Draft Recommendation for Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for FY 2017

Health Services Cost Review Commission
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This document contains the draft staff recommendations for the aggregate amount at-risk under Maryland hospital quality programs for FY 2017. Comments may be submitted via hard copy mail to the Commission's address or email to Dianne.feeney@maryland.gov and are due by COB Monday, 12/22/14

A. Introduction

The HSCRC quality-based payment methodologies are important policy tools with great potential to provide strong incentives for hospitals to improve their quality performance over time. Each of the current policies for quality-based payment programs holds revenue at risk directly related to specified performance targets.

- The Quality Based Reimbursement (QBR) program employs revenue neutral scaling of hospitals in allocating rewards and reductions based on performance, with the net increases in rates for better performing hospitals funded by net decreases in rates for poorer performing hospitals.[1]
- For the Maryland Hospital Acquired Conditions (MHAC) program, hospital performance is measured using observed to expected ratio values for each component measure and revenue allocations are performed using pre-established performance targets. The revenue at risk and reward structure is based on a tiered approach that requires statewide targets to be met for higher rewards and reduced reductions.
- The Readmission Shared Savings Program reduces each hospital's approved revenues prospectively based on its risk adjusted readmission rates.
- The hospital Readmission Reduction Incentive Program (RRIP) policy initiated in FY 2015 is designed to be a positive incentive program to reward hospitals that achieve a specified readmission reduction target. For FY 2017, staff is proposing to strengthen this program by increasing the amount of revenue at risk and including both rewards and reductions. Similar to the MHAC program, staff is proposing the use of a tiered approach that requires statewide targets to be met for higher rewards and reduced penalties. Potentially Avoidable Utilization reductions are applied to global budgets to reduce allowed volume growth based on percent of revenue associated with potentially avoidable utilization for each hospital.

This draft recommendation proposes the amount of hospital revenue at-risk for the following programs: 1. Quality-Based Reimbursement; 2. Maryland Hospital Acquired Conditions; and, 3. Readmission Reduction Incentive Program.

The Shared Savings for Readmissions[2] and Potentially Avoidable Utilization programs that also hold revenue at risk based on performance are determined annually commensurate with the hospital rate update factor process.

B. Background

Maryland has been a leader in initiating quality based payment approaches. Historically, these programs have surpassed the requirements of similar federal programs and as a result Maryland has been exempted from the federal programs. When Maryland entered into the All-Payer Model Agreement with CMS effective January 1, 2014, the continuing exemption process was addressed in

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[1] The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue contingent on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or reductions (negative scaled amounts) are then applied to each hospital's revenue on a "one-time" basis (and not considered permanent revenue).

[2] For the Readmission Shared Savings adjustment, the HSCRC calculates a case mix adjusted readmission rate for each hospital for the base period and determines a statewide required percent reduction in readmission rates to achieve the revenue for shared savings. Current policy is posted at: http://hscrc.maryland.gov/init-shared-savings.cfm

the Agreement. The Agreement requires that the proportion of Maryland hospitals' revenues held at risk for quality programs be equal to or greater than the proportion of revenue that is held at risk under national Medicare programs. The objective of this requirement is two-fold: a) incentivize hospitals to deliver high quality care in support of the Triple Aim of better care, better health, and lower cost, and b) evaluate the extent to which Maryland quality programs are rewarding value as compared to those of the national Medicare program. The relevant agreement language is as follows.

> *Regulated Revenue at risk: [Maryland] must ensure that the aggregate percentage of Regulated Revenue at risk for quality programs administered by the State is equal to or greater than the aggregate percentage of revenue at risk under national Medicare quality programs. Quality programs include, but are not limited to, readmissions, hospital acquired conditions, and value-based purchasing programs.*

It is important to note that under the All-Payer Model Agreement, Maryland is required to achieve specific reduction targets in total cost of hospital care, potentially preventable conditions, and readmissions in addition to its revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and sharing of best practices while holding hospitals accountable for their performance.

