Health Care Reform Work Group
Global Budgets Discussion Part 1

August 30, 2022 Meeting Summary

Recap of Context: CMS Innovation Center's 7 Design Criteria

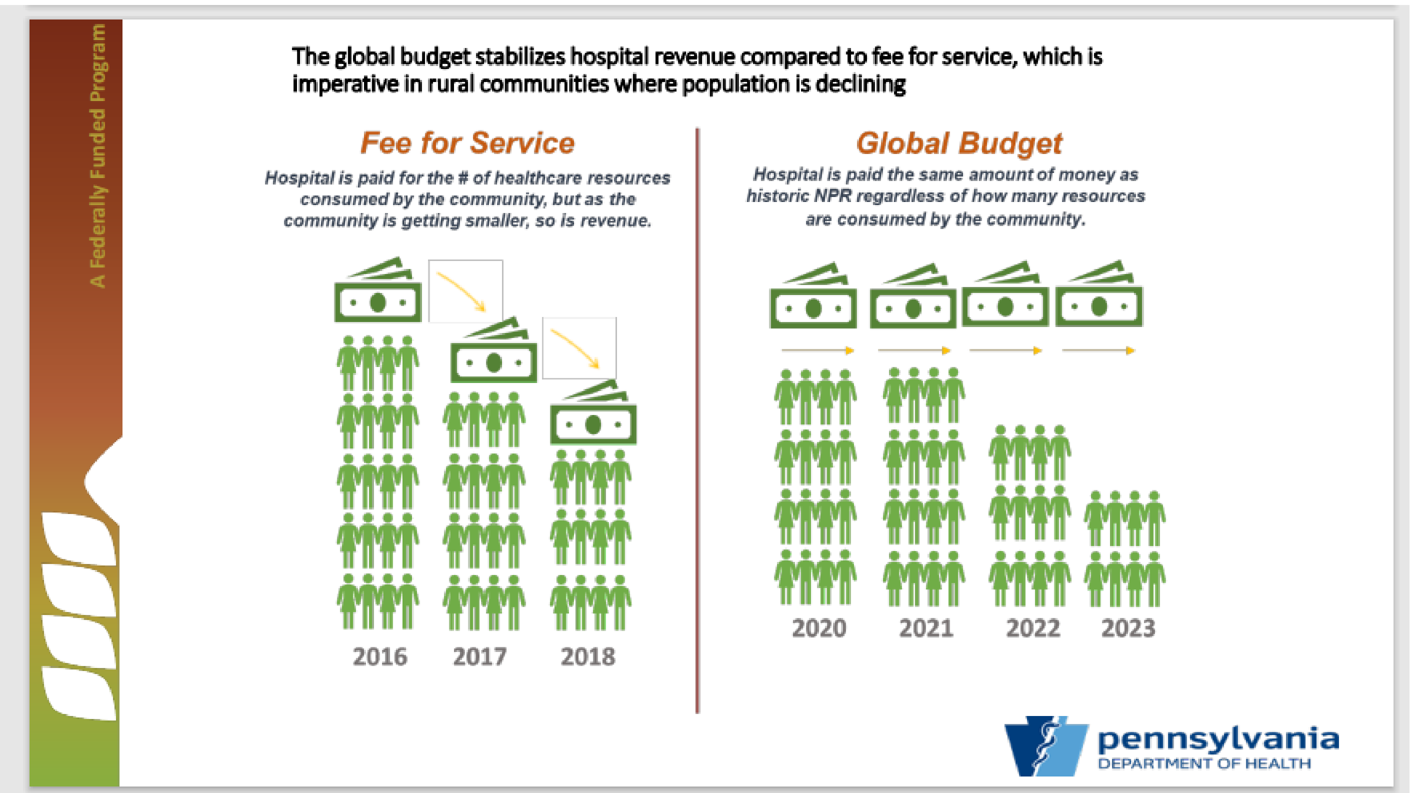
CMMI is signaling it will produce a design to span multiple states from 2025 that will address seven priorities.

