Hospital Global Budget Technical Advisory Group

MAY 9, 2023
MEETING #6

Meeting Agenda

1. Recap of global budget construction
2. Recap of prior meeting discussion
3. Adjustments for utilization
    - Market shift adjustments
    - Volume adjustments
    - Planned service line changes
    - Interhospital transfers

Recap of Global Budget Construction

1) Establish baseline budget

Identify baseline revenue

- Calculate actual hospital revenue using an average of 2022 adjusted data & 2023 data
- Specific revenue streams for exclusion TBD

Apply any adjustments

- Potential one-time adjustment for negative operating margins during baseline period

Trend forward to performance year

- Adjust for inflation (measures to reflect hospital costs & affordability)
- Adjust for demographics

2) Apply annual adjustments (concurrently, prospectively, or retrospective reconciliation)

Performance Year 1 Budget → **Performance Year 2 Budget** → **Performance Year 3 Budget, etc.**

Annual adjustments

Annual adjustments

Recap of April 18th Meeting

April 18th Meeting Recap (1 of 3)

Aligning program years

- If CMMI provides states flexibility to determine the program year of the global budget model, the group members supported an October-September year to align with hospital fiscal years & the GMCB budget review year.

Adjusting baseline budgets for margin

- Members had mixed opinions regarding whether to adjust Year 1 budgets for negative margins during the baseline period; slightly more members supported such adjustments. If included, members supported an adjustment based on operating margin, rather than total margin. The group did not have specific recommendations for the extent of adjustments.

April 18th Meeting Recap (2 of 3)

Trending forward the baseline budget

- Members supported including **inflation adjustments** that use measures reflecting both a hospital cost lens and an affordability lens. Specific measures of inflation will be determined at a future date.
- Members supported including **demographic adjustments** and discussed approaches for defining service areas for each hospital to determine hospital-specific adjustments, rather than using a statewide approach.

April 18th Meeting Recap (3 of 3)

Trending forward the baseline budget (continued)

- Members did not convey support for a **case mix adjustment,** and acknowledged that demographic adjustments are closely correlated.
- Members expressed support for the concept of **adjustments for social risk** but acknowledged it would be premature to incorporate a budget adjustment at this time due to limitations in existing research and tools.
- Members supported including **policy-related adjustments** for changes in Medicare and Medicaid payment, and any changes to the structure of organizations (e.g., acquisitions or transfers).

Today's Meeting Objectives

- Develop recommendations for **annual (or periodic) adjustment methods for utilization changes** for future performance years.
- These adjustments could include:
  - Planned service line changes
  - Market shift adjustments
  - Volume adjustments
  - Interhospital transfers

Reminder: Annual Budget Adjustments

- There are many different types of adjustments that could be considered in designing a global budget, such as adjustments related to:
  - Financial performance
  - Inflation and population trends
  - Utilization
  - Quality and equity
  - Risk mitigation
- We will consider numerous adjustments over meetings. We are not suggesting that all of these adjustments be adopted.
- For each adjustment type, we will discuss whether to adjust, and if so, how (concurrently, retrospectively, prospectively).

Pros and Cons for Annual Budget Adjustments

Reasons for adjusting	Reasons for not adjusting
• Account for changes in the market that hospitals may not be able to fully control • Support hospitals in managing unexpected expenses • Use adjustments to accomplish certain policy aims, such as achieving certain quality and equity benchmarks • Safeguard against unintended consequences	• The more that budgets are adjusted, the less predictable the revenue for hospitals (and payments for payers). • Adjustments for factors such as utilization dampen the effectiveness of the hospital global budget in promoting efficient use of resources. • Adding adjustments makes the model more complex.

Calibrating Adjustments

- There are different ways to implement adjustments.

Strategies to create more predictability, while still allowing for adjustments/ adaptation
• Avoid mid-year adjustments, and instead use annual adjustments or a multi-year approaches (e.g., adjustments every two years). • Begin with a monitoring phase to see if adjustments are necessary. • Establish thresholds or "corridors" that need to be exceeded before adjustments are applied.

- Let’s consider these strategies as we talk through different types of adjustments.

