



**All Payer Hospital System Modernization  
Payment Models Workgroup**

**Meeting Agenda**

**May 19, 2014**

**2:00 pm to 5:00 pm**

**Health Services Cost Review Commission**

**Conference Room 100**

**4160 Patterson Ave**

**Baltimore, MD 21215**

- 2:00                    Introductions and Meeting Overview  
Donna Kinzer, Executive Director
- 2:10                    Discussion of Demographic Adjustment  
Sule Calikoglu, Deputy Director
- 2:30                    Update on Contract Subgroup  
Donna Kinzer, Executive Director
- 2:35                    Discussion of Prioritization of Work  
Donna Kinzer, Executive Director
- Transfers
  - Market share
  - Guardrails
  - Capital policies
  - Gain sharing and shared savings
  - Evolution of model
  - Bundled payments
  - Post-acute bundled payment
- 3:20                    Discussion of Principles for Guardrails  
Donna Kinzer, Executive Director
- 3:40                    Discussion of Principles for Market Share  
Donna Kinzer, Executive Director

4:25 Designation of Sub Groups to Work on Topics  
Donna Kinzer, Executive Director

4:35 Discussion of Timing and Pace of Meetings  
Donna Kinzer, Executive Director

4:45 Comments from Public

4:55 Next Steps

5:00 Adjourn

**ALL MEETING MATERIALS ARE AVAILABLE AT THE MARYLAND ALL-PAYER  
HOSPITAL SYSTEM MODERNIZATION TAB AT [HSCRC.MARYLAND.GOV](https://www.hscrc.maryland.gov)**

## HSCRC Payment Models Workgroup

### Revised Draft Work Plan

Updated 5/19/14

Tentative Meeting Date	Meeting Goals
February 21, 2014 3-5	<ol style="list-style-type: none"> <li>1. Review Workgroup charge and draft work plan</li> <li>2. Discussion of New Model and Global Budget Methodology (HSCRC staff presentation and discussion)</li> <li>3. Discussion of Factors to be Considered in Updates (HSCRC staff presentation and discussion)</li> <li>4. Discussion of Factors to be considered in short term adjustments (HSCRC staff presentation and discussion)</li> </ol>
March 13, 2014 1-4	<ol style="list-style-type: none"> <li>1. Discuss Performance Measurement Draft Staff Recommendations and Payment Approaches (staff presentation and discussion)</li> <li>2. Discussion on Balanced Update</li> <li>3. Discussion of components, approach and principles for update factor and short term adjustments</li> </ol>
March 20, 2014 9-11	<ol style="list-style-type: none"> <li>1. Additional Discussion on Balanced Update</li> <li>2. Discussion of components, approach and principles for update factor and short term adjustments</li> <li>3. Presentation of Initial Uncompensated Care Analysis (HSCRC staff presentation)</li> </ol>
April 3, 2014 3-6	<ol style="list-style-type: none"> <li>1. Brief introductory presentation on Scaling</li> <li>2. Brief introductory presentation on Demographic Adjustment</li> <li>3. Additional Discussion and Finalize recommendation on components, approach and principles for update factor and short term adjustments</li> </ol>
<b>April Deliverable</b>	<b>Report on components, approach and principles for Balanced Update and Short-Term Adjustments for May Draft recommendation to HSCRC</b>
April 23, 2014 10-1	<ol style="list-style-type: none"> <li>1. Discuss of Uncompensated Care Policy</li> <li>2. Discussion of balanced update and short term adjustments recommendations</li> <li>3. Preliminary discussions of guardrails</li> </ol>
<b>May Deliverable</b>	<b>Report on uncompensated care policy recommendations</b>
May 5, 2014 2-5 (May 7 Draft recommendation to Commission)	<ol style="list-style-type: none"> <li>1. Finalize balanced update and short term adjustments recommendations</li> <li>2. Report from Performance Measurement Workgroup on Efficiency</li> <li>3. Discuss and finalize Uncompensated Care Policy</li> </ol>