1. **Include global budgets for hospitals.** ★ ***Focus of today's discussion***
2. Include TCOC target/approach.
3. Be All-Payer.
4. Include goals for minimum investment in primary care.
5. Include safety net providers from the start.
6. Address mental health, substance use disorder and social determinants of health.
7. Address health equity.

CMS's Perspective on Global Budgets

What is a Global Budget?

- A global budget is a prospectively set budget for a fixed period of time (typically one year) for a specified set of services to a population of an assumed size, rather than fixed rates for individual services or cases.
- Global budgets (like other forms of capitation) were originally employed to limit hospital spending by eliminating incentives to increase utilization. However, in recent years and especially since COVID 19, proponents of global budgets have emphasized their ability to improve stability for hospitals, especially in rural areas. *E.g. Pennsylvania, 2019*



Source: Global Budgets for Hospitals; *PowerPoint Presentation (ruralcenter.org)*

How Can Global Budgets Advance Healthcare Reform?

Global budgets *reward* hospitals for reducing utilization by improving health, rather than penalizing them

Example: A hospital invests in a new program to improve diabetes management by collaborating with employed and community physicians, hiring new health educators, and funding cooking and nutrition classes. As a result, hospitalizations and procedures for diabetic patients decline.

Today

- Hospital revenue declines, with fewer admissions and fewer procedures
  - *Can be true even in prospective payments if next year's payments are tied to last year's utilization*
- Hospital no longer has revenue to invest in diabetes management program

Under Global Budgets

- Hospital revenue holds steady because global budget does not take volumes into account
- Hospital continues to have revenue to invest in diabetes management program
- Assuming diabetes management program is less costly than the admissions, hospital margins increase

Source: Global Budgets for Hospitals; *PowerPoint Presentation (ruralcenter.org)*

Global Budget Opportunities and Challenges

OPPORTUNITIES	CHALLENGES
▪ Predictable funding stream for facilities and providers, especially those with low specialty/elective demand ▪ Provides more certainty on spending ▪ Increased flexibility to add services that are responsive to communities' needs rather than traditional profit centers, since revenue holds steady even as services shift to historically lower margin service lines ▪ Provides incentives to improve operating efficiency because hospitals retain dollars	▪ Requires multi-payer commitment to ensure effectiveness at provider level ▪ Complex technical adjustments needed to account for volume shifts to other providers or changing demographics; newer approaches to global budget mitigate some of these challenges ▪ Requires an entity with technical ability to set the budgets across payers and make appropriate adjustments ▪ Challenging to balance global budgets with competition (less relevant to most Vermont communities)

See appendix for further resources on global budgets

Source: Global Budgets for Hospitals

How CMS Defines Global Budgets

There are many different definitions of "global budgets" used in health care literature and in practice. Today we will focus on how CMS defines global budgets.

- CMS has implemented three models it refers to as Global Budgets:
  1) Maryland All-Payer Model; 2) Pennsylvania Rural Hospital Model; and 3) CHART model.
- All have the following features:
  - **"Facility-based" (hospital) based.** Budgets are designed around the spending of a facility (i.e., hospitals) and establish a prospective budget for a facility's spending (inpatient, outpatient care).
  - **Multi-payer.** CMMI's global budget models are multi-payer. Medicare, Medicaid, and commercial payers participate in all three models, although payer participation requirements vary. For example, commercial participation in Maryland's model is mandatory while it is voluntary in Pennsylvania's model.
  - **Population health investments.** Models aim to incentivize investments in population health and prevention, encouraging adjustments to care delivery to better address the needs of a community.

Source: What's in a Name: A Primer on Global Budget Models

Maryland All-Payer Model

- Under Maryland's global budget model, a hospital's revenue for inpatient and outpatient services during a year cannot exceed the budget approved by the state (i.e., "Approved Regulated Revenue").
- **All** hospitals in Maryland **must** participate in the model.
- Maryland has a history of ratesetting from the 1970s. The model has been implemented in its current form since 2014.
- In practice, the Maryland "global budget" is better understood as state-regulated **pricing** that applies to all payers.
  - Hospitals charge payments for individual services in the usual way – unlike in the Pennsylvania model.
  - A hospital may increase pricing to maximize its revenue within the parameters of the budget approved by the state. Pricing must be decreased if a hospital approaches or exceeds its approved budget. A hospital may increase or decrease its fees by up to 5% during the year and may implement larger changes (up to 10%) with approval from the state.

