Development of a Hospital Global Budget for Rhode Island

September 19, 2022

Agenda

- Context for the development of hospital global budgets in Rhode Island
- The Hospital Global Budget Working Group's charge
- State experience with hospital global budgets
- Next steps

Context for the Development of Hospital Global Budgets in Rhode Island

Rhode Island's Value-Based Payment Compact

20 Rhode Island-based organizations voluntarily signed a compact to accelerate adoption of advanced value-based payment models in the state.

- Amica
- Blue Cross Blue Shield of Rhode Island
- Brown University
- Care New England
- Coastal Medical
- CVS Health
- Hospital Association of Rhode Island
- Hope Health
- Lifespan
- Neighborhood Health Plan of Rhode Island
- Point32Health
- Prospect Health Services of Rhode Island
- Rhode Island Business Group on Health
- Rhode Island EOHHS
- Rhode Island Foundation
- Rhode Island Medical Society
- Rhode Island OHIC
- Rhode Island Parent Information Network
- Rhode Island Public Expenditure Council
- WellOne

https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/RI%20Advanced%20VBP%20Compact%202022%2004-20%20FINAL%20%2B%20Signed.pdf

Rhode Island's Value-Based Payment Compact (Cont'd)

The compact specifically calls for adoption of three payment models:

Hospital global budgets for facilities and employed clinician professional services

Prospective payment for high-volume and high-cost specialty care providers who are not employed by hospitals

Prospective payment for primary care

What is a Hospital Global Budget?

A fixed payment, determined prospectively, based on historical utilization and adjusted annually to account for changing demographics, market share and case/service mix