Annual or Periodic Adjustments Can Be Applied At Different Times

- Annual adjustments can be applied **concurrently, prospectively, or retrospectively**.
  - **Mid-year adjustments** would be applied concurrently and impact the budget payments throughout the performance year.
  - **Year-end adjustments** would be calculated at the end of the year and could be paid as a lump sum settlement outside of the budget, or folded into the subsequent year's budget payments.
  - **Prospective adjustments** using forecasted data would be applied to the subsequent year's budget.

Utilization Adjustments: Overview

- Utilization adjustments:
  - Protect hospitals from losses due to higher-than-expected volume
  - Reduce incentives for hospitals to stint or shift care outside the hospital/budget, or cut services
  - Potentially incentivize hospitals to open/expand new services
- However, these adjustments can also dampen incentives to constrain utilization.
- Today we will talk about market shift adjustments, volume adjustments, and planned service line adjustments.

Population Growth	**Demographic Changes**
Other Adjustments	**Utilization Adjustments**

Utilization Adjustment Considerations

If volume adjustments are adopted, this will largely capture utilization changes targeted by these additional categories of adjustments.

Volume Adjustments

- Demographic changes
- Utilization changes (including market shifts & interhospital transfers)
- Service line changes

Demographic Adjustment

Planned Service Line Adjustment

Market Shift Adjustment

Interhospital transfers

Utilization Adjustment Approaches in Other Models

Model	Planned Service Line Changes	Market Shift Adjustment	Volume Adjustment
Maryland	X	X	
Pennsylvania (rural hospitals)	X	X	
CHART (rural communities)	X	X	
Rochester, NY			X
Rhode Island			X

Overview: Market Shift and Volume Adjustments

Market Shift Adjustment	Volume Adjustment
Makes an adjustment for shifts in patient **volume between hospitals and other providers**	Makes an adjustment for **overall hospital volume changes**

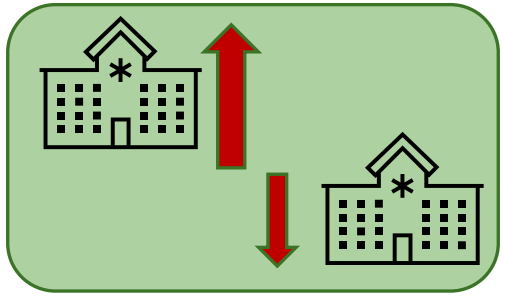
We will review each of these mutually exclusive approaches and then revisit which adjustment to pursue, if any.

Market Shift Adjustments

- A market shift adjustment increases or decreases a hospital's budget to reflect **shifts** in patient volume between hospitals.
- A market shift adjustment can potentially mitigate the incentive for hospitals to shed volume under a global budget model.
- A market shift adjustment can also provide revenue support to hospitals that are absorbing additional volume, such as:
  - Due to market changes, such as a neighboring hospital closure or a neighboring hospital's service closure
  - Due to utilization shifts if one hospital is at capacity and another hospital then absorbs that volume
  - Due to health plans, PCMHs or other coordinated care efforts directing care to (or away from) the facility in order to increase cost-effectiveness, efficiency or quality of care

Maryland Market Shift Adjustments

- Recognizes market shifts that include both an increase in volume (in some institutions) and a decrease in others.
- Calculated at the service line level (e.g., need both increase in orthopedic surgery utilization at one hospital and decrease for same service line at another hospital for the adjustment)



