Rhode Island Hospital Global Budget Working Group
Meeting #5 Summary
HARI Conference Room
405 Promenade Street, Providence
February 9, 2023
10:00 AM – 12:00 PM

Preliminary Recommendations:

- Include all hospital inpatient and outpatient services in the hospital global budget for now.
- Include in the hospital global budget professional services delivered by:
  - employed professionals for whom the hospital bills under its TIN, regardless of place of service and
  - contracted, non-employed professionals for whom the hospital bills under its TIN, regardless of place of service.
- Include in the hospital global budget the cost of hospital subsidies to non-employed professionals for whom the hospital does not bill.
- Exclude from the hospital global budget professional services delivered by:
  - contracted, non-employed professionals that bill on their own, regardless of place of service.

Next Steps:

- Bailit Health will research Medicare's definition of hospital inpatient and outpatient services.
- Bailit Health will research to determine whether using the hospital TIN as a basis for identifying which professional services to include will work the same way for all hospitals and systems across the state.
- The HGB WG will defer consideration of what services to potentially exclude from the model after (a) conducting an analysis to identify high-cost, variable services and (b) identifying areas where there is a state commitment to expanding access to care.
- The HGB WG will consider whether to include system-owned physician groups and other non-hospital-based services at the next meeting after considering (a) the advantages and disadvantages from the patient, physician, hospital and payer perspectives and (b) the intended and potentially unintended consequences associated with including and excluding such services.

Attendees:

- Cory King, Office of the Health Insurance Commissioner
- January Angeles, Bailit Health
- Michael Bailit, Bailit Health
- Deepti Kanneganti, Bailit Health
- Natalya Alexander, NHPRI
- Tom Breen, South County Health

- Scott Brown, Landmark
- Jim Burke, Kent
- Steve Burke, Butler
- Doreen Carlin-Grande, NHPRI
- Kelly Carpenter, Rhode Island Senate Fiscal Office
- Al Charbonneau, Rhode Island Business Group on Health
- Stephanie De Abreu, UnitedHealthcare
- Michael DiBiase, Rhode Island Public Expenditure Council
- Maria Ducharme, Lifespan
- Howard Dulude, Hospital Association of Rhode Island
- Shamus Durac, Rhode Island Parent Information Network
- Eva Greenwood, Lifespan
- Dezeree Hodish, Executive Office of Health and Human Services
- Peter Hollmann, Rhode Island Medical Society
- Dan Moynihan, Lifespan
- Mary Marran, Butler Hospital
- Heather-Rose Mattias, Care New England
- Elena Nicolella, Rhode Island Health Center Association
- Teresa Paiva-Weed, Hospital Association of Rhode Island
- Kim Paull, BCBSRI
- Colleen Ramos, Women and Infants Hospital
- Henry Sachs, Bradley Hospital
- Zach Neider, RI Foundation
- Sam Salganik, Rhode Island Parent Information Network
- Lisa Tomasso, Hospital Association of Rhode Island
- Ira Wilson, Brown University

I. Welcome

- Cory King shared that OHIC, EOHHS and Medicaid are meeting with CMMI to discuss the high-level goals of their hospital global budget innovation model. Cory shared that he would report any findings to the Working Group as permissible by CMMI.
- Michael Bailit shared that CMMI has not yet finalized the model design yet and therefore is still soliciting input from states.
- Teresa Paiva-Weed noted that hospital participation is conditional on sufficient funding from public payers in particular, notably from Medicaid, and an upfront infrastructure investment that can support model development and implementation. Al Charbonneau resource investment should be supported by evidence.

II. Follow-up From the January 23, 2023 Meeting

- Deepti Kanneganti reviewed reasons for pursuing a hospital level budget, which was presented in early meetings. She noted evaluations of the Maryland and Rochester model which saw improved outcomes.
- Howard Dulude asked whether the hospital global budget will be calculated using revenue or expenses. Deepti replied this will be covered in the next meeting.
- Tom Breen asked about what the expectations are for what the appropriate level of spending would be under a hospital global budget in reference to current levels of spending. Sam Salganik noted that different stakeholders will have different perspectives on what spending levels ought to be. Deepti commented that after preliminary recommendations it will be possible to do modeling to compare revenue under the hospital global budget with revenues under the current payment system.

