplanned 30-day readmissions	• 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 - Now using 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 Hospital-Focused Equity Incentive 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 readmissions	• 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 CMS and CMMI hospital payment 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?

Medicare Fee-for-Service Global Payment Straw Model

Focus and Timing of Future All-Payer Model

The Center for Medicare & Medicaid Innovation (CMMI) has provided clarification on the focus and timing of the next model:

- CMMI is moving in the direction of offering only **multi-state models** rather than state-specific models.
- CMMI has outlined **seven priorities** that will be central to this model.
- More details on the model are expected to be released by CMMI in the Fall.
- Applications from states, outlining their proposals, will likely be due in early 2024.
- CMMI has informed Vermont that full implementation of the Medicare payment provisions of this model **will occur in 2026**, not in 2025 as previously anticipated.
- As a result, CMMI and Vermont are negotiating **what 2025 will look like**, with the goal of providing a smooth transition to a new Medicare/multi-payer model in 2026.
- At the same time, CMMI and Vermont are continuing to discuss a potential 2026 model.

Medicare FFS straw model topics of discussion

1. Eligibility and inclusions / exclusions
2. Global budget payment calculations
3. Potential data sources and processes
4. TBD: risk corridors and budget reviews
5. TBD: exogenous factor adjustment
6. TBD: monitoring plan

Overview of Straw Model

- The purpose of the straw model is to incorporate Advisory Group input into our modeling approach and share preliminary information that is concrete.
- Sometimes there was definitive input from Advisory Group members on a particular element of the model, and at other times input varied.
- Some elements of the straw model have not yet been discussed by the Advisory Group.
- Therefore, the analytics team made some assumptions in constructing the straw model and those assumptions are identified. Data is not validated, and some calculations are approximated.
- In the process of creating the straw model, if the team identified data issues or other operational barriers that resulted in a different assumption than what we discussed with the Advisory Group, these are identified.
- This is a first draft at providing this type of information, and we look forward to continued discussion and refinement.

Eligibility and inclusions / exclusions

Summary of eligibility and inclusions / exclusions

Services

- Billed by hospital
  - Hospital inpatient, outpatient, swing bed services
  - Professional services
  - Other facility services

Revenue

- Operating revenue
  - Net Patient Revenue
  - Other revenue

Other

- Vermont residency required for Medicaid only
- Paid amounts

Prioritize Medicare Hospital Facility Services in order to respond to CMMI Model

(Topic discussed at TAG meetings 2 and 3)

Additional data and validation is needed to include professional services in global budget

- Mathematica's analysis of VHCURES indicated that hospital billed professional services comprise only 16 % of total professional services for Vermont residents and varied by Hospital Service Areas (HSAs)

- Next steps:
  - Collect information from hospitals about billing NPI list
  - Discussions with hospital revenue cycle staff to understand how hospitals are billing for professional services delivered inside and outside of hospital campus is billed

HSA	Percent of professional payments billed by VT hospital
Barre	30%
Burlington	22%
Morrisville	15%
Randolph	11%
Newport	13%
St. Johnsbury	10%
St. Albans	13%
Middlebury	22%
Rutland	13%
Bennington	15%
Springfield	6%
White River Jct	2%
Brattleboro	9%
Total	**16%**

Source: VHCURES, VT residents only, excludes some self-insured plans. Payments include amounts paid by insurance and patients. Professional payments are defined as VHCURES claim type id =2, which includes all professional claims (providers, independent labs, ambulance, dental).

Majority of hospital facility payments are for hospital inpatient, swing bed, and outpatient services

- VHCURES analysis showed issues with identifying all facility claims billed by hospitals (see appendix for detail breakdowns)
- Two hospitals, North Country and Northeastern have significant revenue billed for other services (RHC)
- Next steps:
  1. Review the results with hospitals,
  2. Discuss possibility of including other facility services with hospitals
  3. Prioritize hospital IP, OP, SB services for Medicare FFS straw model

Total facility payments billed by hospitals, by place of service, according to the limited NPI List (in millions), CY 2021

Hospital	Total hospital services (IP, OP, SB)	Total other services (FQHC, RHC, Other OP)	Percent of hospital service payments billed by hospital
Brattleboro	$40 M	-	100%
Central Vermont	$97 M	-	100%
Copley	$51 M	$1 M	99%
Gifford	$30 M	$0.05 M	100%
Grace Cottage	$5 M	-	100%
Mt. Ascutney	$17 M	$0.03 M	100%
North Country	$44 M	$3 M	94%
Northeastern	$52 M	$2 M	96%
Northwestern	$58 M	-	100%
Porter	$36 M	$0.02 M	100%
Rutland	$144 M	$0.05 M	100%
Southwestern	$58 M	$0.41 M	99%
Springfield	$24 M	$0.27 M	99%
UVVMC	$541 M	$3 M	99%
Total	**$1,197 M**	**$9 M**	**99%**

Source: VHCURES. Includes VT residents only, excludes some self-insured plans, and includes amounts paid by insurance and patients. A facility payment is defined as VHCURES claim type id=1 or claim type id=3 and type of setting id=9 or 12. See appendix for detail.

Other operating revenue is excluded from straw model due to operational considerations

Hospital Operating Revenue Classification	
1. Net Patient Revenue and ACO Fixed-Prospective Payments	2. Other operating revenue (exclude in straw model)
• Claims-based payments for hospital services (include in straw model) • ACO Fixed Prospective Payments (include in straw model) • Claims-based payments for professional and other services (exclude in straw model)	• Disproportionate Share Payments • Graduate Medical Education • Other reform payments • Revenue streams billed under the pharmacy benefit (e.g., retail pharmacy, including 340-B) • Other non-Net Patient Revenue

(Topic discussed at TAG meeting 7)

Other operating revenue is a small percentage of total operating revenue

- Based on hospital-submitted financial data, other operating revenue, including retail pharmacy and 340-B, comprise only 13% of total hospital operating revenue.