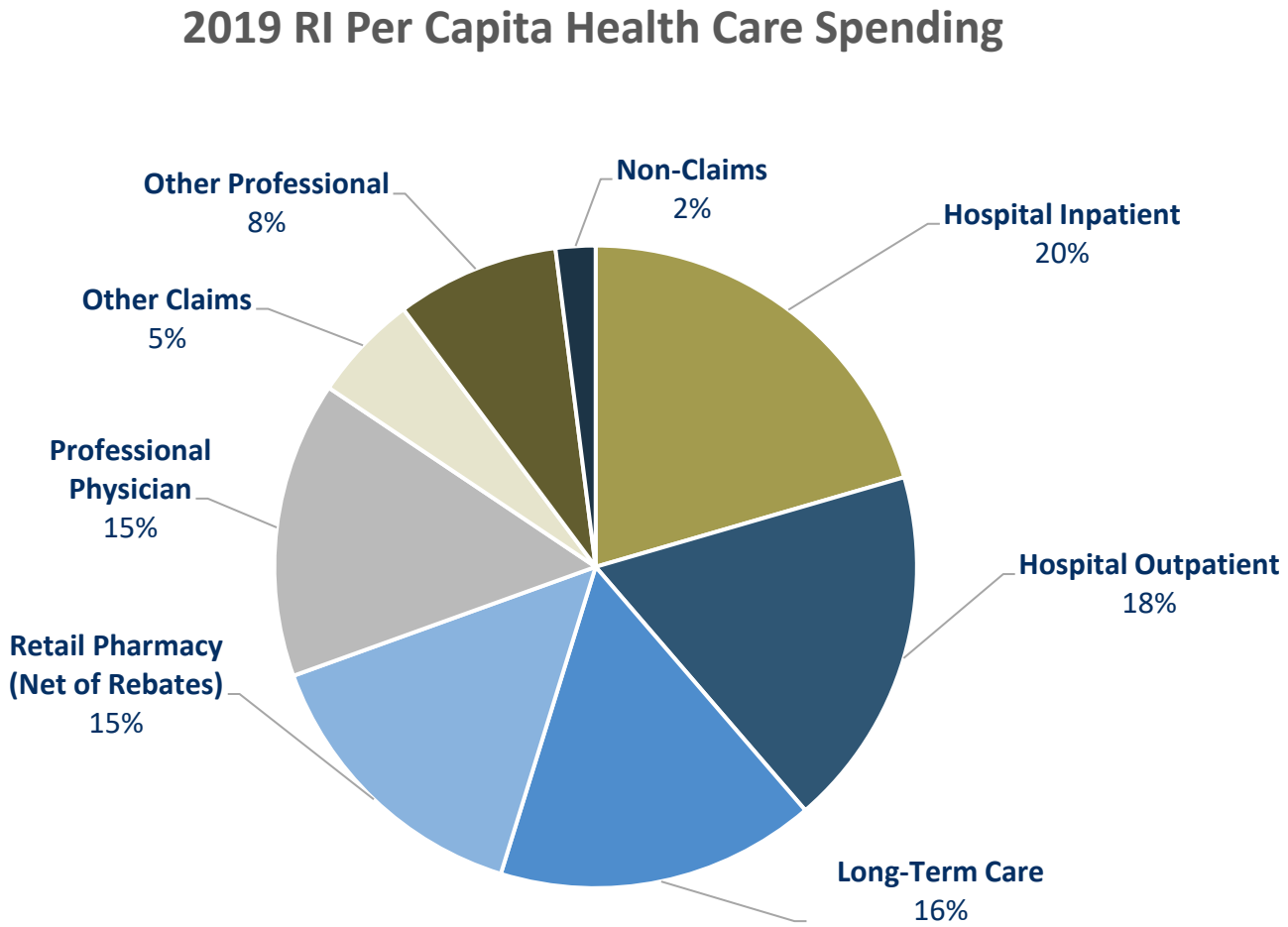
Current Hospital Payment Model

- Hospitals are **paid per unit of service**.
- Hospitals are compelled to **deliver more services**, and **higher margin services**, to maintain financial viability.

Hospital Global Budgets

- Hospitals receive a **budget** for **defined set of services** that is determined **prospectively**.
- Budgets are based on **anticipated utilization** during a specific time period.
- Budgets can be **modified from year to year** based on changes in market share and other factors.

Why Consider a Hospital Global Budget?



Sources:
2019 Rhode Island Cost Growth Target Data Collection

The Cost Trends Steering Committee is interested in increasing the adoption of advanced VBP models.

Its VBP Subcommittee examined how to move away from fee-for-service payment models.

Because hospitals represent a large share of spending (nearly 40% of Rhode Island health care spending in 2019), it made sense to consider VBP models for hospitals.

Why Consider a Hospital Global Budget? (Cont'd)

Hospital global budgets can be supportive of hospitals and advance the Cost Trends objectives by:

- ensuring **steady, predictable financing**;
- providing **greater flexibility** to modify hospital service offerings to best meet community needs;
- producing **positive outcomes** without having adverse effects on hospital finances; and
- **controlling growth** in hospital spending at an affordable level.

Key Milestones in Rhode Island's Value-Based Payment Compact

The compact calls for the formation of a Working Group charged to agree on the details of a hospital global budget model and the completion of the following activities:

July 1, 2023	Identification of the key parameters of the hospital global budget model
July 1, 2024	Completion of an independent study of hospital costs and cost-shifting
July 1, 2025	Establishment of sufficient state government administrative capacity to oversee the successful implementation of the model
January 1, 2026	Implementation of the hospital global budget model

Legislative Interest in Hospital Global Budgets

S2994, introduced in January 2022 by Senators Pearson and DiPalma, sought to put the Cost Trends initiative into statute. S2994 would have mandated the health insurance commissioner and Medicaid director to:

- Develop recommendations for the design of hospital global budgets for facility and employed clinician professional services
- Complete a report examining the cost structure and financial performance of hospitals licensed in Rhode Island
- Complete a report examining cost-shifting between payers, as well as the fiscal and economic impact of changes to Medicaid reimbursement rates for hospital services

http://webserver.rilin.state.ri.us/BillText/BillText22/SenateText22/S2994.pdf

The Hospital Global Budget Working Group's Charge

The Hospital Global Budget Working Group

Who:

- Individuals representing organizations that signed the VBP compact.

