Hospital Global Budget Working Group

February 23, 2023

Agenda

- Wrap-up Discussion of Services to Include in the Budget
- Discussion of What Population to Include in the Budget
- Discussion of How to Calculate and Update Budgets Annually
- Public Comment
- Next Steps

Wrap-up Discussion of Services to Include in the Budget

Preliminary Recommendations from the February 9th Meeting

1. Include all **hospital inpatient and outpatient services** in the hospital global budget for now.

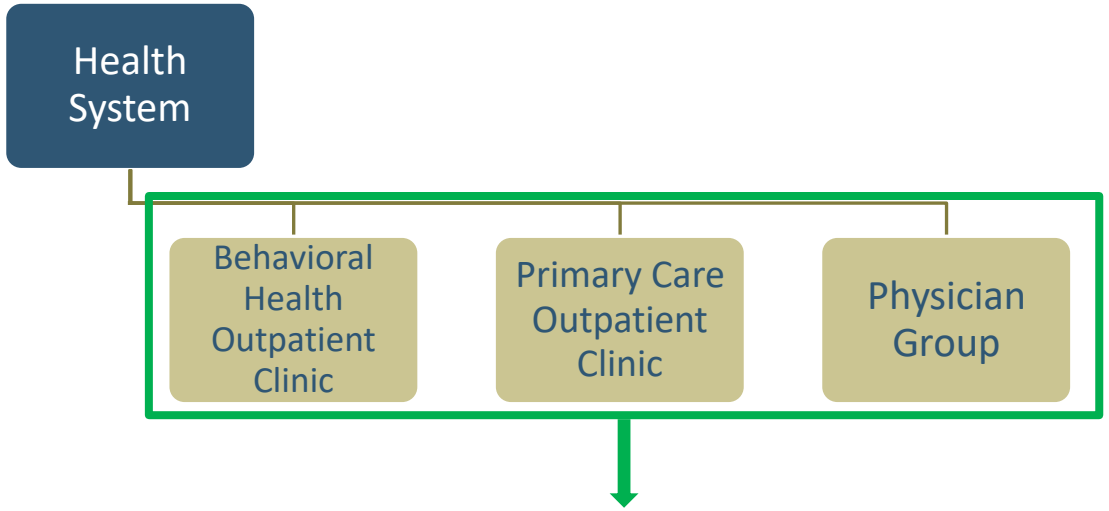
   The Working Group flagged two potential categories of services to exclude:

   - high-cost, variable services (to be defined in a future analysis of hospital costs) and
   - service areas where there is a commitment to expanding access to care (e.g., primary care, behavioral health).

Preliminary Recommendations from the February 9th Meeting (cont'd)

2. *Include* in the hospital global budget **professional services** delivered by:
   a. employed professionals for whom the hospital bills under its TIN, regardless of place of service
   b. contracted, non-employed professionals for whom the hospital bills under its TIN, regardless of place of service
3. *Include* in the hospital global budget the cost of **hospital subsidies** to non-employed professionals for whom the hospital does not bill
4. *Exclude* from the hospital global budget **professional services** delivered by:
   a. contracted, non-employed professionals that bill on their own, regardless of place of service

What Services Should Be Included in the Hospital Global Budget?



We are considering services delivered in system-owned facilities.

Considerations for Including System-Owned Assets in the Budget

REASONS FOR INCLUDING

- Promotes **patient** and **payer** affordability by including a significant volume of services that are otherwise not subject to cost control.
- For **payers**, reduces leakage and provides a way to hold all related parties accountable to cost growth under one payment model.
- Incentivizes coordination of **patient** care across settings within a system.
- Provides greater revenue predictability for **hospitals** and **affiliated providers**.

REASONS FOR EXCLUDING

- Constrains potential revenue growth by **system-owned entities**.
- More **complicated** to implement; no clear methodology for allocating system-owned assets to hospitals.
- Does not necessarily provide more contracting leverage to **hospitals.**
- Perhaps goes **beyond the scope** of what was originally agreed upon in the voluntary compact.

