Maryland Health Services Cost Review Commission

Payment Work Group Meeting 1

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Health Services Cost Review Commission

REVIEW Of OVERALL MODEL CHANGES

Materials are provided for context.

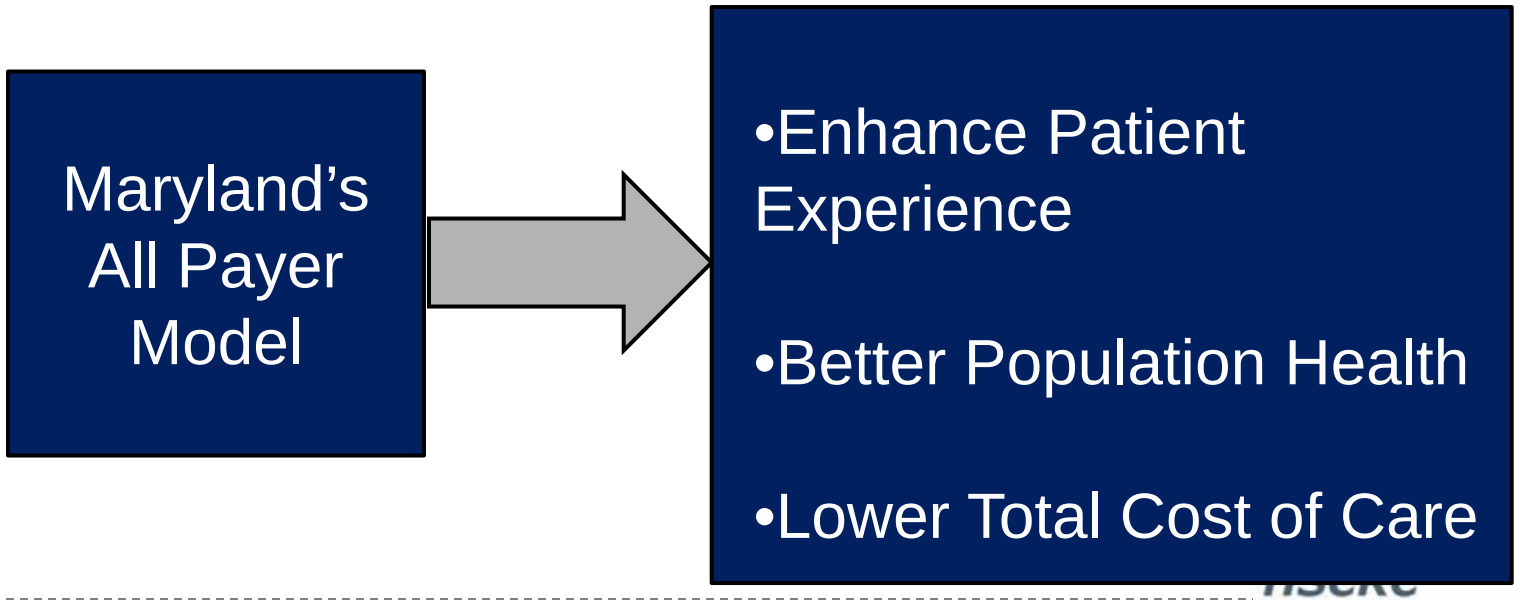
Approved New All-Payer Model

- 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



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

Better care

Better health

Lower cost

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)

- Hospital global model
- Population-based
- Preparation for Phase 2 focus on total costs of care model (Application due 2016 for 2019)

HSCRC Staff All-Payer Model Proposed Implementation Priorities

Hospital Global Models

- 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

Population -Based

- New Efficiency and Value Approaches
- Population-Based Payment Models
- Capital Policies
- Trending & Update
- Alignment Implementation Physicians , Post Acute, Care Coordination
- Data & Infrastructure

Prepare for Phase 2

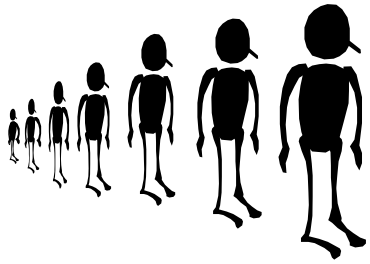
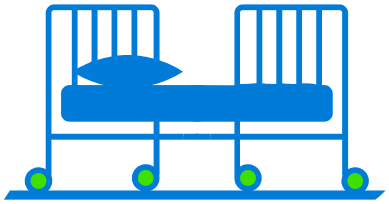
- Address Three-Part Aim Across the Total System
- Work With Participants Across the System to Define Phase 2 Approach

