**Rhode Island Hospital Global Budget Working Group**
Meeting #8 Summary
HARI Conference Room
405 Promenade Street, Providence
April 7, 2023
9:00 AM – 11:00 AM

**Next Steps:**

1. Revise consensus to specify that the basis for developing budgets will be hospital revenue from participating commercial, Medicaid and Medicare payers.
2. Revisit how to establish a routine inflation factor and other budget adjustments after discussed fixed versus flexible global budgets.

**Attendees:**

- Cory King, OHIC
- January Angeles, Bailit Health
- Michael Bailit, Bailit Health
- Deepti Kanneganti, Bailit Health
- Natalya Alexander, NHPRI
- Scott Boyd, AMICA
- Scott Brown, Landmark
- Jim Burke, Kent
- Steve Burke, Butler
- Doreen Carlin-Grande, NHPRI
- Al Charbonneau, RIBGH
- Domenic Delmonico, Tufts
- Chris Dooley, Prospect
- Maria Ducharme, Lifespan
- Howard Dulude, HARI
- Ana Tuya Fulton, Care New England
- Dezeree Hodish, EOHHS
- Peter Hollmann, Rhode Island Medical Society
- Al Kurose, Lifespan
- Nick Lefeber, BCBSRI
- Peter Markell, Lifespan
- Mary Marran, Butler
- Heather-Rose Mattias, Care New England
- Robert Millette, Prospect
- Josh Morris, Westerly
- Dan Moynihan, Lifespan
- Bob Murray, Global Health Payment LLC
- Cathi Newman, BCBSRI
- Elena Nicolella, RIHCA
- Teresa Paiva-Weed, HARI
- Aaron Robinson, South County Health
- Henry Sachs, Bradley
- Sam Salganik, RIPIN

## I. Welcome

- January Angeles reviewed the agenda for the meeting.

## II. Recap of the Consensus from the Last Meeting

- January reviewed the consensus from the last meeting, including which data and years of data to use to develop budgets, implementing a "bottom-up" approach to develop market-specific budgets for each participating payer-hospital dyad and developing one routine budget adjustment to account for changes in age, sex and case mix.
- Howard Dulude advocated for a budget set on hospital costs and noted that hospitals will not volunteer to participate in the model if it does not think it has a sufficient revenue base.
- Aaron Robinson and Teresa Paiva-Weed expressed concern that revenue is not sufficient to cover hospital operating costs.
- Sam Salganik said the concept is to develop a budget that provides a guaranteed revenue base for a hospital. He said consideration of how a hospital will spend its revenue is outside the scope of the Working Group.
- Aaron Robinson reiterated that RI hospital costs are dynamic and dependent on the markets in neighboring states.
- Cathi Newman commented that health plans view costs different from hospitals.
- Sam Salganik acknowledged that the approach for developing base budgets is relatively high-level and may not guarantee sufficient revenue, and it will be up to individual hospitals to determine whether the budget, developed based on the specifications identified by the Working Group, is acceptable.
- Cory King reminded the Working Group that the Cost Trends Steering Committee selected hospital global budgets because they can potentially manage spending growth and ensure financial stability for hospitals. He said the legislature and a future commission will need to assess the costs associated with transitioning from FFS to a hospital global budget.
    - Teresa Paiva-Weed expressed concern that a voluntary move to hospital global budgets may be superseded by a legislative effort.
    - Sam Salganik noted that Medicaid participation is contingent upon the state budget process, which involves the legislature.
    - Cory reiterated that he does not plan to pursue legislation mandating the implementation of a hospital global budget.
- January summarized that budgets based on hospital costs may not have sufficient motivation for hospitals to constrain cost growth.
- Robert Millette said it is fair to consider direct costs (e.g., the cost of doing business and providing services) in the budget, but it is not appropriate to consider indirect costs (e.g., hospital investments). He added that the term hospital operating margin is too broad.
- Deepti Kanneganti explained that other current and historical hospital global budget models use revenue, and current payer-hospital contracting is based on revenue. Cory King added that CMMI is also moving towards a revenue-based model.
- Dan Moynihan recommended considering TCOC models rather than hospital global budgets. Cory King said this is a broader question the Steering Committee can reevaluate.

- Aaron Robinson and Al Kurose recommended revising the consensus to clarify that budgets will be inclusive of commercial, Medicaid and Medicare payers.
- Peter Hollman reminded the Working Group that there will be a technical group to consider how to operationalize the model. Al Charbonneau recommended convening the technical group sooner rather than later.
- Cory King reminded the Working Group of OHIC's goals for hospitals, including to promote affordable and predictable cost growth, improved financial sustainability and technical innovation in care delivery to support population health management and quality excellence.
- **Next Steps**: Revise consensus to specify that the basis for developing budgets will be hospital revenue from participating commercial, Medicaid and Medicare payers.