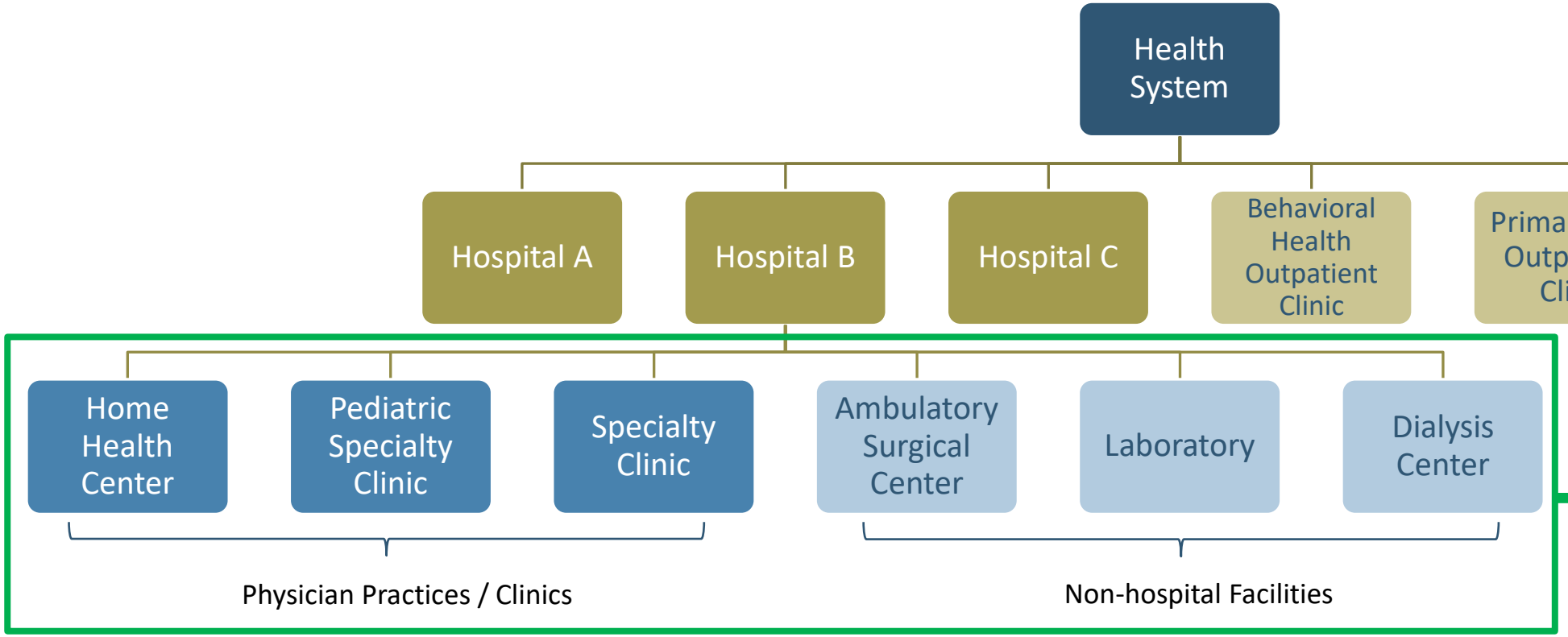
Considerations Around Inclusion of System-Owned Assets in the Hospital Global Budget (cont'd)

1. How would inclusion of services delivered by system-owned assets 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 services**?

Inclusion of Hospital-Owned Technical, Ancillary, and Outpatient Services



We are considering services delivered in hospital-owned clinics/facilities.

Discussion

1. Should budgets include all, some, or none of the technical, ancillary and outpatient (excluding professional) services delivered in **hospital-owned facilities/clinics**?
2. Following the group's recommendation around professional services, does it make sense to:
   - Include services billed under the hospital TIN?
   - Exclude services not billed under the hospital TIN?

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 insured by 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?

Discussion of How to Calculate and Update Budgets Annually

Steps to Calculate Global Budgets

A critical step in designing and implementing hospital global budgets is establishing and later updating budgets for each hospital.

