Hospital Global Budgets

Report of the Hospital Global Budget Working Group

December 2023

This report documents the discussions of the Hospital Global Budget Working Group to inform the parameters of a hospital global budget payment model.

STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

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December 28, 2023

To the Reader:

Over the past decade, Medicare, state Medicaid programs, private insurers, and health care providers have implemented health care payment models that reward efficiency and quality. These value-based payment models, which vary in their complexity and scope, stand among key efforts to improve the performance of the health care system, and promote more affordable health care for consumers, employers, and taxpayers. The terms of contract between payers and providers supply a chassis for innovation in health care by reshaping economic incentives and investing the premium dollar in ways that support more efficient use of health care resources. Rhode Island has been at the forefront of these efforts and the significant work that local health care providers, insurers, and state government have undertaken should be a point of pride. These efforts are worthy of persistence as payment models continue to evolve.

In 2021, the Rhode Island Health Care Cost Trends Steering Committee, convened by the Office of the Health Insurance Commissioner (OHIC), endorsed the acceleration of advanced value-based payment model adoption as a key strategy to keep health care expenditure growth under Rhode Island's health care cost growth target. To advance this vision, OHIC convened a working group of health care organizations and other interested parties to develop a strategy to explore future value-based payment models for potential adoption in Rhode Island. The product of this effort was the Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island. A first effort under the Compact was to convene a Hospital Global Budget Working Group to review and make recommendations concerning the parameters of a hospital specific payment model, known as a hospital global budget.

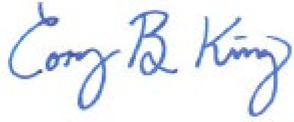
The working group defined six goals for hospital global budgets as follows:

- Reduce the growth rate of health care spending to an affordable and foreseeable level.
- Provide hospitals with predictable revenue to promote financial sustainability.
- Promote access to appropriate care in Rhode Island across all populations, including those who have been historically underserved.
- Enhance coordination and efficiency across delivery systems.
- Support investment in a high-quality clinical workforce and technical innovation in care delivery to support population health management and quality excellence.
- Improve patient experience of care, quality of care, patient outcomes and health equity.

The report that follows summarizes the working group's deliberations concerning the parameters of a hospital global budget payment model. As a product of this effort, stakeholders in Rhode Island have gained an enriched understanding of hospital global budgets as a payment model. This new understanding is timely and will help inform future opportunities. Recently, the Innovation Center within the Centers for Medicare and Medicaid Services announced a new state demonstration program called the States Advancing All-Payer Health Equity Approaches and Development Model (or "AHEAD"). Hospital global budgets are a key component of the new Medicare demonstration program, along with enhanced investment in primary care, and all-payer cost growth targets.

Rhode Island has a long track record of openness to innovation in health care. OHIC looks forward to building on this track record by continuing to engage with providers, payers, and interested parties on payment reform.

Sincerely,



Cory B. King
Acting Health Insurance Commissioner

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Executive Summary

In 2022, the Rhode Island Health Care Cost Trends Steering Committee (hereafter referred to as the "Steering Committee") signed a compact prioritizing the development and adoption of hospital global budgets as a strategy for slowing spending growth and meeting the state's health care cost growth target. Between July 2022 and July 2023, a working group of health care stakeholders in Rhode Island met to develop recommendations on the broad parameters of a hospital global budget model that payers and hospitals in the state could adopt on a voluntary basis. Their recommendations on six components of a hospital global budget model include the following:

1. Hospitals and populations covered by the hospital global budget model
    - Consider budgets for all hospitals, including specialty hospitals.
    - Include revenue generated by participating hospitals from claims paid for members covered by participating commercial, Medicaid, and Medicare payers.
2. Levels at which budgets are established
    - Adopt hospital-level budgets in lieu of system-level budgets.
    - Adopt market-specific budgets for each participating hospital-payer dyad.
3. Services included in the budgets
    - Include all services billed under the hospital Tax Identification Number (TIN), including hospital inpatient, outpatient, and professional services, regardless of place of service.
    - Exclude services provided by hospital-owned provider practices that are billed under a different TIN.
    - Exclude system-owned services from the budget and develop a strategy to monitor for and mitigate against hospitals shifting services (in an undesired manner) out of the budget.
4. How to establish the baseline budgets
    - Use Net Patient Revenue as the basis for developing baseline budgets.
    - Conduct an analysis of hospital finances that includes hospital costs and hospital operating margins to determine if adjustments to the baseline budgets will be needed. The analysis should address what would be a sufficient operating margin to appropriately fund capital investments and investments in services needed by the community.
    - Use 2017-2019 data to model the impact of moving to a hospital global budget. Use more recent data from 2023 onwards when setting budgets for 2026 and evaluate the need for adjustments to account for COVID's impact at that time.
5. How to annually update budgets
    - Adopt a flexible global budget to account for volume changes during the performance year.
    - Develop routine budget adjustments to account for inflation, as well as changes in age, sex and casemix and patient severity.
    - Develop ad hoc budget adjustments to account for approved service line changes, and new technology covered by participating payers for which costs exceed a specified threshold.
    - Develop a process for adjudicating special budget adjustments for major changes in uncompensated care, and modifications to the inflation factor due to market-specific conditions including labor costs and/or major unforeseen changes to hospital costs.
6. How to advance cost, equity, quality and population health goals
    - Incorporate a financial component to quality into the budget, with the specific structure of the financial arrangement to be defined at a future date.

1. Introduction and Background

The Steering Committee established an annual health care cost growth target for the state in 2018 to slow health care spending growth. The Steering Committee subsequently identified the adoption of advanced value-based payment (VBP) models as its primary strategy to support attainment of the state's cost growth target.

