Shifting of Hospital Services from Regulated to Unregulated Setting

Discussion of Deregulation

What is Deregulation?

- Deregulation is the movement of a hospital service from a HSCRC regulated space to an unregulated space (most often outpatient services but also chronic and rehab).
  - A service is presumed to be regulated if the building is on the campus of a hospital
    - Criteria outlined in COMAR are considered for determination of unregulated services, which need to be approved by the Commission
  - Deregulation is most often outpatient services and residual revenue in GBR is spread across all rate centers based on costs
    - In RY 2017, inpatient constituted 57.26% of total hospital charges
    - In RY 2017, Medicare FFS represented 30.86% of outpatient services and 42.12% of inpatient services.

- Service movement can be initiated by 1) payers, or they can be initiated by 2) the hospital itself, 3) physician practices and in some cases the deregulation may simply be a function of 4) service discontinuation or 5) cross border movement to an unregulated hospital
  - 1) Payer Initiative Ex: Remicade, Immunoglobulin, Endoscopies, and Ultrasounds
  - 2) Hospital Ex: Frederick Oncology (Capital Replacement savings - $4M, no 340b - took 65% due to high variable costs)
  - 3) Physician Practices Ex: Easton and Dorchester Endoscopy (TPR hospitals – look back yielded higher than 50%)
  - 4) Service Discontinuation Ex: Union Memorial Eye Services; Sleep Services everywhere
  - 5) Cross Border Movement Ex: Medstar Inpatient Surgery & Cardiology into D.C.

Revenue Adjustment Levels

- Generally fifty percent of affected revenue (50%)
  - May be higher if reduction shifts costs onto Medicare
- Drug deregulation considers the cost of drugs, since markup over cost varies and is tiered (Varies)
- Have not addressed declines in emergency room volume. (0%)
  - ~$40 million over 5 years
  - E.g. not presently adjusting for shifts to primary care settings and urgent care
  - Some circumstances may warrant adjustment, but generally supportive of primary care growth outside of hospitals settings

Hypothetical Deregulation Examples:

	Hospital A			Hospital B	
Line 1	Service Line	Orthopedic Surgery (e.g. knee and shoulder arthroscopy)		Service Line	Imaging Service (e.g. Mammography and Ultrasounds)
Line 2	Unregulated Space	Ambulatory Surgical Center		Unregulated Space	Radiology Center
Line 3	Regulated Budget	$5 million		Regulated Budget	$5 million
Line 4	Unregulated Budget	$3 million		Unregulated Budget	$2 million
Line 5	Default Reduction to GBR	$2.5 million (50%)		Default Reduction to GBR	$2.5 million (50%)
Line 6	Future Charges*	$5.5 million	L4+L5	Future Charges*	$4.5 million
Line 7	Cost Variance %	10% increase in charges	L6/L3-1	Cost Variance %	-10% decrease in charges

*Not inclusive of initial capital costs and not indicative of individual payer impact

Revenue Reductions are Needed When Services Shift to Unregulated Settings

- If services are shifted to deregulated settings, global budgets generally must be reduced to prevent excess billings

- Section IV.B.3a. Of the Global Budget Agreement states the following:
  - *"The HSCRC and the Hospital recognize that some services may be offered more effectively in an unregulated setting. When services covered by the GBR model are moved to an unregulated setting, the HSCRC staff will calculate and apply a reduction to the Hospital's Approved Regulated Revenue. At a minimum, this reduction will ensure that the shift provides a savings to the public and Medicare after taking into consideration the payment amounts likely to be made for the same services in an unregulated setting."*

- Staff is formalizing and strengthening the review process to make more timely reductions but concerns remain:
  - Non-Medicare data availability
  - Ability to accurately project future charges
  - Disclosures of deregulation
  - Overarching Concerns

Overarching Concerns?

- Balance between moving services down the continuum of care and eliminating increases in TCOC is difficult.
  - What movement should be encouraged/discouraged?
  - Medicare FFS is largest consumer of inpatient services and most likely to absorb largest portion of retained revenue
- Recapitalization in unregulated space may not be necessary, especially before replacement time and given current excess capacity in the system (see next slide)
  - To this end:
    - Can changes in regulations help repurpose regulated space (need to ensure no patient steering and patient clarity)? OR
    - Should the HSCRC consider pricing flexibility, which could improve competitiveness but may have adverse impact on Medicare TCOC savings?
- Unregulated settings have no volume controls
- Healthcare Access, especially for Medicaid, and acceptance of assignment from insurance companies

