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Analyses Related to Health Care Cost Drivers In New Mexico: Analysis 1: Feasibility of Implementing a Global Budgeting System

Presented by:

Megan Stead

Stead-megan@norc.org

Charles Betley

Betley-chuck@norc.org

NORC at the University of Chicago

55 East Monroe Street

30th Floor

Chicago, IL 60603

Presented to:

Legislative Council Service

490 Old Santa Fe Trail, Suite 411

Santa Fe, New Mexico 87501

(505) 986-4600

Contributors

This report reflects the contributions of the entire project team, including the following individuals:

Charles Betley, NORC, Project Lead
Megan Stead, NORC, Project Director
Beth Landon, Independent Consultant
Caty DeBroux, NORC
Kali Defever, NORC
Meredith Gonsahn, NORC
Alana Knudson, NORC
Scott Leitz, NORC
Juliana Lewis, NORC
Sai Loganathan, NORC
Lily McNulty, NORC
Tina Nye, NORC
Liyang Xie, NORC

And the key stakeholders who graciously donated their time to be interviewed for this report

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Executive Summary

The New Mexico Legislative Council Service (LCS), on behalf of the New Mexico Interim Legislative Health and Human Services Committee (LHHS), contracted with the National Opinion Research Center at the University of Chicago (NORC) to provide a report on the feasibility of implementing global budgets for New Mexico's rural hospitals.

A global budget fixes in place a health care organization's revenue from specified services for a budget period, regardless of the actual volume of services delivered. Those revenue amounts can be adjusted to add or subtract services the hospital and payment authorities deem necessary. Although there are complex systems for calculating a global budget,¹ budgets are usually based on the individual hospital's historical revenues. A global budget system would also have some method for updating the budget based on actual or targeted inflation, typically annually.

In accordance with the contract, NORC only considered the feasibility for a global budget policy covering rural hospitals providing acute care services; urban hospitals, specialty hospitals, and Indian Health System facilities--which have a special focus--would continue to be paid under current methods.

New Mexico's unique geography, demographics, and economy affect the feasibility of global budgeting in the state. To inform its recommendations, NORC took a three-pronged approach. First, NORC reviewed literature on global budgets, including previous studies on the topic conducted for New Mexico and the ongoing evaluations of related all-payer global payment models across the country. Second, NORC conducted stakeholder interviews with expert representatives of various sectors of New Mexico's health care market – comprising hospitals, payers, and state officials. Finally, NORC reviewed the financial condition of New Mexico's hospitals via cost report data obtained from the federal Healthcare Cost Report Information System (HCRIS), along with conversations with hospital finance officers.

Nationally, global budgets have interested state and federal policy makers as a solution to health care cost control. Although global budget hospital payment systems exist in other countries, their different health care delivery systems make their experience inapplicable to New Mexico. Any global budget system in New Mexico would require agreement from the Centers for Medicare and Medicaid Services (CMS) to allow Medicare and Medicaid to waive current payment rules and to participate in the payment system. CMS sponsors global budget demonstrations in Pennsylvania and Maryland; Vermont has an all-payer system operating under CMS waivers that is making plans to commence global budgets.

CMS recently announced a new state demonstration project called Advancing All-Payer Health Equity Approaches and Development (AHEAD). The AHEAD model would require participating states to

¹ Maryland, at the request of a hospital, performs an in-depth audit of hospital costs and compares such costs with a peer group of hospitals. Maryland Health Services Cost Review Commission. (2021) [https://hscrc.maryland.gov/Documents/global-budgets/2023 Website Update Files/Final Recommendation for Full Rate Application Policy FINAL %28Post Meeting%29 %281%29 %282%29.pdf](https://hscrc.maryland.gov/Documents/global-budgets/2023%20Website%20Update%20Files/Final%20Recommendation%20for%20Full%20Rate%20Application%20Policy%20FINAL%20Post%20Meeting%29%20%281%29%20%282%29.pdf)

implement global budgets as part of a total cost of care (TCOC) growth rate control model. Eight states are being sought to participate in the model. New Mexico is ineligible to participate in AHEAD because it participates in another CMS pilot program—Making Care Primary (MCP) Model. The MCP Model includes payment innovations for primary care clinical groups, who would adopt prospective payments for assigned populations and coordinate between patients’ primary and specialty care clinicians, social service providers, and behavioral health providers. This choice may provide a glide path to a future global budget initiative.

After considering these sources of evidence, NORC finds that global budgets for rural hospitals in New Mexico are not likely to be currently feasible for four main reasons:

1. Although some rural hospitals are at financial risk of closure and could gain stability from a global budget as a revenue source, transferring to a global budget system would require major changes to their clinical operations, billing systems, and information technology. Otherwise stated, the hospitals with the most to gain from adopting the model have the least infrastructure and capacity to support that transition.
2. The New Mexico state government currently lacks the administrative and digital infrastructure requisite to develop, administer and provide technical assistance to support a program as complex as global budgeting across multiple hospitals and payers. The Legislature would need to invest significantly into the development of the New Mexico Health Care Authority to oversee building and monitoring the global budget system, across Medicare, Medicaid, Medicaid managed care organizations and any private insurance participants. New Mexico’s digital infrastructure, including the SYNCRONYS Health Information Exchange (HIE), All-Payer Claims Database (APCD) and Medicaid Management Information System Replacement (MMIS-R), need to be developed further to support the undertaking.
3. Although some in New Mexico have been interested in hospital global budgets, interviewed stakeholders could not identify a “champion” or “champions” currently leading the initiative. Unlike the programs in other states, no voice exists in industry, state government or the Legislature to lead this significant undertaking. That champion is requisite for supporting implementation and working through barriers to build consensus at the hospital, payer, and state levels, and with CMS. The champion will need to take the concept of a global budget and garner stakeholder buy-in.

4. Although conditions for participation in AHEAD might change, or New Mexico might choose to seek a global budget waiver simply as a solo demonstration, other barriers to global budget implementation would persist. Obtaining Medicare and Medicaid participation is vital to the success of a global budget system, but the Center for Medicare and Medicaid Innovation (CMMI) at CMS will likely require that a New Mexico global budget system adhere to certain conditions for savings performance and evaluation which may or may not be satisfactory for New Mexico.² For example, in Pennsylvania, critical access hospitals (CAHs) participating in the global budget model must reconcile Medicare payments with actual Medicare costs, and thus do not gain greater margins from operating below a global budget ceiling.

If a global budget policy were to be adopted in New Mexico, NORC recommends the following key steps:

- Identify a “champion” or “champions” to build consensus: Interviewed experts emphasized the need for a person or group such as a taskforce to champion the policy in the Governor’s office, the Legislature, and in the hospital community. The experience of previous global budget models could be used to develop a vision and plan for identifying a person or group to lead the initiative in New Mexico. This approach is consistent with the experience in other states.
- Dedicate resources to ensure accountability and fidelity to the model: The entity overseeing a global budget model will need to engage with CMS’s Center for Medicare and Medicaid Innovation (CMMI), private payers, and eligible hospitals, and then oversee the resources distributed to build and monitor the endeavor. Interviewed experts suggested the New Mexico Health Care Authority would administer and oversee a global budget in New Mexico due to its scope of management of New Mexico health services, and its position to engage with CMMI on policies. However, given current priorities for Making Care Primary and other initiatives, the Health Care Authority would need additional resources to take on a global budget initiative.
- Engage hospitals: Hospital leadership, including the New Mexico Hospital Association, need to be meaningfully engaged. It is important for hospitals to first understand the overall concept of global budgets and then delve into the details of how it could work in New Mexico. Again, the “champion” or “champions” could use learnings from previous studies on the healthcare landscape and technical and approaches to develop a global budget in New Mexico to launch discussions. To start, one area in which the Legislature would need to negotiate with hospitals include whether participation would be voluntary or mandatory. Voluntary participation would engage hospitals that face the greatest financial risks, while mandatory participation would allow the greatest leverage over hospitals for cost controls. Also, the Legislature would need to specify the basis and methodology for calculating global budgets, including the process for determining annual update factors.
- Enhance the state’s data infrastructure: The state’s data systems, including the MMIS-R, HIE, and the APCD, need sufficient maturity to inform budget development and subsequently monitor and

² Gudiksen, Katherine L., Murray, Robert B., (2022) “Options for states to constrain pricing power of health care providers” *Frontiers in Health Services* <https://www.frontiersin.org/articles/10.3389/frhs.2022.1020920>

inform hospital operations under a global budget payment system. IT infrastructure is needed not only to operate the global budget system but to permit hospitals and other providers to carefully manage patient's care to avoid unnecessary hospitalization and allow hospitals to operate efficiently under a global budget.

Global budget payment may fit the New Mexico's future priorities, as there is evidence that the incentives in the payment system may slow health care cost growth. However, slowed growth in health care costs is predicated on shifting resources to primary care services to prevent the need for more expensive hospital care. Therefore, the groundwork being laid to strengthen primary care through MCP and other initiatives will better position the state to pursue global budgets in years to come.