In 2022, 20 Rhode Island-based organizations voluntarily signed a compact laying out principles, action steps, and targets to accelerate the adoption of advanced value-based payment (VBP) models in the state. The compact specifically outlined three VBP models that payers and provider organizations should seek to implement:

1. hospital global budgets for facilities and employed clinician professional services;
2. prospective payment for high-volume and high-cost specialty care providers who are not employed by hospitals; and
3. prospective payment for primary care.

The Steering Committee's interest in hospital global budgets stemmed from several analyses pointing to hospital spending as a significant contributor to overall health care spending growth both in Rhode Island and nationally.[1,2] The Steering Committee viewed hospital global budgets as a way to slow the growth in hospital spending and provide financial stability and flexibility for Rhode Island's hospitals.

Under a hospital global budget model, hospitals receive a budget for a defined set of services that is determined prospectively based on anticipated utilization for a specific period. This type of arrangement encourages hospitals to be more efficient in their operations and make strategic decisions to optimize care delivery while staying within budgetary constraints. It provides steady and predictable financing, allowing hospitals to have a revenue stream that is not dependent on utilization. Hospital global budgets also provide hospitals greater flexibility to modify hospital service offerings to best meet community needs and encourages hospitals to coordinate more closely with other health care providers to avoid costly hospitalizations.[3]

The compact established a target for implementing a hospital global budget model by January 1, 2026, contingent upon achieving specific milestones. The first milestone involves the formation of a Hospital Global Budget Working Group (hereafter referred to as the "Working Group") charged with developing consensus recommendations on the key design parameters of a voluntary hospital global budget model that Rhode Island payers and hospitals could adopt. This report presents the results of that work.

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[1] Office of the Health Insurance Commissioner (OHIC), *Health Care Spending and Quality in Rhode Island: 2021 Performance*, May 8, 2023.
[2] Health Care Cost Institute, *2021 Health Care Cost and Utilization Report*, April 2023.
[3] For more detailed information on hospital global budgets, see: Robert Murray, *Hospital Global Budgets: A Promising State Tool for Controlling Health Care Spending*, The Commonwealth Fund, March 22, 2022.

2. Hospital Global Budget Working Group Membership and Process

OHIC invited representatives from the 20 organizations that signed the VPB compact to join the Working Group and conducted special outreach to hospital chief financial officers. However, participation in the Working Group was open to the public. Appendix A lists the individuals who attended at least one meeting.

OHIC conducted 13 hybrid in-person and virtual meetings between July 2022 and July 2023. Agendas, PowerPoint presentations, and summaries for all meetings are available on OHIC's website at: Hospital Global Budget Working Group.

To prepare for the discussions, project staff conducted research on other hospital global budget models, notably those implemented in Rhode Island and Rochester, NY in the 1980s, and current models in Maryland and Pennsylvania.[4] Project staff highlighted design options based on those models, while noting that these models were established under different contexts (e.g., Maryland's regulatory agency has had all-payer hospital rate-setting authority since the 1970s) and may strive to achieve different goals (e.g., Pennsylvania's model aims to improve financial stability of rural hospitals).

While the nature of the Working Group membership allowed for participation from a wide range of stakeholders, certain groups were at times overrepresented or underrepresented based on meeting attendance. In addition, while each member had an opportunity to participate in the discussion and share their perspective, some stakeholder representatives were consistently more vocal than others. Thus, some recommendations may heavily reflect the opinion of stakeholders that were overrepresented and/or most vocal. To provide a balanced perspective, project staff documented various stakeholder groups' viewpoints throughout this report and solicited written feedback on a draft of this report from all Working Group participants.

3. Goals for the Hospital Global Budget Model

At the beginning of the meeting series, the Working Group discussed goals for the hospital global budget model to help guide recommendations around model parameters. The Working Group established the following goals, which were drawn from the VBP compact signed by several organizations represented in the Working Group:

- Reduce the growth rate of health care spending to an affordable and foreseeable level.
- Provide hospitals with predictable revenue to promote financial sustainability.
- Promote access to appropriate care in Rhode Island across all populations, including those who have been historically underserved.
- Enhance coordination and efficiency across delivery systems.
- Support investment in a high-quality clinical workforce and technical innovation in care delivery to support population health management and quality excellence.
- Improve patient experience of care, quality of care, patient outcomes and health equity.

4. Summary of Hospital Global Budget Working Group Discussions and Recommendations

This section of the report documents discussions and recommendations on the following key components of a hospital global budget model:

- Levels at which budgets are established
- Hospital participation

[4] For more details on other hospital global budget models, see: Deepti Kanneganti, Ann Hwang, and Michael Bailit, *State Strategies for Controlling Health Care Costs Implementation Guide: Adopting Multipayer Hospital Global Budgets*, The Commonwealth Fund, January 2023; Centers for Medicare and Medicaid Services, *Maryland Total Cost of Care Model*, May 2023; and Centers for Medicare and Medicaid Services, *Pennsylvania Rural Health Model*, January 2023.

- Services included in the budgets
- How to establish the baseline budgets
- How to annually update budgets
- How to advance cost, equity, quality and population health goals

A key premise for the Working Group's deliberations was that model implementation would be voluntary among payers and hospitals. In making their recommendations, Working Group participants sought design features that would encourage as broad participation as possible, and were feasible to implement in a voluntary model. Additionally, in some cases, the Working Group made recommendations for additional analysis and design work, noting that some recommendations may need to be revisited based on the results of those additional analyses.

A. Discussion and Recommendations on Levels at Which Budgets are Established

The Working Group explored whether budgets should be calculated at the health system or individual hospital level. For the purposes of discussion, a health system was defined as a group of healthcare organizations affiliated with each other through shared ownership or a contracting relationship for payment and service delivery. This includes "vertically integrated" systems comprised of acute care hospitals and physician organizations, and "horizontally integrated" systems that consist of multiple hospitals.

