

Health Care Reform Workgroup Meeting
Global Budgets Discussion Part 1

August 30, 2022

Agenda

- **Part 1: CMS's Perspective on Global Budgets**
 - Global Budgets 101
 - CMS Portfolio of Global Budget Models
- **Part 2: Applying Global Budget Concepts to Vermont**
 - AHS/DVHA Activities to Date
 - Key Findings from Interviews with Global Budget Experts
 - Vermont's Design Preferences for Health-System Global Budgets
- **Discussion and Next Steps**

Objectives

1

Establish a shared understanding of global budgets and key design considerations

2

Understand CMMI's current portfolio of global budget models

3

Discuss how global budgets could be implemented in Vermont

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

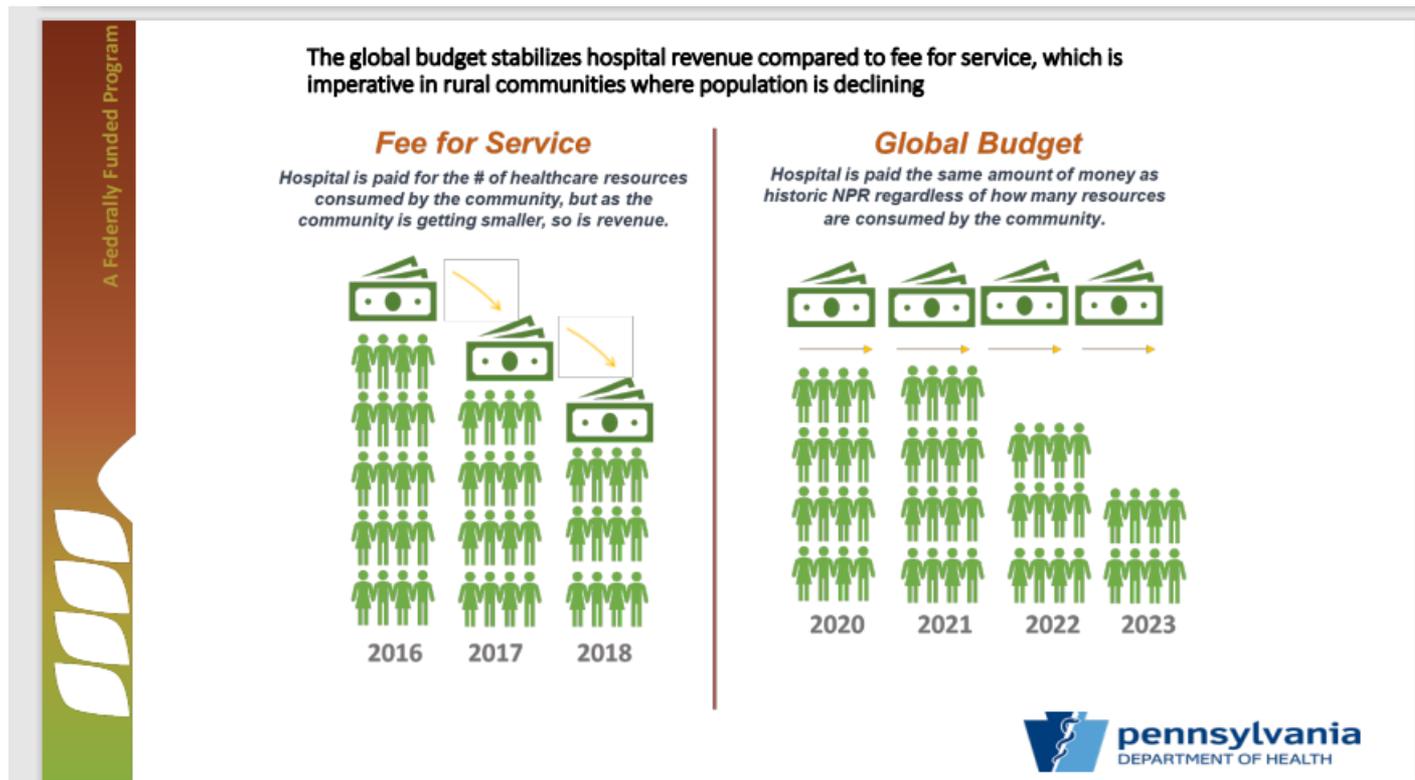
CMMI is signaling it will produce a design to span multiple states from 2025 that will address seven priorities.

