Hospital Global Budget Working Group

January 23, 2023

Agenda

- Review Charge of the Hospital Global Budget Working Group and 2023 Meeting Plan
- Updates on Other Hospital Global Budget Efforts
- Review Goals and Criteria
- Discussion of Hospitals to Include in the Model
- Discussion of Services to Include in the Model
- Public Comment
- Next Steps

Review Charge of the Hospital Global Budget Working Group and 2023 Meeting Plan

Review Charge of the Hospital Global Budget Working Group

OHIC convened the Hospital Global Budget Working Group in 2022 to 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**.

The impetus for this Working Group arose from the Compact to Accelerate Advance VBP Model Adoption in Rhode Island, which called for the 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

Review Charge of the Hospital Global Budget Working Group (Continued)

The VBP compact outlined the following timeline for the Hospital Global Budget Working Group:

Date	Milestone
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

2023 Hospital Global Budget Working Group Meeting Plan

When the Working Group met in 2022, it:

- reviewed prior hospital global budget efforts in other states,
- discussed goals and criteria for a hospital global budget model in Rhode Island and
- began to consider what hospitals and services should be included in the model.

OHIC is reconvening this Working Group in 2023. The Working Group will revisit the previously recommended model goals and criteria before resuming consideration of which hospitals to include in the model.

2023 Hospital Global Budget Working Group Meeting Plan (Continued)

Of note, OHIC made a few changes to the Working Group structure and meeting cadence.

First, OHIC requests that hospitals make a concerted effort to have participation from their hospital financial representatives.

- Hospital participation will ensure that important aspects of hospital financing are appropriately considered during model development.

Second, OHIC is adopting an intense and ambitious schedule to meet the state's goals for having recommendations on broad parameters by July 2023.

- The Working Group will be meeting for two hours approximately two times a month between January and July.
- All meetings will be held at HARI's conference room in Providence.

2023 Meeting Schedule and Draft Agendas

Date	Draft Meeting Agenda
February 9, 2023	• Decide which services to include in the model (continued) • Decide how to calculate and update budgets annually
February 23, 2023	• Decide how to calculate and update budgets annually (continued)
March 6, 2023	• Decide how to calculate and update budgets annually (continued) • Decide how to adjust budgets to account for changes in utilization during the performance period
March 27, 2023	• Decide how to adjust budgets to account for changes in utilization during the performance period (continued)
April 7, 2023	• Decide whether the hospital global budget model should include supplemental arrangements to improve population health, access and quality

2023 Meeting Schedule and Draft Agendas (Continued)

Date	Draft Meeting Agenda
April 17, 2023	• Decide whether the hospital global budget model should include supplemental arrangements to improve population health, access and quality (continued)
May 1, 2023	• Identify opportunities to mitigate hospital technical and financial risk
May 15, 2023	• Create a plan for monitoring progress towards model goals to inform possible design modification
June 5, 2023	• Identify if and how the model should allow for different payers to vary from the recommended model • Discuss how a global budget model should co-exist with other VBP initiatives in the state

2023 Meeting Schedule and Draft Agendas (Continued)

Date	Draft Meeting Agenda
June 19, 2023	• Determine who will be responsible for calculating hospital global budgets • Determine who should manage and oversee the hospital global budget initiative
July 10, 2023	• Determine who will be responsible for calculating hospital global budgets (continued) • Determine who should manage and oversee the hospital global budget initiative (continued)
July 24, 2023	• Review and finalize model recommendations

Updates on Other Hospital Global Budget Efforts

Updates on Other Hospital Global Budget Efforts

Since the Working Group last met, we learned of two other hospital global budget efforts that may be of interest:

1. CMMI's AHEAD Model (in development)
2. CMMI's CHART Model
3. Rhode Island's prior experiment with hospital prospective payments in the 1970s

CMMI's AHEAD Model

CMMI is signaling that it will produce a new model to span multiple states starting in 2025 that will address seven CMS priorities:

1. Include global budgets for hospitals.
2. Include a TCOC target/approach.
3. Be all-payer.
4. Include a 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.