Under a system-level budget, one global budget is calculated for all the hospitals within the system, and the system would be responsible for allocating funds to specific hospitals owned by the system. Budgets calculated at the hospital level would yield a global budget for each individual hospital participating in the model.

Proponents of system-level budgets argued that it promotes financial sustainability and flexibility. They would provide incentives for systems to direct care to more cost-effective hospitals. Systems could also reorient their hospitals to focus on the services they do best.

Proponents of hospital-level budgets argued that services are billed for at the hospital level, and the level at which the hospital global budget is set should follow this practice. Additionally, some argued that setting budgets at the system level would increase complexity due to the evolving relationships between hospitals and systems.

Recommendation:

- Adopt hospital-level budgets in lieu of system-level budgets

B. Discussion and Recommendations on Hospital Participation

The Working Group considered whether hospital participation should be limited to general, acute care hospitals or extended to other specialty hospitals. Currently, Rhode Island has nine general acute care, two psychiatric specialty, and two other specialty hospitals as identified in Table 1 below.[5]

[5] This list excludes the federally-owned and operated VA Hospital, and the state-owned and operated Eleanor Slater Hospital. These hospitals are not included given their different financing structure which makes them unsuitable for a hospital global budget model.

Table 1: Rhode Island Hospitals by Type

General Acute Care	Psychiatric	Other Specialty
• Kent Hospital • Landmark Medical Center • Miriam Hospital • Newport Hospital • Our Lady of Fatima Hospital • Rhode Island Hospital / Hasbro Children's Hospital • Roger Williams Medical Center • South County Hospital • Westerly Hospital	• Bradley Hospital • Butler Hospital	• Rehabilitation Hospital of Rhode Island • Woman & Infants Hospital of Rhode Island

Several participants advocated for allowing specialty hospitals to participate in the model. They argued that treating psychiatric hospitals differently would further divide care delivery and impede efforts to integrate physical and behavioral health care. They stated that including psychiatric hospitals in a hospital global budget model would be crucial to increasing investment in psychiatric services to address psychiatric boarding and provide care continuity. Some noted that if psychiatric hospitals were included, careful consideration needs to be given to how to translate their current payments into a global budget payment, since they are paid differently due to insurers carving out behavioral health in their contracting.

A few participants indicated that without proper safeguards, hospital global budgets could incentivize hospitals to reduce utilization to stay within the budget. Excluding specialty hospitals from the global budget could protect against limiting the specialty services they provide. Some also suggested that a phased implementation of hospital global budgets with specialty hospitals might be more prudent, like how the Medicare Inpatient Prospective Payment System (IPPS) was initially implemented with acute care hospitals, and later extended to psychiatric hospitals.

Recommendation:

- Consider global budgets for all hospitals, including specialty hospitals

C. Discussion and Recommendations on Services Included in the Budgets

The services included in the global budget can significantly influence hospitals' incentives to coordinate care. The current hospital global budget models in Maryland and Pennsylvania, and previous models in Rhode Island and Rochester, encompass inpatient and outpatient hospital services, but exclude professional services and services delivered in non-hospital owned facilities. The Working Group deliberated on the scope of services that should be captured in a hospital global budget.

Inpatient, Outpatient, and Professional Services Delivered in the Hospital Setting

The Working Group agreed that inpatient and outpatient hospital services should form the foundation of what is included in a global budget, but they also recognized the need for a more specific definition. The Working Group considered using Medicare's definition of hospital inpatient and outpatient services, to which Medicaid and commercial plans often align.

Participants discussed potentially excluding high-cost, low-frequency inpatient and outpatient services that could significantly impact hospitals' ability to meet their budget and for which it might be challenging to plan. They also explored the idea of conducting an analysis of outlier spending, with a focus on quaternary care services such as organ transplants and other highly specialized surgeries. The Working Group also proposed excluding services in areas that the state has prioritized for spending growth, such as primary care and behavioral health.

The discussion of professional services revealed that hospitals within the different health systems have different contractual and billing arrangements with physicians for professional services. For example:
Lifespan hospitals have contracted providers who render services that are billed by the hospital under its Tax Identification Number (TIN); contracted providers who bill separately for their services; and hospital-employed providers whose services are billed by the hospital under its TIN.
Landmark has a medical group that is independent but bills under its hospital TIN.
Care New England hospitals have a very small number of employed physicians. Most physicians are part of a medical group that is affiliated with the larger health system, and that bills separately from the hospitals.
South County bills under a separate, non-hospital TIN for its employed professionals.

Some participants advocated for including all professional services that are delivered in the hospital setting, noting that the ability to control the cost of professional services hinges on how a hospital contracts, and not how the hospital bills for the services. They also noted that hospitals have more influence over health system-owned physician groups than over independent physician groups.

However, others raised concerns about the feasibility of including revenue from professional services that are not billed under the hospital TIN. Providers who render those services are part of a separate corporate and legal entity. As such, hospitals have limited ability to influence their practices, nor can hospitals count their revenue towards their global budget.

Recommendation:

- Include revenue for hospital-owned entities, including satellite clinics and facilities, which are billed under a hospital TIN. This includes:
  - Hospital inpatient and outpatient services billed under the hospital TIN.
  - Services delivered by all professionals who bill under the hospital TIN (including employed and contracted, non-employed professionals), regardless of place of service.

Services Delivered in System-Owned, Non-Hospital Facilities

The Working Group also discussed whether non-hospital-based services, specifically professional services delivered by system-owned medical practices and facilities, should be included in the model.

Some felt that including revenues from other system-owned assets would reduce the complexity around which professional services to include in the model and incentivize coordination of care within a system, thereby reducing leakage. These participants argued that health systems should focus on controlling the total cost of care across care settings and not just on the costs of the hospital.