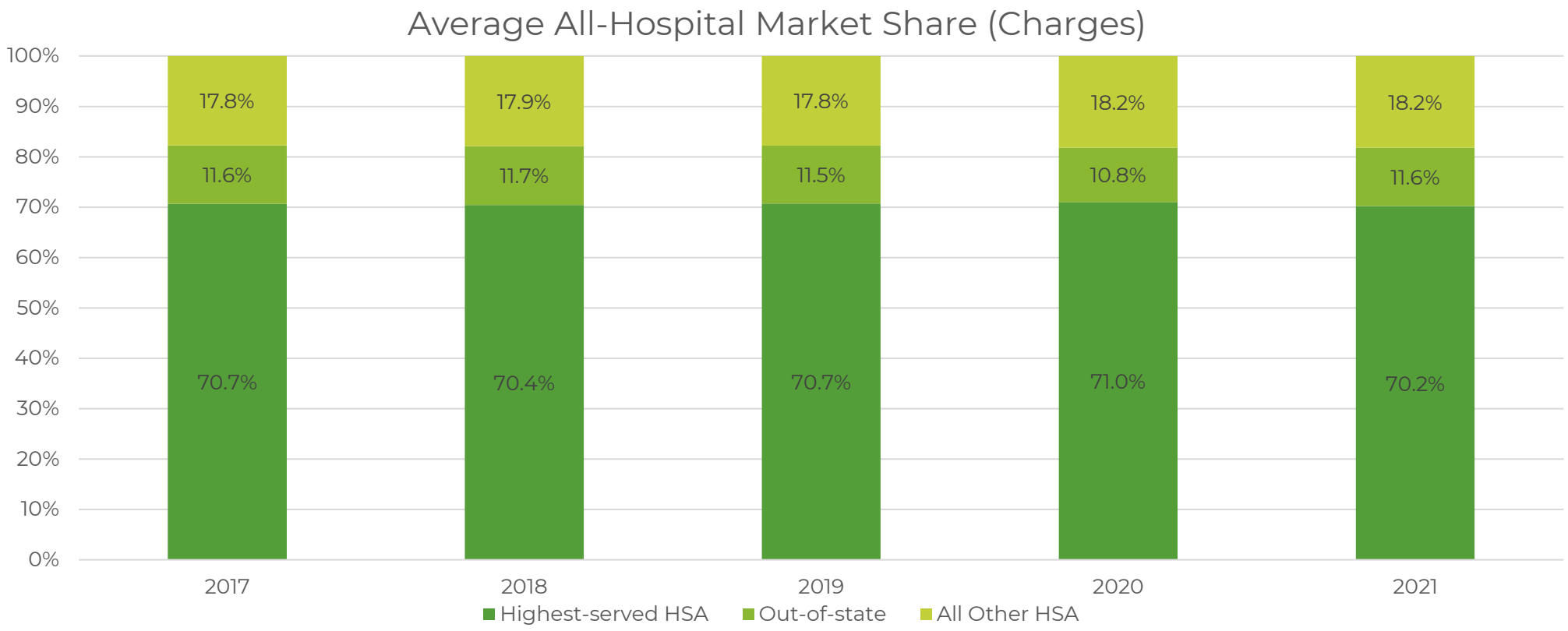
- Measure of volume is a visit count adjusted for case mix and combines inpatient and outpatient.
- Market shifts are calculated at the zip code level or with zip codes aggregated to the county level based on low population density.
- Adjustments are capped at the lesser of the growth for volume gains or the decline for volume losses.
- Adjustments are made at 50% of the payment rate.