New Mexico leaders understand the importance of ensuring access to essential health care services in rural and frontier New Mexico. In New Mexico, one-third of the state population lives in rural and frontier areas, and over half of the population is enrolled in Medicaid. Compared to urban areas of the state, rural New Mexicans have lower life expectancy and higher rates of disability, heart disease, cancer, diabetes, and chronic liver disease³. One of the greatest challenges in New Mexico's healthcare system is provider shortages and providers leaving the state.⁴ Across the stakeholder continuum, no one ever recommended the elimination of vulnerable hospitals. The Legislature already actively supports policies and programs to ensure access to care in isolated communities, including the recent Rural Health Care Delivery Fund. Likewise, the New Mexico Health Care Authority's participation in MCP Model using Medicare, Medicaid, and commercial insurer funds may help support the prevention and care coordination that reduces unnecessary hospital use.⁵ Lastly, Guadalupe County Hospital's recent conversion to the Rural Emergency Hospital (REH) designation illustrates the opportunity to use new federal payment alternatives. Combining these programs with nascent digital infrastructure such as the APCD, MMIS-R and HIE may create a "glide path" to a future global budget system. Collectively, these factors position New Mexico to participate in other, future opportunities such as total health cost growth caps along with global budget payment.

Introduction

Contract

NORC at the University of Chicago (NORC) was contracted by the New Mexico Legislative Health and Human Services Committee (LSC) through a competitive bid process to perform an analysis of the feasibility of implementing a global budgeting system, specifically as applied to rural hospitals. NORC

³ Rural Health Planning Workgroup. "New Mexico Rural Health Plan," (2019). <https://www.nmhealth.org/publication/view/report/5676/>.

⁴ Health Management Associates. Hospital Global Budget Options Paper, (2023). <https://a.storyblok.com/f/132761/x/f63355fbfa/deliverable-2-nm-osi-global-budgeting-study-global-budget-options-final.pdf>

⁵ Manatt Health (2023) Investing in a strong primary care health system: an overview of CMMI's Making Care Primary model. <https://communications.manatt.com/111623CMMI>

had been selected by CMS to be the independent evaluator of Pennsylvania and Vermont's payment reform activities, which provide examples for New Mexico's global budget policy considerations.

The scope of work charged NORC to conduct a feasibility analysis of implementing such a system that would avoid duplicating studies of global budgeting previously performed for the state of New Mexico. There have been studies performed by contractors on behalf of New Mexico agencies that address the process for implementing global budgets.⁶ NORC's contractual charge to assess feasibility takes this report in a different direction. NORC carried out the work through a three-pronged approach, briefly described below. This document represents the final report of NORC's study in fulfillment of the contract.

Methodology

NORC's approach to identifying, describing, and analyzing the implementation of a global budgeting system consisted of an environmental scan, stakeholder interviews, and quantitative analysis. Specifically, NORC reviewed literature on global budgets as applied to health care settings and hospitals, along with previous studies on the topic conducted for New Mexico. In addition, NORC closely assessed ongoing evaluations of related all-payer global payment models across the country. NORC also conducted stakeholder interviews with experts from various sectors of New Mexico's health care market—comprising hospitals, payers, and state officials. Finally, NORC reviewed the financial conditions of New Mexico's hospitals via cost report data obtained from the federal Healthcare Cost Report Information System (HCRIS), which we supplemented with conversations with hospital finance officers. A more detailed description of the study's methodology is included in the Appendices.

Other experiences with global budgets for hospitals

The experiences with hospital global budget payment systems that have been in operation in various states and countries provide examples for New Mexico to consider. Some countries' systems for universal insurance coverage have paid hospitals through global budget systems, including Canada, France, Germany, Taiwan, the Netherlands, and others. We found that these systems are not transferrable to New Mexico's health care environment. These systems were intended to control costs, base their payments on negotiations between hospitals and either a single-payer authority or coalitions of private insurance funds, and have been operating for decades. Health care global budget payment

⁶ These include: Deepti Kanneganti and Michael Bailit, Bailit Health Purchasing, LLC (2022). New Mexico Hospital Global Budgets Report; Health Management Associates (2023). Global Budgeting Principles and Experience in Other States Report: Presented to the State of New Mexico, Office of the Superintendent of Insurance, and Health Management Associates' following reports: Hospital Global Budget Options Paper, Recommendations for Proposal to the CMS Innovation Center, Implementation and Stakeholder Engagement Plan, Data and Administrative Challenges; Beth Landon, (2022). Hospital Global Budgets: A Primer and Considerations for New Mexico.

systems in the United States were created to respond to and take advantage of unique state circumstances and health care environments. CMS pilot programs, such as the recently announced AHEAD model, intend to build on and expand on the experiences of these states, since they provide examples of various levels of success at achieving the state's program goals.

Upper New York State Global Budget in Finger Lakes and Rochester

In 1980 global budget models were developed in two regions in upstate New York, one in the rural Finger Lakes region and another in the metropolitan environment of Rochester. The Rochester experiment was successful at keeping hospital cost growth below the national average.⁷ Hospital margins improved for the rural hospitals in the Finger Lakes Region.⁸ Global budgets were not the only aspect of the New York state models, which included development of a hospital-specific methodology to plan for community beds and services, approval of the reasonable costs of certificate of need projects, and other regulatory tasks. The programs' outcomes might be attributable to some of these other aspects of the model in addition to global budgets. The program ended in 1987 when the hospitals determined that they could receive higher payment levels under the newly implemented Medicare inpatient prospective payment system (IPPS).⁹

Maryland's Total Cost of Care All-Payer Waiver

The state's Health Services Cost Review Commission is allowed to regulate hospital payments and is exempt from participating in the Medicare Inpatient and Outpatient Prospective Payment system. Enacted in 1971, the system began full operations in 1977. As the regulated fee-for-service (FFS) system gradually led to Maryland hospital cost growth, the regulatory body began a global budget system for 10 rural hospitals and adapted the global budget system to cover all urban and rural acute care hospitals in 2014.¹⁰ In 2019 Maryland entered into a new total cost of care (TCOC) model constraining the rate of growth of both hospital and nonhospital costs, while retaining the hospital global budget system.¹¹ The TCOC model includes a hospital payment program, a care redesign program that allows hospitals to make incentive payments to nonhospital care providers, and a primary care program that incentivizes federally qualified health centers (FQHCs) to offer advanced services. The TCOC model reduced Medicare hospital as well as nonhospital spending between 2019 and 2021 while

⁷ Block, James A; Donna I. Regenstreif; Paul F. Griner, (1987). A community hospital payment experiment outperforms national experience: The hospital experimental payment program in Rochester, NY. *JAMA* 257(2): 193-197

⁸ Farnand, Lawrence J.; Philip Jacobs; W. Michael Dickson (1986). An evaluation of a program to regulate rural hospital costs: The Finger Lakes hospital experimental payment program. *Inquiry* 23(2):200-208.

⁹ Gudixsen Katherine L.; Murray Robert B., (2022). Options for states to constrain pricing power of health care providers" *Frontiers in Health Services* 2. <https://www.frontiersin.org/articles/10.3389/frhs.2022.1020920>.

¹⁰ Maryland Health Services Cost Review Commission, (n.d.). Global budget revenue overview presentation. <https://hsrc.maryland.gov/Pages/gbr-tpr.aspx>.

¹¹ Maryland Health Services Cost Review Commission, (n.d.) Total cost of care model. <https://hsrc.maryland.gov/Pages/tcocmodel.aspx>.

showing improvements in measures of quality, as the TCOC model was comprehensive in its scope compared to earlier iterations of a global hospital budget payment system.¹² The relative success of Maryland's model has been attributed to the unique circumstances of the state, including the long-standing hospital rate regulation system that preceded the global budget model.¹³

Pennsylvania Rural Health Model (PARHM)

The model began with a few rural hospitals joining voluntarily, Medicare and Medicaid participation, and eventually five commercial payers. The Pennsylvania Rural Health Redesign Authority was established by the Pennsylvania legislature in 2019 to administer the Pennsylvania Rural Health Model (PARHM). Under the PARHM, participating rural hospitals developed rural hospital transformation plans to improve quality, increase access to preventive care and behavioral health services, and provide patient and staff education. Technical assistance (TA) is an important feature of the model, and CMS provided \$25 million for TA and support through a new Rural Health Redesign Center based in Pennsylvania. Although investments are being made by the federal and state governments and by commercial payers, hospital participation is lower than anticipated, possibly due to market activities (e.g., mergers and acquisitions) and low engagement at the outset, underscoring important considerations for a voluntary global budget model.¹⁴ Although the original terms of the waiver were to enroll 30 hospitals by a deadline, CMS relaxed the requirements and continued the program with 18 existing participants. Most participants are independent hospitals; hospitals that are part of larger health systems were less likely to join. This may be because independent hospitals needed the financial safety net to allow participation in population health efforts, or because some larger health systems felt the model did not align with their value-based care initiatives. Payers do not like having to maintain a global payment system along with an FFS system. The Center for Rural Pennsylvania defines rural counties as having a population density less than the average population density in the Commonwealth. Five of the hospitals participating in PARHM only qualify as rural based on the definition from the Center for Rural Pennsylvania and do not meet the requirements set by the federal Office of Rural Health Policy (FORHP). In this model, participating hospitals initially saw improvements in financial sustainability, but it is not clear if this trend will continue. The model encouraged hospitals to engage new community partners, but the funding from the global budget does not flow to the community organizations needed for these partnerships.¹⁵

¹² Mathematica, Inc. (2022). Evaluation of the Maryland Total Cost of Care Model: Quantitative-Only Report for the Model's First Three Years (2019 to 2021). <https://www.cms.gov/priorities/innovation/data-and-reports/2022/md-tcoc-qor2>.