What:

- Produce a series of recommendations on the features of an all-payer hospital global budget model that are necessary to be successful and could be adopted by the state or private payers.

How:

- Convene monthly to review options and make recommendations for key design parameters.
- Bring organizational expertise to advise and provide input on key issues.

Working Group Draft Goals and Criteria

The Hospital Global Budget Working Group developed draft goals and criteria to inform the next few months of work.

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

The Working Group will finalize the goals and criteria in September.

Draft 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.

Draft 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.

Process for Designing and Implementing Hospital Global Budgets

Design Key Model Components

Ensure Model Success

Calculate & Update Budgets

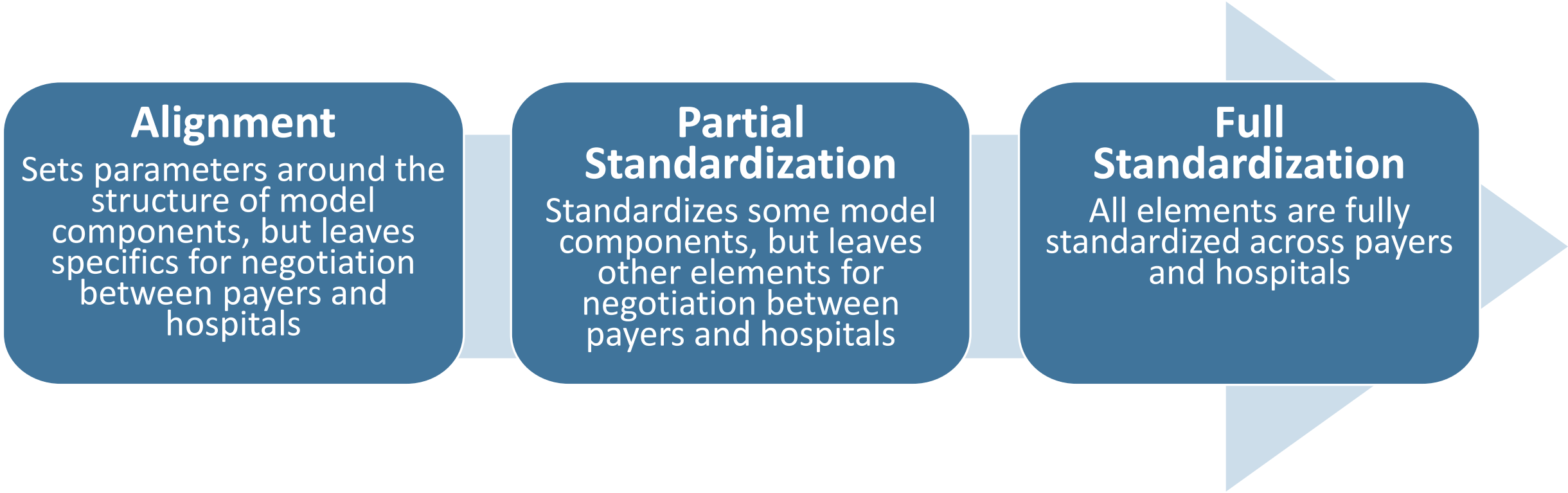
Monitor & Evaluate Performance

Specific Dimensions of the Hospital Global Budget Model Design that the Working Group Will Address

1. Level of desired standardization across the design of the model
2. What services to include in the model
3. How to calculate and update budgets annually
4. How to adjust budgets during the performance period
5. How to distribute payments to hospitals
6. Whether the model should include additional arrangements/adjustments
7. How to mitigate risk
8. Who will calculate budgets and oversee the initiative
9. Plan for monitoring progress and informing design modifications

1. Level of Desired Standardization Across the Design of the Model

Components of the hospital global budget can be aligned, partially standardized or fully standardized. The level of alignment/standardization will be considered in the discussion of specific model design elements.