CMMI's AHEAD Model (Continued)

The tentative timeline for model development is as follows:

- **September-December 2022**: engage with states on conceptual development
- **Late 2023**: release notice of funding opportunity (NOFO)
- **2024**: select model participants
- **2025**: implement model

OHIC will engage CMMI to discuss Medicare's involvement in Rhode Island's hospital global budget initiative, potentially as part of the AHEAD Model.

CMMI's CHART Model

CMMI recently announced the suspension of the first Implementation Year (2023) of its Community Health Access and Rural Transformation (CHART) Model, citing "insufficient participation from rural health hospitals."

CMMI is determining next steps for the model.

For more information, see: https://innovation.cms.gov/innovation-models/chart-model

Rhode Island's Prospective Hospital Reimbursement Program

Rhode Island established prospective payments to hospitals from the 1970s to the 1990s. The two primary goals of the program were to:

- contain growth in hospital costs and
- demonstrate that such an objective can be accomplished without impairing the quality of care.

This effort was a voluntary arrangement between Blue Cross Blue Shield (the dominant commercial payer at the time), Medicaid and Medicare and all 16 hospitals in the state.

The following slides summarize the program design at a high level. We will incorporate more details about the program into future meeting materials.

Rhode Island's Prospective Hospital Reimbursement Program: Key Features

Key program features:

- **Limit on aggregate gross operating expenses across hospitals** statewide (i.e., the MAXICAP) **negotiated** by hospitals, BCBS and the State Budget Office
- A **review process to approve new and/or medical programs** that was separate from RIDOH's certificate of need review process for capital expenditures
- **Budget negotiation process** that required **unanimous consent** from HARI, BCBS and the State Budget Office (with mediation and arbitration sessions)
- **Rate determination approach** based on a ratio of costs and charges
- Provisions to **modify hospital budgets** due to changes in **volume**, **patient mix** and **unexpected increases** (e.g., regulatory or statutory changes, "acts of God")

The RI model ended because it was administratively burdensome, especially due to negotiated MAXICAP rate and the number of retrospective budget adjustments made at the end of each performance period.

Review Goals and Criteria

Review Model Goals and Criteria

When the Working Group met in 2022, it developed a set of goals and criteria to inform the features of a successful, all-payer hospital global budget model for Rhode Island.

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.

Review 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.

Review 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.

Discussion of Hospitals to Include

Hospitals in Rhode Island by System*

System	Hospital
Care New England	• Butler Hospital • Kent Hospital • Woman & Infants Hospital of Rhode Island
Lifespan	• Bradley Hospital • Newport Hospital • Rhode Island Hospital / Hasbro Children's Hospital • The Miriam Hospital
Prospect CharterCARE**	• Our Lady of Fatima Hospital • Roger Williams Medical Center

System	Hospital
Prime Healthcare Services	• Landmark Medical Center • Rehabilitation Hospital of Rhode Island
South County Health	• South County Hospital
Yale New Haven Health	• Westerly Hospital

* The Providence VA Medical Center and Eleanor Slater Hospital are not included in this list.
** CharterCARE to be acquired by Centurion Foundation.

Should Budgets Be Calculated at the System Level or the Hospital Level?

If budgets are calculated at the system level, then the system would receive one payment for all hospitals. The system then would be responsible for distributing payments across all hospitals within the system.

- Would system-level budgets promote the goals of a hospital-level budget model?
- Are system-level budgets or hospital-level budgets consistent with how contracts are negotiated today?
- What are the incentives associated with calculating budgets at the system level versus the hospital level?

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 / Hasbro Children's Hospital • Roger Williams Medical Center • South County Hospital • Westerly Hospital	• Bradley Hospital • Butler 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.

Should Budgets Include Specialty Hospitals?

A hospital global budget model could be limited to general acute care hospitals, or it could include some or all specialty hospitals in the state.