Those who disagreed with including services from non-hospital, system-owned assets expressed the view that doing so went beyond the terms of the VBP compact. They indicated that hospital global budgets should be limited to hospital revenue.

As a compromise, participants discussed excluding non-hospital, system-owned services from the global budget, but monitoring system-level revenues as part of the model evaluation to understand the global budget's impact on the larger health system.

Recommendation:

- Exclude system-owned services from the budget and develop a strategy to monitor for and mitigate against hospitals shifting services (in an undesired manner) out of the budget.

D. Discussion and Recommendations on How to Establish the Baseline Budgets

Establishing a baseline budget that is adequate to fund needed care and support essential functions, while minimizing waste, is a critical step in the process. To establish an appropriate baseline budget, it is important to: (1) define the measure used to build the baseline budget; (2) define the methodology for building each budget; and (3) identify the year or years of data that will be used to develop the baseline budget.

Defining the Measure Used to Build the Baseline Budgets

Working Group participants discussed whether to use hospital operating expenses versus revenues to establish baseline budgets. Some participants indicated that for the Rhode Island hospital global budget model established in the 1980s, budgets were based on hospital expenses. They said using operating expenses as a basis for developing the baseline budget would reflect the cost to hospitals of providing services and ensure hospitals' financial sustainability. Others noted the lack of standardization in the way hospitals report operating expenses creating a problem for expense-based budget development, and added a concern that using operating expenses to set budgets would not incentivize hospitals to be more efficient.

As an alternative, some participants supported using Net Patient Revenue, which represents the aggregate dollars collected from payers for patient services, including private insurance, Medicaid, and Medicare. They argued that this metric is the most appropriate given a hospital global budget is a type of payment reform, and Net Patient Revenue reflects insurer payments.

Hospital representatives were concerned with focusing just on revenues, arguing that current reimbursement rates do not sufficiently fund operating costs. This situation has led to Rhode Island hospitals deferring capital improvements and having an average "age of plant" that is much higher than the U.S. average.[6] Some pressed on the need to consider competition with neighboring states such as Connecticut and Massachusetts for labor. They argued that lower reimbursement rates in Rhode Island make it difficult for hospitals in the state to recruit and retain qualified providers. They also indicated that Medicaid rates would need to be increased to make a hospital global budget model viable, arguing that low Medicaid payments cause them to "cost shift" to commercial payers.[7] Some also pointed out that hospitals shoulder some of the financial costs of Medicaid's low reimbursement rate in the form of the hospital tax that is used to help fund the program. Hospital representatives were concerned that using revenues based on current payment rates would make permanent certain payment inequities that put Rhode Island hospitals at a disadvantage.

Other participants acknowledged that COVID and its economic aftershocks significantly weakened hospitals' finances, and this needs to be accounted for. However, some questioned the need for broad-based payment rate increases. They countered that decisions health care workers make about where to work are more nuanced and are not just about the salary hospitals offer. Decisions consider cost of living, and other intangible factors. They also contended that if commercial insurers are subsidizing low Medicaid reimbursement rates, then a future increase in Medicaid rates should eliminate the alleged cost-shifting that occurs between Medicaid and commercial payers, and therefore, Medicaid rate increases should be accompanied by a corresponding rate decrease for commercial payers. Further, some participants acknowledged that hospitals could improve their operating margins if they focus on improving cost-efficiency rather than only relying on an increase in payment rates.

Working Group participants agreed on the need to fully understand the state of hospitals' finances before setting the baseline budget. They agreed that baseline budgets should consider revenues, expenses, operating margins, and uncompensated care. The Working Group also discussed ways to obtain data and understand hospitals' financial standing, with some indicating the importance of having a "single source of truth." Developing this capacity would require a significant investment given the lack of a standardized approach to hospital accounting.

[6] According to Definitive Healthcare, the average healthcare facility age nationally and in Rhode Island is 13.5 years, see: https://www.definitivehc.com/resources/healthcare-insights/us-states-average-healthcare-facility-age.

[7] The literature on hospital payments do not support the argument that providers negotiate higher prices with commercial insurers to offset lower prices paid by government programs. See: Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*, January 20, 2022; and Michael Chernew, Hongyi Ye, Harrison Mintz, and Nancy Beaulieu, *Public Payment Rates for Hospitals and the Potential for Consolidation-Induced Cost-Shifting*, Health Affairs, Vol 40, No 8, August 2021.

Recommendations:

- Use Net Patient Revenue as the basis for developing baseline budgets. Baseline budgets could be adjusted based on an analysis of hospital finances that includes hospital costs and operating margins.
- Conduct an analysis of hospital finances that includes hospital costs and hospital operating margins to determine if adjustments to the baseline budgets will be needed. The analysis should address what would be a sufficient operating margin to appropriately fund capital investments and future programs.

Defining the Methodology for Building Each Hospital's Budget

Building a global budget requires defining the population whose services will be covered by the budget, and the approach for calculating the budget. This is particularly important in a voluntary model, such as the one being explored in Rhode Island, to ensure there are no over- or under-payments.

Other models, such as those implemented in Maryland and Pennsylvania, define a hospital's population using primary service areas or geographic regions from which the majority of a hospital's market share is drawn. However, this approach is difficult to implement in Rhode Island given its small geographic size, and the presence of several hospitals in the same geographic area.

Rather than defining the population, Working Group members considered a proposal to develop the baseline budget using claims paid for members insured by participating commercial, Medicaid and Medicare payers who received services at a participating hospital. Most of the Working Group members agreed with this proposal, but highlighted that participation from most, if not all, payers in the state would be necessary for success.

The Working Group also discussed the approach for building each hospital's budget. It considered a proposal to use a "bottom-up" approach, which involves setting budgets for each payer-market dyad within a hospital and rolling those up to calculate the hospital budget. There was general support for this approach, with Working Group members noting that some payers that serve multiple markets often operate independently and would likely prefer this "bottom-up" approach. It was also noted that the state budgeting process which determines Medicaid spending makes it difficult to establish one budget across all payers and markets.

