Rhode Island Hospital Global Budget Working Group
Meeting #12 Summary
HARI Conference Room
405 Promenade Street, Providence
June 5, 2023
9:00 AM – 11:00 AM

Preliminary Recommendations and Next Steps:

1. Develop a structured process for considering whether there should be prospective adjustments to the Medicare Market Basket index to account for market-specific conditions. Develop a set of risk corridors to inform retrospective budget adjustments for unforeseen and major hospital cost increases.
2. Fund interest and deprecation for capital investments through adjustments to the base budget that allow for sufficient operating margins (to be defined).
3. Adopt prospective budget adjustments based on approved, planned service line changes.
4. Pay for new technologies (i.e., medical devices, services and pharmaceuticals) that are covered by payers and meet a to-be-specified threshold on a fee-for-service basis for three years; then evaluate whether payment for the technology should be incorporated into the global budget.

Attendees:

- Cory King, OHIC
- January Angeles, Bailit Health
- Michael Bailit, Bailit Health
- Deepti Kanneganti, Bailit Health
- Natalya Alexander, NHPRI
- Tom Breen, South County
- Scott Brown, Landmark
- Steve Burke, Butler
- Doreen Carlin-Grande, NHPRI
- Al Charbonneau, RIBGH
- Stephanie De Abreu, United
- Domenic Delmonico, Tufts
- Chris Dooley, Prospect
- Howard Dulude, HARI
- April Greene, Aetna
- Peter Hollmann, RIMS
- Al Kurose, Lifespan
- Nick Lefeber, BCBSRI
- Peter Markell, Lifespan
- Mary Marran, Butler
- Heather-Rose Mattias, CNE
- Dan Moynihan, Lifespan
- Bob Murray, Global Health Payment
- Elena Nicolella, RIHCA
- Teresa Paiva-Weed, HARI
- Kim Paull, BCBSRI
- Aaron Robinson, South County
- Sam Salganik, RIPIN
- Lisa Tomasso, HARI
- Ira Wilson, Brown University

I. Welcome

- Cory King welcomed the Working Group and reported that the state legislature voted to make changes to hospital licensing fees.
- Teresa Paiva-Weed summarized the proposal included in the Governor's budget, which is a Medicaid managed care directed payment that will result in $135 million in additional funding for hospitals, which, when combined with other new policies (e.g., increases in managed care rates for maternity services), brings total hospital payments to $152.7 million. Teresa added that CMS may not approve the proposal until January 2024, but the change would be retroactive to July 2023. She noted that RI is still behind MA and CT, but this work will help close the gap.
    - Cory King noted that this policy, combined with OHIC's hospital rate cap of 7% for commercial insurers, will result in a healthy rate increase for hospitals this year.
    - Al Charbonneau commented that Marilynn Bartlett's work shows that commercial premiums are subsidizing inadequacy of Medicare and Medicaid rate. He acknowledged that the cost of hospital care will increase if this new policy adds $214 million for hospitals, which is roughly 5-7 percent of hospital expenses, and commercial insurers are still subsidizing other payer rates.
    - Teresa Paiva-Weed shared that $214 million goes to the state general fund, but only $88 million goes back to the hospital as the state share for additional federal money. She said Howard can provide Al with more information.
- January Angeles provided an overview of the meeting agenda and summarized the discussion from the last meeting regarding an annual inflation factor.
    - Howard Dulude questioned why the potential adjustments to the inflation factor were retrospective. January said this is to ensure that any adjustments made are reflective of actual performance and supported by data.
    - Peter Markell said all institutions need to build wage increases into budgets, which could be problematic if the wage increase is greater than the inflation factor. He added that one risk with retrospective adjustments is hospitals may not actually receive the additional payment.
    - Howard Dulude said insurers also want to know any inflation adjustments prospectively.
    - Tom Breen asked how retrospective adjustments would work with self-funded plans. He confirmed with January that the Working Group recommended adopting a separate process to adjudicate unexpected issues.
    - Michael Bailit said Vermont's Working Group is developing a defined process, including a specified threshold and set of criteria, to identify what variation would qualify for a budget adjustment.
    - Al Charbonneau highlighted the need for an organization to run the model on behalf of hospitals, which can help determine how to distribute the contingency fund across hospitals. He said this structure can incentivize hospitals to collaborate and innovate.

- Peter Markell reported that wages, which represent roughly 50-60% of hospital budgets, are market driven unlike the Medicare Market Basket index. He said a retrospective adjustment to align wage increases with an inflation factor could be problematic the if difference is not reflected in insurer premiums.
- Cory King asked how the Medicare Market Basket index differed from the Medicare wage index. Howard Dulude explained that the latter is a regional adjustment.
- Ira Wilson noted there may be a need for both prospective and retrospective adjustments, as the final changes may be different from what is projected.
- Domenic Delmonico highlighted that the 1980s approach included a negotiated process where stakeholders discussed how to reconcile projected cost increases with inflation.
- Sam Salganik said he recalled that a negotiated process would be more challenging to implement given the number of payers in today's market compared to the 1980s.
- Peter Markell proposed adopting prospective adjustments to the inflation factor to account for wage increases, which would provide more certainty for hospitals and insurers. He said there would be additional risk-corridors to inform retrospective budget adjustments.
- Nick Lefeber and Domenic Delmonico supported Peter's proposal. Domenic said it may be necessary to have a two-year process given the time required to calculate the adjustments.
- **Preliminary Recommendation**: Develop a structured process for considering whether there should be prospective adjustments to the Medicare Market Basket index to account for market-specific conditions. Develop a set of risk corridors to inform retrospective budget adjustments for unforeseen and major hospital cost increases.

