Rhode Island Hospital Global Budget Working Group
Meeting #4 Summary
HARI Conference Room
405 Promenade Street, Providence
January 23, 2023
9:00 – 11:00 AM

Attendees:

- Cory King, Office of the Health Insurance Commissioner
- January Angeles, Bailit Health
- Michael Bailit, Bailit Health
- Deepti Kanneganti, Bailit Health
- Scott Boyd, Amica Mutual Insurance Company
- Natalya Alexander, NHPRI
- Tom Breen, South County Health
- Kelly Carpenter, Rhode Island Senate Fiscal Office
- Al Charbonneau, Rhode Island Business Group on Health
- Michael DiBiase, Rhode Island Public Expenditure Council
- Chris Dooley, Prospect
- Maria Ducharme, Lifespan
- Howard Dulude, Hospital Association of Rhode Island
- Shamus Durac, Rhode Island Parent Information Network
- Crista Durand, Newport Hospital
- Eva Greenwood, Lifespan
- Dezeree Hodish, Executive Office of Health and Human Services
- Peter Hollmann, Rhode Island Medical Society
- Al Kurose, Coastal Medical
- Dan Moynihan, Lifespan
- Mary Marran, Butler Hospital
- Josh Morris, Westerly Hospital
- Elena Nicolella, Rhode Island Health Center Association
- Teresa Paiva-Weed, Hospital Association of Rhode Island
- Kim Paull, BCBSRI
- Kim Pelland, Executive Office of Health and Human Services
- Colleen Ramos, Women and Infants Hospital
- Aaron Robinson, South County Health
- Henry Sachs, Bradley Hospital
- Sam Salganik, Rhode Island Parent Information Network
- Michael Souza, Landmark Hospital
- Lisa Tomasso, Hospital Association of Rhode Island
- Ira Wilson, Brown University

I. Welcome

- Cory King welcomed the Hospital Global Budget Working Group (HGB WG). He provided a brief introduction to the origins of the HGB WG and outlined state goals to collaborate with the HGB WG to develop payment models that transform service delivery, provide stability for providers, and improves affordability.

- Cory shared that the open meeting laws require meetings to be in person. He noted that further research revealed that the requirements apply to meetings of bodies that advise OHIC and are established by statute. Since the HGB WG is not a statutory group, but rather made through compact, he is consulting with lawyers to determine if OHIC can allow for virtual participation in the future.
- January Angeles shared that given the new composition of the HGB, Bailit Health is offering to set up an ad hoc meeting to review issues covered in previous meetings and answer any questions new members may have.

II. Review of the Hospital Global Budget Working Group's Charge and 2023 Meeting Plan

- January reviewed the agenda and the HGB WG goals to develop key parameters for a HGB model in RI that payers and hospitals can voluntarily adopt. January outlined the four milestones in the Compact leading to model implementation on January 1, 2026.
- Howard Dulude clarified that the model would be voluntary on behalf of payers and hospitals. January and Cory confirmed. Al Charbonneau said it is important to consider the benefits and drawbacks to a voluntary model. January noted there is broad agreement that a voluntary model that does not garner sufficient participation would not be successful, so the goal is to get agreement among hospitals and payers on the key design elements that would encourage participation. Cory further indicated that consideration of a voluntary model is the starting point and that OHIC needs statutory authority to implement a mandatory model. He indicated the desire to include Medicare and noted that there may be opportunities available through the Center for Medicare and Medicaid Innovation (CMMI).
- January summarized the topics discussed by the HGB WG in 2022, including efforts in other states, goals and criteria, and an initial consideration of what hospitals and services to include in the model. She then reviewed the meeting schedule and draft agendas for the 2023 WG meeting series.
- Al Kurose expressed that the HGB WG should discuss alignment of the HGB model with other VBP models in the state earlier than June. Aaron Robinson and Kim Paull agreed. Kim elaborated that the HGB WG must consider the model population and included services, acknowledging that there may be overlap with other global budget-like models (e.g., ACO TCOC arrangements).
- Eva Greenwood asked whether there will be data modeling to assess the impact on hospital sustainability. January said that there would be initial conversations on what model parameters make sense, which would likely be followed by modeling. Deepti Kanneganti encouraged hospitals to bring data to the meeting to inform conversations.
- Aaron Robinson noted the need to define some terms, such as what is meant by "hospital." For example, does that include other facilities? January indicated that these definitions are what we hope the HGB WG will address in subsequent conversations.
- Kim Paull and Dan Moynihan asked for clarification on whether there will be opportunities beyond July 2023 to revise the model. January confirmed that the goal for July is to have recommendations on broad model parameters and that there will be several opportunities to iterate on those recommendations.