One member advocated for a "top-down approach" that establishes one budget for each hospital across all payers and markets, like how Maryland develops its budget. However, others noted that this approach would require a lot of state regulatory infrastructure and may not be feasible in a voluntary model such as the one Rhode Island is trying to develop.

Recommendations:

- Use hospital revenue generated by participating hospitals from claims paid for members covered by commercial, Medicaid and Medicare payers as the basis for developing baseline budgets.
- Adopt market-specific budgets for each participating hospital-payer dyad.

Identifying the Year or Years of Data that Will be Used to Develop the Baseline Budget

Other state models use financial data from one or more prior years to establish the baseline. For example, Maryland used data from the most recent year before implementing its model, while Pennsylvania used an average of the three most recent years before implementation. However, COVID-19 significantly altered the landscape of hospital finances, making it difficult to rely on data from 2020 through 2022, and potentially 2023. Hospital representatives were particularly concerned that using years during which hospitals experienced negative margins to set the baseline budget would produce payment levels that were insufficient to cover costs, and eventually lead to hospitals' insolvency.

Many Working Group members expressed the need to understand how revenues under a global budget would compare to revenues under the current payment system. Some recommended using three years of

pre-COVID data to model a hospital global budget; this concept received general support. However, it was noted that using pre-COVID data would not account for the recent significant increases in labor costs. Therefore, some members suggested that additional modeling adjustments might be needed to accommodate hospitals' increased labor costs.

Recommendations:

- Use 2017-2019 data to model the impact of moving to a hospital global budget. Use more recent data from 2023 onwards when setting budgets for 2026 and evaluate the need for adjustments to account for COVID's impact at that time.

E. Discussion and Recommendations on How to Update Budgets

The methodology for updating budgets ensures that hospitals receive sufficient revenue to fund necessary services while still motivating them to improve efficiency. There are several types of budget adjustments, including: (1) adjustments during the performance year to account for volume changes; (2) annual adjustments to accommodate routine changes; and (3) ad hoc adjustments to address irregular events or "known unknowns" that impact hospital costs.

Budgets Adjustments During the Performance Year

The Working Group discussed two approaches for hospital global budgets: a fixed global budget and a flexible global budget. With a fixed global budget, hospitals receive a guaranteed amount of revenue per year that does not change based on volume increases or decreases; therefore, there are no further budget adjustments during the performance year. However, hospital payments with a flexible global budget have two components: one component is "fixed" so hospitals are guaranteed an amount of revenue to cover fixed costs when utilization declines, and one component is "variable" or fluctuates to cover variable costs associated with increases in volume during the performance year.

Some participants commented on the shortfalls of both fixed and flexible global budget models, including the need to retain the current claims processing system to monitor volume changes and potential reduction in shared savings that accountable care organizations (ACOs) could accrue compared to the current fee-for-service (FFS) system. However, participants acknowledged that the status quo (FFS approach) did not provide hospitals with sufficient revenue or flexibility. The Working Group then evaluated the advantages and disadvantages of fixed and flexible global budgets.

Participants supported flexible global budgets with quarterly budget reconciliations over fixed global budgets because it provides protection for hospitals even if there are unexpected events that impact volume, such as the COVID-19 pandemic. Flexible global budgets also reduce hospitals' incentives to stint or shift care outside of the hospital global budget and reduce hospitals' incentive to increase utilization to generate profit. Participants highlighted that flexible global budgets can better accommodate ACO shared savings agreements, as discussed in "Discussion and Recommendations on How to Advance Cost, Equity, Quality and Population Health Goals" below, compared to fixed global budgets. Furthermore, quarterly adjustments offer several opportunities to correct budgets during the performance year, which may prevent cash flow issues resulting from unexpected drastic changes in utilization.

The Working Group then considered how to implement a flexible global budget model, which included discussions of how to identify fixed and variable hospital costs and how to measure volume for inpatient, outpatient and professional services.

Recommendation:

- Adopt a flexible global budget to account for volume changes during the performance year and adjust budgets on a quarterly basis.

Fixed and Variable Hospital Costs

Under a flexible budget, it is important to define fixed and variable costs since it determines how much of the hospital's revenue would vary based on utilization during the year. The Working Group raised several important considerations for defining fixed and variable hospital costs. There is no universally accepted definition of fixed costs (e.g., buildings, equipment, salaries), which do not change based on utilization in the short term, and variable costs (e.g., medication, supplies), which do vary based on utilization. Fixed and variable costs may differ by hospital and/or revenue center due to variation in utilization and service offerings. For example, smaller hospitals with low utilization likely have a higher proportion of fixed costs compared to a larger hospital with high utilization. In addition, all costs could be considered variable costs over a long enough period.

Participants estimated that 60 to 70 percent of hospital costs are fixed and 30 to 40 percent are variable. They also acknowledged that using different proportions of fixed and variable costs by hospital may introduce too much complexity into the model. The Working Group recommended deferring to hospital finance experts to provide input on the definition of fixed and variable costs over a one-year period, as well as the percentage of fixed and variable hospital costs by revenue center.

Recommendation:

- Survey Rhode Island hospital CFOs to provide input on the definition of fixed and variable costs and the percentage of fixed and variable costs by hospital and revenue center.

Measuring Inpatient, Outpatient and Professional Services Volume

Making budget adjustments during the performance year requires a consistent approach across hospitals to measuring inpatient, outpatient and professional services volume.

