



Maryland Health Services Cost Review Commission

**New All-Payer Model for Maryland
Global Budget Development for FY 2014
March 12, 2014**

Overview of Global Budget Implementation

- ▶ For implementation of new All-Payer Model with the Center for Medicare & Medicaid Innovation (CMMI), HSCRC approved policies to allow hospitals in addition to the Total Patient Revenue (TPR) hospitals to transition to global budgets, or to remain in current models with new volume policies
- ▶ Global Budgets, referred to as Global Budget Revenue (GBR) were developed based upon the framework used for the TPR arrangements
 - ▶ Constructed using FY 2013 revenue base
 - ▶ Developed in accordance with Commission approved policies
 - ▶ Approved revenue established for FY 2014
 - ▶ Updates and adjustments July 2014 and thereafter based on HSCRC policies and global model

New Context for Hospitals

Old Model

Units/Cases



Rate Per Unit or
Case

Hospital Revenue

Unknown at the beginning of
year. More units/more
revenue

Global Models

Revenue Base Year



Updates for Trend,
Population, Value,
Other

Allowed
Revenue Target Year

Known at the beginning of year.
More units does not create more
revenue



Objectives

- ▶ Objective is to have hospital revenues under a global arrangement, either GBR or TPR
- ▶ Advantages
 - ▶ With a fixed base, gives a higher level of predictability of revenue under the new All-Payer requirements
 - ▶ Provides hospitals a stable and predictable revenue base as they implement population health approaches under the three part aim embodied in the new All-Payer Model
- ▶ Challenges and changes in approach
 - ▶ Requires a number of changes in approach and new Commission policies, many of which are being addressed by work groups with expected recommendations for Commission consideration

BACKGROUND

Background

- ▶ HSCRC staff began development and implementation of transitional policy in September 2013, in light of pending approval of new All-Payer Model.
 1. Presented strategy and plans in public meetings, including transitional approaches and policies
 2. Collected volume and revenue trends by hospital
 3. Developed standard agreement called Global Budget Revenue (GBR) agreement using Total Patient Revenue construct
 4. Reviewed overall historical and projected revenue and volume levels
 5. Approach and tools were developed
 - ▶ Hospital review template
 - ▶ Potentially avoidable utilization (PAU) reports
 - ▶ Demographic adjustment for each hospital based on virtual patient service area
- ▶ 6 Meetings with each hospital

Approach broadly publicized

- ▶ Approach implemented under established Commission policy for TPR and transition policies for the All-Payer Model adopted by the Commission
- ▶ Included in CMMI application and reflected in CMMI contract
- ▶ Approach vetted with Commission (9/4 Exec Session & 11/16 Public Meeting)
- ▶ Webinars for payers and providers (October and November)
 - ▶ Implementation strategy
 - ▶ Staff's draft transition policies, including global budget option
- ▶ Multiple presentations and publication of implementation plans included GBR approach
 - ▶ Monthly executive directors reports,
 - ▶ HSCRC implementation website
 - ▶ Discussed during Advisory Council

Data was collected and reviewed

- ▶ Staff collected data on each hospital to help staff understand background and trends and to provide data needed for agreement models
 - ▶ Multi-year volume and revenue history (3 to 4 years)
 - ▶ Monthly revenue and equivalent admissions for 3 years
 - ▶ Fiscal Year End 2013 revenues and volumes, the most recent year available with case-mix data
 - ▶ Adjustments to permanent revenue:
 - ▶ Reverse prior price and quality adjustments for 7/1/13
 - ▶ Add MHAC and QBR (quality) scaling adjustments effective 7/1/13
 - ▶ Readmissions shared savings policy approved by Commission effective 7/1/13 (approx. -.2% statewide)
 - ▶ Estimated FY13 price variances until analysis completed by staff after receipt of required case mix data in September

Overall projections were analyzed

- ▶ Revenues for FY 2013 were trended forward for:
 - ▶ Approved rate increase of 1.65% - .2% for shared savings
 - ▶ Volume growth
 - ▶ Retro reversals estimated price variances for FY 2013 (later calculated by staff with case mix data)
 - ▶ Staff noted special situations and considerations:
 - ▶ Germantown hospital start up in FY 2015
 - ▶ Bad debts and charity care increased in FY 2013, while Medicaid enrollment is expected to decrease future bad debts after 1/1/14

Tools were developed-Analysis template

- ▶ Staff developed an analysis template based on publicly outlined approach to assist in revenue budget development for each hospital within the new All-Payer Model limits, with a focus on a fair and even-handed approach
 - ▶ FY 2013 was used as the base—(the most recent year with “settlement” data)
 - ▶ Hospital/System projects through December 2013, to provide Calendar Year 2013 base period used in the new All-Payer Model limits
 - ▶ Permanent base calculated adjusting for Price Variances and MHAC and QBR through FY 2013
 - ▶ Template calculates whether global budget and rate adjustments would result in hospital revenues within new All-Payer limits on a calendar year

Tools were developed-Analysis template, cont.

