Rhode Island Hospital Global Budget Working Group
Meeting #3 Summary
OHIC Conference Room
1511 Pontiac Ave, Building 69-1, Cranston
September 20, 2022
1:00 – 2:30 PM

Attendees:

- Patrick Tigue, Office of the Health Insurance Commissioner
- Cory King, Office of the Health Insurance Commissioner
- January Angeles, Bailit Health
- Michael Bailit, Bailit Health
- Deepti Kanneganti, Bailit Health
- Bob Murray, Global Health Payment
- 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
- Shamus Durac, Rhode Island Parent Information Network
- Peter Hollmann, Rhode Island Medical Society
- Dan Moynihan, Lifespan
- Elena Nicolella, Rhode Island Health Center Association
- Zach Nieder, Rhode Island Foundation
- Teresa Paiva-Weed, Hospital Association of Rhode Island
- Kim Paull, BCBSRI
- Kim Pelland, Executive Office of Health and Human Services
- Sam Salganik, Rhode Island Parent Information Network
- Lisa Tomasso, Hospital Association of Rhode Island
- Ira Wilson, Brown University

I. Welcome

- January Angeles welcomed the Hospital Global Budget Working Group.
- Teresa Paiva-Weed expressed concern that Working Group meetings were moving too quickly and did not comprise the right individuals. She recommended convening a technical working group with hospital finance staff and requested that meeting materials be shared at least one week in advance of the meetings.
- Patrick Tigue said the Working Group is a public meeting and therefore is open for any individual to attend. He shared that OHIC did meet with the CFOs and invited them to participate in the Working Group. Patrick said he was open to using the remaining time to discuss whether it makes sense to restructure the Working Group moving forward but questioned why hospital representatives have not participated when they have been invited to do so.
- Elena Nicolella noted that health centers and members of the health system will be impacted by the consequences of a global budget. She expressed interest in avoiding

segmentation of the conversation into two groups, where hospitals are discussing the technical elements of the model and others are discussing the global aspects.

- Sam Salganik said it was important to have a broader set of perspectives represented in these meetings. He recommended convening a technical subgroup or having hospitals send additional representatives to the meetings.
- Tom Breen suggested organizing the meetings as if there was a technical subgroup that presented information and recommendations to a board.
- Michael Bailit asked why more HARI members have not attended meetings. Teresa Paiva-Weed said CEOs are too busy and tend to participate in smaller group meetings rather than larger policy meetings. Michael then asked why hospitals did not send more finance individuals to the meeting. Dan Moynihan expressed his interest in having financial representatives who understand hospital and payer reimbursement at meetings, but noted the room is too small.
- Patrick proposed that OHIC develop a proposal in October on how structure future Working Group meeting to include technical representatives and the broader health system community.
- Sam Salganik commented that the Working Group's recommendations are only the first step, as there will need to be several additional conversations to operationalize the model. Patrick agreed with Sam, highlighting that the charge of the Working Group is to develop high level recommendations, not binding decisions, on parameters and principles for a successful model. He said next steps will include activities such as pursuing legislation or regulation.
- January shared that Bailit Health took responsibility for the delay in sharing materials and committed to developing future materials at least one week in advance. She then reviewed the meeting agenda

II. Review Revised Goals and Criteria

- January reviewed the model goals and criteria that Bailit Health revised to respond to the Working Group's feedback raised during the last meeting. She summarized the changes to the model goals and criteria and invited comment from the Working Group.
- Tom Breen asked how the revised goals address the issue of care leaking to Boston and New Haven. January stated that the goals emphasize promoting access to care in Rhode Island. The issue, however, will need to be addressed as the Working Group discusses model design.
    - Michael commented that Ira Wilson and others at Brown quantified the amount of service volume that has left the state using APCD data.
    - Dan Moynihan added that he believed there would be less leakage of care if hospitals had greater financial sustainability.
- Lisa Tomasso said hospital CFOs expressed an interest in defining financial sustainability and reducing cost growth.
- Ira Wilson highlighted the importance of understanding hospital finances over the last five years before discussing how to design a global budget. He asked whether there were standardized financial data available for all hospitals.
- Peter Hollman recommended adding an eight criterion that prioritizes a data driven approach and a standardized data collection methodology.

