



## Paper 5: Monitoring the Total Cost of Care

Submitted by CareFirst 1-10-2014

### 1. Introduction

1.1 – Under the Demonstration, the HSCRC is required to shift at least 80% of hospital revenue to Global Models by the fifth year. Global Models are arrangements, such as the existing Total Patient Revenue (TPR) model, or the Global Budget Rate (GBR) system, which establish a fixed Target Budget and thereby provide strong financial incentives to reduce unnecessary hospital service use.

1.2 - Under the Global Model structure, hospitals will be expected to attempt to eliminate unnecessary, marginal and duplicative services. These hospitals may engage in efforts that reduce the use of hospital care and increase the use of non-hospital services. For instance, Global Model hospitals will be incentivized to: 1) coordinate with local home health and long-term care providers to actively prevent hospital readmissions; 2) triage or redirect low acuity emergency cases to primary care physician (PCP) offices or urgent care centers; 3) encourage the referral of clinical lab, imaging and other ancillary services to lower cost, non-hospital providers; and 4) restrict physician access to surgical and procedure-based services at the hospital. This last action may result in increased use by surgeons and specialists of non-hospital ambulatory surgery capacity.

1.3 - Other provider organizations operating under the incentives of at-risk or shared savings programs (such as Medicaid MCOs, Medicare Advantage Plans, SSP-ACOs and PCMH programs) will face similar incentives to move care to less expensive non-hospital sites in order to generate cost savings. For instance, the preliminary results of the highly publicized Alternative Quality Contract (AQC) Shared Savings Arrangement organized by Blue Cross of Massachusetts showed that the largest proportion of savings generated under this program in its first year came from shifts in the site of service from high to low cost providers.

1.4 - While shifts in the site of service from hospitals to lower cost non-hospital providers are generally thought to be desirable, because the costs of providing the same services in these settings is less than the cost in the hospital setting, there is a concern that such shifts will not generate overall system savings. This concern issues from the fact that Medicare and the other payers would continue to pay the hospitals for the services that are shifted (if the hospitals on Global Models do not lose revenue when the services are shifted) and they would also pay the non-hospital providers for the services that are re-directed to them.

1.5 – The CMMI has expressed concern that this dynamic could lead to increases in the total cost of care for Medicare Beneficiaries. As a result, CMMI required the contract that will govern the Demonstration to include two limitations on the growth in Medicare per beneficiary costs: one covers hospital expenditures and one encompasses all services (i.e., hospital and non-hospital services). Private payers and the Medicaid program are also concerned about the potential for “double paying” for services that have been shifted from Global Model hospitals to non-hospital providers that are not governed by the HSCRC or included in the Demonstration.

1.6 – The purpose of this Paper is to consider this overall dynamic and to: 1) identify the best available data sources and possible approaches for monitoring trends in the total cost of health care in Maryland and potential shifts of care from regulated hospital to non-hospital settings; 2) suggest a strategy for monitoring trends in the total cost of care in Maryland by payer; and 3) address the feasibility and advisability of making adjustments to hospital Target Budgets in the case of shifts of services from Global Model hospitals to non-hospital providers.

## **2. Considerations regarding the Shifting of Hospital Services to Non-Hospital Sites of Care**

2.1 –As noted above, the CMMI is requiring the Demonstration contract to include two additional payment limitations that are designed to protect CMS against an unintended increase in the total cost of care for Medicare beneficiaries: 1) The annual growth in Medicare per capita total cost of care for Maryland beneficiaries, regardless of the state in which the services are provided, can be no more than 1.5% greater than the national Medicare total cost of care growth rate; and 2) beginning in the second performance year (2015), annual growth in Medicare per beneficiary total cost of care for Maryland residents cannot exceed the national Medicare per beneficiary total cost of care growth rate in any two consecutive years.<sup>1</sup> These tests place a considerable burden and risk on the HSCRC and the Maryland hospitals because excessive increases in non-hospital spending levels, which are not regulated by the HSCRC, could threaten the continuation of the Demonstration.

2.2 – Monitoring the total cost of care trends in Maryland (particularly for Medicare) is thus extremely important in order to ensure that the overall cost containment goals of the Demonstration are met and to avoid the termination of the Demonstration by CMS for non-compliance on either of these two provisions. In particular, the second limitation (i.e., not exceeding the national Medicare trend over any two-year period) imposes an additional and very stringent condition on the Maryland system. Under this provision, if Maryland exceeded the national Medicare trend by, for example, 1% in 2014, it would then have to reduce Medicare costs in the subsequent to a level below nation trend (per 2.1, second term above). The provisions are also problematic for Maryland because the State will not have much notice from Medicare should it exceed either limitation in a given year.