Uniqueness of Maryland Design:

A key defining feature of Maryland's global budget model is the role of the Health Services Cost Review Commission (HSCRC), Maryland's independent hospital rate-setting agency. HSCRC regulates all the fees that hospitals charge.

All payers in the state are required to pay hospitals the HSCRC-set fees, including (uniquely in the country) Medicare. This is an authority that requires a unique Medicare waiver and is not seen in other states.

The effect of the model is that hospitals charge all payers (Medicare, Medicaid, commercial) essentially the same amount for a service. In other states, there are typically large differences in amounts charged by payer—commercial payers usually have the highest fees.

For these reasons, the analogy between Maryland and the new multi-state proposal has limitations.

Source: Strengths and Weaknesses of Global Budgets; HSCRC Overview

Pennsylvania Rural Hospital Model

- The Pennsylvania Rural Health Model (PARHM) tests whether paying rural hospitals a prospectively fixed, global budget for all hospital inpatient and outpatient services promotes improvements in population health.
- **Unlike** the Maryland model:
  - Model applies only to rural hospitals and is voluntary for hospitals to participate. Currently, 13 facilities are participating.
  - Payments to hospitals are made **prospectively in place of** usual payments. The prospective payments need to be adjusted at the end of the year to account for trends out of the hospital's control.
  - **The model is not mandatory for payers and does not change payers' ability to set prices.** Thus, each participating payer is effectively setting its own payer-specific budget for each participating facility.
- The Pennsylvania Rural Health Redesign Center is the governance body set up in state law to manage the model. It is responsible for the common global budget methodology, but individual payers still calculate and make payments.
- This model officially went live in 2018 but did not fully go live until 2019.

Examples of Hospitals' Lessons Learned from Model Implementation

- Global budget payments offered a **stable revenue source** and proved particularly helpful during the earlier part of COVID-19.
- Global budgets **accommodated hospital growth**, encouraging hospitals to expand services (e.g., cancer treatment) based on the needs of the community.
- Hospitals experienced **challenges monitoring global budgets** due to large volumes of data and the need for advanced analytic capabilities. They mitigated these issues by collaborating closely with technical experts and payers.
- Developing hospital transformation plans were **resource and time intensive**.
- Hospitals **needed to leverage funds outside of the global budget** to implement hospital transformation activities, particularly during the first year of model implementation due to a lack of sufficient savings.

Source: Strengths and Weaknesses of Global Budgets; The Pennsylvania Rural Health Model (PARHM) Second Annual Report

CHART Model

- The Community Health Access and Rural Transformation (CHART) Model is targeted to rural hospitals providing services to individuals residing in 1 of 15 rural "Communities" across the country.
- A Community includes: 1) 1+ counties or census tracts that are classified as rural; and 2) At least 10,000 Traditional Medicare beneficiaries residing within its boundaries.
- Like the Pennsylvania model, participation is voluntary for both payers and rural hospitals.
- The strict eligibility criteria preclude most rural hospitals from participating individually due to low numbers of Medicare beneficiaries on Traditional Medicare within their operating counties.
- **The Model is in the very early stages of implementation with COVID-related disruption; it is too soon to generalize lessons learned.**

CHART Capitated Payment Amount (CPA) Mechanics

- Each month, the participating hospital receives a **single, predetermined Medicare Capitated Payment Amount (CPA)** that covers all eligible services delivered to Original Medicare beneficiaries.
  - Eligible services are inpatient and outpatient hospital services and inpatient rehabilitation services delivered in swing beds at CAHs.
  - The CPA is based on historical spend, **with a discount applied.**
  - The CPA may be adjusted based on changes in unit price of services, quality, demographic & population size, as well as distribution of eligible hospital services between hospitals.
- CPAs are prospective payments but are **retroactively adjusted** six months after the end of the year based on claims data.
- Other payers are required to "align" with Medicare but (like Pennsylvania) this is not an exact science. **Medicaid participation is required**, but Medicaid revenue does not need to be paid through a Capitated Payment Arrangement until the second performance year. Commercial payer participation is voluntary.

