Hospital Global Budget Working Group

May 15, 2023

Why Are We Considering Hospital Global Budgets?

Hospital global budgets can be supportive of hospitals and payers and advance the Cost Trends objectives by:

- Ensuring steady, predictable hospital financing
- Providing increased flexibility to modify hospital service offerings to best meet community needs
- Producing positive outcomes without having adverse effects on hospital finances
- Controlling growth in hospital spending at an affordable level

Agenda

- Recap of the Last Meeting
- Continued Discussion of How to Calculate and Update Budgets Annually
- Public Comment
- Next Steps

Recap of the Last Meeting

Discussion and Next Steps from the May 1st Meeting

1. Use the Medicare Market Basket Index as the hospital cost measure to develop an annual inflation factor.
2. Model the impact of different approaches to calculating inflation using ten years of historical data and using forecasted data until 2025.
3. Develop a process for discussing ad hoc changes to the hospital global budget methodology.
4. Use data from Form 990, Schedule H, Line 7 to analyze historical patterns of uncompensated care. Use the data to develop a revised definition of uncompensated care and inform a regular plan to monitor and adjust for uncompensated care.

Continued Discussion of How to Calculate and Update Budgets Annually

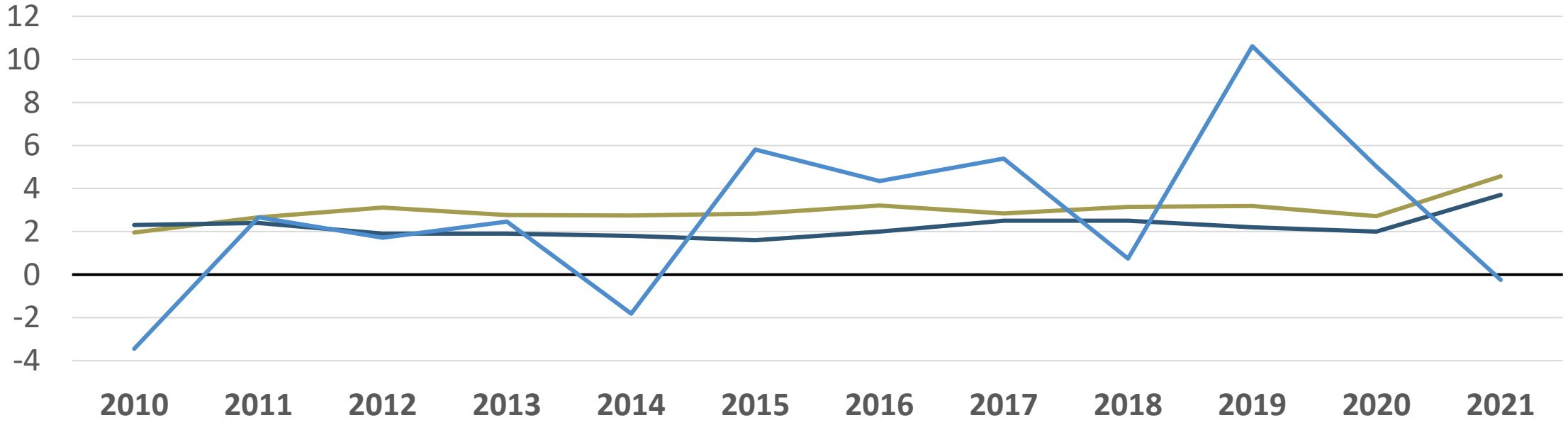
Proposed Formula for Adjusting for Inflation

During the last meeting, we proposed calculating inflation using the following formula, which takes both hospital costs growth and consumer affordability into consideration.

