Rhode Island Hospital Global Budget Working Group
Meeting #6 Summary
HARI Conference Room
405 Promenade Street, Providence
February 23, 2023
10:00 AM – 12:00 PM

Current Consensus:

- 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.
- Include expenditures for hospital-owned entities that are billed under a hospital TIN.
- Include revenue generated by participating hospitals from claims paid for members covered by participating payers.
- Calculate baseline budgets NPR, but with consideration of operating expenses and margin.

Attendees:

- Cory King, Office of the Health Insurance Commissioner
- January Angeles, Bailit Health
- Michael Bailit, Bailit Health
- Deepti Kanneganti, Bailit Health
- John Philippides, Bailit Health
- Natalya Alexander, NHPRI
- Tom Breen, South County Health
- Scott Boyd, AMICA
- Jim Burke, Kent
- Doreen Carlin-Grande, NHPRI
- Al Charbonneau, Rhode Island Business Group on Health
- Todd Conklin, Care New England
- Stephanie De Abreu, UnitedHealthcare
- Domenic Delmonico, Tufts
- Michael DiBiase, Rhode Island Public Expenditure Council
- Chris Dooley, Prospect
- Howard Dulude, Hospital Association of Rhode Island
- Shamus Durac, Rhode Island Parent Information Network
- Ana Tuya Fulton, Care New England
- Eva Greenwood, Lifespan
- Dezeree Hodish, Executive Office of Health and Human Services
- Peter Hollmann, Rhode Island Medical Society
- Al Kurose, Lifespan
- Nick Lefeber, BCBSRI
- Dan Moynihan, Lifespan
- Mary Marran, Butler Hospital
- Heather-Rose Mattias, Care New England
- Bob Murray, Global Health Payment LLC
- Elena Nicolella, Rhode Island Health Center Association
- Teresa Paiva-Weed, Hospital Association of Rhode Island

- Kim Pelland, Executive Office of Health and Human Services
- Henry Sachs, Bradley Hospital
- Zach Neider, RI Foundation
- Lisa Tomasso, Hospital Association of Rhode Island
- Saul Weingart, Lifespan
- Ira Wilson, Brown University

I. Welcome

- January Angeles welcomed the Hospital Global Budget Working Group (HGB WG) and introduced Bob Murray. January reviewed the agenda for the meeting.

II. Wrap-up Discussion of Services to Include in the Budget

- January reviewed the preliminary recommendations from the February 9th meeting on what hospital and professional services to include in the model.
    - Tom Breen asked whether employed physicians that are part of the corporate organization and do not bill under the hospital TIN were currently included in the budget. January indicated that the HGB WG would discuss this question during the meeting.
    - Teresa Paiva-Weed recommended rewording "preliminary recommendations" to "current consensus."
- January asked the HGB WG if services delivered by system-owned entities should be included in the model. She then described some reasons for including and excluding such services from different stakeholder perspectives.
    - Ira Wilson commented that existing global budget efforts did not include system-owned facilities.
    - Elena Nicolella proposed excluding system-owned services from the hospital global budget and monitoring system-level revenue/expenditures as part of the model evaluation to understand the impact of the global budget on the system.
    - Al Charbonneau said the Medicare Cost Reports include two categories of spending with high growth that should be considered in the model: home office and organizational costs. He highlighted that including such spending in the budget would provide an opportunity to improve efficiency. Michael noted that budgets would focus on services, not on overhead expenses. Al added that such costs are attributed to inpatient costs.
    - Al Kurose said expanding to system-owned assets and outpatient care delivery goes beyond the scope of the VBP Compact.
    - Dan Moynihan said he thought hospital global budgets should be limited to hospital revenue only and hospitals should use their budgets to manage costs and expenses accordingly.
    - Howard Dulude said he was interested in considering expenses to ensure hospitals had sufficient margins.
    - Teresa Paiva-Weed said she assumed a voluntary model would establish guardrails that hospitals could then negotiate with the insurers. January highlighted that the HGB has yet to consider the level of standardization for the

model. Cory King added that OHIC is not creating a legal parameter for hospital global budgets at this moment.