- ▶ Hospital volumes considered through 12/31/13, with shift to population based volume considerations effective 1/1/14
 - ▶ .65% for population health infrastructure provided, generally ½ in FY14, ½ FY 15, linked to reduced opportunity to benefit from increased volumes and focus of Model three part aim
 - ▶ Staff developed an approach to adjusting for hospitals' volume situation (increasing, decreasing, or stable), with a focus on providing a fair and reasonable transition and shift to fixed model effective January 2014

Tools Developed-Potentially Avoidable Utilization (PAUs)

- ▶ Staff collected data on PAUs (volumes and revenue by hospital), areas where when care is improved, utilization and cost should decrease
 - ▶ Re-hospitalizations (Readmissions, observations, ER within 30 days)
 - ▶ Potentially Preventable Complications (Maryland Hospital Acquired Conditions)
 - ▶ Potentially Avoidable Admissions-- Prevention Quality Indicators, called admissions for ambulatory care sensitive conditions, of Agency for Healthcare Research & Quality(AHRQ)
- ▶ Used for discussions with hospitals on how to make the new system work

Tools Developed-Hospital Specific Demographic Adjustment

- ▶ Developed demographic adjustment (which will be reviewed and may be modified by workgroups)
- ▶ Uses virtual patient service areas (VPSAs) for each hospital, providing an apportionment of “market share” of population in zip code and age cohort. Market share apportioned based on equivalent case-mix adjusted discharges (ECMADs)
- ▶ Cost weight by age-cohort based on state-wide use, reduced by potentially avoidable utilization for the age-cohort (PAUs)
- ▶ Apportioned population and age/PAU adjusted increase calculated for each hospital, including >65 age group to allow for rough monitoring of Medicare growth per capita

Staff meetings and agreements with hospitals

- ▶ Staff met with all hospitals in the State
 - ▶ Situations reviewed for each hospital
- ▶ Focus on a fair, reasonable and even handed approach to developing the budget within the requirements of the All-Payer Model, giving consideration for previous retroactive adjustments—either increases or decreases
- ▶ GBR agreements effective for settlement of FY 2014.
- ▶ HSCRC policies guide agreement updates starting July 1, 2014 with limited exceptions
 - ▶ E.g. ½ of population infrastructure applied as July 2014 update based on agreements

GLOBAL BUDGET AGREEMENTS AND UPDATES

A standard agreement template was developed

- ▶ Standard Global Budget Revenue (GBR) agreement was based on the TPR construct that was established with input from the Commissioners, with some adjustments to facilitate review and update
- ▶ Agreement is subject to HSCRC policies and other requirements
 - ▶ Policies of the Commission, which are developed and approved on an ongoing basis—e.g. updates, efficiency, quality
 - ▶ Requirements of All-Payer Model contract with CMMI
 - ▶ Statutes and Regulations of HSCRC--for example hospitals and HSCRC may take actions they are entitled to such as full rate reviews
- ▶ Automatically renews 7/1/14 and annually thereafter

Global Budgets—Updates and adjustments subject to HSCRC policies

- ▶ Updates to the Global Budgets, once established may include:
 - ▶ Increased for update factors approved by the Commission
 - ▶ Quality and value adjustments
 - ▶ Quality-based or efficiency based rewards, penalties, or scaling then applicable
- ▶ Approved revenue may also be modified for:
 - ▶ Shifts to unregulated settings: When services are shifted to an unregulated setting, HSCRC staff will work with the hospital to calculate and apply a reduction for an appropriate portion of the Hospital's approved revenue designed to assure a savings to the public.
 - ▶ Service level and market share changes: Approved revenues may be adjusted for changes in service levels (e.g. discontinuing a service) or due to market share changes.
- ▶ Other, e.g. Certificate of Need activities based on Commission policies

STATUS

Status

- ▶ In accordance with Commission approved policies, Staff completed global budgets:

	Actual FY 2013 Revenues
Global budgets finalized	6,627,940,222
TPR revenues under global budgets	1,524,356,990
Subtotal	8,152,297,212
Statewide revenues	15,298,124,525
% of revenues under global budget	53%

- ▶ Remainder of revenue under new volume policies pending continuing negotiations of global budgets.
- ▶ Agreements being finalized and will be published on HSCRC website

Hospitals / Systems with Completed Budgets

Hospital	Affiliation	Actual FY 13 Revenue
Shady Grove	Adventist	362,277,247
WAH	Adventist	249,870,484
Germantown ER	Adventist	13,725,997
	Adventist Total	625,873,728
Levindale	LifeBridge	53,610,127
Northwest	LifeBridge	248,252,705
Sinai	LifeBridge	684,513,503
	LifeBridge Total	986,376,335
Franklin Square	MedStar	469,792,199
Good Samaritan	MedStar	295,622,767
Harbor	MedStar	201,140,964
Southern Maryland	MedStar	253,544,106
Union Memorial	MedStar	406,581,848
	MedStar Total	1,626,681,884
Anne Arundel		541,867,872
Bon Secours		122,596,895
Doctors Community		216,854,386
Frederick Memorial		337,093,592
GBMC		421,172,480
Holy Cross		461,351,270
Mercy		470,760,326
Peninsula General		412,641,496
St. Agnes		404,669,958
Totals		6,627,940,222

Hospitals with budgets that Staff has negotiated for FY 2014 in accordance with Commission approved polices will be updated annually consistent with Commission approved policy beginning July 1, 2014.

TPR Hospitals

Hospital	Actual FY 13
Calvert Memorial Hospital	138,862,906
Chester River Hospital Cen	59,206,382
Dorchester General Hospit	59,897,850
Memorial Hospital at East	186,358,594
Carroll Hospital Center	249,075,082
Garrett County	44,018,658
McCready Memorial	17,976,486
Meritus Hospital	301,350,725
Union of Cecil	153,372,921
Western MD Regional	314,237,386
	1,524,356,990

Renewals of 3
year agreements
for second term
implemented
July 2013.

Next Steps

- ▶ Prepare summaries and disclosures for Commission of global budgets as well as rate order revenues issued under revised CPC/E methods
- ▶ Post agreements and budget summaries to HSCRC website
- ▶ Continue negotiations of additional global agreements
- ▶ Implement new monitoring procedures
- ▶ Continue enhancement of agreement with payment workgroup and Commission input and review