For FY2016 following maximum amounts of revenue at-risk were already approved by the Commission:

- QBR: 1% maximum penalty, with revenue neutral scaled rewards up to 1%.
- MHAC—4%maximum penalty if statewide improvement target is not met; 1% maximum penalty and revenue neutral rewards up to 1% if statewide improvement target is met.
- RRIP—0.5% positive incentive for any hospital that improves by at least 6.76%.

During the upcoming annual revenue update process for FY 2016, HSCRC staff expects that two additional quality adjustments will be applied.

- Readmissions Shared Savings Program—A savings of 0.4% total hospital revenue (approximating an average 0.6% and maximum reduction of 0.8% of inpatient revenue) based on risk adjusted readmission levels.
- PAU Reduction Program—A reduction of allowed revenue for volume increases associated with potentially avoidable utilization that had a maximum revenue reduction of 0.9% and an average reduction of 0.3% in FY 2015.

Currently staff is in discussions with CMMI regarding the methodology for comparing the Maryland aggregate amount of revenue at risk and the national Medicare aggregate amount-at-risk provided for in the Agreement. In addition to calculating maximum at risk ("potential risk"[3]), CMMI staff expressed a need to measure the actual revenues impacted by the programs ("realized risk"). Discussions on "realized risk" are in progress.

C. Assessment

CMMI staff proposed that measurement of both the potential and realized aggregate percentage of revenue at-risk occur annually across all quality programs comparing the State fiscal year (July 1 –

[3] Potential risk is defined as maximum percentage of revenue that an individual hospital stands to gain or lose based on their performance within a given quality program.

June 30) to the Federal fiscal year (October 1 – September 30). For example, Maryland's SFY 2015 (July 2014 – June 2015) will be evaluated against CMS' FFY 2015 (October 2014 – September 2015). The calculations will be based on cumulative difference allowing Maryland to catch up to the national aggregate amount at risk by the end of the contract period.

Some Maryland quality programs are applied to both inpatient and outpatient revenue. For these programs, outpatient revenues at risk will be converted to an equivalent inpatient revenue base (Formula: percent of revenue at risk/percent inpatient revenue). Where applicable, both upside and downside risk will be considered.

Based upon these assumptions, Figure 1 shows the potential risk for each quality program and in aggregate for Maryland and Medicare, as well as the cumulative difference between Maryland and Medicare from 2014 to 2016. CMMI and HSCRC staff are currently discussing how to include the reduction for PAU in the Maryland program totals. Based on the latest feedback, CMMI staff expressed concerned about including Preventive quality Indicator (PQIs) in the calculation. For informational purposes, the tables contain three sets of totals--the first excluding the reduction for PAU and the second including the reduction for PPC and Revisit components of PAU and third overall reduction of PAU. CMMI may want to separate the impact of Prevention Quality Indicators (admissions for ambulatory care sensitive conditions) from the other PAU components in evaluating the results.

Since Readmission shared savings and PAU adjustments are determined during the update factor determinations, we applied FY15 reductions to FY2016 and FY2017 for evaluating the results.

Figure 1: Maryland Versus Medicare Quality Programs' Potential Revenue at Risk, 2014-2016

Maryland - Potential revenue at risk

% Inpatient Revenue	2014	2015	2016	2017
MHAC	2%	3%	4%	*4%*
Readmits	0.41%	0.86%	1.36%	*2.86%*
QBR	0.50%	0.50%	1.00%	*2%*
GBR PAU: PPC/Revisits	0.54%	0.54%	*0.54%*	*0.54%*
GBR PAU: PQI Only	0.32%	0.32%	*0.32%*	*0.32%*
GBR PAU: Total	0.86%	0.86%	*0.86%*	*0.86%*
Sum without PAU	2.91%	4.36%	6.36%	8.86%
Sum with PPC/Revisit PAU Only	3.45%	4.90%	6.90%	9.40%
Sum with Total PAU	3.77%	5.22%	7.22%	9.72%

italics are estimated numbers

Medicare National - Potential IP revenue at risk

% Inpatient Revenue	2014	2015	2016	2017
HAC	0	1%	1%	1%
Readmits	2%	3%	3%	3%
VBP	1.25%	1.50%	1.75%	2%