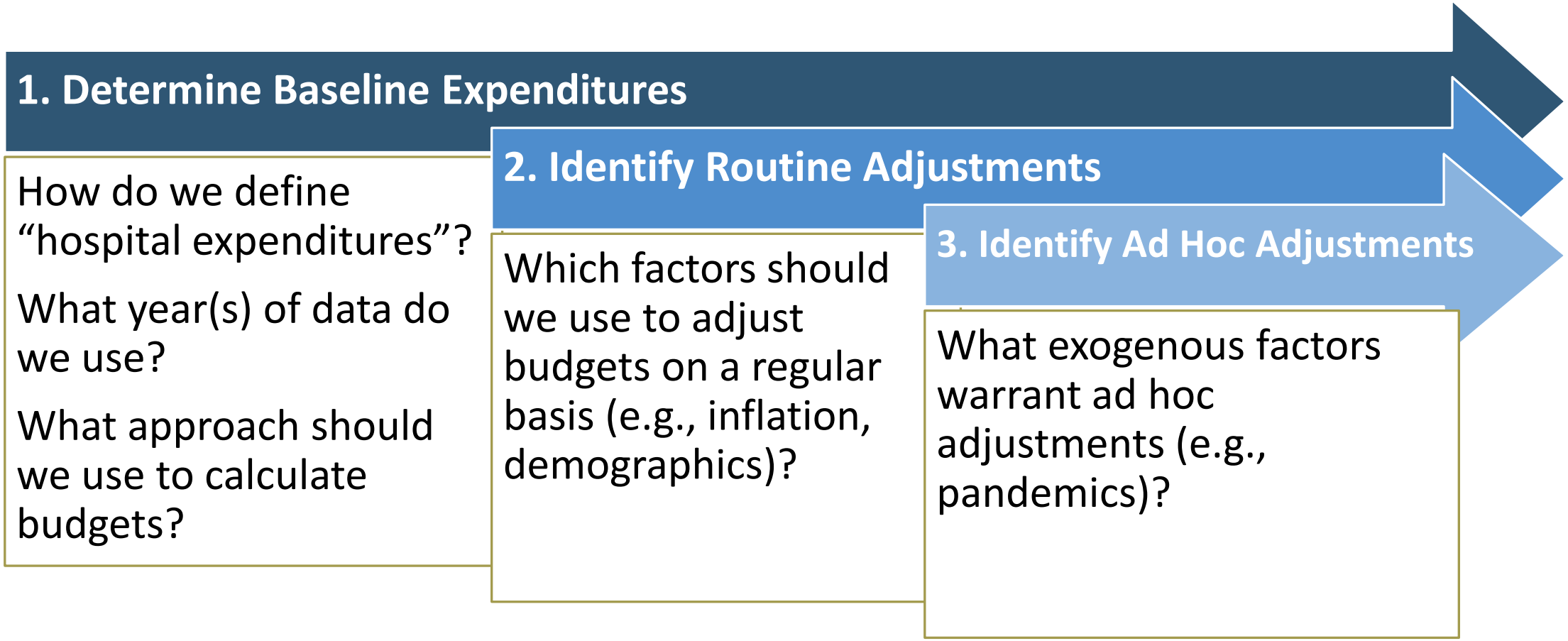
Each hospital's budget must be adequate to:

- fund fixed and variable costs associated with appropriate care,
- enhance coordination and efficiency across delivery systems,
- support investment in a high-quality clinical workforce and technical innovation in care delivery, and
- improve patient experience of care, quality of care, patient outcomes and health equity.

These budgets must also manage the growth rate of health care spending at an affordable and predictable level.

Steps to Calculate Global Budgets (cont'd)

There are three overarching steps to calculating global budgets.



1. How Do We Determine Baseline Expenditures?

States typically use historical financial data from one or more prior years to establish baseline expenditures. To define the baseline, the group must consider the following:

1. How do we define “hospital expenditures”?
2. What year or years should we use to determine the baseline budget?
3. What approach should we use to calculate budgets?

How Do We Define Hospital Expenditures?

States typically use Net Patient Revenue (NPR) as the primary data source to identify hospital expenditures.

In prior conversations, the Working Group mentioned operating expenses could be another way to define hospital expenditures. **We recommend using NPR** over operating expenses for the following reasons:

- There is no uniform methodology for tracking operating expenses across hospitals. Creating such a system would require significant effort.
- Paying based on operating expenses provides no incentives to reduce input costs or be more efficient.

How Do We Define Hospital Expenditures? (cont'd)

We recognize, however, that in recent years, some hospitals have experienced operating losses due to the COVID-19 pandemic.

We recommend revisiting whether we should make adjustments to account for such losses until we have hospital financial data for years closer to the model implementation date of 2026.

What Year(s) of Data Should We Use to Determine the Baseline Budget?

