FY 2017 Balanced Update

March 21, 2016

HSCRC
Health Services Cost Review Commission

CG1

Model Progression

Maryland Model Highlights:

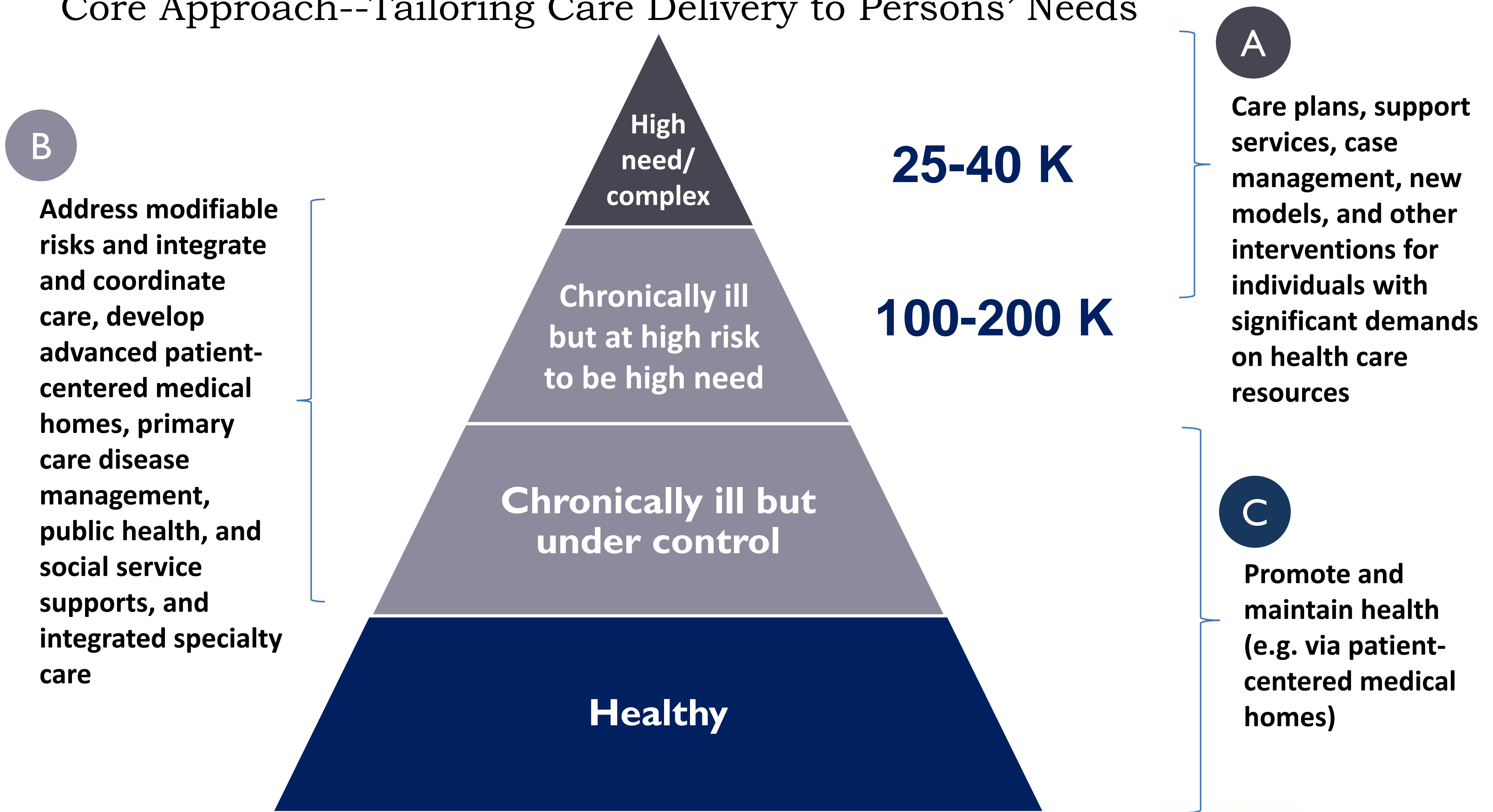
- Implement Complex and Chronic Care Interventions
  - Launch Care Redesign components in 2016 for complex and rising risk patients, including LTPAC approaches, focus on regional partnerships
- Gain **approvals** and **data** needed to support activities for:
  - Physician and practitioner engagement
  - Care coordination
  - Understanding and evaluating system-wide costs of care
- Incorporate additional elements in the future
  - Dual eligible approach being developed by DHMH in alignment with the model
  - Post-acute/acute optimization
  - Provide MACRA support for physicians

Planning for Next Phase: High Level Overview—Direction from Advisory Council Meeting

- Direction
  - Very significant progress in payment design (global budgets)
  - Need to focus on concrete initiatives that can be accomplished within the timeframes of the model—e.g. to meet the needs for cost containment to achieve Medicare savings both prior to 2019 and shortly thereafter
  - Focus on high need/complex patients and rising risk with multiple chronic conditions—Medicare FFS first
  - Critical need for Medicare TCOC data
  - Do not reinvent the wheel
  - Important opportunity to engage physicians—need alignment tools
  - Post-acute and long-term care vitally important roles
  - Test several accountability approaches—build on existing models

Large Scale Care Redesign: Fully Implement to Scale, First for Complex and High Needs Patients

Core Approach--Tailoring Care Delivery to Persons' Needs



Current Amendment Initiatives

Model Amendment Objectives

- Gain approvals and data needed to support activities for:
  - Creating greater engagement and outcomes alignment capabilities for providers practicing at hospitals and non-hospital providers
  - Care coordination, particularly for patients with high needs
  - Understanding and evaluating system-wide costs of care

Two Potential New Programs: Creating Alignment Across Hospitals & Providers

- 1. Internal Cost Savings (ICS) Program for providers practicing at hospitals
  - Designed to reward improvements in efficiency and cost savings in all services delivered for an acute care event, including readmissions
- 2. Pay for Outcomes (P4O) Program for non-hospital providers
  - Incentives for high-value activities focused on high needs patients—Complex and rising needs, such as dual eligible patients
- Hospitals will be able to share resources with hospital and non-hospital providers through these programs as long as quality targets are met, costs do not shift and the total cost of care does not rise above a benchmark.

Internal Cost Savings (Gainsharing) Program

- Goal: Reward improvements in the quality of hospital encounters and transitions in care that will create internal hospital cost savings
- Activities that may be included:
  - Care coordination and discharge planning
  - Evidence-based practice support
  - Patient safety practices
  - Harm prevention such as self-reporting adverse events
  - Staff development such as CPOE training
  - Efficiency and cost reduction such as discharge order by goal time

Pay for Outcomes (P4O) Program

- Goal: Address the needs of complex patients and those patients with chronic conditions that would qualify for Medicare's CCM fee and other available non-visit fees, tying resources from hospitals together with resources from Medicare payments to providers
  - By tying such programs together, a chronic medical home is created for these high needs persons, including beneficiaries in long-term care
- Activities that may be included:
  - Care management, such as using HRAs and creating care plans
  - Care coordination, such as obtaining discharge summary, updating records, and reconciling medications
  - Access to care, such as after-hours care or transportation
  - Risk stratification
  - Community activities (e.g. services outside traditional office setting)
  - Post-acute and long term care redesign, such as deploying health professionals to settings or using telemedicine

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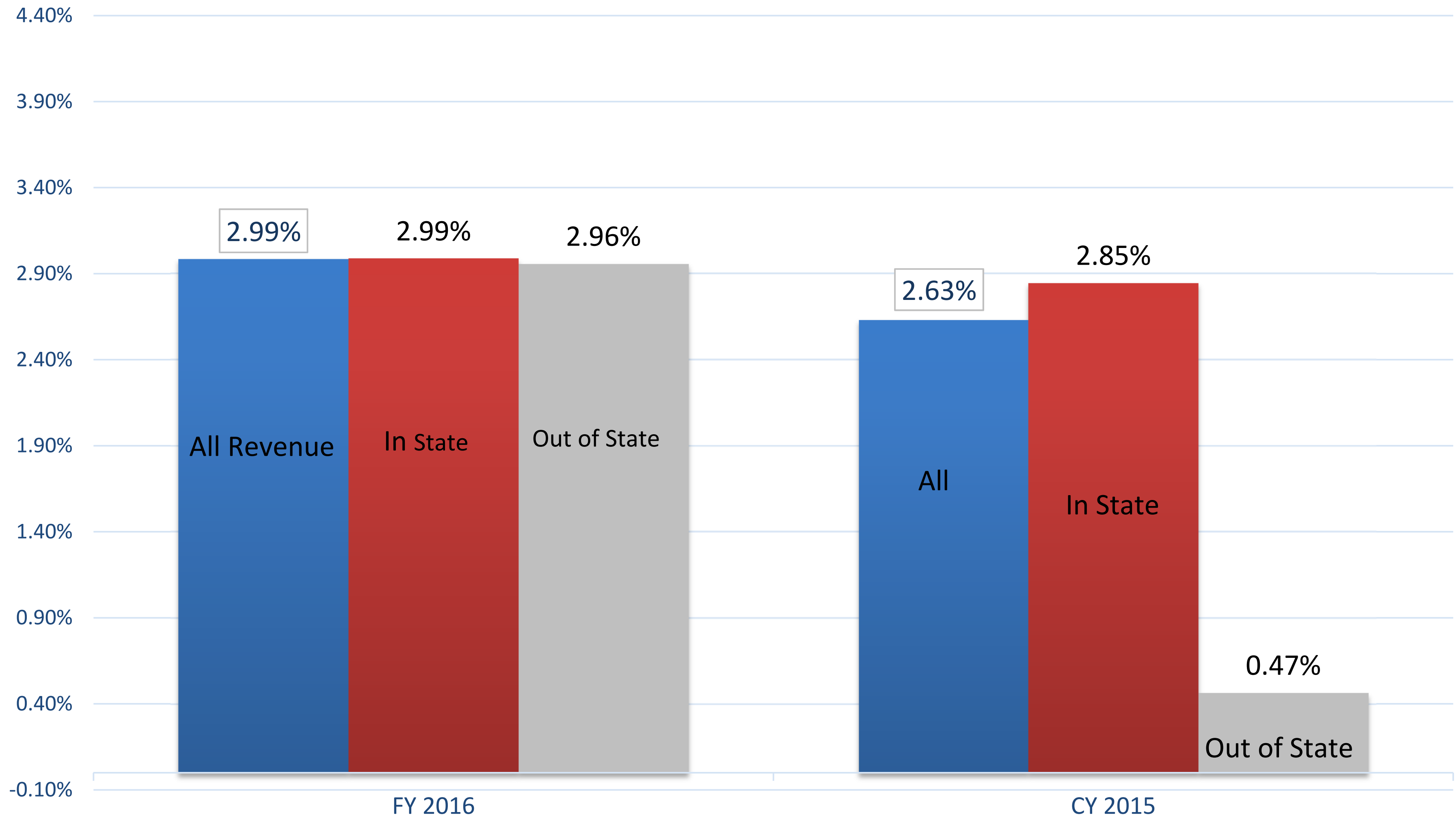
Model Performance

Gross All Payer Revenue Growth

Year to Date (thru December 2015) Compared to Same Period in Prior Year



Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru December 2015) Compared to Same Period in Prior Year

	All Revenue	In State	Out of State
FY 2016	3.44%	3.55%	2.19%
CY 2015	3.82%	4.25%	-0.99%