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*



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

Global Budget Opportunities and Challenges

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none">▪ 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	<ul style="list-style-type: none">▪ 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

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.

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.

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.

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.**

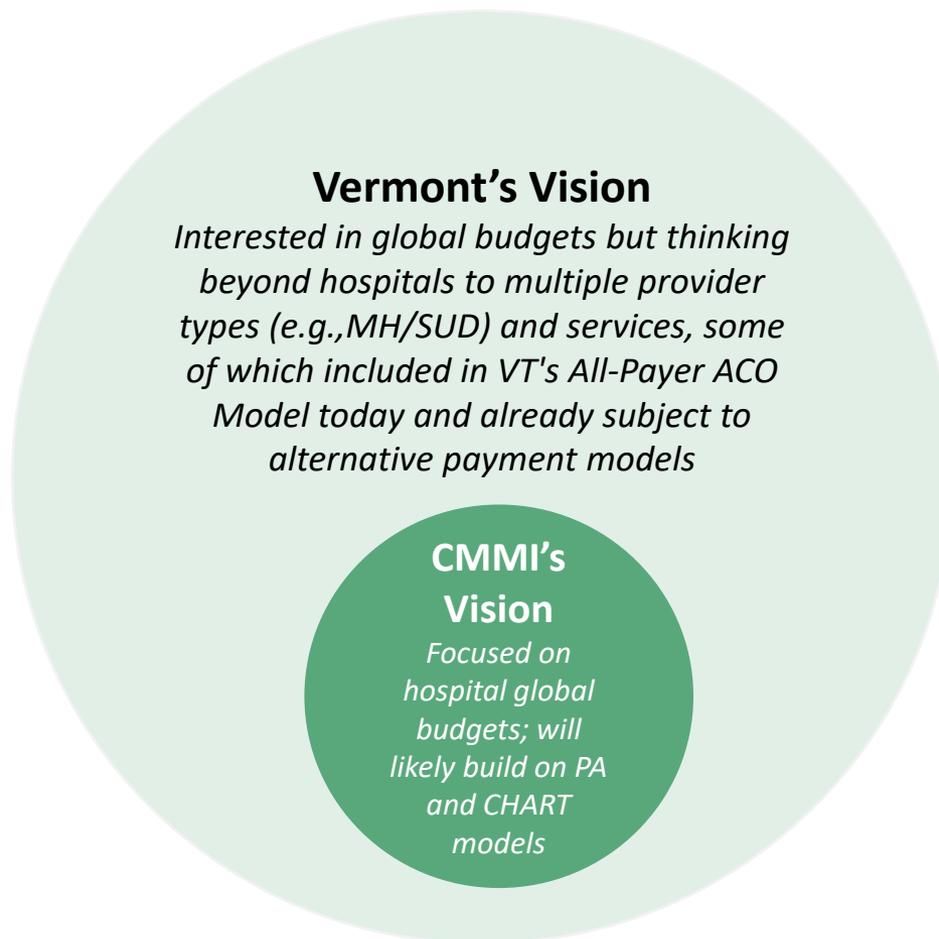
CHART Capitated Payment Amount (CPA) Mechanics

- 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.

