Rhode Island Hospital Global Budget Working Group
Meeting #2 Summary
OHIC Conference Room
1511 Pontiac Ave, Building 69-1, Cranston
August 18, 2022
1:45 – 3:15 PM

Attendees:

- Patrick Tigue, Office of the Health Insurance Commissioner
- Cory King, Office of the Health Insurance Commissioner
- January Angeles, Bailit Health
- Deepti Kanneganti, Bailit Health
- Bob Murray, Global Health Payment
- Garry Bliss, Prospect Medical
- Scott Boyd, Amica Mutual Insurance Company
- Tom Breen, South County Health
- Doreen Carlin-Grande, NHPRI
- Al Charbonneau, Rhode Island Business Group on Health
- Michael DiBiase, Rhode Island Public Expenditure Council
- Chris Dooley, Prospect Medical
- Shamus Durac, Rhode Island Parent Information Network
- Peter Hollmann, Rhode Island Medical Society
- Nick Lefeber, Blue Cross Blue Shield of Rhode Island
- Dan Moynihan, Lifespan
- Elena Nicolella, Rhode Island Health Center Association
- Teresa Paiva-Weed, Hospital Association of Rhode Island
- Aaron Robinson, South County Health
- Lisa Tomasso, Hospital Association of Rhode Island
- Ira Wilson, Brown University

I. Welcome

- January Angeles welcomed the Hospital Global Budget Working Group and introduced Bob Murray, a former Executive Director of the Maryland Health Services Cost Review Commission (HSCRC). She said Bob will attend Working Group meetings and will serve as a technical expert.
- January Angeles reviewed the meeting agenda.

II. Define Goals and Criteria

- January Angeles shared six draft goals for hospital global budgets that pull from the VBP Compact and OHIC's goals for Rhode Island hospitals. She explained that the goals focus on high-level outcomes the Working Group hopes the model will achieve whereas the criteria, which the Group will discuss later, focus on how the recommended model would achieve the goals, and would be used later to evaluate specific model elements. She invited comment from the Working Group.

- Teresa Paiva-Weed recommended rewording goal six so it also focuses on improving and maintaining access to care.
- Aaron Robinson raised concerns about the first goal's premise that health care is unaffordable and the growth rate is high in Rhode Island. He recommended assessing whether spending in Rhode Island is appropriate relative to market trends in New England.
- Patrick Tigue said the first two goals align with the VBP Compact, which states that there needs to be a lower health care spending growth rate to improve affordability and that there are genuine issues with hospital financial stability.
- Al Charbonneau highlighted that efficiency, referenced in the third goal, is important because health systems may not be able focus on certain care elements given high costs in other expense categories (e.g., nursing wages). Al recommended addressing stinting, the focus on the sixed goal, and low-value care at a system level, not as part of the hospital global budget model.
- Aaron Robinson commented that the fourth goal should explicitly call out having a sufficient and qualified workforce, which is essential for achieving quality goals. He added that Rhode Island hospitals have challenges recruiting and retaining clinical staff because of the state's low fee schedule and national provider shortages. Peter Hollman recommended revising the fourth goal to reference "technical innovation and a high quality clinical workforce."
- Teresa Paiva-Weed questioned whether the need to increase Medicaid and Medicare rates to increase financial sustainability conflicted with any of the draft goals.
- Michael DiBiase said the goal of setting the cost growth target was to keep the health care growth rate in line with gross state product (GSP) trends. The Steering Committee also determined that the hospital global budget model is one of the key strategies the state would pursue to meet the cost growth target. Therefore, if hospital input costs increase, other factors would need to change to offset those increases. Michael said if the Working Group believes that spending on hospital services should grow at a faster rate than GSP, then it is not reasonable to develop a hospital global budget methodology.
- Teresa Paiva-Weed said Rhode Island hospitals supported a cost growth target before the pandemic, but now they are concerned with supply chain issues, labor issues, etc.
- Al Charbonneau shared that an efficient market is one that drives innovation and change at an affordable rate, which is not the case for Rhode Island Hospitals. Al added that hospital global budgets provide hospitals with a guaranteed income, which would have been helpful during the pandemic. He also noted that the fixed revenue unleashed substantial innovation in the New York model.
- Shamus Durac expressed concern around having primary vs. secondary goals. He noted that focusing on slowing cost growth as a primary goal may come at the expense of not making progress on quality and access. He said the Working Group should prioritize both types of goals.
- Patrick Tigue noted that the draft goals draw from the VBP Compact, which members of the VBP Subcommittee (which includes several members of the Hospital Global Budget Working Group) signed as a means of advancing the goals identified in the Cost Growth Target compact. He expressed confidence in the Working Group coming to consensus on model goals. If not, then the Working Group will need to reconsider the meaning behind the VBP Compact.