May 19, 2014 2-5	<ol style="list-style-type: none"> <li>1. Discussion of guardrails for model</li> <li>2. Report from Physician Alignment Work Group on Shared Savings/Gain sharing</li> <li>3. Discussion of Market Share Papers</li> </ol>
<b>June Deliverable</b>	<b>Report on balanced update and short term adjustments recommendations</b>
June 2, 2014 2-5	<ol style="list-style-type: none"> <li>1. Discussion of Major Capital Projects Papers and presentation from MHCC</li> <li>2. Comments on Contract Recommendations</li> <li>3. Discussion of options for guardrails for the model performance</li> <li>4. Update from Physician Alignment Work Group on Shared Savings/Gain Sharing</li> <li>5. Discussion of Transfers Analysis</li> <li>6. Initial discussion of future role and work plan for workgroup</li> </ol>
June 16, 2014 2-5  <b>*Meeting date Subject to Change</b>	<ol style="list-style-type: none"> <li>1. Presentation on global budget experience in other states/countries (expert presentation and discussion)</li> <li>2. Discuss relationship of hospital utilization and benefit design changes and premiums</li> <li>3. Finalize Guardrails for the model performance recommendation</li> <li>4. Finalize Market Share recommendations</li> <li>5. Finalize recommendation on future role and work plan for workgroup</li> </ol>
<b>July Deliverable</b>	<b>Report on Balanced Update and Short Term Adjustments</b> <b>Report on Guardrails for Model Performance</b> <b>Report on Market Share</b> <b>Report on Future Role and Work Plan for Workgroup</b>

**Note: This is a preliminary work plan. It is possible that meetings or conference calls could be added or that some materials may be reviewed via email.**



# Maryland Health Services Cost Review Commission

## Population and Demographic Adjustment

**05/19/2014**



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**HSCRC**

Health Services Cost  
Review Commission

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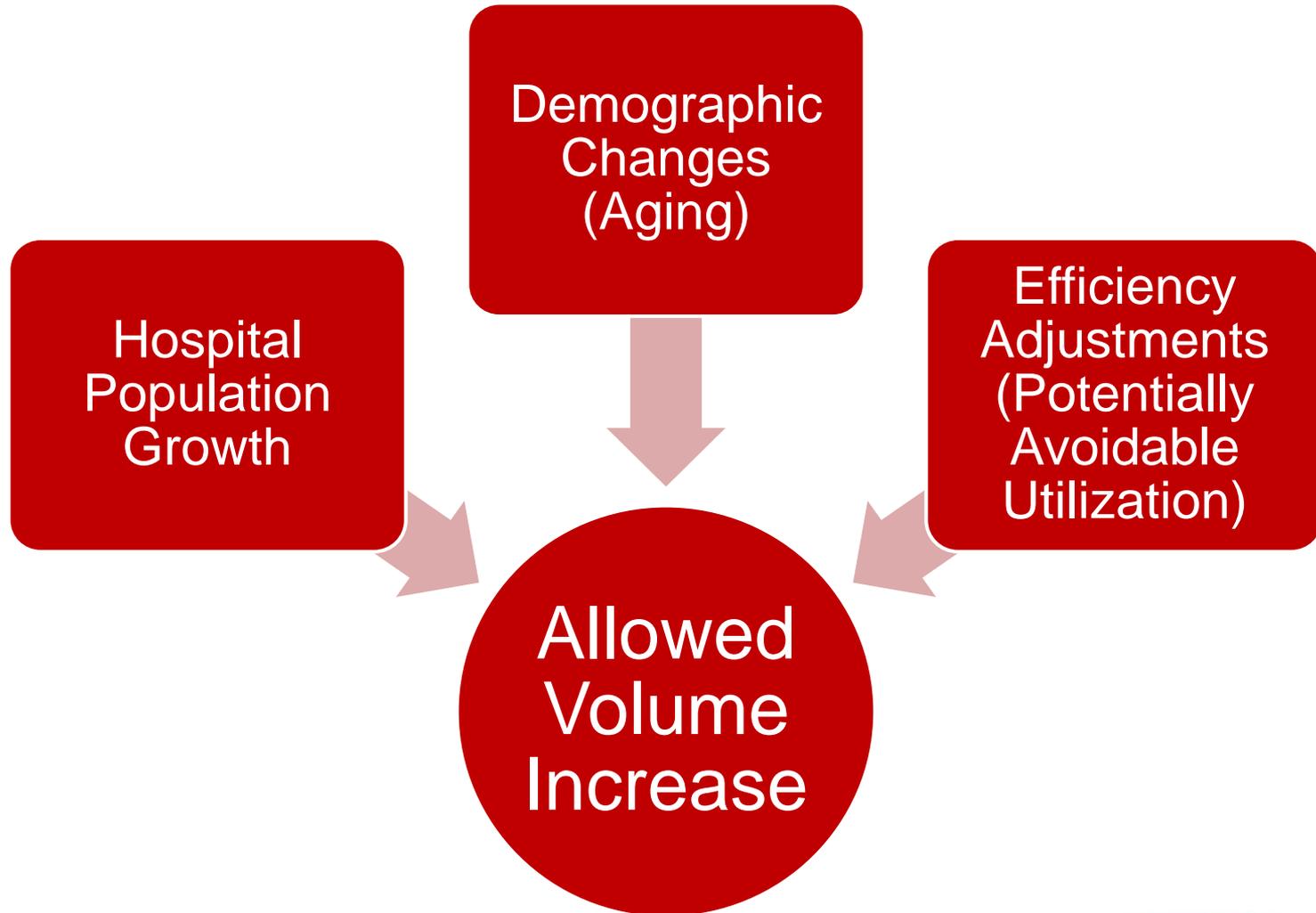
# Population Growth