Discussion

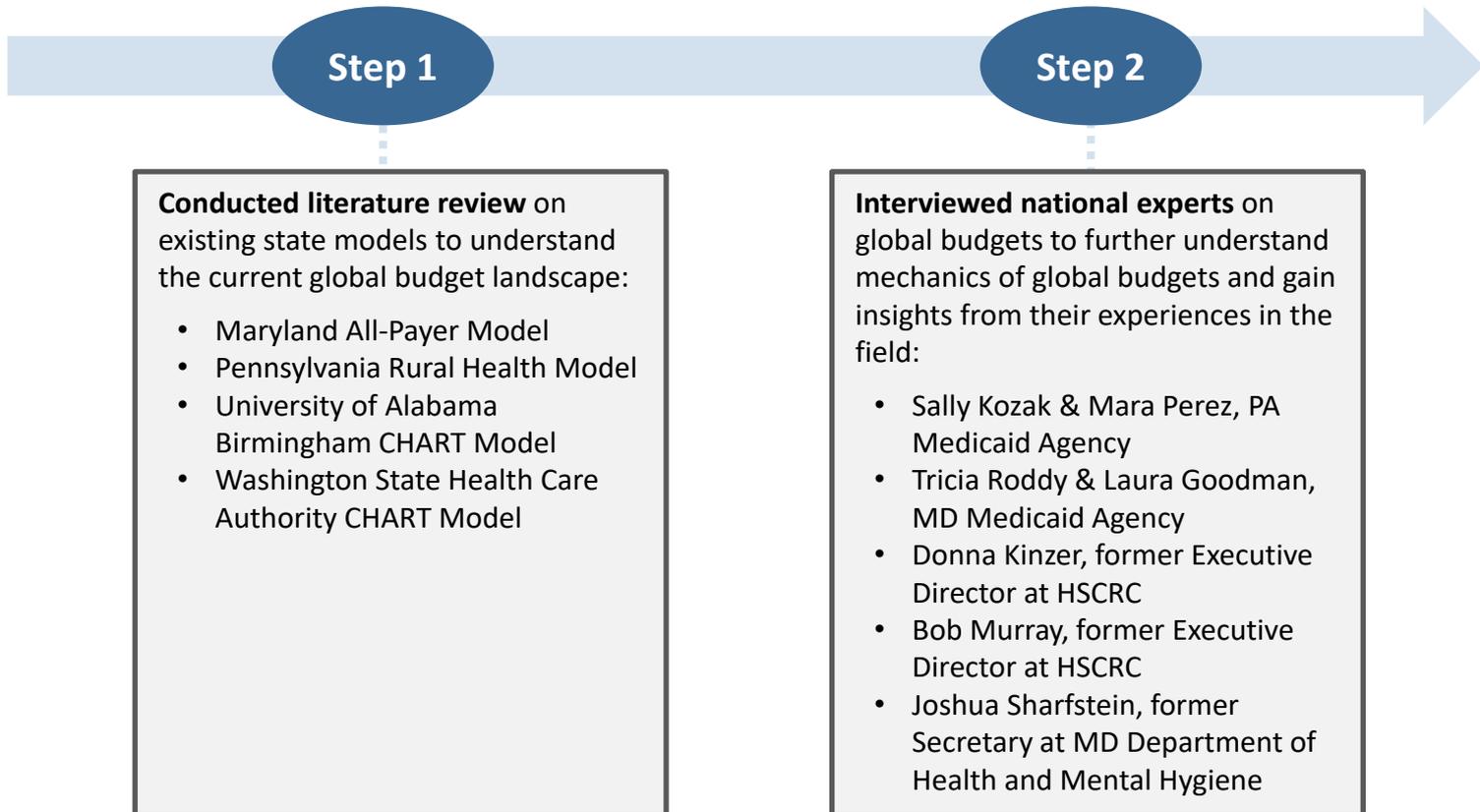
Applying Global Budget Concepts to Vermont

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



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



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?

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?

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.

