Hospital Global Budget Working Group

June 5, 2023

Why Are We Considering Hospital Global Budgets?

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

- Ensuring steady, predictable hospital financing
- Providing increased 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

Agenda

1. Continued Discussion of How to Calculate and Update Budgets Annually
   - Capital investments
   - Planned service line changes
   - Social risk/equity
2. Discussion of Whether to Include Supplemental Arrangements
3. Public Comment
4. Next Steps

Recap of the Last Meeting

Summary of Discussion from the May 15th Meeting

Working Group members did not support including a consumer affordability measure in the inflation factor. Members generally leaned towards using the Medicare Market Basket Index (MBI) but some hospitals were concerned about how well it reflects increases in labor costs.

Hospital representatives wanted a mechanism for making adjustments to the inflation factor. Other representatives generally supported flexibility to adjust the Medicare MBI for special cause, but noted there should strong justification supported by data.

The preliminary recommendations were to:

1. Prospectively adjust for inflation using the Medicare Market Basket Index without the productivity adjustment.
2. Develop a process for adjudicating special adjustments to the budget.

Continued Discussion of How to Calculate and Update Budgets Annually

Summary of Last Meeting's Discussion on Capital Investments

Hospitals did not want to use the Certificate of Need (CON) process to identify capital investments that might call for budget adjustments.

- Rhode Island has low CON thresholds that hospitals find problematic.
- Many capital investments, such as replacement capital, IT, and equipment don't go through the CON process.

Hospitals' preferred approach would be for base budgets and inflation adjustments to provide adequate operating margins so that hospitals can regularly invest in infrastructure.

- This allows hospitals to have a steady flow of funds for capital investments, which facilitates planning.
- It gives hospitals flexibility to invest as necessary without having to regularly "seek permission."

Options for How to Account for Capital Investments

OPTION 1:

- Do not include a specific budget adjustment. Instead, allow for adequate operating margins in the base budget and adequate inflation factors.
- Use the planned study of hospital finances to inform what would be a reasonable portion of operating margin that would adequately cover interest and depreciation.

OPTION 2:

- Include an adjustment for **major** capital investments to support interest and depreciation costs.
- Identify mechanism, such as the Certificate of Need (CON) process, for determining what investments would qualify for such adjustments.

Considerations for Option 1: Incorporating Capital Investments into Base Budget and Inflation

Option 1

No special adjustment. Allow for adequate operating margins in the base budget and inflation factor.

- Administratively simple.
- In line with hospitals' desire for predictable, stable flow of funds for infrastructure.
- Cost of capital investments are equally borne by participating and non-participating payers.
- Consistent with how capital projects are funded today.

- No guarantee that margins are allocated to fund capital investments.

Considerations for Option 2: Incorporating Capital Investments into Base Budget and Inflation

Option 2

*Include adjustment for **major** capital investments to support interest and depreciation costs.*

- Provides additional and explicit financial support to hospitals for capital investments.

- More administratively complex.
  - Requires relying on existing CON process or developing a new process for identifying spending that would merit a budget adjustment.
- Provides less predictability/stability for hospitals.
- Costs are not spread evenly among payers since payer participation will be voluntary.

How Should Global Budgets Account for Capital Investments?

How does the Working Group want to handle capital investments?

- Option 1: No special adjustment. Allow for adequate operating margins in the base budget and the inflation factor.
- Option 2: Include adjustment for major capital investments to support interest and depreciation costs.
- Another alternative?

Planned Service Line Changes

Hospitals may make changes to their services, such as:

- Adding services that were not included in the baseline data.
- Halting services that were included in the baseline data.

The Working Group needs to weigh in on how to address these service line changes in the budget development.

As a reminder, the Working Group recommended adopting *a flexible global budget* approach to addressing volume changes. The flexible budget discussions assumed the set of services offered would be the same.

In Maryland, hospitals can request a budget adjustment based on service line changes for prospective adjustments and retrospective reconciliation. However, Maryland's model is based on a fixed budget, and does not adjust for volume changes.

Options for How to Account for Service Line Changes

OPTION 1:

- Do not make a specific adjustment.
- Use the volume adjustments under the flexible budget approach to handle service line changes.