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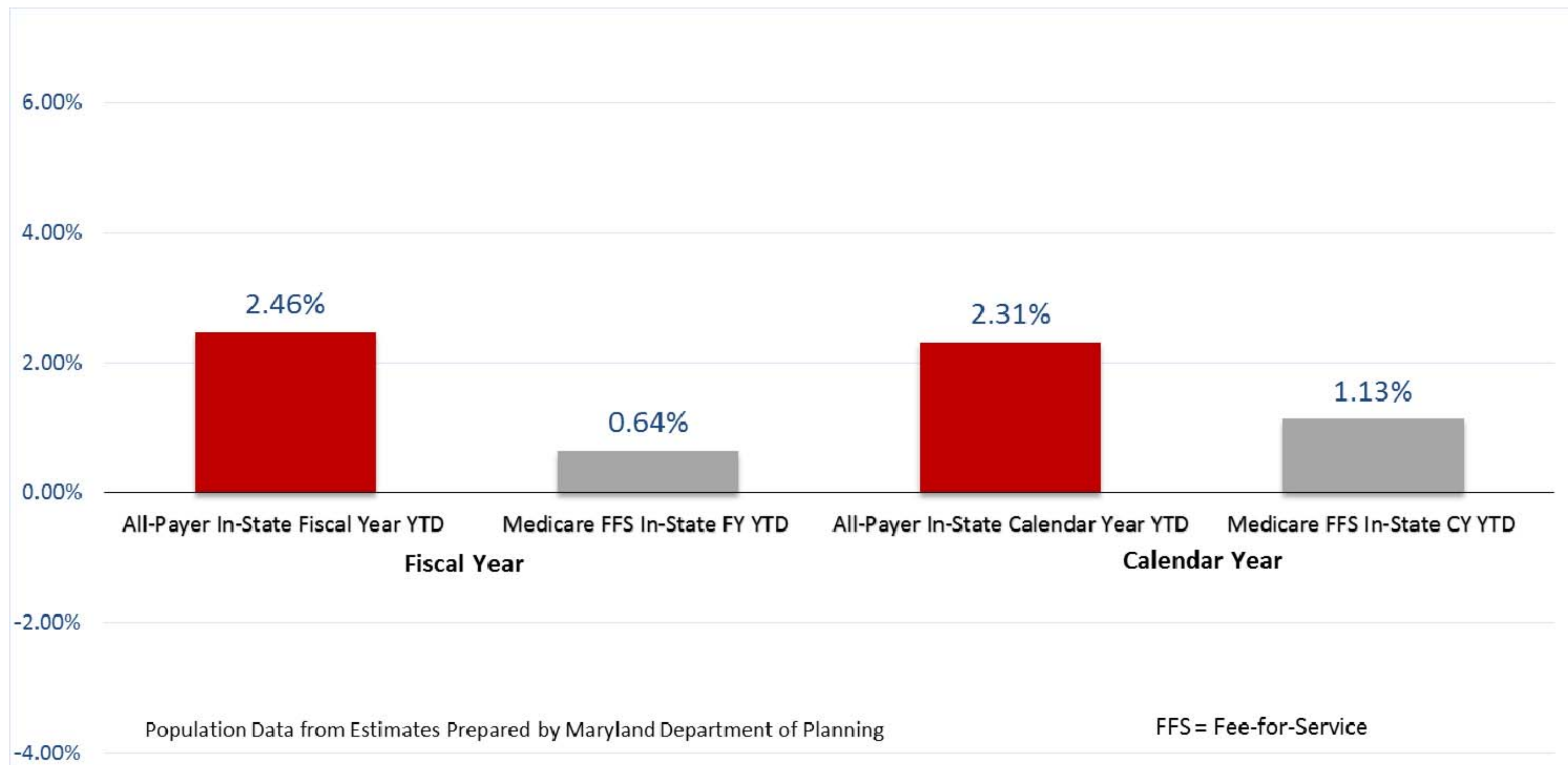
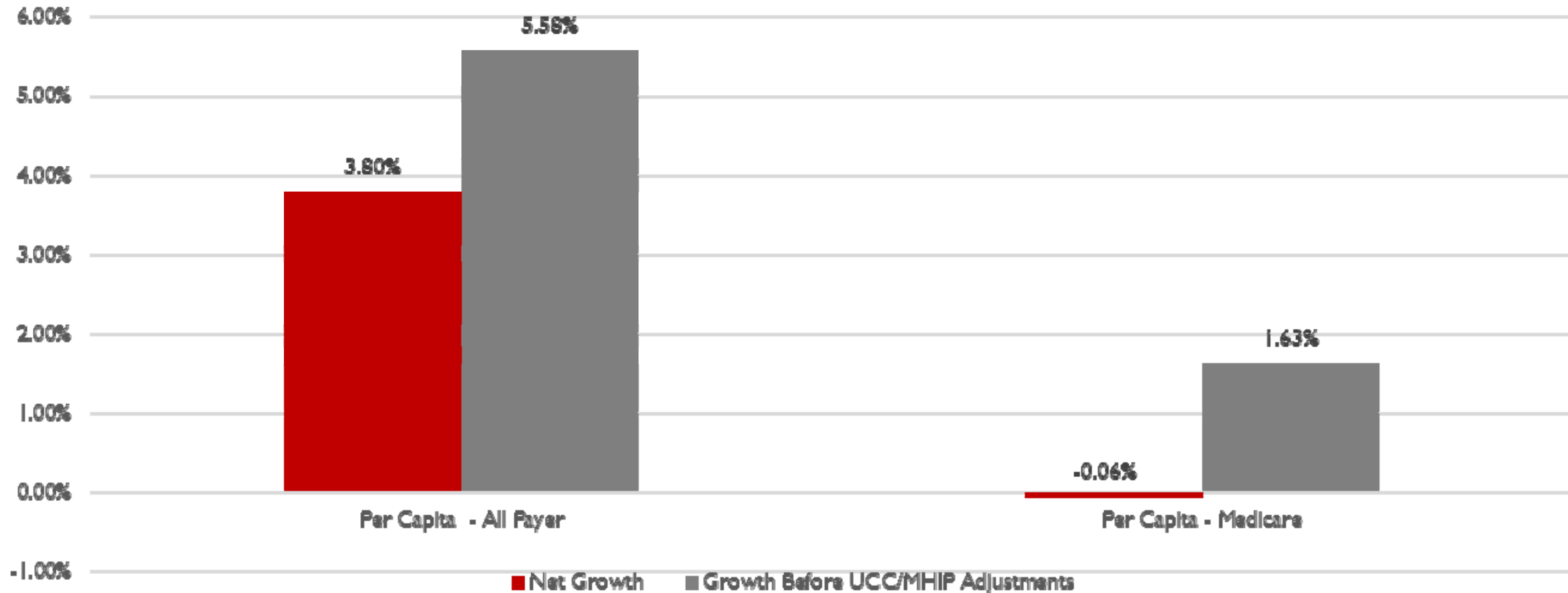
Per Capita Growth Rates
FY 2016 and CY 2015



- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail of 3.58% for per capita growth.**

Per Capita Growth – Actual & Underlying Growth
CY 2015 YTD Compared to Same Period in Base Year (2013)



- Two year per capita growth rate is well below maximum allowable growth rate of 7.29% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 15 & FY 16 revenue decreases that were budget neutral for hospitals. 1.09% decrease from MHIP assessment and hospital bad debts in FY 15. Additional 1.41% adjustment in FY 16 due to further reductions to hospital bad debts and elimination of MHIP assessment.

TCOC Spending

- In year two, (CYTD through Sept 2015), Maryland Total Cost of Care spending grew faster than the nation, reducing savings compared to year one.
- Part A expenditures significantly contributing to growth in TCOC spending:
  - Non-Hospital growing at a much faster rate than hospital Part A
  - Largest growth in Home Health, but largest % in spending per bene in SNF expenditure
  - Causing pressure on the TCOC guardrail for Maryland

Provider Type	CYTD 2014 Spend	CYTD 2014 Spend Per Beneficiary	CYTD 2015 Spending	CYTD 2015 Spending Per Beneficiary	Spending Change	Spending per Beneficiary Change	% per Beneficiary Change
Inpatient Hospital	**$2,537,260,007**	**$3,113.57**	**$2,646,562,720**	**$3,148.82**	**$109,302,713**	**$35.25**	**1.1%**
Non Hospital							
SNF	$473,442,116	$580.98	$499,985,384	$594.87	$26,543,268	$13.89	2.4%
HHA	$193,894,382	$237.94	$213,178,547	$253.64	$19,284,165	$15.70	6.6%
Hospice	$126,391,856	$155.10	$135,720,859	$161.48	$9,329,003	$6.38	4.1%
Non Hospital Subtotal	**$793,728,354**	**$974.02**	**$848,884,790**	**$1,009.98**	**$55,156,436**	**$35.97**	**3.7%**

TCOC Spending

- The number of Medicare beneficiaries' using SNF, as well as total SNF expenditures, are increasing at a much higher rate in Maryland, compared to the Nation
  - SNF users increasing by 4%, both SNF stays and days increasing by 3% (Chart 1)
  - Expenditures increasing by 5% and average expenditure per eligible beneficiary increasing by 2% (Chart 2)
- However, average number of stays per SNF user have remained flat in Maryland (-.01%), compared to the Nation.
  - SNF LOS is also declining in MD, though not as fast as Nationally, illustrated by the average number of days per SNF stay and the average number of days per SNF user (Chart 3)
- This may be the result of the increases (2.9%) in Medicare Eligible Beneficiaries in Maryland, compared to nationally (-0.2%) (Chart 4)

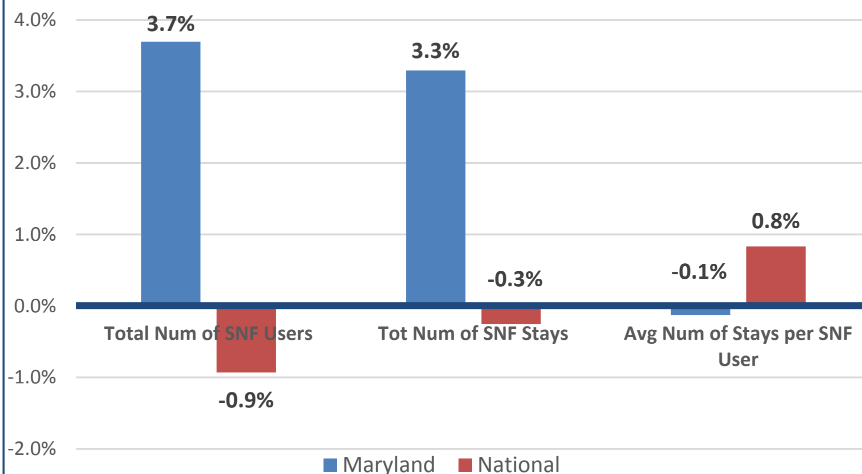


CHART 1: Percent Change in Total Number of SNF Users, Total Number of SNF Stays and Average Stays per SNF User CY 2014 – 2015 (January – September)
4.0%
3.0%
2.0%
1.0%
0.0%
-1.0%
-2.0%
3.7%
-0.9%
3.3%
-0.3%
-0.1%
0.8%
Total Num of SNF Users
Tot Num of SNF Stays
Avg Num of Stays per SNF User
Maryland
National

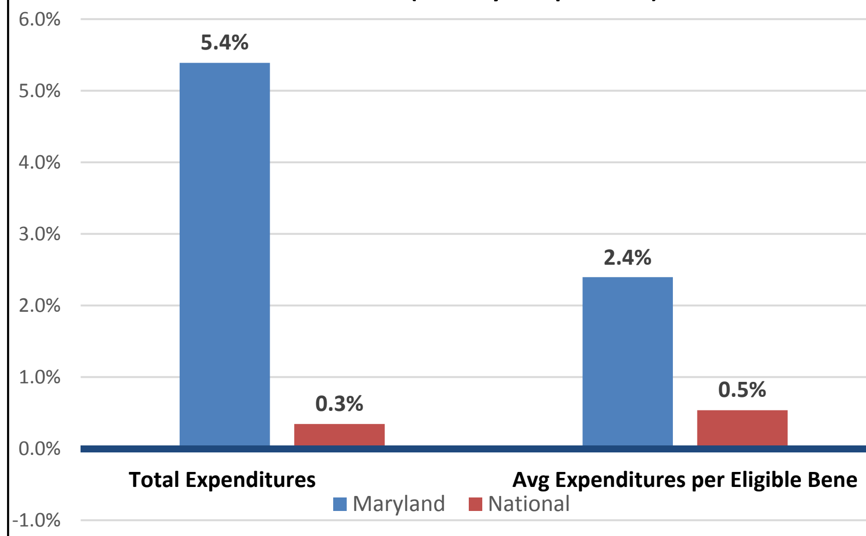


CHART 2: Percent Change in Total SNF Expenditures and Average Expenditure per Eligible Beneficiary CY 2014 – 2015 (January – September)
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
-1.0%
5.4%
0.3%
2.4%
0.5%
Total Expenditures
Avg Expenditures per Eligible Bene
Maryland
National

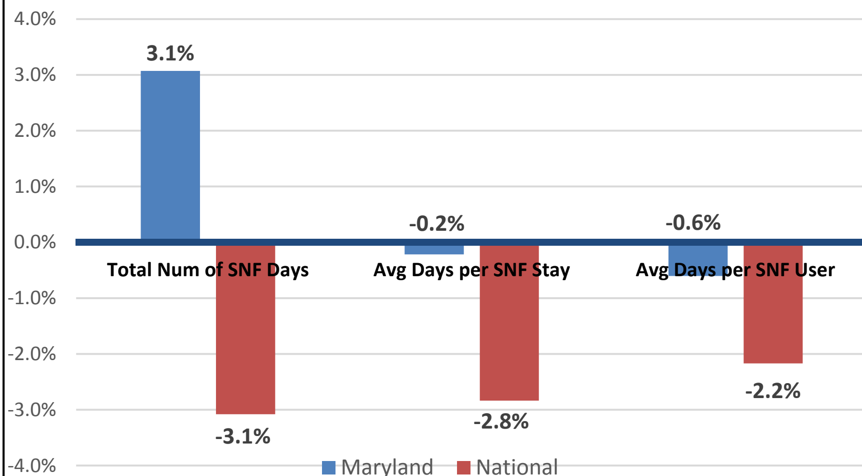


CHART 3: Percent Change in Number of SNF Days, Average Number of SNF Stays and Average Days per SNF User CY 2014 – 2015 (January – September)
4.0%
3.0%
2.0%
1.0%
0.0%
-1.0%
-2.0%
-3.0%
-4.0%
3.1%
-3.1%
-0.2%
-2.8%
-0.6%
-2.2%
Total Num of SNF Days
Avg Days per SNF Stay
Avg Days per SNF User
Maryland
National