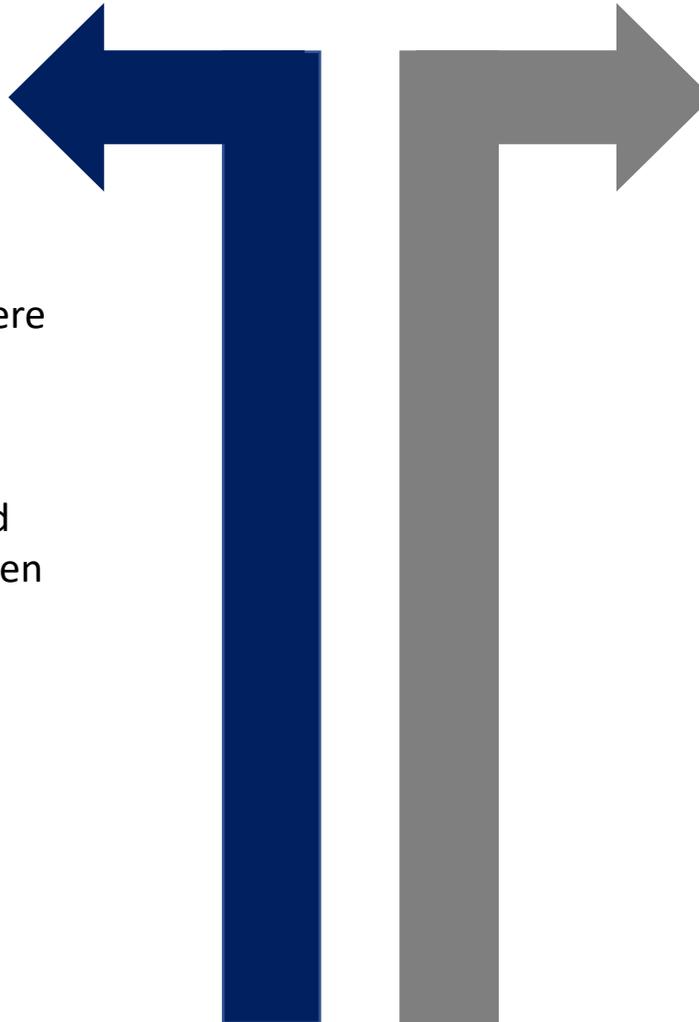
Considerations for Vermont:

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

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”

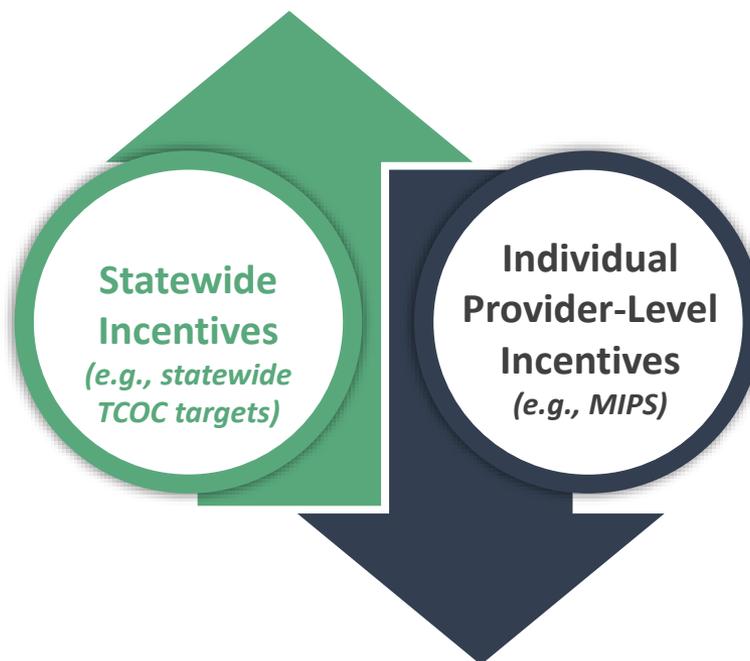
Facility global budgets and other APMs for independent professionals (primary care, BH, etc.) operate separately but together can produce better stability and predictability within each geographic area.

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.

