Intro to Global Budgeting

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Agenda

• Goal of global budgeting
• Global budget models and examples
• Global payment model and examples
• Funding global payments
• Vermont: current state
• Key design issues
Global Budgeting Goal

• BISHCA 3 year forecast 2009-12
  – Total health care expense  + $1.0 B (6.5%/yr)
  – Total hospital expense  +$414 M (6.5%/yr)
  – Total per capita expense  +$2,049 (6.3%/yr)

• Impact of 1%/yr reduction in trend for FY11 &12
  – Total health care expense  - $118 M
  – Total hospital expense  - $40 M
  – Total per capita expense  - $190
Types of Savings

- Lowering the level e.g.
  - Reducing admin costs
- Reducing the rate of growth over time “bending the curve” requires support of ongoing process improvements e.g.
  - Expand Blueprint
  - Reducing variation in rates of high cost procedures
  - Adopting best practices
  - Prevention

- Recommended goal: must bend the curve
- Consequence:
  - must create ‘systemness’ out of fragmentation
  - Budget/payment reform model is only one building block
  - Example of Blueprint medical home payment reform
Global budget models and examples

• Scope of services
  – All hospital: BISHCA rate review, Maryland (all payer rate)
  – Global (hospital, MD, Dx, Rx): Vermont Medical Expense Target, ACO

• Scope of payers
  – All in multiple e.g. BISHCA hospital budget
  – Single in multiple e.g. MVP/VMC
  – Single payer e.g. H.510, H.196, H.100

• Approaches
  – Set total state budget first, then allocate to communities
  – Build community budgets first: BISHCA
  – Institution based vs. population based
  – Payment models vary from Fee For Service to Global

• Enforcement/incentives
  – Risk if exceed budget? Limits?
  – Shared savings if under budget? Limits?
VT Medical Expense Target Model

- Global budget except for Rx, mental health
- Implemented with
  - MVP: 3 VT PHO’s (7 hospitals) for > 10 yrs
  - Blue Cross (TVHP): now just 1 PHO?
- Population based method using global per capita Medical Expense Target
- Process
  - Pay fee for service minus withhold (~15%)
  - Reconcile budget vs actual at end of year
  - Savings sharing with risk limited to withhold
- In depth financial and utilization reports to PHO
- PHO functions: care management, process improvement
- Issues: Scale too small to drive changes
Global payment models and examples

• Scope of services
  – Primary care: e.g. Bennington PCP capitation
  – Hospital e.g. Rochester HEPP, H.100, VA, Canada
  – Comprehensive e.g. managed care capitation, MA Blue Cross Alternative Quality Contract

• Scope of payers
• Approach: institution based vs. population based
• Issues
  – Transfer all risk to providers: risk adjustment models
  – Incentive to restrict services ‘rationing by waiting’: balanced scorecard e.g. Triple Aim
  – Estimating administrative savings, particularly for multi-payer model
    • Health plans
    • Providers: need for administrative data for management, planning and process improvement
Rochester Hospital Experimental Payment Program (HEPP) 1980-8

- Regulated hospital revenues from all payers (commercial, Medicaid, Medicare)
  - Individual and regional ap on inpatient revenue with hospital retaining 100% savings
  - Adjustment for outpatient services (substitute)
- Supporting factors
  - 30 year history of community based planning & limited capacity
  - Single, dominant commercial insurer: (BCBS admin 7%)
  - Strong community based health services
  - 65% in managed care, strong physician IPA structure, care management
  - Community wide administrative and clinical data base for planning and quality monitoring
- Results 1980-5:
  - hospital expense increase 46% vs. 52% NYS vs. 68% US
  - Per capita hospital expense: $775 vs. $1064 NYS vs. $811 US
  - Quality comparable
- Weaknesses
  - MD’s paid fee for service created major conflict with hospital global payment
Key components of MA model

Unique contract model:
- Physicians & hospital contracted together as a “system” – accountable for cost & quality across full care continuum
- Long-term (5-years)

Controls cost growth:
- Global payment for care across the continuum
- Annual inflation tied to CPI
- Incentive to eliminate clinically wasteful care (“overuse”)

Improved quality, safety and outcomes:
- Robust performance measure set creates accountability for quality, safety and outcomes across continuum
- Substantial financial incentives for high performance (up to 10% upside)
What is covered by the MA global payment?