- Teresa Paiva-Weed shared that in her conversations with hospitals in Maryland, some indicated there were significant clawbacks of COVID funds which hurt the hospitals and these are not reflected in the evaluations. Al Charbonneau mentioned Mathematica's recent evaluation of the Maryland effort which suggests the model is working.
- Deepti summarized the recommendations from the January 23, 2024 meeting to: (1) adopt hospital-level budgets; and (2) include all hospitals, including specialty hospitals. Kim Paull suggested rewording the first recommendation to make clear that the consensus was to pursue hospital-level budgets *in lieu of system-level budgets.*

III. Discussion of Services to Include

- January Angeles explained that the Hospital Global Budget Working Group (HGB WG) will consider three types of services during today's meeting: hospital inpatient and outpatient services, professional services and non-hospital-based services. January then described high-level considerations for why the HGB WG could consider a comprehensive approach that includes professional and/or non-hospital-based services versus a limited approach that includes hospital inpatient and outpatient services only.
    - Sam Salganik noted that a comprehensive approach could potentially limit access to care for select outpatient, community-based services.
    - Al Charbonneau and Deepti explained that model design, such as use of a flexible global budget model, can help protect against Sam's concern.
    - Michael Bailit added that, from a system perspective, partial inclusion of services in a hospital global budget model could incentivize leakage from one care setting that is covered by the global budget to another care setting that is being paid on a FFS basis.
- Dan Moynihan recommended considering what services to include based on how payers view hospitals in terms of payment, which is based on federal tax ID numbers. Rhode Island Hospital, for example, bills for hospital inpatient and outpatient services, as well as professional services, under one corporate ID, whereas Lifespan Physician Group uses a separate ID.

Hospital Inpatient and Outpatient Services

- January began a discussion of what inpatient and outpatient services to include. The group discussed potential definitions of hospital inpatient services and outpatient services to guide the conversation. January asked whether hospital outpatient facility services should be limited to those that are provided in a hospital.
- Howard Dulude recommended focusing on hospital outpatient services rather than hospital outpatient facility services.
- Howard Dulude and Dan Moynihan recommended using Medicare's definition of hospital inpatient and outpatient services.
    - Michael Bailit asked if Medicaid and commercial payers also use Medicare's definition. Dan Moynihan said Lifespan tries to use Medicare standards as much as possible. Kim Paull and Natalya Alexander noted that BCBSRI and NHPRI, respectively, align with Medicare's definition as well. Peter Hollman added that Medicaid intentionally aligns with Medicare.
    - Al Charbonneau shared that Medicare considers some outpatient services as inpatient services and recommended referring to the Medicare Cost Report.

- Howard Dulude asked if Medicare's definition was applicable for Women and Infants hospital. Colleen Ramos said she would confirm whether it was applicable, and added that all of Woman and Infants' outpatient clinics are on one license.
- Ira Wilson commented that cost growth for inpatient services, when narrowly defined, is flat or decreasing; hospital-based outpatient care is where costs are really increasing.
- Michael Bailit added that the more inclusive the budget, the more consistency there will be across hospitals.
- Tom Breen questioned whether the HGB WG should just align with CMMI if it intended to standardize models across states.
    - Michael Bailit shared that CMMI has been generally responsive to Vermont's requests for some flexibility. He added that CMMI has been very positive about inclusion of professional services.
    - Cory King added that he would raise Tom's concern when he meets with CMMI.
- January asked if there were any inpatient or outpatient hospital services that the Working Group recommended excluding from the model.
- Howard Dulude said if there is an analysis done on hospital costs, then it may become apparent for what outlier services should be excluded.
- Dan Moynihan said quaternary care could perhaps be excluded (e.g., organ transplants, NICU).
- Peter Hollman recommended having principles to guide which services to exclude, such as services that are highly variable and therefore do not have predictable costs.
- Peter Hollman and Howard Dulude also recommended potentially excluding some services that are priorities for state, such as behavioral health outpatient services and teaching programs. Peter added that perhaps there could be budget adjustments to account for such priorities.
- Michael DiBiase said each exclusion to the budget will result in distortions and therefore recommended retaining most services and making adjustments accordingly.
- **Next Steps**: Bailit Health will research Medicare's definition of hospital inpatient and outpatient services.
- **Preliminary Recommendation**: Include all hospital inpatient and outpatient services in the hospital global budget for now.
- **Next Steps**: The HGB WG will defer consideration of what services to potentially exclude from the model after (a) conducting an analysis to identify high-cost, variable services and (b) identifying areas where there is a state commitment to expanding access to care.

Professional Services

- Deepti began a discussion around whether professional services should or should not be included in the budget. She noted that Maryland and Pennsylvania's models did not extend to professional services but for very different reasons.
- Dan Moynihan categorized Lifespan's billing relationship with physicians into three groups: (1) independent or contracted providers for whom the hospitals bill; (2) independent or contracted providers who bill for their own services; and (3) hospital-employed providers for whom the hospitals bill.