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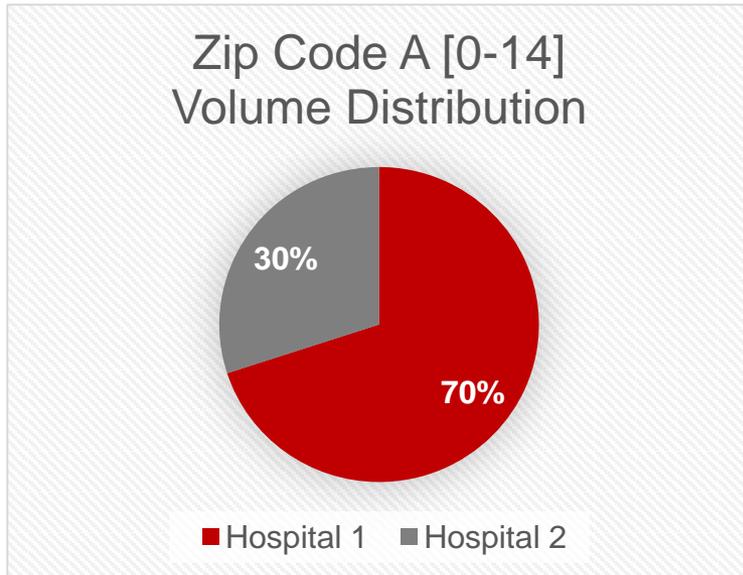
- ▶ State-wide all-payer per capita limit is based on unadjusted population growth (0.7%)
- ▶ Variation in hospital use by different population segments
  - ▶ Age
  - ▶ Sex
  - ▶ Others
- ▶ Hospital budget caps (GBR, TPR) needs updated to reflect changes in demographics

# Allowed Volume Increase in Global Budget due to Population Growth

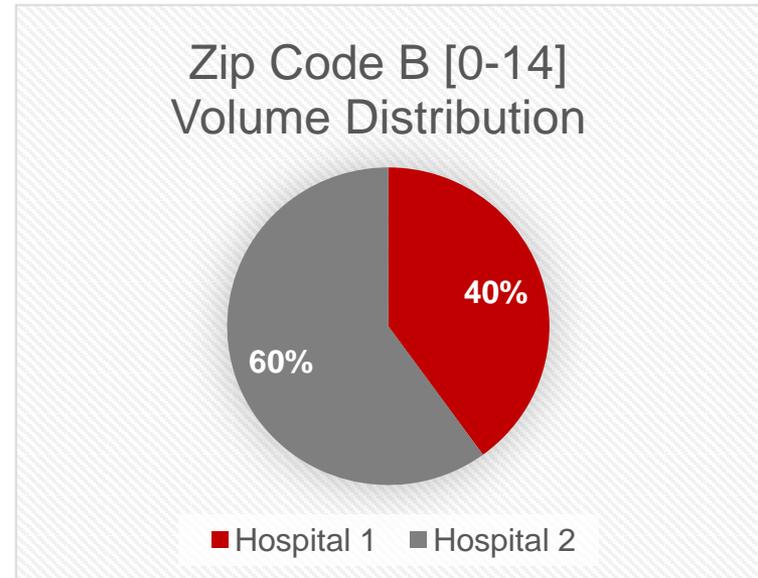
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# Calculating Virtual Patient Service Population