- Al Charbonneau shared that the long-term trend in Rhode Island over the last 25 years suggests that hospitals have low margins. He recommended looking at a composite across Rhode Island hospitals for each market before proceeding further.
- Teresa Paiva-Weed added that issues, such a nursing staffing shortages, are impacting hospitals' ability to generate revenue.
- Cory King shared that Colorado's Department of Health Policy and Finance produces annual hospital cost reports. He said Rhode Island has a lot of insurance data, but not a lot of hospital data. Michael added that a few states have similar hospital reports.
- Sam Salganik suggested revising the sixth criterion to focus on incentivizing seeing populations with high disease burden and social needs in addition to populations with financial need.
- Michael shared that CMMI is developing a national hospital global budget model and it may bring its own goals and criteria to the table.

III. Approach to Aligning or Standardizing Elements of the Hospital Global Budget

- Deepti Kanneganti reviewed how different components of the hospital global budget model can be standardized as well as the tradeoffs with each type of standardization. She then explained how two states, Pennsylvania and Maryland, approached standardization of their models.
- Ira Wilson said that it would be helpful to understand in detail the way Maryland deals with heterogeneity among hospitals.
- Al Charbonneau indicated that for New York's HEPP model, after establishing the base year, they developed market basket approach to trend factor. Hospitals were paid for services they could manage.
- Dan Moynihan asked about CMS' preferences for how flexible the model should be. Michael responded that CMMI will be settling on the details of the model in the next few months and other states are likely going to ask for more flexibility.
- Bob Murray described standardization in Maryland, as well as an exceptions or appeals process that was applied. Even though Maryland had a fairly standardized model, it made adjustments for different facilities, such as for teaching programs and magnitude of teaching programs, as well as variation in levels of bad debt and uncompensated care. The exceptions process allowed hospitals to ask for a full rate review. This rate review could go either way – if HSCRC determined that hospital's priorities did not align, the hospital that asked for a rate increase could actually receive a rate decrease.
- Patrick indicated that for Rhode Island, all features of the model be addressed within or across markets. Maryland standardized across markets, but it is feasible to develop different models that are specific to a market, and be consistently applied within that market.

IV. Discussion of Services to Include in the Model

- Deepti discussed how other models, specifically Maryland, Pennsylvania and CHART, addressed which types of hospitals to include. She then reviewed considerations for including specialty hospitals.
- Teresa Paiva-Weed noted that how hospitals are listed in the slides is not accurate. For example, the Hasbro Children's Hospital is part of Rhode Island Hospital. They do not

operate on two distinct licenses. Dan Moynihan noted that from a system and hospital financial perspective, it is possible separate Hasbro from Rhode Island Hospital.

- Elena Nicolella indicated that it would be worth exploring whether the group should look at individual hospitals vs the system overall since it all rolls up to the system.
- Dan Moynihan suggested using tax ID numbers to identify separate corporate entities within a specific health system.
- Ira Wilson said that with hospital acquisition of provider practices, more and more care is being delivered in ambulatory settings. He recommended considering inclusion of such facilities, such as ambulatory surgery centers.
- Patrick indicated that he would want as the budget to be as global as possible, but feasibility would be a big consideration.
- Sam Salganik said he was uncertain about whether to include specialty hospitals. He expressed concern about incentivizing decreased utilization and potentially locking in disparities.
- Teresa Paiva-Weed asked how the HSCRC interacted with the Department of Health (DOH). Bob Murray replied that the HSCRC was structured to be independent, but administratively it reported to the DOH. They had an arm's length relationship.
- Patrick indicated that administrative capacity is important to consider when recommending model features. Bob Murray shared that the HSCRC had a fairly small staff to implement its hospital global budget model. New York had an even smaller staff of around six people to administer the HEPP.
- Mike DiBiase said the model shouldn't bake in historical cost structures and then simply grow spending by inflation. This doesn't get into efficiency of moving investments. He expressed that the model should address the current cost structure.
- Sam Salganik responded that efficiency is not just about cost reduction. It is also about providing the right services. He said that it would not be fair to expect the system to perform better if the model takes money off the table right away.
- Al Charbonneau said that it would be critical to bring clinicians together across the state to look at quality and evidence-based practice.

V. Public Comment

- Patrick asked for public comment. There was none.

VI. Next Steps

- Cory noted that there will not be a Working Group meeting in October and that he would work on scheduling future meetings starting in November