Maryland Health Services Cost Review Commission

Payment Work Group Meeting 1
REVIEW Of OVERALL MODEL CHANGES

Materials are provided for context.
Approved New All-Payer Model

- Updated application submitted to CMMI in October
- Approved effective January 1, 2014
- Focus on new approaches to rate regulation
- Moves Maryland
  - From Medicare, inpatient, per admission test
  - To an all payer, total hospital payment per capita test
    - Shifts focus to population health and delivery system redesign
Focus Shifts to Patients

Unprecedented effort to improve health, improve outcomes, and control costs for patient.
Gain control of the revenue budget and focus on providing the right services and reducing utilization that can be avoided with better care.

- Enhance Patient Experience
- Better Population Health
- Lower Total Cost of Care
Approved Model at a Glance

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate for first 3 years
- **Medicare payment savings** compared to dynamic national trend of $330 million over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement and better care
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland’s Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets
New Context for HSCRC

- Align payment with new ways of organizing and providing care
- Contain growth in total cost of hospital care in line with requirements
- Evolve value payments around patients and populations—efficiency, health and outcomes

Priority tasks:
- Transition to population/global and patient-centered payment approaches for hospital services.
- Major data and infrastructure requirements
Maryland Innovating for Better Value in Health Care

- Maryland innovations at a glance:
  - State Health Improvement Process
  - Health Information Exchange (CRISP)
  - State Innovation Model—Care Coordination and Community Integrated Medical Homes
  - Health Enterprise Zones
  - Medicaid Expansion and Exchange Enrollment
- Innovation in Maryland’s unique all-payer hospital system

Better care
Better health
Lower cost
Timeline of All-Payer Model Development

Phase 1 (5 Year Model)

- **Short Term (2014)**: Hospital global model
- **Mid-Term (2015-2017)**: Population-based
- **Long Term (2016-Beyond)**: Preparation for Phase 2 focus on total costs of care model (Application due 2016 for 2019)
HSCRC  Staff All-Payer Model Proposed Implementation Priorities

**Short Term (FY 2014)**
- Transition to Global Models, Volume Policy Changes
- Revenue Update Process for Global Models
- Monitoring & Compliance
- Quality & Avoidable Utilization
- Alignment with Physicians, Post Acute, SIM, other
- Prepare for Mid Term

**Mid-Term (FY 2015-2017)**
- New Efficiency and Value Approaches
- Population-Based Payment Models
- Capital Policies
- Trending & Update
- Alignment Implementation Physicians, Post Acute, Care Coordination
- Data & Infrastructure

**Long Term (2016-2019)**
- Address Three-Part Aim Across the Total System
- Work With Participants Across the System to Define Phase 2 Approach

**Hospital Global Models**
- Prepare for Phase 2

**Population-Based**
- Address Three-Part Aim Across the Total System
- Work With Participants Across the System to Define Phase 2 Approach
What Does This Mean?

- New Model represents most significant change in nearly 40 years
- Focus shifts to gain control of the revenue budget and focus on gaining the right volumes and reducing avoidable utilization resulting from care improvement
- Potential for excess capacity will demand focus on cost control and opportunities to optimize capacity
- Opens up new avenues for innovation
- Increased efficiency creates opportunities for improved care and better population health
History Provides Example

**DRGs and New Technology Reduced Length of Stay and Admissions and Freed Up $$$ for Major Improvements in Cardiac Care, Minimally Invasive Procedures, Advanced Imaging and Other Care**

<table>
<thead>
<tr>
<th>U. S. Population</th>
<th>1980</th>
<th>2010</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHG</td>
<td>227M</td>
<td>309 M</td>
<td>+36%</td>
</tr>
<tr>
<td>Occupied beds</td>
<td>755,000</td>
<td>473,000</td>
<td>37%</td>
</tr>
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</table>
Opportunities for Success

Model Opportunities

- Global revenue budgets providing stable model for transition and reinvestment
- Lower use—reduce avoidable utilization with effective care management and quality improvement
- Focus on reducing Medicare cost
- Integrate population health approaches
- Control total cost of care
- Rethink the business model/capacity and innovate

Delivery System Objectives

- Improved care and value for patients
- Sustainable delivery system for efficient and effective hospitals
- Alignment with physician delivery and payment model changes
GLOBAL MODEL CONCEPTS-
STATEWIDE

