Hospital Global Budget Working Group

September 20, 2022

Agenda

- Review Revised Goals and Criteria
- Approach to Aligning or Standardizing Elements of the Hospital Global Budget
- Discussion of Services to Include in the Model
- Public Comment
- Next Steps

Review Revised Goals and Criteria

Revisit Revised Goals and Criteria

During the August meeting, the Working Group reviewed and provided feedback on a set of goals and criteria to inform the next few months of work. As a reminder:

- The **goals** outline the high-level outcomes that an all-payer hospital global budget model in Rhode Island should achieve.
- The **criteria** are intended to aid the Working Group when recommending features of an all-payer hospital global budget model.

Please keep these goals and criteria in mind as we begin to discuss the features of a successful all-payer hospital global budget for Rhode Island.

Revised Model Goals

The following goals pull from the Compact to Accelerate Advanced VBP Model Adoption in Rhode Island and OHIC's goals for Rhode Island hospitals:

1. Reduce the growth rate of health care spending to an affordable and foreseeable level.
2. Provide hospitals with predictable revenue to promote financial sustainability.
3. Promote access to appropriate care in Rhode Island across all populations, including those who have been historically underserved.
4. Enhance coordination and efficiency across delivery systems.
5. Support investment in a high-quality clinical workforce and technical innovation in care delivery to support population health management and quality excellence.
6. Improve patient experience of care, quality of care, patient outcomes and health equity.

Revised Model Criteria

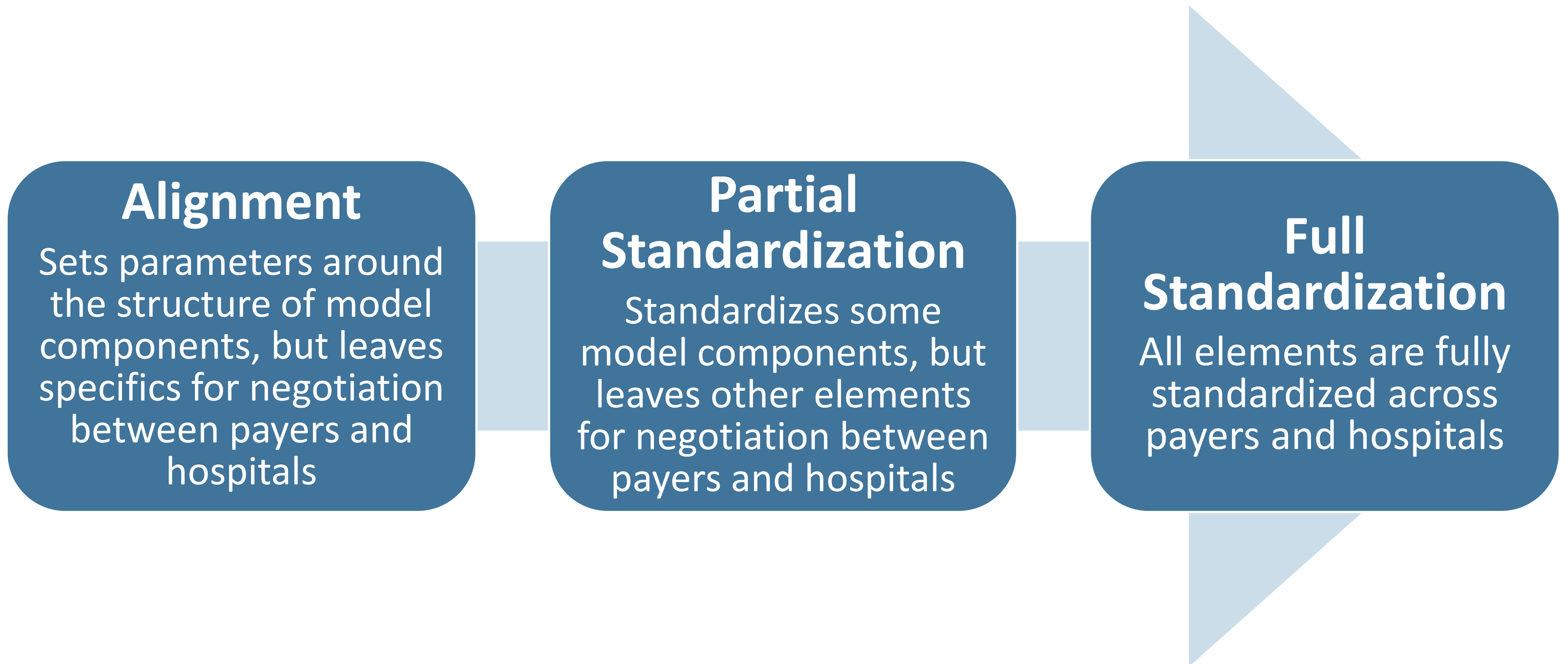
The following criteria pull from the Compact to Accelerate Advanced VBP Model Adoption in Rhode Island and OHIC's goals for Rhode Island hospitals:

1. Incentivize, to the greatest extent possible, participation from all relevant stakeholders, including all hospitals and insurers in the State.*
2. Move towards rationalized distribution of reimbursement rates across the commercial, Medicaid and Medicare markets.
3. Reduce provider administrative cost.
4. Provide flexibility to account for varying hospital types, plan market share, composition of the population served by the provider, and exceptional circumstances not covered under the budget methodology.
5. Aligning incentives between hospitals and other providers to develop cross-organizational relationships that promote efficiency and avoid unnecessary service duplication.
6. Provide adequate incentives for hospitals to serve the neediest populations.
7. Align and/or integrate with ACO/AE TCOC models and other quality-linked models.

*While the Working Group is developing a multi-payer model, it is possible that CMMI may want to introduce additional ideas at the time it is prepared to engage with the State.

Approach to Aligning or Standardizing Elements of the Hospital Global Budget

Levels of Standardization



Considerations Around Standardization

- ✓ More flexibility to tailor contracts, which could increase payer and hospital willingness to participate in a voluntary model
- ✗ May create misaligned incentives across contracts, diminishing the likelihood of improved affordability, quality and equity
- ✗ Could result in greater complexity and burden for payers and hospitals to administer

- ✓ Provides a common set of incentives for hospitals, encouraging cooperation to meet larger system goals
- ✓ Provides greater transparency
- ✓ Reduces administrative costs and complexity
- ✗ Requires greater involvement from a state agency and/or another third party to implement
- ✗ Depending on how standardized, could discourage participation among payers and hospitals

Examples of How Two States Have Approached Standardization of their Hospital Global Budgets

Pennsylvania

A technical assistance provider calculates budgets for commercial payers using a standardized methodology. Payers can determine which hospitals with which to partner on a hospital global budget model and which markets and lines of business to include.

LESS — **ALIGNMENT / STANDARDIZATION** — **MORE**

The Health Services Cost Review Commission calculates budgets for all payers for all lines of business for all general acute care hospitals using one standard methodology. Hospitals can elect to participate in supplemental population health programs.

Maryland

Standardization of Model Elements

The Working Group will discuss the level of alignment or standardization for the following model elements over the course of the next few meetings:

1. Services included in the model
2. Methodology to calculate and update budgets annually
3. Methodology to adjust budgets during the performance period
4. Methodology to distribute payments to hospitals
5. Inclusion of supplemental arrangements in the model

Discussion of Services to Include

Hospitals in Rhode Island by Type*

General Acute Care	Psychiatric	Other Specialty
• Kent Hospital • Landmark Medical Center • Miriam Hospital • Newport Hospital • Our Lady of Fatima Hospital • Rhode Island Hospital • Roger Williams Medical Center • South County Hospital • Westerly Hospital	• Bradley Hospital • Butler Hospital	• Hasbro Children's Hospital • Rehabilitation Hospital of Rhode Island • Woman & Infants Hospital of Rhode Island

* The Providence VA Medical Center and Eleanor Slater Hospital are not included in this list.