• All medical expenses including primary care, specialty care, hospital care, ancillary, behavioral health and pharmacy

• Provider infrastructure costs associated with performing under the contract

• Risk management
  – Total or aggregate risk
  – High cost claimants (specific stop loss)
### Performance Measures For The AQC

#### Hospital Quality and Safety

- Clinical process measures
  - Acute MI
  - Heart Failure care
  - Pneumonia care
  - Surgical care
- Clinical outcomes measures
  - Hospital-acquired infections
  - Complications after major surgery (AMI, PE/DVT, Pneumonia)
  - Obstetric trauma
- Patient Care Experiences
  - Communication quality: physicians
  - Communication quality: nurses
  - Responsiveness
  - Discharge support/planning

#### Ambulatory Care Quality

- Clinical process measures
  - Depression
  - Diabetes
  - Cardiovascular Disease
  - Cancer Screening
  - Pediatric: Appropriate Testing / Treatment
  - Pediatric: Well Child Visits
- Clinical outcomes measures (triple-weighted)
  - Diabetes (HbA1c, LDL-c and BP control)
  - Hypertension (blood pressure control)
  - Cardiovascular Disease (BP control, LDL-c control)
- Patient Care Experiences
  - Quality of clinical interactions
  - Integration of care
  - Access to care
MA Performance Achievement Model

Performance Payment Model

Performance Score

% Payout

2.0% 3.0% 5.0% 9.0% 10.0%

1.0 2.0 3.0 4.0 5.0
Global Payment as A Tool for System Reform

• “…Relative to other options, global payment has the greatest potential for encouraging shifts in health care resource use from low-value to high-value services. To counter the possibility of undertreatment, global payment should be implemented in the context of ongoing performance measurement and reporting. Expanding global payment will also encourage provider to become more organized….”

• “…There are obviously important challenges for global payment, including developing credible risk-adjustment mechanisms and finding provider systems willing to accept global risk.”

• Source: Mechanic RE, Altman SH. *Health Affairs* 2009
Funding global payments

• Multi-payer direct to provider
  – Each payer pays for its population
  – Provider payment: capitation or trended budgets

• Multi-payer through Trust Fund
  – Assessment to each payer: capitation with separate pools for commercial, Medicaid, Medicare
  – Provider payment: capitation or trended budgets

• Single payer through Trust Fund
  – Revenues raised by taxes and premium contributions
  – Provider payments: capitation or trended budgets
Vermont: current state

- BISHCA regulation of hospital net revenues (Act 61)
- Issues in achieving critical mass for global payments:
  - Hospital payers: commercial 51%, (self insured & WC 17%) Medicaid 11%
  - Total expense: commercial 38% (self insured & WC 13%) Medicaid 23%
  - Migration
    - 15% of VT admissions from out of state
    - 34% of VT resident hospital costs out of state
- Blueprint payment reform & expansion
- ~ 7 HSA’s with existing integrated hospital/MD structure
Future state: Key design issues

- Establish the vision for the integrated delivery system model
- Choose focus for achieving savings: admin costs vs. medical trends?
- Scope of services: hospital vs. comprehensive?
- Global budget and/or global payment?
- Scope of payers: what’s the minimum % to drive structural change?
- Incentive structure: cost + ? (e.g. Triple Aim)
- Single payer vs. multi-payer with employer sponsored insurance?
- How to fund the global payments
- Patient in migration and out migration (emergency & referral?)
- Benefit design:
  - single or multiple designs?
  - Cost sharing by patients?
- Required supporting infrastructure: Other building blocks
  - Public, private or hybrid?
  - Provider capabilities
  - Data and information system
One Possible Vision: Community Health System

Task: marry short term needs to longer term vision of Community Health System

- Comprised of local hospital, medical staff and other key providers
- Build on Blueprint: Create principle source of care (medical home) for a defined population
- Accountable for a balanced scorecard of outcomes for their population (Accountable Care Organization)
  - Total costs
  - Health status and outcomes
  - Care experience
- Budgeting/payment model is one key element of a much broader design.
  - Financial incentives alone will not drive changes we seek.
  - What critical mass is needed to drive structural changes?