- January highlighted the importance of having clear, articulate goals because these goals will influence model design. January and Patrick summarized that there appeared to be consensus around the goals at a high level, but that there will need to be some additional editing.
- January introduced the draft criteria that the Working Group will use to inform the development and evaluation of its recommended model. She said that based on the conversation so far, there may need to be an additional criterion focused on payment levels for commercial, Medicaid and Medicare. Patrick indicated that the VBP Compact may have language focused on this topic.
- Dan Moynihan expressed concern that inclusion of the third criterion meant the model must include professional spending in the model. Chris Dooley indicated that this may make it challenging for hospitals to recruit and employ physicians.
- Peter Hollman said he was comfortable retaining the third criterion because it's important to consider. He noted that the Working Group did not need to recommend inclusion of professional spending because of the criterion. January agreed and suggested revising the criterion to focus on aligning incentives across hospitals and professional services.
- Dan Moynihan and Teresa Paiva-Weed asked whether ambulatory surgical centers and independent physician organizations would be included in the model. January said the Working Group will revisit this question in detail in a subsequent meeting.
- Dan Moynihan highlighted that the Working Group should also consider whether the criteria should be modified based on hospital type (e.g., academic medical hospitals, specialty hospitals).
- **Next Steps**: OHIC and Bailit Health will revise the goals and criteria to address the Working Group's feedback.

III. Review Key Decision Points for Designing a Hospital Global Budget

- January introduced the general process for developing hospital global budgets, including nine specific decision points the Working Group will discuss. She said that Deepti will provide a high level description of each of these steps as context for future discussions, and asked the Group to consider: 1) if there are any issues that will be important to address that have not been contemplated, and 2) whose expertise and what information Working Group members would need to weigh in.
- Theresa Paiva-Weed requested practical information that members of the Working Group could bring back to their CFOs. Patrick indicated that there will be opportunities to involve CFOs.
- Aaron Robinson asked what the base assumptions are around designing the core structure of the model, and whether the goal is to standardize within each market, or standardize across markets. Deepti indicated this would be a topic for future discussion and recommendation by the Working Group. Dan Moynihan indicated that the Working Group should aim for as much standardization as is feasible.
- Peter Hollman asked how facilities that are not hospital owned would be treated. Theresa Paiva-Weed and Dan Moynihan expressed the need to address them. Working Group members discussed whether it is feasible to incorporate these services since they are not within the hospitals' control. Aaron Robinson commented that these facilities may not be part of the hospital global budget model, but they need to be addressed somehow.

- Aaron Robinson noted that Maryland incorporated avoidable utilization in the calculation of its base budget. Dan Moynihan indicated that case-mix is an important variable to consider as well.
- Al Charbonneau expressed that one of the model goals should be to structure incentives to emphasize lower cost patient care.
- Ira Wilson asked whether there is any debate about what's a fixed cost and what's a variable cost.
- Deepti described three approaches to distributing payments: 1) retrospective approach, 2) prospective approach, and 3) combined approach. Aaron Robinson asked for data around which of the three approaches are more effective at reducing administrative costs.
- Theresa Paiva-Weed noted that CMS was very focused on equity targets. She also asked that measures used for the hospital global budget model be consistent with measures used for other efforts in the state. Patrick agreed.
- Theresa Paiva-Weed asked for more information on whether other states have provider licensing fees. She noted that the use of licensing fees in Rhode Island seems to be unique and that it would be important to understand the impact this has on hospital risk and strategies for mitigating such risk.
- Aaron Robinson noted that the technology needs associated with monitoring a hospital global budget can be enormous, given disparate records across systems. He asked whether there is support for uniformity across technology and documentation systems in other states.
- Al Charbonneau noted the importance of getting as much information on other states' models. He requested a summary document that compares the states that have hospital global budget models on the various dimensions that Deepti described. Deepti indicated that Bailit Health is working on such a document that can be made available to the Working Group.

IV. Public Comment

- Patrick asked for public comment. There was none.

V. Next Steps

- Deepti shared that the next meeting will be on September 20, 2022 during which the Working Group will discuss the level of standardization across hospital global budget model design.
- Cory King announced that there will be no meeting in October. OHIC will schedule additional meetings beginning in November 2022.