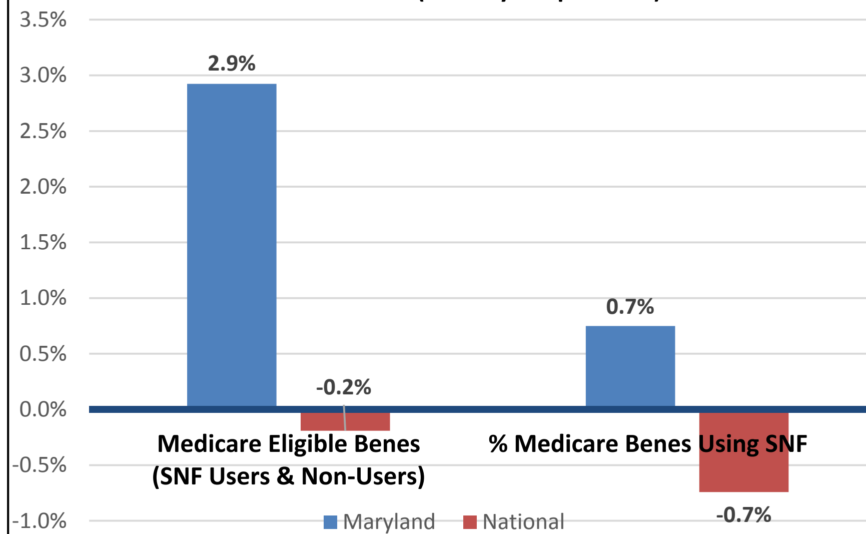


CHART 4: Percent Change in Eligible Medicare Beneficiaries and Percent of Medicare Beneficiaries Using SNF CY 2014 vs 2015 (January - September)
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
-0.5%
-1.0%
2.9%
-0.2%
0.7%
-0.7%
Medicare Eligible Benes (SNF Users & Non-Users)
% Medicare Benes Using SNF
Maryland
National

Update Factor

Goals to Guide Payment Policy

- Meets All-Payer Requirement
- Provides Hospitals with overall fair and reasonable compensation
- Provides rates and revenues that are sufficient for efficient and effectively operated hospitals and equity among payers
- Promotes health equity

Desirable Features of Payment Policies

- Promotes adequate information sharing
- Promotes cooperation and collaboration
- Provides sound value incentives
- Considers other requirements

Key Considerations

- Compliance with All-Payer and Medicare Guardrails
- Expected growth in Medicare Hospital Rates
- Inflation
- Population and Demographic Adjustments
- Financial condition of hospitals
- Shared Savings
- Unforeseen adjustments
- Others including categoricals and transfers

***Medicare will release IPPS Figures in April. The chart below will aid discussion of possible factors.

Balanced Update Model for Discussion

Maximum allowed growth		
Maximum revenue growth allowance	A	3.58%
Population growth	B	0.52%
Maximum revenue growth allowance ((1+A)*(1+B)	C	4.12%
Components of Revenue Change Linked to Hospital Cost Drivers/Performance		
		Weighted Allowance
Adjustment for Inflation		1.91%
- Allowance for High Cost New Drugs		0.20%
Gross Inflation Allowance		2.11%
-Adjustment for ACA Savings		-0.75%
Net Inflation Allowance	A	1.36%
Possible Care Coordination Allowances Based on Successful Implementation		
-Rising Risk With Community Based Providers		0.25%
-Complex Patients With Regional Partnerships & Community Partners		0.25%
-Long Term Care & Post Acute		0.25%
	B	0.75%
Adjustment for volume	C	0.52%
-Demographic Adjustment		
-Transfers		
-Categoricals		
-Market share adjustments		
Other adjustments (positive and negative)		
- Set Aside for Unknown Adjustments	D	0.50%
- Workforce Support Program	E	0.06%
-Holy Cross Germantown	F	0.07%
-Reverse prior year's shared savings reduction	G	0.60%
-Shared Savings	H	-1.10%
- Non Hospital Cost Growth	I	TBD
-Positive incentives (Readmissions and Other Quality)	J	TBD
-Negative scaling adjustments	K =	TBD
Net increase attributable to hospitals	L = Sum of A thru K	
Per Capita	M = (1+L)/(1+0.52%)	
Components of Revenue Change with Neutral Impact on Hosptial Finanical Statements		
-Uncompensated care reduction, net of differential	N =	-0.25%
-Deficit Assessment	O =	-0.15%
Net decreases	P = N + O	-0.40%
Net revenue growth	Q = L + P	
Per capita revenue growth	R = (1+Q)/(1+0.52%)	

*****2016 and 2017 Figures are being discussed with CMS**

Maximum Increase that Can Produce Medicare Savings

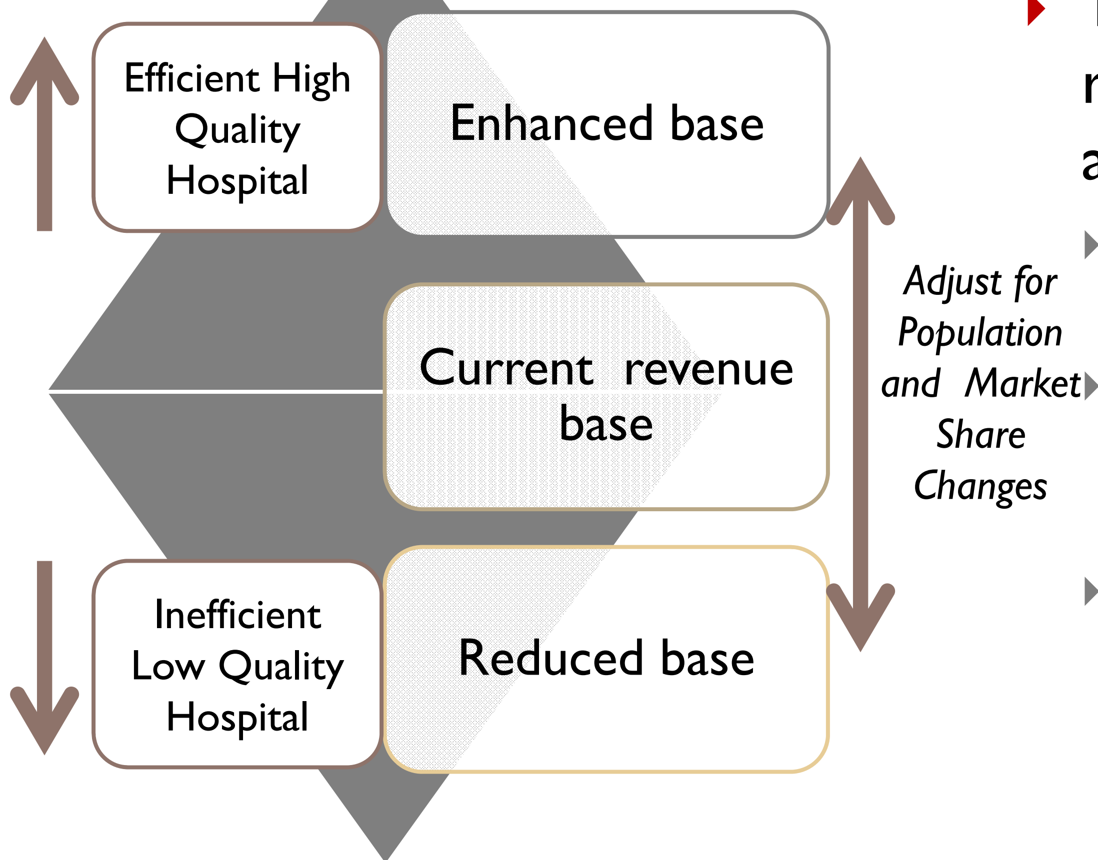
Medicare		
Medicare Growth CY 2016	A	1.20%
Savings Goal for FY 2017	B	-0.50%
Maximum growth rate that will achieve savings (A+B)	C	0.70%
Conversion to All-Payer		
Actual statistic between Medicare and All-Payer	D	1.27%
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	1.98%
Converstion to total All-Payer revenue growth (1+E)*(1+0.52%)-1	F	2.51%

Performance-Based Payment Programs Update

Payment

03/09/2016

Global Budget Model

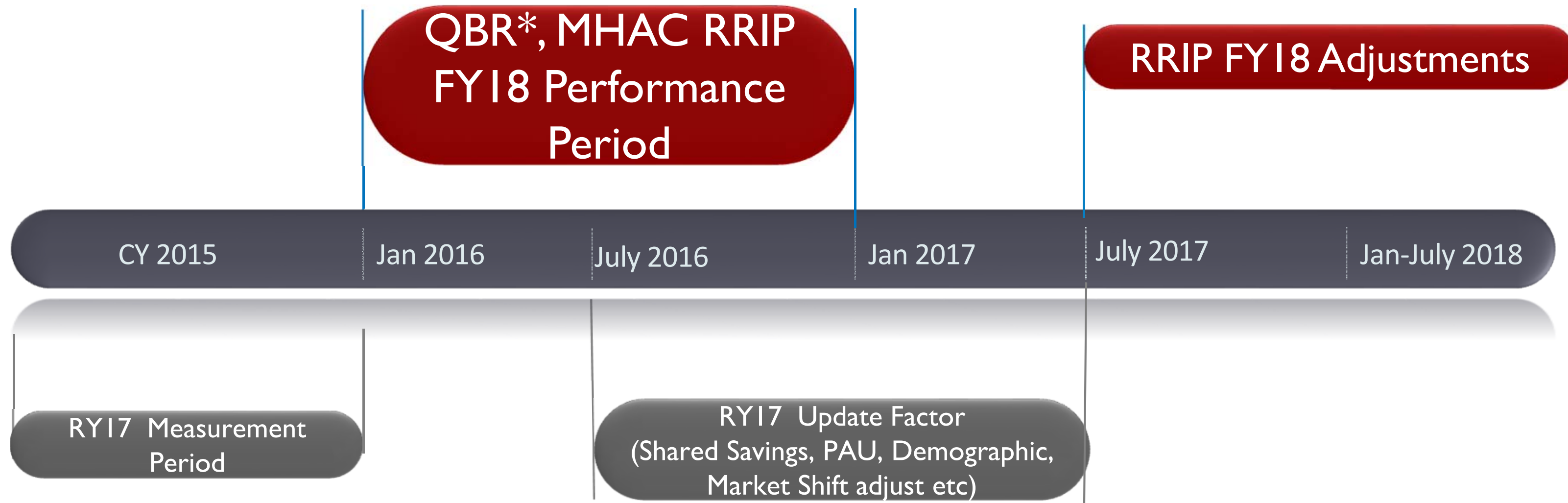


- The Global Budget Model: revenue budget with annual adjustments
  - *The initial revenue budget would be based on historical revenue*
  - *This budget could be enhanced or reduced based on hospital efficiency and utilization*
  - *The budget would be adjusted annually for changes in market share, population and quality*

Maryland Performance-Based Payment Programs and Risk levels

Program	Details
QBR	• Process of care, Safety, Mortality, Patient Experience • 2 % Maximum Penalty, 1 % Reward in FY2017
MHAC	• Potentially Preventable Complications • 3% Maximum Penalty, 1 % Reward in FY2017
RRIP	• 30-Day Inpatient Readmission Rate Improvement • 2 % Maximum Penalty, 1 % Reward in FY 2017
Shared Savings	• 30- Day Inpatient Readmission Rate • Average next reduction of 0.2 % in FY2016
PAU Efficiency Adjustments	• 30 Day Inpatient and Observation Readmissions, Prevention Quality Indicators, MHAC cost • Allowable volume growth is reduced by % GBR Revenue in PAU

RRIP and Shared Savings Timelines



* Performance Period for several measures in QBR start in October 1st, 2015.