Source: Strengths and Weaknesses of Global Budgets; CHART Model; CHART Model Overview Webinar

Applying Global Budget Concepts to Vermont

Global Budgets are One Part of Vermont's Broader Health Care Reform Efforts

Vermont's Vision

Interested in global budgets but thinking beyond hospitals to multiple provider types (e.g.,MH/SUD) and services, some of which included in VT's All-Payer ACO Model today and already subject to alternative payment models

CMMI's Vision

Focused on hospital global budgets; will likely build on PA and CHART models

Vermont's vision for APM 2.0 may be broader than CMMI's design starting point for the next state model.

GMCB and AHS are Actively Exploring Global Budgets

Step 1

Conducted literature review on existing state models to understand the current global budget landscape:

- Maryland All-Payer Model
- Pennsylvania Rural Health Model
- University of Alabama Birmingham CHART Model
- Washington State Health Care Authority CHART Model

Step 2

Interviewed national experts on global budgets to further understand mechanics of global budgets and gain insights from their experiences in the field:

- Sally Kozak & Mara Perez, PA Medicaid Agency
- Tricia Roddy & Laura Goodman, MD Medicaid Agency
- Donna Kinzer, former Executive Director at HSCRC
- Bob Murray, former Executive Director at HSCRC
- Joshua Sharfstein, former Secretary at MD Department of Health and Mental Hygiene

Key Themes from Global Budget SME Interviews

Scope of services within a global budget should be narrow. Incorporating too many services across different providers into the global budget may lead to operational and governance challenges.

Considerations for Vermont:
- What types of services are ideal to include in global budgets?
- What types of services should be excluded from global budgets? How can these be incorporated into the State's overall health care reform efforts?

All-Payer participation is critical to the success of the model. This will ensure that providers face the same incentives across all payers.

Considerations for Vermont:
- Are providers in agreement that all payers should participate in the global budgets?

Various provider organizations should not be tied to the same payment arrangement, though there can be ways to tie providers together in some respects. It is difficult for the State to identify and implement the appropriate division of funds among the different provider organizations.

Considerations for Vermont:
- How will Vermont develop an adequate governance structure to ensure dollars are distributed appropriately among provider types?

Incentives should be close to individual providers. Incentives that are too distant will not encourage optimal behavior.

Considerations for Vermont:
- How have providers experienced these incentives under the current ACO model?

Global Budget Conceptual Straw Models

"True" Community-Based Global Budget Approach

Prospective budget for a specific geographic area where providers are accountable together for spending associated with all or most health care services received by the population in that given geographic area.

"Portfolio Approach"

