Rhode Island Hospital Global Budget Working Group
Meeting #7 Summary
HARI Conference Room
405 Promenade Street, Providence
March 6, 2023
9:00 AM – 11:00 AM

Current Consensus:

1. Use insurer paid amounts as the basis for developing budgets, but also inform the budgets by an analysis of hospital finances during the base years, considering hospital costs and hospital operating margins.
2. Use 2017-2019 data to model the impact of moving to a hospital global budget. Utilize more recent data from 2023 onwards when setting budgets for 2026 and evaluate the need for adjustments to account for COVID's impact at that time.
3. Use a "bottom-up approach" to develop market-specific budgets for each participating payer-hospital dyad. Reach out to insurers before the next meeting to solicit further input.
4. Develop one routine budget adjustment (frequency to be defined) to account for changes in age, sex and case mix.

Next Steps:

1. The Working Group will consider how to conduct an inventory of current billing practices by hospital and health system to inform how to mitigate against unintended consequences associated with changes in accounting practices.
2. Bailit Health will revise the current consensus on the population covered by the budget to specify inclusion of participating Medicaid, Medicare and commercial payers.
3. The Working Group will separately consider budget adjustments to account for social risk.

Attendees:

- Molly McCloskey, OHIC
- January Angeles, Bailit Health
- Michael Bailit, Bailit Health
- Deepti Kanneganti, Bailit Health
- Scott Boyd, AMICA
- Tom Breen, South County Health
- Scot Brown, Landmark
- Jim Burke, Kent
- Doreen Carlin-Grande, NHPRI
- Al Charbonneau, RIBGH
- Tony Clapsis, Aetna CVS Health
- Chris Dooley, Prospect
- Maria Ducharme, Lifespan
- Howard Dulude, HARI
- Shamus Durac, RIPIN
- Crista Durand, Newport
- Ana Tuya Fulton, Care New England
- Dezeree Hodish, EOHHS

- Peter Hollmann, Rhode Island Medical Society
- Al Kurose, Lifespan
- Mary Marran, Butler Hospital
- Heather-Rose Mattias, Care New England
- Robert Millette, Prospect
- Josh Morris, Westerly
- Dan Moynihan, Lifespan
- Bob Murray, Global Health Payment LLC
- Elena Nicolella, RIHCA
- Teresa Paiva-Weed, HARI
- Kim Paull, BCBSRI
- Aaron Robinson, South County Health
- Henry Sachs, Bradley Hospital
- Sam Salganik, RIPIN
- Lisa Tomasso, HARI
- Saul Weingart, Lifespan
- Ira Wilson, Brown University

I. Welcome

- Molly McCloskey opened the meeting and January Angeles reviewed the agenda.

II. Recap of the Consensus from the Last Meeting

- January summarized the consensus from the last meeting related to which services were included in the budget.
    - Aaron Robinson noted that different systems may have different billing practices, leading to inconsistency in what services are included in the budget for each system.
    - Ira Wilson said the group aimed to create an approach that was practical versus one that was consistent across systems. Peter Hollman added that with, this approach, each hospital will at least be compared against itself.
    - Aaron Robinson said that this could result in some systems changing their billing practices and corporate structures based on what is advantageous to them. January agreed, noting that this is a risk with any VBP arrangement. She said that there will be future discussions around how to mitigate against unintended consequences.
    - Aaron Robinson recommended doing an inventory of billing practices by health systems to determine what the structure is now and how this might incentivize unintended consequences.
    - Al Charbonneau said perhaps this is a challenge that is a result of looking at revenue over expenses. Sam Salganik and Aaron Robinson noted that there could be expenses that are allocated to a system as opposed to a hospital. Aaron added that there is still an incentive to change accounting practices when using expenses.
    - **Next Steps**: The Working Group will consider how to conduct an inventory of current billing practices by health system to inform how to mitigate against unintended consequences associated with changes in accounting practices.
- January summarized an additional consensus on using revenue generated by participating hospitals from claims paid for members covered by participating payers.