Excluded other operating revenue, FY 2022

Hospital	All-payer total operating revenue	Excluded other operating revenue	Percent of other operating revenue excluded from the model
Brattleboro	$101 M	$8 M	8%
Central Vermont	$263 M	$23 M	9%
Copley	$95 M	$3 M	3%
Gifford	$63 M	$4 M	7%
Grace Cottage	$25 M	$1 M	4%
Mt. Ascutney	$66 M	$4 M	5%
North Country	$91 M	$5 M	6%
Northeastern	$111 M	$5 M	5%
Northwestern	$123 M	$7 M	6%
Porter	$105 M	$7 M	6%
Rutland	$332 M	$27 M	8%
Southwestern	$195 M	$9 M	4%
Springfield	$61 M	$8 M	14%
UVMMC*	$1,826 M	$328 M*	18%
Total	**$3,457 M**	**$439 M**	**13%**

*Approximately $171 M of UVVMC's $328 M other operating revenue is for specialty pharmacy.

Source: GMCB, Adaptive Platform, Payer Revenue Sheet and Income Statement

Model maximizes participation to show potential impact

- Include all patients in global budgets regardless of Vermont residency, except those with Medicaid (no authority over other state's Medicaid programs).
- Include only insurance portion of payments. Member co-pays and co-insurance will continue to be paid by the member based on claims. (no way to capture)
- Exclude workers compensation payments (established by VDOL)
- Exclude revenue from uninsured/self-pay (no way to capture)

Potential GB coverage as percentage of hospital operating revenue if all eligible payers participate in the program, FY 2022

Hospital	Total operating revenue	Included revenue*	Percentage of included revenue of total operating revenue
Brattleboro	$101 M	$82 M	81%
Central Vermont	$263 M	$166 M	63%
Copley	$95 M	$48 M	51%**
Gifford	$63 M	$46 M	72%
Grace Cottage	$25 M	$15 M	59%**
Mt. Ascutney	$66 M	$38 M	57%**
North Country	$91 M	$66 M	72%
Northeastern	$111 M	$73 M	66%
Northwestern	$123 M	$76 M	62%
Porter	$105 M	$72 M	69%
Rutland	$332 M	$234 M	71%
Southwestern	$195 M	$138 M	70%
Springfield	$61 M	$45 M	73%
UVMMC	$1,826 M	$971 M	53%**
Total	**$3,457 M**	**$2,069 M**	**60%**

*Included revenue includes Medicare VT residents/non-residents, commercial residents/non-residents, Medicaid VT residents only, and insurer payments (i.e., removes beneficiary payments) and FPP for hospitals (and does not include physician revenue)

**Of Copley's $37 M of commercial NPR, $26 M is Workers Comp, which is not included in global budget. Grace Cottage had a high proportion of beneficiary payments (30%). Mt. Ascutney had 25% of NPR as physician NPR and a relatively high beneficiary payment portion (18%). UVVMC had large amounts of "other" commercial revenue ($137 M), $255 < in physician NPR, and $26 M in out-of-state Medicaid, along with other high amounts of excluded revenue categories

Source: GMCB, Adaptive Platform, Payer Revenue Sheet and Income Statement

Global budget payment calculations

Summary of eligibility and inclusions / exclusions

Services

- Billed by hospital
  - Hospital inpatient, outpatient, and swing bed services
  - ~~Professional services~~
  - ~~Other facility services~~

Revenue

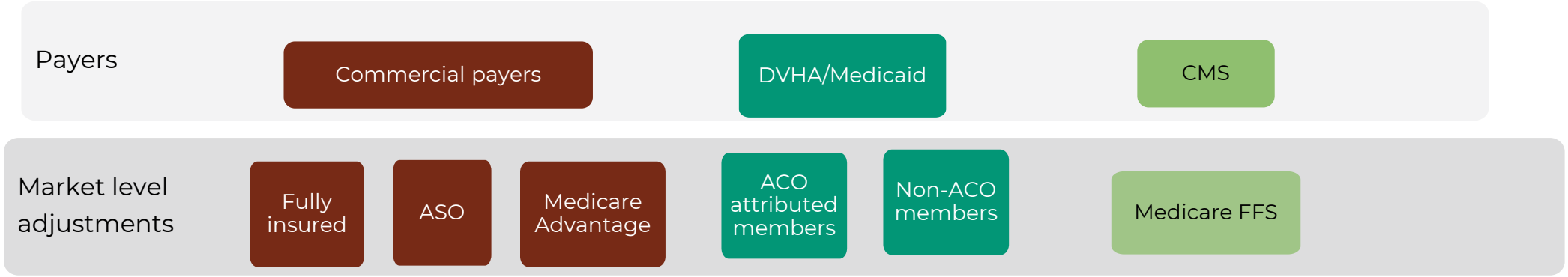
- Operating revenue
  - Net patient revenue
  - ~~Other revenue~~