Market-based Adjustments in Rural Models

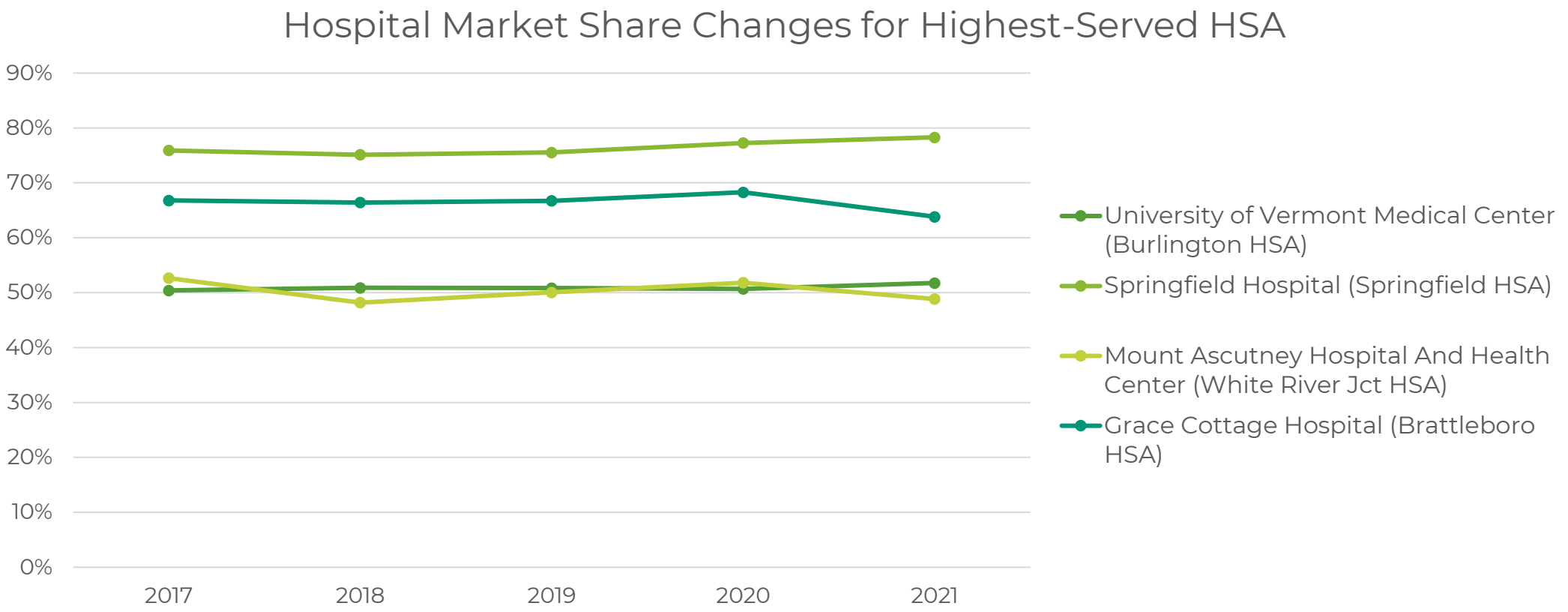
- Rural hospitals may experience fewer market shifts most years than urban markets due to less overlap in service areas.

Pennsylvania	CHART
Includes a provision for annual *market shift* adjustments; the methodology is not publicly disclosed	Calculated changes in the percentage of *market share* in the community to adjust for shifts.

Average Vermont Hospital Market Share by HSA is Relatively Constant



Low Fluctuation in Hospital-Specific Market Share



Advantages and Disadvantages of Market Shift Adjustments

- Supports hospitals that are experiencing volume increases due to shifts in the market
- Reduces incentive for hospitals to stint or shift care outside the hospital/budget

- Dampens the incentive to constrain utilization
- Increases complexity of the model
- Creates uncertainty for hospitals about revenue

Operational Considerations for Market Shift Adjustments

If a market shift adjustment is included, we will need to consider the following:

1. Should the adjustment apply only if volume changes exceed a certain threshold or “corridor”? If so, how should that threshold be established?
2. How should the payment impact of market shift be calculated? Would there be consideration for paying only for marginal costs?
3. Should payment occur by adjusting the next year's budget, or by making a one-time payment after the performance year?
4. Should the adjustment apply annually or less frequently (2-3 years)?

Volume Adjustments

- With a volume adjustment, a hospital receives additional revenue for variable costs associated with increases in utilization during the year.
- If a hospital experienced a decline in utilization, the global budget would flex down, reflecting the proportion of variable costs associated with the lost volume, while retaining payment to cover fixed costs.
- Volume adjustments in hospital global budgets were used in Maryland from 1976-1990, Rochester from 1980-1987, Rhode Island in the 1970s and 1980s and have been used in international global budgets since 2010 (e.g., Germany).

Volume Adjustment Example

Assuming a hospital that has 50% fixed costs and 50% variable costs:

- If this hospital experiences a 1% increase in volume, its global budget payments would be reduced by 0.5% to meet its budget (1% x 50% variable costs = 0.5%).
- Conversely, if this hospital experiences a 1% decrease in volume, its global budget payments would increase by 0.5% to meet its budget, thus continuing to cover its fixed costs when volumes decline.

