Rhode Island Hospital Global Budget Working Group
Meeting #9 Summary
HARI Conference Room
405 Promenade Street, Providence
April 17, 2023
12:00 PM – 2:00 PM

Next Steps:

1. Revise consensus language around development of base budgets to reflect that budgets could be adjusted based on analysis of hospital finances.
2. Use flexible global budgets to adjust for volume changes during the performance year.
3. Use Case Mix Adjusted Discharges (CMADs) to adjust for inpatient volume, but perform further research on: (1) how to convert per diem behavioral health and Medicaid payments to DRGs; and (2) how to address outliers.
4. Task a technical workgroup with developing an approach for outpatient volume that uses either APCs or that takes the proposed Equivalent Case Mix Adjusted Discharge (ECMAD) approach and groups similar services.
5. Use RVUs to adjust for changes in professional services volume.
6. Implement a survey of RI hospital CFOs to assess the percentage of fixed and variable costs by revenue center.

Attendees:

- Cory King, OHIC
- 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
- Al Charbonneau, RIBGH
- Chris Dooley, Prospect
- Howard Dulude, HARI
- Peter Hollmann, Rhode Island Medical Society
- Al Kurose, Lifespan
- Nick Lefeber, BCBSRI
- Peter Markell, Lifespan
- Mary Marran, Butler
- Robert Millette, Prospect
- Dan Moynihan, Lifespan
- Bob Murray, Global Health Payment LLC
- Cathi Newman, BCBSRI
- Elena Nicolella, RIHCA
- Teresa Paiva-Weed, HARI
- Henry Sachs, Bradley
- Ira Wilson, Brown University

I. Welcome

- Cory King acknowledged two repeating comments raised during the meetings, including adequacy of Medicaid rates and hospital operating deficits. He acknowledged that OHIC and the Working Group will need to address these concerns outside of the meeting series. He noted that legislation and activities to reform hospital licensing may address the former.
    - Howard Dulude said the language in the first consensus point "informed by an analysis" needs to be revised to "include adjustments for." January Angeles said "informed" alluded to an analysis of detailed hospital finances and modeling for what the budget would look like.
    - Lisa Tomasso said perhaps the language could say "include, but not limited to." "Informed" implies that the adjustments could be dismissed.
    - Al Charbonneau said he would prefer seeing language around expenses as it relates to efficiency.
    - **Next Steps**: Revise consensus language around development of base budgets to reflect that budgets could be adjusted based on analysis of hospital finances.
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- January Angeles reviewed the agenda for the meeting.

II. Recap of the Discussion from the Last Meeting

- January reviewed the discussion from the April 7th meeting which included inflation adjustments and fixed vs flexible global budgets. She acknowledged issues raised around how global budgets relate to ACO shared savings, and indicated that conversation around global capitation should be deferred to the Cost Trends Steering Committee.
- Peter Markell asked whether the budgets would be set using insurer paid vs allowed amounts. He noted that this could change benefit design and if it shifts significantly to incorporate greater enrollee cost-sharing obligations it would impact hospitals' financial viability under hospital global budgets. Teresa Paiva-Weed added that this is increasingly becoming an issue in Medicare Advantage.
    - January replied that the hospital global budget changes how hospitals are paid by insurers and not how benefit design decisions are made. The assumption is that cost-sharing requirements remain the same. Michel Bailit added that this is not different from the current scenario where providers have responsibility for pursuing member cost-sharing obligations.
    - Cathi Newman added that as a payer, she would want to negotiate budgets that are transparent and ensure that budgets are set in a fair manner.
- Howard Dulude asked how much room for flexibility there would be in negotiating. Michael Bailit noted that the current landscape allows for payers and hospitals to sit together to negotiate the budget. Cory added that budgets are set via a bottom up process with standard model parameters that will inform budget development.