[0-14] Population in Zip Code A = 1000



[0-14] Population in Zip Code B = 1000

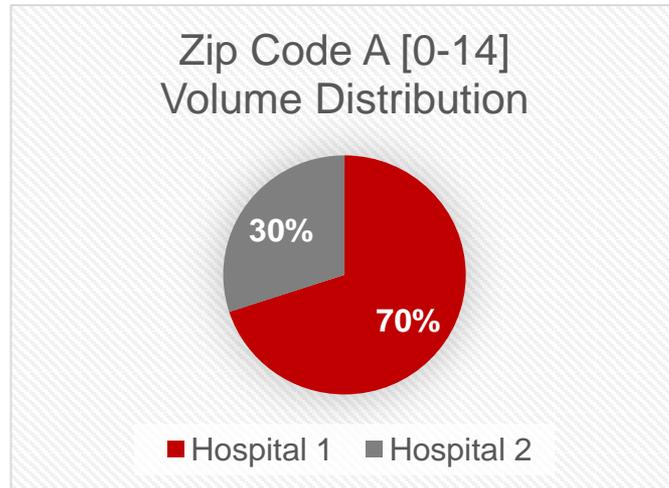
## Sample Calculation: Total [0-14] Population at Hospital 1

	Age Group	Population	% of Population at Hospital 1		Base Population for Hospital 1
Zip Code A	0-14	1000	70%	$1000 * 70\% = 700$	700
Zip Code B	0-14	1000	40%	$1000 * 40\% = 400$	400
					<b>1100</b>

**Total [0-14] Population for Hospital 1 = 1100**

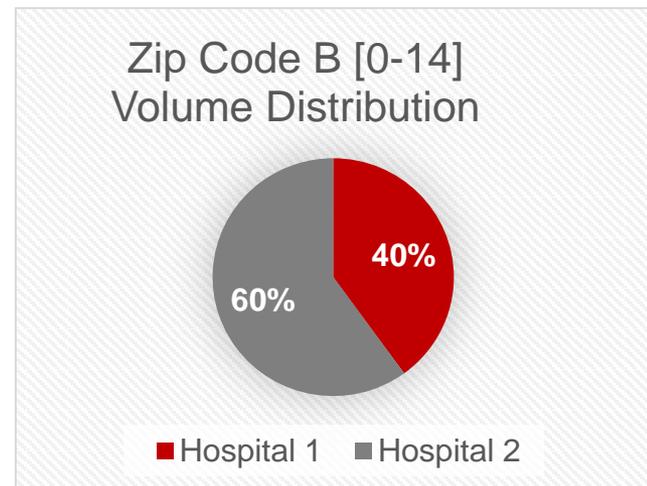


# Hospital Population Growth



[0-14] Population in Zip Code A = 1000

[0-14] Population Growth in Zip Code A = 1%



[0-14] Population in Zip Code B = 1000

[0-14] Population Growth in Zip Code B = 5%

## Sample Calculation: [0-14] Population Growth Rate at Hospital 1

	Age Group	Base Population	Population Growth Rate		Population Growth	
Zip Code A	0-14	700	1%	$700 * 1\% = 7$	7	
Zip Code B	0-14	400	5%	$400 * 5\% = 20$	20	
		1100			27	$27/1100 = 2\%$

[0-14] Population Growth Rate at Hospital 1 = 2%



# Volume Calculations

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- ▶ **Limited Exclusions**
  - ▶ Inpatient charges  $\leq$ \$200
  - ▶ Inpatient charges trimmed at \$2,000,000
- ▶ In areas where there is no inpatient admission, hospital's age specific average casemix adjusted charge per case is used.
  - ▶ For Free Standing Emergencies we used hospital average casemix of the following hospitals:
    - ▶ Prince George's Hospital for Bowie
    - ▶ Memorial Hospital at Easton for Queen Anne's
    - ▶ Shady Grove Hospital for Germantown