Recommendations for RY 2017/RY 2018

- Readmission Reduction Incentive Program RY 2018
  - Adjusting CY 2015 results (RY 2017)
  - Determining the CY 2016 policy (RY 2018)
- Aggregate At Risk RY 2018
  - MHAC, QBR and RRIP
- Shared Savings RY 2017

Aggregate At Risk Draft FY 2018 Recommendation

Background

- Maryland quality based programs are exempt from Medicare Programs.
  - Exemption from the Medicare Value-Based Purchasing (VBP) program is evaluated annually
  - Exceptions from the Medicare Hospital Readmissions Reduction Program and the Medicare Hospital-Acquired Condition Reduction Program are granted based on achieving performance targets
  - Maryland aggregate at-risk amounts are compared against Medicare programs

Maryland surpasses National Medicare Aggregate Revenue at Risk in Quality Payments

Figure 1. Potential Revenue at Risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2017

% of MD All-Payer Inpatient Revenue	FY 2014	FY 2015	FY 2016	FY 2017
MHAC - Complications	2.00%	3.00%	4.00%	3.00%
RRIP - Readmissions			0.50%	2.00%
QBR – Patient Experience, Mortality, Safety	0.50%	0.50%	1.00%	2.00%
Shared Savings	0.41%	0.86%	1.16%	1.16%*
GBR Potentially Avoidable Utilization (PAU)	0.50%	0.86%	1.10%	1.10%*
MD Aggregate Maximum At Risk	3.41%	5.22%	7.76%	9.26%

*Italics are based on RY 2016 results, and subject to change based on RY 2017 policy, which is to be finalized at June 2016 Commission meeting.

Medicare National				
% of National Medicare Inpatient Revenue	FFY 2014	FFY 2015	FFY 2016	FFY 2017
Hospital Acquired Complications (HAC)		1.00%	1.00%	1.00%
Readmissions	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%

Cumulative MD-Medicare National Difference	0.16%	-0.12%	1.89%	5.15%

Payment Adjustment Methodologies - "Scaling": QBR, MHAC, RRIP

- Preset payment scale: Payment adjustments are determined using scores in the base year. (e.g. A score of 0.10 = -1% payment adjustment.)
- Continuous adjustments: Payment adjustments vary based on score differences. (e.g. If a score of 0.10= -1% payment adjustment, a score of 0.20= -0.98 % payment adjustment).
- Contingent scale: Payment adjustment scale depends on predetermined statewide performance. (If the state did not meet MHAC reduction target, maximum penalty was 3% and no rewards, otherwise maximum penalty was reduced to 1% and awards were provided up to 1%.)
- Payment adjustments are no longer "revenue neutral," i.e. statewide overall impact could be negative or positive.
- Maximum penalties and reward amounts are set by the Commission before the performance year starts, usually the calendar year.

RY 2016 Payment Adjustments: Total Net Adjustment is -$38.3 mil, -0.4 % of State Inpatient Revenue

	MHAC	RRIP	QBR	Shared Savings	PAU	Aggregate (Sum of All Programs)	Net Hospital Adjustment Across all Programs
Potential At Risk (Absolute Value)	4.00%	0.50%	1.00%	1.16%	1.10%	7.76%	
Maximum Hospital Penalty	-0.21%	NA	-1.00%	-0.29%	-1.10%	-2.59%	-1.95%
Maximum Hospital Reward	1.00%	0.50%	0.73%	NA	NA	2.23%	1.09%
Average Absolute Level Adjustment	0.18%	0.15%	0.30%	0.93%	0.39%	1.95%	0.70%
Total Penalty	-$1,080,406	NA	-$12,880,046	-$27,482,838	-$26,900,004	-$68,343,293	
Total Reward	$7,869,585	$9,233,884	$12,880,046	NA	NA	$29,983,515	
Total Net Adjustments	$6,789,180	$9,233,884	$0	-$27,482,838	-$26,900,004	-$38,359,778	

RY 2017 Year to Date Results

	MHAC	RRIP**	QBR***	Shared Savings/PAU*	Aggregate (Sum of All Programs)	Net Hospital Adjustment Across all Programs
Potential At Risk (Absolute Value)	3.00%	2.00%	2.00%		7.00%	
Maximum Hospital Penalty	0.00%	-2.00%			-2.00%	-1.92%
Maximum Hospital Reward	1.00%	1.00%			2.00%	2.00%
Average Absolute Level Adjustment	0.37%	0.71%			1.08%	0.78%
Total Penalty	$0	-$38,994,508			-$38,994,508	
Total Reward	$26,338,592	$11,586,425			$37,925,017	
Total Net Adjustments	$26,338,592	-$27,408,083			-$1,069,491	

**Shared Savings and PAU adjustments will be determined with the FY2017 Update Factor.*
***RRIP results are preliminary results as of October 2015 and do not reflect any potential protections that may be developed based on the approved RY 2017 recommendation.*
**** QBR YTD results are not available due to 9 month data lag for measures from CMS. Staff will provide updated calculations for the final recommendation.*

Focus on Performance-Based Adjustments and PAUs

- Maryland hospitals improved their performance in reducing complications and more recently in improving readmissions.
- All-Payer Model financial success will depend on further reductions in PAU. Accordingly, the Commission's funding of infrastructure focused on reducing PAUs more broadly than readmissions.
- Staff intends to shift more focus on PAUs in quality-based payment programs in the future and reduce penalties in other areas.
- If Maryland increases the prospective adjustment for these PAUs, we may moderate the maximum penalty under the RRIP program.

Potentially Avoidable Utilization

Potentially Avoidable Utilization- Unplanned Care

Definition

"Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health".

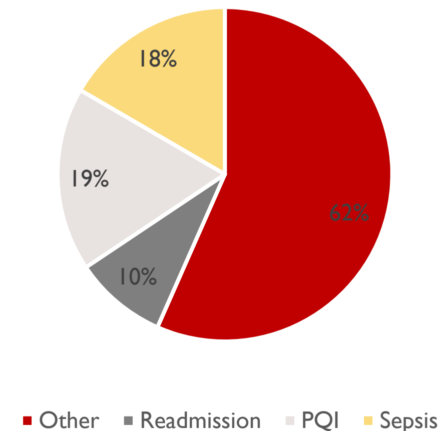
Unplanned Admissions

- 55 % of all inpatient admissions are Medical admissions from Emergency Departments
- 61 % of all inpatient admissions are from ED

Number of Admissions by Source of Admission-FY 2015

	From ED	Percent	Other Admission Source	Percent	Grand Total	Percent
Medical	389,461	55%	168,981	24%	558,442	78%
Surgical	48,965	7%	106,257	15%	155,222	22%
Grand Total	438,426	61%	275,238	39%	713,664	100%

PAU Distribution of Medical Cases from ED



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PAU Measure List RY 2016

- Readmissions/Revisits
  - Inpatient and 23+ hour Observation Stays- All Hospital, All Cause 30 Day Readmissions, excluding planned readmissions
- Potentially Avoidable Admissions/Visits
  - Inpatient- AHRQ Prevention Quality Indicators (PQIs)*
- Hospital Acquired Conditions
  - Potentially Preventable Complications (PPCs)

*Developed by Agency For Health Care Quality and Research
http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx
Also known as Ambulatory Care Sensitive Conditions, that is conditions for which good outpatient care can potentially prevent the hospitalization

PAU distribution: All-Payer vs Medicare

- Overall, PAUs are 15% of total hospital charges in Maryland in CY 2015; 55% of total PAUs are for Medicare patients. Compared to CY 2013 levels, PAUs decreased by -0.5% for All-Payer and increased by 1.8% for Medicare patients.

	All Payer					Medicare					
	Total Charge CY15	**ECMAD CY15**	**ECMAD CY13**	**% ECMAD Change CY13-CY15**	**% Grand Total Charge**	**Total Charge CY15**	**ECMAD CY15**	**ECMAD CY13**	**% ECMAD Change CY13-CY15**	**% Grand Total Charge**	**% Medicare**
Readmission	$1,288,435,419	90,260	95,614	-5.6%	8.0%	$680,347,206	50,068	52,034	-3.8%	11.2%	53%
PQI	$651,465,870	51,679	52,100	-0.8%	4.1%	$391,016,430	30,914	29,969	3.2%	6.4%	60%
Sepsis	$516,098,092	39,131	34,251	14.2%	3.2%	$288,257,794	22,887	20,013	14.4%	4.7%	56%
PAU Total	**$2,455,999,381**	**181,069**	**181,966**	**-0.5%**	**15.3%**	**$1,359,621,430**	**103,868**	**102,016**	**1.8%**	**22.4%**	**55%**
Grand Total	**16,073,397,565**	**1,155,421**	**1,161,441**	**-0.5%**	**100%**	**$6,079,614,526**	**447,172**	**440,416**	**1.5%**	**100.0%**	**38%**

	Total Charge CY15	**PPC Count CY15**	**PPC Count CY 13**	**% PPC Count Change CY13-CY15**	**% Grand Total Charge**	**Total Charge CY15**	**ECMAD CY15**	**ECMAD CY13**	**% PPC Count Change CY13-CY15**	**% Grand Total Charge**	**% Medicare**
PPCs/MHACs	$231,919,620	21,026	29,740	-29.30%	1.44%	$129,912,439	11,143	10,910	-27.50%	2.14%	56%

Annualized based on Jan-September 2015 Final data. Updated 02-29-2016

% Total Charges in PAU varies between 7% to 28% - CY 2015 All-Payer Jan-Sept.

MERCY
MCCREADY
GARRETT COUNTY
JOHNS HOPKINS
ANNE ARUNDEL
G.B.M.C.
UM ST. JOSEPH
UNIVERSITY OF MARYLAND
ST. MARY
SINAI
FREDERICK MEMORIAL
EASTON
WESTERN MARYLAND
UPPER CHESAPEAKE
HOPKINS BAYVIEW
SUBURBAN
Grand Total
CALVERT
ATLANTIC GENERAL
UNION MEMORIAL
PENINSULA REGIONAL
MERITUS
SHADY GROVE
CHESTERTOWN
FT. WASHINGTON
HOWARD COUNTY
UNION HOSPITAL OF CECIL COUNT
WASHINGTON ADVENTIST
CARROLL COUNTY
MONTGOMERY GENERAL
PRINCE GEORGE
ST. AGNES
HARBOR
LAUREL REGIONAL
HOLY CROSS
FRANKLIN SQUARE
NORTHWEST
BALTIMORE WASHINGTON
GOOD SAMARITAN
CHARLES REGIONAL
HARFORD
SOUTHERN MARYLAND
DORCHESTER
DOCTORS COMMUNITY
UMMC MIDTOWN
BON SECOURS
HOLY CROSS GERMANTOWN