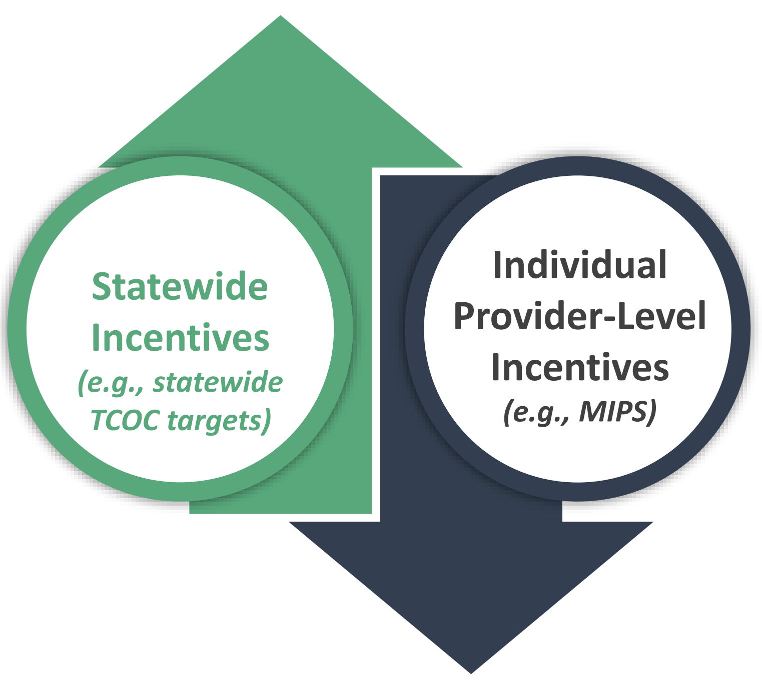
Facility global budgets and other APMs for independent professionals (primary care, BH, etc.) operate separately but together can produce better stability and predictability within each geographic area.

Locations of Financial Incentives

SMEs advised that design should consider how to balance problems that occur with incentives at either too large or too small a scale.

Distant Incentives Do Not Drive Transformation

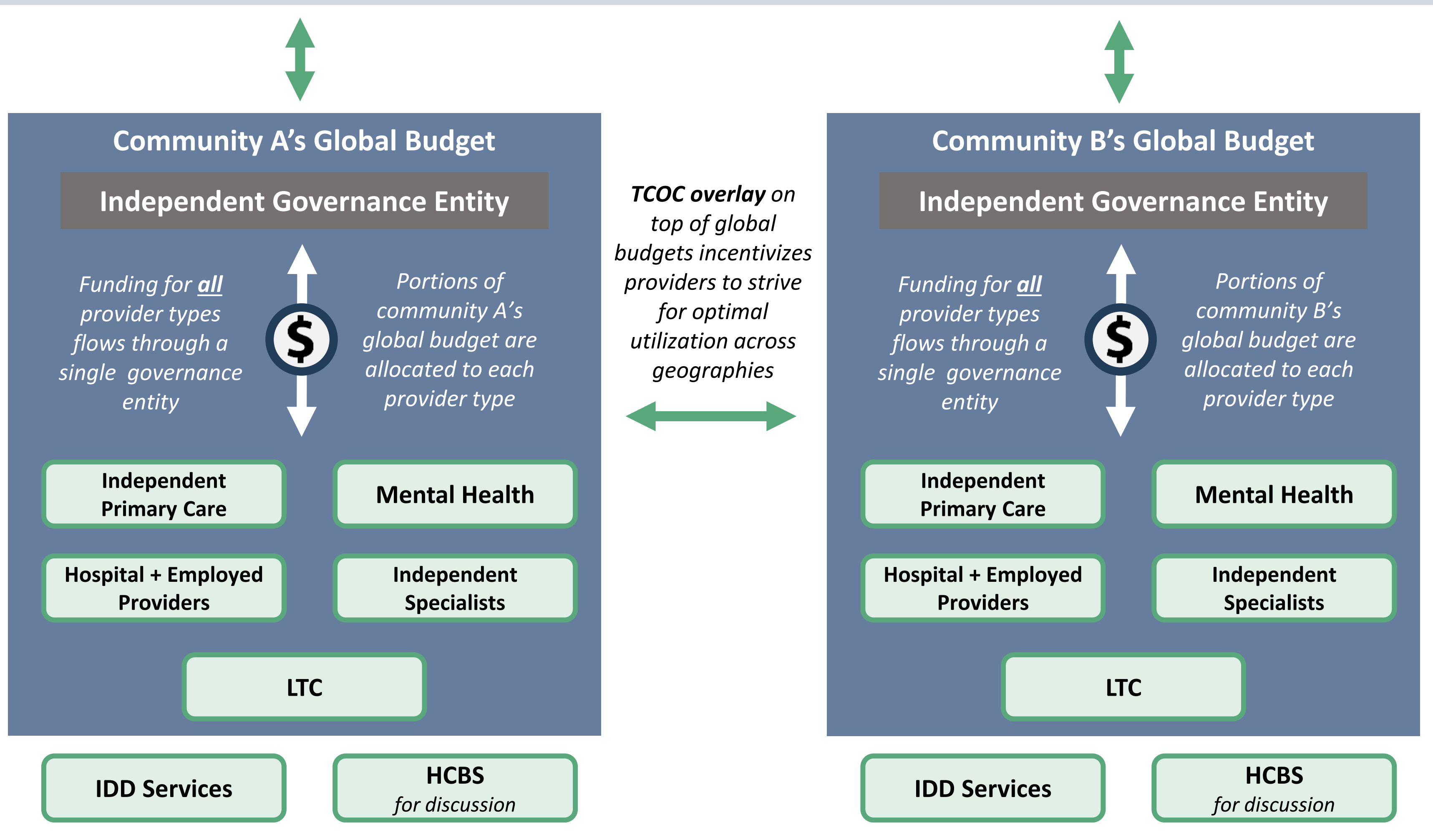
For example, if a hospital invests in better discharge planning and post-discharge follow-up, it generates savings for the total cost of care (TCOC) model. However, these savings are offset if another hospital in Vermont increases utilization, leading to no gains. Additionally, even if there are gains statewide, it is unclear that the hospital will see a return on its investments in discharge planning and post-discharge follow-up.