Materials provide context for changes in the model and the implications for changes to the update process at a state-wide level.
Rate Setting Components Supporting Prior Model

- The rate setting components focused on unit rates and charge per case

  **Annual Update (Inflation less productivity, policy adjustments)**

  **Financial Incentive Programs (MHAC, QBR, CPC, CPE, TPR)**

  **Other (Uncompensated care, assessments, other)**

  **One Time Adjustments (hospital specific overages/underages, other)**

  **Change in Volume (Inpatient cases, outpatient units) (except TPR hospitals)**

  **Total Revenue Target Year**

  **Unknown at beginning of year**
New Model--Change in Approach Under Population Based System

The new approach will shift the focus to total revenue per capita.

**Example:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Revenue</td>
<td>$15.0 Billion</td>
</tr>
<tr>
<td>Less: Out of State</td>
<td>$1.2    (Note)</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$13.8</td>
</tr>
<tr>
<td><strong>X Hard Cap Increase</strong></td>
<td>3.58%</td>
</tr>
<tr>
<td><strong>X Population Increase</strong></td>
<td>0.60%</td>
</tr>
<tr>
<td><strong>Target Year Maximum Revenue</strong></td>
<td>$14.4 Billion</td>
</tr>
</tbody>
</table>

**Out of State Revenue**

Actual

Note: Subject to HSCRC approved rates
Change in Approach Under Population Based System – Major Paradigm Shift

HSCRC focuses on total revenue and incentives for attainment and improvement of desired outcomes.

- Maximum Allowed Revenue Target Year-Residents
- Update requirements must be balanced under maximum revenue targets
- Annual Update (Inflation)
- Financial Incentive Programs for Attainment and Improvement—Efficiency, Quality, Health
- Change in Volume—Limited by Population Based Reimbursement
- One time adjustments (hospital specific and state-wide overages/underages, other)
- Other (Capital, uncompensated care, assessments, other)

Out of State Residents—Rates regulated
MODEL CONCEPTS-HOSPITAL SPECIFIC AND 2014 UPDATE

Materials provide context for global budgets and updates at a hospital-specific level, provide a high level review of the demographic adjustment HSCRC staff has prepared, and provide a history of how the rate update was calculated in 2014.
New Context for Hospitals

Old Model

- Units/Cases
- Rate Per Unit or Case
- Hospital Revenue

Unknown at the beginning of year. More units/more revenue

Global Models

- Revenue Base Year
- Updates for Trend, Population, Value, Market, Other
- Allowed Revenue Target Year

Known at the beginning of year. More units does not create more revenue
Payment Models Envisioned

- Shift of hospital revenue to global/population based payment models
  - Total Patient Revenue (TPR)
  - Global Budget Revenue (GBR)
  - Future--Population-based Revenue Structures

- Integration and Alignment with Other Providers and Initiatives
Payment Models Envisioned

- Significant continuing progress and expansion of revenue tied to performance measures
  - Readmission reductions to bring Maryland into alignment with national performance, program enhancements
  - Continued aggressive reduction in MHACs
- Expansion and enhancement of other value measures
  - Quality Based Reimbursement enhancement and targets (addresses experience of care)
  - New efficiency measures (episode, population based)
  - Population health
Approach for January 1 Approved by HSCRC

- Approaches in place that assure hospital revenues fall within the maximum requirements for calendar year 2014 (3.58% per capita limit)
- Use existing frameworks with some modifications (initially effective through June 30, 2014)
Methods in Place for FY 2014

• ARR (Admission-Readmission Revenue and Unit Rates; Modernized)
  – 50% limit on volume changes
  – Cap on volume and service mix growth (case-mix and volume governors)
• TPR (Total Patient Revenue)
  – Fixed revenue cap
• GBR (Global Budgeted Revenue)
  – Fixed revenue cap based on TPR framework
Global Budgets in Brief

- Global Budgets based upon the framework used for the Total Patient Revenue arrangements that are already in place

  - Approved revenue established for the Base Period (FY 2013, CY 2013)

  - An adjustment provided to help establish the infrastructure needed to manage on a global budget basis

