



Paper 3: A Proposal for Providing Hospitals with Differential Incentives to Reduce their Levels of Potentially Avoidable Volumes (PAVs)

Submitted by CareFirst 1-10-2014

1. Introduction

1.1 – In Paper 2, we proposed a population-based volume allowance methodology. The proposed methodology accounted for expected volume changes associated with changes in the demographics of a Global Budget hospital's Patient Service Area. The methodology did not, however, account for or make any adjustment for a hospital's level of Potentially Avoidable Volumes (PAVs).

1.2 - The Commission staff recently indicated its interest in adjusting demographic Volume Allowances for an estimate of the level of PAVs in a particular Service Area. In this Paper, we discuss two approaches to providing hospitals with differential incentives to reduce PAVs. The first approach would place a portion of a hospital's annual allowance at risk if the hospital has a disproportionate level of PAVs and does not sufficiently reduce them. The second approach reflects work that is being carried out by the HSCRC staff that would modify the Global Model demographic adjustments to account for a hospital's PAVs.

1.3 – At this time, PAVs are not clearly defined. However, when we refer to PAVs, we assume they will include at least unnecessary readmissions and some proportion of Hospital Acquired Conditions, given that the Maryland Demonstration Agreement requires the State to realize specified reductions in both of these measures. In addition, PAVs could include the Agency for Health Research and Quality's (AHRQ) Prevention Quality Indicators (PQIs), or potentially preventable Emergency Room visits and other potentially unnecessary utilization (3M Health Information Systems has developed a list of Potentially Preventable Events which include preventable Emergency Room visits which can be used in the definition of PAVs).¹ Other possible sources of PAVs include excessive lengths of stay.

¹ PQIs represent hospital admissions for various "ambulatory sensitive conditions." These are conditions for which the availability of "good" outpatient and primary care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

1.4 – This Paper also discusses the HSCRC’s history of “technology adjustments” and suggests that no such adjustments should be included in the Global Model or in the modified CPC system.

2. Creating Incentives to Reduce PAVs by Adjusting Each Hospital’s Annual Update Allowance

2.1 - Future financial incentives for hospitals to eliminate PAVs should be structured to be greater than the incentives to eliminate other marginal or unnecessary services.² A hospital operating under a Global Model has a basically fixed target budget with undifferentiated incentives to reduce all services once the budget is set. It would be useful to provide the hospitals with explicit guidance and incentives regarding the types of utilization that would be most readily and appropriately reduced. The HSCRC could achieve this objective by reflecting the level of PAVs in its determination of the annual adjustments to the target budgets of the particular hospitals.

2.2 - Under this approach, the HSCRC would establish a hospital-specific level of PAVs and place each hospital with a greater than “standard” or “expected” percentage of PAVs at risk for a certain amount of their annual allowance in the subsequent year. For example, suppose a hospital with a 10% standard or expected level of PAVs had 15% of its services classified as PAVs. The hospital might then be placed at risk for a specified share of its excessive PAVs (i.e., $15\% - 10\% = 5\%$) multiplied by a factor (e.g., 20%).

2.3 – For instance, if its percentage of PAVs remained at 15%, the hospital would receive no incremental adjustment and its annual allowance would be 1% below the annual allowance of hospitals that had a percentage of PAVs within their standard. If the hospital eliminated one fifth of the overage, the hospital’s PAVs would be at 14%, and the penalty would be 0.8%, or 80% of the 1% at risk; if the percentage of the hospital’s PAVs were reduced to 13%, eliminating two fifths of the overage, the incremental adjustment would be .6%, and so on. In particular, if the hospital’s PAVs were reduced to 10%, the hospital would receive the full annual allowance of hospitals operating within their PAV standard.

2.5 – Clearly, hospitals on the Modified CPC system should also face incentives to reduce PAVs. Similar to the methodology proposed above in section 2.1 for the Global Model hospitals, we believe that the HSCRC could apply a revised set of weights per resident (with PAVs excluded from these weights) to the Volume Governor applicable to the Modified CPC hospitals. Thus, the same type of adjustment could be applied in both situations; one directly by affecting the Volume allowance of the TPR and GBR hospitals and the other by affecting the aggregate Volume Governor of all the hospitals on the CPC system.

2.6 – We strongly prefer that the PAV related adjustment begin in the first Performance Year of the Demonstration (CY 2014) because it is vital to start the Demonstration by beating the

² As will be discussed in Paper 4 (“Calculating the Annual Update Allowance”), the Maryland Demonstration imposes two per capita tests (both the Medicare specific test and the All-Payer test). The Medicare test imposes a substantially tighter constraint. Therefore, it would behoove the Commission to focus hospital incentives on eliminating PAVs associated with the Medicare population.

Medicare and All Payer tests so that a cushion is created for later years. The reduction of PAVs could be especially useful to efforts to meet the Medicare savings requirements. We also believe that hospitals should be given notice of how the PAV adjustment would work prior to the actual implementation of the program. We recommend that the HSCRC staff should develop a proposed PAV methodology early in CY 2014 and have the HSCRC adopt a PAV policy effective July 1, 2014 for performance during the last 6 months of the first Performance Year). Alternatively, the PAV adjustments could go into effect in the second year of the Demonstration, but we believe this delay would be very unfortunate.

3. An Alternative Approach to Creating Incentives to Reduce PAVs: Adjusting Each Hospital's Demographic Allowance

3.1 – In Paper 2, we suggested that the volume allowance for the hospitals in each County, exclusive of Baltimore City, should be calculated as a uniform Demographic Adjustment applicable to each hospital in the County using the Weights of the current TPR Agreement with the HSCRC.³ This approach to calculating demographically induced Volume Allowances does not account for different levels of PAVs in the hospitals, nor does it involve adjustments to the Weights for varying levels of PAVs across the age cohorts. Each of these features of the proposed volume allowance methodologies can be modified to give hospitals incentives to reduce PAVs. It is our understanding that the HSCRC staff is considering this alternative approach and we consider it to be quite reasonable.

