Hospital Global Budget Technical Advisory Group

APRIL 18, 2023
MEETING #5

Meeting Agenda

1. Revised hospital global budget design goals
2. Recap of prior meeting discussion
3. Aligning program years
4. Overview of budget adjustments
5. Adjustments to baseline budgets
6. Annual adjustments to budgets for inflation and demographic changes

Revised Hospital Global Budget Design Goals

- A subgroup of the Hospital Global Budget Technical Advisory Group met twice to discuss proposed revisions to the hospital global budget design goals.
- The updated goals incorporate the feedback shared in writing and during the subgroup meetings.

Recap of March 28th Meeting

Calculating Baseline Budgets (1 of 2)

- Members in attendance supported using a **“top-down” approach** for constructing baseline budgets for a few reasons, including consistency of approach, reduced admin burden for hospitals and payers, and minimizing hospital-payer negotiations. Rick Vincent expressed interest in a **“bottom-up” approach** but noted potential consistency with the current GMCB budget review process for top-down. The State will develop more detailed “top-down” and “bottom up” model descriptions for discussion at a future meeting.
- Members supported using ***actual revenue*** as the primary data source for determining baseline budgets, provided that baseline budget adjustments will take into consideration the financial experiences of the hospitals.

Calculating Baseline Budgets (2 of 2)

- Members cited the importance of **understanding the full scope of non-claims-based payment revenue streams** for determining which revenues should be included in the baseline budget. The State will review all non-patient service hospital revenue (operating & non-operating) and develop recommendations regarding commercial payer and Medicaid revenues for budget inclusion.
- Assuming 2025 as the first performance year, the group supported using an **average of 2022 adjusted data and 2023 data** to establish baseline budget expenditures, acknowledging that 2023 data will not be complete until at least summer 2024. If the first performance year begins later than 2025, the group supported using the most recent year with complete data.
- Began discussion of whether global budgets should be established at the **system or hospital level**, acknowledging input was needed from UVMHN.

Meeting Objectives

1. Discuss the implications of a fiscal year versus calendar year approach and develop a recommendation.
2. Develop recommendations for how baseline budgets should be adjusted
3. Develop recommendations for how baseline budgets should be trended forward to the first performance year
4. Introduce the topic of annual budget adjustments and how they will be covered in the workplan schedule
5. Develop recommendations for how budgets should be adjusted on an ongoing basis for inflation and demographic trends

Aligning Program Years

Aligning Program Years

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

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? Would we want to align a Vermont-developed global budget model with the Medicare year or with the hospital fiscal year?

	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	

Adjusting Baseline Budgets

Creating the Baseline Budget: Adjustments

Identify baseline revenue

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

Apply any adjustments

- Adjustment for margin?

We are starting here

Trend forward to performance year

- Inflation
- Demographic changes
- Policy changes
- Other

Adjustments to Baseline Budget

- In calculating the baseline budget, the global budget model could potentially include adjustments to that baseline.
  - These adjustments are distinct from the annual and ongoing adjustments that we will discuss later this meeting and in subsequent meetings.
- We will discuss whether the baseline budget should be adjusted for hospital margins.
- Are there other types of baseline budget adjustments that should be considered?

Adjustments Based on Margins: Definitions

- In the next few slides, we will explore options for making adjustments for hospitals based on margins. We consider two different calculations of margin:
- **Operating Margin** = (Net Operating Revenue)/(Total Operating Revenue) *where*
  - **Net Operating Revenue** = Operating Revenue minus Operating Expenses and
    - **Operating Revenue** = Patient service revenue plus revenue from ongoing non-patient care activities (e.g., parking, cafeteria, gift shop).
    - **Operating Expenses** = Expenses associated with delivering patient care and other operating expenses
- **Total Margin** = Total Net Revenue/Total Revenue, where
  - **Total Revenue = Operating Revenue + Non-Operating Revenue**

Adjustments Based on Margins: Definitions (Example: FY22 Actuals)

		Hosp A	Hosp B
A	Patient service revenue	$305M	$53M
B	Operating revenue (Patient care revenue + revenue from non-patient care activities (e.g., cafeteria, research, parking)	$332M	$61M
C	Operating expenses (Expenses associated with delivering patient care (e.g., salaries and benefits, professional fees, medical supplies, pharmaceutical, etc.) and other operating expenses (e.g., utilities, administrative costs, capital-related costs, etc.).	$344M	$58M
D	Total revenue (Operating revenue plus non-operating revenue, which includes investment income)	$303M	$63M
	Operating Margin (B-C)/B	-3.8%	5.4%
	Total Margin (D-C)/D	-13.6%	8.2%