- A model could also begin with acute care hospitals only and then expand over time to include specialty hospitals.

With that in mind, how would inclusion or exclusion of specialty hospitals incentivize leakage of select services? What impact would this have on a specialty hospital's ability to provide care for populations with specialized care needs?

Should Budgets Include Specialty Hospitals? (Cont'd)

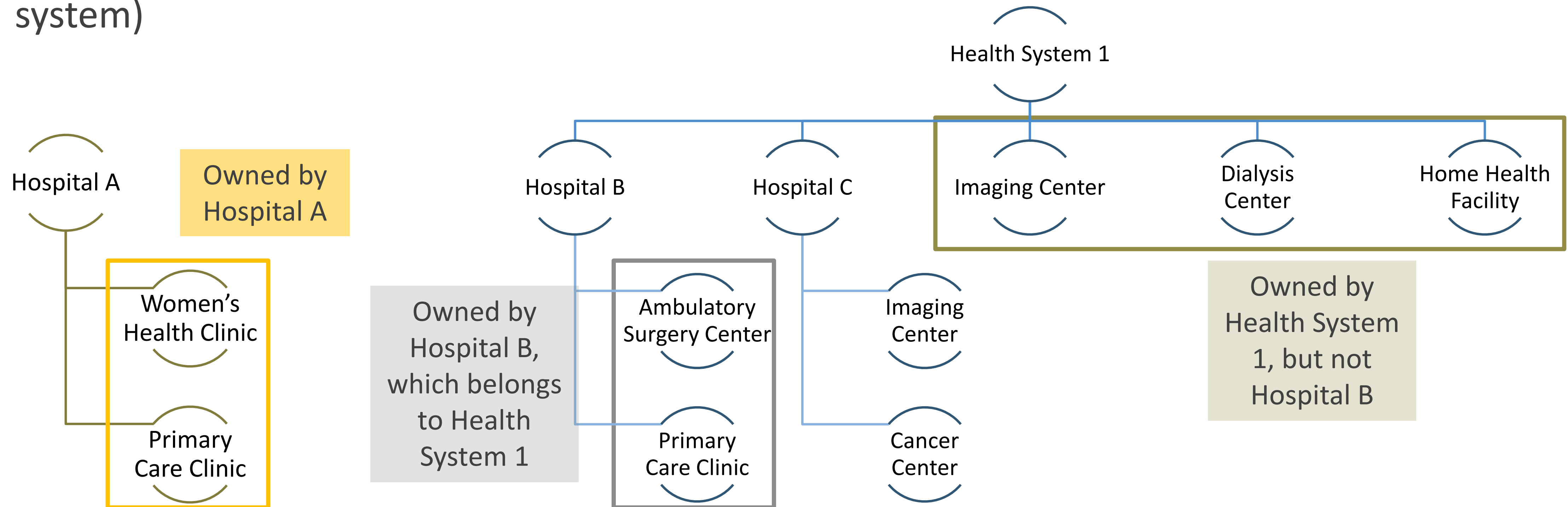
- If a health system includes both acute care and specialty hospitals and specialty hospitals are excluded from hospital global budgets, acute care hospitals could shed services included in the model to specialty hospitals to maximize savings.
  - For example, if psychiatric services are included in the model, but psychiatric hospitals are excluded from the model, then an acute care hospital that provides psychiatric services may be incentivized to shift those services to psychiatric hospitals.
  - If psychiatric services and psychiatric hospitals are both included the model, hospitals may be incentivized to shift care to settings where costs are lowest.
- If leakage is significant, a specialty hospital may have limited resources to care for populations that need higher acuity services.