Sum	3.25%	5.50%	5.75%	6.00%
Cumulative MD-US Difference				
Without PAU	-0.34%	-1.48%	-0.87%	1.99%
With PPC/Revisit PAU Only	0.20%	-0.40%	0.76%	4.16%
With Total PAU	0.52%	0.23%	1.70%	5.41%

Staff discussed two alternative methods to measure realized risk with the CMMI. One option is to compare Maryland and Medicare hospital average percent revenue allocated in quality programs by taking the average of all absolute value of all revenue adjustments within each program. A second option is to calculate total revenue allocated in each program and sum all absolute values as a percent of total inpatient revenue in the state. Staff calculated Maryland and Medicare percentages for FY2015 for these options (see Figure 2), revealing that Maryland is slightly above Medicare in terms of average absolute percent for FY2015 or slightly below Medicare when excluding PAU.

Figure 2. Maryland Versus Medicare Quality Programs Realized Revenue at Risk, 2015

Maryland: (SFY 15)

%tile (FY 15)	MHAC	Readmits	QBR	GBR PAU: PQI Only	GBR PAU: PPC/Revisits	GBR PAU: Total	Sum without PAU	Sum with PPC/Revisit PAU Only	Sum with Total PAU
100%	0.13%	-0.08%	0.28%	0.00%	0.00%	0.00%			
75%	0.06%	-0.59%	0.08%	-0.01%	-0.13%	-0.14%			
50%	0.05%	-0.64%	0.01%	-0.06%	-0.22%	-0.29%			
25%	0.02%	-0.72%	-0.15%	-0.11%	-0.32%	-0.44%			
0%	-1.00%	-0.86%	-0.50%	-0.32%	-0.54%	-0.86%			
FY 15 Absolute % Average	**0.11%**	**0.64%**	**0.14%**	**0.07%**	**0.22%**	**0.29%**	**0.89%**	**1.11%**	**1.18%**
FY 15 Total Value Percent	**0.09%**	**0.67%**	**0.13%**	**0.06%**	**0.21%**	**0.27%**	**0.89%**	**1.11%**	**1.17%**

CMS National: (FFY 15)

%tile (FY 15)	HAC	Readmits	VBP	Sum
100%	0.00%	0.00%	1.06%	
75%	0.00%	-0.06%	0.15%	
50%	0.00%	-0.31%	0.00%	
25%	0.00%	-0.77%	-0.21%	
0%	-1.00%	-3.00%	-1.37%	
FY 15 Absolute % Average	**0.22%**	**0.52%**	**0.24%**	**0.97%**

D. Recommendations

Based upon the above assessment, current quality results for CY2014 YTD, and discussions with CMMI on our quality programs, staff's position and rationale for revenue amounts at-risk for FY2017 are outlined below.

1. **QBR** – 2% maximum penalty. This matches Medicare's VBP program and increases the incentive for hospitals to improve HCAHPS scores, which continue to be low compared to the Nation.

2. **MHAC**—4%maximum penalty if statewide improvement target is not met; 1% maximum penalty and revenue neutral rewards up to 1% if statewide improvement target is met. This continues the current FY2016 at-risk revenue levels that have resulted in significant quality improvements.
3. **RRIP**— 2% scaled maximum penalty and 0.5% reward for hospitals which reduced readmission rates at or better than the minimum improvement target if the statewide Medicare readmission target is not met; 1% scaled maximum penalty and 1% reward for hospitals which reduced readmission rates at or better than the minimum improvement target if the statewide Medicare readmission target is met. The decision to add reductions and increase potential rewards is based on staff and stakeholder concerns regarding the CY2014 YTD improvement and the fact that almost one third of hospitals have had an increase in their readmission rate.

HSCRC staff will convene meetings of the Performance Measurement and Payment Workgroups to deliberate and further refine quality-based programs' aggregate amount at risk and individual component program details prior to the January 2015 Commission meeting.