50% x Hospital Cost Measure + **50% x RI Consumer Affordability Measure** = **Annual Inflation Factor**

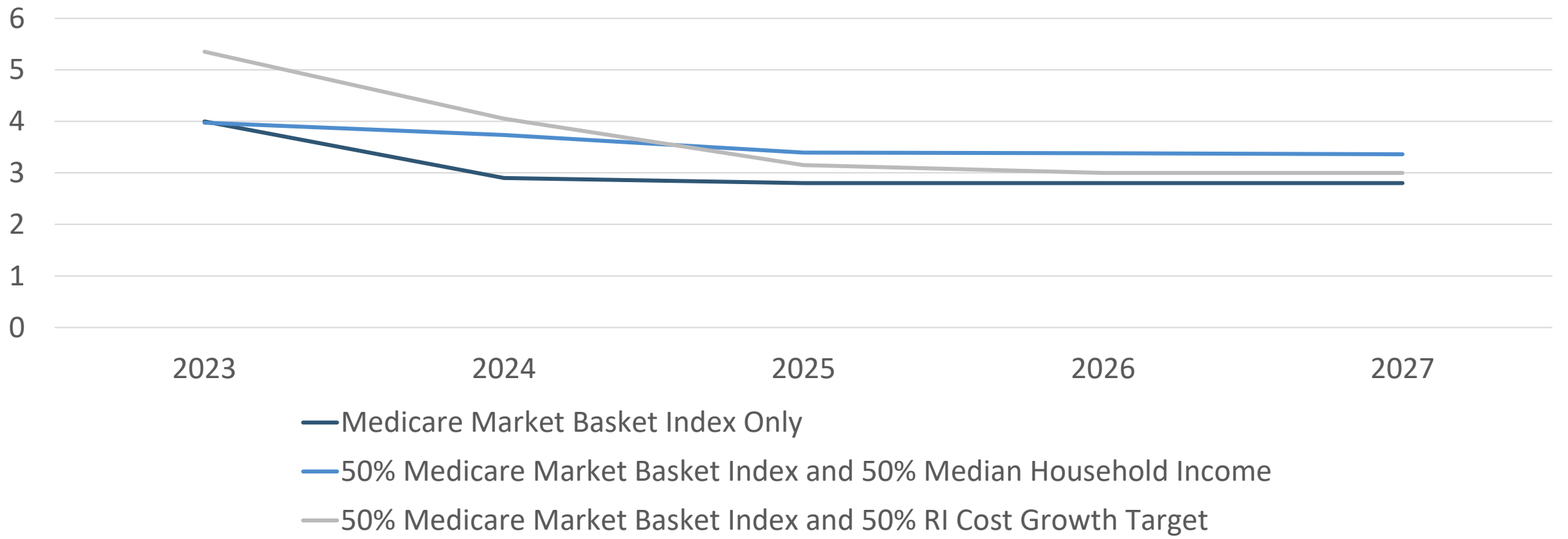
Hospital Cost Measure	Consumer Affordability Measure Options
• Medicare Market Basket Index (without productivity adjustments)	• RI Median Household Income • RI Cost Growth Target

Historical Inflation Trends



	5-Year Avg (2017-2021)	10-Year Avg (2012-2021)
CPI-U +1	3.3	3.1
Medicare Market Basket Index	2.6	2.2
Median Household Income	4.3	3.4

Projected Inflation Values



Forecast Sources: Medicare Market Basket Index: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/marketbasketdata (last updated April 21, 2023)
Median Household Income: S&P Global (formerly IHS Economics) forecast as of July 2022.

Proposed Formula for Adjusting for Inflation

How do you recommend calculating an annual inflation factor?

- ***Do you recommend using historical or forecasted values?***
- ***Do you recommend using one year or two or more years of data?***

Option 1:	Option 2:	Option 3:
Medicare Market Basket Index Only	50% Medicare Market Basket Index and 50% Median Household Income	50% Medicare Market Basket Index and 50% RI Cost Growth Target