- Al Charbonneau said he did not consider system-owned assets to be off the table when signing the VBP Compact.
- Peter Hollman agreed with Al Kurose and added that the VBP Compact specified inclusion of hospital-employed professionals, not hospital-owned entities. Peter shared that there are different configurations of system-owned entities that would make it challenging to create standardization across systems. He agreed with excluding system-owned assets from the model and monitoring spending in parallel. Peter added that he did not understand where subsidies for professionals fit into the budget.
- Teresa Paiva-Weed said there were instances in which certain professional groups are asked to be subsidized and questioned whether there would be a process to discuss ad hoc changes to a global budget. Deepti and January indicated that the group will discuss adjustments to the budget, which could capture some of this concern. There will also be a separate meeting during which the HGB WG will discuss an appeals process.
- Todd Conklin said he was not sure if he understood the implications of including or excluding system-owned entities. January explained that there is a concern around shifting services from the hospital global budget to other system-owned entities that are not regulated by the budget. She said there could be other ways to control for this, such as monitoring mechanisms or additional VBP arrangements.
- Michael Bailit commented that this is a generic risk of any global budget. If there is a fixed budget, there is an incentive to shift services out of the budget to generate a margin.
- Dan Moynihan asked whether this exists with programs that are in place today. He recommended looking to such examples to see whether this has occurred.
- Bob Murray explained that a fixed global budget presents a greater risk of shifting services to system-owned entities. He said a flexible global budget could help mitigate against this risk.
- Teresa Paiva-Weed indicated that all shifting is not bad, adding that there are some federal initiatives that aim to move spending outside of hospital settings.
- Al Charbonneau reiterated that systems spend more money on home office and organizational costs than nursing. He said it would be hard for hospitals to generate margin because there is no revenue associated with these costs. Cory King recommended revisiting how to address Al's concerns.
- **Current Consensus**: 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.
- Cory King highlighted that the initial hospital global budget model can evolve to become more complex, such as through inclusion of system-owned services.

- January Angeles asked if services provided by hospital-owned entities are billed under the hospital TIN and therefore should be included in the budget, or if they are billed under a separate TIN and therefore should be excluded from the budget.
    - Teresa Paiva-Weed questioned whether including hospital-owned entities in the budget (such as an ambulatory surgical center) would impact that entity's ability to complete with freestanding entities that are not part of a budget.
    - Tom Breen said he thinks hospital-owned entities would have separate TINs but would be included under the system corporate structure.
    - Dan Moynihan shared that Lifespan does have laboratory services that are billed under the hospital TIN that he would consider to be part of the hospital.
    - Elena Nicolella recommended starting with the hospital TIN and then adjusting the budget parameters later if needed.
    - Cory King asked whether Maryland included services provided by hospital-owned entities in its model. Bob Murray explained that services delivered outside of a hospital are excluded in Maryland. Michael added that this is in part a result of Maryland's history of having all-payer hospital rate setting authority.
    - Teresa Paiva-Weed noted that there are some hospital-owned facilities that have outside investors that would make it challenging to include in the budget.
    - Tom Breen shared there are two potential approaches to developing budgets – one based on service category definitions or one based on hospital TINs.
    - Peter Hollman commented that using hospital TINs will result in each hospital budget potentially including different service categories because of the unique billing structures, but at least every hospital will be compared with itself.
    - **Current Consensus**: Include expenditures for hospital-owned entities that are billed under a hospital TIN.

III. Discussion of What Population to Include in the Budget

- Deepti Kanneganti explained the proposed definition for what population to include in the budget: revenue generated by members covered by participating payers who receive services at a participating hospital. She noted the HGB WG will need to revisit this definition when considering whether to adopt a fixed or flexible budget model.
- Peter Hollman asked whether BlueCard members would be included in this definition, as they would effectively be treated as if they are BCBSRI members. Deepti recommended modifying the definition to say "claims paid by a participating payer."
- Tom Breen highlighted that there needs to be participation from most, if not all, payers for the model to be successful.
- Teresa Paiva-Weed confirmed with Deepti that the HGB WG would separately consider exclusions for certain high-cost variable services.
- **Current Consensus**: Include revenue generated by participating hospitals from claims paid for members covered by participating payers.