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<sup>1</sup> As noted, the CMMI/CMS limitations discussed here refer to the total cost of care per Medicare beneficiary (for both hospital and non-hospital) care. However, based on conversations with the HSCRC staff, there does not appear to be a consistent understanding regarding the definition of “non-hospital care” (i.e., whether it involves all non-hospital services, including professional services or whether it is restricted to just institutional non-hospital care). This definitional issue should be resolved with the CMMI/CMS.

2.3 - Medicaid and the private payers have expressed concern about Global Model hospitals retaining all of the savings from the shift of services to non-hospital sites. Shifts of this nature that are caused by hospital activities or brought about by insurer-sponsored activities (such as ACOs, MCOs, MA plans and the PCMH) will generally result in some level of overpayment if the hospitals retain their full prior payments and additional payments are made to the non-hospital providers that receive the shifted care. Because of the undesirable total cost implications of this dynamic, and the need to stay in compliance with the two Medicare total cost of care limitations imposed by the CMMI, the HSCRC staff has discussed the potential need for individual hospital rate adjustments to offset the windfall profits that would otherwise accrue to Global Model hospitals due to service shifts from such hospitals to non-hospital providers and to prevent the duplicative payments that would be made by payers for the shifted services.

2.4 – Overall, the situation described above presents a complicated set of circumstances and policy alternatives for the HSCRC. On one hand, there is a desire on the part of HSCRC staff and the major payers for the use of negative adjustments to the rate base of Global Model hospitals in the event that services shift away from these hospitals to less expensive non-hospital providers. On the other hand, there are a number of subtle dynamics that must be considered regarding these service shifts.

2.5 - Organizations operating under at-risk or shared savings arrangements, such as ACOs, face strong financial incentives to shift services to less expensive non-hospital-based settings. These shifts are usually applauded and encouraged if they are payer-sponsored activities and they result in lower total health care costs. Most such organizations pay on a straight fee-for-service (FFS) basis so, when they eliminate volume at a hospital, and purchase it instead from a lower cost provider, as has occurred in the AQC, they eliminate the payments to the hospital and pay only the lower costs at the non-hospital provider. Similarly, under the HSCRC's long-standing DRG-based per case constraint system, Maryland hospitals have been incentivized to reduce LOS and ancillary use per case without adjustment for observed shifts in cases from acute to post-acute settings. Global Model hospitals operating under much stronger incentives to control costs will understandably attempt to reduce the frequency of unnecessary admissions, readmissions, emergency room visits and other hospital services. While there is a legitimate concern about possible overpayment for care as a result of these dynamics, the HSCRC should be careful not to unnecessarily discourage hospitals from engaging in these activities.

2.6 - These considerations raise a fundamental question; namely, under what circumstances should rate adjustments to the Target Budgets of Global Model hospitals take place? In a previous Paper, we argued that upward rate adjustments to Target Budgets are necessary to promote and accommodate the channeling of market demand by "Market Sponsoring Organizations" from low value to high value hospitals, or to respond to other circumstances such as a service closure or a shift of patient volume/demand that is caused by circumstances beyond the particular hospital's control. Unfortunately, in the case of general pressure in the system to migrate services from hospitals to non-hospital providers, it will be difficult to distinguish between deliberate attempts to "shed" hospital-based services and service shifts that occur for other reasons.

2.7 – This problem of how and when to adjust Target Budgets for service shifts into non-hospital settings is extraordinarily complex. Many difficulties will be involved in accurately measuring the

shifts that take place, in attributing causation to these shifts, and in appropriately implementing related reductions to hospital Target Budgets. Nevertheless, given the adverse implications of exceeding the limitations on the growth in Medicare total cost of care that are included in the Maryland Demonstration, and the potential for overpayment by other payers, it will be very important for the HSCRC to monitor trends in hospital and non-hospital care in Maryland at an aggregate level and, as needed, at a disaggregated level. The primary goal of this monitoring exercise should be to measure the total cost of care growth for Medicare on a quarterly basis and to give the HSCRC the information it would need to formulate proactive adjustments to hospital rates to ensure that the Medicare total cost of care limitations that are included in the Demonstration are not exceeded. The secondary goal would be to monitor all payer trends in total cost of care and to develop mechanisms that can curb any excessive increases and help to position the State to submit an effective strategy for a second stage of the Demonstration that would encompass all services, across all payers, rather than just for Medicare.

2.8 - Through this monitoring effort, the HSCRC may learn more about how hospitals (and the Maryland health delivery system overall) are responding to the incentives of the Demonstration and what, if any, policy interventions will be required to meet the State's and CMS's cost containment goals.