Hospitals Participating in Other States' Global Budget Model

Maryland

- All 47 general acute care hospitals are required to participate
- Excludes specialty hospitals (e.g., psychiatric, pediatric) because of the HSCRC's limited authority and intent to protect access to care for special needs populations

Pennsylvania

- All Critical Access Hospitals (CAHs)* and acute care hospitals that receive prospective payments from Medicare and located in rural areas were invited to participate
- As of 2022, 18 hospitals volunteered to participate. It is unclear why other hospitals declined to participate

CHART

- All acute care hospitals and CAHs located in the community or receive significant Medicare FFS revenue are eligible to participate
- Hospitals with multiple inpatient and outpatient locations are considered as distinct hospitals

*CAH is a designation given to eligible rural hospitals by the Centers for Medicare & Medicaid Services

Advantages and Disadvantages of Including Specialty Hospitals in the Model

ADVANTAGES

- Takes a more comprehensive approach to hospital global budgets, i.e., captures all of the private hospital spend in the state
- Protects against leakage or shedding of care from acute care hospitals to specialty hospitals

DISADVANTAGES

- Some specialty hospitals may have difficulty managing to a global budget given the complex care needs of the patient populations, smaller volumes served and annual variability in patient morbidity
- May result in increased complexity to include hospitals that do not account for significant proportions of health spending in the state
- May be more difficult to negotiate with CMMI as all other models involving waivers did not include specialty hospitals

Discussion on Inclusion of Specialty Hospitals

- Does the Working Group recommend including specialty hospitals in the hospital global budget model?
- If so, should all specialty hospitals be included, or should this be limited to certain types of specialty hospitals? Why?

What Services Should be Included in the Hospital Global Budget Model?

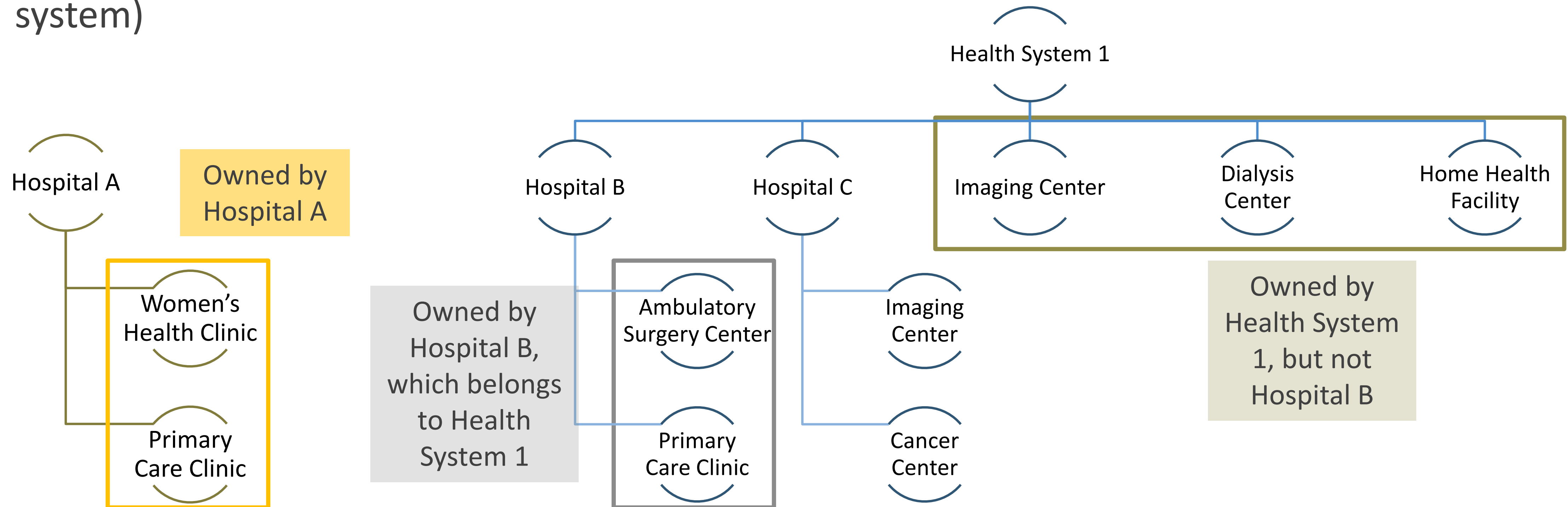
Other states have approached inclusion of services in a hospital global budget model as follows:

We will discuss what to do for each of these categories of services for Rhode Island.