Advantages and Disadvantages of Volume Adjustments

- 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 budget
- May provide additional revenues to accommodate new technologies and drugs
- Provides better protection for all parties in the case of sudden, unexpected shifts in volume

- Does not provide as much revenue certainty before the start of the year, as the budget will fluctuate based on utilization (variable costs)
- Challenging to precisely identify the proportion of 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 over time to apply incrementally stronger incentives to manage care

Operational Considerations for Volume Adjustments

If a volume adjustment is included, we will need to consider the following:

1. How should the volume for inpatient and outpatient services be measured? How should the volume for professional services be measured?
2. How should we set the fixed and variable cost factor percentages?
3. How often should budget adjustments be made to account for volume changes (e.g., monthly, quarterly, annually)?

Recap of Considerations for Market Shift vs. Volume Adjustments

Market Shift Adjustment	Volume Adjustment
• Makes an adjustment for shifts in patient **volume between hospitals and other providers** • Provides stronger cost containment incentives as a budget-neutral approach, and with potentially smaller adjustments overall if limited to specific service lines • Can be tailored to specific service lines • Applied at year-end, creating greater revenue certainty for hospitals during the performance year	• Makes an adjustment for **overall hospital volume changes** • Provides the hospital with more financial protection in the event of an unexpected upward swing in volume • Is not tailored to specific service lines • Applied periodically throughout the performance year

Discussion

- Should the global budget model include a market shift adjustment or volume adjustment?
  - Note that we will discuss the more detailed operational questions during the following meeting based on the group's preferred approach.

Planned Service Line Changes

- An adjustment for a planned service line change allows a hospital to request an update to its budget if the hospital:
  - Chooses to add services that were not included in the baseline data.
  - Stops providing services that were included in the baseline data.
  - Plans to strategically shift a service from one hospital to another to meet model goals.

Planned Service Line Changes

Maryland (ad hoc) **Pennsylvania & CHART (formalized)**	Hospitals can request a budget adjustment based on service line changes for prospective adjustments and retrospective reconciliation.

GMCB Hospital Budget Review Process

- The GMCB Hospital Budget Review Process similarly provides opportunities for hospitals to report budget impacts associated with structural changes, specifically physician transfers and acquisitions.
- Hospitals provide information about budget impacts, either off-cycle (for transfers occurring no later than May 1), or with their annual budget submission.

Should We Adjust for Planned Service Line Changes?

- Ensures that budgets are modified to support planned service changes (e.g., additions/expansions)
- Encourages hospitals to modify service offerings to meet community needs
- Protects payers when service line changes are negative (e.g., reductions/closures)

- Adds administrative complexity

Proposal for Service Line Change Adjustment

- Hospitals submit a list of planned service line changes on an annual basis for service lines with an expected impact of +/- $100K or +/-0.5 % of budget payments (*similar to the current GMCB budget review process*)
- Calculate the global payment adjustment as :

  Base-year average FFS paid amount x budget year inflationary adjustment x change in projected number of visits

- Assess the reasonableness of the expected change in utilization for planned service lines and make a prospective adjustment
- Monitor the utilization trend for the planned service line and reconcile if the projections were 5% higher/lower than the prospective adjustment

Does this approach seem reasonable to you? Would you recommend any changes?

Interhospital Transfers (1 of 2)

- Interhospital transfers may need to be addressed to ensure a) that revenue appropriately follows the patient when changes to transfer rates occur and b) that resources are readily available to care for complex cases.
- Maryland's transfer policy:
  - Defined transfers as same or next-day inpatient or emergency room transfers to the AMC.
  - Established a baseline for level and pattern of transfers, with subsequent revenue adjustments based on changes in transfer levels above determined thresholds.
  - Levels of transfers monitored on a quarterly basis.

Interhospital Transfers (2 of 2)

- Should we consider an adjustment for interhospital transfers?
  - For example, the model could include monitoring of interhospital transfers, where an adjustment would only apply if transfers increase or decrease beyond established corridors in a given year.

Wrap-up and Next Meeting

The next Hospital Global Budget Technical Advisory Group meeting is scheduled for Tuesday, **May 23rd** from 10 am – 12 pm.