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

# Meeting Agenda

**March 6, 2018**
**8:30 am – 11:30 am**
**Health Services Cost Review Commission**
**Conference Room 100**
**4160 Patterson Avenue**
**Baltimore, MD 21215**

| | |
|---|---|
| I | Introductions and Meeting Overview |
| II | Data Update |
| III | MPA Efficiency Adjustment |
| IV | Update Factor for FY2020 |
| V | ER & Clinic RVU Workgroup Update |
| VI | Adjourn |

# MPA Efficiency Adjustment

# Achieving Required Incremental Medicare Savings and Incentivizing Care Transformation

## Executive Summary

- HSCRC intends to use:
  - Update Factor to control all-payer hospital revenue growth
  - Medicare Performance Adjustment (MPA) Efficiency Adjustment to achieve the required incremental savings to Medicare
- The MPA Efficiency Adjustment is intended to:
  - Prospectively reduce hospitals' Medicare payments to achieve the Medicare savings target
  - Be paired with opportunities for hospitals to earn reconciliation payments to offset these reductions
- The HSCRC will work with hospitals to quantify current care transformation efforts and "credit" hospitals
- Hospitals that do not transform care will bear a larger proportion of the required incremental Medicare savings

# Medicare Specific Savings Requirement: Incremental Savings to Add Up to $300M

- Increase the current run rate (from 2013 base) to $300M by the end of 2023

| Year | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Required level of TCOC savings | $120M | $156M | $222M | $267M | $300M |
| Incremental savings from prior year | $0 | $36M | $66M | $45M | $33M |

- In other words, increase in annual Medicare TCOC Savings of $180M from 2019 to 2023
- If the run rate is ahead of target, provides opportunity to smooth MPA Efficiency Adjustment to hit $300M

# Example of Applying the MPA Efficiency Adjustment in CY 2020

- Prospectively determine how the MPA Efficiency Adjustment will be allocated among hospitals
  - If $36M in additional Medicare savings are required, and Hospital A has a 10% share, Hospital A's MPA Efficiency Adjustment = $3.6M
  - Different allocation methods are feasible (for first year, staff leaning toward hospital share of statewide Medicare payments)
- Allow hospitals to recoup their savings through care transformation efforts such as ECIP
  - If a Hospital A earned a $5M ECIP reconciliation payment, then net MPA Efficiency Adjustment of +$1.4M

# Example of Statewide Impact: Operationalizing MPA Efficiency Adjustment to Achieve Medicare Savings

HSCRC Accounting of Medicare Savings:

| **FY19 TCOC Savings** | |
|---|---|
| FY19 Projected Medicare Savings Run Rate | $120M |
| ECIP Impacts (Reductions in PAC Utilization) | +$5M<br>(Decreases in utilization adds to RR Savings) |
| **FY19 Medicare Savings Run Rate** | **$125M** |

| **FY20 TCOC Savings** | |
|---|---|
| FY19 Medicare Savings Run Rate | $125M |
| FY19 ECIP Reconciliation Payments (to hospitals) | -$5M |
| FY20 Projected Net Medicare Savings Run Rate | $120M |
| FY20 Prospective MPA Adjustment<br>($120M - $156) = -$36M | $36M |
| **FY20 Net Run Rate** | **$156M** |

# Operationalizing MPA Efficiency Adjustment to Achieve Medicare Savings: Hospital Perspective

| | **Hospital A** | **Hospital B** |
|---|---|---|
| *ECIP Participation Status* | *Participating* | *Not Participating* |
| Expected annual Medicare hospital payments: | **$200 M** | |
| MPA Efficiency Adjustment Allocation: | 10% of $36M<br>(Hospital Market Share * Medicare Incremental Savings)<br>**-$3.6M** | |
| ECIP Recon. Payment: | +$5M | $0 |
| **MPA Savings Accounting Net:** | **$1.4M** | **-$3.6M** |
| ***Resulting Medicare Payments :*** | ***$201.4 M*** | ***$196.4M*** |

# Timing and Allocation Options

- Staff intends to submit a draft recommendation to the Commission for the MPA Efficiency Adjustment policy at March Commission meeting
- Default allocation would be to base each hospital's "haircut" on their share of statewide Medicare revenue
- Other allocation options are feasible, for example:

1. Attainment on TCOC benchmarks
2. Opportunity for ECIP savings, measured by the PAVE tool
3. Other participation in care transformation opportunities

- The allocation of the "haircut" will likely be determined after the recommendation by HSCRC staff with hospitals

# HSCRC Policy and Payment Updates

| | 2019 | 2020 | 2021 |
|---|---|---|---|
| | J A S O N D | J F M A M J J A S O N D | J F M A M J J A S O N D |
| **FY20 Payment Policies** | FY20 Rate Update; CY 20 Prosp. MPA EA | FY20 Rate Update; CY 20 Prosp. MPA EA | |
| **FY21 Payment Policies** | | CY20 MPA EA True-Up; FY21 Rate Update | FY21 Rate Update; CY21 Prosp. MPA EA |
| **FY22 Payment Policies** | | | CY21 MPA EA True-Up; FY22 Rate Update |