III. Update on Other Hospital Global Budget Efforts

- Deepti provided an overview of what CMMI is planning with its AHEAD model. Cory mentioned that under the voluntary VBP compact, OHIC committed to engaging CMMI.

He added that the National Academy for State Health Policy convened a small group of states to provide input to CMMI on the AHEAD model.

- Teresa Paiva-Weed mentioned that she understood CMMI was engaging with six states to develop papers that CMMI intended to release in January or February 2023. She asked if the group needed to convene sooner to inform the CMMI process. Michael Bailit indicated he was not familiar with such an effort.
- Michael Bailit elaborated that CMMI is moving away from state-specific agreements and is trying to develop a common construct where there is some state flexibility within broad parameters. Aaron Robinson indicated that it would be good to have clarity from CMMI on what model features might be common across states and what features could vary.
- Deepti updated the group on CMMI's recent decision to temporarily suspend the first implementation year of its CHART Model due to insufficient participation.
- Deepti also provided an overview of the Rhode Island MAXICAP program that was implemented in the 1970s through 1990s. Howard Dulude elaborated that this program was not just focused on expenses, but also included negotiation of revenue. It also involved an interim payment process, had incentives built in, and factored in fixed vs. variable costs. Tom Breen indicated that there was a parallel effort in Connecticut to implement something similar but it was not effective and there were wild swings in what the price increase or decrease was supposed to be.

IV. Discussion of Hospital Global Budget Model Goals and Criteria

- Deepti reviewed goals and criteria for the model that had been previously discussed with the HGB WG.
- Aaron Robinson suggested revising the goals to address market-based spending and revenue. He expressed concern about competition with Connecticut and Massachusetts for labor, which is a significant driver of hospital costs, and indicated the need to be realistic about hospitals' ability to affect that market. Teresa Paiva-Weed and Mike Souza agreed with Aaron. Peter Hollman indicated that part of the goal is to affect the market. Al Charbonneau noted that hospitals need to be responsible for managing their margin. Sam Salganik indicated that he thought the current goals addressed the concerns raised around the labor market.
- Al Kurose suggested it would be good for hospitals to bring forward data on the health care workforce in Rhode Island.
- Regarding criterion 3, Kim Paull asked what needs to be true in the market to ensure aligned incentives across hospital and professional services. As follow-up to this, Teresa Paiva-Weed asked whether this envisions that the state would need to revisit the Certificate of Need Process. January replied that when the group makes recommendations, it could include statements about what else needs to happen in other parts of the system to support the recommendations.

V. Discussion on Hospital Types to Include in the Model

- January highlighted two questions the HGB will consider: (1) whether budgets should be calculated at the system or hospital level; and (2) whether the model should focus on just general acute care hospitals or extend to specialty care hospitals.

