All Payer Hospital System Modernization
Payment Models Workgroup

Meeting Agenda

May 20, 2016
12:30 pm to 3:30 pm
Health Services Cost Review Commission
Conference Room 100
4160 Patterson Avenue
Baltimore, MD 21215

12:30	Introductions and Meeting Overview
12:35	FY 2017 Quality Update Discussion
1:10	FY 2017 Update Factor Discussion
2:45	FY 2017 UCC Policy Discussion
3:15	Other Staff Updates
3:30	Adjourn

ALL MEETING MATERIALS ARE AVAILABLE AT THE MARYLAND ALL-PAYER HOSPITAL SYSTEM MODERNIZATION TAB AT HSCRC.MARYLAND.GOV

Balanced Update Model for Discussion

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

			Weighted Allowance
Adjustment for Inflation			1.72%
- Allowance for High Cost New Drugs			0.20%
Gross Inflation Allowance	A		1.92%
Implementation for Partnership Grants	B		0.25%
Care Coordination			
-Rising Risk With Community Based Providers			
-Complex Patients With Regional Partnerships & Community Partners			
-Long Term Care & Post Acute			
	C		
Adjustment for volume	D		0.52%
-Demographic Adjustment			
-Transfers			
-Categoricals			
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	E		0.50%
- Workforce Support Program	F		0.06%
- Holy Cross Germantown	G		0.07%
- Non Hospital Cost Growth	H		0.00%
Net Other Adjustments	I =	Sum of E thru H	0.63%
-Reverse prior year's PAU savings reduction	J		0.60%
-PAU Savings	K		-1.25%
-Reversal of prior year quality incentives	L		-0.15%
-Positive incentives & Negative scaling adjustments	M		0.27%
Net Quality and PAU Savings	N =	Sum of J thru M	-0.53%
Net increase attributable to hospitals	O =	Sum of A + B + C + D + I + N	2.80%
Per Capita	P =	(1+O)/(1+0.52%)	2.27%

Components of Revenue Change with Neutral Impact on Hosptial Finanical Statements

-Uncompensated care reduction, net of differential	Q		-0.49%
-Deficit Assessment	R		-0.15%
Net decreases	S =	Q + R	-0.64%
Net revenue growth	T =	O + S	2.16%
Per capita revenue growth	U =	(1+V)/(1+0.52%)	1.63%

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth CY 2016	A	1.20%
Savings Goal for FY 2017	B	-0.50%
Maximum growth rate that will achieve savings (A+B)	C	0.70%
Conversion to All-Payer		
Actual statistic between Medicare and All-Payer	D	0.89%
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**1.60%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.52%)-1	F	**2.12%**

Comparison of Medicare Savings Requirements to Model Results			
Comparison to Modeled Requirements	**All-Payer Maximum to Achieve Medicare Savings**	**Modeled All-Payer Growth**	**Difference**
Revenue Growth	2.12%	2.16%	0.03%
Per Capita Growth	1.60%	1.63%	0.03%