Revisit Demographic Adjustment

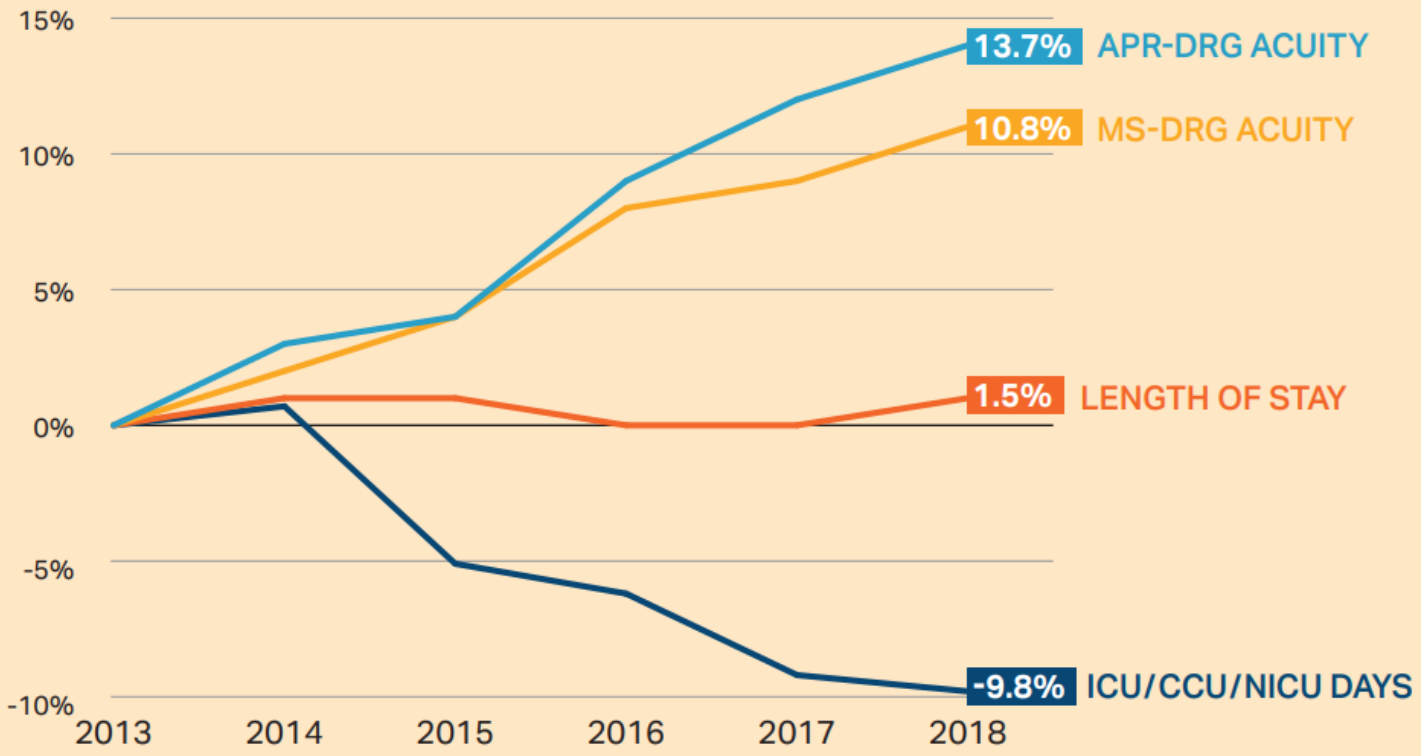
The Working Group previously recommended adopting a demographic adjustment that accounts for changes in age, sex and case mix.

We propose revising the demographic adjustment to only include changes in the age and sex of the population because:

- When the Working Group initially discussed a demographic adjustment, it recommended including one adjustment for age, sex and case mix because age and sex is highly correlated with case mix.
- Case mix is highly subject to coding distortion. Higher acuity is not correlated with increased length of stay or use of intensive care.

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

FIGURE 1: 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: Massachusetts Health Policy Commission 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)

Should Routine Adjustments be Made Prospectively?

There is consensus to adopt two routine budget adjustments to account for (a) demographics and (b) inflation.

We recommend making budget adjustments for these two factors prospectively for the following reasons:

- **Demographic adjustments will likely be small**, as the age and sex of the population typically does not change significantly year-over-year.
- **Inflation is a relatively stable indicator** (except in recent years!). The Working Group has already identified the need to develop a **process to discuss ad hoc budget adjustments for when there are significant events** (e.g., dramatic changes to inflation, increases in uncompensated care) that would impact hospital budgets.
- Use of **flexible global budgets** provides hospitals with an opportunity to **reconcile budgets on a quarterly basis** to reflect changes in utilization during the year rather than waiting to reconcile budgets after the end of the year.