# Age Weights and Potentially Avoidable Utilization Adjustment

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Cohort	Population 2013	Total Revenue FY 2013	Per Capita Revenue	Weights
	A	B	C=A/B	D=C/Total
0-14	1,116,379	\$869,605,897	\$779	0.33
15-54	3,237,264	\$5,533,410,294	\$1,709	0.73
55-64	753,340	\$2,545,877,489	\$3,379	1.44
65-74	451,737	\$2,332,612,349	\$5,164	2.21
75-84	228,153	\$1,672,564,159	\$7,331	3.13
85+	104,429	\$836,711,222	\$8,012	3.42
Total	5,891,302	\$13,790,781,409	\$2,341	1.00

# Potentially Avoidable Utilization: Unplanned Care

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## Definition of PAU:

“Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health.”

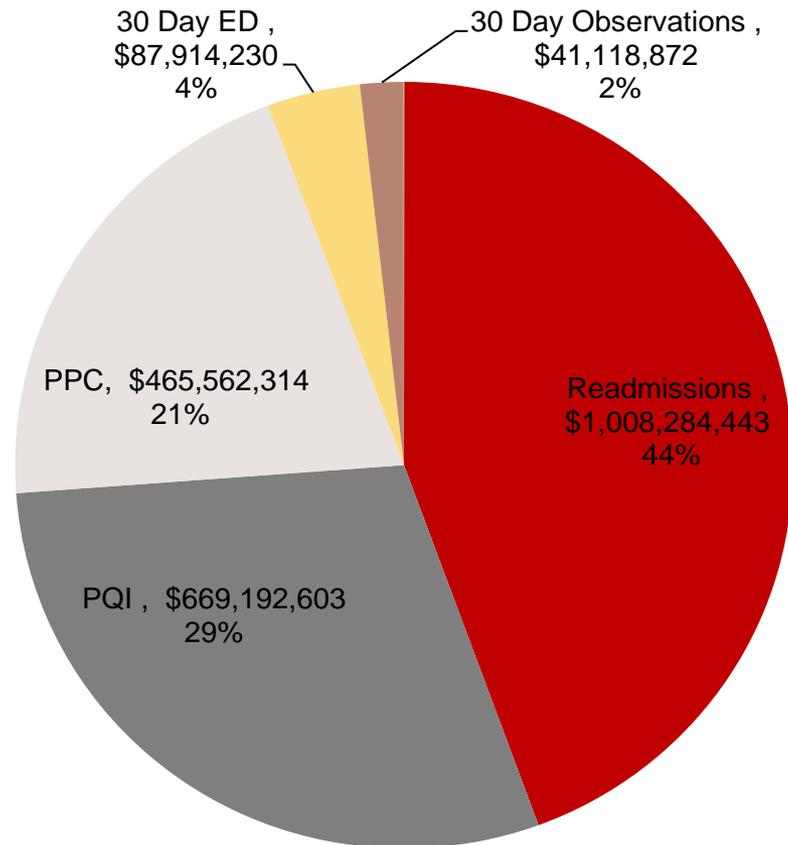
# Work and Considerations up to date

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- ▶ **Readmissions**
  - ▶ Inpatient- All Hospital, All Cause 30 Day Readmissions using CMS methodology with adjustment for planned admissions
  - ▶ ED – any visit within 30 days of an inpatient admission
  - ▶ Observation- any observation within 30 days of an inpatient admission
- ▶ **Potentially Avoidable Admissions/Visits**
  - ▶ Inpatient- AHRQ Prevention Quality Indicators (PQIs)
  - ▶ Outpatient - TBD
- ▶ **Hospital Acquired Conditions**
  - ▶ Potentially Preventable Complications (PPCs)

# Distribution of Potentially Avoidable Utilization, CY2012

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Note: Categories may overlap; Readmissions are based on ARR methodology adjusted for planned admissions.