Adjustment Based on Margin: Rationale

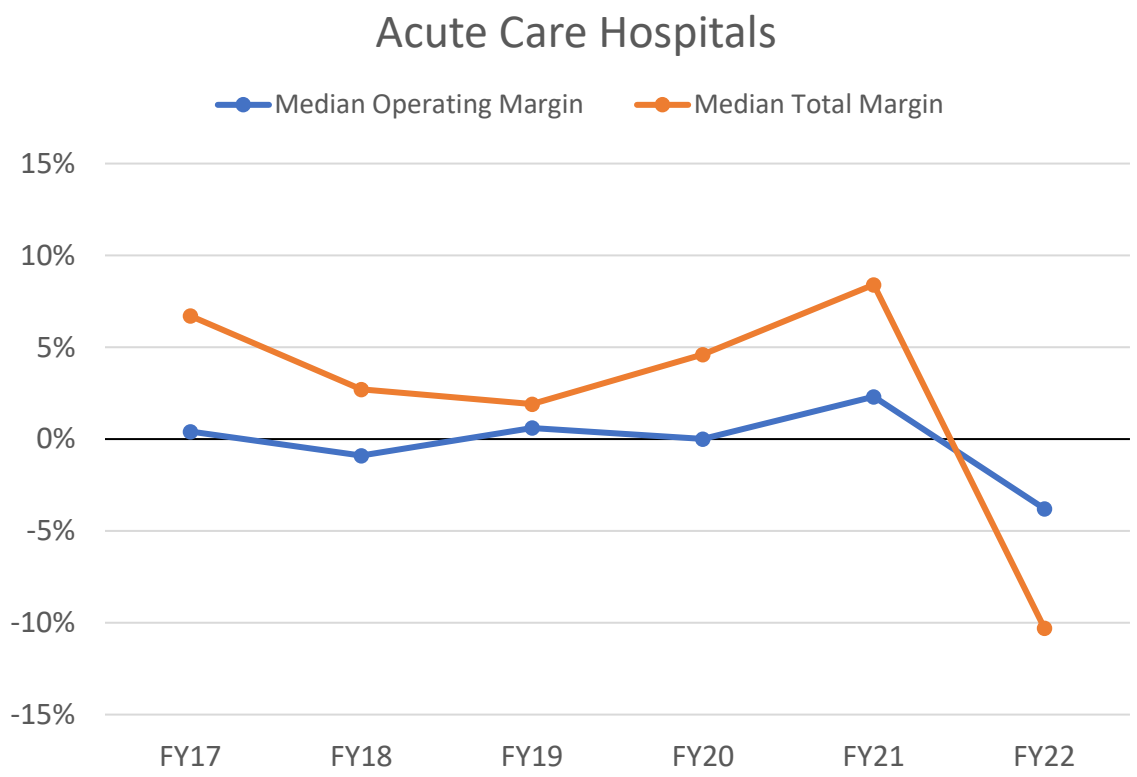
- Hospitals need to generate positive margins to support operations and capital planning to be viable for the long-term.
- Vermont acute care hospitals and CAHs have generally exhibited operating margins *below* non-Vermont hospitals.

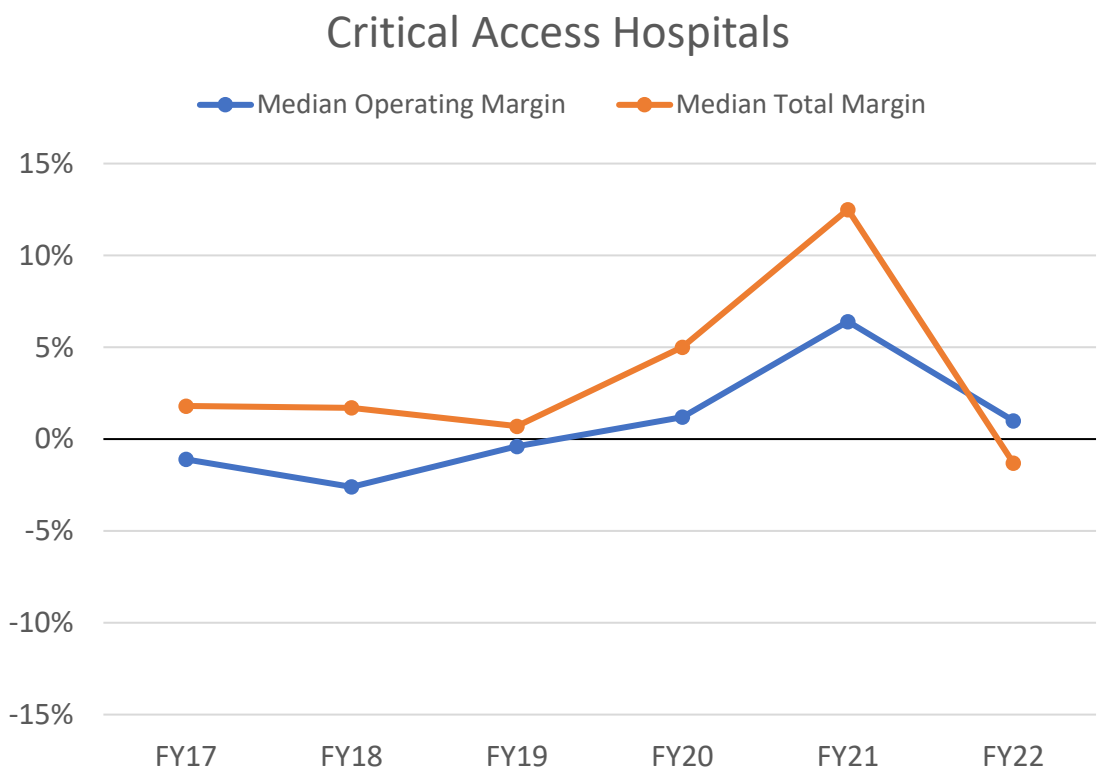
Vermont hospital margins had a marked decline in the most recent year.