Key Assumptions Around Services to Include

At the last meeting, there was some discussion around how to treat services that are not “owned” by hospitals. For example:

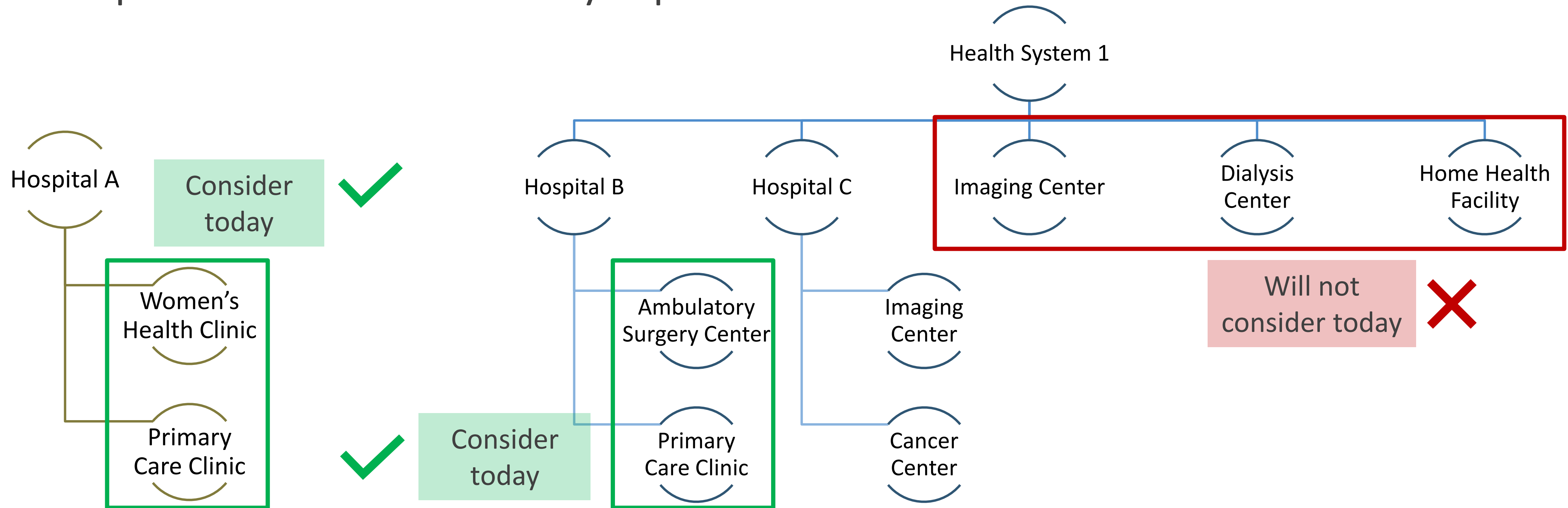
- Professional services delivered in the hospital setting by non-hospital-employed providers
- Other facility services that are not owned by the hospital (but may be part of a larger health system)



Key Assumptions Around Services to Include (Cont’d)

For the purposes of our conversation, we will consider inclusion or exclusion of *hospital-owned* services only for the following reasons:

- We are developing a hospital global budget and not a global capitation payment.
- A hospital cannot be reasonably expected to control costs for services it doesn’t own.



Definition of Inpatient and Outpatient Services in the Model

All states with hospital global budget experience have included spending for hospital facility inpatient and outpatient services in their models. For the purpose of this conversation:

- **Hospital facility inpatient spending** includes spending for room and board, procedures, treatments, and ancillary services (e.g., diagnostic tests, pharmaceuticals, ER services) when a member is admitted to a hospital
- **Hospital facility outpatient spending** includes spending for procedures, treatments, or testing provided in the hospital setting that do not require an overnight stay

Discussion Inpatient and Outpatient Hospital Spending in the Hospital Global Budget Model

- Are there any specific inpatient and/or outpatient facility services that should not be included in a hospital global budget arrangement?
- If so, what are they and what is the rationale for excluding them?