# Data Sources

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- ▶ **Statewide Population Growth for the Waiver Calculations**
  - ▶ Department of Planning
- ▶ **Demographic Adjustments**
  - ▶ Claritas: Zip code age specific current and 5 year projections
- ▶ **HSCRC Inpatient and Outpatient Casemix Data Sets**
  - ▶ CRISP Master Patient Index = Revisits
  - ▶ Agency for Health Care Research (AHRQ)= Preventive Quality Indicators Software
  - ▶ 3M Potentially Preventable Complications Software

# Updates from the Demographic Subwork group for FY 2015

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- ▶ Updated Age cohorts
  - ▶ FY 2014 (0-14, 15-64, 65-74, 75-84, 85+ )
  - ▶ FY 2015 (0-4, 5-14, 15-44, 44-55, 55-64, 65-74, 75-84, 85+).
- ▶ Considered sex, race but determined no need for additional demographic factors
- ▶ Application of efficiency (PAU adjustments) based on percent of each hospital revenue from PAU volume
- ▶ Per Capita Policy Reduction after the PAU adjustment to ensure the state-wide allowed amount
- ▶ Negative results are converted no additional volume

# Review of Global Budget Contracts

## Introduction

Under the new All-Payer Model in Maryland, hospitals have chosen to have their revenues regulated under global models as the system moves from a system focused on cost-per-case to a system that has a three part aim of promoting better care, better health, and lower cost. In contrast to the previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the new All-Payer Model focuses on controlling increases in total hospital revenue per capita.

Central to the All-Payer Model are global revenue models that encourage hospitals to focus on population health and care improvement by prospectively establishing an annual revenue budget for each hospital. There are two global models being used: The Total Patient Revenue (TPR) model was expanded in 2008 and now includes 10 hospitals in more rural areas of the State. In 2013, the Global Budget Revenue (GBR) model, which was based on the TPR methodology, was introduced to all other hospitals in the State, including those in urban and suburban areas.

Under GBR and TPR, each hospital's total annual revenue is known at the beginning of the fiscal year. Total annual revenue is determined from a historical base period that is adjusted to account several factors.

In order to evaluate the potential for immediate changes that are needed for the GBR and TPR agreements as well as addressing any policy issues raised during the implementation of these agreements, HSCRC staff reviewed both GBR and TPR agreement templates and provided a summary of the provisions for discussion and review with a subgroup that broadly represented stakeholders from all groups. This draft report contains recommendations arising from the review of the agreement templates that require near term changes as well as recommendations for consideration when redrafting the contract in its entirety.

## Overview of Demographic Adjustment Calculation

*Updates--*Many of the agreement provisions of both GBR and TPR are identical or similar. This is expected because the GBR agreement was modeled after the TPR agreement, with some modifications to reflect the difference in nature of TPR and GBR hospitals. There was general consensus that it would be appropriate to move to a single agreement when the agreement is

redrafted that would cover both TPR and GBR arrangements, recognizing that there may be differences in the terms of the agreements due to the nature of the hospitals and the situations resulting from the different lengths of time hospitals have been under the model. In particular, the GBR agreement contains a number of clauses aimed at consumer protection. It is important that these protections be available in all circumstances and that the intent be explicitly stated. The aim would be to have a new standard agreement in place for FY 2016, while addressing any immediate requirements with an addenda to existing agreements. This will give adequate time to update the document, while addressing the more immediate concerns.

**Reporting templates**--The GBR agreement provides for monthly reports on compliance and other aspects of the model. Additionally, the GBR agreement calls for a report on investments and infrastructure for implementing the agreement (e.g. case managers, care coordinators, etc.). HSCRC staff has asked for assistance from DHMH in developing the reporting requirements for infrastructure. HSCRC staff will ask for volunteers and convene each subgroup with a goal of completion over the next two to three months.

**Underage and overages**--The GBR agreement addresses underages and overages relative to the total global budgets. It includes a provision that provides for a penalty of 40% when underages or overages exceed .5%. Commenters felt that this corridor may be too tight and that it did not fully address the need to limit carry forwards of undercharges from year to year. HSCRC staff notes the need for enhanced compliance under the new All-Payer Model. Nevertheless, the following table is proposed to replace the .5% corridor in the GBR agreement, and also be provided as an addendum to TPR agreements.

