**GBR Construct Overview**

- Global Budget Revenue (GBR) construct overview
  - Potential benefits of GBR
  - Developing a GBR model
  - How is GBR funded?
  - Key GBR metrics
- GBR initiatives in other state initiatives
  - Pennsylvania and Maryland
  - Value vs. volume
  - Review of outcomes
  - Lessons learned
  - How will California be different?
- GBR value proposition
  - Hospital benefits
  - Payor expectations
  - Medicare
  - Medi-Cal
  - Other payors
  - Value to the patient

**Points for Discussion**

- Global Budget Revenue (GBR) construct overview
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POTENTIAL BENEFITS OF GBR

- Hospitals
  - Financial stability
  - Opportunity for transformation
  - Opportunity for population health improvement
- Payers
  - Predictability
  - Transparency
  - Volume to value
  - Alignment of incentives with population health
- Non-hospital provider alignment
  - Physician alignment models
- Primary care
- Specialists
- Post-acute care bundling

CHALLENGES FOR HOSPITALS IN LOW POPULATION DENSITY AREAS

- Sociodemographic challenges
  - Population tends to be older and lower income
  - Higher prevalence of chronic conditions
- Access issues
  - Physician shortages and difficulty recruiting
  - Long travel to specialists or for tertiary care
- Operating challenges
  - Low volume, unpredictable revenue base
  - Lack of scale to support expensive fixed costs

PROGRAM GOALS

- Ensure stability for low population density communities and care providers
  - Financial stability through a fixed revenue model
  - Continue to provide appropriate access to acute care
- Emphasize population health
  - Value-based model: generating utilization savings produces the most favorable reimbursement
  - Direct investments in care transformation/redesign
  - Data infrastructure and capabilities
- Maintain/improve quality of care
  - Continue quality requirements/incentives
  - Direct linking of reimbursement to population health outcomes
- Provide value to Medicare/Medi-Cal and other payers as well as patients
  - Improve outcomes
  - Bend the cost curve
  - Potential shared savings models for utilization savings over time

California Statistics by County 2016

<table>
<thead>
<tr>
<th>Rural Population</th>
<th>Population</th>
<th>Density (pop/sq mi)</th>
<th>% 65+</th>
<th>Median household income</th>
<th>PCP ratio</th>
<th>Life expectancy</th>
<th>Premature death</th>
<th>Adult Obesity</th>
<th>Physical inactivity</th>
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<tbody>
<tr>
<td>50%-100%</td>
<td>291,742</td>
<td>23.7</td>
<td>23.3%</td>
<td>$50,359</td>
<td>2,110</td>
<td>78.0</td>
<td>377</td>
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<td>21%</td>
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<td>20%-50%</td>
<td>1,210,110</td>
<td>61.1</td>
<td>18.8%</td>
<td>$57,309</td>
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<td>78.7</td>
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<td>18%</td>
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<td>14.0%</td>
<td>$59,969</td>
<td>1,705</td>
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<td>319</td>
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<td>0%-10%</td>
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<td>2,229.9</td>
<td>13.6%</td>
<td>$76,696</td>
<td>1,331</td>
<td>81.9</td>
<td>261</td>
<td>22%</td>
<td>17%</td>
</tr>
<tr>
<td>CA average</td>
<td></td>
<td></td>
<td></td>
<td>$71,800</td>
<td>1,270</td>
<td>81.5</td>
<td>270</td>
<td>23%</td>
<td>17%</td>
</tr>
</tbody>
</table>

• GBR represents a shift away from a "fee-for-service" (FFS) to a fixed revenue model.
• Under the GBR model, hospitals receive a fixed revenue amount at the onset of each year.
  – Limited funding for volume growth beyond expected demographic changes.
• Stabilization of hospital’s revenue stream relieves year-to-year financial volatility.
  – Particularly important for providers in low population density areas with relatively fixed cost bases.
• GBR provides significant incentives to manage utilization.
  – Utilization savings generate retained revenue to reinvest in population health.
  – Hospitals are at risk for cost increases beyond what is allotted under GBR.
• GBRs typically include direct incentives to manage population health.
  – Stronger reimbursement incentives to reduce utilization determined to be “avoidable.”
  – Portions of revenue potentially linked directly to quality and outcomes.
  – Portions of revenue linked directly to care transformation/redesign initiatives.

MOVING FROM VOLUME TO VALUE

DEVELOPING A GBR CAP

• The GBR cap is based on a historical “base period” and is typically adjusted for a series of annual variables:
  – Annual update factors/inflation adjustments.
  – Quality and Pay for Performance incentives.
• The base period establishment may include a series of adjustments to the cap for the following considerations:
  – Age-adjusted population growth cap adjustment.
  – Other special circumstance adjustments.
• The GBR cap may have special allowances for certain case types such as:
  – Select tertiary volumes.
  – Extreme outliers.
  – Epidemic/Natural Disaster adjustments.
  – Other.