Professional Services Delivered in the Hospital Setting

Hospital employees include physicians, nurses, therapists and other clinical and administrative personnel who are salaried.

- The hospital bills for professional services rendered by hospital employees separately from facility fees.

Non-employed physicians who have professional services agreements or have admitting privileges may also deliver professional services in the hospital.

- These physicians bill separately for their professional services.

Other States Approaches with Regards to Professional Spending

Maryland

- HSCRC lacked regulatory authority to set physician fees
- Model evaluation cited exclusion of professional services as a barrier
- Created the Care Redesign Program, which aimed to align incentives across hospitals and providers

Pennsylvania

- No rationale stated for why professional spending is excluded
- Model evaluation cited exclusion of professional services as a barrier

CHART

- No rationale stated for why professional spending is excluded

Advantages and Disadvantages of Including Hospital-Employed Professional Services

ADVANTAGES

- Consistent with the VBP compact, which references the development of "hospital global budgets for facility and **employed clinician professional services**"
- Takes a more comprehensive approach to hospital global budgets, i.e., captures more of hospitals' services and spending
- Increases incentives to integrate hospital and professional care
- Reduces incentives for hospitals to steer care to other facilities that are not part of the global budget, and for which there would therefore be no cost controls

DISADVANTAGES

- Increases the complexity of the budget by making it more inclusive
- May make it more difficult for hospitals to employ clinical staff if payment for professional services rendered by non-hospital employed clinicians are not addressed in some fashion

Discussion on Inclusion of Professional Services

- Does the Working Group recommend including hospital-employed clinician professional services in the hospital global budget model?
- If so, should this include all or only some professional services delivered by hospital-employed clinicians?

Hospital Ownership of Non-Hospital Facility Health Care Services

Hospitals may also own other non-hospital facility health care services, such as primary care clinics, home health agencies, imaging centers, urgent care centers, etc.

- These may be located within or outside of the hospital's campus.
- They may or may not be part of the hospital's license.

As the Working Group considers whether to include other hospital-owned, non-hospital facility services, one of the key issues that will need to be worked through is how to define and identify these hospital "assets."

Other States Approaches with Regards to Other Facility-Based Services

Maryland

- Excluded since HSCRC lacked regulatory authority to set prices for facilities that are not owned or operated by a hospital.
- MD witnessed a shifting of care from hospitals to other facilities (e.g., ASCs, lab and imaging centers, etc.)

Pennsylvania

- Excluded other facility-based services because the model aimed to provide financial stability for rural hospitals
  - PA viewed expansion of provider-based clinics as a necessary growth opportunity for rural hospitals

CHART

- No rationale stated for why other facility-based services excluded

Advantages and Disadvantages of Including Other Hospital-Owned Facility-Based Services

ADVANTAGES

- Provides expanded revenue predictability to the hospital/hospital system
- Protects against shifting care to other hospital-owned services that do not have any cost controls as a mechanism to lower hospital costs
  - A flexible arrangement may also help address this concern
- Incentivizes better coordination across hospital-owned care settings

DISADVANTAGES

- Treats hospital owned facilities differently from non-hospital owned facilities
- Increases the complexity of the budget by making it more inclusive

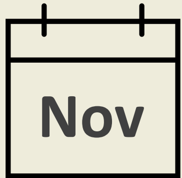
Discussion on Inclusion of Spending by Other Hospital-Owned Facilities

- Does the Working Group recommend including non-hospital facility-based services that are owned by hospitals in the hospital global budget model?
- If so, what types of other facility services should be included?

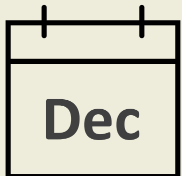
Public Comment

Next Steps

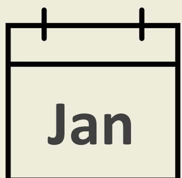
Working Group Meeting Plan and Schedule



- Decide how to calculate and update budgets annually



- Decide how to adjust budgets to account for changes in utilization during the performance period



- Decide whether the model should include additional arrangements