OPTION 2:

- Make prospective budget adjustments to based on planned service line changes.
- Hospitals submit a list of planned service line changes on an annual basis for service lines with an expected impact of +/- 0.5 % of budget payments.

Considerations for Option 1: Use Volume Adjustments Under Flexible Budgets

Option 1

No special adjustment. Use volume adjustments under flexible budget to handle service line changes.

- Administratively simple.
- Consistent with the goal to give hospitals the flexibility to modify service offerings to meet community needs.

- Volume adjustments may not accurately reflect cost of opening/closing specific service lines.
- Adjustments for new/closed services are conducted retrospectively providing less certainty around the overall budget amount.

Considerations for Option 2: Prospectively Adjust Budgets for Planned Service Line Changes

Service Line Changes

Conduct prospective adjustments to budgets based on planned service line changes.

- Ensures that budgets accurately reflect planned service changes.
- Protects payers when service line changes are negative (e.g., reductions/closures).

- Adds administrative complexity.
- Budget project may not be accurate.
- Only works for planned (and not unplanned) service line changes.

How Should Global Budgets Account for Planned Service Line Changes?

How does the Working Group want to handle planned service line changes?

- Option 1: No special adjustment. Use volume adjustments under flexible budgets to handle service line changes.
- Option 2: Conduct prospective adjustments to budgets based on planned service line changes.
- Another alternative?

Summary of Last Meeting's Discussion on New Technologies

The Working Group began discussion of what new medical technology would trigger an ad hoc review for budget adjustments.

- There was a suggestion to set a dollar threshold.
- One payer said that the new technology/offering needs to first be approved for coverage before considering inclusion into the budget.
- There was a suggestion to pay FFS until the service could be incorporated into the budget.

As a reminder, in previous discussions the Working Group recommended carving out certain infrequent but high-cost services (still to be determined) from the global budget.

- Based on how those carved out services are defined, that policy may obviate the need for a separate policy to deal with new, high-cost technologies.

Proposal for How to Address New Technologies

- Use the planned study of hospital finances to identify a dollar threshold for which technologies would qualify for a global budget carve out.
- When the new technology is covered by participating payers and the technology meets the identified threshold, pay on a fee-for-service basis for the first three years.
- After collecting three years of utilization data, evaluate whether payment for the service should be incorporated into the global budget.

Are there any concerns with this approach?

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.
- Funds hospitals to improve access and facilitate appropriate utilization.

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

Should We Adjust for Social Risk/Equity? (Cont'd)

Below are some potential approaches to incorporate social risk/equity into a hospital global budget model.

Adjustments based on **population**	• CMS ACO REACH Health Equity Benchmark Adjustment: monthly adjustment to PMPM based on individual's geographic residence (using the Area Deprivation Index) and dual eligibility status
Adjustments based on **improved equity**	• MD's Readmissions Reduction Incentive Program: hospitals can receive up to 0.5% of their inpatient revenue for reductions in within-hospital readmission disparities
Adjustments based on **data collection**	• CMS ACO REACH Health Equity Data Reporting Adjustment: up to a 10% positive adjustment to an ACO's quality score if the ACO submits patient-reported demographic data and up to a 5% adjustment for SDOH data

Should We Adjust for Social Risk/Equity? (Cont'd)

Adjustments for social risk/equity would require either:

- **redistributing money** from hospitals that treat populations with low social risk to those that treat populations with high social risk, or
- a **separate funding pool** to invest in hospitals that serve populations with disproportionate social risk.

We propose deferring adjustments for social risk/equity and revisiting such adjustments after RI gains experience with hospital global budgets. In the interim, we propose studying how social risk varies by hospital and/or hospital service area.

Do you agree with this proposal?

Discussion of Whether to Include Supplemental Arrangements

Types of Supplemental Arrangements

A hospital global budget model can include supplemental **financial arrangements** and/or **reporting requirements** to advance other policy goals, such as:

Quality and Population Health

Cost

Incorporating Quality Into Hospital Global Budgets

Incorporating quality into a hospital global budget can help incentivize improvements in access to care, care coordination, patient safety, clinical outcomes, patient engagement and/or population health.