0.00% 5.00% 10.00% 15.00% 20.00% 25.00% 30.00%

% Total CHARGE Readmission | % Total CHARGE PQI | % Total CHARGE Sepsis

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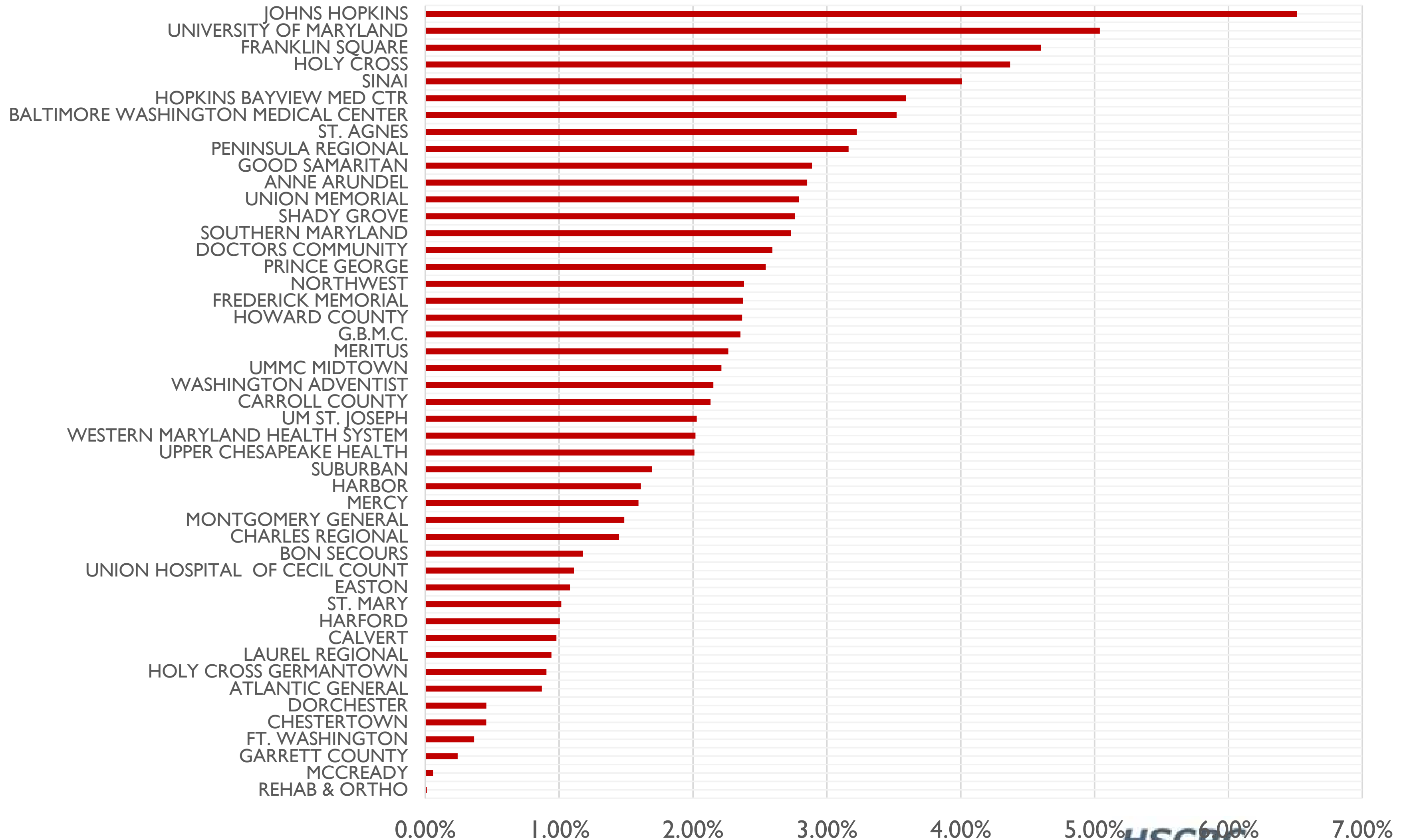
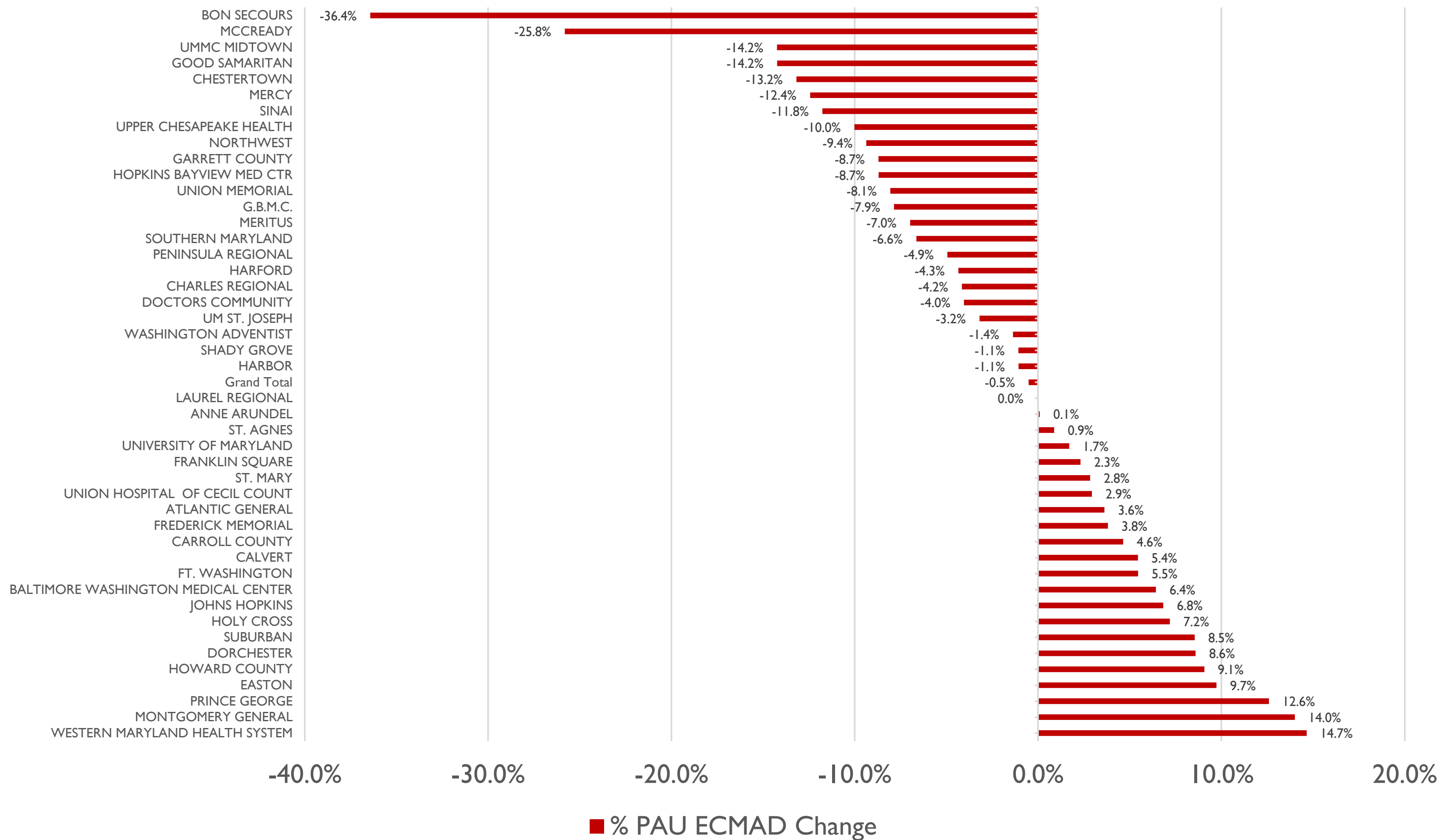
State PAU Distribution : % Total PAUs by Hospital



Average PAU ECMAD change between CY 2013 vs CY 2015 Was -0.5 %



RY 2018 Draft Recommendations

1. QBR: The maximum penalty should be 2 percent, while the maximum reward should be 1 percent.
2. MHAC: There should be a 3 percent maximum penalty if the statewide improvement target is not met; there should be a 1 percent maximum penalty and a reward up to 1 percent if the statewide improvement target is met.
3. RRIP: The maximum penalty should be 2 percent, and the reward should be 1 percent for hospitals that reduce readmission rates at or better than the minimum improvement.
4. Maximum penalty guardrail: The hospital maximum penalty guardrail should continue to be set at 3.5 percent of total hospital revenue.
5. The quality adjustments should be applied to inpatient revenue centers, similar to the approach used by CMS.

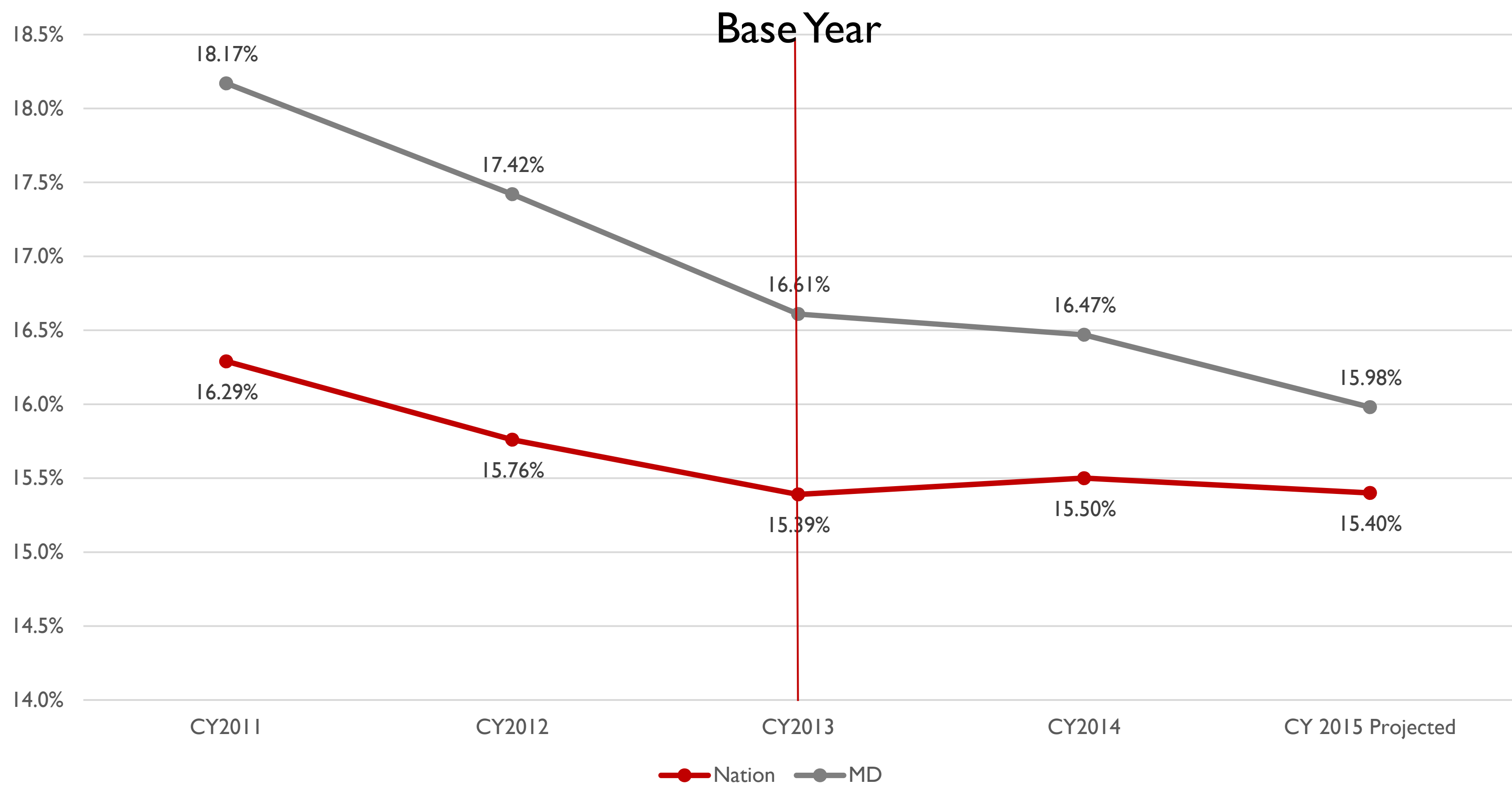
Readmission Reduction Incentive Program Draft FY 2018 Policy

RRIP Background

- Started in CY 2014 performance year with 0.5% inpatient revenue bonus if a hospital reduced its case-mix adjusted readmission rate by 6.76% in one year.
- Last year
  - Improvement target was set at 9.3% over two years (CY 2015 compared to CY 2013 rates)
  - Rewards scaled up to 1% commensurate with improvement rates
  - Penalties scaled up to -2% were introduced for hospitals that were below the improvement target commensurate with improvement rates
  - Continue to evaluate factors that may impact performance and meeting Medicare readmission benchmarks

Medicare Benchmark: At or below National Medicare Readmission Rate by CY 2018

Maryland is reducing readmission rate faster than the nation. Maryland is projected to reduce the gap from 7.93% in the base year to 3.74 % in CY 2015



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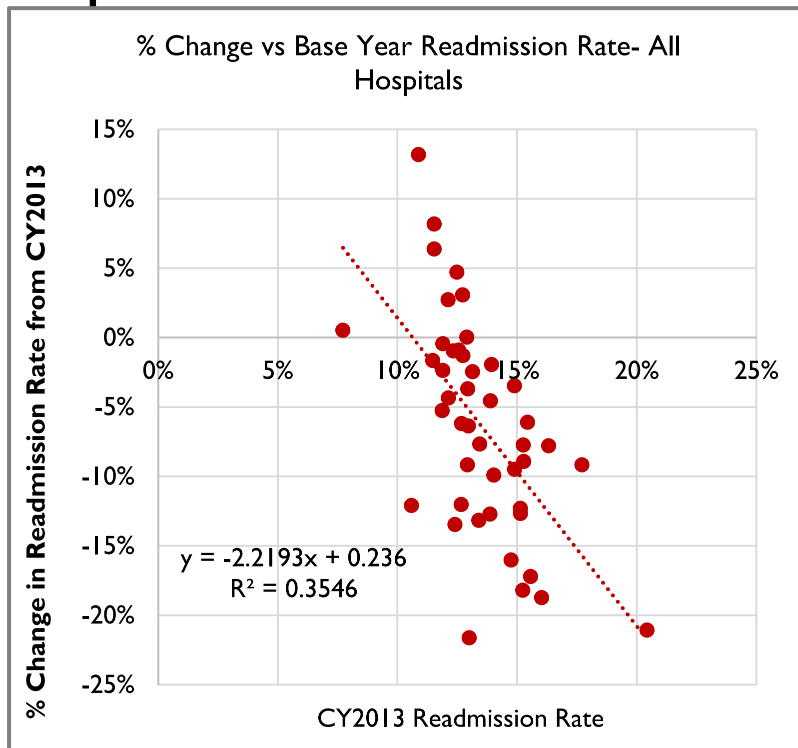
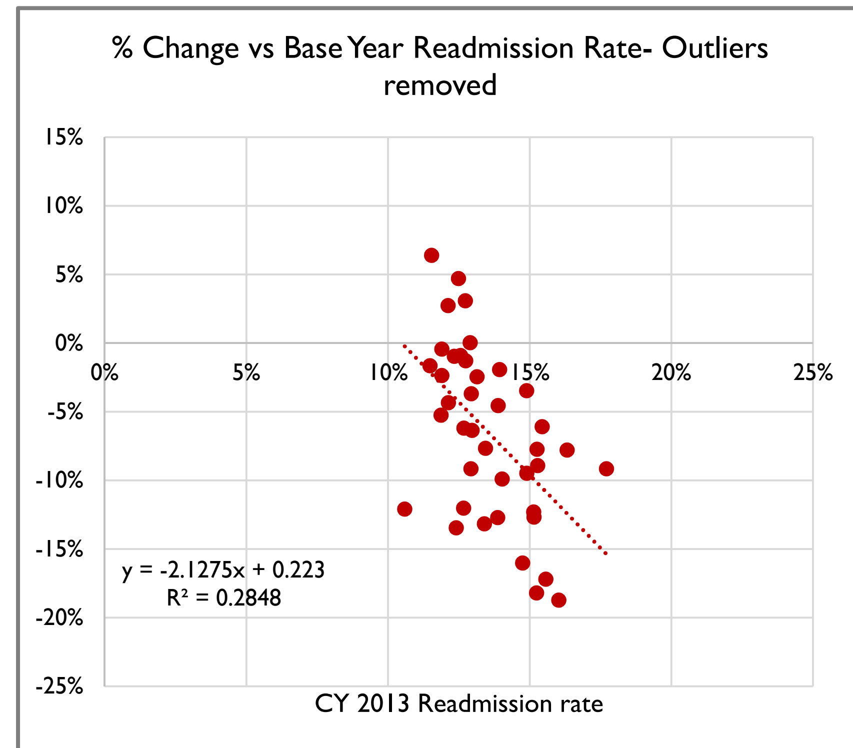
Analyses of Issues Discussed in FY 2017 Policy

- Medicare vs All-Payer Targets
- Relationship between overall admissions (denominator) and readmission rate
- Impact of Socio-economic and Demographic Factors
- Impact of Observation stays
- Diminishing impact to reduce readmissions as readmission rates are lower

Correlation between CY 2013 Readmission Rate and Improvement

- Hospitals with lower CY 2013 Readmission Rates appear to have lower reductions but there is a big variation in performance even at the same base level CY 2013.