To measure hospital inpatient volume, the Working Group considered and recommended adapting Maryland's approach by using case mix-adjusted discharges (CMADs). To calculate CMADs, payers and hospitals would multiply hospital discharges, summed by diagnosis-related groups (DRGs), with a case weight assigned to each DRG, which considers the resource intensity required to deliver specific groups of services. Several participants highlighted that select services that are paid on a per diem basis (e.g., Medicaid behavioral health payments) would need to be converted to DRGs. Other participants raised the need to consider outliers in terms of number of inpatient days and length of stay.

On measuring outpatient volume, participants agreed that the approach should take resource use into consideration. However, the Working Group did not reach consensus on the specifics of how to categorize outpatient services or account for resource use. Participants suggested convening a technical work group to evaluate two approaches. One approach uses Ambulatory Payment Classifications (APCs), which is the outpatient-equivalent of DRGs. Another approach establishes Equivalent Case Mix Adjusted Discharges (ECMADs), which is an equivalent approach for outpatient resource use based on inpatient resource use. To calculate ECMADs, payers and hospitals would divide total revenue for outpatient services by the revenue for CMAD calculated for inpatient services. Participants acknowledged the ECMADs provide a simple approach for measuring outpatient volume, but expressed concern that the approach was too high-level and treated all outpatient services as equivalent. Participants suggested developing a more nuanced approach to calculating ECMADs based on categories of outpatient services (e.g., laboratory services, imaging services). One participant noted the need to consider shifts in unlisted code revenue, which can be significant.

To measure and adjust for changes in volume of professional services, participants unanimously agreed upon using Relative Value Units (RVUs). They appreciated that CMS uses RVUs to determine physician payment for Medicare and take resource use into consideration. Participants indicated that RVUs are also commonly used to determine compensation for non-salaried physicians.

Recommendations:

- Use Case Mix Adjusted Discharges (CMADs) to measure inpatient volume but perform further research on: (1) how to convert per diem behavioral health and Medicaid payments to DRGs; and (2) how to address outliers.
- Task a technical work group with developing an approach for measuring outpatient volume that uses either APCs or that establishes ECMADs using categories of outpatient services.
- Use RVUs to measure professional services volume.

Annual Budgets Adjustments

The Working Group considered several annual budget adjustments for routine factors that affect hospital budgets. Participants advocated for an annual demographic adjustment for changes in the age, sex and case mix profile of patients served by the hospital. The Working Group recommended convening a subgroup of technical experts to develop an approach for calculating the demographic adjustment. Some observed that other variables, such as race and income, also influence resource use and, consequently, budget adjustments. However, the Working Group recommended revisiting social risk when discussing supplemental financial and reporting arrangements to complement a hospital global budget.

They also recommended adopting an annual inflation adjustment to account for changes in the cost of producing services. The Working Group evaluated two approaches to developing an annual inflation factor: a negotiated approach and a formula-driven approach. Proponents of the former approach noted that Rhode Island's hospital prospective payment system from the 1970s negotiated annual inflationary increases. They argued that a negotiated approach would ensure the inflation adjustment is Rhode Island-specific and help build trust between hospitals and other stakeholders. Other stakeholders preferred a formula-driven approach because it would establish a common parameter for how to define inflation on an annual basis and would be simpler and more feasible to implement given the number of payers in today's market. In addition, a formula-driven approach would incentivize hospitals to focus on improving efficiency, whereas a negotiated approach would be too similar to a cost-based reimbursement model.

The Working Group then explored two lenses for considering inflation:

- a hospital cost lens (e.g., Medicare Market Basket Index, Consumer Price Index for All Urban Consumers (CPI-U)), which ensures that hospitals remain viable by adequately considering the annual changes in input prices they face, and
- an affordability lens (e.g., median household income, state Cost Growth Target), which protects consumers' interests and ensures hospital spending grows at an affordable rate.

Participants, notably hospital representatives, expressed concern with adopting an affordability lens because historically, they argued, inflation in medical input costs has outpaced regular inflation. They questioned whether an affordability-based inflation factor would sufficiently cover the full cost increases that hospitals will face. Further, an analysis of historical trends found that median household income is more volatile than cost-based approaches.

Participants coalesced around using the Medicare Market Basket Index, excluding CMS' productivity adjustments, to prospectively adjust budgets for inflation. The Working Group highlighted that the Medicare Market Basket Index is produced annually by CMS, is a neutral source of hospital cost growth and is in use by Maryland for its hospital global budget model. Some participants, however, still raised doubt that a national inflation factor, such as the Medicare Market Basket index, would sufficiently address Rhode Island-specific market factors that impact hospital costs. Hospital representatives also did not believe the Medicare Market Basket index accurately accounts for increases in labor costs.

Some participants expressed concern that a formula-driven approach based on a national inflation metric would not sufficiently cover the cost increases that Rhode Island hospitals will face. For example, wage increases, which represent a significant portion of hospital budgets and are subject to negotiation, could be greater than the annual inflation increase. Some participants also highlighted the need to know inflation

factor adjustments in advance of the performance period so that insurers could accurately account for them in their annual rate filings. Participants then commented that there could be additional changes during the performance period that warrant retrospective adjustment, but recommended adopting risk-corridors to inform retrospective budget adjustments. The Working Group acknowledged the need for a structured, potentially multi-year process to inform prospective and retrospective adjustments to the inflation factor.

Recommendations:

- Develop routine budget adjustments to prospectively account for changes in:
    - Age, sex and case mix. Task a technical subgroup to develop the calculation for this demographic adjustment.
    - Inflation using the Medicare Market Basket Index without productivity adjustments.

Develop a structured process for adjudicating special adjustments to the formula-driven approach due to market-specific conditions and/or major unforeseen changes to hospital costs, such as unanticipated increases in labor costs, which are not well-reflected in the Medicare Market Basket Index. Set threshold/corridors for retrospective adjustments for unforeseen and major hospital cost increases.