Vermont Hospitals: Operating Margins vs. Total Margins

	Margin	FY17	FY18	FY19	FY20	FY21	FY22
VT System Aggregate	Operating	2.7%	1.1%	0.7%	0.1%	2.8%	-1.8%
	Total	5.8%	3.5%	1.9%	1.5%	8.7%	-8.2%
PPS Median	Operating	0.4%	-0.9%	0.6%	0.0%	2.3%	-3.8%
	Total	6.7%	2.7%	1.9%	4.6%	8.4%	-10.3%
CAH Median	Operating	-1.1%	-2.6%	-0.4%	1.2%	6.4%	1.0%
	Total	1.8%	1.7%	0.7%	5.0%	12.5%	-1.3%

Vermont Hospitals: Operating Margins vs. Total Margins





Adjustments for Margin

- The baseline budget could include an adjustment for hospitals that had negative margins during the baseline period.

Rationale for making an adjustment for hospitals with negative margins:	Rationale for NOT making an adjustment for hospitals with negative margins:
• Setting a baseline budget at a level where a hospital experienced losses may not provide sufficient resources to that hospital to operate effectively in the future.	• Adjustments "reward" less efficient hospitals, relative to peers. • Paying for these adjustments will lead to higher health care spending overall.

Adjustments for Margin: Discussion

1. Should the global budget model include an adjustment for hospitals that had negative margins during the baseline period?
    - Conversely, should the model include an adjustment if a hospital had high positive margins, i.e., above a pre-defined threshold, recognizing that Vermont hospitals have not been in this position in recent years?
2. Given the significant percentage of income that some hospitals derive from investments in some years, if there is an adjustment, should it consider **operating margin** or **total margin**?
    - What if operating margin is positive, but total margin is negative? Or vice versa?
3. If there is an adjustment for negative margin, should it get the hospital to breakeven, or to some other point?

Other Baseline Budget Construction Considerations

- Other implications for the baseline budget construction include interactions with other initiatives, including the anticipated primary care spend target in a potential new CMMI model.

Trending Forward Baseline Budgets

Creating the Baseline Budget: Adjustments

Identify baseline revenue

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

Apply any adjustments

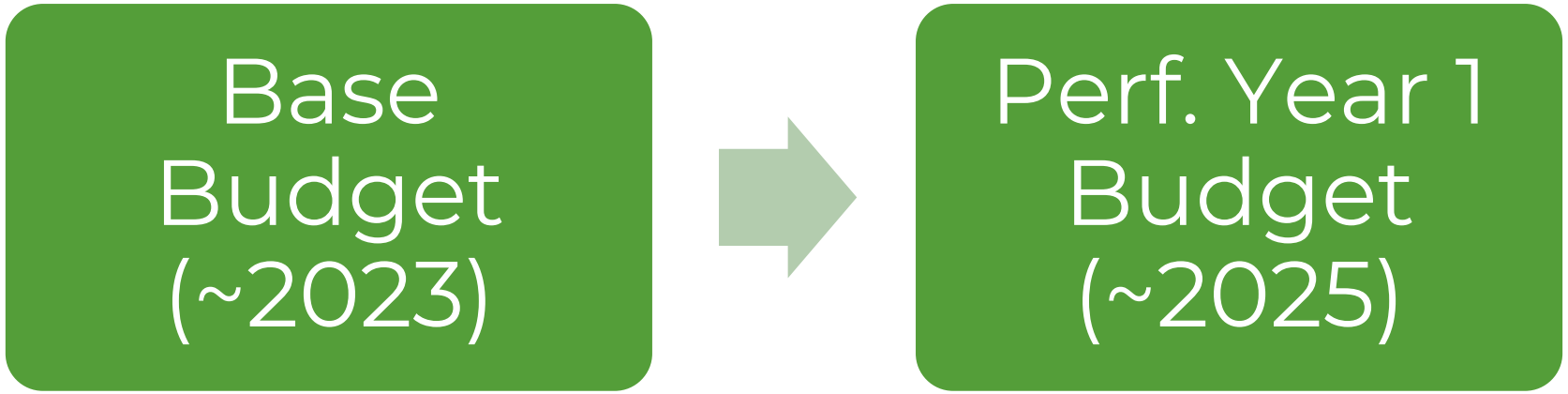
- Adjustments for margin?

Trend forward to performance year

- Inflation
- Demographic changes
- Policy changes
- Other

We are discussing these adjustments

Trending Forward Baseline Budgets: Common Adjustments



- Inflation
- Demographics
- Policy Changes

We will discuss inflation, demographic and policy-related adjustments.

- Are there other adjustments that are important to consider for this specific time period?

(Note that a more comprehensive set of adjustments will be discussed for annual updates after Performance Year 1).

Inflation Adjustment

- Global budgets are adjusted for inflation in other states.
- There are many different measures of inflation that could be used, assessing different types of "inflation."
- We will now seek your feedback on the type of inflation that is most appropriate to incorporate when the base budget is trended forward to the first performance year.
- Later we will also ask you if the annual inflation adjustment for global budgets should be the same or different than what is applied for the base year.

Inflation Adjustment: Considerations for Medicaid

- Medicaid methodologies currently factor in an annual inflationary adjustment.
- Any further inflationary adjustments would require legislative approval.

Inflation Adjustment: Additional Considerations

- We expect the next CMS agreement to include a TCOC target.
- We will need to consider if and how the global budget inflation adjustment will align with this future target.

What Type of Inflation Measure(s) Should be used to Trend Forward Budgets from the Base Year to the First Performance Year?