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Considerations for the RY 2017 RRIP Policy

- Recognize improvement in the Medicare readmission rates.
- Lower the All-Payer readmission target for hospitals whose readmission rates are lower than the statewide average.
- The Maryland Hospital Association is proposing to reduce the RY 2017 target to the statewide average reduction rate (current trend is at 7.2% decline) and remove all of the penalties if a hospital's readmission rate was in the lowest quintile in both CY 2013 and CY 2015. Staff does not agree with changing the overall target.

Draft Recommendations for the RY 2018 RRIP Policy

- The reduction target should continue to be set for all-payers.
- The All-Payer reduction target should be set at 9.5 percent.
- The reduction target should be adjusted downward for hospitals whose readmission rates are below the statewide average.

Other Updates

Payment Work Group

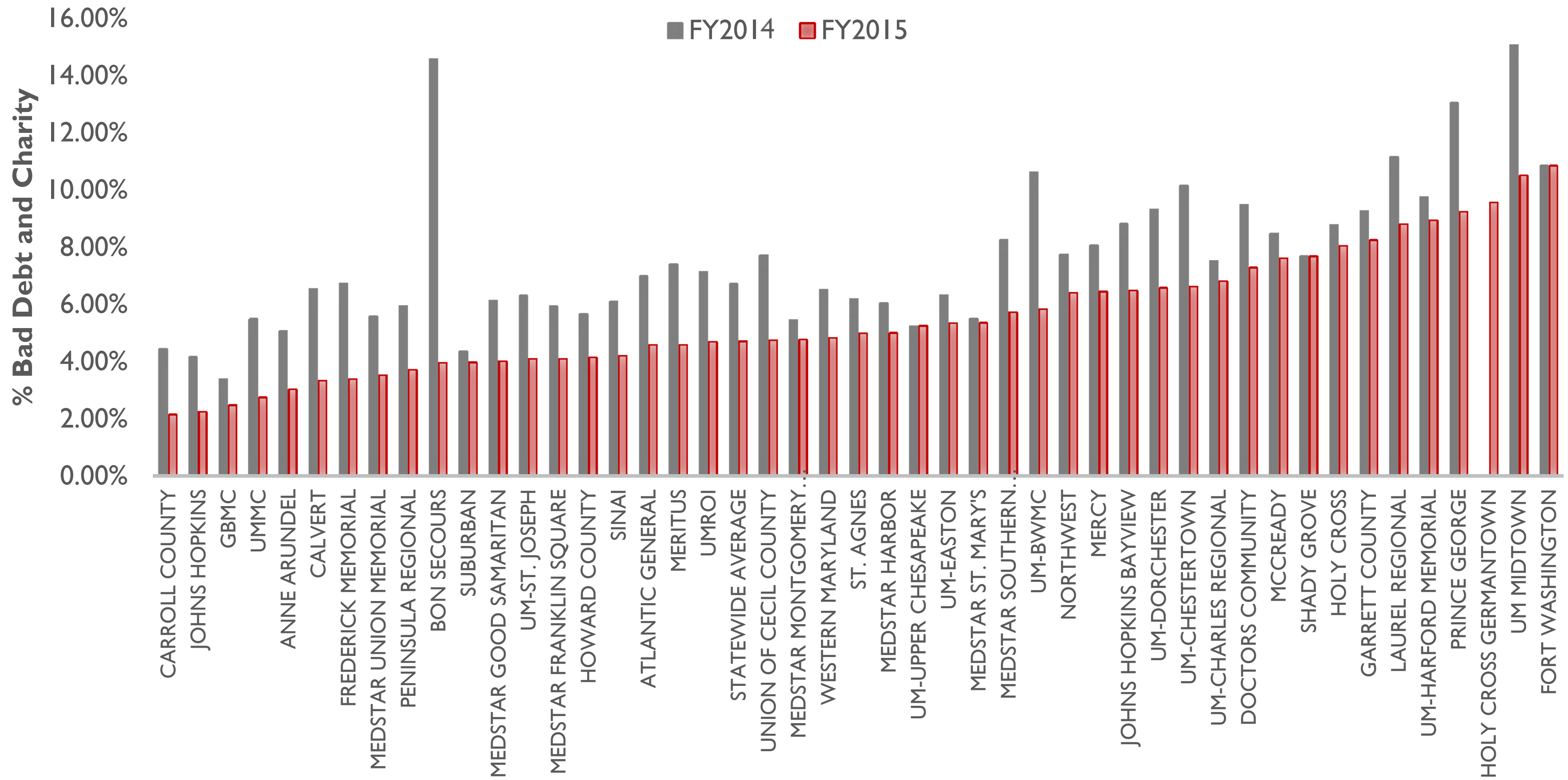
03/21/2016

Uncompensated Care Data Review

What is Uncompensated Care (UCC) in Maryland?

- The HSCRC's provision for uncompensated care in hospital rates is one of the unique features of rate regulation in Maryland.
- Uncompensated care (UCC) includes bad debt and charity care.
- By recognizing reasonable levels of bad debt and charity care in hospital rates, the system enhances access to hospital care for those who cannot pay for care.

Reductions in UCC vary by Hospital in post-ACA period



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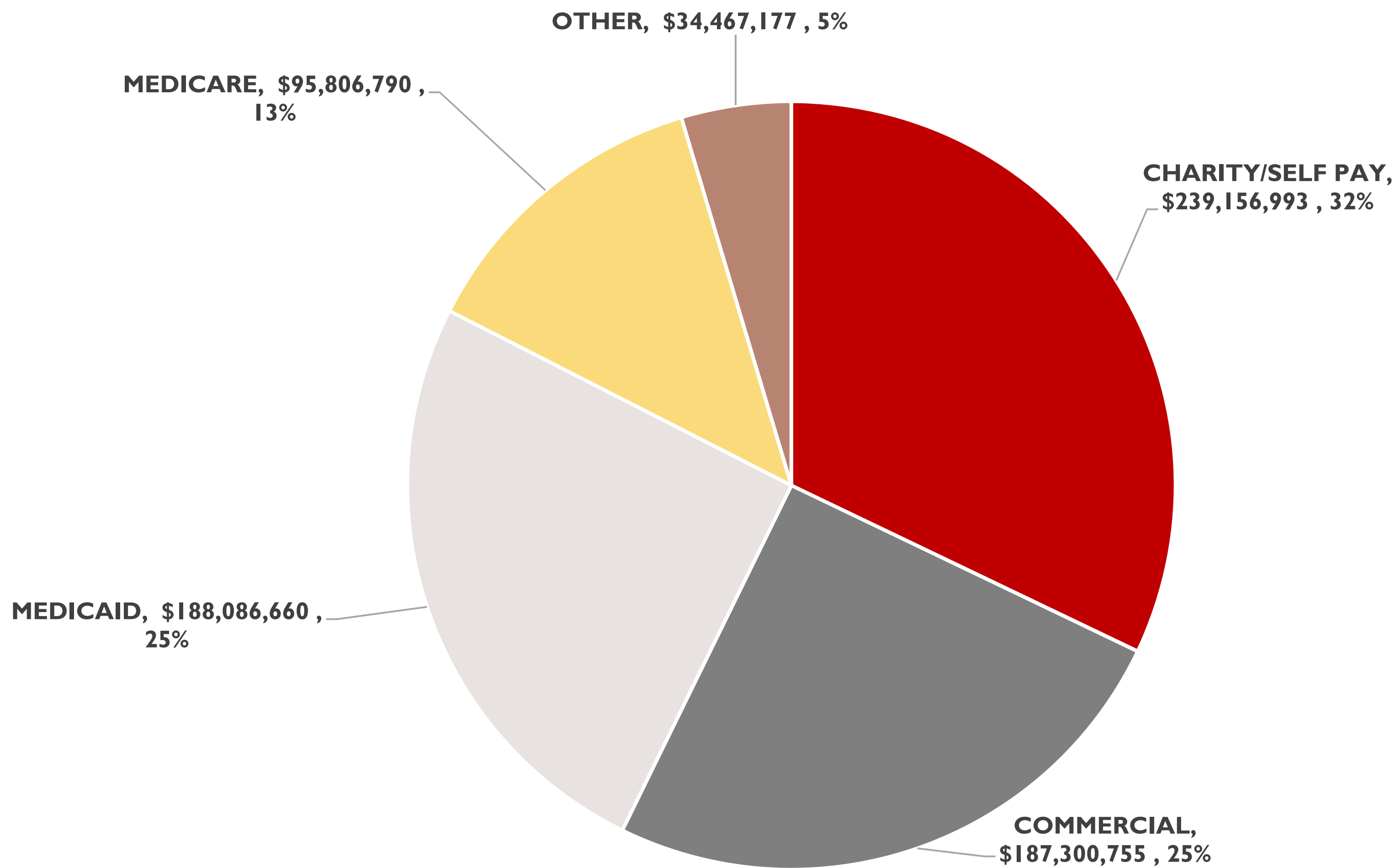
Is UCC increasing in FY16 ?

- Due to disenrollment levels in Medicaid program, concerns have been raised about increasing UCC levels in recent time period
- Comparing audited FY2015 rates to July-Dec 2015 unaudited data, there is no significant change at the state-level UCC levels.
- Staff is working to understand hospital level variations, distinguishing changes due to reporting vs actual trend.