¹³ Kilaru AS, Crider CR, Chiang J, Fassas E, Sapra KJ. (2022). Health care leaders' perspectives on the Maryland all-payer model. *JAMA Health Forum*. 3(2): e214920. Available at: <https://doi.org/10.1001/jamahealthforum.2021.4920>.

¹⁴ NORC. (2023) Pennsylvania Rural Health Model (PARHM) third annual evaluation report. Available at: <https://www.cms.gov/priorities/innovation/data-and-reports/2023/parhm-ar3>

¹⁵ NORC. (2023) Pennsylvania Rural Health Model (PARHM) third annual evaluation report. Available at: <https://www.cms.gov/priorities/innovation/data-and-reports/2023/parhm-ar3>.

Vermont All Payer Model (VTAPM)

Vermont does not yet have a global budget system. Currently, under the Vermont All-Payer Model, the Vermont Medicaid Next Generation ACO Program pays hospitals through fixed prospective payments. All payers participate in an accountable care organization (ACO) covering hospitals and primary-care and specialist providers. Most of the critical access hospitals (CAHs) in the rural areas of Vermont chose not to participate in the Medicare ACO initiative, due to the financial reserves required for participation.¹⁶ For the next phase of its federal waiver, Vermont is considering a global budgeting payment system. Vermont's Act 167 of 2022 requires the Green Mountain Care Board (GMCB) to develop "value-based payments, including global payments, from all payers."¹⁷ The evaluation of the VTAPM is difficult because during the evaluation, Vermont was affected by the COVID-19 public health emergency and a ransomware cyberattack. However, the VTAPM did help providers and residents throughout this time and was associated with reductions in spending and utilization. It is also difficult to interpret the results of the evaluation of the VTAPM, because there has been a history of health reform efforts in Vermont. There have been overlapping models with multiple types of payers, and these initiatives might have delayed results, thereby affecting the results of the evaluation.¹⁸

Application to New Mexico Rural Hospital Global Budgets

Although the programs discussed above show some favorable experience with global hospital budgets, they do not necessarily present viable pathways that New Mexico could pursue, given the state's policy environment. One common aspect of the New York, Maryland, and Vermont approaches is that their global payment models were a part of a more comprehensive regulatory background for health care delivery. Maryland has had 50 years of hospital rate regulation, and global budgets for the entire state have been in place for nearly 10 years. Based on its long-running system of all-payer based payment and the waiver from Medicare's prospective payment system, the Maryland health care market has evolved and adapted to create a comprehensive approach to cost control and quality monitoring. The two experimental global budget systems in New York also were adopted in a strong regulatory environment, in which the rural hospitals believed global budgets would permit a more beneficial financial return.¹⁹ Vermont has not yet adopted a global budget system for its mostly rural hospitals but has participated in an all-payer ACO for a decade.

Among the global budget models, only Pennsylvania's payment experiment was adopted without a previous payment regulatory structure, and it has had mixed results. Although participating hospitals

¹⁶ NORC. (2022) Evaluation of the Vermont All-Payer Accountable Care Organization Model (VTAPM). Available at: <https://www.cms.gov/priorities/innovation/data-and-reports/2023/vtapm-2nd-eval-full-report>.

¹⁷ Green Mountain Care Board (2023) Hospital Global Budgets Technical Advisory Group. Available at: <https://gmcboard.vermont.gov/global-budget-technical-advisory>.

¹⁸ NORC. (2022) Evaluation of the Vermont All-Payer Accountable Care Organization Model (VTAPM). Available at: <https://www.cms.gov/priorities/innovation/data-and-reports/2023/vtapm-2nd-eval-full-report>.

¹⁹ Farnand LJ, Jacobs P, Dickson WM (1986). An evaluation of a program to regulate rural hospital costs: The Finger Lakes hospital experimental payment program. *Inquiry* 23(2):200-208.

had improved margins, it had lower than expected hospital participation, even as the definition of eligible rural hospitals was expanded from the standard federal definition of a rural location.²⁰ Pennsylvania's experience suggests that moving hospitals serving rural areas to an entirely new payment model is difficult and uncertain.

Taking lessons from the previous models, CMS designed the AHEAD program so that each state awarded the program grants would be responsible for recruiting hospitals to volunteer to participate in the hospital global budget payment system. Rather than having a goal for a fixed number of participating hospitals as in Pennsylvania, the state would be held responsible for meeting a minimum percentage payment target for total Medicare FFS revenues to be paid under global budgets.²¹ This provision may be difficult to meet for states that have a large penetration of Medicare Advantage private coverage plans, even if both urban and rural hospitals are recruited to participate. In New Mexico, 49 percent of Medicare beneficiaries were enrolled in Medicare Advantage as of November 2023.²²

Insights from Stakeholder Interviews and Literature Review

NORC gathered insights into the feasibility of implementing a global budget system from key stakeholders who have years of expertise as providers, hospital administrators, commercial payers, state health officials, and other supporting roles in New Mexico. Many of the interview key takeaways are supported by the literature the NORC team reviewed. The following summarizes findings from the interviews and supporting literature.

Initial Reactions

Stakeholder reactions to global budgets were mixed, but the underlying theme was consistent: New Mexico's hospitals and other key stakeholders are not ready to pursue this undertaking. They underscored the need for more information and consideration of current priorities at play for rural hospitals.

Generally, the topic of implementing a global budget system was met with questions about the fundamental design and operations, including:

- What are the goals?

²⁰ NORC. (2023) Pennsylvania Rural Health Model (PARHM) third annual evaluation report. Available at: <https://www.cms.gov/priorities/innovation/data-and-reports/2023/parhm-ar3>.

²¹ Centers for Medicare & Medicaid Services. Notice of funding opportunity 2023, Available at: <https://www.grants.gov/search-results-detail/349644>.

²² Centers for Medicare & Medicaid Services (2023). Monthly enrollment by state 2023. Available at: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/monthly-enrollment-state-2023-11>.

- Who will determine payments? And how will they be set?
- Hospital and payer participation—who would need to be on board for successful implementation?
- Will participation be voluntary or mandatory?
- How will misaligned incentives between hospitals and providers and/or hospitals that are part of affiliated systems not participating in global budgets be addressed?
- What quality measures will be selected? How will they be tied to payment?
- How does a global budget deal with unexpected fluctuations in cost?

Furthermore, stakeholders are concerned that New Mexico’s hospitals lack the financial resources to undertake a transformational change required in the implementation of such a system. Stakeholders emphasized that no two hospitals in New Mexico are the same, and the approach to implementing this system would look different for each hospital.

Elements Needed for Implementation

Across the interviews, stakeholders identified various elements critical to the implementation of a global budget model in rural hospitals. One common element was the need for a dedicated advocate, referred to as a champion, of the global budget. Without an advocate consistently championing the success of the budget, it is not likely to be realized.

Another element was that alignment across all entities that would be involved in implementation of the global budget is critical to its success—while acting in a thoughtful, intentional way with the community’s needs at the forefront. This also means that a global budget needs a global approach to health reform rather than a fragmented one. In its principles for a potential global budget, the Vermont GMCB notes: “A hospital global budget or global payment model should support achievement of our goals and is not a goal in and of itself; at the same time, a payment model change cannot achieve all of Vermont’s goals for our state’s health care system.”²³

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“You have to have shared alignment on all those things, and... That’s where the opportunity and the challenge is. Really, global budget is really trying to drive towards shared value creation between the purchaser, the payer, the provider, the member patient, and the community that it would be trying to serve.”