2. What Services to Include in the Model

Calculation of a hospital global budget requires defining the services that will be included in the payment model. Services that will be considered for inclusion include:

Inpatient hospital facility services

Outpatient hospital facility services

Professional services delivered by hospital-employed providers

Other hospital-owned facility-based services (e.g., clinic services, home health, skilled nursing facilities, other specialty facilities)

3. How to Calculate and Update Budgets Annually

Hospital global budgets must be adequate enough to **fund needed care** and **support strategies to constrain spending growth**, but must incentivize hospitals to **prevent avoidable and inappropriate utilization**.

Budgets are typically produced using a hospital's **historical inpatient and outpatient** revenue.

Budgets are **adjusted annually** to account for inflation, changing demographics, and market share, at the very least.

- Budget adjustments can also be applied for changes in case mix and service intensity, for quality performance, performance managing TCOC, and for changes in uncompensated care.

4. How to Adjust Budgets During the Performance Period

FFS MODEL	FIXED GLOBAL BUDGET	FLEXIBLE GLOBAL BUDGET
Hospital is paid 100 cents on the dollar for each service, even though cost to produce the service (i.e., variable costs) is <$1 Results in profit with volume increase and vice versa	Hospitals do not receive additional revenue for volume growth May encourage stinting as hospital receives 100 cents on the dollar for volume decline	Hospital receives revenue for volume growth, but only for variable costs Provides a predictable revenue source, but reduces incentive to decrease volume to increase savings

5. How to Distribute Payments to Hospitals

Retrospective Approach

- Hospitals submit claims and receive payments on an FFS basis
- There can be one flat rate for all services or service-specific rates (which is highly complex)

Prospective Approach

- Hospitals receive fixed payments on a regular schedule (e.g., biweekly, monthly) equal to a portion of their annual budget
- Hospitals still submit claims, which are not paid, to inform budget modifications

Combined Approach

- Different payers adopt separate approaches, which allows them to adhere to existing statutory and regulatory requirements

6. Whether the Model Should Include Additional Arrangements

Complementary payment models can potentially support improved cost, access, quality, and population health (e.g., P4P models with utilization quality measures, TCOC models).

Supplemental payments can help hospitals invest in population health (e.g., care management, data analytics, HIT) and thereby potentially improve quality of care and generate savings.

CMMI may also require states to establish **additional performance targets** as part of the negotiation process to secure a waiver to implement a state model that includes Medicare FFS.

7. How to Mitigate Hospital Risk

One approach to address financial risk is through the **design of the hospital global budget** (e.g., a flexible arrangement ensures a hospital's fixed and variable costs are covered).

Other potential approaches include:

- **reconciling payments made to select hospitals** for some or all of their populations to the FFS-equivalent spending,
- using **reconciliation as a temporary strategy** to transition to global budgets,
- implementing **stop-loss provisions** and/or
- providing **technical assistance** to hospitals, payers and other partners to aid model implementation.

8. Who Will Calculate Budgets as Well as Manage and Oversee the Initiative

There are two approaches to **calculating individual hospital budgets**.

- *One entity calculates all budgets*: ensures budgets are calculated consistently across payers and hospitals.
- *Individual payers and hospitals calculate budgets*: may be more feasible to implement; states may wish to provide technical assistance for budget calculation.

The entity that **manages and oversees** the initiative can be the same entity that calculates budgets referenced above, or a separate public or private entity. Key responsibilities include:

- working with hospitals to **mitigate technical and financial risk**;
- providing **technical assistance** to hospitals and payers implementing the model and
- ensuring there are **consequences** for failing to meet budgets or model parameters (may be more applicable for a mandatory model).

