Hospital Global Budget Working Group

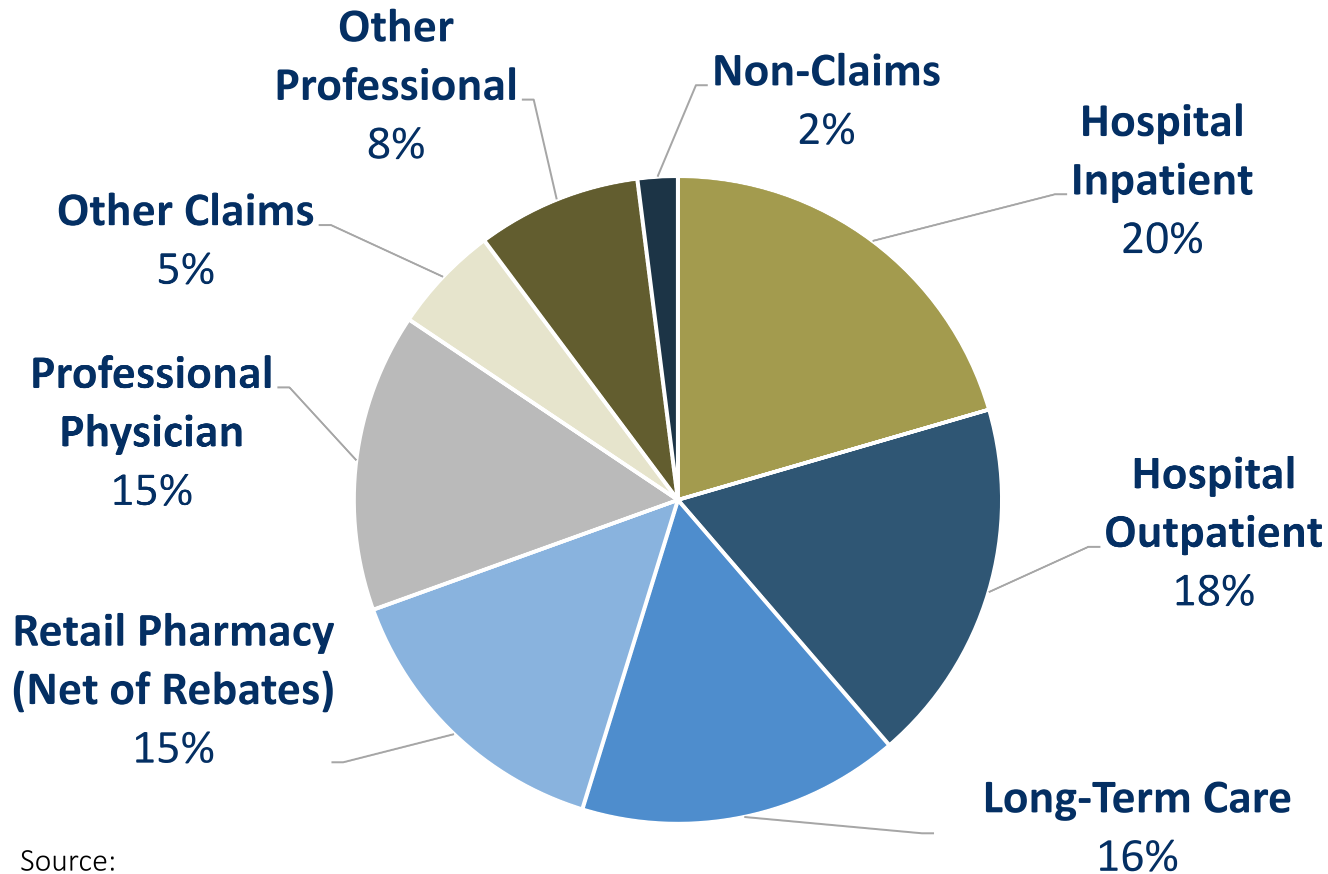
February 9, 2023

Agenda

- Follow-up from the January 23, 2023 Meeting
- Discussion of Services to Include in the Model
- Discussion of What Population to Include in the Budget
- Public Comment
- Next Steps

Follow-up from the January 23, 2023 Meeting

Why Consider a Hospital Global Budget?