Other

- Vermont residency required for Medicaid only
- Insurance paid amounts

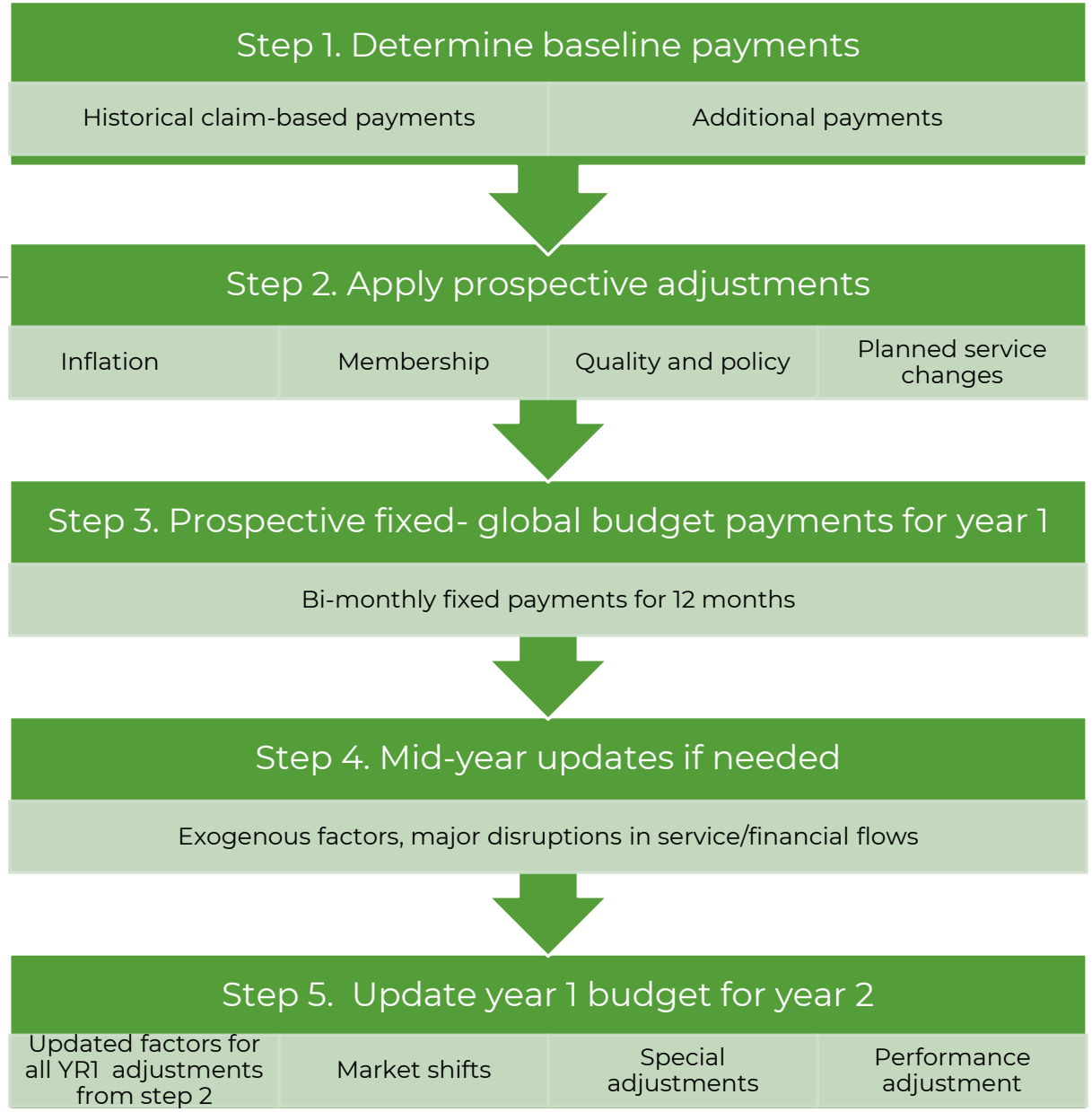
Global budget payment determinations

- Global budgets will be calculated for each payer with market level adjustments
- Methodologies will be aligned as much as possible across different payers
- Commercial participation is in development



Medicare FFS global payment straw model

- Straw model describes main concepts in each step in global budget payment
- Many details are still need to be determined
- Commercial payers may align in most steps but will have their unique considerations



Step 1: Determine baseline payments

Include all CMS payments to Vermont hospitals for hospital inpatient and outpatient services made through claims

- Excludes Part D payments (retail pharmacy benefits administered by Part-D plans)
- Excludes beneficiary co-pays / coinsurance
- Excludes payments outside of claims (cost-reports, additional payments)

Will model in CY 2025 and implement in CY 2026

Average the last two/three years of payments:

- For example: First year = CY 2025, baseline = average FY 2023 and FY 2022

Medicare FFS claim types	CMS claim payment	CMS cost report payment

• Included
  • Part A (inpatient)
  • Part B (outpatient)
• Excluded
  • Part D (drugs)
	•DRG, APC and RVU payments
	•CMS quality adjustments
	•Indirect Medical Education (IME)
	•Disproportionate Share Hospital (DSH)
	•Uncompensated Care (UCC)
		• Bad debt (BD)
		• Organ acquisition (OA)
		• Direct medical education (DME)
		• Nurse and allied health education (NAHE)

Step 1: Calculate total paid amounts

Example: CY 2025 budget based on FY2023 and FY2022 baselines

Commercial payers may need to use CY periods for baselines

1. Price level the base years through FY 2024 (FY 2022 will need to be trended through 2023, 2024, FY 2023 will need to be trended through FY 2024)
2. Apply policy changes to baselines based on FY 2024
   Example: UVM designation changed to sole community hospital in FY2024, which increased their Medicare outpatient payments by 7%
3. Blend the two price-leveled adjusted base years and weight the current year higher

Step 1. Determine baseline payments	
Historical claim-based payments	Additional payments

Step 1. Determine baseline payments

Step 2. Apply prospective adjustments

Step 2: Apply prospective adjustments

Inflation

- CMS market basket
- High-cost drugs inflation factor

Membership

- Beneficiary changes
- Adjusted for age/gender
- Proportional adjustments based on hospital's share in health service areas

Quality and policy

- Current CMS quality program scores and rules
- Policy updates, wage index, low volume adjustment etc.
- Health equity and infrastructure investment

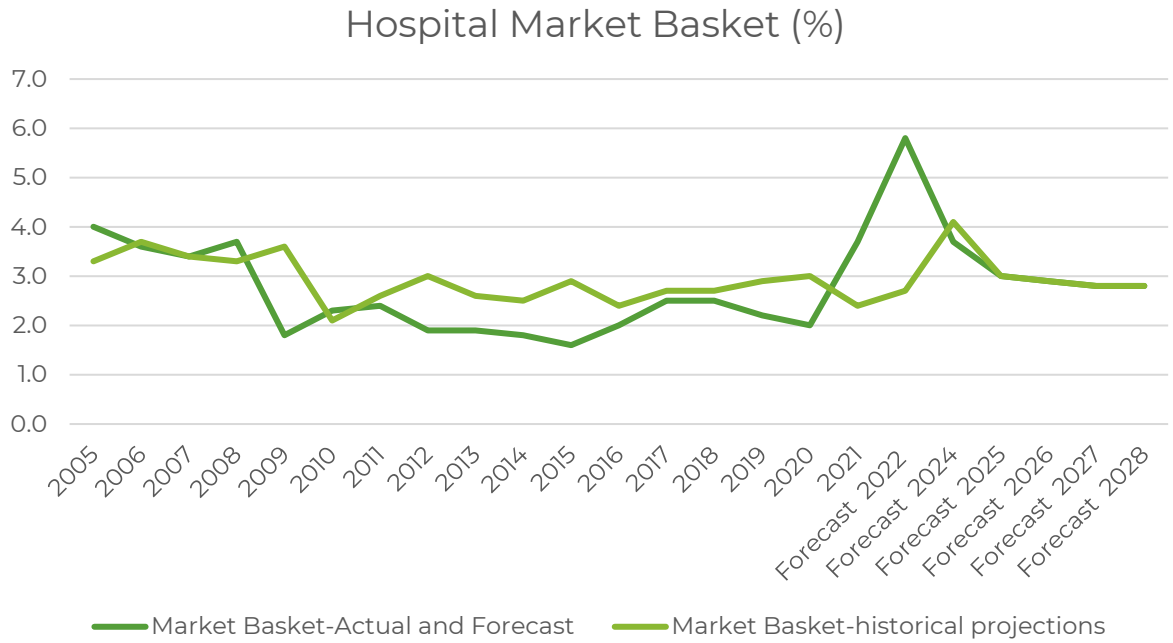
Planned service line changes

- New service lines or closed services
- Threshold for impact (e.g., $100K or more impact)
- Payment adjustment considerations