	Inflation Description	Examples of Possible Measures
Hospital Cost Lens	Reflects increase in input prices experienced by hospitals & potentially physicians	Specific Producer Price Index (PPI) components (e.g., for pharmacy)
	Reflects increase in medical expenditures	Producer Price Index
Affordability Lens	Reflects increase in overall price growth experienced by consumers across the economy as a whole	Core CPI
	Reflects income growth	Median household income

Demographic Adjustments

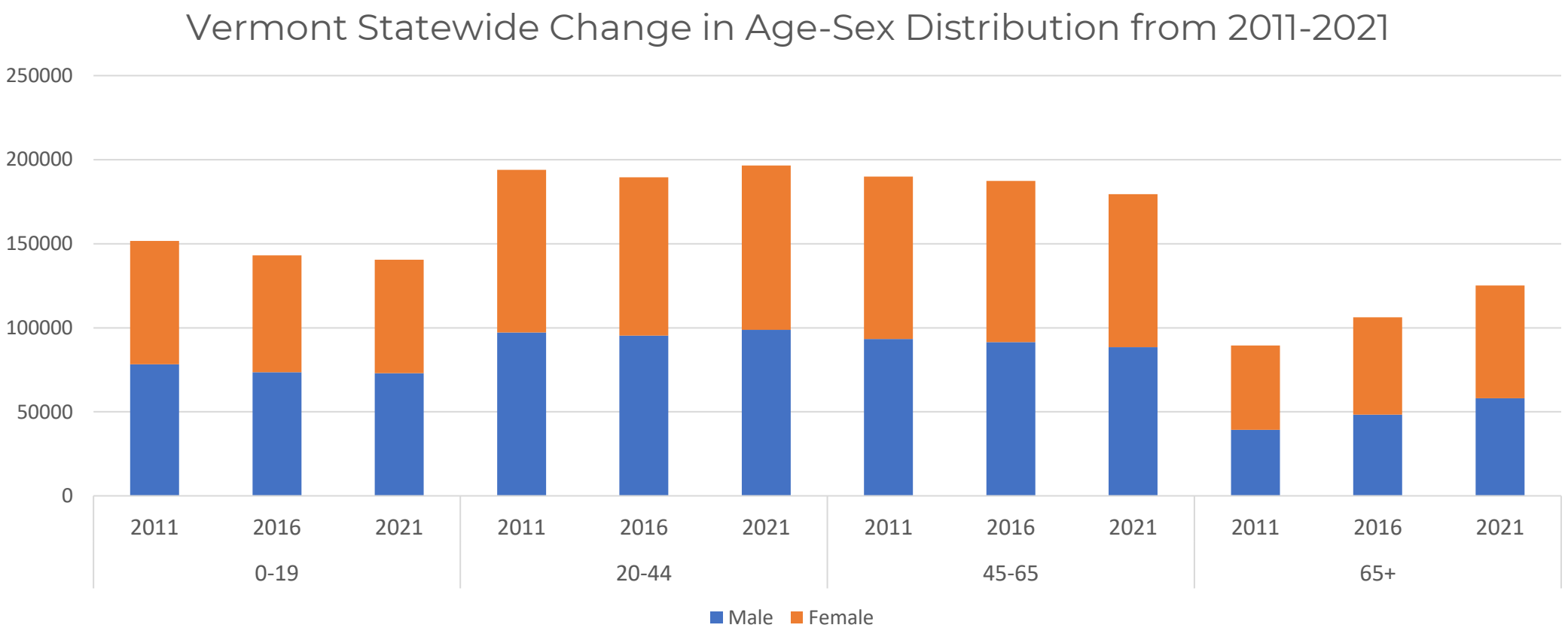
- Other states have adjusted budgets for changes in a hospital's patient population, based on age and sex.
- For determining demographic adjustments when the base budget is trended forward to the first performance year, we propose a two-step process:

  1) A *prospective adjustment*, based on projected population-based changes

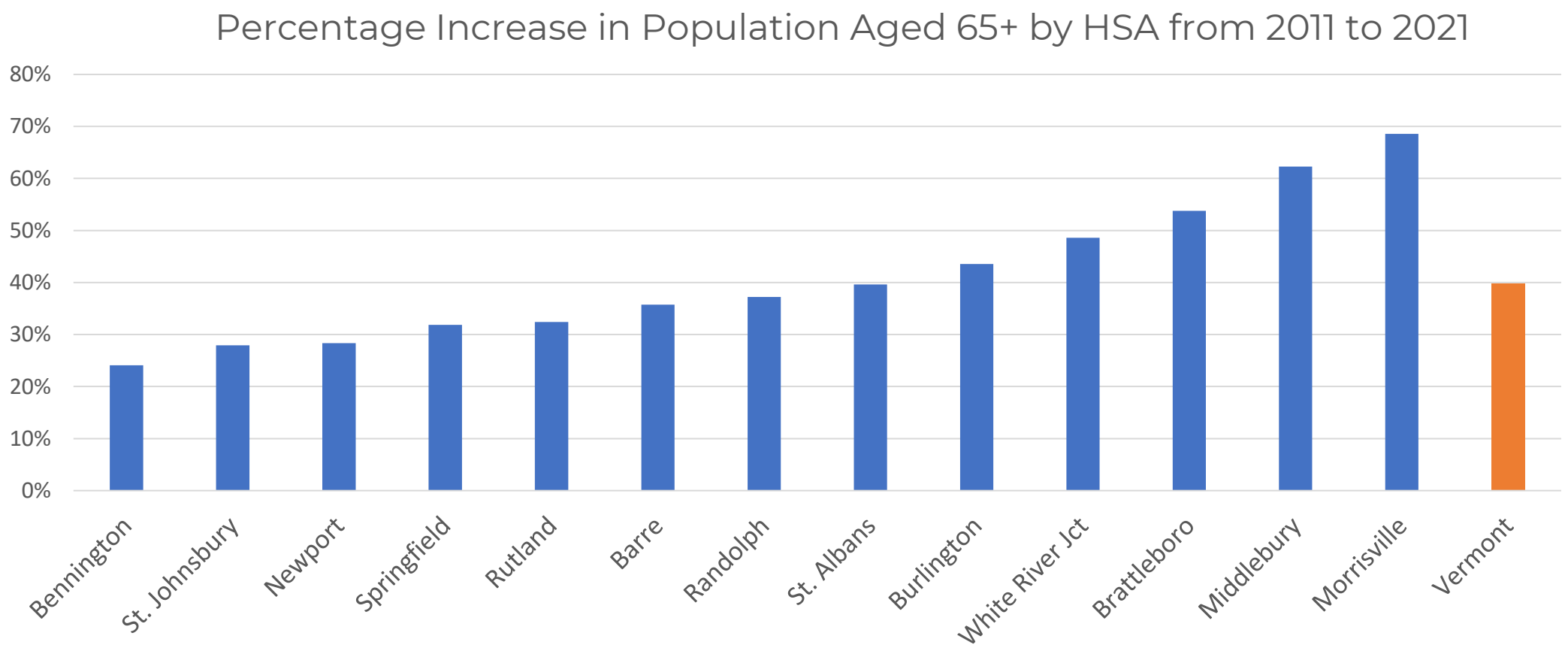
  2) A *retrospective refinement*, based on actual population changes related to a payer's membership, using data reported by payers.

- The following slides display Vermont demographic changes over time and hospital spending by demographics to help inform how to determine prospective adjustments.

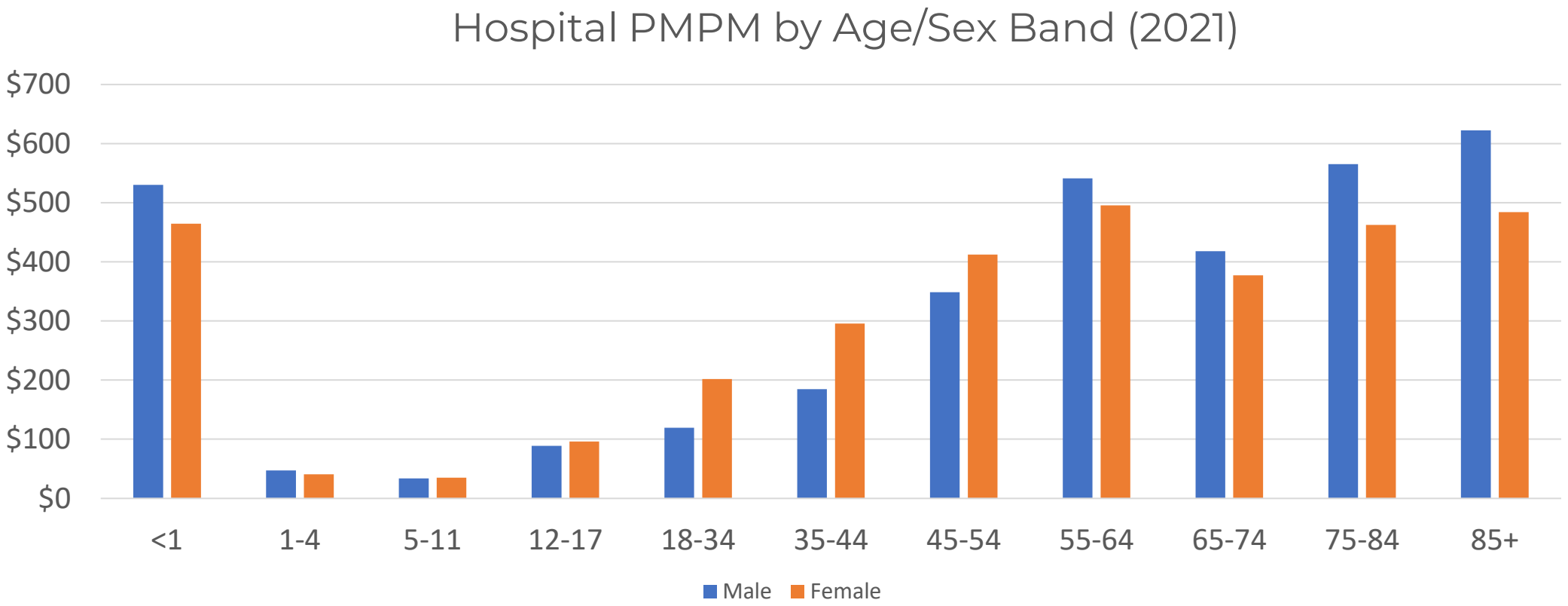
Vermont Demographic Changes



Significant Increase in 65+ Population in all Health Service Areas



Vermont Hospital Spending by Age and Sex



Demographic Adjustments Discussion

- If we adopt a two-step process for demographic adjustments for trending forward the baseline budget:

  1) Should the prospective adjustment be based on:

  - Projected statewide population changes?
  - Projected changes in a given Health Service Area?
  - Payer projections? And if so…
    - What approaches do payers currently use to project population changes?
    - Is there value in defining a standard methodology or allowing payers to use their own?
    - Can payers provide these projections by geographic area?