  - The approved revenue may be adjusted to include an allowance for population driven volume increases for the upcoming year

- Other adjustments may be applied
Global Budgets in Brief

- Updates to the Global Budgets once established may include:
  - Revenue base would be increased for update factors approved by the Commission.
  - Quality and value adjustments
    - Quality-based or efficiency based rewards, penalties, or scaling then applicable to global budget hospitals would be applied.
    - Any savings adjustments, such as the readmissions savings requirement, would be applied;

- Approved revenue may also be modified for:
  - Shifts to unregulated settings: Some services may be offered more effectively in an unregulated setting. When services are shifted to an unregulated setting, HSCRC staff will work with the hospital to calculate and apply a reduction for an appropriate portion of the Hospital's approved revenue designed to assure a savings to the public.
  - Service level and market share changes: Approved revenues may be adjusted for changes in service levels (e.g., closure of a program) or due to market share changes.

- Other
  - E.g. CON

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HSCRC
Health Services Cost Review Commission
Demographic Adjustment for Workgroup Review

- Claritas zip code population projections
- Virtual patient service areas (VPSAs) for each hospital, providing an apportionment of “market share” of population in zip code and age cohort. Market share apportioned based on equivalent case-mix adjusted discharges (ECMADs)
- Cost weight by age-cohort based on state-wide use, reduced by potentially avoidable utilization for the age-cohort (PAUs)
- Apportioned population and age/PAU adjusted increase calculated for each hospital, including >65 age group to allow for rough monitoring of Medicare growth per capita
Maryland All Payer and Medicare FFS Payment Per Capita Growth Trends

2013 estimates are based on FY14 Update (1.65 % and previous year’s volume increases and beneficiary growth rate)
## FY 2014 Approved Update Factor

### Table

<table>
<thead>
<tr>
<th>Category</th>
<th>Inpatient/Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Basket</td>
<td>2.31%</td>
</tr>
<tr>
<td>Policy Adjustment</td>
<td>-0.66%</td>
</tr>
<tr>
<td><strong>Base Update</strong></td>
<td>1.65%</td>
</tr>
<tr>
<td>Case Mix Allowance</td>
<td>0.00%</td>
</tr>
<tr>
<td>Maximum Base Update + Case Mix Change</td>
<td>1.65%</td>
</tr>
</tbody>
</table>

- Policy Adjustment is MB minus labor costs plus financial condition adjustment (2.31%-1.38%) +0.72%

- Governs state-wide case mix change to 0.0%
FY 2014 Update Factor Considerations

- By direction of the Commission, HSCRC staff approached annual update discussion considering:
  - Factor Cost Inflation
  - Sequester Impact
  - Financial Condition
  - Waiver Cushion
  - Other Factors

- HSCRC adopted a “bridge period” from July to December with no adjustments – 1.65% update

- Commission re-evaluate update and kept the same and applied normal retroactive and policy adjustment
Factors for Consideration in Updates

Discussion of key topics for workgroup to address
Workgroup Priorities

For July 1 implementation
- Update approach (and updates) for global budgets - short term
- Updates for revenues not under global budgets
- Other short term adjustments and policies

Beyond July
- Policies
- Strategic direction of payment models
Factors for Update--Statewide

- Approach for Non-Global Revenues
  - Inflation less productivity, other
  - Other policies

- Update for Global Methods
  - Trend or inflation
    - Differential from non-global
  - Demographic Adjustments

- Other Changes
  - Uncompensated care (ACA impact, 2013 growth, formula)
  - Assessments
  - Value based payments
    - QBR and MHAC
    - Readmission shared saving
    - Other positive incentives
Factors for Consideration regarding Other Short Term and Long term Adjustments

Discussion of key topics for workgroup to address
FY 15 Short Term Adjustments—Hospital Level

- Germantown hospital opening
  - Statewide impact
  - Market share adjustments
- Other short term market share/volume adjustments
  - Changes in transfers to AMCs beyond population adjustments
  - Other
  - Excluded cases
Beyond Immediate

- Direction of model development
- Market share considerations
  - Other hospitals
  - Unregulated
- Efficiency (short-term on longer term), PAU
- Other model adjustments
- Overage policy adjustments
- Capital policies
- Excess capacity
- Excluded revenue model enhancements
- Different trending approaches