Global Budget Subgroup

OCTOBER 25, 2022, MEETING #4 SUMMARY

Meeting Agenda

1. Recap of Prior Meeting Discussion
2. Potential Flexibility to Account for Current Hospital Operating Losses When Establishing Budgets
3. Potential Flexibility for Voluntary or Mandatory Hospital Participation
4. Next Steps

1. Recap of Prior Meeting Discussion

Recap of 10/18 Meeting

- Subgroup members supported seeking flexibility from CMMI to utilize flexible budgets.
- Subgroup members identified the following issues as requiring future discussion when considering potential flexible global budget design:
  - How to account for employed professional services?
  - How to avoid penalizing hospital investments in upstream social determinants of health?
  - How and at what level to set the fixed /variable expense budget percentages?
  - Whether to vary demographic adjustments for referral hospitals and whether there should be different approaches for CAHs

2. Potential Flexibility to Account for Current Hospital Operating Losses When Establishing Budgets

What Does It Mean to Set a Global Budget?

- One of the most critical steps in designing and implementing hospital global budgets is establishing and later updating budgets for each hospital.
- Each hospital's budget must be adequate to fund needed care, future needed capital investment, and to support other activities that support community health and/or constrain spending growth (for example, care management and population health activities). They should also take into account any desired investments, such as in primary care or behavioral health.
- These budgets must also incentivize hospitals to prevent unnecessary and avoidable ED and inpatient utilization, as well as to pursue efficient operations.

What Does It Mean to Set a Global Budget?

This schematic is generalized from the CMMI CHART model with questions for the Subgroup noted in italics.

Determine baseline expenditure	Project forward to performance year	Apply adjustments
• *Which years?* • *Which services?* • *Any adjustments?*	• Trend • Population changes • (Medicare payment policy changes)	• Special status • Other (CMS identifies bad debt, IME, LVA) • CMS established discounts

Data Used to Calculate Budgets

- Current CMMI models (MD, PA and CHART) used hospitals' historical utilization and inpatient and outpatient revenue to produce their budgets.
- Historical experience can be adjusted when setting prospective budgets to serve state policy interests.
- It is possible to begin using historical data and phase in adjustments over time to reach a desired payment level; adjustments could also vary year to year.
- Historical data can come from one year or an average across multiple years.
- It is important to ensure that the budget for the first year does not rely upon historical data during which hospitals generated operating losses unless adjusted to account for the losses.

State and Federal Examples of Different Revenue Data Sources

	CMMI Community Health Access and Rural Transformation Model (CHART)	Maryland All-Payer Model and Total Cost of Care Model	Pennsylvania Rural Health Model
Service categories included	Inpatient and outpatient revenue	Inpatient and outpatient revenue	Inpatient and outpatient revenue
Years of data	Average across two years	Most recent prior year	Average across three years
Level of data and payment approach	Use payer-specific revenue to establish different rates and hospital-specific budgets for each payer	Aggregate data across payers to establish one all-payer budget; state uses data to calculate service-specific rates for use across payers	Use payer-specific revenue to establish different rates and hospital-specific budgets for each payer

GMCB's Hospital Budget Review

- The GMCB reviews and establishes budgets for Vermont's 14 community hospitals.
- In its review, the GMCB takes several factors into consideration, such as the needs of the hospital's local community, as well as each hospital's:
  - cost structure;
  - administrative costs;
  - capital investments;
  - workforce needs;
  - utilization patterns, and
  - overall financial health, including hospital operating margin.
- These factors are more extensive than those used in existing global budget models, which focus on patient revenue.

Operating Margins for Vermont Hospitals

Acute care hospitals

- Acute care hospitals in Vermont have generally exhibited median operating margins below non-Vermont hospitals over the past four years.

Critical Access Hospitals

- CAHs in Vermont have exhibited median operating margins above or near non-Vermont hospitals in recent years..

Operating margins have generally been inadequate the last three years.