Step 2: Inflation adjustment

- Hospital market basket means the input price index used by CMS to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.
- It is currently used to update both hospital inpatient and outpatient services.

TAG discussed a 50/50 blend of annual income and market basket for commercial payers



Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata.
Latest update: reflects the 2022Q4 forecast with historical data through 2022Q3

Step 2: Inflationary adjustment for drug cost increases

- A potential consideration could be implementing an inflationary adjustment for drugs with higher price growth.
- These would be drug cost increases that are not captured by the market basket adjustment.
- Maryland has a similar program.

Step 2. Apply prospective adjustments			
Inflation	Membership	Quality and policy	Planned service changes

Step 2: Membership changes

1. Calculate Medicare FFS beneficiary growth trend by hospital service area
2. Apply age and gender weights to factor demographic changes
3. Calculate hospital's proportion of payments from each health service area
4. Apply calculated demographically adjusted growth using proportions for each hospital

Commercial payers would have different weights and different proportions

Source: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata. Latest update: reflects the 2022Q4 forecast with historical data through 2022Q3

Numbers are illustrative for modeling purposes

Example calculations for 2020-2021 Medicare beneficiary change

Step 1

Example HSA	Total beneficiary months	
	2020	2020 to 2021
HSA-1	159,688	1.2%
HSA-2	330,136	1.9%
HSA- 3	69,600	1.3%

Step 2.a

	Per member per month	Relative to average (weights)
Female		
18-34	$660	0.885
35-44	$704	0.944
45-54	$870	1.167
55-64	$938	1.258
65-74	$556	0.745
75-84	$831	1.115
85+	$1,185	1.590
Male		
18-34	$417	0.560
35-44	$615	0.825
45-54	$779	1.046
55-64	$920	1.234
65-74	$577	0.774
75-84	$913	1.225
85+	$ 1,285	1.724
Average	**$745**	**N/A**

Step 2.b

Example HSA	Average age-gender factor	
	2020	2020 to 2021
HSA –1	0.992	-0.4%
HSA -2	1.003	-0.5%
HSA- 3	0.998	-0.6%

Step 2.c (step 1 + step 2 b)

Example HSA	Beneficiary change with demographic adjustment
	2020 to 2021
HSA-1	0.8%
HSA-2	1.3%
HSA- 3	0.7%

Numbers are illustrative for modeling purposes

Example membership change for hospitals

Step 3: Calculate proportions

Example hospital	Top HSA (all-payer)*, 2021
Hospital A	HSA – 2 (92%)
Hospital B	HSA –3 (78%)
Hospital C	HSA –1 (60%)

*Top HSA means that, for that example hospital, the most VT residents come from that HSA

Step 4: Combine steps 2 and 3

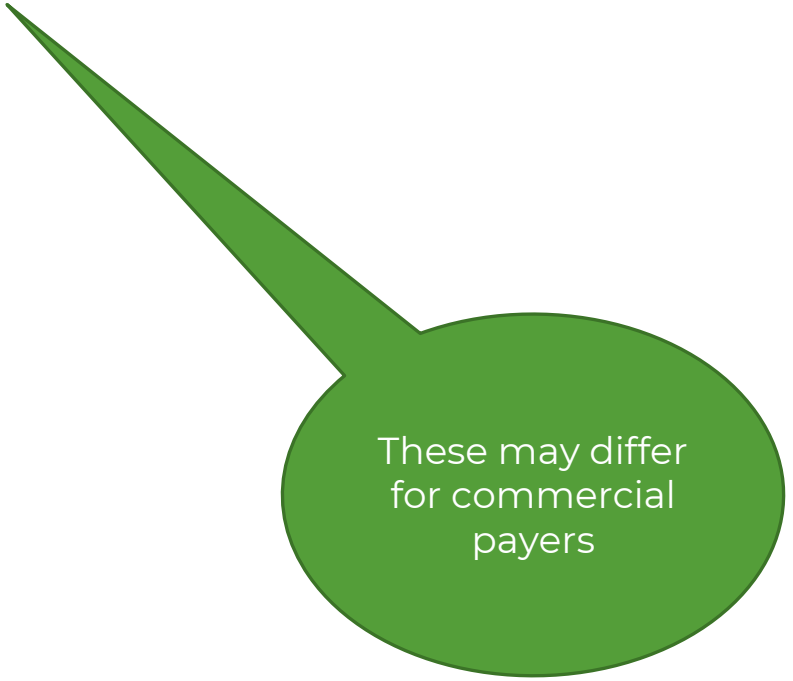
Example HSA	Beneficiary change with demographic adjustment, 2020-2021 (Medicare only)
HSA-1	0.8%
HSA-2	1.3%
HAS- 3	0.7%

Example hospital	Annual demographic adjustment by hospital, 2020-2021 (Medicare only)
Hospital A	1.2%
Hospital B	0.5%
Hospital C	1.0%

Step 2. Apply prospective adjustments			
Inflation	Membership	Quality and policy	Planned service changes

Step 2: Quality and policy

- CMS quality programs
- CMS policy adjustments
- Vermont health equity and infrastructure payments
  - Blueprint payments
  - Potential for other payments for improving primary care



Step 2. Apply prospective adjustments			
Inflation	Membership	Quality and policy	Planned service changes