9. Plan for Monitoring Progress and to Inform Design Modifications

There must be a plan to track whether the model is achieving its proposed objectives and to inform modifications over time.

Key monitoring and evaluation activities include:

- annually **assessing and reporting progress** against achieving model goals, including statewide cost, access and quality performance;
- performing **market conduct exams** and **reviewing contracts** to ensure adherence to the model (easier to do under a mandatory approach), and
- **meeting with stakeholders** to discuss progress towards meeting model objectives and troubleshooting challenges.

State Experience with Hospital Global Budgets

State Implementation of Hospital Global Budgets

Four states have experimented with hospital global budgets to date:

- New York Hospital Experimental Payment Program (1980 – 1987)
- Maryland All-Payer Model and TCOC Model (2010 – present)
- OneCare Vermont's model (2017 – present)
- Pennsylvania Rural Health Model (2019 – present)

Each state's model is unique and is reflective of state-specific policies and market dynamics.

- We will review these examples to help you understand how hospital global budgets have been employed.
- Rhode Island's approach is likely to differ from all four examples.

Of note, CMMI's CHART Model (2021 – 2027) is intended to provide prospective capitated payments to rural hospitals, like a hospital global budget, in AL, SD, TX and WA.

State Implementation of Hospital Global Budgets (Cont'd)

Hospital Participation

- **NY**: seven Rochester hospitals and one hospital outside city limits
- **MD**: all acute care hospitals
- **PA**: critical access and acute care hospitals in rural areas
- **VT**: 14 VT hospitals distributed across the state and Dartmouth-Hitchcock (NH) – all part of OneCare VT (statewide ACO)

Payer Participation*

- **MD**: all-payer (i.e., commercial, Medicaid, Medicare)
- **NY, PA**, **VT**: Medicaid, Medicare and select commercial participation

*Medicare participates in hospital global budget arrangements via a special state agreement with CMMI.

Findings from State Experiences

New York

- Reduced growth in hospital operating revenues and expenses
- Improved net margins
- May have yielded stronger results with model expansion

Vermont

- Decreased hospital-based utilization and expenditures for Medicare
- Majority of hospital payments are still based on FFS, which is challenging for hospitals
- Some hospitals in rural areas have been reluctant to participate due to financial risk

Maryland

- Reduced hospital spending for Medicare and commercial
- Reduced total expenditures for Medicare
- Reduced admissions for Medicare and commercial
- Reduced ED visits for Medicaid and commercial

Pennsylvania

- Limited data to assess effectiveness (one year of non-COVID-impacted data (2019))
- Participation from many hospital types (Critical Access, system-owned, independent)

Four Key Factors for Success

1. **Broad participation and support** from hospitals, payers and hospital-employed providers.

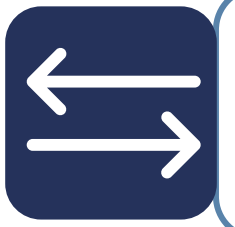
2. Robust, transparent **methodology** for establishing and updating **budgets**.

3. Depending on the model, **state government support** to oversee implementation and regulate and enforce the model annually.

4. Strong **infrastructure to support population health** activities that reduce emphasis on service volume.

Challenges with Hospital Global Budgets

Hospitals and/or payers may be **reluctant to engage** in a global budget arrangement due to perceived **financial risks** or due to **technical challenges** associated with implementing the model.



Global budgets **could lead to stinting of needed care or shifting care** to settings not captured under the global budget if there are not sufficient mechanisms in place to monitor and respond to this risk.

Global budgets may **reinforce undesired structures** and **perpetuate inequities** in access to and/or quality of care.

Next Steps

Future Meetings

OHIC welcomes participation of hospital CFOs in future Working Group meetings to discuss key model design elements.

The next Working Group meeting will be on September 20, 2022.

OHIC will schedule future monthly meetings starting in November.