III. Continued Discussion of Whether (and if so, How) to Adjust Budgets to Account for Volume Changes

- Deepti Kanneganti asked the group to weigh in on whether Rhode Island should adopt a fixed or flexible global budget.
    - Cathi Newman advocated for a flexible budget with quarterly reconciliations.
    - Al Charbonneau asked whether there is an overall budgetary goal that hospitals will need to incorporate into their spending goals, and expressed that a bottom-up approach to building the budget won't work.
        - Bob Murray replied that this is the case in Maryland, but that it is very different because the state sets the budgets for the hospitals. This would not be possible in a voluntary approach like Rhode Island's. Cathi Newman and Dan Moynihan agreed with Bob.
        - Al Charbonneau said that if the largest insurer and hospital system participate then all others are likely to participate.
        - Cory King reiterated that this is a voluntary effort and the Working Group needs to operate within those constraints.
    - Peter Hollman expressed that the flexible budget approach makes the most sense in terms of how hospitals get paid. It seems to be fairest and has protections against windfall losses and gains.
    - Al Kurose said that there are too many troublesome scenarios with a fixed budget approach.
    - Peter Markell said he did not think either fixed or flexible budget models would work.
    - Chris Dooley asked whether Maryland readjusted the budgets for extenuating circumstances. Peter Markell asked what would happen with capital improvements under a fixed budget.
        - Deepti replied there will be a future discussion on these topics.
    - **Next Steps/Consensus**: Use flexible global budgets to adjust for volume changes during the performance year.
- Deepti presented a proposal for how to measure volume for inpatient services under a flexible global budget, using Case Mix Adjusted Discharges (CMAD).
    - Dan Moynihan suggested the Working Group also consider volume in terms of inpatient days and length of stay.
    - Cathi Newman commented that the Working Group would need to decide on which DRG version to use. She also indicated that behavioral health is mostly paid on a per diem basis and would have to be converted to DRGs. Natalya Alexander added that Medicaid does not pay based on DRGs. Dan Moynihan noted that the reason Medicaid gets paid on a per diem basis is that there is a greater preponderance of social factors that influence discharge.
    - Peter Markell raised concerns about outliers. He also indicated that from a cost point of view, medicine costs more than surgery but surgery services often have a higher case weight.

    - **Next Steps/Consensus**: Use CMADs to adjust for inpatient volume, but perform further research on: (1) how to convert per diem behavioral health and Medicaid payments to DRGs; and (2) how to address outliers.
- For outpatient volume adjustments, Deepti described a proposal that tries to mirror the approach for measuring volume on the inpatient side. This approach would use Equivalent Case Mix Adjusted Discharges (ECMADs). Deepti noted that while the approach tries to account for resources use, it doesn't do so at the same level as CMADs.
    - Peter Hollman suggested using Ambulatory Payment Classifications (APCs), which have case weights.
    - Peter Markell said that the method should group services into categories (e.g., labs, imaging, etc.) rather than one that treats every service as equivalent. He said using ECMADs is too high level and does not accurately reflect resource use. Tom Breen agreed with Peter.
    - Ira Wilson asked about pharmacy, specifically mentioning 340B revenue, and how this fits in the model. Peter Markell indicated that 340B is about pricing and not utilization.
    - Cathi Newman said that it is important to consider shifts in unlisted code revenue, which can be significant from year to year.
    - Bob Murray said that using ECMADs are reasonably accurate and that researchers often do a similar type of calculation. He cautioned that the precision the alternatives provide may not outweigh the difficulty associated with implementation. He indicated that in Medicare, using APCs has been very difficult.
    - **Next Steps/Consensus**: Task a technical workgroup with developing an approach for outpatient volume that uses either APCs or that takes the proposed ECMAD approach and groups similar services.
- Deepti presented the option of using Relative Value Units (RVUs) to adjust for changes in volume of professional services and asked the group for their thoughts.
    - Peter Markell supported use of RVUs, indicating that most non-salaried compensation aligns with RVUs. Dan Moynihan and Peter Hollman agreed with Peter.
    - **Next Steps/Consensus**: Use RVUs to adjust for changes in professional services volume.
- January discussed the issue of setting the fixed and variable cost percentages and presented two options for the Working Group to consider: using an allocation of 60% fixed costs and 40% variable costs, or having independent experts analyze Medicare Cost Report data.
    - Peter Markell noted that hospital accountants consider fixed, semi-variable (e.g., nurse staffing on the floor) and variable (e.g., consumables) costs. He asked what we consider to be variable costs.
    - Bob Murray recommended surveying hospital CFOs in RI to get their assessment of what is fixed vs variable for inpatient and outpatient services over one or two years, and what their cost percentages are.