Source:
2019 Rhode Island Cost Growth Target Data Collection

Hospitals* represent a large share (nearly 40%) of health care spending in Rhode Island

*Excludes hospital-employed professional services and hospital-owned non-hospital facilities

How Hospital Global Budgets Can Be a “Win-Win”

Hospital global budgets can be supportive of hospitals and payers 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
- Controlling growth in hospital spending at an affordable level

Summary of Preliminary Recommendations

During the last meeting, the Working Group made two preliminary recommendations.

1. Adopt **hospital-level** budgets.
2. Consider budgets for **all hospitals, including specialty** hospitals.

The Working Group can choose to revisit any of these preliminary recommendations as it considers additional questions related to model design.

Discussion of Services to Include

Services to Consider for a Hospital Global Budget

We'll discuss whether to include each of these categories of services in a hospital global budget model.

Hospital Facility Services

- Inpatient hospital facility services
- Outpatient hospital facility services

Professional Services

- Delivered by hospital-employed professionals
- Delivered by contracted professionals

Non-Hospital-Based Facility Services

- Hospital-owned facility services
- System-owned facility services

Considerations Around More Comprehensive and Limited Approaches to the Budget

COMPREHENSIVE APPROACH

Also includes professional and/or non-hospital facility services

- Greater revenue predictability
- Increases incentives to integrate care across settings and services
  - For example, MD's and PA's experience highlighted exclusion of professional services as a barrier to delivery system reform

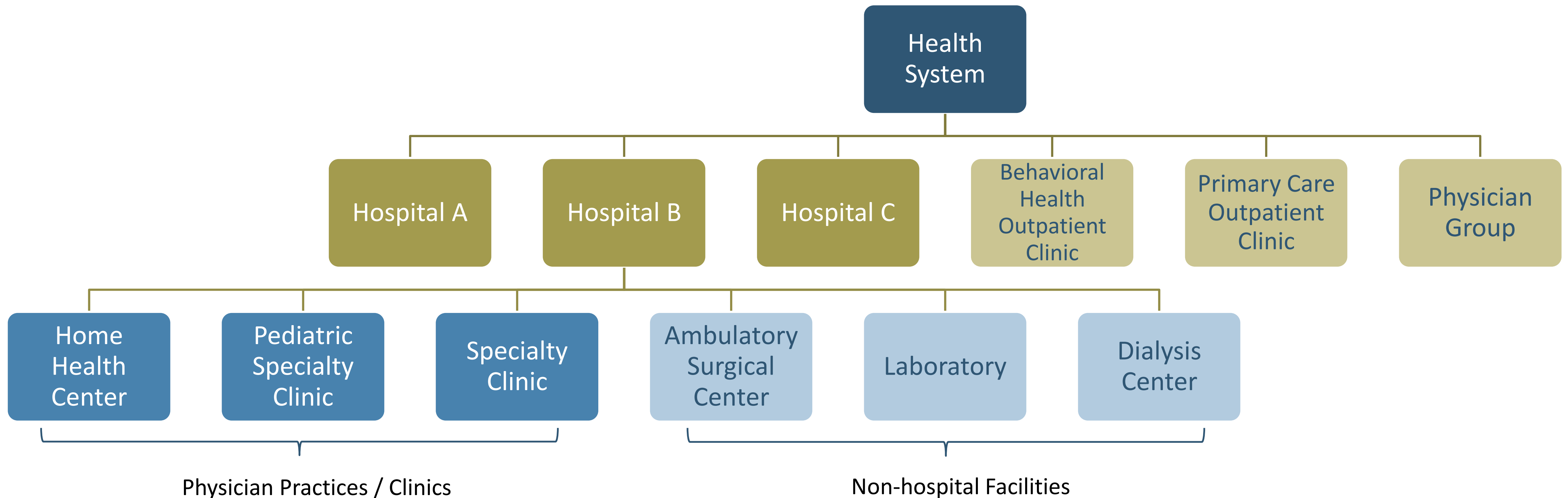
LIMITED APPROACH

Limited to hospital inpatient and outpatient services only

- May be simpler to administer
- Does not preclude future expansion of included services
  - Allows for a period of learning and adjustment before going "all in"

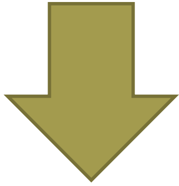
What Services Should be Included in the Hospital Global Budget Model?