Should Routine Adjustments be Made Annually or Less Frequently?

Routine budget adjustments are typically made annually. This:

- Ensures hospital budgets reflect the most recent performance.
- Results in one methodology to calculate budgets every year.

Does this approach seem reasonable to you, or do you recommend adjusting budgets less frequently (e.g., every other year)?

- This approach may be more feasible if budget adjustments are expected to be small.
- As a reminder, the Working Group can revisit the frequency of budget adjustments as RI gains experience with the model.

Which Ad Hoc Adjustments Should We Make?

In addition to routine adjustments, there may be grounds to adjust budgets on an ad hoc basis due to planned future changes and/or exogenous factors.

Of note, Maryland rarely makes ad hoc budget adjustments. There are two structured pathways that Maryland uses to identify if changes are beyond a hospital's control and warrant ad hoc adjustments:

1. Hospitals can file an application for a full rate review. The commission has a strict, published methodology to guide this review, which could result in rate increases or decreases.
2. The commission can vote on recommended changes to existing methodologies that are proposed by commission staff and/or that are made in response to stakeholder feedback.

Which Ad Hoc Adjustments Should We Make? (Cont'd)

Over the last few meetings, the Working Group recommended making ad hoc adjustments to account for the following factors:

- Planned service offerings/closures
- Capital investments
- Introduction of new medical technology (e.g., drug offerings, medical devices)

Does the Working Group still recommend making these ad hoc adjustments?

Which Ad Hoc Adjustments Should We Make? (Cont'd)

If so…

Planned Service Offerings/Closures and Capital Investments

1. We propose leveraging the current Certificate of Need review process to identify and approve expenditures for new equipment, service offerings and facilities (including acquisitions of existing facilities).

   How should we evaluate budget adjustments (e.g., as a result of service closures) that are not covered by the Certificate of Need review process?

2. How should we differentiate between investments that require a budget adjustment versus ones that are funded through a reallocation of existing hospital resources?

Which Ad Hoc Adjustments Should We Make? (Cont'd)

If so…

Introduction of New Medical Technology

3. What new medical technology would trigger an ad hoc review (e.g., drug offerings, medical devices)?

Should We Adjust for Social Risk/Equity?

Social Risk/ Equity

Accounts for the social risk of the population served and aims to correct existing inequities in payments

- Supports hospitals that serve historically marginalized communities that may need additional resources
- Encourages hospitals to improve access and facilitate appropriate utilization

- Limited existing research on how to implement social risk adjustment
- No certainty that added funds would further population health equity

Should We Adjust for Social Risk/Equity? (Cont'd)

Below are some potential approaches to incorporate social risk/equity into a hospital global budget model. Which do you recommend exploring further?

Adjustments based on **population**	• CMS ACO REACH Health Equity Benchmark Adjustment: monthly adjustment to PMPM based on individual's geographic residence (using the Area Deprivation Index) and dual eligibility status
Adjustments based on **quality**	• MD's Readmissions Reduction Incentive Program: hospitals can receive up to 0.5% of their inpatient revenue for reductions in within-hospital readmission disparities
Adjustments based on **data collection**	• CMS ACO REACH Health Equity Data Reporting Adjustment: Up to a 10% positive adjustment to an ACO's quality score if the ACO submits patient-reported demographic data and up to a 5% adjustment for SDOH data

Other Ad Hoc Budget Adjustments

Are there any additional ad hoc budget adjustments we should consider?

Public Comment

Next Steps

Working Group Meeting Plan and Schedule

Please note that we rescheduled the 6/22 meeting (3-5pm) to 6/26 (9-11am).

6/5

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

6/26

- Decide whether the hospital global budget model should include supplemental arrangements to improve population health, access and quality (cont'd)
- Discuss how a global budget should co-exist with other VBP initiatives

7/10

- Identify if and how the model should allow for different payers and hospitals to deviate from the recommended model