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

	1980	2010	% CHG
U. S. Population 	227M	309 M	+36%
Occupied beds 	755,000	473,000	37%

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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

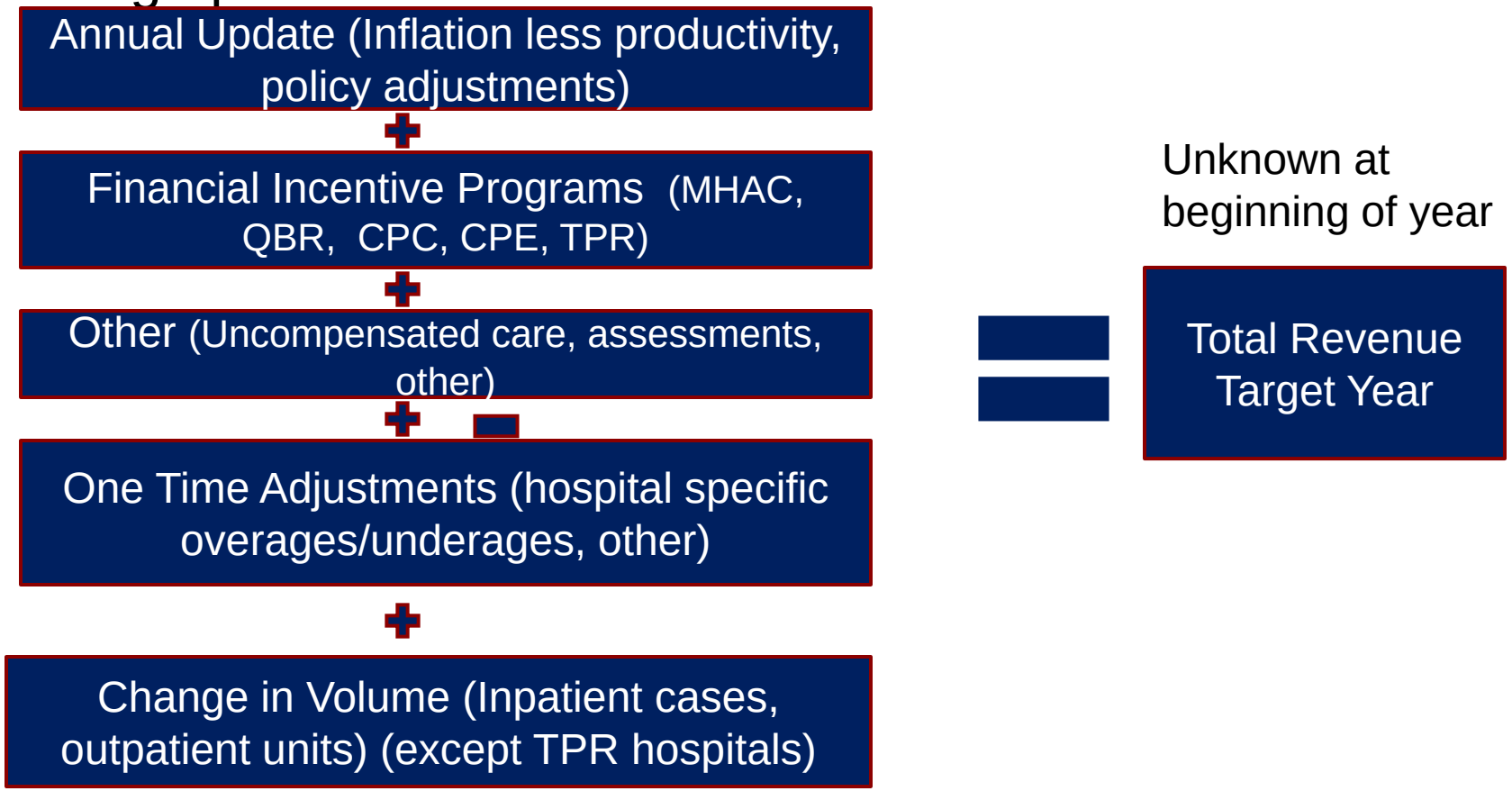
- Improved care and value for patients
- Sustainable delivery system for efficient and effective hospitals
- Alignment with physician delivery and payment model changes