In the following slides, we will use a hypothetical organizational structure as an example of what category of services we are currently discussing.



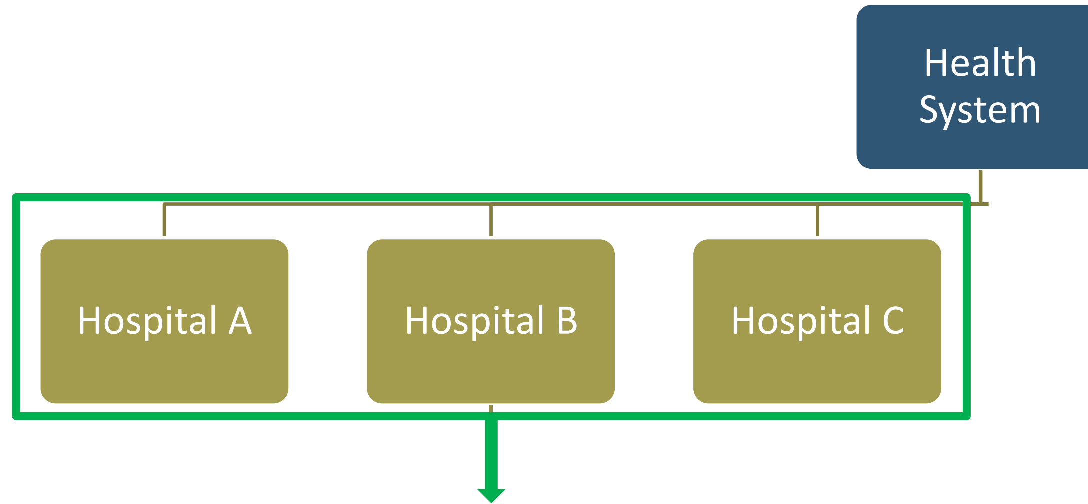
NOTE: May not represent all organizations within a health system. This is example is intended to facilitate discussion.

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



Hospital Facility Services	Professional Services	Non-Hospital-Based Facility Services
Inpatient hospital facility services	Delivered by hospital-employed professionals	Hospital-owned facility services
Outpatient hospital facility services	Delivered by contracted professionals	System-owned facility services

Inclusion of Inpatient and Outpatient Services



We are considering inpatient and outpatient services delivered in these facilities.

Inclusion of Inpatient and Outpatient Services

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

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

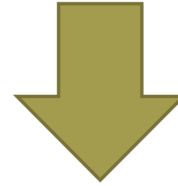
- **low frequency, high-cost specialty services**.
- services in areas where there is a **commitment to expanding access to care**.

Discussion

1. Are there specific types of **hospital inpatient and outpatient services** that we should consider excluding?

   - If so, which services and why?

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



Hospital Facility Services	**Professional Services**	Non-Hospital-Based Facility Services
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How Other Models Treat Professional Spending

Maryland and Pennsylvania did not include professional spending.

- In MD, the regulatory agency had statutory authority only to set hospital budgets.
- For 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 leaning towards inclusion of professional spending in its parallel design discussions.

Developing Common Definitions

Here, we are only considering the costs associated with a professional fee and *not* any clinical or personnel costs that may be included in a facility fee.

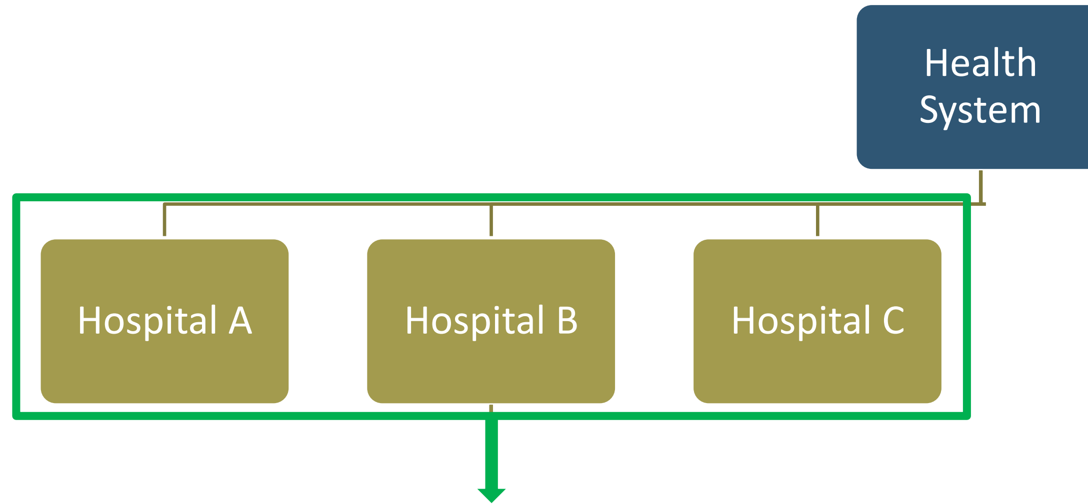
How do hospitals define "hospital-employed" staff?