### **3. Sources of Data and Potential Monitoring Effort**

3.1 – Successful monitoring of the total cost of care will require access to comprehensive and timely claims data from each major payer. The Maryland Health Care Commission has long maintained a database—i.e., the Medical Care Database (MCDB)—that was meant to collect all health care claims from all payers. However, the MCDB has significant gaps and is not available on a timely basis (The MCDB is only available annually with a lag of 24 months). Efforts that are now underway to enhance the MCDB will likely take many years. Thus, in the short term, these data will need to be generated directly from the major payers (Medicare, Medicaid through UMBC, CareFirst, United Healthcare, and possibly, from other payers including Aetna, Cigna, Coventry and other smaller payers). Comprehensive claims from even the four major payers would constitute about 85% of all health care expenditures for Maryland residents. Trends in per capita payments to hospital, non-hospital providers and for all services that would be computed using the data from the four major payers would be highly reliable indicators of overall trends.

3.2 – More specifically, in its monitoring efforts, the HSCRC might arrange to have direct access to raw claims data (and/or summary reports that it specifies) from the following sources:

- **Medicare:** Per the terms of the Maryland Demonstration, the HSCRC will be receiving total Medicare FFS claims data (including both hospital and non-hospital claims) each quarter three to six months after the quarterly reporting period. The HSCRC staff will be the primary custodian of these data and should have the primary responsibility for analyzing these data and producing the necessary reports to monitor trends in total Medicare costs per Maryland Beneficiary.
- **Medicaid:** Theoretically, Maryland Medicaid should be able to generate comprehensive claims data for all Medicaid beneficiaries. However, based on analyses performed by the HSCRC, Medicaid data suffer from serious gaps: for example, not all MCOs submit complete

encounter data and the HSCRC staff has observed many inconsistencies in the data available through the State's vendor i.e., the Hilltop Institute at the University of Maryland Baltimore Campus (UMBC). Despite these historical limitations, the Medicaid program has indicated that it will participate in any necessary data monitoring activities and has indicated it will be able to prepare periodic reports requested by the HSCRC for this purpose.

- **Private Payers:** Large insurers, such as CareFirst Blue Cross of Maryland and United Healthcare, have the ability to provide raw data (with sufficient patient confidentiality and other non-disclosure protections) and summary quarterly reports of both hospital and non-hospital claims and expenditures in a manner prescribed by the HSCRC staff.<sup>2</sup>
- **Chesapeake Regional Information System for Our Patients (CRISP):** CRISP is the State-designated regional health information exchange. Although the data collected by CRISP is limited, it could be expanded with appropriate funding through the hospital rate setting system. CRISP may ultimately be the best source for timely data on both hospital and non-hospital expenditures and utilization.

3.3 – Given the availability of data from at least the major payers (i.e., Medicare, Medicaid, CareFirst and United), the HSCRC should consider organizing a coordinated “team-based” data monitoring effort with participation of representatives from the Commission, Medicaid/UMBC, CareFirst and United (The Data-Monitoring Team). The HSCRC could take the lead in this effort by providing specifications to each payer for the type of data and reports that would be needed to match the analyses and reports that the HSCRC staff would perform on the Medicare claims data. The reports specified by the HSCRC would be shared with HSCRC staff on a quarterly basis with the general results reported to the Commissioners.<sup>3</sup>

3.4 – We recommend that the analysis of the Medicare and individual payer data should begin by establishing the baseline historical relationship between hospital and non-hospital expenditures on a county-specific basis over a 5-year period (from CY 2008 – CY 2013). These aggregate level reports would provide the HSCRC with a sense of the historical trends and year-to-year fluctuations in hospital vs. non-hospital expenditures. The Data Monitoring Team could track hospital, non-hospital and total per capita expenditures by county on an ongoing (e.g., quarterly) basis during the Demonstration and could generate “drill down” reports (by type of service, etc.) as needed in any locations that show problematic trends. The historical data (for the State or by county or other designated regions) would be used to establish baseline parameters and triggers for monitoring and comparison purposes during the Demonstration. For instance, if a particular region experienced “significant” decreases in services that are thought to be substitutable hospital services (e.g., simple ambulatory surgery services or CT/MRI or other imaging services), and corresponding increases in non-hospital services of these same types, the HSCRC staff and the individual payers could perform consistent and more detailed analyses of the hospitals and services involved in the identified shifts. The fact that over 50% of hospital outpatient services are

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<sup>2</sup> We would need to verify CareFirst's ability and willingness to produce both quarterly reports on hospital and non-hospital expenditures for Maryland residents.