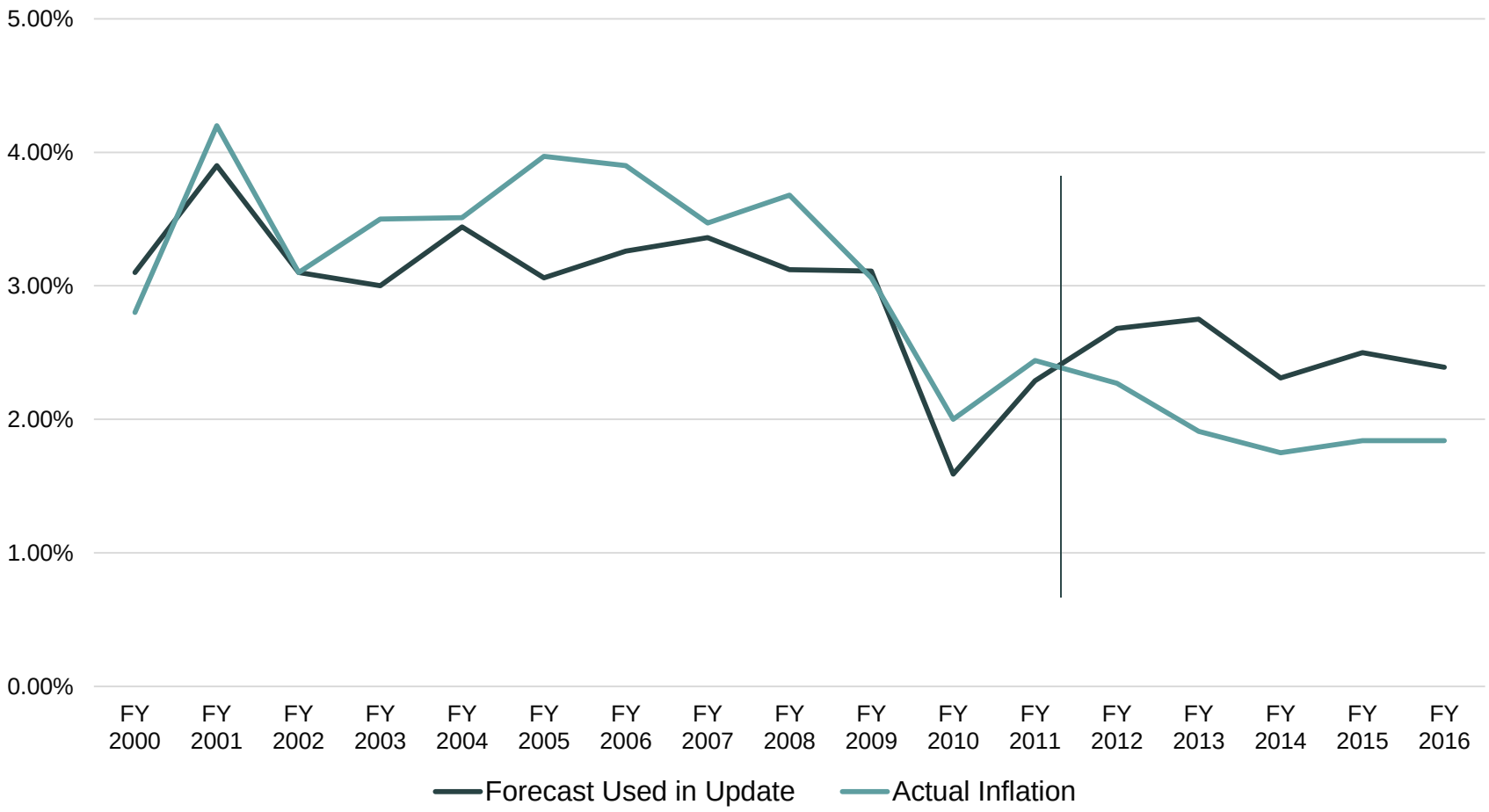
Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth (CY 2016 + CY 2017)/2	A	1.75%
Savings Goal for FY 2017	B	-0.50%
Maximum Growth Rate that will Achieve Savings (A+B)	C	1.25%
Conversion to All-Payer		
Actual Statistic between Medicare and All-Payer	D	0.89%
Conversion to All-Payer Growth per Resident (1+C)*(1+D)-1	E	**2.15%**
Conversion to Total All-Payer Revenue Growth (1+E)*(1+0.52%)-1	F	**2.68%**

Comparison of Medicare Savings Requirements to Model Results			
Comparison to Modeled Requirements	**All-Payer Maximum to Achieve Medicare Savings**	**Modeled All-Payer Growth**	**Difference**
Revenue Growth	2.68%	2.16%	-0.53%
Per Capita Growth	2.15%	1.63%	-0.52%