HSCRC started collecting account level write-off data

- Analysis focused on service dates in FY 2015, which could be recorded in FY2015 or FY2016 UCC financial data due to time lags in data processing
- Matched the accounts to case-mix records
- State level matching is 98 % of charges reported in write-off records
- Two additional quarterly reports are needed to include more than 98% of total write-offs due to time lags in account processing
- One more reporting cycle in March (third reporting cycle for FY15Q4) will provide almost complete data for services provided in FY2015

UCC Distribution by Payer: Self-Pay/Charity and Medicaid comprise more than half of UCC



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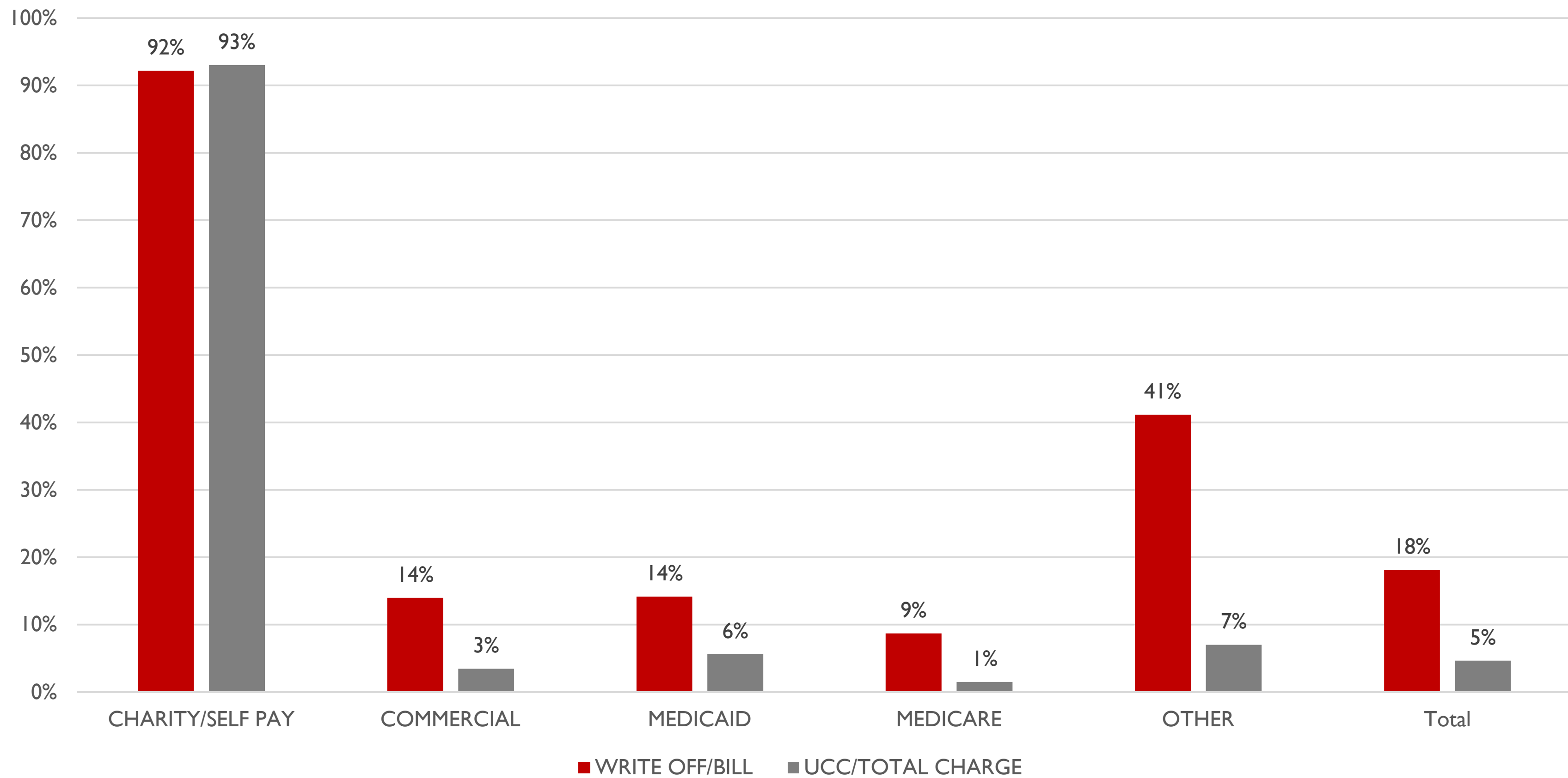
Payer Source is Still A Strong Predictor

92% of the patient bill is written off for self-pay charity patients (almost all of the bill). Overall UCC amount is 93 % of total self-pay charity charges (almost all patients).



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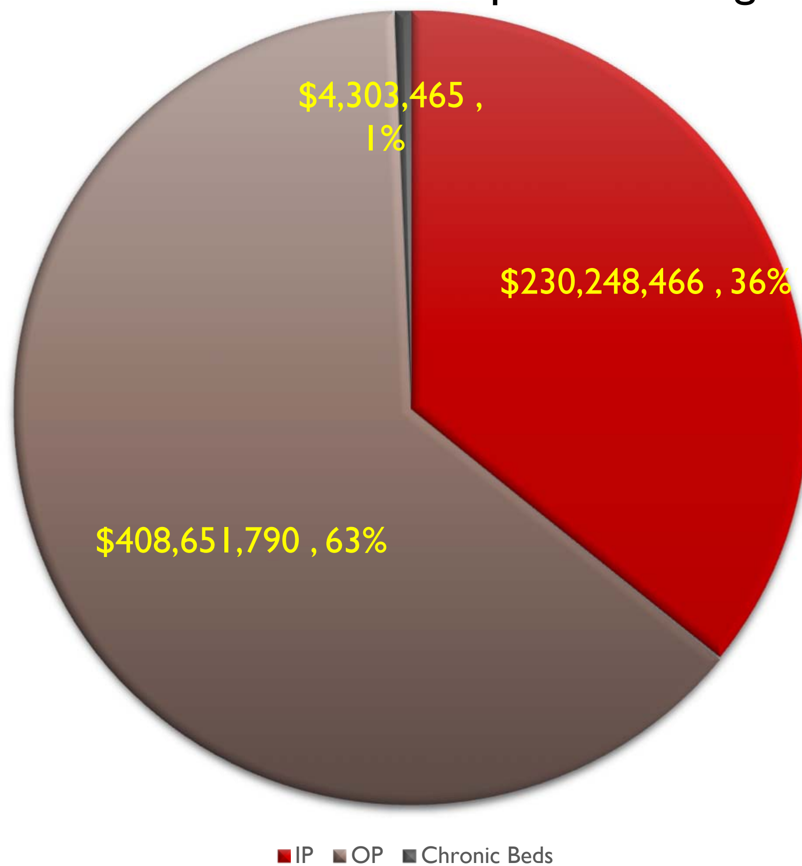
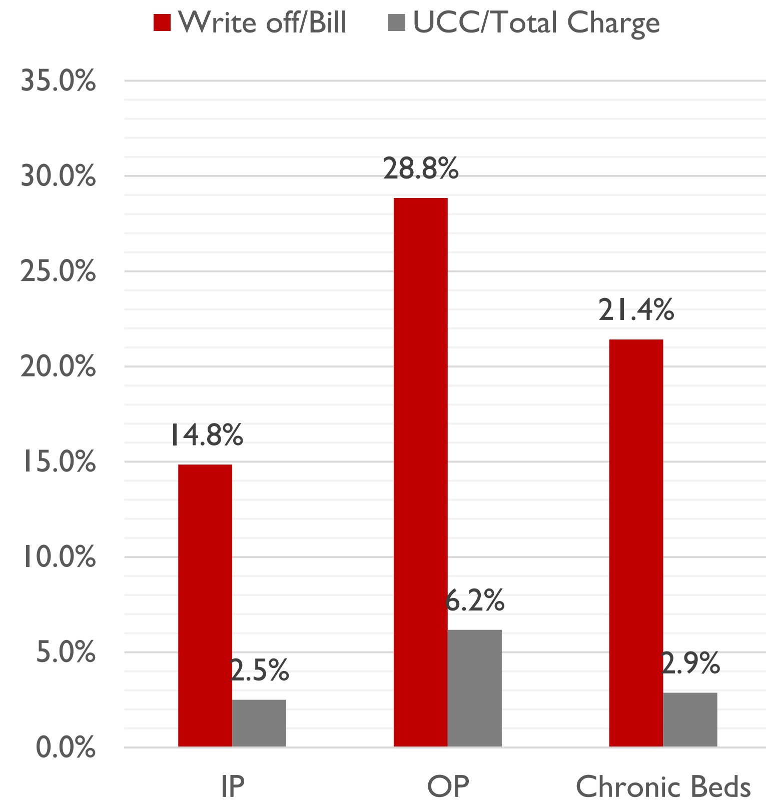
Outpatient services constitute the majority of UCC dollars.

- Higher proportion of the patient bill is written-off for outpatient services (29%).
- 6 % of Total Outpatient Charges are UCC.





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UCC Policy 2017 Considerations

- Focus on post ACA period
- Evaluate the current hospital level regression model
  - Payer source is still a strong predictor
  - Use Write-off data to clean payer classifications
- Evaluate geographical statistics and other predictive models
  - Poverty, unemployment, income level, deprivation, undocumented immigrants etc.

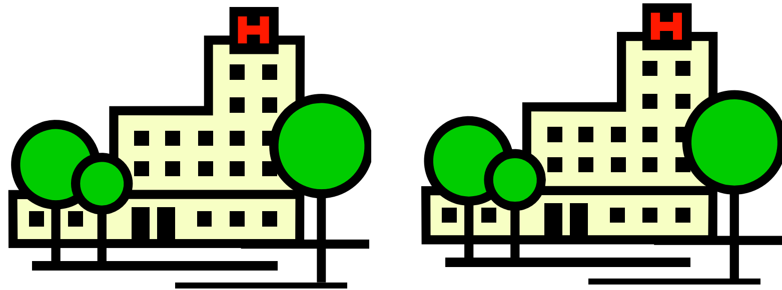
Market Shift Adjustments Update

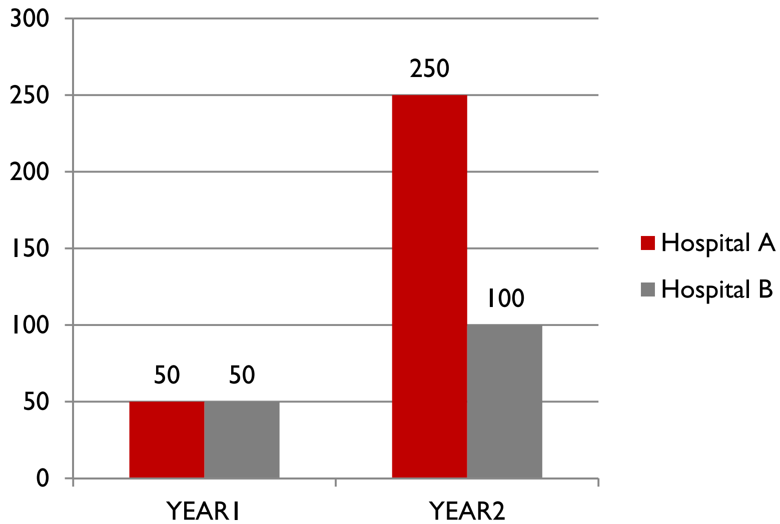
Market Shift Adjustments

- Market shift adjustment should not undermine the incentives to reduce avoidable utilization
- Market shift adjustment should provide necessary resources for services shifted to another hospital
- Calculations are based on
  - 66 inpatient and outpatient service lines
  - Zip codes and county level
  - Excludes Potentially Avoidable Utilization
  - Hospital service line average charge per ECMAD**
  - 50% variable cost factor applied
- Staff send out preliminary results for outpatient oncology service lines

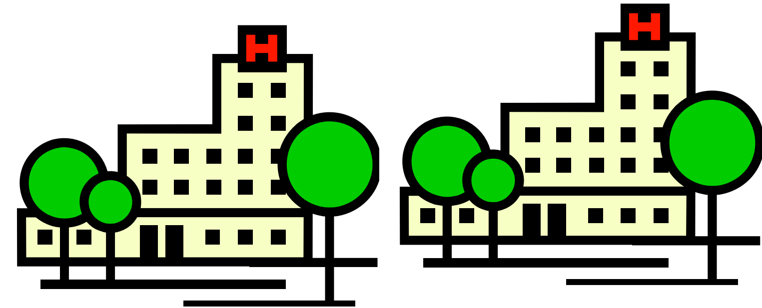
*AHRQ Prevention Quality Indicators
**Equivalent CaseMix Adjusted Discharges

