Hospital Global Budget Working Group

April 17, 2023

Agenda

- Recap of the Discussion from the Last Meeting
- Continued Discussion of Whether (and if so, How) to Adjust Budgets to Account for Volume Changes
- Public Comment
- Next Steps

Recap of the Discussion from the Last Meeting

Recap of April 7th Meeting Discussion

We clarified that the "budget" represents hospital revenue from participating commercial, Medicaid and Medicare payers.

- We also confirmed that final budgets will be informed by an analysis of hospital finances during the base years, considering hospital costs and operating margins.

The Working Group discussed, but did not come to consensus on, how to develop a routine budget adjustment for inflation. It will resume this discussion and consider other possible budget adjustments (e.g., for uncompensated care, social risk) in May.

Finally, the Working Group reviewed the advantages and disadvantages of fixed and flexible global budget approaches. We will continue this discussion today.

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

Reminder: Overview of Three Different Approaches to Hospital Payment

FFS MODEL	FLEXIBLE GLOBAL BUDGET	FIXED GLOBAL BUDGET
Hospital is paid 100 cents on the dollar for each new service, even though the cost to produce the service is <$1 Predominant payment model for hospitals in the U.S.	Hospital receives additional revenue for variable costs associated with increases in utilization during the year and retains payment to cover fixed costs when utilization declines MD from 1976-1990; Rochester 1980-1987; RI 1980s; Int'l global budgets since 2010 (e.g., Germany)	Hospitals receives a guaranteed amount of revenue per year that does not change whether volumes increase or decrease MD All-Payer and TCOC Models; Int'l approaches in early 2000s (e.g., Canada, Germany, France)

Discussion

Should we adopt a fixed or flexible global budget approach?

Additional Considerations for a Flexible Global Budget Approach

If the Working Group recommends pursuing a flexible global budget approach, we need to consider the following questions:

1. How should we measure volume for inpatient and outpatient services?
2. How should we measure volume for professional services?
3. How should we set the fixed and variable cost percentages?
4. How often should we make budget adjustments to account for volume changes?

How Should We Measure Volume for Inpatient Services?

We propose using the following approach for measuring volume for inpatient services. **Does this approach seem reasonable to you?**

Inpatient Services: Case Mix-Adjusted Discharges (CMADs)

To calculate:

1. Sum hospital discharges by DRG
2. Multiply discharges by DRG by case weight* assigned to each DRG
3. Sum total case mix-adjusted discharges across DRGs
4. Calculate hospital-specific case mix index by dividing case mix-adjusted discharges by actual discharges

*Case weights are calculated by taking a hospital's cases by DRG and multiplying each case by a weight that indicates the resource intensity required to deliver the service. For example, the case weight for a normal newborn delivery may be 0.60 while the case weight for coronary bypass surgery with catheterization may be 2.55.

How Should We Measure Volume for Inpatient Services? (Cont'd)

We propose using the following approach for measuring volume for inpatient services. **Does this approach seem reasonable to you?**

Inpatient Services: Case Mix-Adjusted Discharges (CMADs)

Example:

1 2

DRG Category	Actual Discharges (A)	Weight (B)	Case Mix-Adjusted Discharges (C = A x B)	Case Mix Index (C / A)
176	40	0.75	30	N/A
177	20	1.5	30	N/A
178	30	0.9	27	N/A
Total	**90**	**N/A**	**87** 3	**0.967** 4

How Should We Measure Volume for Outpatient Services?

The following slides describe one approach for measuring volume for outpatient services. It uses revenue to establish an equivalent CMAD for outpatient resource use based on inpatient resource use statistics.

Does this approach seem reasonable to you? Are there other approaches we should consider?

Outpatient Services: Equivalent Case Mix-Adjusted Discharges (ECMADs)

To calculate:

1. Use revenue* for inpatient services to calculate revenue per CMAD
2. Identify revenue for outpatient services
3. ECMADs = revenue for outpatient services / revenue per CMAD

*We previously defined revenue as hospital revenue from participating commercial, Medicare and Medicaid payers.

How Should We Measure Volume for Outpatient Services? (Cont'd)

We propose using the following approach for measuring volume for outpatient services. **Does this approach seem reasonable to you?**

Outpatient Services: Equivalent Case Mix-Adjusted Discharges (ECMADs)

Example:

1. Revenue for inpatient services = $100,000,000
   CMADs = 8,500
   Revenue per CMAD = $100,000,000 / 8,500 = $11,765
2. Revenue for outpatient services = $80,000,000
3. ECMADs = revenue for outpatient services / revenue per CMAD
   ECMADs = $80,000,000 / $11,765 = 6,800

How Should We Measure Volume for Professional Services?

We propose that there be a separate mechanism to measure volume for professional services. There are several approaches we are considering, including:

- Services: simple to administer, but does not differentiate varying intensities of services (e.g., a routine newborn delivery vs. hip replacement)
- RVUs: does take into consideration resource use, but there may be critiques in how RVUs are set

Do any of these approaches resonate with you? Are there other approaches we should consider?