Investment in resources for TA and data infrastructure is another key element successful implementation. A state agency or some other entity would require resources, infrastructure, and staff to support hospitals. Adequate staffing is a challenge in New Mexico government agencies due to current priorities to support other transformation initiatives and staffing vacancies. Interoperability is

²³ Green Mountain Care Board (2023) “Hospital Global Budget Technical Advisory Group (TAG) Hospital Global Budget Design Goals” https://gmcboard.vermont.gov/sites/gmcb/files/documents/GBTAG_RevGoals_20230418_FINAL_0.pdf

important. Global budget implementation requires significant IT infrastructure modifications. These modifications require qualified staff members to support procurement, reporting, data analytics and validation, reconciliation, audits, provider support, and partner management.²⁴ The staffing and technology needs will compete with ongoing initiatives in the state like the APCD launch, HIE upgrades, Making Care Primary Model, and more.^{24,25}

These sentiments align with key facilitators found in other states and the literature. An environment that is conducive to global budget success should have a large participating hospital network, an engaged state government, and the availability of an IT infrastructure, TA, and startup funds.²⁶

Benefits

Although initial reactions were hesitant about pursuing implementation, several stakeholders expressed the potential benefits that could come from implementing a global budget system. When implemented correctly, a global budget could have the potential to provide a stable, predictable budget for rural hospitals that need financial support to provide the services and investments in population health. The hospitals in rural New Mexico that are experiencing low patient volumes would benefit from a stable revenue stream and could offer needed services vs. specialty services, like sleep clinics. Furthermore, global budgets are not intended to generate savings in rural areas. Rather, they help contain costs so that spending grows at an affordable rate and provide sustainable funding for hospitals.²⁷

Although the stable revenue would allow some hospitals to keep their doors open and provide focused services that are needed in the community, it would also allow for reduced administrative costs for activities such as billing. Compared to a line-item budget, global budgets provide hospital administration with more autonomy and flexibility to improve hospital efficiency. They are also straightforward for the hospital to administer and not as susceptible to fraud.²⁸

Disadvantages

Stakeholders pointed out potential downsides involved in the implementation of a global budget system in New Mexico. By and large, stakeholders were skeptical concerning the ability for the global budget to account for unexpected costs, such as replacing a CT scanner or dealing with malpractice, a prevalent

²⁴ Health Management Associates. (2023) Data and administrative challenges. Available at: https://a.storyblok.com/f/132761/x/630e0e0b64/deliverable-5-nm-osi-global-budgeting-study_-data-and-admin-challenges_final.pdf

²⁵ Landon B (2022). Hospital global budgets: A primer and considerations for New Mexico. Available at: https://static1.squarespace.com/static/5605b825e4b0054d16fec43c/t/62df1310528d6a3af1f40dad/1658786576883/Landon_GlobalBudgetsHS_A_220127.pdf.

²⁶ Sharfstein JM. (2016) Global budgets for rural hospitals. *The Milbank Quarterly* 2016;94(2): 255-259. Available at: <https://doi.org/10.1111/1468-0009.12192>.

²⁷ Kanneganti D, Bailit M. New Mexico hospital global budgets report; January 28, 2022. Available at: https://static1.squarespace.com/static/5605b825e4b0054d16fec43c/t/62df131fa46da575372eb994/1658786592219/Bailit_NM-Hospital-Global-Budgets-Report_220128.pdf.

²⁸ Berenson RA, Upadhyay DK, Delbanco SF, Roslyn Murray M. Global budgets for hospitals. Urban Institute and Catalyst for Payment Reform, April 2016. Available at: https://www.urban.org/sites/default/files/2016/05/03/05_global_budgets_for_hospitals.pdf.

problem in the state. This issue is supported by information from the literature review, “A possible danger is that providers become exposed to too much financial risk. As a result, they may be inclined to skimp on quality or act too aggressively in attempts to reduce spending by underproviding necessary but expensive services.”²⁹ One interviewee noted that there are already difficulties with covering costs, and “it wouldn’t be a new problem. It’d just be the same problem with a different source of payment.” On the other hand, a global budget would allow for certain clinical practices to be maintained, like obstetrics. However, if utilization of specialized services is not driven by sufficient patient volume, with community members regularly utilizing them, low service volume could inadvertently increase the likelihood of mistakes in clinical care.

Another stakeholder consideration is the level of preparation required for the successful implementation of a complex system like global budgets. One participant noted, “I don’t know that New Mexico is ready for that.” Another stakeholder discussed the difference in landscapes when comparing previous examples of the global budget system, noting that New Mexico cannot afford to lose a rural facility, and that it “actually puts more volatility and risk for our rural hospitals, under a global budget as it exists today.” Overall, there is a high level of doubt among the key informants regarding the actual benefits that a global budget system may provide.

Alternatives

The stakeholders that participated in these discussions offered valuable insight into the feasibility of implementing a global budget system in rural New Mexico hospitals. Given the wariness and concern about the readiness of rural hospitals, payers, and the state to commit to this model, participants noted the importance of exploring alternatives to global budgets. One participant explained, “there are other strategies or alternatives that should be considered to be really honest. That might be a little easier to implement.” Limitations because of health care personnel shortages in New Mexico were cited by several stakeholders. Some of the options include:

- **The Rural Health Care Delivery Fund.** In March 2023, the state passed a bill to establish the Rural Health Care Delivery Fund to allow providers to receive grant funding for new facility start-up costs or expanded services at existing facilities.³⁰ The estimated total funding is \$80,000,000 over three years. At least three rural hospitals received funding from the initial round of grants.
- **Rural Healthcare Tax Credits.** In 2019, all small-town rural counties in New Mexico were designed as primary care and behavioral health professional shortage areas by the U.S.

²⁹ Buck ID. (2022). Financing rural health care. *West Virginia Law Review* 124. Available at: <https://researchrepository.wvu.edu/wvlr/vol124/iss3/8/>.

³⁰ Gleason M. (2023) Health care fund could grow specialty medical services in rural New Mexico. *Source NM*, March 1, 2023. Available at: <https://sourcennm.com/2023/03/01/2-million-fund-could-grow-specialty-health-care-services-in-rural-new-mexico/>.

Department of Health and Human Services.^{31,32} New Mexico offers rural health care tax credits as an incentive to retain providers in rural areas. The New Mexico Health Care Workforce Committee recommended expanding eligibility to a larger group of professionals.³³

- **Other Support for Rural Hospitals.** Initiatives to increase rural health care access in New Mexico are underway, including the Hospital Access Program (HAP) directed payment system required of Medicaid MCOs, and a partnership between a private, local foundation and the University of New Mexico's Office for Community Health. This partnership is working to address local health care capacity by increasing recruitment and retention.³⁴

Summary of Stakeholder Input

In conversations with New Mexico stakeholders, NORC found that there is no perfect answer for rural hospitals across the state and no champion for the idea of enacting global budgets. However, global budgets are not seen as a feasible next step for New Mexico stakeholders—the path to implementation is long and complex and will take a great deal of planning, holding space for rural hospitals to speak with one another, and creating an entity that is dedicated to overseeing the global budget model. Although the global budget was not completely written off in these conversations, stakeholders expressed a need for greater understanding, preparation, and advocacy efforts to successfully implement a global budget system in the future and suggested looking at existing initiatives as alternatives.

Financial analysis

New Mexico Hospital Financial Status

New Mexico has 40 hospitals—29 acute care hospitals (of which four are Indian Health Service hospitals outside the scope of a state global budget system) and 11 CAHs. To better understand the financial status of hospitals in New Mexico over time, NORC compiled the most recent data on both urban and rural hospitals in New Mexico from the HCRIS from 2013 to 2021. The following exhibits illustrate measures of financial performance. When tables are shown below the exhibits, these show

³¹ Essienyi P, Zambrotta M. (2021). Overcoming the distance: New Mexico tribal behavioral and mental health response to the COVID-19 pandemic. Available at: https://www.iad.state.nm.us/wp-content/uploads/2021/05/NMIAD_NBII_FINAL_REPORT.pdf.

³² Rural Health Planning Workgroup. New Mexico rural health plan. (2019). Available at: https://www.nmlegis.gov/handouts/LHHS_092519_Item_2_New_Mexico_Rural_Health_Plan.pdf.