…But Close Incentives May Not Encourage Collaboration and System-Wide Thinking

Incentives located at the individual provider level ensure that providers “feel” the incentives. However, they do not support awareness of costs and quality across the broader system, and can even encourage gaming (e.g., shifting care to other providers – “cherry picking”).

“True” Community Global Budget



“Portfolio Approach”

Proximity of Incentives

More diffuse incentives that continue to encourage system-wide efficiency

All-Payer TCOC incentives *(continued ACO structure)*

Incentives based on TCOC would remain in place but would be supplemented by tailored payment models by provider type to encourage sustainability and coordination.

ACO could continue to manage calculation and distribution of shared savings based on TCOC and the proposed new “shared interest payments.”

Intermediate “shared interest payments” that bridge across 2-3 Provider types

Potentially administered by local governance entity (could be similar to ACH) or coordinated by participating providers in shared quality bonus arrangement

Shared Quality Bonuses and Penalties
(e.g., for MH follow-up after hospitalization, MH/SUD follow-up after ED visit)

Example of shared quality bonus arrangement between hospital/employed providers + MH

More direct financial incentives for individual Provider**

Population-Based Payments*	Health System Global Budget	TBD	Case Rate	TBD
Independent Primary Care	Hospital + Employed Providers	Independent Specialists	Mental Health	LTC

Focus of discussions with CMMI

** Includes funding for Blueprint and SASH*

*** DVHA is currently administering and designing several alternative payment models related to adult and children’s mental health, applied behavior analysis services, residential SUD services, children’s integrated services, high-technology nursing services, and developmental disabilities services. These models can be integrated into the portfolio approach.*

Work Group Questions About Global Budgets

1. How have global budgets worked for hospitals near state borders that serve many non-state residents?
2. Have states seen a change in how physicians are compensated after implementing global budgets?
3. Which services will be included in the global budget?
4. How can global budgets be based on historical revenue if current revenue is insufficient?
5. How will budget adjustments work, and will there be reconciliations?
6. How will the independent governance entity be structured?
7. How will “geographic area” be defined in the community-based global budget straw model?
8. How does the portfolio straw model differ from the status quo?
9. What will be the role of the ACO under each straw model?

Proposed Timeline and Next Steps

Topic *(subject to change)*	Date
Global Budgets (Pt. 2), APM 2.0 Principles	Early September
Total Cost of Care, All-Payer Participation	Mid September
Minimum Investment in Primary Care	Late September
Safety Net Providers	Late September
Social Determinants of Health, Health Equity	Early October
TBD	Mid-October and beyond

Meeting topics may change depending on workgroup discussions.