- Are clinical and non-clinical staff employed by hospital-owned clinics and facilities considered employees of the hospital to which the clinics and facilities roll up?

How do hospitals define contracted staff?

- Do hospitals bill for services delivered by contracted staff in a different way than non-contracted staff?

Inclusion of Hospital-Employed or Contracted Professional Services



We are considering professional services delivered by providers employed or contracted by these hospitals.

Inclusion of Spending on Hospital-Employed Professional Services

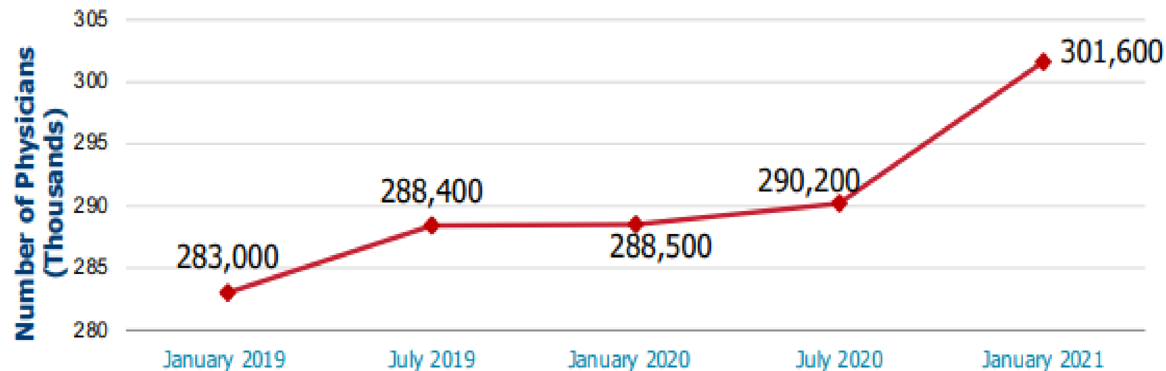
The Value-Based Compact signed in April 2022 by RI stakeholder leaders refers to the development of “hospital global budgets for facility and **employed clinician professional services**.”

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

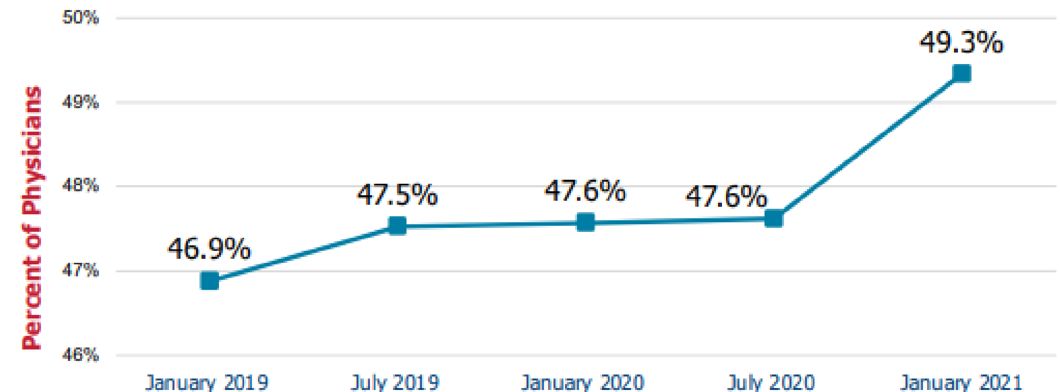
Hospital Employment of Physicians Has Increased Substantially Over Time

How reflective are national trends of what is happening in RI?