<b>Proposed Corridors Relative to Overages</b>	
<b>Overages</b>	
0 to .5% above total approved revenue budget	No penalty
.5% to 1% above total approved revenue budget	40% penalty
1% and more above total approved revenue budget	50% penalty
<b>Proposed Corridors Relative to Underages</b>	
<b>Underages</b>	
0 to .5% below total approved revenue budget	No penalty
.5% to 1% above total approved revenue budget	20% penalty applied to reduce carryover
1% to 2% above total approved revenue budget	50% penalty applied to reduce carryover
Above 2%	No carryover

**Unit rate charge corridors**--Both TPR and GBR agreements have charge corridors to allow hospitals to increase or decrease charges to stay in compliance with the overall revenue budget target. If rates exceed or are lower than 5% of unit rates, then the hospital must seek permission to expand the charge corridor to 10%. The agreement does not address a process to provide corridors above 10%. Underages below 10% are not added back to hospitals' approved revenues. The HSCRC staff intended to address several issues of concern with this policy.

Policy Intent	Commentary
<p>HSCRC staff does not want to allow cross subsidization or shifting through undercharging in one center that is made up by overcharging in another center.</p>	<p>The limits provide some assurance that this will not occur beyond the corridors. Contracts state that the policy is to spread overages and underages ratably, and staff will be on the look out for other patterns.</p>
<p>HSCRC staff wants to review volume decreases, to ensure that they are not the result of a market share shift or failure to provide needed services.</p> <ul style="list-style-type: none"> <li>• If hospitals need to increase rates beyond the corridor of either 5% or 10%, this means that volumes have fallen overall by more than 5% or 10%.</li> </ul>	<p>There is a concern that the agreement does not specify how the intended policy will be addressed in evaluating requests for corridor relief. There is also a concern that there should be corridor relief beyond 10% to allow hospitals to continue to address reductions in avoidable utilization.</p> <p>Recommendation: HSCRC staff should draft a policy that addresses these concerns and outlines how it will review requests. In general, the HSCRC staff will want the hospital to demonstrate that its market share has not decreased, services have not been shifted outside of the hospital, and that the hospital has not stopped providing needed services or serving severely ill patients. If avoidable volumes have fallen below 10%, HSCRC staff will want to ensure that variable operating costs have been reduced commensurate with volume reductions over an appropriate period of time. Furthermore, the hospital should present a plan relative to volume reductions beyond 10%, including the funds that are needed for investments in population health, care improvement interventions, and physician alignment activities. Additionally, the plan should address the amount of savings that will be shared with the purchasers and payers.</p>
<p>HSCRC staff indicated that the corridor policy requires that the base period volumes be maintained in place to avoid undermining the intent. TPR hospitals had their volumes updated annually and this has undermined the intent for these hospitals. Moving forward, the intent will be retained.</p>	<p>There was a concern raised that rate realignment cannot occur effectively if volumes are not updated. HSCRC staff agrees with the importance of rate realignment. The policy can be maintained by updating the volumes but maintaining the corridors through the rates assigned. For example, if the hospitals volumes have dropped overall by 3%, then the rates assigned should produce total revenues that are 3% below the overall cap. This will allow rate realignment to occur while maintaining the intent of the agreement. If the hospital receives a demographic adjustment, this can be reflected by increasing the volumes used in calculating the allowed revenue and treated as a volume</p>

increase.
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These are the main clauses that require immediate attention. The attachment summarizes the key terms and discussions relative to the proposed amendment of the contract for the 2016 renewal year.

***December 31 targets***--While the agreements are for fiscal years, the hospitals need to maintain compliance with targets that are for calendar years, due to the nature of both the All-Payer Model and Medicare savings requirements which are calculated on a calendar year basis. A contract addenda should be provided with the July 1, 2014 rate orders that specifies the December 31 target that should not be exceeded.

## DRAFT DISCUSSION POINTS

### PRINCIPLES AND DEFINITION EXTRACTS FROM WHITE PAPERS SUBMITTED BY HEALTH CARE FOR ALL, MHA, AND CAREFIRST

#### **Provide clear incentives**

- Provide clear incentives to emphasize value rather than volume
- Reward improved utilization, taking care not to reduce budgets when hospitals have to invest in interventions such as care coordination and physician alignment
- Be careful not to diminish resources available for care coordination
- Encourage reductions in utilization that help achieve the Three Part Aim.  
Discourage reductions in utilization that undermine the achievement of the Three Part Aim.
- Avoid incentives for overutilization that undermine the Three Part Aim.