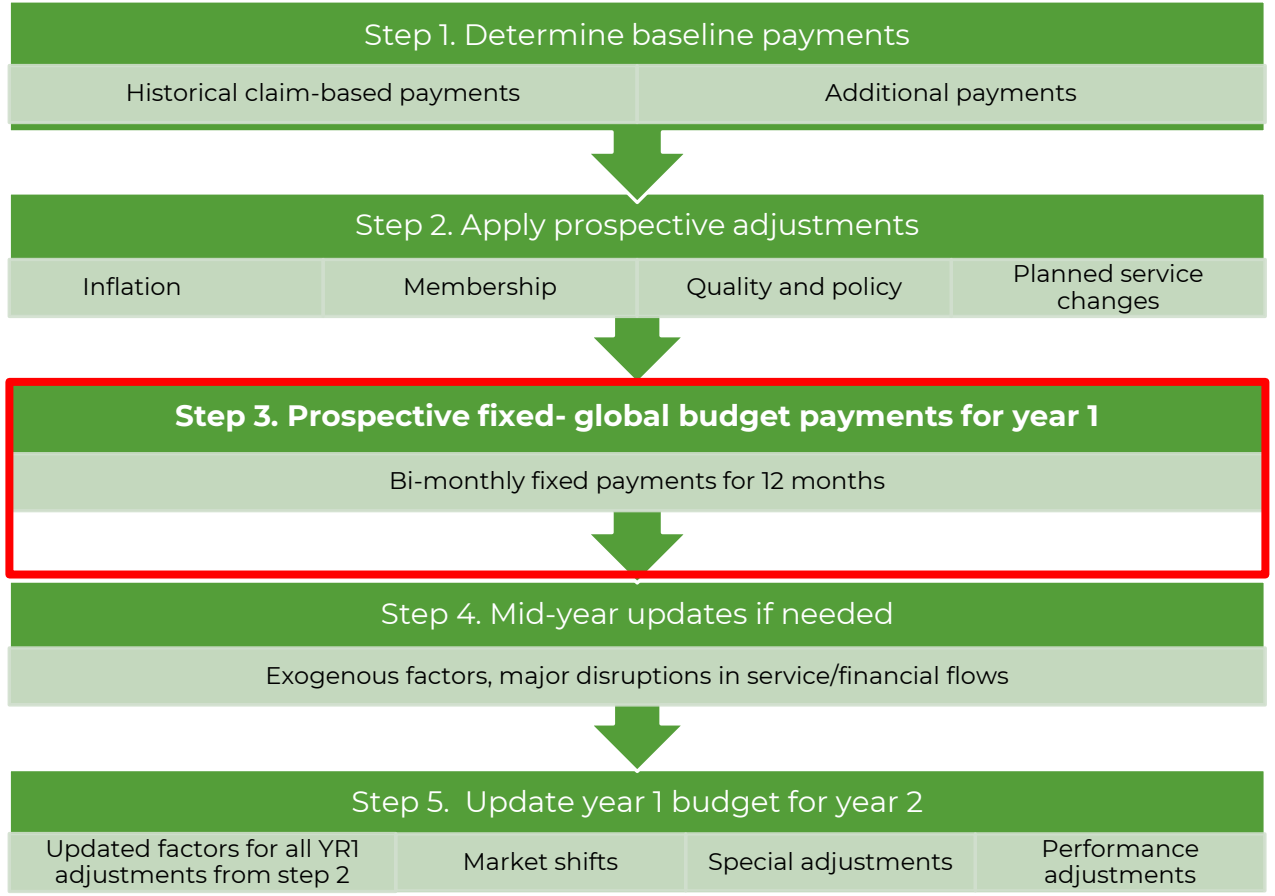
Step 2: Prospective service line changes

Need to develop a process to identify service line changes with significant impact and adjust baseline budgets prospectively.

- Hospitals may submit transformation plans and plan updates. Service additions and closures will be identified and can be updated annually if needed.
- August meeting will include strategies for transformation under global budgets and priority setting for strategy
- Questions to discuss
  - How to define service lines
  - How to calculate payment adjustments (e.g., average Medicare FFS payment per visit adjusted for variable cost factor)
  - How to compare actual vs. projected for future years