HOW IS THE GBR CAP FUNDED?

• GBR Hospitals continue to bill patients according to current practices.
  – Negotiated annual updates.
  – GBR payments made as either Fee For Service (FFS) or Per Member Per Month (PMPM) payments.
• However, the Hospital must track volumes and adjust billing rates in order to maintain the approved revenue cap established.
  – This can be calculated on a total hospital basis or on a payor-specific basis depending on who is participating in the GBR payment model.
  – Volume increases result in lower per case revenues.
  – Volume reductions result in increased per case revenues.
• How do we get payors to participate in GBR?
  – Each payor must be negotiated.
  – Medicare and Med-Cal.
  – Commercial payors.
WHAT ARE THE KEY OPERATIONAL METRICS?

- Measurement of Volume
  - Inpatient Case Mix Adjusted Discharges
  - Equivalent Inpatient Admissions (EIPAs)
  - Equivalent Case Mix Adjusted Discharges (ECMADs)
  - Supply and Drug Invoice Cost + Markup + Overhead

- Potentially Avoidable Utilization (PAU)
  - GBR models typically target avoidable utilization and reward reductions
  - Redemissions
  - Prevention Quality Indicators (PQIs)
  - Hospital Acquired Conditions (HACs)
  - Reduced ED visits
  - Other measures

- Revenue should follow the patient for other non-PAU or “medically necessary” volume that shifts among hospitals within markets
  - Utilization reduction achieved by limiting access to care should not be rewarded

WHAT ARE THE KEY OUTCOME METRICS?

- Key outcome metrics include traditional hospital volume performance measures such as admissions, case-mix, ALOS, and outpatient volumes, mortality rates and patient safety indicators but also introduce the following quality and population health measurements:
  - Potentially avoidable utilization (PAU)
  - Hospital expenditures per capita
  - Total cost of care (TOCC)

- Most of these measurements are calculated on both an attainment and improvement basis against a set base period or on a year-over-year analysis

- Beyond year-to-year revenue stabilization, one of the most powerful outcomes of a successful hospital under the GBR payment model is retention of revenues achieved through appropriate volume reductions
  - Stable/totter annual financial performance
  - Reinvestment to support population health initiatives outside the four walls of the hospital
  - Support future capital requirements
  - Invest in new technologies and innovation

TECHNOLOGY REQUIREMENTS

- While the GBR model is a mechanism to free up resources to use to improve population health within our service areas, hospitals still need a very robust patient clinical transaction data

- A robust Health Information Exchange (HIE) is a real aide in accessing that information

- Authorized health providers can use HIEs to access real-time patient information for the following purposes:
  - Shared information across disparate systems
  - Identification of potential readmissions in ED
  - Avoid repeating tests and procedures
  - Flagging PAU at risk populations
  - Enhancing complete documentation
Global Budget Initiatives in Other States

• The GBR model has garnered growing attention across the country over the past several years.

• The concept's most apparent application is in low population density regions of select States due to the financial stability it provides as smaller, low-volume facilities experience significant volume swings from year to year.

• In more recent years, some States have identified the GBR model as a broader tool to change the healthcare paradigm from a volume-driven model to a value/outcome model.

• Currently, Maryland and Pennsylvania are the states most actively pursuing GBR development and implementation.

STATE GBR INITIATIVES

• All-payer global budgets established for all hospitals (rural hospitals under TPR since FY12)
  - Fixed annual budget for covered hospital-based services
  - FFS payments based on rates that fluctuate based on volume realization (i.e., hospital increase rates if volumes decline and decrease rates if volumes increase to comply with approved annual revenue)

• Global budgets set in FY2014 and adjusted annually on a prospective basis
  - Annual adjustments for update factor, population growth, certain volume changes, quality
  - System savings: no inflation or volume adjustment provided on Potentially Avoidable Utilization (readmissions and Prevention Quality Indicators)
  - Annual all-payer increase per resident capped at annual growth rate for gross state product (3.58%)

• Participation
  - Required participation by all Maryland acute hospitals
  - Payment rates are set by an established State regulatory agency

• Commitments to Medicare
  - Required savings amount
  - Annual total cost of care growth rate must not outpace national rate

StateMachine: MARYLAND

Note: Maryland is unique in its hospital reimbursement is regulated on the State and rates are set by a regulatory agency rather than negotiated.
**LOW POPULATION DENSITY CONSTRUCT: PENNSYLVANIA**

- All-payer global budgets for participating low population density hospitals
  - Fixed annual budget for covered hospital-based services
  - Monthly payments from payors
- Global budget is based on historic net patient revenue with annual updates
  - Annual adjustments for update factor, population growth, certain volume changes, quality
  - System savings on Potentially Avoidable Utilization (hospitals retain 100% of utilization savings in Year 1, retained amount is reduced over time)
  - Annual all-payer increase per resident capped at annual growth rate for gross state product (3.38%)
- Participation
  - Voluntary participation with targets
  - 6 participating hospitals in Year 1, 18 in Year 2, 30 in Years 3-6
  - 75% of hospital’s net patient revenue under fixed budget in Year 1, 95% in Years 2 and beyond
- Commitments to Medicare
  - Required savings amount
  - Budget neutrality (growth rate must not outpace national rate for low population density hospitals)