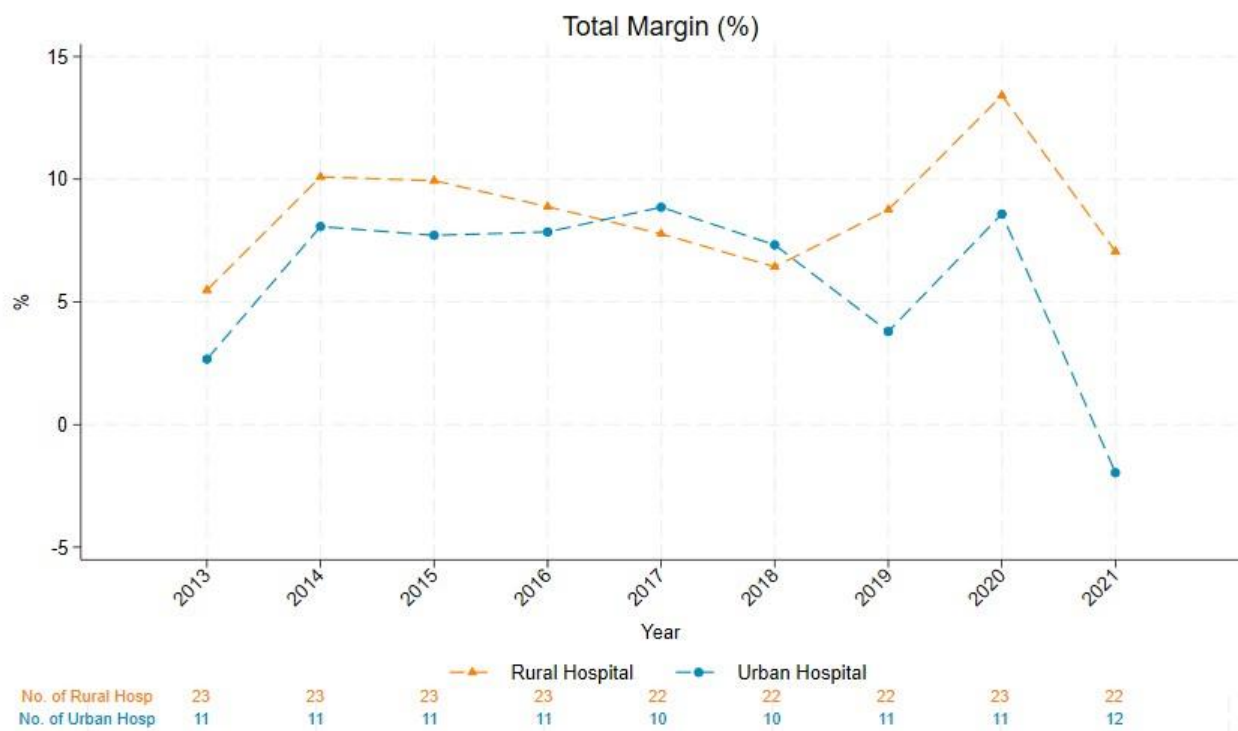
³³ Childress M. (2023) Lawmakers tackled New Mexico's crisis of rural health care workers. It wasn't enough. *Albuquerque Journal*. October 11, 2023. <https://nmindepth.com/2023/lawmakers-tackled-new-mexicos-crisis-of-rural-health-care-workers-it-wasnt-enough/>.

³⁴ Reid R, Rising E, Kaufman A, Bassett A, Cole McGrew M, Silverblatt H, Haederle M. (2019) The influence of a place-based foundation and a public university in growing a rural health workforce. *Journal of Community Health* 44(2):292-296. Available at: <https://doi.org/10.1007/s10900-018-0585-y>.

the count of hospitals included in the exhibits. Counts can vary because hospitals did not report in certain years.

In terms of total margin (total hospital revenues as a percentage of total expenses), Exhibit 1 shows that New Mexico’s urban and rural hospitals performed similarly between 2013 and 2021. During the COVID-19 public health emergency, both urban and rural hospitals experienced a drop in total margins, although the margins were higher among rural hospitals. Hospital closure may be the worst-case result of financial risk. However, only one rural IHS hospital in New Mexico has closed since 2005, out of 186 rural hospital closures nationwide.³⁵

Exhibit 1. Total margin for urban and rural hospitals in New Mexico, 2013-2021.



Source: NORC analysis of HCRIS data

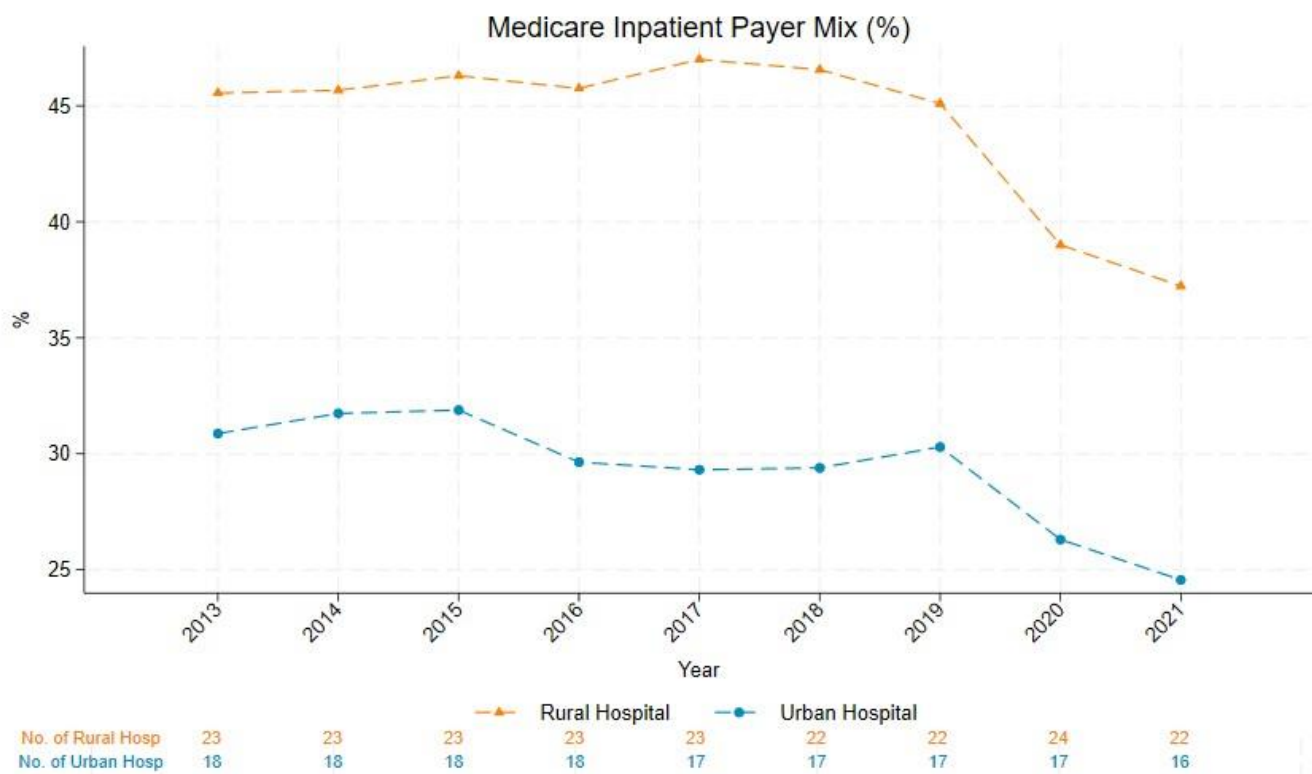
New Mexico hospitals are more dependent on government payment systems than hospitals nationally. Only 14 percent of 2019 New Mexico hospital revenues came from commercial insurers. However, insurers would play a large role in global budget revenue implementation because Medicaid services are largely paid through private managed care organizations.³⁶

³⁵ Cecil G. Sheps Center for Health Services Research, (2023). Rural hospital closures. Available at: <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>. Rural Health Research Gateway. Rural hospital closures: 2023 update. Available at: <https://www.ruralhealthresearch.org/assets/5299-24183/hospital-closures-2023-recap.pdf>.

³⁶ New Mexico Hospital Association; Legislative Health and Human Services Committee (2020). New Mexico hospitals: Financial status and impact. Available at: https://nmlegis.gov/handouts/LHHS_102120_Item_1_nmha_to_lhhs_hospital_finance_TO_COMMITTEE_10-06-20.pdf.

Compared to urban hospitals, rural New Mexico hospitals are more highly dependent on Medicare for their inpatient revenue, as shown in Exhibit 2. Until the COVID Public Health Emergency, urban hospitals received about 30 percent of their inpatient revenue from Medicare, while rural hospitals received about 45 percent. COVID likely increased the proportions of patients who had other sources of coverage such as commercial insurance. When later data are available, they may show a return to historic patterns. Obtaining from CMS a waiver from Medicare payment rules, should New Mexico adopt a global budget payment policy, is a necessity.

Exhibit 2. Percent of inpatient revenue provided by Medicare 2013-2021, New Mexico rural and urban hospitals