Before we consider supplemental quality arrangements for a hospital global budget model, it is important to consider existing quality incentive programs to which RI hospitals are subject.

- Alignment with existing programs may improve hospital outcomes, as multiple initiatives would reinforce the same priorities.
- There should, however, be consideration of creating financial incentive to address other priorities for which financial incentives are currently lacking.

OHIC Hospital-Focused Quality Programs

OHIC has several hospital-related quality requirements of commercial insurers for their fully insured line of business, including:

- The OHIC Affordability Standards, which state that:
  - Hospital contracts shall include a quality incentive program that pulls from the Aligned Measure Sets and has sufficiently challenging performance levels for all measures.
  - A portion of a hospital's average rate increase is for expected quality incentive payments.
- The OHIC Aligned Measure Sets, which includes measures from which insurers must select if they incorporate quality measures into payment terms for provider contracts.
  - There are specific measure sets focused on acute care and behavioral health hospitals.

Other State Hospital-Focused Quality and Population Health Programs

There are three primary ways in which states have incorporated quality and population health into global budget arrangements. Some examples include:

To adjust hospital global budgets	As complementary VBP arrangements	For monitoring/ public reporting
• PA Rural Health Model quality adjustment for Medicare FFS budgets	• MD Quality Based Reimbursement Program	• PA Rural Health Model statewide monitoring measures and hospital transformation plans

Other State Hospital-Focused Quality and Population Health Programs (Cont'd)

To adjust hospital global budgets

- PA Rural Health Model quality adjustment for Medicare FFS budgets

- Medicare FFS portion of hospital budgets adjusted based on quality performance
  - Intended to establish an All-Payer Quality Program, which was cancelled due to the COVID-19 pandemic
  - Now use Medicare hospital quality reporting programs

Other State Hospital-Focused Quality and Population Health Programs (Cont'd)

As complementary VBP arrangements

- MD Quality Based Reimbursement Program

- Up to 2 percent of inpatient hospital revenue is at risk
- 17 measures across 3 domains: person and community engagement, safety and clinical care

Other State Hospital-Focused Quality and Population Health Programs (Cont'd)

For monitoring/ public reporting

- PA Rural Health Model statewide monitoring measures and hospital transformation plans

- Statewide quality measures for monitoring purposes
  - Focus areas: readmissions, ED use, opioid use, preventive care, care coordination
- Hospitals develop and receive approval on their plan to redesign care delivery in a way that:
  - Invests in population health
  - Tailors services to meet the needs of the local population
  - Emphasizes preventive care and reduces potentially avoidable services

Should There Be A Supplemental Arrangement Focused on Quality and Population Health?

Do you recommend including a supplemental arrangement focused on improving hospital quality and population health?

If so, do you recommend using quality and/or population health:

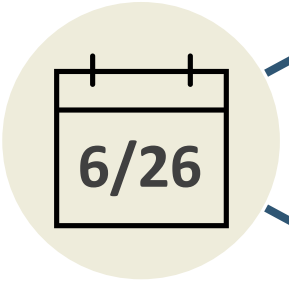
- ***to adjust hospital global budgets?***
- ***as complementary VBP arrangements to the hospital global budget?***
- ***for monitoring and/or public reporting purposes?***

Public Comment

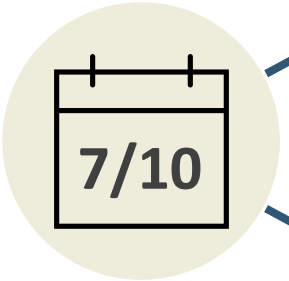
Next Steps

Working Group Meeting Plan and Schedule

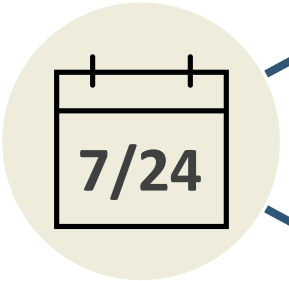
Please note that we rescheduled the 6/22 meeting (3-5pm) to 6/26 (9-11am).



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



- Identify if and how the model should allow for different payers and hospitals to deviate from the recommended model



- Review and finalize recommended model parameters