**IMPACT OF GBR: STABILIZED FINANCIAL PERFORMANCE**

- Low population density facilities in Maryland have been under a fixed revenue budget since FY2012
  - In general, hospital expense at these facilities is fairly fixed as volumes fluctuate
  - Revenue remains stable as volume declines, but expense remains fixed

**IMPACT OF GBR: BENDING THE COST CURVE**

- Incentives to reduce avoidable utilization of hospital services have succeeded in bending the cost curve in Maryland
  - While Maryland’s population has grown nearly 2.9% since CY2013, utilization of hospital services has remained stable (<0.03% growth since CY2013)

Note: Maryland has traditionally had significant opportunity to generate utilization savings in the acute care setting, with hospital use rates well above national averages.
IMPACT OF GBR:
SAVINGS TO MEDICARE

Since CY2013, Medicare FFS total cost of care in Maryland has grown by 5.68% per beneficiary compared to 7.87% national growth.

$879M cumulative savings to Medicare since CY2013

IMPACT OF GBR:
MEDICARE TOTAL COST OF CARE

• Since CY2013, Medicare FFS total cost of care in Maryland has grown by 5.68% per beneficiary compared to 7.87% national growth.

• Hospitals with significant volume increases have struggled to secure adequate incremental revenue to maintain profitability:
  – Price compression
  – Operating margin erosion
  – How to address population growth and aging issues within a constrained system

• Market redistribution and new technology/innovation
  – Migration of patients from hospitals that have discontinued clinical programs
  – Pressure from expanding drug costs

• Limited ability to generate necessary funds for programmatic investment

• Lack of aligned incentives among physicians/non-hospital providers
  – Post-acute alignment strategies
  – Harder to control TOC growth

LESSONS LEARNED:
HOSPITALS WITH VOLUME GROWTH
LESSONS LEARNED:
HOSPITALS WITH VOLUME EROSION

- Hospitals with significant declines have retained revenue that drives:
  - Price inefficiency
  - Inflated profit margins
- Addressing issues with manipulation of service delivery
  - ED diversion
  - Non-renewal of physician contracts
  - Movement of services to non-hospital setting
  - Hospital service line and program closures
- Need for rebasing or resetting of GBR cap
  - Timing of rebasing
  - Factors considered in rebasing process

LESSONS LEARNED:
HOSPITALS WITH VOLUME EROSION

- In Maryland, The GBR model has succeeded in providing low population density providers a reliable stream of revenue that helps to stabilize operating margins
- GBRs allow the institution to focus on improving population health through care management, high utilizer interventions, medication reconciliation, focus on duals management, partnerships with post acute provider
- In addition, hospitals with retained revenue have been able to use these resources to fund routine capital requirements and deal with expanding drugs cost and utilization issues
- These hospitals have also been generally successful in reducing the rate of growth in hospital per capita spending and total cost of care trends
WHAT WILL MEDICARE/MEDI-CAL WANT?
1. CMS/CMMI envisions the GBR model as a potential National model for low population density regions.
2. The GBR by nature allows for a more stable and predictable payment level to these hospitals.
3. CMS will also likely want to see some level of savings versus statewide historical or National growth rate in hospital per capita operating and/or total cost of care.
4. Governmental payors will also be on the watch for bad behaviors such as the elimination of medically necessary services and/or patient dumping to other sites.
5. In addition, the movement of volumes to non-hospital venues must be disclosed and adjusted for in the GBR cap.
6. CMS will likely demand continued focus on quality metrics including progress towards improved clinical outcomes and reduction of readmissions.
7. They will also require an evaluation period in which the outcomes of the program can be reviewed and critiqued.

WHAT WILL COMMERCIAL PAYORS WANT?
1. The major commercials would likely see improved cost efficiency that should go along with a stabilized revenue stream.
2. The are also likely to push for a PAU reduction goal and performance incentives if those goals are achieved.
3. The model cannot be overly complex, the commercials don't look positively to models that require complex settlement calculations.
4. The commercials may require a periodic release process to remove retained revenues after some period of time.

WHAT ABOUT OUR PATIENTS?
1. Some things don't change with the payment model, our patients want high quality, safe, efficient and effective clinical care!
2. Ensures continued access to care in low density areas.
3. One potentially negative outcome of GBRs for our patients is higher coinsurance costs as per case costs rise in hospitals that are successful in reducing unnecessary utilization. – This distortion would have to be addressed if it becomes significant.
QUESTIONS
RAISE YOUR HAND OR SUBMIT QUESTIONS AT WWW.MENTI.COM AND ENTER CODE 69 32 61

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