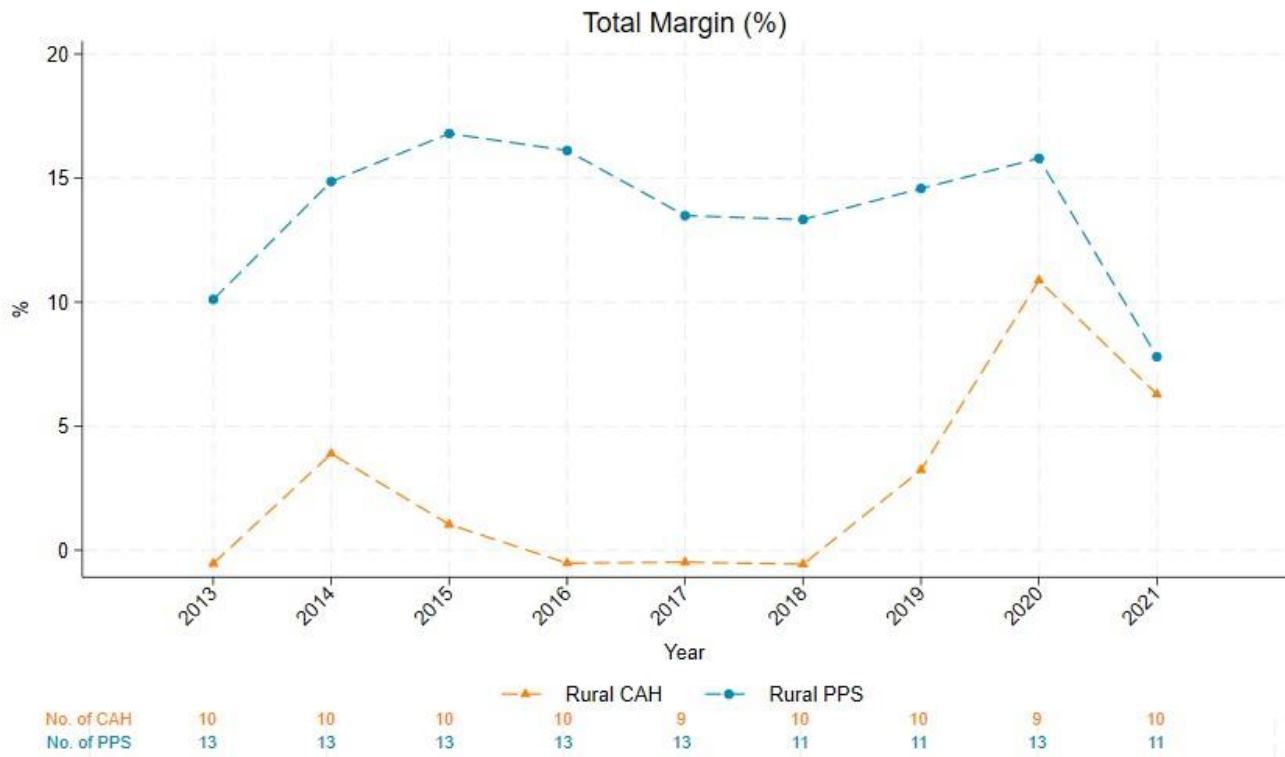
Source: NORC analysis of HCRIS data

Among rural hospitals, financial performance varied according to whether the hospital was classified as a CAH, receiving payments from Medicare based on an annual reconciliation of costs for Medicare patients, and hospitals receiving Medicare payment under the Prospective Payment System (PPS). Exhibit 3 shows that PPS hospitals experienced higher total margins over the measured period, until COVID-19 relief supplemental payments almost equalized performance.

CAHs qualify for cost-based Medicare reimbursement based on being located a minimum distance from other hospitals, having 25 or fewer beds, and having an average inpatient stay of four or fewer days. As such, they typically serve the most remote communities and are expected to transfer patients with complex needs to facilities offering more advanced treatment. Nonetheless, their levels of financial risk

tend to be higher. Payment according to a global budget might stabilize CAH finances by allowing level payments over the course of a year, but any improvement in their financial risk depends on the terms of their global budget waiver from CMS. Under the Pennsylvania model, CAHs still must reconcile their costs with Medicare, leaving their net annual revenues the same as under the current cost-based reimbursement system.³⁷

Exhibit 3. Total margin of New Mexico critical access hospitals vs. rural PPS hospitals, 2013-2021



Source: NORC analysis of HCRIS data

To better understand the numbers of New Mexico rural hospitals at financial risk, NORC evaluated individual hospitals’ measures of financial health from 2013 to 2021, including total and operating margins, days of cash in hand, and current ratio. NORC identified seven rural hospitals at comparatively greater financial risk than the others. Both the higher-risk and lower-risk hospital groups included PPS hospitals as well as CAHs. Guadalupe County Hospital, which is converting to an REH, and Holy Cross Hospital, which converted to a CAH and had missing cost report data, were excluded from the analysis.

Summarizing their performance in terms of total margin over 2013 to 2019, the higher risk hospitals performed with consistently lower margins than lower risk hospitals, although they earned positive margins in some years. Margins for both groups increased in 2020, but higher risk hospitals

³⁷ NORC (2021). The Pennsylvania Rural Health Model (PARHM) first annual report. Available at: <https://www.cms.gov/priorities/innovation/data-and-reports/2021/parhm-ar1-full-report>.

experienced negative average margins in 2021. A negative margin in a single year may not necessarily affect a hospital’s financial stability if the hospital has sufficient cash reserves or access to working capital. But a pattern of consistently low or negative margins does not allow a hospital to accumulate reserves over time and places the hospital at risk of financial distress or closure. Pennsylvania’s example suggests that rural hospitals with worse measures of financial health, and those who are independent rather than part of larger health systems, are more likely to participate in a voluntary global budget system.

Exhibit 4. Total margins of New Mexico rural hospitals at greater and lesser financial risk, 2013-2021



Source: NORC analysis of HCRIS data

New government policies

The New Mexico Rural Health Care Delivery Fund (RHCDF)

Enacted in 2023, SB 7 grants to rural health care providers are limited to covering operating losses for which revenue is not sufficient³⁸—i.e., the grants fill gaps where providers might have registered negative margins. The initial round of \$18 million in grants included a number of rural hospitals,

³⁸ <https://www.nmlegis.gov/Sessions/23%20Regular/final/SB0007.pdf>

including Covenant Health Hobbs, Champion Regional Medical Center, and Mimbres Memorial Hospital.³⁹ A total of \$80 million has been authorized in grants.

Making Care Primary

MCP emphasizes payment reform with federal subsidies to primary care practices, whereby physician practices with a minimum of 125 Medicare FFS enrolled patients can receive an upfront infrastructure payment to invest in staffing, social determinants of health strategies, and IT infrastructure. Further risk-adjusted per-member per-month payments would be made for the Medicare members of the practice's enrolled patient cohort. The eight participating states are expected to adopt similar Medicaid payment structures and recruit commercial payers to do the same. The program's ideal is to develop an integrated primary care network which coordinate care with specialists as needed, and ultimately to avoid hospitalizations. Among the practices eligible for MCP participation include Independent or solo primary care practices, group practices, Federally Qualified Health Centers (FQHCs), health systems, Indian health programs, and certain CAHs.⁴⁰

Conclusion

Gathering information through multiple methodologies, NORC has assessed the feasibility of proposed policy to implement a global budget system for rural hospitals in New Mexico. Although a global budget system has potential to support rural hospital finances, it requires a broad infrastructure, including an agency responsible for development and maintenance of the system and data sufficient to support its operations. Although certain rural hospitals are at higher financial risk, others are being supported in fulfilling their missions under current reimbursement policies. Medicare payment is a primary support for rural New Mexico hospitals, even more so than urban hospitals. Medicare payment policies such as the CAH designation that reconciles actual costs for Medicare services, and the newly enacted REH option both place limitations on the hospital services offered but allow for hospitals to accept the limitations in exchange for greater financial certainty. A global budget would require alignment among payers, non-hospital providers, and population health measures. Several hospital representatives have stated they are not ready to take on the financial risks of operating under a global budget without some mechanisms to adjust payments for performance and outside shocks to the system, such as COVID. These mechanisms make a global budget system more complex. These issues illustrate how a New Mexico champion for the principle of global budgets would be needed to persuade and negotiate.

³⁹ Office of the Governor; Michelle Lujan Grisham. (2013). Governor announces initial recipients of Rural Health Care Delivery Fund. Press release; Oct. 17, 2023. Available at: <https://www.governor.state.nm.us/2023/10/17/governor-announces-initial-recipients-of-rural-health-care-delivery-fund/>.

⁴⁰Manatt Health (2023). Investing in a strong primary care health system: An overview of CMMI's Making Care Primary Model. Available at: [https://communications.manatt.com/l/745343/2023-11-16/47xm4l/745343/170015533501tdU1U3/Manatt Presentation Investing in a Strong Primary Care Health System v.pdf](https://communications.manatt.com/l/745343/2023-11-16/47xm4l/745343/170015533501tdU1U3/Manatt%20Presentation%20Investing%20in%20a%20Strong%20Primary%20Care%20Health%20System%20v.pdf).

Other financial supports for these expanded roles for rural hospitals and providers exist in the MCP program and the state's Rural Health Care Delivery Fund. Given the state's investment in these programs, as well as the expansion of data tools such as the APCD, SYCHRONYS, and MMIS-R, there may well be a glide path to creating global budgets in the future. Whether those global budgets are limited to rural hospitals or expanded in eligibility to all hospitals, or perhaps combined with a TCOC healthcare growth limitation like in the CMS AHEAD model or in Maryland, is a policy choice that New Mexico will be better equipped to face in the future.

Appendices

Methodological Appendix A: Literature Search

The NORC team conducted a literature review to understand the feasibility of implementing a global budgeting system for rural hospitals in New Mexico, focusing on two domains: 1) capacity and infrastructure and 2) healthcare access and quality of care.

Searches were conducted in PubMed, PubMed Central, Google Scholar, and Google to capture relevant peer-reviewed and grey literature. The list of primary and secondary search terms for each domain can be found in Table A1.

Table A1.