- Teresa Paiva-Weed asked whether it was realistic if Medicare Advantage would participate in the model. Deepti shared that Medicare Advantage participates in PA. January added that the concern is usually around including Medicare FFS.
- Aaron Robinson recommended revising the consensus to reflect participation from Medicaid, Medicare and commercial payers.
- Teresa Paiva-Weed commented that there is a large portion of the commercial market is self-insured and asked whether they would be included in the model. Deepti explained that commercial self-insured payers have participated in prior models and could do volunteer to participate in RI too.
- Tom Breen noted that the next level of detail around model parameters will have big implications on which payers participate in the model.
- Ira Wilson asked what minimum threshold of participation would be required (e.g., 60%? 80%) to make the model effective.
- Howard Dulude asked if OHIC could provide a report that assesses the percentage of the population covered by commercial, Medicaid managed care, Medicare FFS and Medicare Advantage plans in the state.
- **Next Steps**: Bailit Health will revise the current consensus on the population covered by the budget to specify inclusion of participating Medicaid, Medicare and commercial payers.

- January summarized the final consensus around using net patient revenue (NPR), operating expenses and margins to set the base budget.
  - Aaron Robinson recommended using NPR to set the budget, as gross charges would not be accurate. Dan Moynihan agreed with Aaron.
  - January clarified whether the baseline budgets should actually be set using insurer payments to hospitals, with an eye on operating margin.
  - Al Charbonneau and Teresa Paiva-Weed asked how MD sets its budget. Deepti noted that Maryland is not a good comparison because it has all-payer hospital rate setting authority, which RI does not have. Deepti and Michael shared that PA uses insurer paid amounts to set the budgets.
  - Michael summarized that the Working Group expressed interest in considering margin when developing the budget, but that it was challenging to develop a consistent way to assess margin.
  - Sam Salganik confirmed that the budget design should not impact patient benefit design.
  - Robert Millette asked whether MD's model goals take into account hospital operations, noting some hospitals are more efficient than others. Bob Murray explained that MD's priority was to control hospital payment growth. He said that over time, hospitals have focused on reducing operating expenses to become more efficient and generate a margin. If there were issues with solvency, the MD commission could step in to help the hospitals.
    - Robert Millette asked if any hospitals closed during the model. Bob said yes, but those closures were planned by the state and done in an orderly

way. He explained that MD's commission did step in to help hospitals remain solvent.
        - Robert Millette shared that he believed it was important to focus on revenue when developing budgets because it is easier to implement. He commented that the RI's model does not seem to be focused on improving hospital margins.
    - **Consensus**: Use insurer paid amounts as the basis for developing budgets, but also inform the budgets by an analysis of hospital finances during the base years, considering hospital costs and hospital operating margins.

III. Continue Discussion of How to Calculate and Update Budgets Annually

- January said that the Working Group will need to decide which year(s) of data to use to set the budget and recommended that deferring this question until there are hospital financial data for years closer to 2026.
    - Dan Moynihan recommended using three years of data (i.e., 2017, 2018 and 2019) to do some initial modeling to compare a hospital global budget model to the current FFS system. He added that the Working Group should consider data from 2023 on when developing budgets for 2026.
    - Al Charbonneau asked if the HGB WG could consider hospital financial data before 2020 and adjust to account for COVID.
    - Aaron Robinson said that hospital finances will likely be impacted by COVID until 2025 at the earliest. He recommended using pre-COVID data and analyzing data from 2020 on to understand the COVID impact.
    - Howard Dulude said one of the most significant impact of COVID has been workforce, which must be considered if budgets are set using pre-COVID data.
    - **Consensus**: Use 2017-2019 data to model the impact of moving to a hospital global budget. Utilize more recent data from 2023 onwards when setting budgets for 2026 and evaluate the need for adjustments to account for COVID's impact at that time.
- Deepti described and proposed a "bottom-up approach" to building the hospital global budget, which would involve setting budgets for each payer-market dyad within a hospital and rolling those up to calculate the hospital budget. An alternative would be to set three budgets for each hospital for each payer across all markets.
    - Sam Salganik supported use of payer-market dyad budgets and noted that it doesn't seem possible to only have one budget per market because of the state budgeting process. Michael responded that MD, which is a highly regulated state, has one budget across all payers and markets.
    - Peter Hollman said some payers that serve multiple markets often operate independently and noted that payers would likely prefer the bottom-up approach.
    - Al Charbonneau advocated for a "top-down approach" that starts with the entire hospital's expenses. Deepti responded that this approach would require a lot of state regulatory infrastructure. Bob Murray added that this approach is likely not feasible in a voluntary model like the one RI is trying to develop.