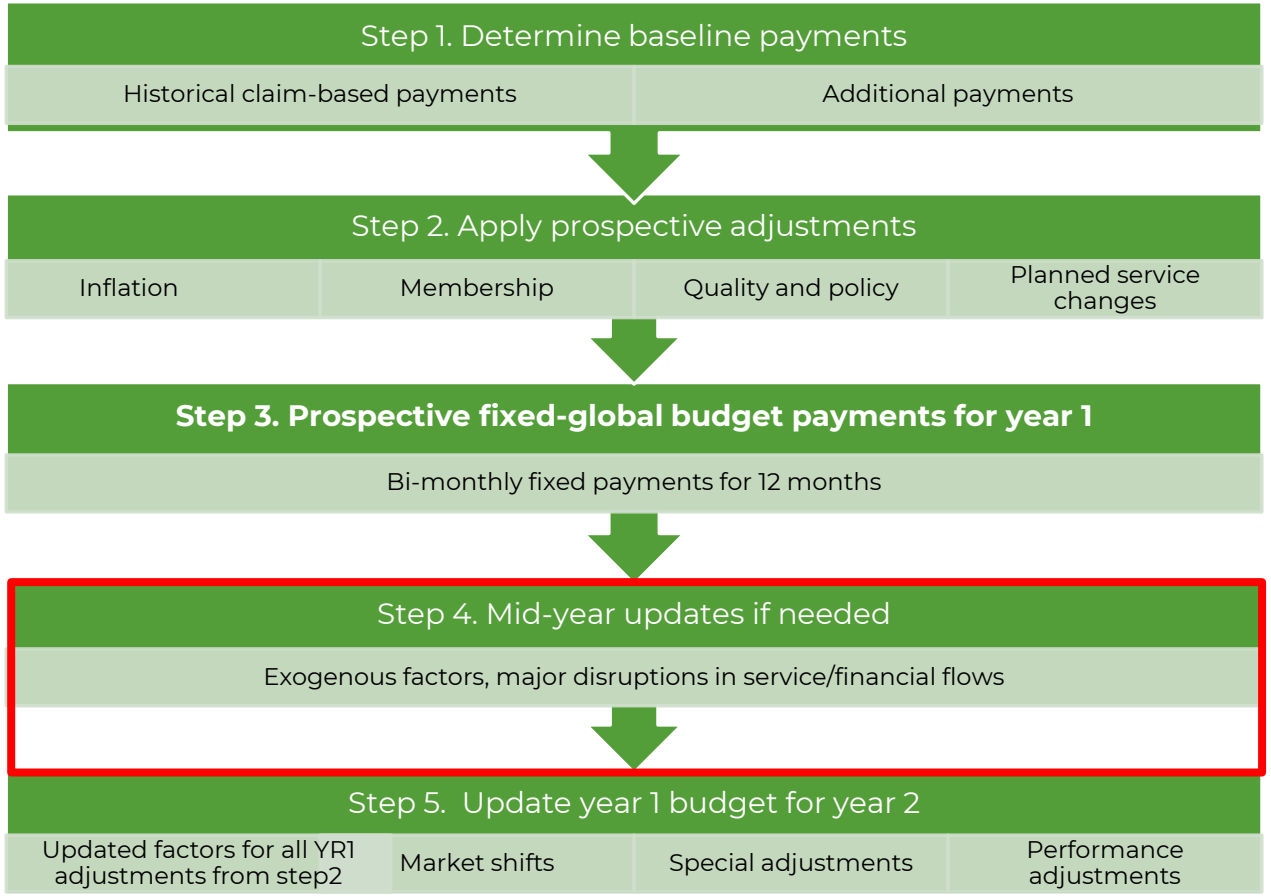
Step 3: Payment method

- CMS will stop claim payments for included claims and issue bi-monthly fixed payment amounts.
- Global payments: Year 1 prospective global budget payment/26



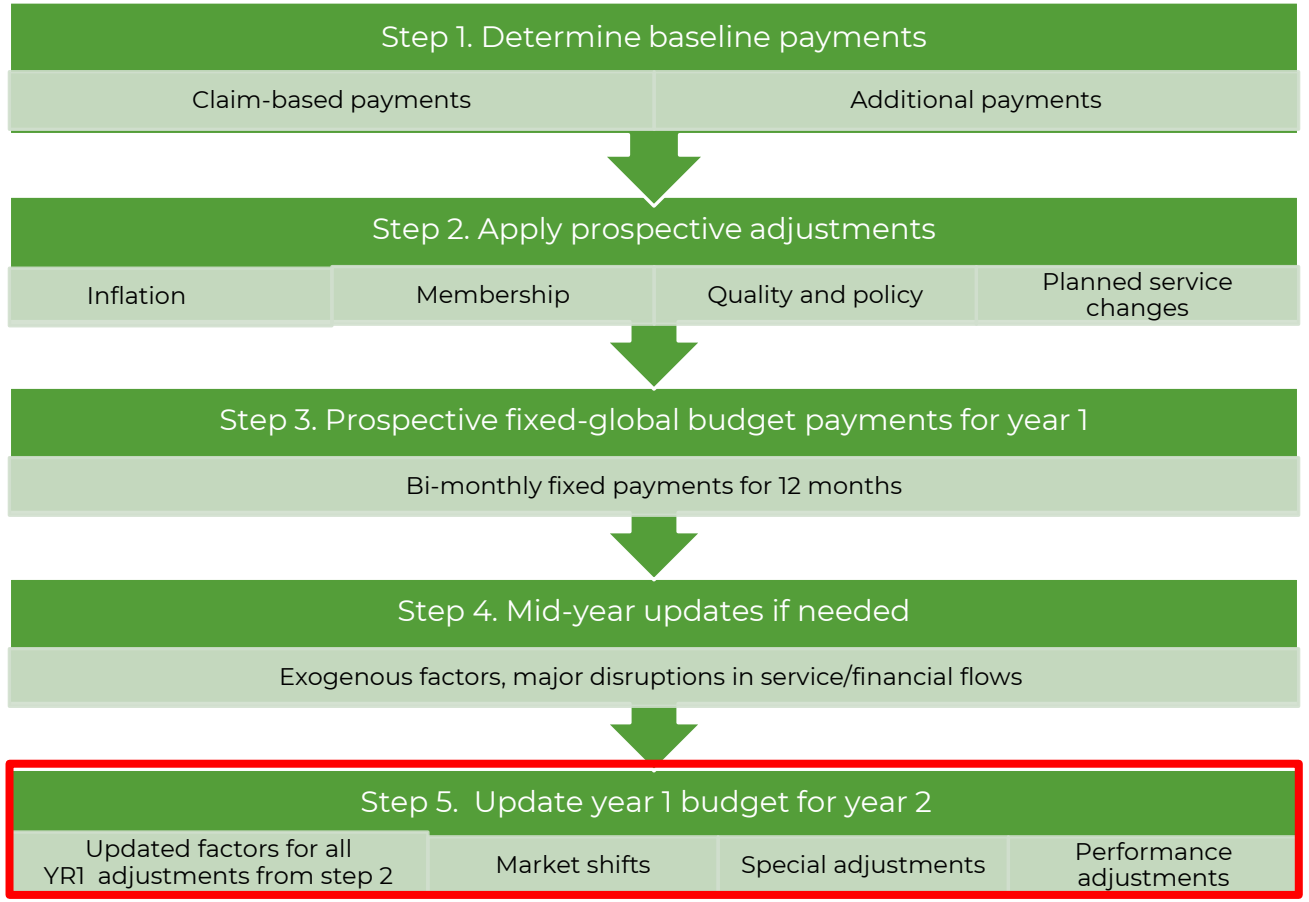
Step 4: Mid-year updates

- Hospitals could request mid-year adjustments for certain conditions (e.g., exogenous factors, major disruptions in services, financial flows, etc.)
- Align timing of GMCB hospital budget process and GB processes



Step 5: Payment updates in future years

1. Inflation, membership and planned service changes will be implemented using similar methods from year 1
2. Additional adjustments will be calculated starting year 2
    1. Market shifts
    2. Special adjustments
    3. Performance adjustments



Step 5: Calculation of year 2 prospective payment

1. Determine baseline: year 1 prospective budget + volume adjustments compared to baseline at determined payment rate
    1. Approved prospective service line changes to actual utilization
    2. Tertiary / quaternary services to actual utilization
    3. Market shifts to / from other hospitals and providers
2. Apply prospective adjustments (all year 1 adjustments updated for one more year)
3. Performance adjustments
    1. Total cost adjustments in relation to the statewide savings target
    2. Population health achievement bonus
    3. Hospital specific adjustments (efficiency, financial health, CAH cost adjustments)
    4. Service access review (e.g., vacancies, service reductions, wait times, etc.)