IV. Discussion of How to Calculate and Update Budgets Annually

- January reviewed three categories for how to develop a budget, including how to determine baseline expenditures, identify routine adjustments for things that are outside of the hospital's control that happen on a regular basis, and identify adjustments for things that are outside of the hospital's control that happen infrequently and that are hard to predict.
    - Domenic Delmonico asked if capital expenses and certificate of need (CON)-related expenses are considered are part of this process. January explained that would be a potential ad hoc expense.
- January explained that states typically use net patient revenue (NPR) to identify hospital expenditures. She elaborated on why we recommend use of NPR over operating expenses to set the baseline budget. She noted that hospitals today are experiencing operating losses and recommended revisiting how to make an adjustment to account for this when there are hospital financial data closer for years closer to 2026.
    - Howard Dulude said he considered budgets to be based on revenue, expenses, operating margins, and statistics like uncompensated care. He noted that hospitals currently have negative operating margins. He did not recommend moving to cost-based reimbursement, in part because funding all costs doesn't incentivize desired outcomes, but added that using revenue alone isn't sufficient. Tom Breen agreed with Howard.
    - Cory King said that as a model progresses, it becomes critically important that RI has a single source of truth on publishing hospital financial operating costs that is consistent across hospitals. He shared that the Rhode Island Foundation found that the RI Department of Health is currently not exercising its authority to collect financial data from hospitals and hospital systems. He noted that annual reporting on hospital revenue, expenses and reserves would be valuable when developing budgets.
    - Al Kurose commented that it will be a significant investment to develop this capacity, in part because there is no standardized approach to hospital accounting.
    - Cory King noted that one of the parameters in the VBP Compact was to develop sufficient state capacity to administer the model by 2025, which may include some of this reporting.
    - Domenic Delmonico said the RI hospital global budget model in the 1980s was expense-based and had an approach to develop an annual inflation factor that was based on expenses for approximately ten service categories. Those individual inflation factors were aggregated to develop a MAXICAP growth rate.
        - Deepti asked whether it was appropriate to refer to the 1980 model because she understood the relationships between charges and expenses to be different then than they are today.
        - Al Charbonneau said the amount of revenue per dollar charged is going to decrease.
    - Michael Bailit summarized that budget development could consider how other budget elements, such as margins, impact NPR. He added that the HGB WG needs to consider how to obtain additional financial data to inform the model.

        - Ira Wilson said the legislature needs to vote to provide funding for the infrastructure that Cory recommended, which is significant.
        - Tom Breen said a budget that is based on revenue and margins inherently considers expenses.
    - Dan Moynihan said he supported use of NPR because it is focused on payments and hospital global budgets is a type of payment reform. Elena Nicolella agreed with Dan, adding that any additional analysis of hospital finances can provide additional context for the second phase of this work.
    - Al Charbonneau said Rochester's hospital global budget had a regulatory body run by the hospitals that allowed hospitals to collaborate on ways to control costs. He added that hospitals have had ongoing challenges with margins that even prior to the pandemic that need to be addressed in the budget.
    - **Current Consensus**: Calculate baseline budgets NPR, but with consideration of operating expenses and margin.

V. Public Comment

- Cory King asked for public comment. There was none.

VI. Next Steps

- Cory King thanked the HGB WG for taking on challenging problems. He shared that OHIC and EOHHS recently spoke with CMMI about its hospital global budget model. He said OHIC asked CMMI about the value proposition for hospitals if they joined the model and whether there would be infrastructure funding available. He said OHIC cannot convey any specifics about the model, but could report that CMMI is still developing its model parameters.
- The next HGB WG meeting will be on March 6, 2023.