HSCRC Staff Preliminary Update Factor Component Breakdown FY 2017

	HSCRC Staff Proposal 05/11/16	MHA Proposal 05/11/16	Difference
Inflation (Current Market Basket is 2.49%)	1.72%	2.49%	0.77%
Net Quality-Based Payment Programs	-0.61%	-0.16%	0.45%
Adjustment for ACA Savings (Productivity)	0.00%	0.00%	0.00%
Subtotal	**1.11%**	**2.33%**	**1.22%**
Adjustment for Volume	**0.52%**	**0.52%**	0.00%
Care Coordination Allowances, by Application			
Rising Risk with Community Based Providers	0.00%	0.00%	0.00%
Complex Patients w/ Regional & Community Partnerships	0.25%	0.25%	0.00%
Long Term & Post-Acute Care	0.00%	0.00%	0.00%
Workforce Support Program, by Application	0.06%	0.06%	0.00%
Allowance for High Cost New Drugs, by Application	0.20%	0.20%	0.00%
Subtotal - available through application process	**0.51%**	**0.51%**	**0.00%**
Other Statewide Amounts			
Holy Cross Germantown	0.07%	0.07%	0.00%
Set Aside for Unknown Adjustments	0.50%	0.40%	-0.10%
Subtotal	**0.57%**	**0.47%**	**-0.10%**
Statewide Total Revenue Growth, prior to UCC/assessments	**2.72%**	**3.84%**	**1.12%**
Statewide Per Capita Growth, prior to UCC/assessments	**2.18%**	**3.30%**	**1.12%**
Other Adjustments			
Uncompensated Care Allowance	-0.55%	-0.55%	0.00%
Medicaid Tax Reduction	-0.15%	-0.15%	0.00%
Statewide Total Revenue Growth, after UCC/assessments	**2.02%**	**3.14%**	**1.12%**
Statewide Per Capita Growth, after UCC/assessments	**1.49%**	**2.60%**	**1.12%**

Why Adjust the Inflation Forecast Now?



Note: 9 of 16 years under estimated by avg. 0.02%
2000-2010 Underestimated 8 of 10 years by avg. 0.40%
2011-2016 Overestimated 5 of 6 years by avg. 0.54%

Allowable All-Payer Growth

Maximum Medicare Increase that Can Produce Desired FY 2017 Medicare Savings

	Scenario 1 (Staff proposal)	Scenario 2 (Staff proposal)	Scenario 3 (Current difference statistic)
Estimated Medicare Growth (FY 2017)	1.20%	1.75%	1.75%
Savings Goal (FY 2017)	-0.50%	-0.50%	-0.50%
Maximum Growth Rate that Will Achieve Savings	0.70%	1.25%	1.25%

Conversion to All-Payer

	Scenario 1 (Staff proposal)	Scenario 2 (Staff proposal)	Scenario 3 (Current difference statistic)
Actual Statistic Between Medicare and All-Payer	0.89%	0.89%	2.13%
Conversion to All-Payer per capita	1.60%	2.15%	3.38%
Conversion to Total All-Payer Revenue Growth	2.12%	2.68%	3.92%

Regional Budget Payment Concept

Share

The Centers for Medicare & Medicaid Services (CMS) is interested in seeking input on a concept that promotes accountability for the health of the population in a geographically defined community. Under the Maryland All-Payer Model, CMS and the State of Maryland are testing a new hospital global budget payment program in which all payers in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. CMS is seeking input on the feasibility of similar approaches for other geographical areas, which could include areas smaller than a state. In this concept, providers could receive a prospective budget for the care of the population of a community, and would be accountable for the total cost of care across the entire continuum of care and health outcomes for the entire population. The purpose of this approach would be to support better management of cost and quality for a community's population, by providing clear revenue expectations and connecting services across outpatient and inpatient sectors. The concept could also incentivize collaboration of provider systems with community-based services outside the traditional health system. Lastly, this concept could encourage the inclusion of rural providers through providing incentives tailored to the unique needs and opportunities presented in rural areas.

Potential Options

- HSCRC staff draft recommendation reflects a blend of 50% fiscal year 2015 actual UCC and 50% predicted or estimated UCC
- Hospital members working with HSCRC staff to recommend a predicted or expected approach. Final analyses of four options underway:

1) Similar to the MHAC logic, calculating “expected” UCC, by hospital, using an all-hospital average for a defined geographic area, payer type and patient type
2) Predicting UCC by hospital, using a logistic regression and defined variables
    a. Area Deprivation Index (ADI), payer
    b. Area Deprivation Index (ADI), payer, patient type (inpatient, outpatient, emergency room)
    c. Area Deprivation Index (ADI), payer, patient type (inpatient, outpatient, emergency room), undocumented immigrants (zip codes with a high percentage of emergency Medicaid)

Outstanding Considerations

- Financial Technical Work Group still analyzing the undocumented immigrant variable
- Out-of-state ADI percentages have not been updated
  - Evaluate the impact of out-of-state ADI, when available
- Data may be adjusted to reflect out-of-state Medicaid payment differences that are considered UCC (excluding D.C.)
- ADI variable: continuous (linear) versus discrete
- Complete overhaul from previous policy approach – new patient level data set, one year of post ACA actual UCC, etc.