- January described two potential approaches for global budgets – a system-level budget for all hospitals combined, where the system could allocate budgets to individual hospitals within the system, or a hospital-level budget for each individual hospital.
    - Howard Dulude clarified that hospitals bill for all payments, so there are no dollars going to a system. Others agreed, and Christa Durand and Mary Maran said it would increase complexity to create a system-level budget. Aaron Robinson and Mary also noted there could be significant changes in the relationship between hospitals and systems over the next few years.
    - Howard Dulude noted there are services provided by hospital providers that are independent from the system.
    - Mike Sousa said the Rehabilitation Hospital of RI is owned 50% by Prime Healthcare Services and 50% by Lifepoint.
- Elena Nicollela said this is substantial question without understanding the implications of the decisions one way or another. She asked if there would be a way to use data to model the potential impacts of key design decisions. Michael Bailit agreed that there will need to be modeling at some point.
    - Tom Breen noted that the group skipped over the critical question of why we are considering hospital global budgets, and what is the problem that we're hoping to fix.
    - Michael Bailit noted that the group discussed this in earlier meetings. The goal was to have long-term sustainability of hospitals with affordable rates of spending growth and increased flexibility so that hospitals can change their service models and better serve their communities.
    - Michael Dibiase said if the goals were financial sustainability and flexibility, budgets would need to be calculated at a system level.
    - There was broad agreement among the HGB WG that the status quo was not sustainable.
- Eva Greenwood indicated that Lifespan budgets at the hospital level but this does not mean that in the future Lifespan could not reorient its hospitals to focus on certain services more than other hospitals. She noted it would be important to make sure system-level decisions on how to reconfigure care do not penalize individual hospitals. January noted this is an issue that group will address later.
- January summarized that the group consensus seems to be that it is more practical to have hospital-level budgets, although some individuals have noted that system-level could promote greater efficiencies.
- **Preliminary recommendation on system vs. hospital-level budgets**: Adopt hospital-level budgets.
- January asked whether budgets should be limited to acute care hospitals or if they should be extended to other specialty hospitals as well. She noted the HGB WG can recommend starting with acute care hospitals and then expand the model later.
- Eva Greenwood said Lifespan would consider Rhode Island Hospital as general acute care and Hasbro as other specialty.
- Mary Maran expressed that psychiatric hospitals should not be treated differently, and that consideration of psychiatric hospitals should also extend to Eleanor Slater. She recommended against bifurcating the system further by excluding psychiatric hospitals. Henry Sachs, Sam Salganic, Colleen Ramos, Al Charbonneau, Maria Duchame, and Christa Duran all agreed. They noted that inclusion of psychiatric hospitals would be

important to integrate care, to increase investment in psychiatric services where historically there has been underinvestment, to provide continuity of care, and to address psychiatric boarding.
    - Dan Moynihan noted one potential complexity, which is the difference in how payments are made to psychiatric hospitals because of behavioral health carve outs.
- Peter Hollman said it may make sense to remove specialty hospitals from consideration if it could protect against reducing access to or utilization of select services. He said it may be hard to have equitable budgets across all these different types of hospitals. Peter added that the Medicare IPPS system first started with acute hospitals and then extended to psychiatric hospitals later.
- **Preliminary recommendation on inclusion of specialty hospitals**: Consider budgets for all hospitals, including specialty hospitals.
- January explained that there are services that are not "owned" by hospitals, including professional services delivered by non-hospital-employed providers as well as other facility services that are not owned by hospitals.
- Teresa Paiva-Weed said the distinction may not be as clear as hospital-employed or non-hospital-employed because hospitals may subsidize services for select providers.
- Christa Durande and Maria Ducharme said all clinical services are assigned to one TIN for one hospital within the system. The only component of system budgets are corporate expenses. They recognized that each system may look different.
- January commented that Gateway had a separate TIN when she looked at form 990s for Lifespan. She asked which facilities are assigned to a hospital TIN and which have their own TIN.
- Aaron Robinson said each hospital has its overall TIN. Within that, employees have their individual IDs and there are additional contracted services.
- Maria Ducharme said while multiple hospitals use the same services, in Lifespan all facilities that deliver similar services (such as laboratory services) would be assigned to one hospital TIN.
- Peter Hollman acknowledged that other models, such as ACO TCOC models, may better address certain services compared to a hospital global budget. He commented that it was important to consider the power dynamics between hospitals and physician groups. He added that hospitals may take actions regarding medical staff structure that may be cost-effective for the hospital, but that may not promote high-quality care.
- Elena Nicollela asked if there was alignment between the HGB WG and the independent report on hospital costs. Cory King said OHIC is identifying funding for that report. Teresa Paiva-Weed asked for more information about this report and raised the importance of having an independent funding source. Cory said the report will focus on understanding hospital operating costs, financial performance, and the phenomenon of cost shifting.

VI. Public Comment

- Cory asked for public comment. There was none.

VII. Next Steps

- January noted the next Working Group meeting will be on February 9, 2023.