<sup>3</sup> The Private Payers may not wish to have the results of their total cost experience made public.

concentrated in ambulatory surgery and other procedure-based services would make it possible to focus much of the detailed analyses on these services.<sup>4</sup>

3.5 – Simultaneously, for informational purposes, the HSCRC staff might wish to generate hospital-specific monitoring reports focusing on services that the staff identifies that can be provided by non-hospital entities. Unusually large annualized reductions of some pre-determined magnitude (say 10%) could trigger additional analyses, especially where the reductions in hospital services seem to be linked with increases in services at non-hospital providers (e.g., free standing ASCs, labs, imaging centers, etc.) owned by or affiliated with the particular hospitals.<sup>5</sup>

3.6 - The HSCRC staff should require all Global Budget hospitals to file (and regularly update) a comprehensive list of all entities that they own, control, share ownership with or with which they are affiliated to facilitate the HSCRC's efforts to track service utilization shifts that may warrant budget adjustments. This requirement would be similar to the requirement to identify such entities that is currently included in the TPR agreements.

#### **4. Suggested Policy Action with Regard to Hospital Rate Adjustments for Volume Shifts**

4.1 – Based on the discussion above, we recommend that the primary focus of the HSCRC's monitoring effort should be on aggregate trends in hospital versus non-hospital services and costs and the growth in total costs relative to historical baseline and expected national trends by payer. Given the importance of meeting the total cost of care limitations imposed by the Demonstration, there should be an extra focus on monitoring the trend in Medicare cost per Maryland beneficiary and on alerting the Commission in a timely way of the need for a proactive policy response if it

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<sup>4</sup> For the purposes of any more detailed analyses, it might behoove the HSCRC to identify non-hospital provider types and services that are most readily substitutable for hospital care and focus these enhanced monitoring efforts in these areas. For instance, the outpatient services most at risk for movement to non-hospital providers might include: ambulatory surgery, other procedure-based care, clinical laboratory; imaging services, such as CAT scan and MRI; low acuity emergency room visits, and outpatient primary care clinic services provided by hospital-based physician practices. The services least at risk for migration to non-hospital providers might include: hospital pharmacy, hospital supplies, specialty clinic services, "high-end" outpatient procedures and surgeries.

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appears the Maryland growth rate in total Medicare payments per beneficiary exceeds the projected trend in total per capita Medicare payments per beneficiary on a national basis.

4.2 – In regards to general increases in non-hospital services that are substitutions for hospital care, we suggest that there should be hospital specific adjustments only in limited circumstances. In the suburban and urban areas it will be virtually impossible to tie increases in free-standing surgery, lab, imaging, or urgent care to reductions in the services of particular hospitals (unless the HSCRC sees that the shift is between a hospital and a non-hospital entity that has been identified as either owned by or affiliated with the hospital in the TPR and GBR agreements. Also as demonstrated by the ACQ experience in Massachusetts, relocating the site of service can result in significant system savings.

4.3 - Consistent with the principle of providing hospitals with incentives to shift care to less expensive settings, we recommend that the HSCRC should establish a policy whereby it would apply rate offsets associated with the growth in Medicare's non-hospital care in the form of an across-the-board rate reduction equal to, say, 125% of the increase in Medicare's non-hospital care statewide, measured as a percentage of the hospitals' Medicare charges, in any county in which the rate of increase exceeded a specified limit. Hospital-specific rate offsets, rather than county-wide offsets, would be applied whenever the shifts could be tied to particular hospitals and (especially) any non-hospital entities associated with them.

The key point of this proposal is to recognize that significant cost savings can be achieved if all parties (both hospitals and payer-sponsored entities) are incentivized to shift care to lower cost settings. But total cost levels can be driven upward if service shifts result in duplicative payments. It would be appropriate to give the individual hospitals general incentives to redirect care to non-hospital settings but to offset at least a portion of the costs of the redirected services against the hospitals in general (except where the shifts can be tied to specific hospitals and non-hospital providers (especially here they are associated by ownership, etc.). The HSCRC would then debit the hospital industry in the aggregate (by county or at a more aggregated level) to reduce Medicare and other payer payments in line with the waiver requirements by offsetting a bit more than the incremental costs of the redirected services. In other words, we should encourage the desired activity and then assess the industry for a little more than the incremental costs of the care they shift through their collective enterprise.

4.4 – Certainly, the effectiveness of the monitoring effort and the potential for appropriate rate action will become clearer after the effort is underway and the HSCRC and the Data Monitoring Team members can see how hospitals appear to be responding to the incentives under the Demonstration. However, given the complicated nature of the incentives and dynamics at play, and the relatively tight nature of the Target Budgets being established for hospitals under the HSCRC's Global Models, it may be most appropriate and efficient for the HSCRC to focus on monitoring trends in the cost of hospital and non-hospital care and to make adjustments only in situations where it finds that total Medicare cost growth is in excess of the projected national trends.