Discussion of Services to Include

Key Assumptions Around Services to Include

In previous meetings, there was some discussion around how to treat services that are not "owned" by hospitals. For example:

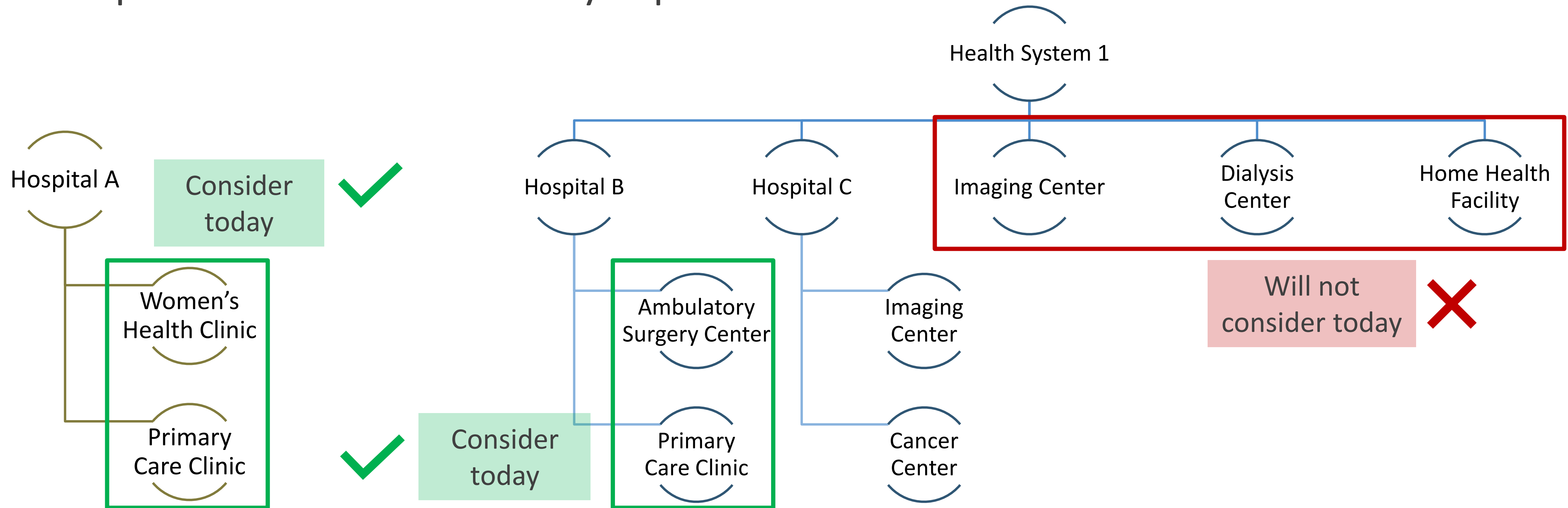
- Professional services delivered in the hospital setting by non-hospital-employed providers
- Other facility services that are not owned by the hospital (but may be part of a larger health system)



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.



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:

- Inpatient hospital facility services
- Outpatient hospital facility services

Included

- Professional services delivered in an inpatient and outpatient hospital setting

Excluded

- Hospital-owned, non-hospital-based facility services (e.g., clinic services, home health, skilled nursing facilities)

Excluded

We will discuss what to do for each of these categories of services for Rhode Island. Of note , the VBP Compact refers to the development of "hospital global budgets for facility and employed clinician professional services."

Inclusion of Inpatient and Outpatient Services in the Model

All states with hospital global budget experience have included revenue for hospital facility inpatient and outpatient services in their models.

A hospital global budget is more likely to support affordable spending growth if all or most inpatient and outpatient services are captured under the arrangement.

However, it may be desirable to exclude certain services, such as:

- low frequency, high-cost specialty services (e.g., organ transplants, cardiac surgery, neurosurgery), as these services have a big impact on a hospital's overall budget but are hard to predict and plan for.
- areas where there is a commitment to expanding access to care and, consequently, utilization (e.g., pediatric psychiatric care, primary care).

Should Any Specific Inpatient and/or Outpatient Facility Services Not Be Included in the Budget?

Considerations for whether to exclude specific inpatient and/or outpatient facility services:

1. Are there specific types of services that we should consider excluding. If so, what services and why?
2. What implications would exclusion of specific services have on the administrative burden associated with calculating the budget?