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



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New Model--Change in Approach Under Population Based System

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

Total Actual Revenue Base Year—Maryland Residents

✖ Hard Cap Increase

Population Change

Maximum Allowed Revenue Target Year—Maryland Residents

Known at the beginning of year

Example:

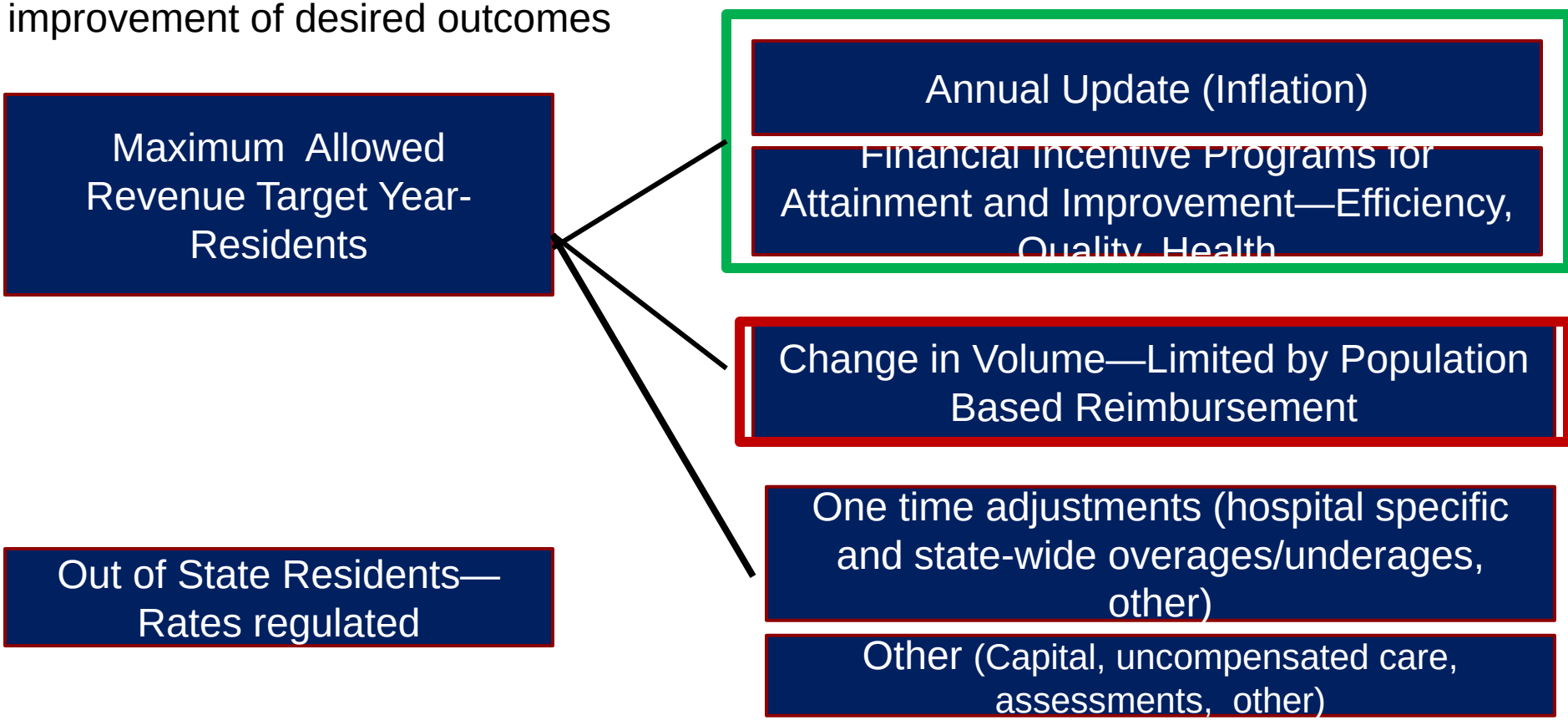
Base Revenue	**$ 15.0**	**Billion**
Less: Out of State	**$ 1.2**	**(Note)**
	$ 13.8	
X Hard Cap Increase	**3.58%**	
X Population Increase	**0.60%**	
Target Year Maximum Revenue-Residents	**$ 14.4**	**Billion**
Out of State Revenue	**Actual**	

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

Update requirements must be balanced under maximum revenue targets



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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;