  2) A retrospective refinement would then be based on actual population changes related to a payer's membership, using data reported by payers.

Should We Adjust for Case Mix?

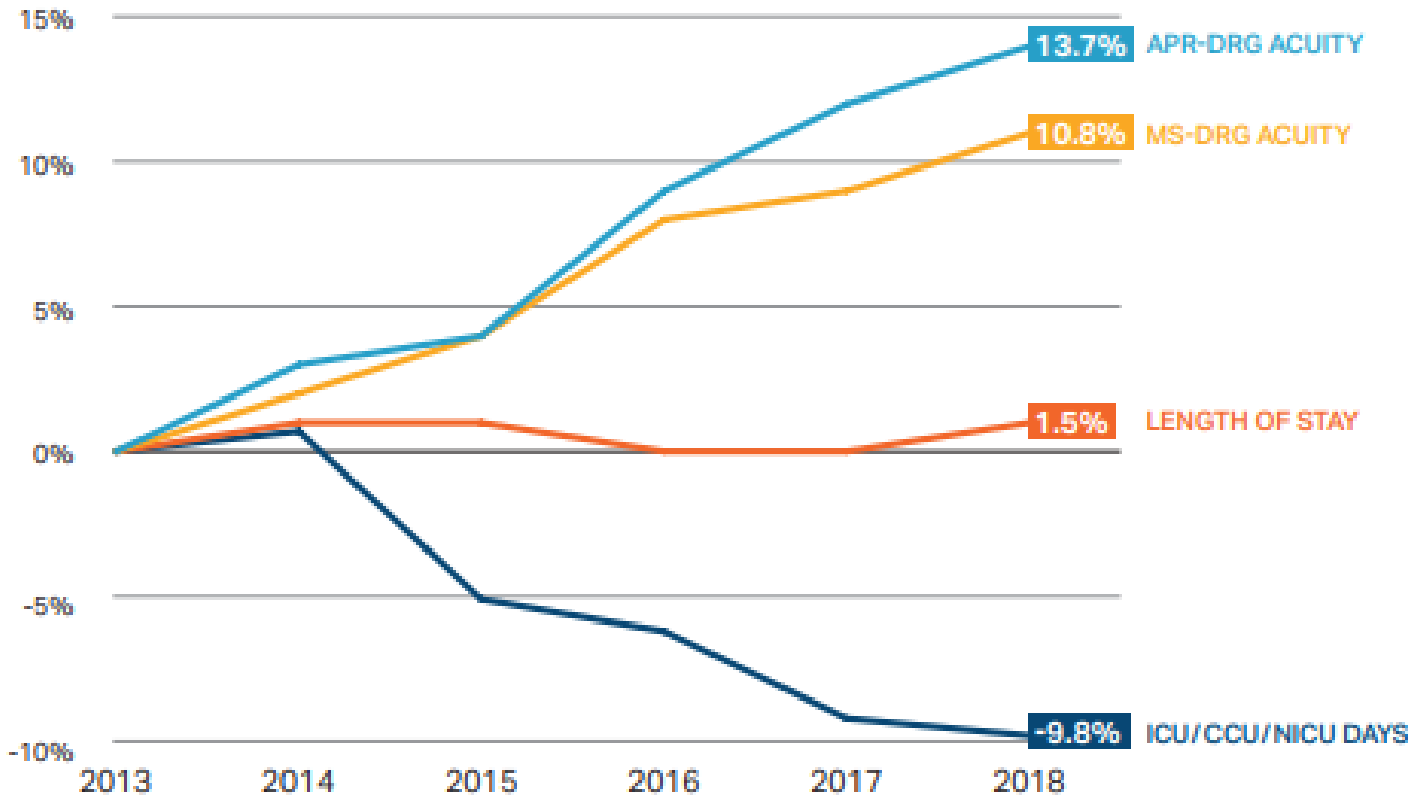
Accounts for changes in the patient population's health status

- Modifies hospital payments to account for the patient population's health status
- Reduces the incentive for hospitals to only treat healthy patients

- May not accurately reflect changes in risk due to coding practices

Example from Massachusetts: Trends in Measured Patient Acuity Compared with LOS and Intensive Care Use

Exhibit 3.1.3 Percent increase in overall DRG weight, patient length of stay, and use of intensive care settings, 2013 – 2018



Notes: ICU = intensive care unit; CCU = cardiac care unit; NICU = neonatal intensive care unit. This curve represents days in any of these settings combined**.**
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, FY2013-FY2018; MS-DRG classification system for each year (weights updated each year), 3M APR™DRG classification system v30.0 using MassHealth weights (weights held constant)