Inclusion of Spending on Hospital-Employed Professional Services in the Model

Maryland and Pennsylvania did not include professional spending.

- In MD, the HSCRC lacked regulatory authority to set physician fees.
- In PA, CMMI did not identify inclusion of professional spending as a priority.
- Evaluations of both models cited exclusion of professional services as a barrier. Consequently, MD created the Care Redesign Program which aimed to align incentives across hospitals and providers.

Vermont is actively considering inclusion of professional spending in its design discussions.

As a reminder, The VBP Compact refers to the development of "hospital global budgets for facility and employed clinician professional services."

- Inclusion of professional services aligns incentives among hospitals and professionals, which could increase the likelihood of achieving model goals

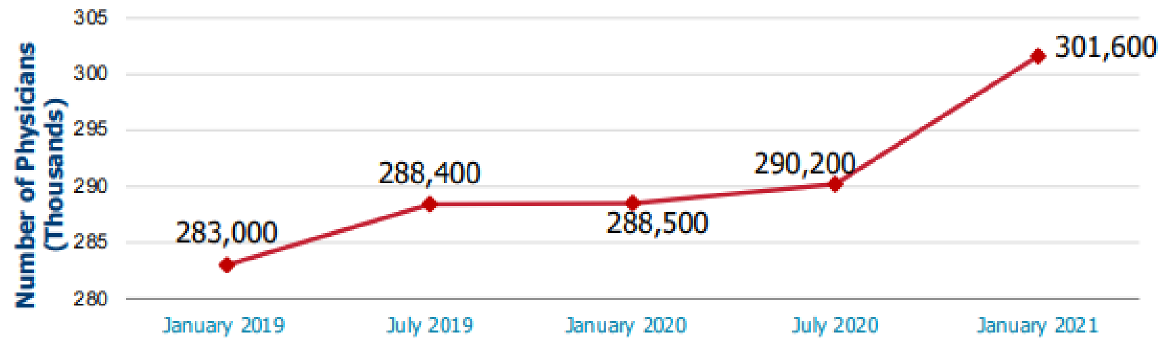
Should the Budget Include Hospital-Owned Professional Services?

Considerations for whether to include hospital-owned professional services delivered in the hospital setting:

1. How much of a hospital's revenue do hospital-employed professionals services represent?
   - The effort to calculate and administer budgets should be commensurate with the size of spending.
   - National and regional trends suggest that nearly half of physicians were employed by hospitals as January 2021. This percentage has been growing.

Should the Budget Include Hospital-Employed Professional Services? (Cont'd)

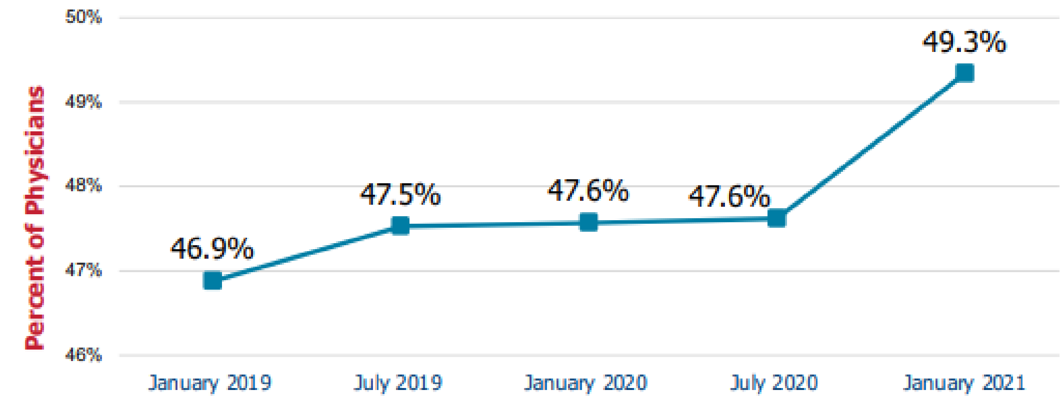
National Trends: Sharp Uptick in Physician Hospital Employment in Months Following Onset of Pandemic