**III. Continued Discussion of How to Calculate and Update Budgets Annually**

- January Angeles reminded the Working Group of the prior discussion on inflation. She described the advantages and disadvantages for two lenses by which to view inflation – hospital costs and consumer affordability.
- Elena Nicolella confirmed that budget adjustments are to ensure that budgets are adequate to meet the goals for the hospital global budget model. January shared that budget adjustments are also to ensure that the budget accounts for things that are out of the hospital's control and is reflective of annual trends.
- Elena Nicolella asked how insurers currently account for inflation. Cathi Newman said BCBSRI follows Medicare's approach, which is not sufficient. She said BCBSRI also looks at how premiums are set and how contracts are negotiated across a network. Sam Salganik confirmed that BCBSRI adopts one negotiated rate for inflation for each network, and that rates were relatively consistent across networks in part because of OHIC's cap on hospital price growth.
- Teresa Paiva-Weed and Aaron Robinson commented that Medicare uses different inflation rates in RI compared to neighboring states.
- Peter Markell advocated for an inflation rate that provides fair wage increases and accounts for increases in the cost of supplies.
- Sam Salganik noted that some of these inflation measures have national, regional and local indexes that the Working Group could consider.
- Domenic Delmonico described how stakeholders in the 1980s RI hospital global budget model negotiated annual increases based on inflation for different expense categories. He added that inflation for Medicaid is set by the General Assembly.
    - Howard Dulude said the RI approach resulted in one inflation factor for use by all hospitals and insurers that was based on forecasted trends. He later added that the inflation factor was negotiated by HARI, BCBSRI and Medicaid. There was some minor flexibility that allowed payers to modify the negotiated value.
- Cathi Newman highlighted that it is important to consider what is affordable. Aaron Robinson asked for a definition of affordability. Michal Bailit said the Steering Committee uses PSGP and median household income.

- January summarized that there seemed to be an initial interest in having an inflation factor that is based on multiple indices and that perhaps has a negotiated component.
    - Peter Hollman advocated for using one standard, formula-driven methodology for calculating inflation.
    - Aaron Robinson said he preferred an approach similar to the 1980s RI model.
- Deepti commented that having an annual negotiated component to the inflation factor could increase administrative burden and may introduce variation in what the inflation factor could be by hospital or hospital system (depending on who is involved in the negotiation). One member added that the negotiated component would reduce the predictability of future budgets.
- Teresa Paiva-Weed advocated for having flexibility how the model is adopted by hospital. January said the Working Group will revisit this topic.
- Peter Markell indicated that the model could establish corridors for how to modify the inflation factor if actual inflation is different than projected inflation. He expressed concern with the unintended consequences associated with a fixed global budget.
- **Next Steps**: Revisit how to establish a routine inflation factor and other budget adjustments after discussed fixed versus flexible global budgets.

**IV. Discussion of Whether (and if so, How) to Adjust Budgets to Account for Volume Changes**

- Bob Murray introduced the concepts of fixed and flexible global budgets and described how they vary from the standard FFS payment approach.
    - Domenic Delmonico highlighted that the 1980s RI model had different fixed and variable adjustments for outpatient and inpatient services. Bob added this was true in Rochester as well, in part because of the state's priority to encourage a shift to outpatient care.
    - Domenic Delmonico indicated that the coverage of fixed costs when volumes decline was very advantageous for hospitals. Bob agreed, noting that this feature adds predictability for hospitals.
    - Sam Salganik asked how hard it would be to come up with the fixed and variable cost percentages.
        - Domenic Delmonico answered that the 1980s RI model used 80% fixed for routine inpatient services and 65% fixed for ancillary inpatient services.
        - Bob said there may not be universal agreement on what the percentages may be, and that percentages could vary by hospital size and/or type. He added that MD assumed 50% fixed costs in the past, which worked well.
- Bob outlined various advantages and disadvantages of fixed and flexible global budgets.
    - Howard Dulude asked whether CMS tried to recoup costs from MD hospitals after COVID-19. Bob said several large MD health systems and suburban hospitals shifted volume to unregulated, free-standing facilities and were therefore paid twice for the same services. Those systems therefore generated significant reserves and did not necessarily reinvest those savings into

population health. CMMI was disappointed in this and directed MD to reinvest surpluses in population health.

- Dan Moynihan commented that an ACO may realize less savings under a flexible global budget model compared to the status quo. Bob agreed, but noted that having a higher variable cost factor would result in more savings.
- Al Kurose said that a physician-led ACOs may take steps to generate savings by improving population health, but may not experience those savings if the ACO is not owned by the hospital/health system.
    - Bob noted that a flexible global budget aligns hospital and ACO incentives that is not present in an FFS system or fixed global budget. He added that hospitals and ACO could have additional risk sharing arrangements that would allow the ACO to share in savings with the hospital.
    - Al Kurose said it would be complex for an ACO to establish agreements with multiple health systems to share savings, especially compared to the current ACO/payer shared savings arrangements.
    - Nick Lefeber said that 70-75% of BCBSRI members are in an ACO, which have been successful in taking on more risk.
    - Cory King said he questioned whether there was a meaningful distinction between hospital-led and physician-led ACOs other than FQHC-based ACOs in RI.
    - Cathi Newman said the majority of the savings currently go back to the providers, whereas a hospital global budget would allow hospitals to retain savings to reinvest into new facilities or new lines of service.
    - Aaron Robinson said this is how the model started, but not the current reality because most ACOs are hospital-led.
    - Bob commented that ACOs still exist in MD, but he did not think ACOs have been as profitable as he would have expected because of the fixed global budget approach.
- Sam Salganik highlighted that a flexible global budget would require hospitals and payers to retain the current claims processing system. Bob agreed, but indicated that there could be some streamlining because there wouldn't be as many denials or appeals of claims. Aaron Robinson added that a lot of administrative cost is associated with coding.
- Teresa Paiva-Weed asked what roles unions played or are playing in MD. Bob said labor was more active back at the beginning of the rate setting system. He said unions wanted to control costs to improve wage growth, because union costs increased as a result of increased hospital costs and increased premiums. He said in the short-term, unions might advocate for higher hospital prices.
- Cory King said he believed that hospital global budgets may be more likely to result in real savings for employers and employee premiums. Currently, ACOs use clinical risk-adjusted budget targets, which are highly dependent on coding practices. He advocated for developing a hospital global budget model and

focusing on how to adequately pay physicians, and then allowing hospitals and ACOs to negotiate how to share in savings.

**V. Public Comment**

- Cory King asked for public comment. There was none.

**VI. Next Steps**

- The next Working Group meeting will be on April 17, 2023.