Ad Hoc Budget Adjustments

The Working Group reviewed how to address two types of ad hoc budget adjustments: approved ad hoc adjustments for irregular but predictable events and special budget adjustments that account for “known unknown” factors that impact hospital budgets.

Approved Ad Hoc Budget Adjustments

The Working Group discussed how to address events that are predictable but occur sporadically and that could increase hospital costs and impact hospitals’ ability to maintain their budgets. These include capital improvements, planned service line changes, and the introduction of new technologies.

Participants discussed whether to make special adjustments for capital improvements, and if so, the mechanism for making such adjustments. One participant noted that in Rhode Island’s previous hospital prospective payment system, hospitals received automatic budget adjustments for interest and depreciation if their Certificate of Need (CON) application was approved; other adjustments were negotiated through the budget process. One discussed option was to use the CON process to identify capital investments that might call for budget adjustments. Health plan representatives noted that the cost of special adjustments for capital improvements would be borne by health plans participating in the hospital global budget model and would put them at a financial disadvantage relative to non-participating health plans. Hospitals expressed concern with relying on the current CON process, which they claimed is outdated and has a low financial threshold. They added that many capital investments, such as replacement capital, information technology, and equipment do not go through the CON process. Hospitals indicated that their 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.”

The Working Group also discussed planned service line changes, i.e., the addition of new services – with the approval of the Rhode Island Department of Health – that were not included in the baseline budget, or the halting of existing services that were included in the baseline budget. The Working Group considered a proposal for hospitals to receive prospective budget adjustments for planned service line changes that have an expected impact of plus or minus 0.5 percent of budget payments. One participant shared that this approach is like the one adopted by Rhode Island in the 1970s for its hospital prospective payment system and highlighted the importance of aligning service line changes with state health care planning. One participant questioned the purpose of making additional adjustments for service line changes, adding that part of the goal of a hospital global budget is to incentivize hospitals to provide community-based services to prevent expensive hospitalizations.

Finally, the Working Group discussed adjustments to address the introduction of new drugs and medical technology that can have significant impact on hospital budgets. Maryland, for example, introduced a one-time budget adjustment for hospitals in 2019 to fund the introduction of high-cost biologics and outpatient-administered treatments, such as Spinraza (a medication used in treating spinal muscular atrophy) and CAR-T (a treatment that uses such transformed cells for cancer therapy). The Working Group suggested carving out new medical devices and pharmaceuticals that meet a specified, to-be-defined dollar threshold and pay for such technologies on a FFS basis. It further recommended that after three years and if the technology is covered by participating payers, a future body should evaluate whether payment for the technology should be incorporated into the budget. Participants acknowledged the need to develop separate thresholds for individual unit prices as well as aggregate cost based on utilization and to assess whether the new technology is advantageous and aligned with state goals.

Recommendations:

- Develop ad hoc budget prospective adjustments to account for:
  - Approved and planned service line changes.
  - New medical devices and pharmaceuticals that are covered by participating payers and meet a specified dollar threshold. Carve out such technologies from the global budget and pay on an FFS basis for the first three years. Then evaluate whether the payment for the service should be incorporated into the budget.
- Adjudicating Special Budget Adjustments
  - Do not make special budget adjustments for planned capital improvements. Instead, ensure the baseline budgets provide sufficient operating margins to allow hospitals to regularly invest in capital improvements and needed services.

Special Budget Adjustments

Throughout the hospital global budget development process, the Working Group indicated that hospitals will encounter a series of “known unknown” incidents that will require adjustments. Some participants advocated for developing a structured process to account for these events, which helps standardize how budgets are calculated across payers and hospitals. As discussed in the prior section, the Working Group already acknowledged market-specific conditions and/or major unforeseen changes to hospital costs that could impact the annual inflation adjustment. The Working Group also considered a special adjustment for uncompensated care.

The Working Group adopted a working definition of uncompensated care as free care or charity care, which the hospital provides at no cost to the patient, and bad debt, which the hospital bills for but does not collect. There were differing views for how to account for uncompensated care. Some participants indicated that making an additional adjustment for uncompensated care would be duplicative of existing adjustments such as federal disproportionate share hospital (DSH) payments, and potential baseline budget adjustments to close the gap in hospital operating budgets that the Working Group already recommended incorporating. These multiple adjustments would increase spending and negatively impact consumer affordability. Others expressed concern that excluding uncompensated care could negatively impact hospitals if uncompensated care grows because of rising deductibles. This would force hospitals to cut services for which reimbursements do not adequately cover costs, thus hurting consumer access. The Working Group agreed to analyze historical patterns of uncompensated care using data from Schedule H, Line 7 of the federal Form 990. The Working Group or a successor body would use the data to develop a formal definition of uncompensated care and plan to monitor and adjust for uncompensated care.

Recommendations:

- Develop a structured process for adjudicating special budget adjustments for major changes in uncompensated care. Specifically, use data from Form 990, Schedule H, Line 7 to analyze historical patterns of uncompensated care. Use the data to develop a formal definition of uncompensated care and a regular plan to monitor and adjust for uncompensated care.

F. Discussion and Recommendations on How to Advance Cost, Equity, Quality and Population Health Goals

In addition to global budget design, states have leveraged supplemental financial arrangements and/or reporting requirements to advance the goals of a hospital global budget. These arrangements can either incentivize hospitals for performance within the hospital system, or outside the hospital system.

Incentivizing Hospitals for Performance Within the Hospital System

Other states, such as Maryland and Pennsylvania, use quality measures to incentivize hospitals to improve care coordination, clinical outcomes, equity, patient safety and patient engagement within the hospital system. For example, Maryland hospitals can earn additional incentives for improving hospital quality performance (e.g., hospital-acquired infections, mortality rates) and for reducing disparities in readmission rates.