Market shift example: during 2020 and 2021 period, we see similar trends across hospitals in the largest service line across all hospitals

Top 20 highest dollar service lines, CY 2019-2021

Service lines	Allowed amount	Utilization
Drug Revenue Code	$860 M	$433 K
Major Surgery Revenue Code	$556 M	$178 K
ED - Revenue code	$430 M	$507 K
Lab Revenue Code	$303 M	$1906 K
Imaging Revenue Code	$243 M	$626 K
Orthopedic surgery	$169 M	$12 K
Clinic Revenue Code	$165 M	$1637 K
Psychiatry	$143 M	$11 K
Other	$141 M	$291 K
Respiratory	$125 M	$14 K
Minor Surgery Revenue Code	$107 M	$111 K
General surgery	$101 M	$6 K
Cardiology	$96 M	$14 K
Gastroenterology and hepatology	$93 M	$12 K
Infectious disease	$92 M	$10 K
Invasive cardiology	$78 M	$4 K
Neurology	$76 M	$8 K
Rehab and Therapy Revenue Code	$76 M	$251 K
Obstetrics/delivery	$74 M	$10 K
Neonatology	$74 M	$6 K

Drug service line spend and utilization by HSA, CY 2019-2021

HSA	Drug revenue code- Allowed amount	Drug revenue code- utilization
Burlington	$217 M	$91 K
Rutland	$120 M	$57 K
Barre	$90 M	$53 K
White River Jct	$79 M	$39 K
Bennington	$56 M	$37 K
Springfield	$44 M	$24 K
Brattleboro	$43 M	$28 K
St. Johnsbury	$43 M	$18 K
St. Albans	$41 M	$25 K
Newport	$40 M	$16 K
Morrisville	$31 M	$15 K
Randolph	$25 M	$13 K
Middlebury	$25 M	$16 K
Non-VT Resident	$5 M	$2 K
Total	**$860 M**	**$433 K**

Drug service line utilization in Burlington HSA by hospital, CY 2019-2021

Hospital	2019	2020	2021	2019 to 2020 difference
UVMMC	28,394	22,312	25,888	(6,082)
Other Non-VT hospital	2,171	1,829	2,032	(342)
Northwestern	947	920	1,069	(27)
Copley	833	761	895	(72)
Dartmouth	345	372	390	27
Porter	204	183	222	(21)
Central Vermont	169	174	206	5
Rutland	30	43	50	13
Southwestern	13	3	42	(10)
Gifford	13	10	21	(3)
North Country	9	8	7	(1)
Brattleboro	7	3		(4)
Mt. Ascutney	2	3		1
Springfield			13	
Northeastern		9	19	9
Total	**33,137**	**26,630**	**30,854**	**(6,507)**

Source: VHCURES, VT residents only, excludes some self-insured plans

Medicare FFS Straw model topics of discussion

1. Eligibility and inclusions / exclusions
2. Global budget payment calculations
3. Potential data sources and processes
4. TBD: risk corridors and budget reviews
5. TBD: exogenous factor adjustment
6. TBD: monitoring plan

Potential data sources

Data need	Potential data source	Notes
Baseline paid amount	Hospital and payer claim data CAH Medicare cost reports	Compare data and verify paid amounts/included excluded services
Membership counts	Payer enrollment data	VHCURES can be used for verification
Planned service line, tertiary care utilization	Hospital data	Payer data can be used for verification
Market shifts	VHCURES/Payer claims	Hospital data can be used to verify
Total cost	Payer claims	N/A
Population health outcomes and quality measures	Claims, survey and/or clinical data	Measure selection will determine data source

Additional data needs for global budget modeling

Hospital data:

1. Hospital NPI list for professional and other facility services
2. Insurance plan detail (names/ids/market segments) and paid amounts
3. CAH Medicare rate letters
4. Final cost settlements

Payer data:

1. Membership counts by age and gender and market segment
2. Total paid amounts by HSA (breakdown by VT hospitals, other services, and pharmacy

Roadmap: Remaining Hospital Global Budget Topics

Overview of Remaining Hospital Global Budget Topics

Meeting 10: Terms of payer participation and implications for commercial plan administration (9/5)

Meeting 11: Revised straw model (9/26)

Meeting 12: Terms of hospital participation and care transformation opportunities (10/10)

Meeting 13: Budget calculation and payment administration (10/31)

Meeting 14: Model description review and CMMI comparison (11/14)

Meeting 15: Monitoring and evaluation (12/5)

See Appendix for further details on the meeting topics.

Wrap-up and Next Meeting

The next Hospital Global Budget Technical Advisory Group meeting is scheduled for Tuesday, **September 5th** from 10 am – 12 pm.

Appendix

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 are 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 services billed by hospital

Total facility payments billed by hospitals, by place of service, according to the limited NPI List, CY 2021

Hospital	Hospital Inpatient	Swing Bed	Hospital Outpatient	FQHC	Rural Health Clinic	Other Outpatient
Brattleboro	$11.3 M	-	$28.2 M	-	-	-
Central Vermont	$26.0 M	-	$70.5 M	-	-	-
Copley	$16.4 M	$0.9 M	$33.3 M	$0.5 M	-	-
Gifford	$8.6 M	-	$21.4 M	-	-	-
Grace Cottage	$0.6 M	-	$4.7 M	-	-	-
Mt. Ascutney	$2.6 M	-	$14.9 M	-	-	-
North Country	$12.7 M	$1.3 M	$29.8 M	-	$2.7 M	-
Northeastern	$16.1 M	-	$36.2 M	-	$1.8 M	-
Northwestern	$24.1 M	-	$34.4 M	-	-	-
Porter	$7.9 M	-	$28.1 M	-	-	-
Rutland	$52.7 M	-	$91.5 M	-	-	-
Southwestern	$13.6 M	-	$44.6 M	-	-	$0.4 M
Springfield	$7.6 M	-	$16.1 M	$0.3 M	-	-
UVMMC	$218.4 M	-	$322.6 M	-	-	$3.4 M
Total	**$418.5 M**	**$2.2 M**	**$776.3 M**	**$0.8 M**	**$4.5 M**	**$3.9 M**

Source: VHCURES. Includes VT residents only, excludes some self-insured plans, and includes amounts paid by insurance and patients. A facility payment is defined as VHCURES claim type id=1.