- **18,600** additional physicians were employed by hospitals over the two-year study period – **11,400** of that shift occurred after the onset of COVID-19
- Physician employment grew in each of the four 6-month periods analyzed
- There was a **3.1% increase** in the growth rate of hospital-employed physicians in the last half of 2020, following the onset of COVID-19

Avalere analysis of IQVIA OneKey database that contains physician and practice location information on hospital/health system ownership

National Trends: Nearly Half of Physicians Employed by Hospitals/Health System at the End of 2020



- **49.3%** of physicians were hospital-employed by January 2021
- Over the two-year study period, the percentage of employed physicians **grew by 5%**

Avalere analysis of IQVIA OneKey database that contains physician and practice location information on hospital/health system ownership

Should the Budget Include Hospital-Employed Professional Services? (Cont'd)

2. Should budgets include all services provided by hospital-employed professionals, or should some services (e.g., professional services delivered in non-hospital settings, primary care services) be excluded?
   - If health systems are interested in increasing investment in some service lines (e.g., primary care, outpatient mental health care), it may be reasonable to exclude them from the budget.
   - However, if certain service lines are excluded, there may be incentives for hospitals to steer care to other facilities that are not part of the global budget, and for which there would be no cost growth controls.
3. How would inclusion of hospital-employed professional services impact budget implementation?
   - Adding professional services may make the hospital global budget model more comprehensive, but it could increase complexity in how budgets are calculated and tracked during the performance year.

Inclusion of Hospital Owned, 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.

Inclusion of hospital-owned, non-hospital facility services can:

- align incentives across hospital-owned assets
- provide expanded revenue predictability to the hospital/hospital system
- protect against shifting care to other hospital-owned services that do not have any cost growth controls
- incentivize better coordination across hospital-owned settings

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 has 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

Should the Budget Include Hospital-Owned Non-Hospital Facility Health Care Services?

Considerations for whether to include hospital-owned non-hospital facility services in the model:

1. How do we define and identify these hospital "assets."
2. How would inclusion of hospital-owned, non-hospital facility services impact budget implementation? Do hospital-owned, non-hospital facility services operate under separate contracts from the hospital?
   - Adding non-hospital facility services may make the hospital global budget model more comprehensive, but it could increase complexity in how budgets are calculated and tracked during the performance year.
   - Of note, if payment for non-hospital facilities is not included in the budget, it is important to consider how to mitigate against potential leakage to such facilities (e.g., through supplemental payment or quality models).

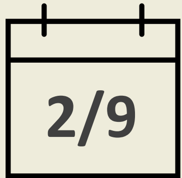
Should the Budget Include Hospital-Owned Non-Hospital Facility Health Care Services? (Cont'd)

3. How much of hospitals' revenue do non-hospital facility services represent?
   - The effort to calculate and administer budgets should be commensurate with the amount of revenue generated by the non-hospital facilities.
4. Should budgets include all hospital-owned, non-hospital facility services, or should some services be excluded? If so, which services?
   - It may be worthwhile to exclude services from some non-hospital facilities that provide unique specialty services that may not be directly impacted by hospital operations.
   - In addition, such facilities may provide services that are low frequency but high-cost services, which may have big impacts on a hospital's overall budget.

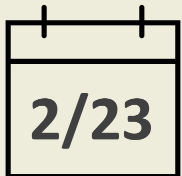
Public Comment

Next Steps

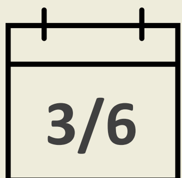
Working Group Meeting Plan and Schedule



- Discuss what services to include (continued)
- Discuss how to calculate and update budgets annually



- Discuss how to calculate and update budgets annually (continued)



- Discuss how to calculate and update budgets annually (continued)
- Discuss how to adjust budgets to account for changes in utilization during the performance period