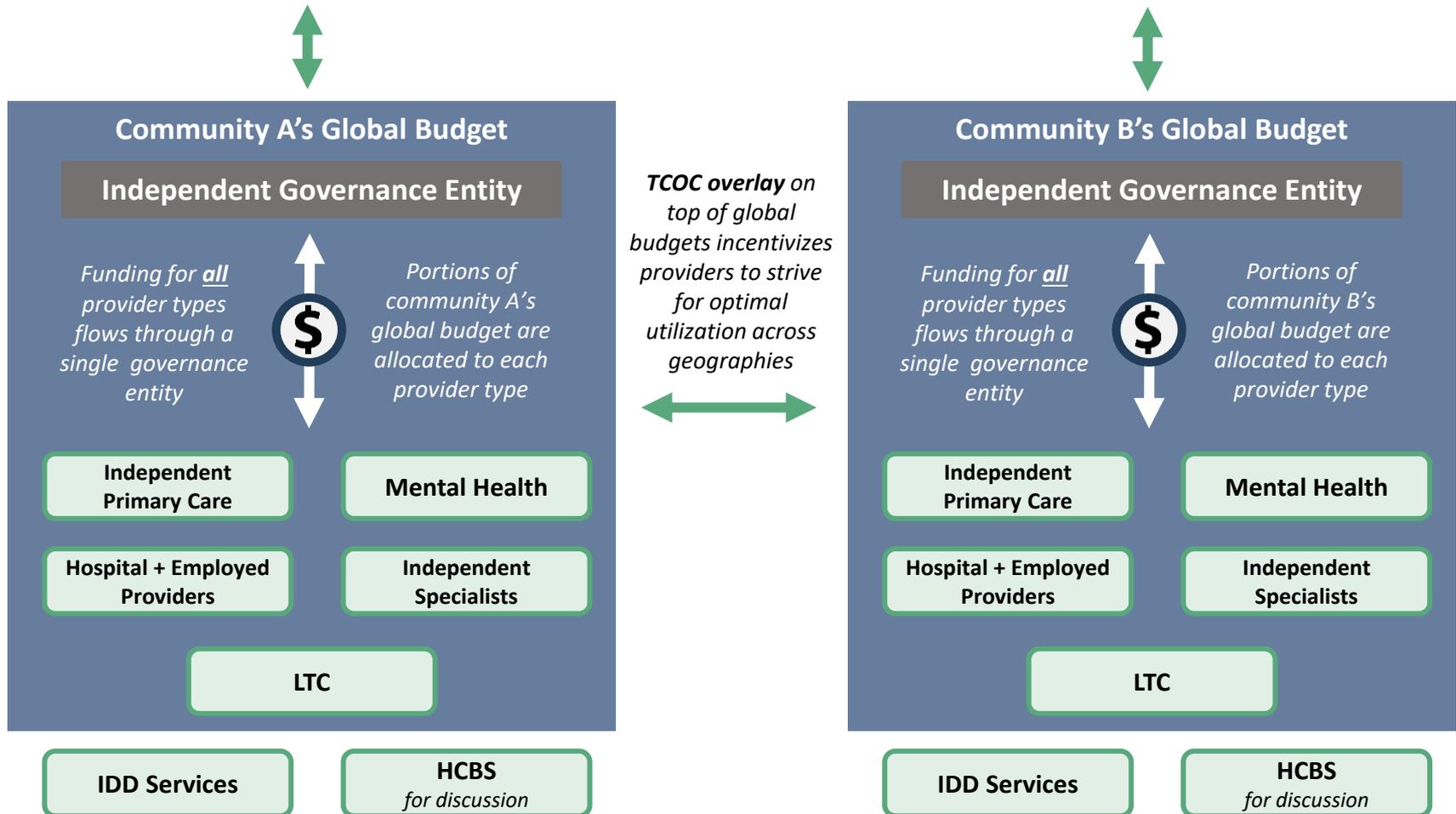


...But Close Incentives May Not Encourage Collaboration and System-Wide Thinking

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

All-Payer TCOC incentives (continued ACO structure)