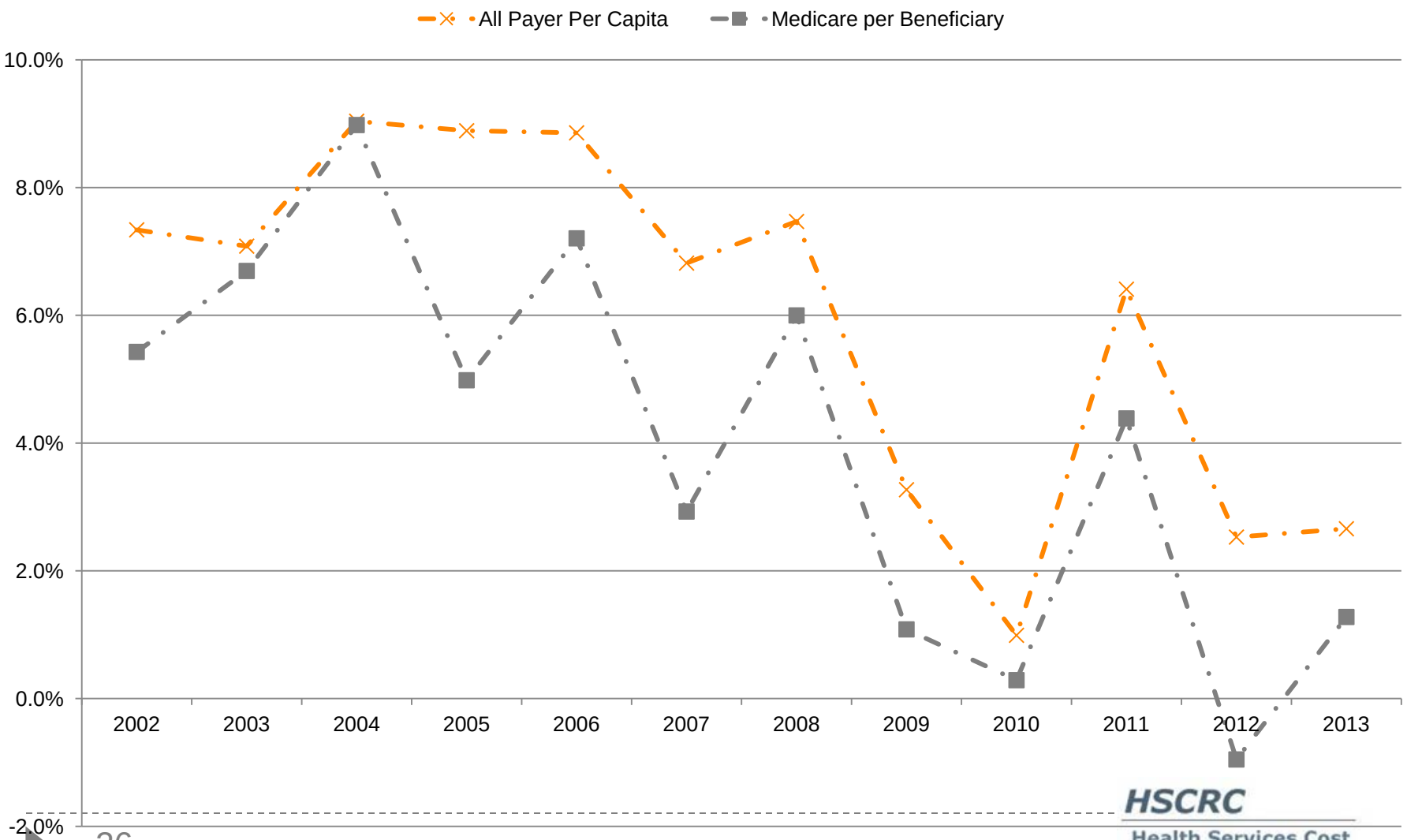
- Approved revenue may also be modified for:
  - Shifts to unregulated settings: Some services may be offered more effectively in an unregulated setting. When services are shifted to an unregulated setting, HSCRC staff will work with the hospital to calculate and apply a reduction for an appropriate 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

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



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2013 estimates are based on FY14 Update (1.65 % and previous year's volume increases and beneficiary growth rate)

FY 2014 Approved Update Factor

Category	Inpatient/Outpatient
Market Basket	2.31%
Policy Adjustment	-0.66%
Base Update	1.65%
Case Mix Allowance	0.00%
Maximum Base Update + Case Mix Change	1.65%

- 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