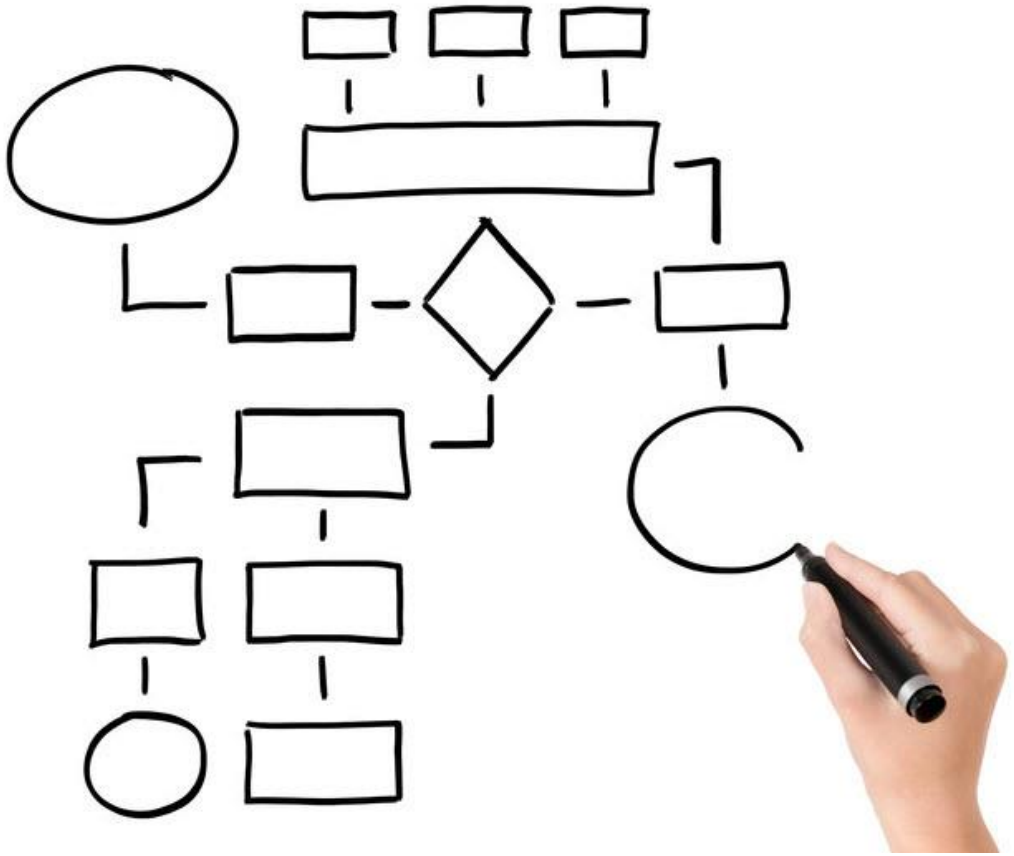
Inpatient Excess Capacity Analysis

Inpatient Urban Hospital Excess Capacity

Hospital Name	2010 Patient Days	2017 Patient Days	Change in Patient Days	% Change in Patient Days
Bon Secours Hospital	35,530	18,422	(17,108)	-48.15%
Harbor Hospital Center	50,086	31,843	(18,243)	-36.42%
Johns Hopkins Bayview Medical Center	113,606	110,403	(3,203)	-2.82%
Mercy Medical Center	62,042	47,368	(14,674)	-23.65%
Prince Georges Hospital	72,965	60,618	(12,347)	-16.92%
Sinai Hospital	121,906	107,531	(14,375)	-11.79%
St. Agnes Hospital	80,737	67,167	(13,570)	-16.81%
UMMC Midtown	48,756	34,764	(13,992)	-28.70%
Union Memorial Hospital	70,293	50,161	(20,132)	-28.64%

- Statewide Average Patient Day Decline from 2010 to 2017 was 12.87%.
- It was18.53% if you remove the 9 hospitals who experienced increases.
- And statewide it is 11.1% if you account for observations volume greater than 24 hours and OP surgery cases with a LOS greater than 1

How does HSCRC Identify Deregulation?