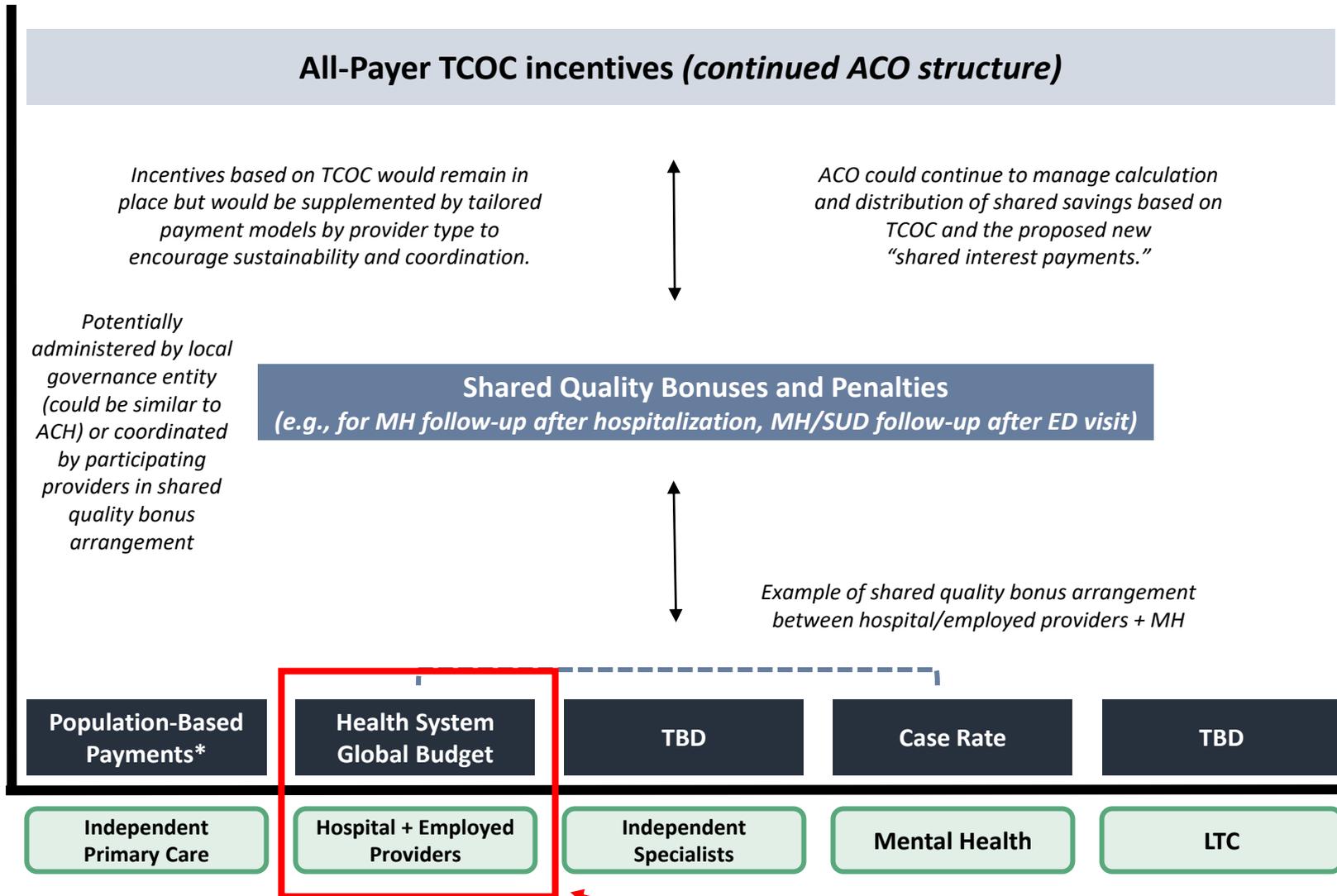


“Portfolio Approach”

More diffuse
incentives that continue to encourage system-wide efficiency

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

More direct
financial incentives for individual Provider**



* 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.