Primary Search Terms	Secondary Search Terms (Capacity and Infrastructure)	Secondary Search Terms (Health Care Access & Quality)
<ol style="list-style-type: none"> 1. Global budget* (global payment, price regulation, all payer, cost control) 2. Rural 3. Health care 4. Payers 5. Finance 6. Hospital 	<ul style="list-style-type: none"> <input type="checkbox"/> Infrastructure OR capacity OR capabilities <input type="checkbox"/> Staffing OR providers <input type="checkbox"/> Availability <input type="checkbox"/> Efficiency OR care coordination <input type="checkbox"/> Specialized services <input type="checkbox"/> Needs assessments <input type="checkbox"/> Function* <input type="checkbox"/> Facilities OR equipment <input type="checkbox"/> Rural hospital closures 	<ul style="list-style-type: none"> <input type="checkbox"/> Access <input type="checkbox"/> Quality <input type="checkbox"/> Distance <input type="checkbox"/> Critical access hospital <input type="checkbox"/> Health professional shortage area (HPSA) <input type="checkbox"/> Patient satisfaction <input type="checkbox"/> Primary care access – primary physicians, nurse practitioners, et al. <input type="checkbox"/> Statistics <input type="checkbox"/> Behavioral health <input type="checkbox"/> Maternity care <input type="checkbox"/> Network adequacy <input type="checkbox"/> Health disparities

Asterisks denote truncated search terms. For example, “Function” will search terms “function,” “functions,” “functionality,” “functional,” and so forth.

Each search was limited to 100 results. We imported all results into Zotero, where they were screened for relevance before being uploaded to Covidence for extraction. Results were included if they met the following criterion:

- Published in or after 2013
- Discusses hospital capacity or infrastructure
- Describes key facilitators and/or barriers for implementing a global budget system for rural hospitals

- Provides information on regulatory pathways for global budgets
- Provides insights on key elements needed for rural hospitals, payers, and/or state entities to assess readiness for global budget implementation and sustainment
- Discusses alternative payment approaches for rural health hospitals
- Discusses health care access barriers and facilitators in southwest United States or New Mexico
- Health disparities in southwest United States including New Mexico

Once all relevant results were imported into Covidence, the team reviewed each source and extracted relevant information. Two team members reviewed each relevant article to reach consensus. Once consensus was reached, Covidence data was exported into an Excel file to review and synthesize the findings. The resulting references are listed under “References Consulted.”

Methodological Appendix B: Methods for Key Informant Interviews

Interviewee selection

NORC worked with consultant Beth Landon to identify and contact potential key stakeholders with expertise who might inform the feasibility of global budgets in rural New Mexico hospitals. Landon's extensive experience in this field allowed the NORC team to engage with stakeholders from a variety of perspectives, including hospitals, commercial payers, state officials, among others. Upon identifying potential key informants, we reached out to 19 individuals. In total, NORC was able to conduct 14 interviews, listed below:

- **Kari Armijo, Cabinet Secretary**, Human Services Department for the State of New Mexico
- **Colin Baillio, Deputy Superintendent**, Office of the Superintendent of Insurance
- **Christina Campos, Administrator**, Guadalupe County Hospital
- **Troy Clark, President and CEO**, New Mexico Hospital Association
- **John Cook, Vice president for Network Management**, BlueCross BlueShield of New Mexico
- **Brenna Gaytan, Director of Government Relations**, BlueCross BlueShield of New Mexico
- **Martin Hickey, New Mexico State Senator**
- **Donna Kinzer, Consultant**, DK Healthcare Consulting
- **Bret Goebel, CFO**, Guadalupe County Hospital
- **Tony Hernandez, Vice President/General Manager Medicare Transformation**, Presbyterian Healthcare Services
- **Annie Jung, Executive Director**, New Mexico Medical Society
- **Lorelei Kellogg, Medicaid Deputy Director/Acting Medicaid Director**, Human Services Department, State of New Mexico
- **Allyson Roberts, CFO**, Nor-Lea General Hospital District
- **Terri Stewart, President and CEO**, SYNCRONYS

Data Collection

The interviewing teams had a lead interviewer, a note taker, and one or two other NORC team members matched based on scheduling availability. When the stakeholder held expertise in both global feasibility and reducing administrative costs, staff from both teams attended. The lead interviewer facilitated the interview, other NORC staff provided probing questions and additional information where needed, and the notetaker captured details of the interview. All interviews were conducted and recorded using Zoom.

We generated the interview protocol and questions to draw out key themes. Interviewers used the questions and outline shown in the interview protocol below as guidance, but often asked other questions that they saw as auxiliary to get at the core themes.

Interview Protocol

Background

Building on previous global budget studies for New Mexico, and recognizing the progress achieved in Maryland, Pennsylvania, and Vermont, the interim Legislative Health and Human Services (LHHS) seeks a next-level feasibility assessment on this topic. To this end, the Legislative Council Service contracted with NORC to perform this study.

For purposes of this project, a global budget for hospitals' operations, or for a subset of hospitals such as rural hospitals, or select hospital services like maternity care, fixes in place that organization's revenues from those services for a budget period, regardless of the actual volume of services delivered. The principles of global budgeting are simple to describe but are complex to implement.

The team is conducting key informant interviews to:

- Identify questions and concerns across the stakeholder space that must be answered or addressed before proceeding; and
- Identify barriers and constraints, as well as opportunities and advantages, towards implementation

In addition to the interviews, NORC is conducting background national research and a literature review. The experience of other states can help shed light on the potential for New Mexico to lower health care spending and improve population health through global budgeting.

Interview outline

Introduction: Hi, thank you for participating in this interview to support this project. My name is (X), and I am a (X) at NORC at the University of Chicago (NORC) based in (X). Today I am joined by (name of NORC participants). *Introductions*

As a reminder, NORC is working with the New Mexico Legislative Service Council to assess the feasibility of implementing a global budget system across hospitals in rural New Mexico. With this information, we will provide a comprehensive look at the potential benefits, disadvantages, and mechanisms of implementing global budgets. We recognize that your time is valuable, and we'd like to reiterate our gratitude for your participation today.

We'll keep the discussion between 45-60 minutes. Please let us know if you need to stop, or step away at any moment during the interview. Do you have any questions so far?

(Pause)

Okay. We would like to record this conversation for our own records. It will not be shared outside of this team at NORC and will be deleted once we are sure we've accurately transcribed the conversation. Is that okay? (Yes or no, offer to stop recording if interviewee objects).

Questions

We realize this is a big topic. What questions do you have about the concept or our project to best frame your understanding?

What's your first gut reaction to this concept? (Probe accordingly)

If this were undertaken and successful, how would it benefit rural New Mexico hospitals and the patients they serve? Likewise, how would it compromise them?

As you consider the enormity of the task to support this transition, even before implementation, what do you see as the highest priority assurances, technical support, and/or other resources to begin contemplation?

Depending on respondent position/org, probe on how to support hospital readiness, state infrastructure, risk to payers

Analysis Approach

Transcripts of each interview were used for analysis. The NORC team used the qualitative data analysis software program, NViVO14 to code interview transcripts. Key themes from the interviews were coded using a coding framework tailored to the core project questions. A total of thirty-four codes under eight main code topics were used: background on interviewee, interviewee question about global budgets for rural hospital, initial reaction(s) to implementing a global budget for rural hospitals in New Mexico, potential benefits of global budgets, potential disadvantages of global budgets, highest priority elements needed for successful implementation, readiness, role (e.g. hospital, payer, state, other).

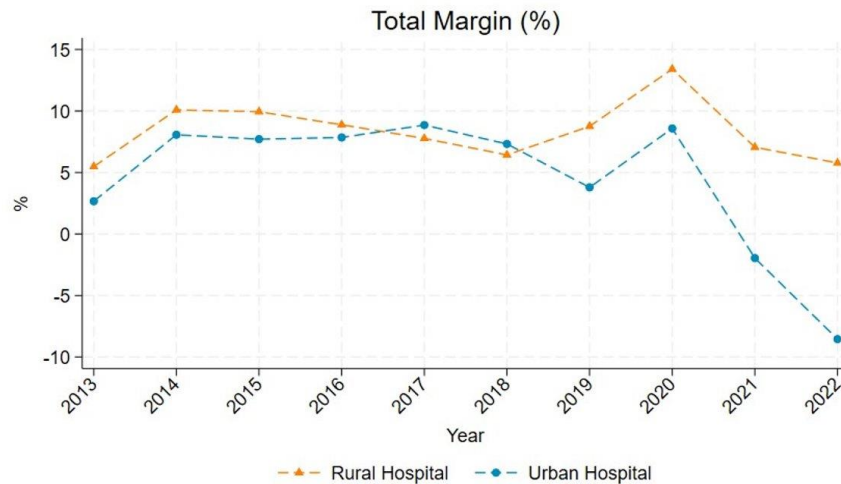
Prior to NORC's review of the interview transcripts, all coders were trained on how to code them using the qualitative data analysis software program, NViVO14. Following the training, three reviewed and coded interview transcript text using the coding framework as a guide.