2019 Annual Health Care Cost Trends Report, https://www.mass.gov/doc/2019-health-care-cost-trends-report/download

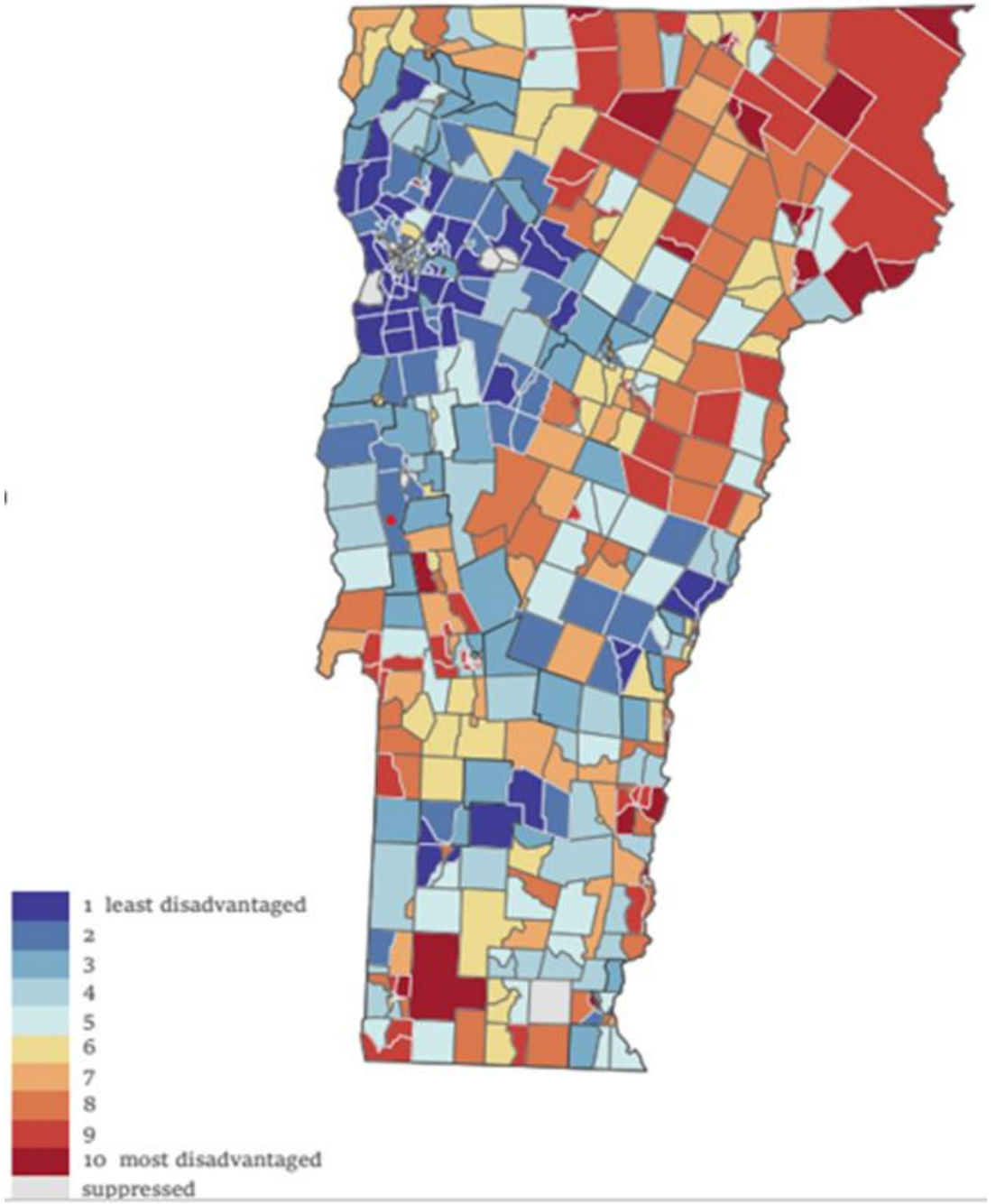
Should We Adjust for Social Risk?

Accounts for the social risk of the population served

- Supports hospitals that serve historically marginalized communities that may need additional resources
- Could be defined geographically based on Area Deprivation Index, Social Vulnerability Index, or other factors such as uncompensated care
- Allows funding that would support hospitals to improve access and facilitate appropriate utilization

- Limited existing research on how to implement social risk adjustment
- No certainty that added funds would be used to further population health equity

Vermont Area Deprivation Index Rankings (2020)



Policy Adjustments

- The CHART model included an adjustment in the base period for changes to Medicare payment (IPPS/OPPS).
  - We recommend that changes to Medicare payment as well as Medicaid payment be reflected in the calculation of the Performance Year 1 budget.
- Adjustments could be also required when there are changes to the structure of organizations (such as acquisitions or transfers).
- Finally, the ending of the Public Health Emergency in 2023 will have as-yet unknown effects. These will need to be monitored.
- Are there other types of policy adjustments that should be explored?

Overview of Annual Budget Adjustments

Annual 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 numerous adjustments over meetings #5-9. We are not suggesting that all of these adjustments be adopted.
- For each adjustment type, we will be discussing whether to adjust, and if so, how the adjustment should be applied (concurrent, retrospective, prospective).

Pros and Cons for Annual Budget 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	• 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 efficient use of resources. • Adding adjustments makes the model more complex.

- Are there other pros or cons to annually adjusting budgets?