- Al Kurose commented that costs associated with age of plant and innovation may be considered fixed costs, which would be significant in RI.
- Howard Dulude indicated that there could be corridors (e.g., no adjustments for 1% volume change and different variables for increasing volume change).
- Ira Wilson asked if it is appropriate to use one set of fixed and variable cost ratios for all hospitals. Peter Markell said it depends on the definition of fixed and variable costs. Consumables may be different depending on what services the hospital provides. For example, if one hospital delivers a lot of cancer care, they will have high-cost drugs which would increase their variable costs.
- Peter Markell supported Bob Murray's survey idea. He said he thought the fixed/variable cost ratio is closer to 70%/30%.
- Howard Dulude recommended asking hospital financial staff to review the survey prior to implementation.
- Bob Murray commented that using varying fixed/variable cost ratios by hospital would be more specific, but it would introduce greater complexity. He recommended, at most, using one set of variable cost percentages for medium/large hospitals, and another for small hospitals that have higher percentages of fixed costs.
- **Next Steps/Consensus**: Implement a survey of RI hospital CFOs to assess the percentage of fixed and variable costs by revenue center.

- January presented two options for how often to make budget adjustments: quarterly and semi-annual.
  - Peter Markell asked whether hospitals would still need to bill under a hospital global budget. Cathi Newman confirmed that this would still be needed, and that on the plan side the claims would be turned into encounters. The hospitals would get $0 for those claims, and get their regular global budget payment. Peter Markell commented that he would not get any efficiency out of this approach.
  - Cathi Newman suggested it could be helpful to start with quarterly adjustments because it's a new payment mechanism, and then consider moving to semi-annual once hospitals and payers have more experience. She added that it would be important to wait for at least three months of claims runout to do the adjustments.
  - Bob Murray said quarterly adjustments make sense, noting that annual adjustments make the model closer to fixed budgets and could lead to hospital cash flow issues if there are big changes in utilization. He said as the model becomes more sophisticated, RI could consider more frequent adjustments, such as monthly adjustments which MD does.
- Tom Breen asked if there would be a process to consider big changes that would operate outside the fixed/variable cost percentages and the quarterly adjustments, such as an introduction of a new drug. He advocated for having the ability to work through these types of issues on an ongoing basis.

- Howard Dulude noted that hospitals will need to work with multiple payers, which could result in increased model complexity if there is a lot of flexibility given to payers and hospitals.
- January reiterated the distinction between the base budget conversation and the annual adjustments, both of which assume a set level of utilization during the year, and the quarterly adjustments, which look at utilization variation during the year. She noted that the negotiations would happen in setting the yearly budgets, but that adjustments during the year should be formula-driven and not negotiated.
- Lisa Tomasso asked what would happen if a major employer changes contracts. Cathi Newman noted that that would be change that is known in advance of the measurement year and could be accounted for in the budget design.
    - Al Charbonneau said if this is a hospital experiment, it doesn't matter who is covered by whom, because the formula would just apply to a different payer. HEPP was a formula-based, hospital experiment that didn't have negotiation. There were finance and CEO committees that discussed changes and other issues that came up each year.
    - Dan Moynihan agreed with Al, but noted that if there is a payer that isn't participating, that will impact the model.
    - Al Charbonneau said if everyone in the room is committed and interested in the model, then other hospitals and payers would elect to participate as a result. He said the model has the potential to deliver transformation and innovation.

- Peter Markell commented that he cannot see an upside to a hospital system through a global budget.
    - January shared that the Working Group did initially discuss the goals and benefits of a hospital global budget model, and the Cost Trends Steering Committee prioritized this model in the VBP Compact. She noted that the Working Group should focus on developing model parameters.
    - Cory King agreed and indicated that individual organizations could opt to not participate if there is no value proposition.

IV. Public Comment

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

V. Next Steps

- The next Working Group meeting will be on May 1, 2023.