States typically use historical financial data from one or more prior years to establish baseline expenditures.

MD All-Payer and TCOC Model	PA Rural Health Model
Most recent prior year	Average across three most recent prior years

Given the impact of COVID-19 on hospital financials, we recommend using data from 2023, 2024, and/or other years when developing budgets for 2026.

We recommend deferring consideration of what year(s) of data to use until hospital financial data for years closer to 2026 are available.

What Approach Should We Use to Calculate Budgets?

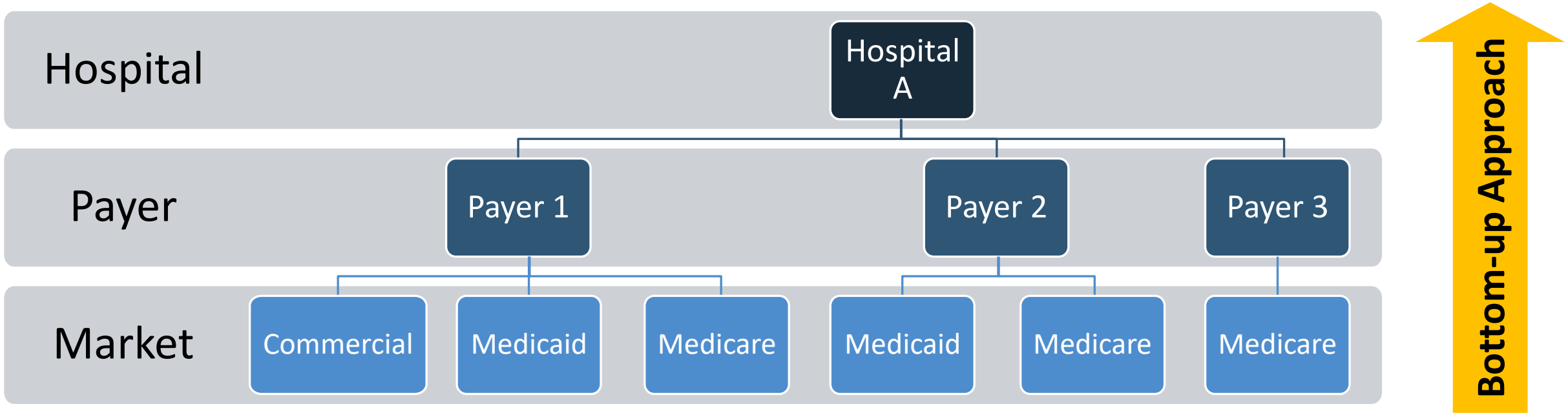
Hospital global budgets can be calculated using a **bottom-up approach**.

- This approach relies on using payer financial data to calculate **individual payer budgets** (either by market or across markets).
- It then leverages hospital financial data to develop budget adjustments (to be discussed later).

As we review the following example, consider whether you recommend adopting (a) one budget for each payer across markets or (b) individual budgets for each payer/market dyad.

What Approach Should We Use to Calculate Budgets? (cont'd)

In this example, a hospital would have **at least three budgets** (one for each payer) and **possibly six budgets** (one for each payer/market dyad)



2. Which Routine Adjustments Should We Make?

As you read the following slides, consider which of the following budget adjustments you recommend.

Please note that we will discuss the following topics in future meetings:

- How to define each of these adjustments in greater detail
- How to incorporate these adjustments into the budget calculation

Demographics	Inflation	Market Share*
Case Mix	Uncompensated Care	Other?

*We will defer consideration of market share adjustments until after we discuss flexible global budget arrangements.

Confirm Adjusting for Demographics and Inflation

It is common practice to annually adjust budgets using two factors at a minimum.

Demographics	• Accounts for changes in the age and sex profile of the patients served by the hospital
Inflation	• Accounts for changes in the cost of producing services

Do you agree with adjusting the budgets to account for these factors?

Should We Adjust for Case Mix?

Case Mix

Accounts for changes the patient population's health status

- Modifies hospital payments to account for the patient population's health status
- Reduces the incentive for hospitals to only treat healthy patients

- May not accurately reflect changes in risk due to coding practices
- Does not reflect changes in service intensity

Should We Adjust for Uncompensated Care?