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Trends in non-VT resident revenue are relatively stable

Percent of Medicare charges for nonresidents

Hospital	2016	2017	2018	2019	2020
Brattleboro	15.1%	16.6%	17.7%	15.7%	13.5%
Central Vermont	1.4%	1.3%	1.4%	1.4%	1.3%
Copley	3.4%	3.6%	2.8%	3.2%	2.2%
Gifford	1.6%	1.9%	2.6%	2.9%	2.1%
Grace Cottage	6.9%	8.0%	4.7%	5.8%	4.3%
Mt. Ascutney	29.4%	25.6%	28.6%	28.9%	27.8%
North Country	2.5%	2.8%	2.5%	2.5%	2.0%
Northeastern	3.6%	4.1%	5.7%	3.4%	3.2%
Northwestern	1.0%	0.9%	1.4%	1.3%	0.9%
Porter	5.8%	7.1%	6.2%	5.4%	6.7%
Rutland	6.4%	6.4%	6.4%	6.1%	6.2%
Southwestern	24.7%	28.9%	25.6%	26.5%	27.2%
Springfield	13.9%	14.3%	14.8%	16.0%	16.5%
UVVMC	18.3%	17.2%	15.9%	16.2%	17.3%

Annual change in percent of Medicare charges for nonresidents

Hospital	2016 to 2017	2017 to 2018	2018 to 2019	2019 to 2020	Average annual
Brattleboro	1.4%	1.2%	-2.1%	-2.1%	-0.4%
Central Vermont	-0.2%	0.1%	0.0%	-0.2%	0.0%
Copley	0.2%	-0.9%	0.4%	-1.0%	-0.3%
Gifford	0.3%	0.7%	0.2%	-0.8%	0.1%
Grace Cottage	1.1%	-3.3%	1.1%	-1.5%	-0.7%
Mt. Ascutney	-3.8%	3.0%	0.3%	-1.1%	-0.4%
North Country	0.3%	-0.2%	0.0%	-0.5%	-0.1%
Northeastern	0.5%	1.6%	-2.3%	-0.1%	-0.1%
Northwestern	-0.1%	0.5%	0.0%	-0.4%	0.0%
Porter	1.4%	-0.9%	-0.8%	1.3%	0.2%
Rutland	0.0%	0.0%	-0.2%	0.0%	-0.1%
Southwestern	4.2%	-3.3%	0.9%	0.7%	0.6%
Springfield	0.3%	0.5%	1.2%	0.5%	0.6%
UVVMC	-1.1%	-1.3%	0.3%	1.1%	-0.3%

Source: VUHDDS, VT and non-VT residents included in database; however, tables above include non-VT residents only

VT hospitals provide 60 percent of total facility payments to VT residents, and 40 percent of all payments included in TCOC

HSA	Total Facility Payments	Facility Payments to VT Hospital NPI	Percent of Facility Payments Billed by VT Hospital
Barre	$201 M	$139 M	69%
Burlington	$488 M	$386 M	79%
Morrisville	$76 M	$57 M	75%
Randolph	$56 M	$25 M	45%
Newport	$115 M	$63 M	55%
St. Johnsbury	$110 M	$49 M	45%
St. Albans	$122 M	$98 M	80%
Middlebury	$81 M	$60 M	74%
Rutland	$230 M	$148 M	64%
Bennington	$138 M	$67 M	49%
Springfield	$111 M	$38 M	34%
White River Jct	$175 M	$24 M	14%
Brattleboro	$111 M	$40 M	36%
Total	$2,016 M	$1,193 M	**59%**

HSA	All Payments	All Payments to VT Hospital NPI	Percent of All Payments Billed by VT Hospital
Barre	$371 M	$172 M	46%
Burlington	$935 M	$472 M	51%
Morrisville	$144 M	$65 M	45%
Randolph	$85 M	$28 M	33%
Newport	$186 M	$71 M	38%
St. Johnsbury	$173 M	$55 M	32%
St. Albans	$237 M	$110 M	47%
Middlebury	$148 M	$72 M	49%
Rutland	$405 M	$167 M	41%
Bennington	$233 M	$79 M	34%
Springfield	$182 M	$41 M	23%
White River Jct	$289 M	$26 M	9%
Brattleboro	$185 M	$46 M	25%
Grand Total	$3,574 M	$1,404 M	39%

Source: VHCURES, VT residents only, excludes some self-insured plans.
Payments include amounts paid by insurance and patients.
Professional payments are defined as VHCURES claim type id=2

Hospital Global Budget Topics

Term of Payer Participation and Implications for Commercial Plan Administration

Meeting 10 (September 5)

- Identify which payers should participate in the model and whether participation should be voluntary or mandatory
- Review GMCB's rate-setting authority and discuss the necessity of its application to ensure self-funded employer participation (ERISA plans)
- Identify areas where the model should allow for different payers to vary from the model
- Assess the impact of hospital global benefit on commercial benefits administration, especially consumer cost-sharing

Hospital Global Budget Topics

Revised Straw Model

Meeting 11 (September 26)

- Present revised straw model for TAG consideration and input

Hospital Global Budget Topics

Term of Hospital Participation and Care Transformation

Meeting 12 (October 10)

- Determine hospital participation requirements
- Discuss whether participation should be voluntary or mandatory
- Identify whether, and if so how, the model should allow for hospital variation
- Determine how a global budget and an ACO should co-exist
- Discuss hospital accountability for resource redeployment, including care transformation plans
- Identify desired supports for hospitals and strategies for payers to support care transformation

Hospital Global Budget Topics

Budget Calculation and Payment Administration

Meeting 13 (October 31)

- Determine who should calculate budgets and manage and oversee the hospital's global budget
- Discuss who should administer the payments
- Discuss if and how to incorporate funding for capital improvement expenditures

Hospital Global Budget Topics

Model Description Review and CMMI Comparison

Meeting 14 (November 14)

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

Hospital Global Budget Topics

Monitoring and Evaluation

Meeting 15 (December 5)

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