Coders and other NORC staff communicated and met regularly with each other during the coding process to ensure a consistent approach was taken. The coded text selected for deeper analysis were driven by the goals of the study to assess potential benefits, disadvantages, questions to consider, crucial elements needed for implementation, readiness and role(s) of hospitals, the state, payers, and other key stakeholders.

Methodological Appendix C: Methods for Financial Analysis

To analyze the financial status of New Mexico hospitals, NORC downloaded data from the CMS Healthcare Cost Report Information System (HCRIS)⁴¹ for reporting years 2013 to 2021 for New Mexico. The most recent data available were for 2021. NORC made initial comparisons in the interim report between hospitals that CMS indicated as rural and urban using the Inpatient Prospective Payment System Hospital Impact File for Fiscal Year 2024.⁴² NORC's interim report on global budgets for New Mexico rural hospitals found that, over the 2013 to 2019 period, New Mexico rural and urban hospitals performed roughly the same in terms of total margin (Exhibit A1). Average total margins deviated during the COVID-19 public health emergency during 2020 to 2021.

Exhibit A1. Average Rural vs Urban Total Margin in New Mexico Hospitals, 2013-2021



Source: NORC analysis of HCRIS data

For this final report, NORC focused on differences among rural hospitals. Using multiple criteria including total and operating margins, days of cash, and current ratio, NORC identified seven hospitals that seemed at greater risk of financial instability. Exhibit 4 in the main report showed that greater-risk rural hospitals had consistently lower total margins than lesser-risk hospitals. Further characteristics distinguishing lesser- and greater-risk hospitals are shown in the following Exhibits.

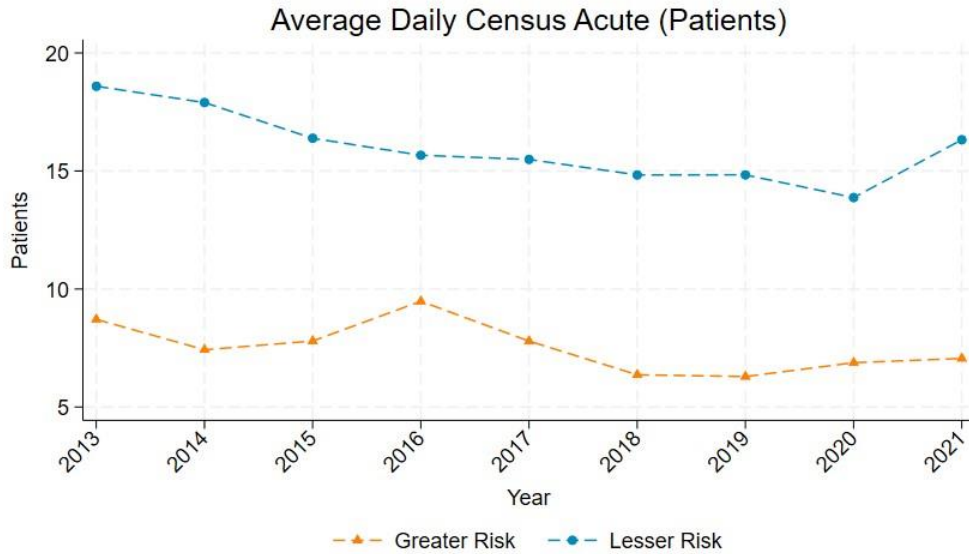
⁴¹Centers for Medicare & Medicaid Services. Cost reports. Available at: <https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports>.

⁴²Centers for Medicare & Medicaid Services. FY 2024 IPPS final rule home page. Available at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipp-pps-final-rule-home-page>. FY 2024 was selected to accord with any forthcoming policy changes.

Average Census

Exhibit A2 shows that lower-risk hospitals had higher inpatient utilization than greater-risk hospitals. Average daily census (i.e., the average daily number of inpatients) for greater-risk hospitals was fewer than 10 for greater-risk hospitals and was consistently higher for lesser-risk hospitals.

Exhibit A2. New Mexico Rural Hospitals Average Daily Census by Lesser and Greater Risk of Financial Instability, 2013-2021

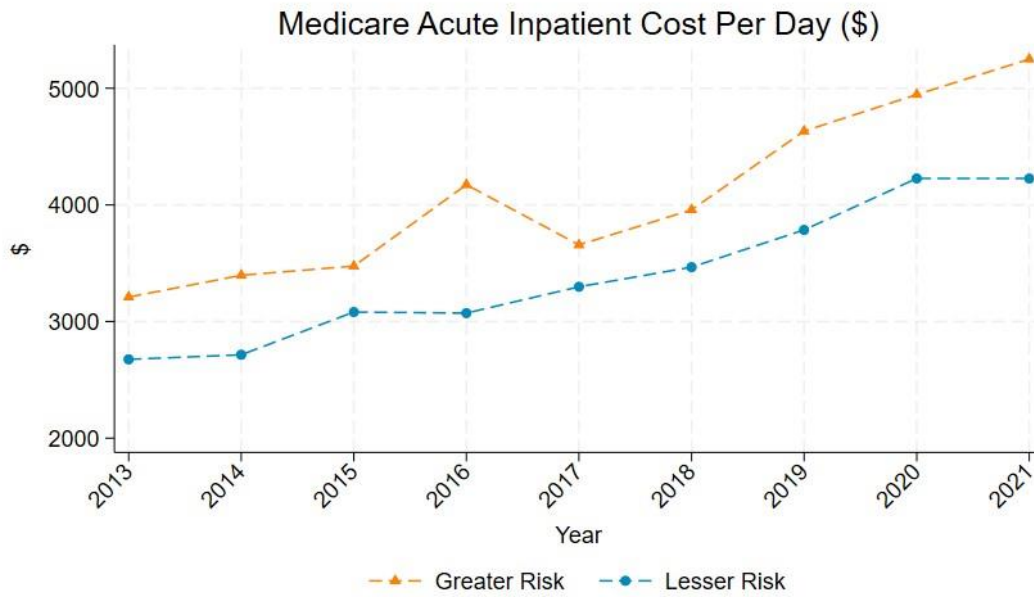


Source: NORC analysis of HCRIS data

Inpatient Cost

Greater-risk hospitals had consistently higher Medicare inpatient costs per day, as seen in Exhibit A3.

Exhibit A3. New Mexico Rural Hospitals' Average Medicare Inpatient Cost Per Day by Lesser and Greater Risk of Financial Instability, 2013-2021

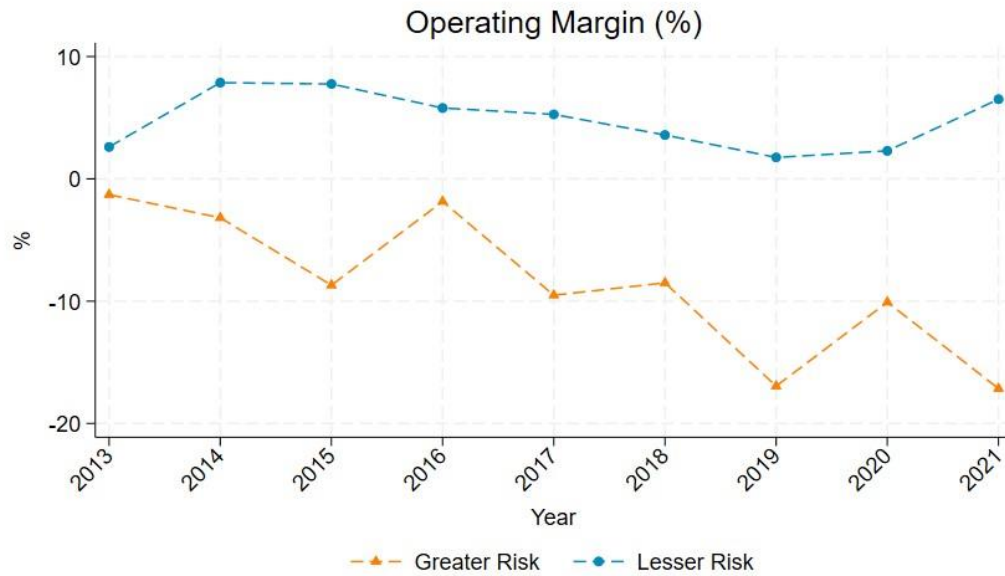


Source: NORC analysis of HCRIS data

Operating Margin

Greater-risk hospitals also had consistently negative operating margins, compared with positive operating margins for lesser-risk hospitals (Exhibit A4).

Exhibit A4. Average Operating Margin in New Mexico Rural Hospitals by Lesser and Greater Risk of Financial Instability, 2013-2021



Source: NORC analysis of HCRIS data

In summary, rural hospitals at greater risk of financial instability had smaller inpatient caseloads, higher costs, and lower margins. To support these hospitals, New Mexico policy-makers concerned about the solvency and potential closure of greater-risk rural hospitals might consider focused policies other than a global budget payment policy.

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