- Teresa Paiva-Weed noted that there are also some professional services that hospitals subsidize due to labor shortages. The HGB WG cited anesthesiology as a prime example.
- Mary Marran said that excluding professional services is problematic. She indicated that ability to control cost of professional services is more about how a hospital contracts rather than whether the hospital bills for the services. There are many provider groups for which hospitals can exert significant influence even if the hospital does not bill those services directly. She also indicated that hospitals have more influence over system-owned physician groups than over independent physician groups.
- Scott Brown indicated that Landmark has a medical group that is independent but under its hospital's TIN. Heather Rose-Mattias said that Care New England has a very small number of physicians that are employed by the hospital. Most are part of a medical group that is under the system. Tom Breen indicated South County bills under a separate, non-hospital TIN for its employed professionals.
- Kim Paull suggested being open to new definitions, and not limiting services that are included or excluded based on how hospitals currently bill for the services. Howard Dulude indicated that including more services gets closer to a total cost of care model and not a hospital global budget.
- Michael DiBiase asked about what will be done to get at costs of non-employed professionals for whom the hospital does not bill. He indicated that there is some evidence that costs are growing in the area. Elena Nicolella agreed with Michael and said that the HGB WG should recommend monitoring for uncontrolled spending.
- **Preliminary Recommendation:**
    - Include in the hospital global budget professional services delivered by:
        - employed professionals for whom the hospital bills under its TIN, regardless of place of service and
        - contracted, non-employed professionals for whom the hospital bills under its TIN, regardless of place of service.
    - Include in the hospital global budget the cost of hospital subsidies to non-employed professionals for whom the hospital does not bill.
    - Exclude from the hospital global budget professional services delivered by:
        - contracted, non-employed professionals that bill on their own, regardless of place of service.
- **Next Steps:** Bailit Health will research to determine whether using the hospital TIN as a basis for identifying which professional services to include will work the same way for all hospitals and systems across the state.

Non-Hospital-Based Services

- January began a discussion of whether non-hospital-based services, specifically system-owned physician groups, should be included in the model.
- Mary Marran and Tom Breen noted that system-owned physician groups do provide a significant number of services in the hospital. Mary shared that it is relatively easy to negotiate with system-owned physician groups. The biggest concern, however, is how to control spending for independent provider groups that the hospitals subsidize.
- Michael Dibiase advocated for system-level budgets because they reduce the complexity around which professional services to include in the model.

    - Sam Salganik agreed with Michael, commenting that system-level budgets can incentivize coordination of care within a system and reduce leakage.
- Elena Nicolella questioned whether it was feasible to have both hospital and system level budgets.
- Teresa Paiva-Weed and Dan Moynihan suggested convening a technical group to discuss the parameters of what to include in the model. January agreed, but noted that there needs to be broad parameters from which the technical group can work. She added that the HGB WG can always revisit recommendations if the technical group has a differing recommendation.
- Peter Hollman and Ira Wilson discussed what services can be controlled by a hospital versus a system.
    - Ira said that a system should be focused on controlling total costs across care settings, not only the costs of a hospital system.
    - Peter Hollman advocated for including system-owned physician groups in the model. He added that it would be complicated to develop value-based arrangements for specialty care providers.
- Teresa Paiva-Weed shared that she did not want to put providers that work for hospitals at a disadvantage from their peers by including them in the model and excluding system-owned physician groups.
- Dan Moynihan expressed that consideration of system-owned entities is scope creep, as the HGB WG committed to developing hospital global budgets and not system global budgets.
- Kim Paull asked what the consequences are associated with including or excluding services. For example, if the model excludes primary care and behavioral health outpatient care, what message does that send? How does this impact future business models? Does this incentivize systems to provide the right care in the right setting?
- Teresa Paiva-Weed requested sharing a brief summary of unanswered questions following each meeting so that HGB WG members can solicit additional feedback prior to the next meeting.
- **Next Steps**: The HGB WG will consider whether to include system-owned physician groups and other non-hospital-based services at the next meeting after considering (a) the advantages and disadvantages from the patient, physician, hospital and payer perspectives and (b) the intended and potentially unintended consequences associated with including and excluding such services.
- **Next Steps**: Bailit Health will share a list of preliminary recommendations, next steps and unanswered questions following each meeting.

IV. Public Comment

- Cory asked for public comment. There was none.

V. Next Steps

- The next HGB WG meeting will be on February 23, 2023.