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



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

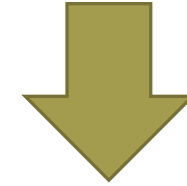


Source: Avalere analysis of IQVIA OneKey database that contains physician and practice location information on hospital/health system ownership.

Discussion

1. Should budgets include all, some, or none of the services provided by **hospital-employed professionals**?
2. Should budgets include all, some, or none of the services provided by **contracted professionals**?

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



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Inclusion of Non-Hospital-Based Facility Services

Health systems and hospitals may also own other non-hospital facilities such as home health agencies, imaging centers, urgent care centers, etc.

Inclusion of non-hospital-based services can:

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

How Other State Models Treat Other Facility-Based Services

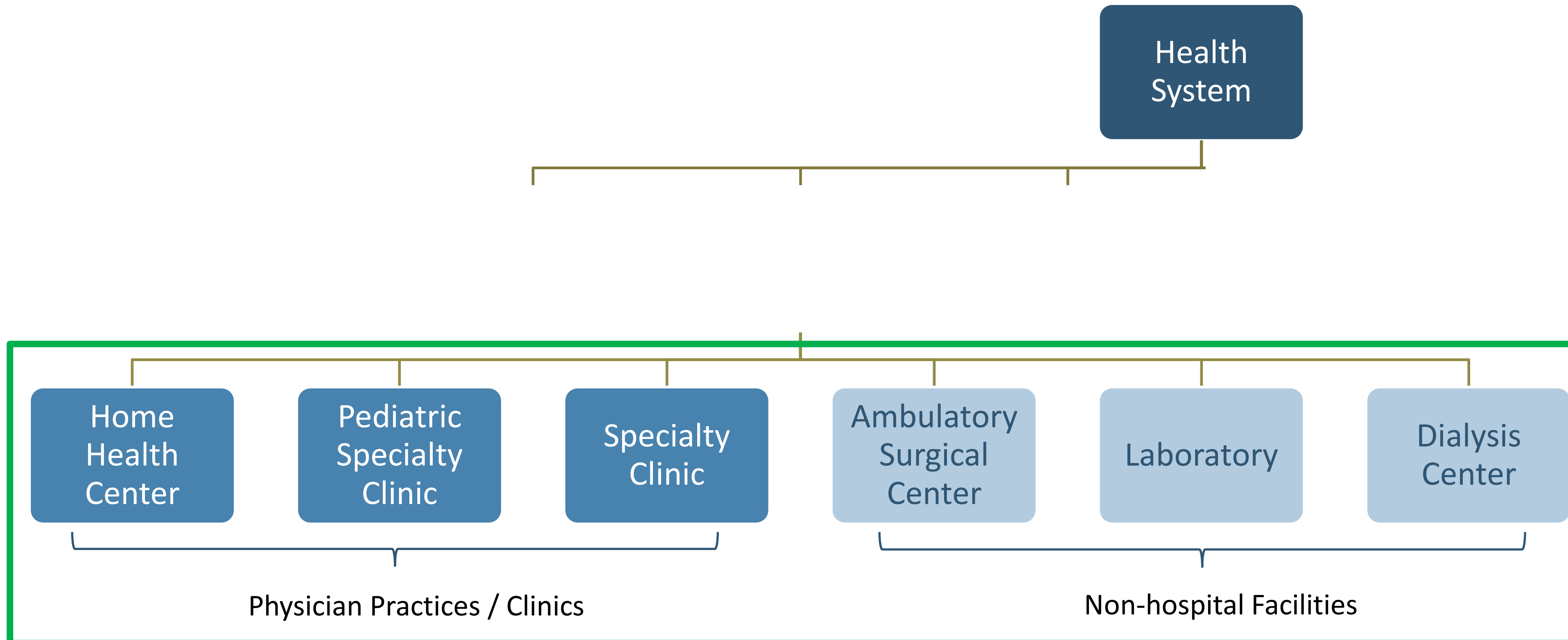
Maryland

- Excluded since the state agency 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 focus was on financial stability for rural hospitals
  - PA viewed expansion of provider-based clinics as a necessary growth opportunity for small rural hospitals

Inclusion of Hospital-Owned Facility Services



We are considering services delivered in hospital-owned facilities.