Discussion Questions

- What are the Work Group's reactions to a global budget model for Vermont?
 - Given that CMS is likely to take PA/CHART as the starting point for the Medicare component of the new state model, what design elements would need to be in place for it to make sense for Vermont?
- Please share any initial reactions to the two global budget straw model concepts.
 - Does this group agree that budgets should include services beyond facilities?
 - How all inclusive should budgets go and why?

Proposed Timeline and Next Steps

Topic (<i>subject to change</i>)	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.

Appendix

Selected Reading

- Health Care Transformation Task Force. (2019). *What's in a Name: A Primer on Global Budget Models*. <https://hcttf.org/wp-content/uploads/2019/09/HCTTF-Whats-in-a-Name-A-Primer-on-Global-Budget-Models-2.pdf>
- Murray, R. (2022, March). *Hospital Global Budgets: A Promising State Tool for Controlling Health Care Spending* [Issue brief]. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/hospital-global-budgets-state-tool-controlling-spending>
- State Health & Value Strategies. (2018, May). *Toward Hospital Global Budgeting: State Considerations* [Issue brief]. https://www.shvs.org/wp-content/uploads/2018/05/SHVS_Global-Hospital-Budgets_FINAL.pdf

Definitions

- **“Global Budget”¹**: Prospective budget for a fixed period of time (typically one year) for a specified population, rather than fixed rates for individual services or cases.
- **“Community-Based Global Budget”²**: Prospective budget for a specific geographic area where providers are accountable for spending associated with all or most health care services received by the population in that given geographic area.
- **“Health System Global Budget”³**: Prospective budget for a facility’s spending on services provided within the health system that is not linked to specific patient visits or services. A facility’s initial budget is based on the historical spend of a facility or the anticipated resource needs for a facility as a function of expected or desired set of health care services and utilization rates. Employed outpatient providers are included in the global budget (“health system”).
- **“Fixed Global Budget”⁴**: Fixed prospective budget for a hospital for a defined period, usually one year.
- **“Variable Global Budget”⁴**: Prospective budget that shifts up or down on the basis of a hospital’s variable costs, flexible to adjust for changes in patient volume.

Sources: ¹ [Global Budgets for Hospitals](#); ² [Request for Information on Concepts for Regional Multi-Payer Prospective Budgets](#); ³ [What’s in a Name: A Primer on Global Budget Models](#); ⁴ [Hospital Global Budgets: A Promising State Tool for Controlling Health Care Spending](#)

High-Level Summary CMS Portfolio of Global Budget Models

MD All-Payer Model



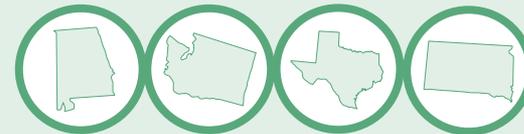
- **Budget Type:** Fixed global budgets, adjusted for demographic/market shifts, patient transfers, and other factors
- **Scope of Services:** Inpatient and outpatient hospital care
- **Payers:** Medicare, Medicaid, commercial participation is mandatory
- **Providers:** Hospital participation is mandatory (47 acute care hospitals)

PA Rural Health Model



- **Budget Type:** Fixed global budgets, adjusted for demographic/market shifts, patient transfers, and other factors
- **Scope of Services:** Inpatient and outpatient hospital care, critical access hospital swing bed services
- **Payers:** Traditional Medicare and Medicaid participation is mandatory; commercial participation (including MA and Medicaid MC) is voluntary
- **Providers:** Hospital participation is voluntary (13 ACHs, 5 CAHs)

CHART Model



- **Budget Type:** Prospective, biweekly payments for CHART participants; budgets are based on historical expenditures with community and hospital-level adjustments
- **Scope of Services:** Inpatient and outpatient hospital care, inpatient rehab services delivered in swing beds at CAHs
- **Payers:** Traditional Medicare and Medicaid participation is mandatory; commercial participation and MA is voluntary
- **Providers:** Hospital participation is voluntary