The Working Group acknowledged the significance of advancing high-quality care and recognized the existing hospital-focused quality requirements outlined in OHIC's Affordability Standards. Some participants expressed concern about implementing an additional quality-focused arrangement due to the level of effort required to transition to a new payment model. One participant emphasized that financial accountability for quality is necessary, especially with the implementation of a new model. Participants suggested including a hospital quality-focused financial arrangement that builds upon existing state and national quality programs but defining the structure of the arrangement at a future date.

Recommendation:

- Include a financial arrangement based on a hospital's quality performance, with the specific structure of the financial arrangement to be defined at a future date.

Incentivizing Hospitals for Performance Outside the Hospital System

One goal of a hospital global budget model is to provide hospitals with the flexibility to reallocate their assets to best meet their communities' needs. The Working Group explored the use of community-focused quality measures, such as improved access to primary and behavioral health care services, as incentives to encourage this behavior. However, participants expressed concern about holding hospitals accountable for community-level performance that are subject to factors outside of a hospital's control. This could divert focus away from improving hospital care. Instead, they recommended leveraging other initiatives, such as enhanced investment in primary care, to advance community-focused goals.

A hospital global budget could also include adjustments based on hospital performance on total cost of care (TCOC). For example, Maryland hospitals receive an adjustment for the traditional Medicare portion of their budgets based on TCOC for an attributed population. This topic garnered particular interest given the prevalence of ACO TCOC models in Rhode Island.

The Working Group acknowledged that compared to the status quo, a flexible hospital global budget may generate fewer shared savings because the increase or decrease in hospital payments resulting from increased or decreased utilization is smaller. However, spending on hospital services will still vary based on utilization, providing an opportunity for ACOs to share in savings. Further, ACOs and hospitals could establish their own shared savings arrangements since ACOs and community providers are crucial partners in helping hospitals manage global budgets. The Working Group also acknowledged that hospital global budgets capture patients served by the hospital, which may or may not overlap with patients attributed to an ACO.

Participants expressed interest in retaining use of ACO TCOC arrangements, even with the adoption of a hospital global budget, as they create unique incentives for community-based physicians. There was consensus to keep ACO TCOC arrangements separate from hospital global budgets because there are still incentives for hospitals and ACOs to work together. Specifically, in today's environment, ACOs factor hospital rate increases into their approach for meeting TCOC targets.

Recommendation:

- Include community-based performance measures as part of an ongoing monitoring plan.
- Do not adjust hospital global budgets based on TCOC performance, but allow for current ACO shared savings arrangements to continue.

5. Areas for Future Development

The Working Group outlined key parameters for a hospital global budget model in Rhode Island. However, several issues remain unresolved and will need further development should providers and payers decide to move forward with this effort.

The VBP compact, which called for the formation of a work group to identify key parameters for a hospital global budget model, also directed the completion of an independent study of hospital costs and cost shifting by July 1, 2024. The Working Group also discussed the need for a technical subgroup of hospital finance experts to evaluate and use this study, as well as any additional assessments of hospital financials, to inform the following:

- which services to exclude from the model (e.g., high-cost services, services with variable utilization, areas where there is a state commitment to expanding access to care);
- what adjustments, if any, would need to be made to the baseline budget to allow for sufficient hospital operating margins to fund necessary services and capital improvements; and
- the impact of moving from the current payment system to a hospital global budget model.

The Working Group acknowledged the need for additional subgroups with appropriate subject matter expertise to further develop some of its initial recommendations, such as how to calculate an annual demographic adjustment that accounts for changes in age, sex and case mix; how to measure outpatient volume using APCs or ECMADs; and how to structure a supplemental quality-focused financial arrangement. In addition to the recommendations outlined above, the Working Group advocated for developing several monitoring plans, including evaluating changes in revenue by care setting to assess whether hospitals shift revenue to non-hospital-owned settings excluded from the budget; observing patient cost-sharing obligations to understand whether financial risk is being unfairly transferred to patients; and creating an inventory of current billing practices by health system to inform how to mitigate against unintended consequences associated with changes in accounting practices.

OHIC also outlined several additional topic areas for the Working Group or a successor body to discuss to finalize model development and inform implementation:

- identify if and how the model should allow for different payers to vary from the recommended model;
- identify opportunities to mitigate hospital technical and financial risk;
- create a plan for monitoring progress towards model goals to ensure accountability and inform design modifications;
- determine who will be responsible for calculating hospital global budgets and
- determine who should manage and oversee the hospital global budget initiative.

6. Conclusion

The Hospital Global Budget Working Group sought to develop recommendations on the broad parameters of a hospital global budget model that could be voluntarily adopted in Rhode Island. The Working Group represented a broad group of stakeholders, and the discussions and preliminary recommendations described in this report reflect this diversity, as well as the challenges associated with implementing significant payment reforms. The recommendations made and issues raised by the Working Group represent a starting point for interested parties to continue exploring as they work towards the goal to lower health care cost growth in the state.

Appendix A: Organizations Represented by Hospital Global Budget Working Group Participants

Aetna	Neighborhood Health Plan of Rhode Island
Amica Mutual Insurance	Newport Hospital
Blue Cross Blue Shield of Rhode Island	Point32Health
Bradley Hospital	Prospect Medical
Brown University	Rhode Island Business Group on Health
Butler Hospital	Rhode Island Health Center Association
Care New England	Rhode Island Hospital
Coastal Medical	Rhode Island Foundation
CVS Health	Rhode Island Medical Society
Executive Office of Health and Human Services	Rhode Island Public Expenditure Council
Hasbro Children's Hospital	Rhode Island Parent Information Network
Hospital Association of Rhode Island	South County Hospital
Integra Community Care	UnitedHealthcare
Kent Hospital	Westerly Hospital
Landmark Hospital	Women & Infants Hospital
Lifespan	