II. Continued Discussion of How to Calculate and Update Budgets Annually
Capital Investments

- January Angeles summarized the prior conversation related to adjustments for capital investments. She described two options for how to account for capital investments:
  - Option 1 would involve no budget adjustments and fund such investments through adequate operating margins in the base budget.
  - Option 2 would include an adjustment for major capital investments to support interest and depreciation costs.
- Domenic Delmonico said the 1980s model used option 2. He explained that hospitals would receive automatic budget adjustments for interest and depreciation if their CON was approved; other adjustments were negotiated through the budget process. He asked how either option would address the existing capital deficit.
- January and Michael acknowledged the existing capital deficit, but noted that is outside the scope of the Working Group and hard to achieve without universal payer participation.

- Teresa Paiva-Weed and Lisa Tomasso reported that hospitals need to provide funding for renewable energy per 2021 state legislation that specifies that the state needs to get to zero emissions by 2050. Lisa added that this is another cost that must be considered as part of the budget process.
    - Sam Salganik clarified that this is a local, market-specific issue that could potentially be addressed through the prospective budget adjustment.
- Peter Markell advocated for option 1, including a 3-5% margin to fund 150% of depreciation costs. He added that unfunded mandates (e.g., the renewable energy issue) could be addressed outside the budget.
    - Domenic Delmonico said he would support these numbers from a hospital finance perspective. However, hospitals may not spend the 3-5% margin on capital without a mandate.
    - Deepti asked if there should be any accountability for how margins are spent.
    - Peter Markell said the real issue is to consider margins relative to costs, which are measured by CMADs.
- **Preliminary Recommendation**: Fund interest and deprecation for capital investments through adjustments to the base budget that allow for sufficient operating margins (to be defined).

Planned Service Line Changes

- Deepti Kanneganti described two options for how to handle planned service line changes:
    - Option 1 would involve no adjustments. Rather, absorb changes in utilization resulting from planned service line changes through the flexible global budget.
    - Option 2 would prospectively adjust the budget based on planned service changes. Hospitals would need to submit a list of planned service line changes that have an expected impact of plus or minus 0.5 percent of budget payments.
- Domenic Delmonico confirmed with Deepti that either option would not replace or change the existing Certificate of Need process.
- Sam Salganik questioned the purpose of making additional adjustments for service line changes, adding that part of the goal of a hospital global budget is to incentivize hospitals to provide community-based services to prevent expensive hospitalizations. He reiterated the need to examine the reasons for considering hospital global budgets to begin with, and how the ultimate design of the hospital global budget is different from the current payment system.
- Domenic Delmonico shared that the 1980s model used option 2. He commented on the importance of aligning service line changes with state health care planning. Deepti noted that while important, this was outside of the Working Group's scope.
- Aaron Robinson recommended revising the options to specify approved service line changes.
- **Preliminary Recommendation**: Adopt prospective budget adjustments based on approved, planned service line changes.

New Technologies

- January Angeles summarized the prior conversation related to adjustments for new technologies and a proposal for how make these ad hoc adjustments moving forward.
- Domenic Delmonico recommended revising the proposal to specify that "new technology" includes medical devices, services and pharmaceuticals.
- Peter Hollman asked whether the threshold would be applied as the price for individual units, or if it would be the aggregate projected volume times price. Howard Dulude said there could be two thresholds.
- Peter Hollman commented that it may be hard to assess whether new, beneficial procedures are "approved" because they don't always have corresponding CPT codes.
- Domenic Delmonico highlighted the importance of developing a process to determine whether new technologies are advantageous and aligned with state goals, even if it is outside the scope of the Working Group.
    - Teresa Paiva-Weed said the CON process, at a minimum, needs to be updated as a precondition for a successful hospital global budget model.
    - January recommended acknowledging these concerns in the recommendations report.
- Peter Hollman and Peter Markell noted the proposal was reasonable. Peter Hollman added that the proposal is similar to what Medicare follows for outpatient procedures.
- Lisa Tomasso noted that hospitals contribute to a statewide HIT fund focused on technology and IT.
- **Preliminary Recommendations**: Pay for new technologies (i.e., medical devices, services and pharmaceuticals) that are covered by payers and meet a to-be-specified threshold on a fee-for-service basis for three years; then evaluate whether payment for the technology should be incorporated into the global budget.

III. Public Comment

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

IV. Next Steps

- The next Working Group meeting will be on June 26, 2023.