3.2 - The calculation of the TPR Demographic Adjustment would be modified in two ways in order to give hospitals incentives to reduce PAVs:

- First, all or a portion of the claims for PAVs would be removed from the calculation of the Weights for the six age cohorts and a revised Demographic Adjustment would be computed for each County.
- Second, for each hospital in a particular County, the Demographic Adjustment would be applied to the hospital's target budget reduced by the proportion of the hospitals' claims that were excluded as PAVs in establishing Weights.

For example, if the calculation of the Weights for the six age cohorts involved the exclusion of all PAV claims, then the Demographic Adjustments for each County would be applied to the target budget of each hospital in the County exclusive of its PAV claims. Similar adjustments would be made in deriving the volume allowances of the Baltimore City hospitals.

4. PAVs and Modified CPC Hospitals

4.1 - In order to encourage hospitals to adopt Global Models, rather than the Modified CPC option, it is useful to craft the rate setting systems so that the implications of these two approaches are

³ An example of the calculation of a Demographic Adjustment using the weights of the TPR agreement is provided in Appendix 1 to Paper 2 ("Calculating Population-Based Volume Allowances").

readily comparable. The approaches we have suggested would derive the volume adjustments for the Global model hospitals and the modified CPC hospitals on a consistent basis tied to demographic changes. We believe that, under these approaches, the Global Models will be preferred by most hospitals because they would enable the hospitals operating under them to eliminate unnecessary care without suffering budget reductions (whereas the modified CPC hospitals would lose 50% of the associated revenue) and because the Global Budget hospitals would receive their population-based volume allowance even if they didn't realize any additional volume.

The reduced Demographic Adjustments and related volume allowances described above would operate to reduce the Volume Governor under the volume allowances described in Paper 2. In Paper 2, the Volume Governor equals the sum of the volume allowances (i.e., the Demographic Adjustments) that would have applied to the Modified CPC hospitals if they had opted for a Global Model.

4.2 - Therefore, the Volume Governor is reduced in two ways: (1) as a result of the partial or full exclusion of PAV claims in the calculation of the Weights for the six age cohorts, and (2) as a result of the derived Demographic Adjustments being applied to the hospitals' allowable claims excluding the PAV claims. These changes in the calculation of the Volume Governor would maintain a reasonable level of comparability between the volume allowance of the Modified CPC hospitals and the volume allowances of the Global Model with the latter allowances being slightly more attractive.

5. Comments on Technology Adjustments

5.1 - The HSCRC's 1.0% New Services/Technology provision was proposed in the late 1970s because the Medicare actuaries had estimated at that time that the increase in services per Medicare case added 3% to 4% to the annual increase in costs per discharge. These service increases were primarily in the form of greater use of routine diagnostic and therapeutic services (e.g., lab tests, x-rays, etc.) that were unrelated to new technology. Therefore, the 1% technology adjustment gave the hospitals, under per case payment arrangements, strong incentives to control ancillary use per case.

5.2 - The 1.0% adjustment was euphemistically labeled a "technology and new services" adjustment to camouflage the true purpose of the adjustment: namely, to establish a fixed allowance that would not pay for and would therefore discourage marginal or unnecessary testing. In particular hospitals, the 1.0% adjustment may or may not have covered the actual costs of new technology. However, its real purpose was to close the spigot on the continuing increase in overused routine ancillaries.

5.3 – Today, the level of inpatient cases is generally falling and volume increases are concentrated in the hospital outpatient departments. Some of these increases involve the expansion of observation services and other substitutes for inpatient care. However, one only needs to consider the rapid expansion of facility-based clinics with high fees, the use of CT and MRI scans, the substitution of ED services for primary care office visits and the proliferation of "sleep clinics" to

suspect that many of these services are inefficient, ineffective, and promoted by the HSCRC's FFS outpatient arrangement. Therefore, limiting the growth in outpatient services should be a key cost control initiative of the Demonstration under a Global Model savings model. This objective will require reductions in the level of unnecessary outpatient care.

5.4 - Accordingly, we do not favor additional volume adjustments for "new technology," other than new technology related to CONs, for the following reasons:

- There does not appear to be an operational definition of the services which should be considered to be covered by "new technology" nor is there a credible methodology for determining their incremental costs;
- In many cases, new technology has a relatively high initial cost, such as in the case of cataract surgery, angioplasty, or OHS, with subsequent year costs declining as the related procedures are gradually perfected. These productivity offsets are rarely mentioned in discussions of new technology (which is always alleged to increase costs) but are appropriately offset against incremental technology expenditures; and
- Historically, the hospitals with the greatest apparent need for technology adjustments (the Academic Medical Center [AMC] hospitals) haven't needed them. Specifically, the increase in the charge per case of JHH from 1980 to 2000 equaled the statewide average charge increase and UMMS's increase was well below the statewide average. Their charges included their charges for new technology. Both institutions generated strong financial results in the year 2000.
- It is not clear that the hospitals differ in their new technology needs. The AMCs may be at the cutting edge of implementation of new technologies but many of these technologies inevitably migrate from the AMCs to the community hospitals over time and become "new technology" for them at that time. Under the Demonstration, the payment limits do not make any explicit allowance for new technology. Therefore, the only source of funding would be a reduction in the other allowances (e.g., the inflation allowance) that would be available. It is not readily apparent that the needs for new technology could be reliably differentiated across the hospitals and it would be unfair to use a general reduction in another allowance (e.g., the inflation allowance) to fund a technology adjustment that would be given to particular hospitals (e.g., the AMCs).