Considerations on Inclusion of Hospital-Owned Facility Services

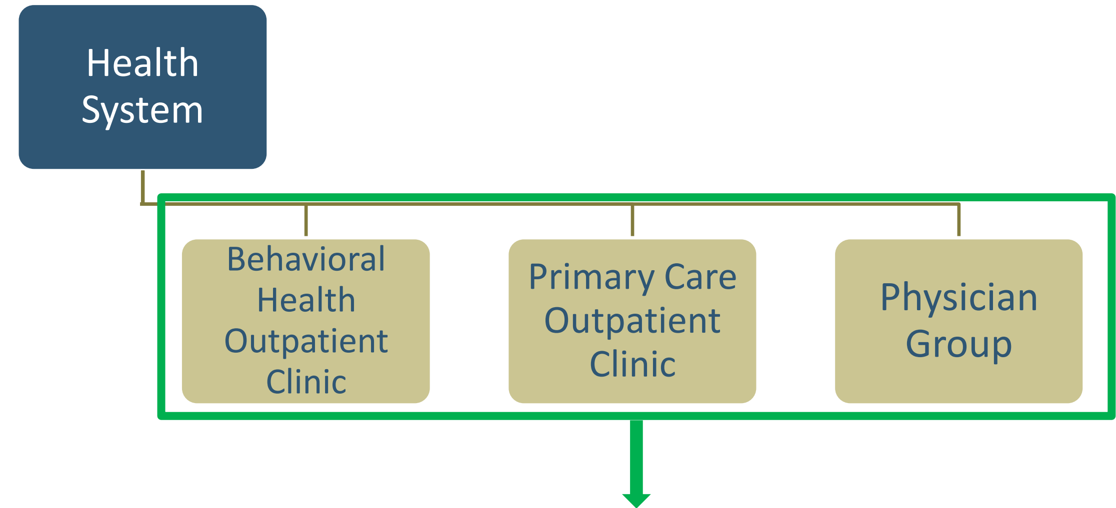
1. How much of hospitals' revenue do hospital-owned facility services represent? How does this vary across Rhode Island hospitals?
   - Would inclusion result in significantly different impacts across the hospitals?
2. How would inclusion of hospital-owned facility services impact budget implementation?

Discussion

1. Should budgets include all, some, or none of the **hospital-owned facility services**?

Ambulatory Surgical Centers	Behavioral Health Clinics	Home Health Centers	Laboratories
Primary Care Clinics	Radiology/ Imaging Centers	Rehabilitation Centers	Research Centers
	Specialty Care Clinics	Other?	

Inclusion of System-Owned Facility Services



We are considering services delivered in system-owned facilities.

Considerations on Inclusion of System-Owned Facility Services

1. How would inclusion of system-owned facility services contribute towards achievement of goals for the hospital global budget?
   - Are there other, more effective ways to achieve these goals, such as through VBP models that complement a hospital global budget?
2. How feasible is it to include system-owned facility services if their budgets are independent from hospital budgets?

Discussion

1. Should budgets include all, some, or none of the **system-owned facility services**?

Discussion of What Population to Include in the Budget

Population Captured By Global Budgets

Developing a hospital global budget requires defining the population captured by each budget.

Other states have defined the population using **“primary service areas”** or geographic regions from which the majority of a hospital's market share draws from.

It may not be reasonable to adopt the same approach in Rhode Island given its small geographic size.

Population Captured By Global Budgets (Cont'd)

In developing the budget, we propose focusing on including **revenue** generated by **members insured by a participating payer** who received services at a **participating hospital**.

Under this approach, global budgets **will not** include revenue generated by:

- members attributed to a participating payer who receive services at a non-participating hospital (including non-RI hospitals).
- members attributed to non-participating payers (including non-RI payers), regardless of whether they receive services at a participating hospital.

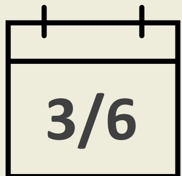
Does this approach seem reasonable? Should there be any exclusions to the proposed population captured by the budget?

Public Comment

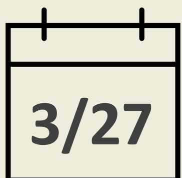
Next Steps

Working Group Meeting Plan and Schedule

- Discuss how to calculate and update budgets annually



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



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

Appendix

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.

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 overhead 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. Align 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.