Uncompensated Care

Accounts for services for which hospitals do not get reimbursed (i.e., charity care, bad debt)

- Reduces the incentive to shift uncompensated care to other hospitals

- Requires a separate pool of funding to cover uncompensated care, as costs are not reimbursed by payers

Are There Other Routine Adjustments We Should Consider?

Are there any additional optional budget adjustments you think we should consider?

As a reminder, a hospital global budget focuses on payments for hospital services. As a result, there will be other payment streams that will remain independent from the hospital global budget, such as:

- Graduate/indirect medical education
- Disproportionate share hospital (DSH) payments

Should Routine Adjustments be Made Prospectively or Retrospectively?

PROSPECTIVE ADJUSTMENTS

- Ensures changes in performance during the measurement year are reflected in that year's budget

RETROSPECTIVE ADJUSTMENTS

- Easier to administer because hospitals can adjust future budgets to account for past performance (rather than waiting 1-2 years to calculate performance to reconcile budgets)

Should Routine Adjustments be Made Annually or Less Frequently?

ANNUAL ADJUSTMENTS

- Ensures hospital budgets reflect the most recent performance
- Results in one methodology to calculate budgets every year

LESS FREQUENT ADJUSTMENTS

- May be more reasonable to implement less frequently (e.g., every other year) if budget adjustments are small

3. Which Ad Hoc Adjustments Should We Make?

In addition to routine adjustments, there may be grounds to adjust budgets on an ad hoc basis due to planned changes and/or exogenous factors.

Examples may include:

- New service offerings/ closures
- Pandemics*
- Significant macro-economic changes
- Social risk/ equity

In the following slides, consider which ad hoc adjustments you recommend. Please note that we will discuss how to operationally define these adjustments in future meetings.

*We will defer consideration of pandemics until after we discuss flexible global budget arrangements.

Should We Adjust for New Service Offerings/ Closures?

New Service Offerings/Closures

Accounts for approved expansions or planned reductions in hospital service offerings

- Ensures that budgets are modified to support planned service offerings
- Encourages hospitals to modify service offerings to meet community needs
- Builds upon existing Certificate of Need (CON) process

- May be challenging to predict how changes in service offerings will impact the budget
- Requires coordinating with the CON review process and timeline
- Could result in unnecessary expansions/restrictions if the CON process is too lenient

Should We Adjust for Significant Macroeconomic Changes?

Significant Macroeconomic Changes

Accounts for economic changes that could impact hospital finances (e.g., recessions, expansions)

- Acknowledges that economic factors outside of a hospital's control can impact finances

- Challenging to identify
  - what changes are significant enough to warrant budget adjustments and
  - the methodology for making such adjustments

Should We Adjust for Social Risk/Equity?

Social Risk/ Equity

Accounts for the social risk of the population served and aims to correct existing inequities in payments

- Supports hospitals that serve historically marginalized communities that may need additional resources
- Encourages hospitals to improve access and facilitate appropriate utilization

- Limited existing research on how to implement social risk adjustment
- No certainty that added funds would be used to further population health equity

Are There Other Ad Hoc Budget Adjustments We Should Consider?

Are there any additional ad hoc budget adjustments we should consider?

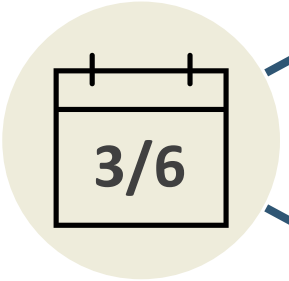
Should ad hoc budget adjustments be made prospectively or retrospectively?

Public Comment

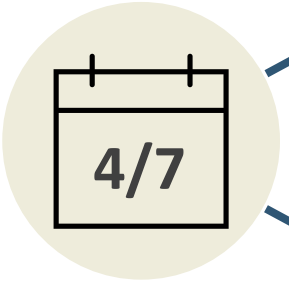
Next Steps

Working Group Meeting Plan and Schedule

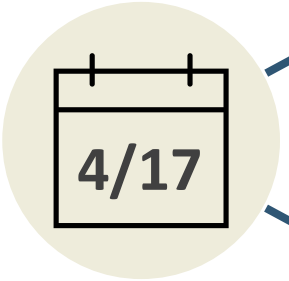
OHIC is cancelling the March 27 meeting. The updated meeting schedule is as follows.



- 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)



- Decide whether the hospital global budget model should include supplemental arrangements to improve population health, access and quality