#### **Reinforce the maintenance of services to the community.**

- Encourage competition to promote rational provision of services.
- Competition should be based on value.
- Generally revenue should follow the patient.
- Discourage poor services and low-quality care.

#### **Changes constituting market share shifts should be clearly defined**

- Should be used as a mechanism to channel patients from low value to high value hospitals
  - Should be based on channeling of market share by entities such as ACOs, PCMH, MCOs seeking to direct patients to low cost high quality setting
- Closures of services or discrete readily identifiable events should result in a market share adjustment
- Wholesale migrations of patients from one facility to another because of perceived reductions in quality should result in market share adjustment
- There is a distinction between shifts from competitively-induced channeling versus shifts in patients that are not market driven. For instance, large health care systems often acquire practices or provide bonuses. These practices have little to do with improving efficiency and are not consistent with the goals of population-based health payment
- Revenue shifts should not provide excessive funds to reward movement of services that do not add value, that would result in funding the purchase of physician practices to gain market share without adding value
- Changed hospital expenditures resulting from improvements or efficiency losses should not be considered market share shifts. (Be careful when using charges in the calculation.)

## How to calculate market share changes

- Increases in the global budget of one hospital should be funded fully by the decrease in another hospital's budget
- If one hospital increases production and another does not decrease production, a market share shift should not be awarded.
- Judge market share shifts with overall volume to ensure that shift has occurred, rather than volume growth
- Reflect market for services provided by the hospital
- Exclude PAU
- Do not exclude ambulatory sensitive conditions with other PAU
- Adjust budgets for substantial shift in market share, after the fact. Use corridors to avoid shifts for minor variations.
- Adjust budgets gradually to reflect the fixed nature of capital

# Market Share Adjustments: Demonstration Requirements, Principles and Examples

CareFirst

May 19, 2014

# Requirements of the All-Payer Demonstration

- A certain Proportion of Maryland hospital revenue must be covered by Population-Based Payment in each year of the Demonstration
- Population-Based Payment is defined, in part, as the establishment of a fixed global budget for hospitals for services unconnected to a specific population
- A Global Budget such as the GBR arrangement is not fixed if it is subject to Volume Adjustments
- Therefore, a Market Share Adjustment in the GBR must be fundamentally different from a Volume Adjustment

# Features of a Market Share Adjustment (MSA) Consistent with Population-Based Payment

- A MSA consistent with Population-Based Payment requires that:
  - A Population be specified from which Hospitals' Market Shares will be calculated
  - The Covered Services of the MSA be defined,
  - The Redistribution of Covered Services of the Population subject to the MSA result in Lower Costs or Demonstrably Higher Quality, and
  - To the Maximum Extent Practicable each MSA be (at most) Budget Neutral

# The Principles of Population-Based Payment as Reflected in Fixed Global Budgets of the GBR Arrangement

- A GBR hospital should:
  - Have clear incentives to eliminate Marginal or Unnecessary Services
  - Maintain its Fixed Global Budget despite random fluctuations in its Volume of Service
  - Maintain its Fixed Global Budget despite fluctuations in the Volume of Service of other Hospitals, including increases associated with Volume Inducing Initiatives
  - Have its target budgets adjusted by an MSA only for the Redistribution of the Covered Services of a Specified Population in which the Market Share Adjustment decreases the Volume of the Redistributed Services

# Limitations of a Market Share Adjustment

- Two Hospitals:

- A Community Hospital (C), and
- A Teaching Hospital (T)

provide virtually all hospital services to the residents of a zipcode (z)

# Limitations of a Market Share Adjustment

- An MSA should be Applied if:
  - An ACO redirects its cases from T to C to reduce its expenditures
  - The patients diagnosed with certain cancers by the attending staff of C are referred to a newly established multi-specialty cancer program at T
  - C elects to close a service with patients directed to T
  - C gets approval for an OHS program, drawing patients from T

# Limitations of a Market Share Adjustment

- An MSA should not be Applied if:
  - T applies effective clinical management, reducing its volume of services to the residents of z, while C's volumes of services to the residents of z remain fixed
  - C recruits (and subsidizes) a Cardiology Group, increasing the level of its cardiology services
  - T is the sole provider of certain services and T increases the level of such services to the residents of z