How Should We Set the Fixed and Variable Cost Percentages?

There is little empirical evidence on fixed and variable cost proportions for hospitals or different sized hospitals.

- Hospitals of different types and sizes are going to have different fixed vs variable cost proportions.

What is most important is to determine a fixed versus variable proportion that is somewhere in between the two extremes of the current FFS system and a fixed hospital global budget.

- The FFS system assumes 100% of costs are variable.
- A fixed hospital global budget assumes 0% of costs are variable.

How to set the proportions depends on how strong the incentive to manage care should be.

Proposed Approaches for Allocating Fixed Versus Variable Percentages

Option 1:
Use Allocation of
60% Fixed / 40% Variable

- Simpler approach
- Provides modest incentive to manage care
- Provides more protection for hospitals against volume decreases

Option 2:
Have Independent Experts Analyze Medicare Cost Reports

- More accurate representation of RI hospital finances overall, but not at individual hospital level
- Will require significant work
- Could result in higher proportion of variable costs, which would provide less protection for hospitals against volume decreases

Which option does the Working Group prefer?

How Often Should We Make Budget Adjustments to Account for Volume Changes?

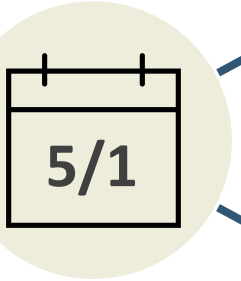
Option 1: Quarterly	Option 2: Semi-Annual
▪ Provides hospitals with more opportunities to adjust budgets during year to reflect actual utilization ▪ Requires more resources to administer	▪ Simpler to administer ▪ May pose challenges for hospital finances if utilization is much higher than forecast

Which option does the Working Group prefer?

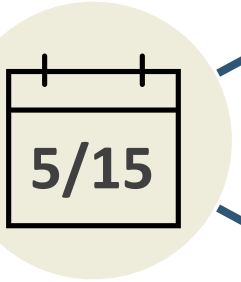
Public Comment

Next Steps

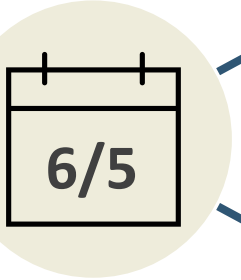
Working Group Meeting Plan and Schedule



- Discuss how to adjust budgets to account for changes in utilization during the performance period (cont'd)
- Discuss routine and ad hoc budget adjustments (cont'd)



- Decide whether the hospital global budget model should include supplemental arrangements to improve population health, access and quality



- Decide whether the hospital global budget model should include supplemental arrangements to improve population health, access and quality (cont'd)

Appendix

Comparison of Payment Approaches: Example of Hospital with 50/50 Variable vs Fixed Costs

- Under FFS payment, the profit margin increases with increases in volume
- Under Fixed Global Budgets (GBs), decreases in volume lead to higher profits
- Under Flexible GBs, volume increases or decreases do not impact profit margins

Volume Change over Baseline	**Fee for Service** Paid 100c on the $ VC = 50c on the $	**100% Fixed GBs** Revenue Guarantee 0 Pmt for new Volume	**Flexible GBs** Example 50% FC & 50% VC Volume Adj.	**Modified Flex GB** Stronger Incentive 60% FC & 40% VC.
+5.00%	5.63%	0.92%	3.33%	2.86%
+3.00%	4.74%	1.88%	3.33%	3.05%
+2.00%	4.28%	2.37%	3.33%	3.14%
+1.00%	3.81%	2.76%	3.33%	3.24%
0.00% (baseline)	3.33%	3.33%	3.33%	3.33%
-1.00%	2.85%	3.82%	3.33%	3.43%
-2.00%	2.35%	3.92%	3.33%	3.53%
-3.00%	1.84%	4.78%	3.33%	3.63%
-5.00%	0.79%	5.75%	3.33%	3.83%

Profit Margin

There is some Flexibility in how the Flexible Global Budget is structured (e.g., incentives to manage care can be modified based on experience over time).

Considerations for Fixed Global Budgets

ADVANTAGES

- Guarantees a set level of revenue each year regardless of patient volume or a hospital's cost experience
- Provides a set budget that allows hospitals to allocate resources prior to the start of the year
- Provides the flexibility for hospitals to redesign care delivery to meet the needs of the community and improve population health
- Simpler to administer

DISADVANTAGES

- Incentivizes restrictions in services and shifting care to other providers or settings not covered by the budget
  - May impede technology adoption
- Can only be adjusted for market shifts and not overall utilization changes
- Limits ability to redirect patient volume to low-cost/high quality hospitals
- Does not allow ACOs to realize savings from better care management activities (hospital captures the savings)
- Results in higher levels of financial risk for smaller hospitals