**Legend:**

| | |
|---|---|
| Rate Update | Update Factor Set to National Growth % |
| Prospective MPA | ½ (Projected Run Rate – Savings Target) |
| MPA True-Up | ½ (Projected Run Rate – Savings Target) + (Actual Run Rate – Projected Run Rate) |

**Example:**

Prospective MPA: ½ ($120– $156) = **$18M**

MPA True-Up: ½ ($120 – $156) + ($125 – $120) = **$13M**

# MPA Efficiency Adjustment: Impact on All-Payer Hospital Rate-Setting

- Required incremental Medicare savings is not a component of all-payer hospital rate-setting
  - Incremental Medicare savings only required through CY 2023
- Setting all-payer Rate Update at appropriate level remains crucial
- All-payer Rate Update is used to ensure Medicare Guardrail is not tripped (that is, Maryland Medicare TCOC growth cannot exceed national growth (a) by more than 1% in any one year, or (b) by more than any amount for two consecutive years)
- All-payer Rate Update to take into account:

1. Base inflation update (next agenda item)
2. Annual national Medicare growth
3. State economic growth

# Measuring Existing Care Transformation

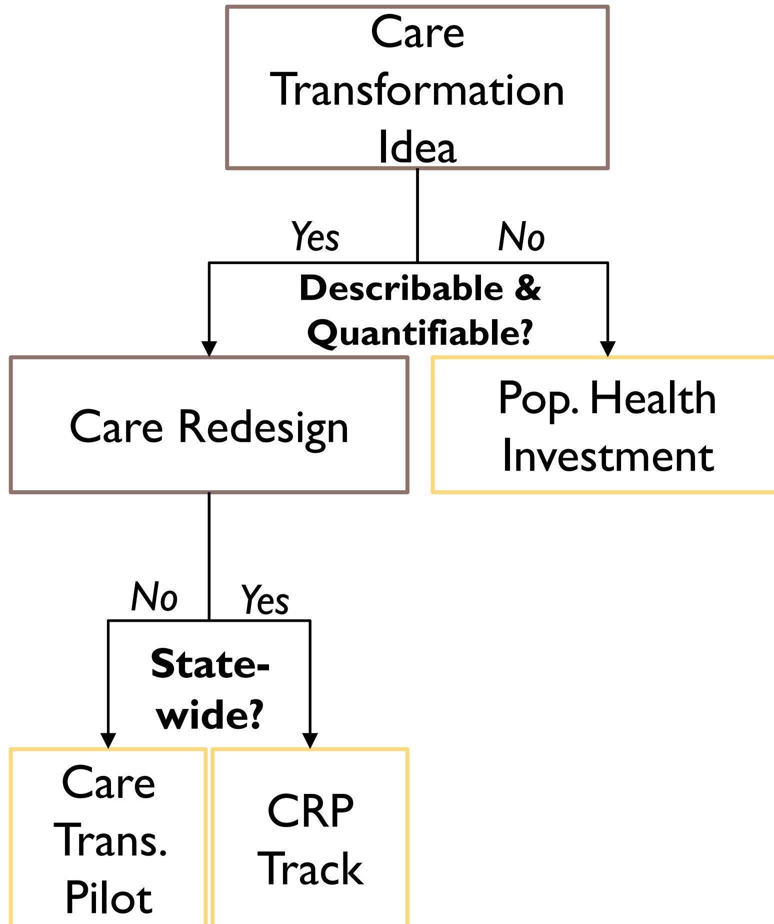
# Price vs Care Transformation Levers

- CMS approved the TCOC Model to achieve both sustainable Medicare spending and to enable care transformation
  - The State agrees and is seeking to operationalize policies that incentivize these complementary approaches
- Achieving Medicare savings through the MPA Efficiency Adjustment uses a price lever that will be allocated to incentivize care transformation efforts
  - If a hospital earns an MPA Efficiency Adjustment, that payment will be offset by other hospitals
  - Hospitals less engaged in care redesign will bear a greater share of any savings required through the MPA Efficiency Adjustment

# Measuring Existing Care Transformation

- HSCRC is developing a process to measure care transformation
- In order to quantify care transformation efforts and factor them into the MPA Efficiency Adjustment accounting, those efforts must have:
  - Clearly identifiable care redesign interventions
  - An identifiable patient population
  - A measurable impact on the TCOC
- HSCRC will work with hospitals to quantify existing or new care transformation efforts and factor those efforts into the MPA Efficiency Adjustment accounting

# Care Transformation Pathway Decision Tree




- Based on this decision tree, there are three care transformation endpoints:

1. Population Health Investment: If a care transformation idea can't be measured precisely or if the interventions don't generate savings within a year
2. Care Redesign Program (CRP) Track: If a care transformation can be described and quantified but requires a Medicare waiver to function or is available statewide
3. Care Transformation Pilot: If a care transformation can be described and quantified, but not available statewide or does not require a Medicare waiver

# Quantifying Care Transformation

| Categories | Criteria for Quantification |
|---|---|
| Defined Care Redesign Interventions | • A standardized pathway to address unmet clinical or social needs<br>• Identifiable "partners" at the hospital or in the community who will implement the intervention |
| Identifiable Intervention Population/Period | • A "trigger" to identify when a patient is enrolled in the intervention<br>• A bound on the measurement period after which the intervention effects should be observable |
| Measurable Impact on TCOC | • Predictable costs for the intervention population to create a counterfactual for if the intervention did not occur<br>• A method to isolate the intervention period from other care transformation efforts |

# Next Steps

- HSCRC will conduct outreach to hospitals on policy updates and survey care transformation efforts
- HSCRC will develop a Care Transformation Intake Form to gather structured data from hospitals on existing care transformation efforts so that:
  - Categorize care transformation ideas using the Care Transformation Pathways Decision Tree
  - Add approved Care Redesign Interventions to the Care Transformation Menu
  - Collect hospital spending on population health through the ICC reporting process

## Balanced Update Model for Discussion

**Components of Revenue Change Linked to Hospital Cost Drivers/Performance**

| | | | | Weighted Allowance |
|---|---|---|---|---|
| Adjustment for Inflation (this includes 1.5% for wages) | | | | 2.72% |
| - Total Drug Cost Inflation for All Hospitals* | | | | 0.33% |
| **Gross Inflation Allowance** | **A** | | | **3.05%** |
| | | | | |
| Care Coordination | | | | |
| -Rising Risk With Community Based Providers | | | | |
| -Complex Patients With Regional Partnerships & Community Partners | | | | |
| -Long Term Care & Post Acute | **B** | | | |
| | | | | |
| **Adjustment for Volume** | | | | |
| -Unfunded Inpatient Market Shift | | | | |
| -Transfers | | | | |
| -High/Low Efficiency Outliers | | | | |
| -Drug Population/Utilization | | | | |
| **Total Adjustment for Volume** | **C** | | | **0.30%** |
| | | | | |
| **Other adjustments (positive and negative)** | | | | |
| - Set Aside for Unknown Adjustments | D | | | |
| - Capital Funding -Adventist White Oak Medical Center | E | | | 0.09% |
| - Categoricals (1%) | F | | | 0.23% |
| -Reversal of one-time adjustments for drugs | G | | | |
| **Net Other Adjustments** | **H=** | **Sum of D thru G** | | **0.32%** |
| | | | | |
| **Quality and PAU Savings** | | | | |
| -Reverse prior year's PAU savings reduction | I | | | 1.75% |
| -PAU Savings | J | | TBD | -1.95% |
| -Reversal of prior year quality incentives<br>-QBR, MHAC, Readmissions | K | | | 0.53% |
| -Positive incentives & Negative scaling adjustments | L | | TBD | -0.53% |
| **Net Quality and PAU Savings** | **M =** | **Sum of I thru L** | | **-0.20%** |
| | | | | |
| **Total Update First Half of Fiscal Year 19** | | | | |
| Net increase attributable to hospitals | **N =** | Sum of A + B + C + H + M | | **3.47%** |
| Per Capita First Half of Fiscal Year (July - December) | **O =** | (1+N)/(1+0.30%) | | **3.16%** |
| **Adjustments in Second Half of Fiscal Year 19** | | | | |
| -Oncology Drug Adjustment | P | | | TBD |
| -QBR | Q | | | TBD |
| **Total Adjustments in Second Half of Fiscal Year 19** | **R =** | P + Q | | |
| **Total Update Full Fiscal Year 19** | | | | |
| Net increase attributable to hospital for Fiscal Year | **S =** | N + R | | **3.47%** |
| Per Capita Fiscal Year | **T =** | (1+S)/(1+0.30%) | | **3.16%** |

**Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements**

| | | | |
|---|---|---|---|
| -Uncompensated care reduction, net of differential | U | | 0.03% |
| -Deficit Assessment | V | | -0.25% |
| Net decreases | **W =** | U + V | **-0.22%** |
| **Total Update First Half of Fiscal Year 19** | | | |
| Revenue growth, net of offsets | **X =** | N + W | **3.25%** |
| Per Capita Revenue Growth First Half of Fiscal Year | **Y =** | (1+X)/(1+0.30%) | **2.94%** |
| **Total Update Full Fiscal Year 19** | | | |
| Revenue growth, net of offsets | **Z =** | S + W | **3.25%** |
| Per Capita Fiscal Year | **AA =** | (1+Z)/(1+0.30%) | **2.94%** |

* Provided Based on proportion of drug cost to total cost (drug index 5.6% X 5.9% national weight)