See Flow Charts

Hospital A – Discontinuation with notification to HSCRC

Sleep Lab Discontinuation

- Hospital generated revenue for this service was $1,500,000
- Staff reviewed EAPG/monthly data to confirm this amount
- Staff also reviewed payer mix from the monthly data. Staff found that the payer mix could have a possible **negative** impact on Medicare since it was a higher commercial mix than the rest of services in the hospital.
- Adjustments are as follows:
  - $1,500,000 x 50% = **$750,0000 permanent** amount to be removed from GBR
  - $750,000 x 6/12 (for Jan-June) = **$375,000** to be removed as one-time
  - Hospital must submit a modified Ms schedule removing volume and cost from the EEG rate center. A proforma Ms schedule will also need to be completed for the June 30, 2018 annual file for FY 2020.

Importance of Payer Mix (Simple Example)

Hypothetical Service Discontinuation Example by Varying Medicare Payer Mix Rate Centers

	A	B	C =B/A	D	E = D*C	F	G=F*C	H	I =H*C
	Revenue	Medicare Share ($)	Medicare Share (%)	50% Reduction to ED Revenue	Medicare Share ($)	50% Reduction to Radiology	Medicare Share ($)	50% Reduction to Chemotherapy	Medicare Share ($)
ED	$100	$50	50%	$0	$0	$125	$63	$125	$63
Radiology	$100	$40	40%	$125	$50	$0	$0	$125	$50
Chemotherapy	$100	$60	60%	$125	$75	$125	$75	$0	$0
Total	$300	$150	50%	$250	$125	$250	$138	$250	$113

	E Total/D Total	G Total/F Total	I Total/H Total
Resulting Total Medicare Share	50%	55%	45%
	B Total – E Total	B Total – G Total	B Total – I Total
Remaining Medicare Charges to Breakeven on TCOC	$25	$13	$38

D, F, H = distribution of charges following service discontinuation

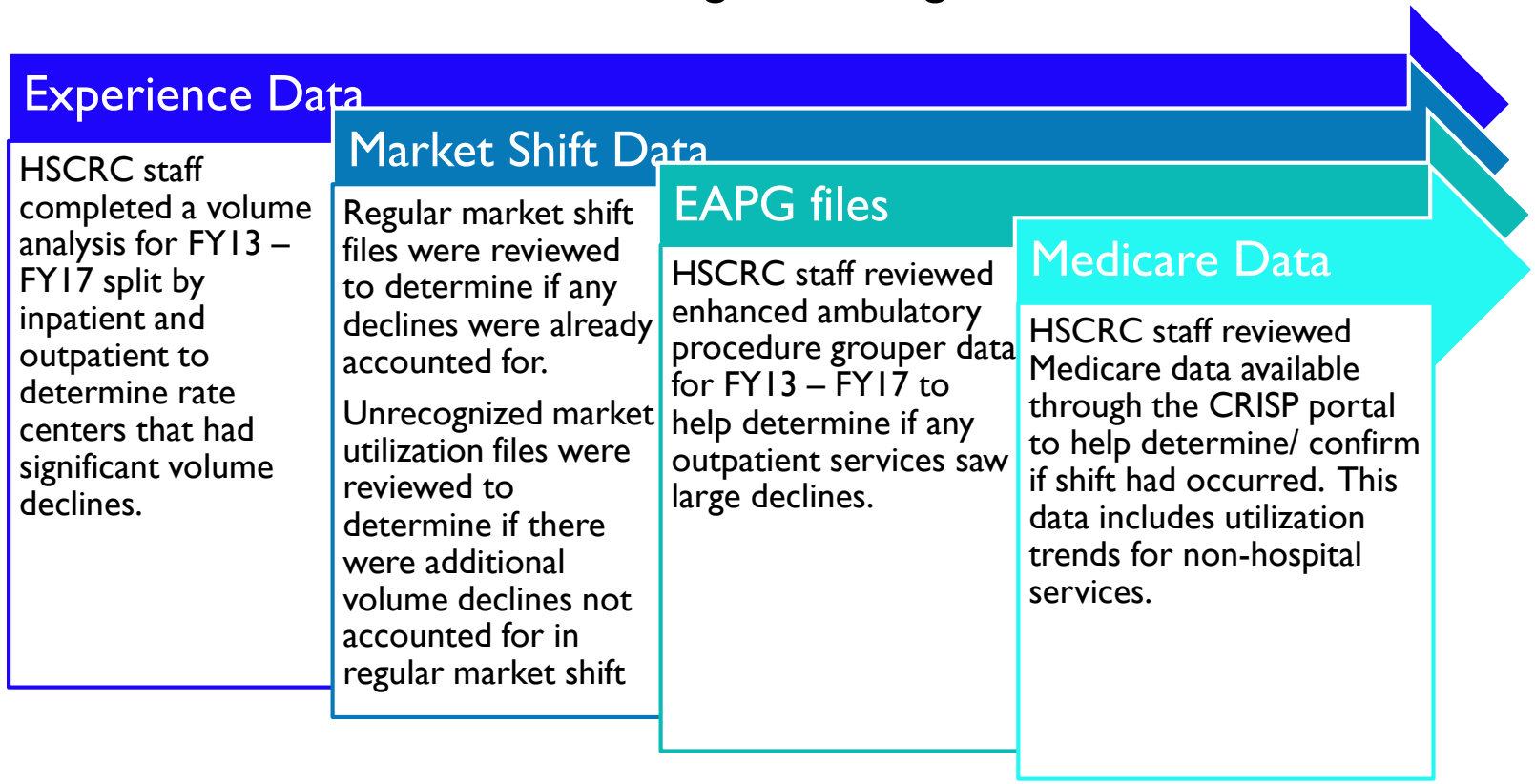
Hospital A – Deregulation with notification to HSCRC