Average Operating Margins for CAH and PPS						
	FY20		FY21		FY22	
	CAH	PPS	CAH	PPS	CAH	PPS
Operating Margin	-0.18%	0.29%	5.92%	1.83%	0.65%	-2.70%

Subgroup Member Input

- Subgroup members expressed difficulty assessing how best to set baseline budgets given certainty about financial performance during 2023 and 2024.
- Subgroup members voiced concern about how to set budgets if hospital operating margins continue to be poor.
- Members noted the following challenges with adjusting baseline budgets if operating margins continue to be poor:
  1. identifying the revenue source for the increased budget, and
  2. equity implications of rewarding hospitals that have been less efficient and effective in their financial management obligations.

3. Potential Flexibility for Voluntary or Mandatory Hospital Participation

Introduction: Voluntary vs. Mandatory Hospital Participation

- As CMMI develops its proposed model, Vermont should consider whether it should advocate for flexibility to allow voluntary *or* mandatory hospital participation in the CMMI model.
- **Voluntary participation**: Hospitals can choose to participate in the model and if they elect to participate, have an option to leave the model at a future date.
- **Mandatory participation**: All hospitals are required to participate.
- We will be discussing *payer* participation in a future session. The focus of this conversation is hospital participation in the CMMI model for Medicare.

Rationale for Requesting Flexibility for Either a Voluntary or Mandatory Approach

- States and providers will want to see more specifics of the model before determining whether a voluntary or mandatory approach would be more appropriate
- In the appropriate context, including an option for a mandatory approach would:
  - Guarantee broad participation in global budgets
  - Create uniformity and decrease administrative costs for payers if payment mechanisms are consistent across providers (the same is true on the provider side if there is broad payer participation)
  - Allow for mandatory participation as a back-stop if increased participation is needed to achieve the model's goals, potentially as part of a phased approach

Additional Considerations for Voluntary vs. Mandatory Approach

- A **hybrid approach** is conceivably possible, with some design elements voluntary and others mandatory. For example:
  - Hospitals could be required to participate but could choose to exclude **certain services** from the global budget, e.g., employed physician services, hospital-owned entity services.
  - Hospitals could be required to participate for one or two **lines of business**, but not for all lines of business.

Mandatory Approach: Maryland

- Maryland's Health Services Cost Review Commission's all-payer hospital rate-setting authority has allowed the Commission to compel private payers and Medicaid to use hospital global budget arrangements with the state's 46 general acute care hospitals since 2014.
- Maryland entered into an agreement with CMS exempting hospitals from Medicare's inpatient and outpatient prospective payment systems.
- The State's hospital payment structure shifted to an all-payer, annual global budget, which ensured that global budgets encompassed 95% of hospital revenue.

Voluntary Approach: Pennsylvania and CHART

Pennsylvania Rural Health Model	CMMI Community Health Access and Rural Transformation Model (CHART)
• Open to both Critical Access and acute care hospitals in rural PA • Of the 67 hospitals in rural PA, 18 participate in the model • Hospital participation targets increased over time; participation has been below the targets • Initial goal of 30+ hospitals for 2022-2024; reduced to 18+ hospitals due to difficulties with recruitment • Higher participation among independent hospitals than system-affiliated hospitals	• Open to both Critical Access and acute care hospitals in select rural communities • Hospital participation in AL, SD, TX, WA not yet established, but forecasts are for limited participation due to the details of the CHART program design.

Voluntary Approach: Vermont All-Payer ACO Model

- Vermont's all-payer ACO model is voluntary and has strong hospital participation, with 13 of 14 hospitals in the state participating:
  - 13 of 14 participate for Medicaid
  - 12 of 14 participate for Commercial
  - 9 of 14 participate for Medicare

Subgroup Member Input

- Subgroup members supported seeking flexibility, however noted that it is difficult to make this decision at this time.
- Members expressed support for a consistent approach across payers and hospitals, but recognized it is first necessary to know the model that CMMI puts forth.
- One member suggested that it might be helpful to have the flexibility to transition from a voluntary hospital participation to a mandatory hospital participation approach over time.

4. Next Steps

Planned Topics for 11/1

1. Potential Flexibility for Specialty Hospital Participation
2. Considerations Specific to Critical Access Hospitals (CAHs)