Considerations for Flexible Global Budgets

ADVANTAGES

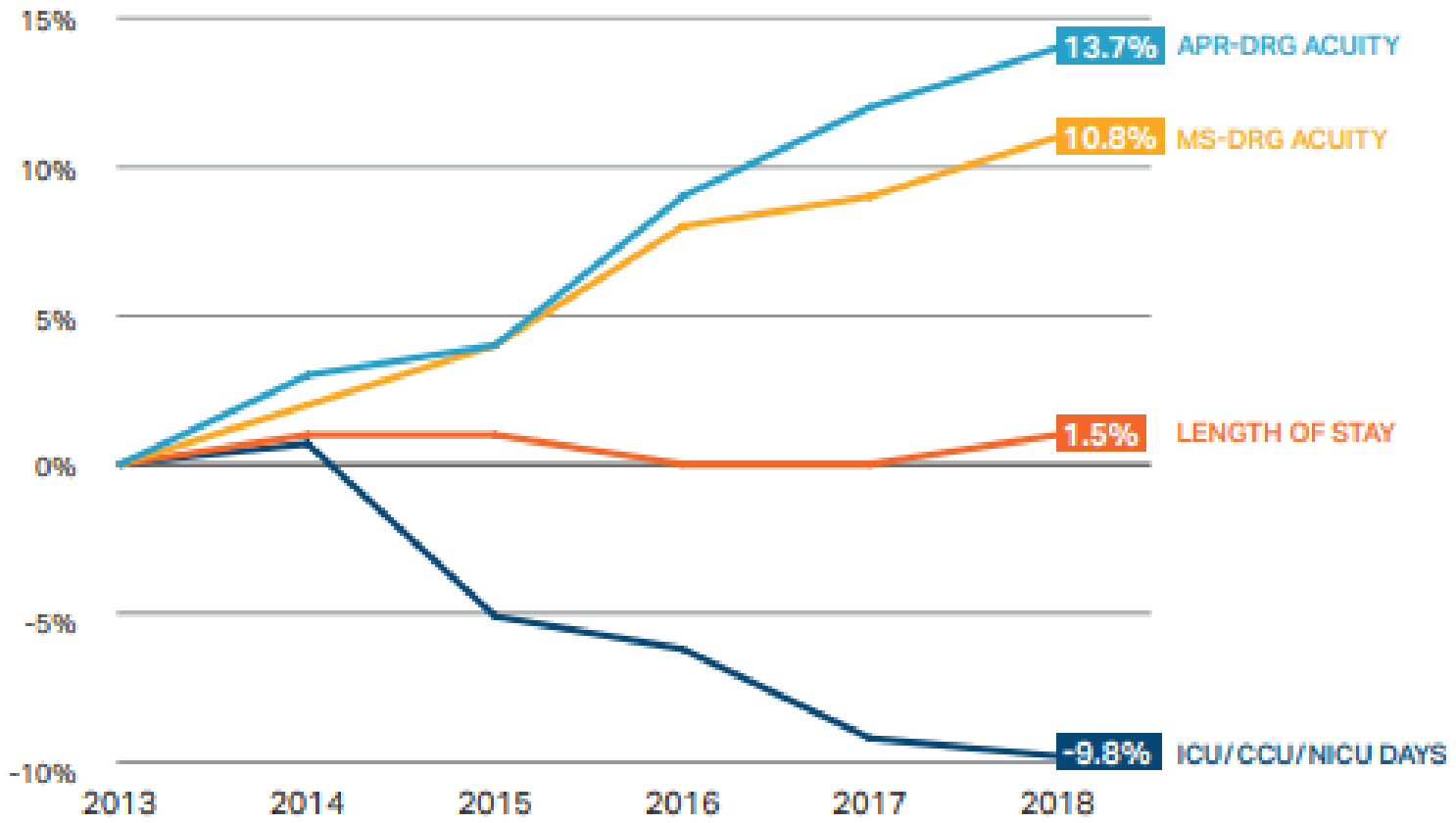
- Covers hospital fixed costs regardless of volume fluctuations
- Eliminates incentive for hospitals to increase utilization to generate savings/profit, as hospitals only receive additional payments for variable costs
- Reduces incentive for hospitals to stint or shift care outside the hospital/budget
- Provides additional revenues to accommodate new technologies/drugs
- Accommodates payer-induced shifts of care from high-cost to low-cost hospitals
- Provides better protection for all parties in the case of sudden, unexpected shifts in volume

DISADVANTAGES

- Does not provide revenue certainty before the start of the year, as the budget will fluctuate based on utilization (variable costs)
- Challenging to precisely identify the proportion hospital fixed vs. variable costs
- Reduces pressure for hospitals to manage utilization/efficiency; may incentivize hospitals to focus on growing profitable service lines
  - Note: Variable Cost factors used can be adjusted to apply incrementally stronger incentives to manage care

Research Example: Trends in Measured Patient Acuity Compared with LOS and Intensive Care Use

Exhibit 3.1.3 Percent increase in overall DRG weight, patient length of stay, and use of intensive care settings, 2013 – 2018



Notes: ICU = intensive care unit; CCU = cardiac care unit; NICU = neonatal intensive care unit. This curve represents days in any of these settings combined.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, FY2013-FY2018; MS-DRG classification system for each year (weights updated each year), 3M APR™DRG classification system v30.0 using MassHealth weights (weights held constant)