- Theresa Paiva-Weed commented that there needs to be strong investment by the state to have an independent body looking at hospital financial data. She expressed concern about anti-trust implications associated with having information about rates of reimbursement for each hospital be made available.
  - Sam Salganik shared that he did not think this was a significant concern since all payers have an accounting of how much they pay in a market to each hospital.
  - Aaron Robinson added that it is now less problematic as federal law requires hospitals to post their rates.
- Peter Hollman noted that it might be hard to adjust for margin if budgets are based on payer-market dyads. Sam Salganik responded that hospitals could develop an approach to either use the same adjustment across all payer-market dyads, or modify adjustments based on market share.
- Aaron Robinson confirmed that the Working Group can revisit its consensus after convening a technical subgroup to confirm the feasibility of the current model parameters.
- **Consensus**: Use a "bottom-up approach" to develop market-specific budgets for each participating payer-hospital dyad. Reach out to insurers before the next meeting to solicit further input.

- Deepti discussed the types of routine adjustments that can be made to account for factors outside of the hospital's control. She noted that a future technical group will make recommendations on a specific methodology for the adjustments.
- Deepti asked the Working Group to confirm whether demographic and inflation adjustments should be part of the routine adjustments.
  - Aaron Robinson advocated for volume adjustments rather than market share, noting that market share is extremely unreliable and data needed for such adjustments are significantly lagged. Dan Moynihan agreed with Aaron.
  - Aaron Robinson commented that demographics drives case mix and recommended considering them together because of this correlation. Bob Murray agreed, adding that MD includes case mix in its demographic adjustment.
  - Ira Wilson asked whether the demographic adjustment focuses on age and sex, or whether it also includes race and income. He indicated that race and income also influence resource use, though data on these variables are not reliable.
  - Deepti proposed using age and sex because this is what other models have used, but also noted that at a later date the Working Group will discuss whether it wants to incorporate a separate adjustment for social risk.
  - **Consensus**: Develop one routine budget adjustment (frequency to be defined) to account for changes in age, sex and case mix.
  - **Next Steps**: The Working Group will separately consider budget adjustments to account for social risk.
  - Deepti asked the Working Group to confirm that an inflation adjustment should be part of the routine adjustments.

- Aaron Robinson proposed an amendment to use health care inflation and not general inflation.
- Bob Murray described MD's approach to adjusting for inflation. He indicated that MD wanted an external, unbiased methodology for measuring change in hospital input costs. MD uses the Medicare Market Basket Index, which has some components that are specific to hospitals and others that are related to general inflation.
- Howard Dulude commented that hospital costs are largely driven by labor. He added that health care wages in RI have historically lagged behind other states and advocated for a specific investment for workforce development for RI to be able to compete with CT and MA. Aaron Robinson added that RI has the highest vacancy in the nation because of underinvestment in the health care system.
- Howard Dulude advocated for a separate adjustment for workforce investment that is separate from inflation. Bob Murray noted that MD had a pool of funds to help train nurses and provide grants and tuition support.
- Ira Wilson commented that this will cause structural inflation in health care budgets, which will cause an increase in costs. He said it was important for the HGB WG to be aware of this impact.
- Teresa Paiva-Weed responded that it is common in payment reform to make upfront investments to save costs in the long run. These investments don't have to be baked in, but it is important to acknowledge them.

IV. Public Comment

- Deepti asked for public comment. There was none.

V. Next Steps

- The next Working Group meeting will be on April 7, 2023.