Deregulation of infusion drugs (non-chemo)

- HSCRC staff reviewed Hospital A's analysis to calculate an appropriate adjustment
  - Staff found that the payer mix could have a possible positive impact on Medicare since it was a higher Medicare mix than the rest of services in the hospital.
  - Staff used an estimate of ASP + 10% for drug costs to incorporate an All-Payer amount (Medicare = ASP +6%, Commercial = ASP+15%); Staff also included in the deregulation calculation an amount for administrative costs
  - Staff also included hospital markup of 8.81% to account for uncompensated care and payer differential.
    - Assessments were not included because the calculation for assessments occurs at the beginning of the year when the hospital had higher revenue figures, i.e. before deregulation
      - This will be corrected the following year (RY 2020)
  - Hospital must submit a modified Ms schedule removing volume and cost related to this shift. A proforma Ms schedule will also need to be completed for the June 30, 2018 annual file for FY 2020.
- In total, the deregulation reductions for sleep labs and infusion drugs equated to roughly 50% of associated GBR revenue in order to ensure no additional cost shift to Medicare FFS.
- **HSCRC and the hospital will evaluate at mid-year whether the adjustment is correct and make adjustments as necessary moving forward.**

Hospital B – Deregulation/Shifts without notification to HSCRC

HSCRC staff found that Hospital B was charging beyond their monthly corridor between 15-25% for consecutive months in all rate centers and launched an investigation using HSCRC available data



Findings: Hospital B had shifted physical therapy and radiation therapy to an unregulated setting

Notes regarding Deregulation Standard Operating Procedures

- HSCRC has a methodological approach to reviewing deregulations, however, hospital specific circumstances may impact final adjustment.

  i.e Payer Mix or has the service been offset by opening of another service

- It can be difficult to accurately predict and extrapolate what will occur in the unregulated setting due to hospital uncertainty and limited all-payer data availability. A settle-up may be necessary to ensure appropriate adjustment
- Adjustments may not always be at 50% if the shift has a substantial negative impact on a payer or if the service differs drastically from average 50% cost factor.
- All data sources and tools work together to provide support for determination of adjustment. Unrecognized shifts may be a function of reduced utilization and in line with incentives of model.

Appendix

Revenue Adjustments Made for RY18 and RY19 to date

- Identified Revenue Adjustments from hospital's global budgets to deregulation*:
  - RY18 & RY19
    - Permanent adjustments: $56,000,000
    - One-time adjustments: $16,000,000 (still reviewing)
    - **Identified Revenue Adjustments in RY18 & RY19** : $72,000,000
  - RY20
    - **Identified Revenue Adjustments in RY20**: $11,400,000
- These figures exclude drug utilization reductions made through the annual drug volume review for high cost oncology and infusion drugs
- Additional adjustments are being reviewed and staff expects to made additional adjustments in January

*These figures are preliminary. Some adjustments are still in discussion and have not been finalized.

Revenue Adjustments Made Prior to Rate Year 2018

- Prior to 2018, there were adjustments for oncology deregulations and shifts of hospitals on global budgets under the Total Patient Revenue system (2011-2014)
  - Carroll Hospital Center, Western Maryland Health System, and UM-Shore Regional Health (3 hospitals) had revenue reductions for shifts to unregulated settings for the period of time they were under a global budget from 2011 through 2014.
  - Frederick Memorial Hospital and Atlantic General Hospital deregulated oncology services in prior periods and their revenues were reduced accordingly.