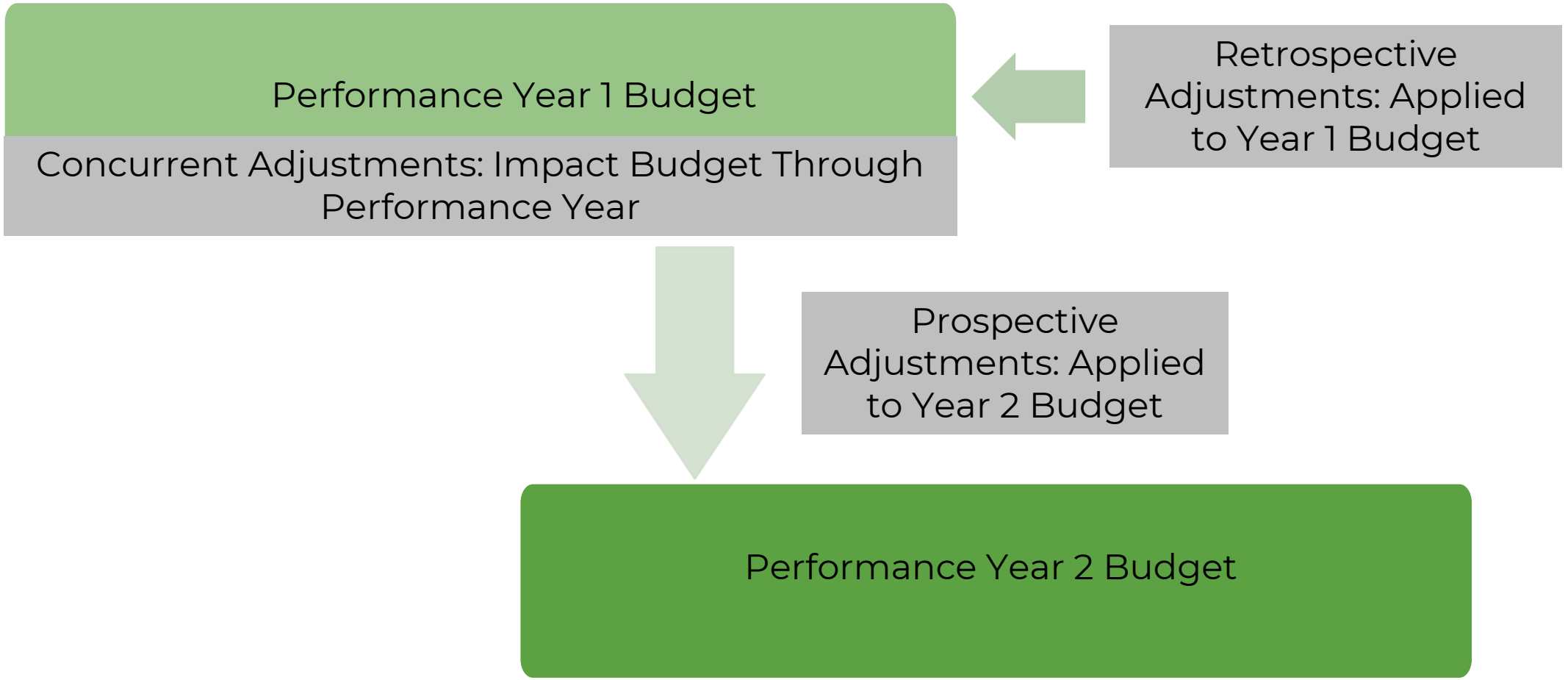
Calibrating Adjustments

- There are different strategies for how an adjustment could be implemented.
- These different strategies seek to balance the desire to reflect changes in the market with the goal of establishing predictable revenue.

Strategies to create more predictability, while still allowing for adjustments/ adaptation
• Avoid mid-year adjustments, and instead work toward multi-year approaches. • Begin with a monitoring phase to see if adjustments are necessary. • Establish thresholds or "corridors" that need to be exceeded before adjustments are applied.

- Let’s consider these strategies as we talk through different types of adjustments.

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)

• Adjustments for Margin	• Inflation
	• Population
	  • Demographics
	  • Case Mix Socioeconomic Factors
	• Other Drivers
		• Service line changes
		• Market shifts
		• Flexible budget
			• 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 we be considering?

Mid-Cycle Check-in on Technical Advisory Group Process

Annual Budget Adjustments for Inflation and Demographics

Annual Adjustments for Inflation & Demographics

Budgets are usually updated annually to reflect inflation & demographic trends.

Inflation

Should the same inflation measure used to trend forward baseline budgets also be used to calculate annual changes moving forward?

Demographics

Should the same approach planned for trending forward the baseline budget also be used to calculate annual changes moving forward?

Should the Inflation and Demographic Adjustments be Made Prospectively?

- Routine adjustments are typically known ahead of the performance period and therefore made prospectively.
  - Prospective adjustments ensures changes in performance during the year are reflected in a future year's budget.
  - They also provide greater certainty around what a hospital's budget will be in advance of the performance period.

Do you agree with a recommendation for prospective adjustments?

Should Inflation & Demographic Adjustments be Made Annually or Less Frequently?

ANNUAL ADJUSTMENTS

- Ensures hospital budgets reflect the most recent performance
- Results in one methodology to calculate budgets every year

LESS FREQUENT ADJUSTMENTS

- May be more reasonable to implement less frequently (e.g., every other year) if budget adjustments are small

Wrap-up and Next Meeting

The next Hospital Global Budget Technical Advisory Group meeting is scheduled for Tuesday, **May 9th** from 10 am – 12 pm.