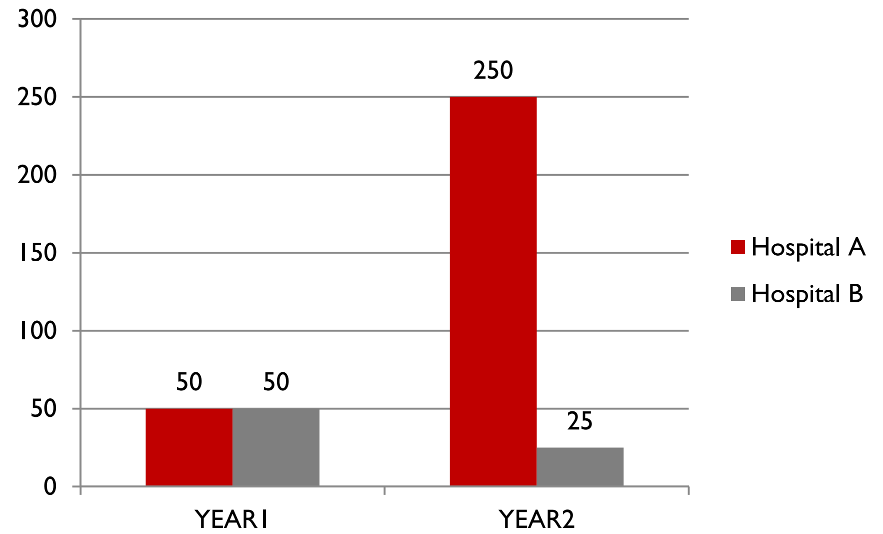
Market Share vs. Market Shift





Market Shift Adjustment=0





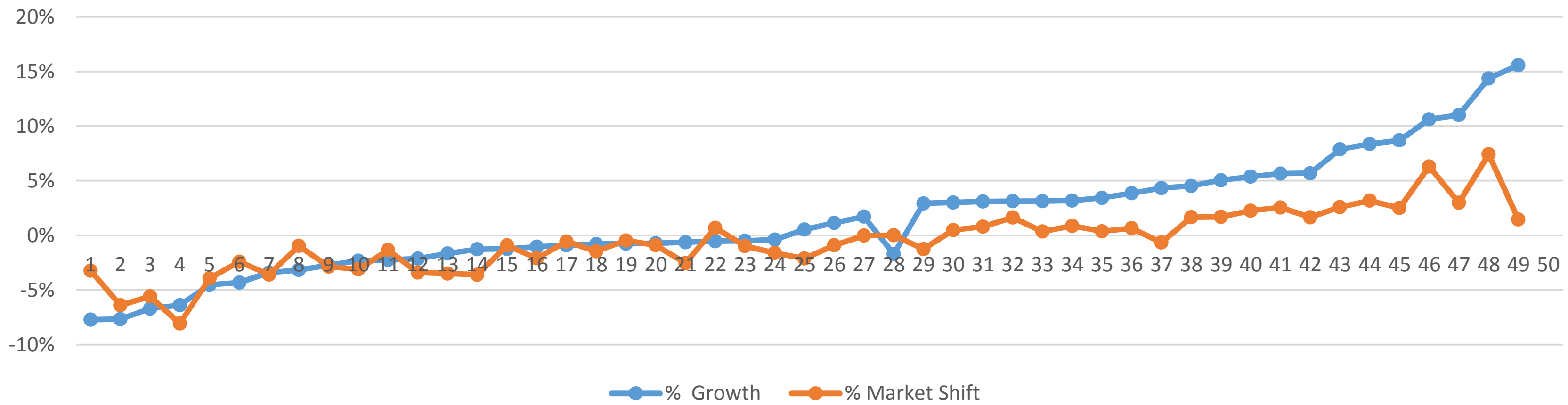
Market Shift Adjustment=25

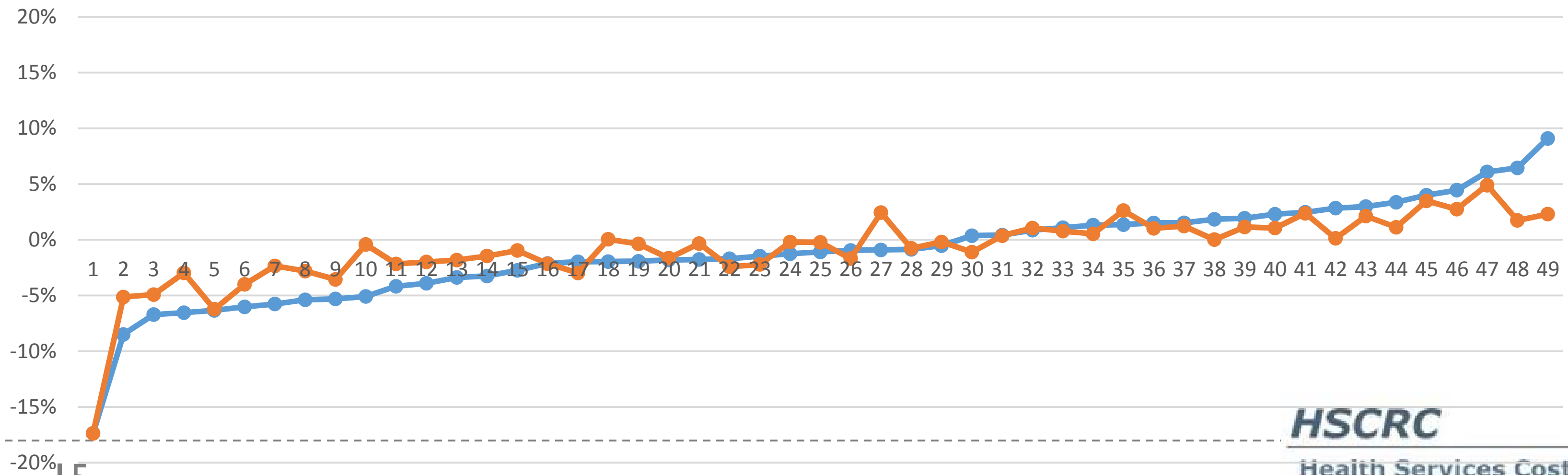
RY 2016 and FY 2017 Year to Date Statewide Impact*

Statewide Impact	FY 2016 (6 Month data)	FY 2017 (9 Month Year to Date)
A	B	C
Grand Net Total	**($756,341)**	**($1,473,282)**
Positive Adjustment Total	$27,741,411	$45,416,696
Negative Adjustment Total	($28,497,752)	($46,889,978)
Absloute Adjustment as Percent of Total Charges in MSA	1.02%	1.10%

*excludes oncology/radiation therapy/infusion service line and other manual adjustments

Market shift adjustments and volume growth is more closely linked in the FY 2017 period





Market Shift - Timing

- RY 2017 will be based on CY 2015 compared to CY2014, done on an annual basis
- Staff have been sending market shift calculations on a quarterly basis to all hospitals both with preliminary and final data
- Any changes in hospital service provisions (closure of services, deregulation etc) are reflected immediately.
- Semi annual adjustments may be considered for significant shifts
- Recently, we have had several major problems in receiving case mix data from hospitals. These quality problems are causing delays in reporting on ECMAD volume changes and in analyzing market shifts, readmissions, MHACs and other policies. This could cause a delay in the annual update process and deter the monitoring of the model, if not rectified.

Non-Hospital Cost Growth-Medicare Data

Skilled Nursing Facility Utilization and Expenditures

Year to Date Thru September 2015

Growth in Part A Expenditures

- In Year 2, Part A expenditures significantly contributing to growth in TCOC spending:
  - Non-Hospital growing at a much faster rate than hospital Part A
  - Largest growth in Home Health, but largest % in spending per bene in SNF expenditures
- Causing pressure on the TCOC guardrail for Maryland

Trends in SNF Utilization & Expenditures

The number of Medicare beneficiaries' using SNF, as well as total SNF expenditures, are increasing at a much higher rate in Maryland, compared to the Nation

- SNF users increasing by 4%, both SNF stays and days increasing by 3% (Chart 1)
- Expenditures increasing by 5% and average expenditure per eligible beneficiary increasing by 2% (Chart 2)
- SNF LOS is also declining in MD, though not as fast as Nationally, illustrated by the average number of days per SNF user, average number of days per SNF stay and the average number of days per SNF user (Chart 3)
- Maryland has a higher increase in beneficiaries in Medicare FFS, which accounts for some of the difference (Chart 4)

Estimated Maryland Medicare Part A Spending per Beneficiary, CYTD Sept 2014 vs CYTD Sept 2015

Provider Type	CYTD 2014 Spend	CYTD 2014 Spend Per Beneficiary	CYTD 2015 Spending	CYTD 2015 Spending Per Beneficiary	Spending Change	Spending per Beneficiary Change	% per Beneficiary Change
Non Hospital							
SNF	$473,442,116	$580.98	$499,985,384	$594.87	$26,543,268	$13.89	2.4%
HHA	$193,894,382	$237.94	$213,178,547	$253.64	$19,284,165	$15.70	6.6%
Hospice	$126,391,856	$155.10	$135,720,859	$161.48	$9,329,003	$6.38	4.1%
Non Hospital Subtotal	**$793,728,354**	**$974.02**	**$848,884,790**	**$1,009.98**	**$55,156,436**	**$35.97**	**3.7%**

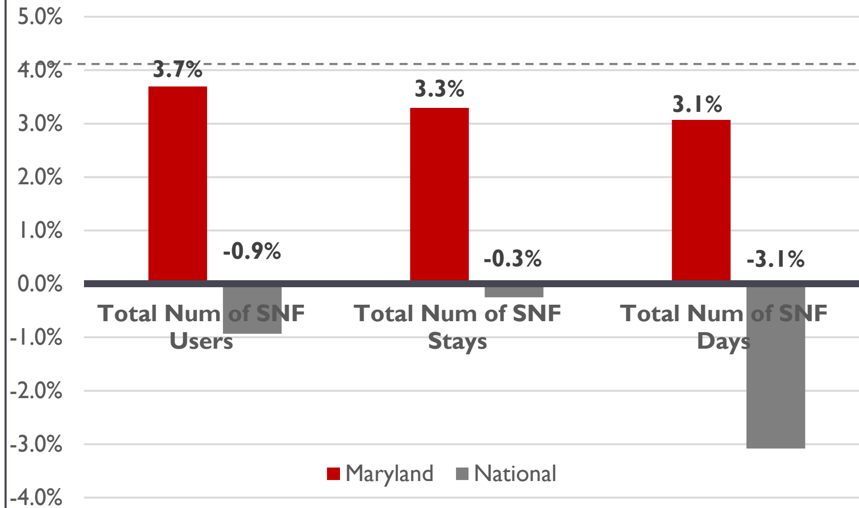


CHART 1: Percent Change in Total Number of SNF Users, Total Number of SNF Stays and Average Stays per SNF User
CY 2014 – 2015 (January – September)
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
-1.0%
-2.0%
-3.0%
-4.0%
3.7%
-0.9%
3.3%
-0.3%
3.1%
-3.1%
Total Num of SNF Users
Total Num of SNF Stays
Total Num of SNF Days
Maryland
National

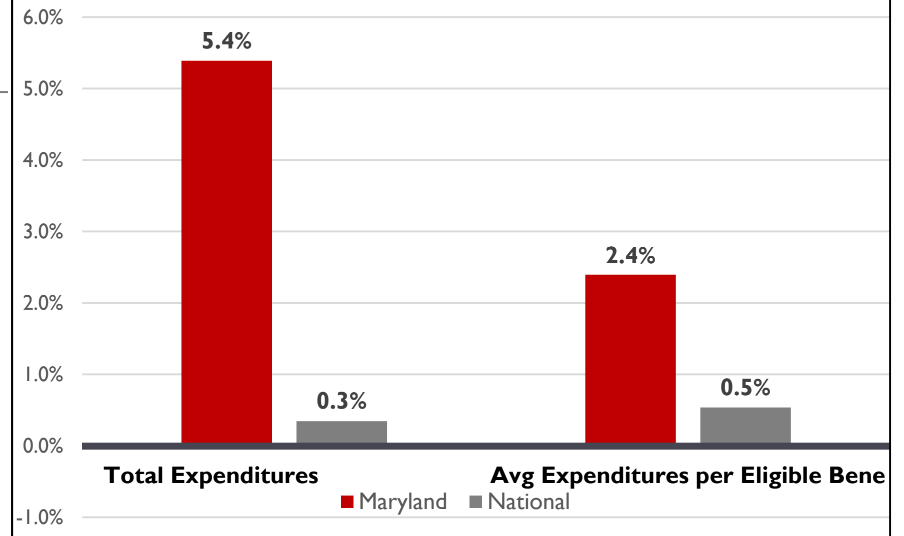


CHART 2: Percent Change in Total SNF Expenditures and Average Expenditure per Eligible Beneficiary
CY 2014 – 2015 (January – September)
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
-1.0%
5.4%
0.3%
2.4%
0.5%
Total Expenditures
Avg Expenditures per Eligible Bene
Maryland
National

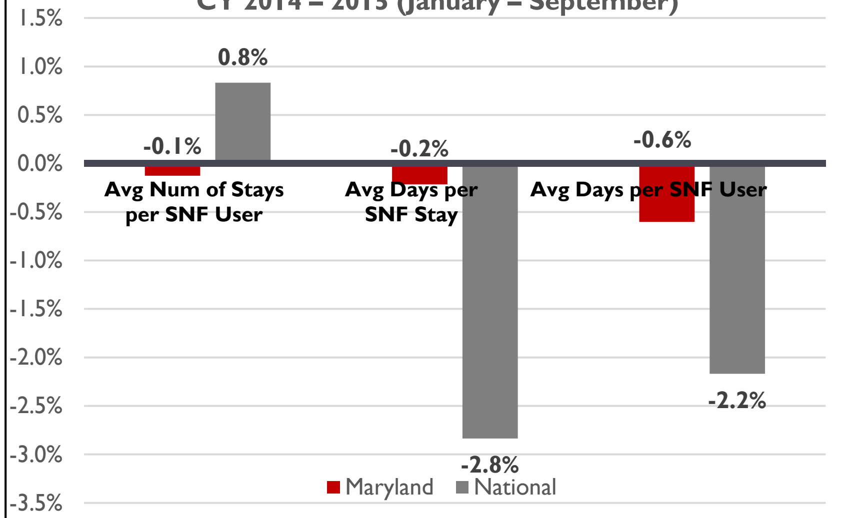


CHART 3: Percent Change in Average Number of Stays per SNF User, Average Number of SNF Stays and Average Days per SNF User
CY 2014 – 2015 (January – September)
1.5%
1.0%
0.5%
0.0%
-0.5%
-1.0%
-1.5%
-2.0%
-2.5%
-3.0%
-3.5%
-0.1%
0.8%
-0.2%
-2.8%
-0.6%
-2.2%
Avg Num of Stays per SNF User
Avg Days per SNF Stay
Avg Days per SNF User
Maryland
National

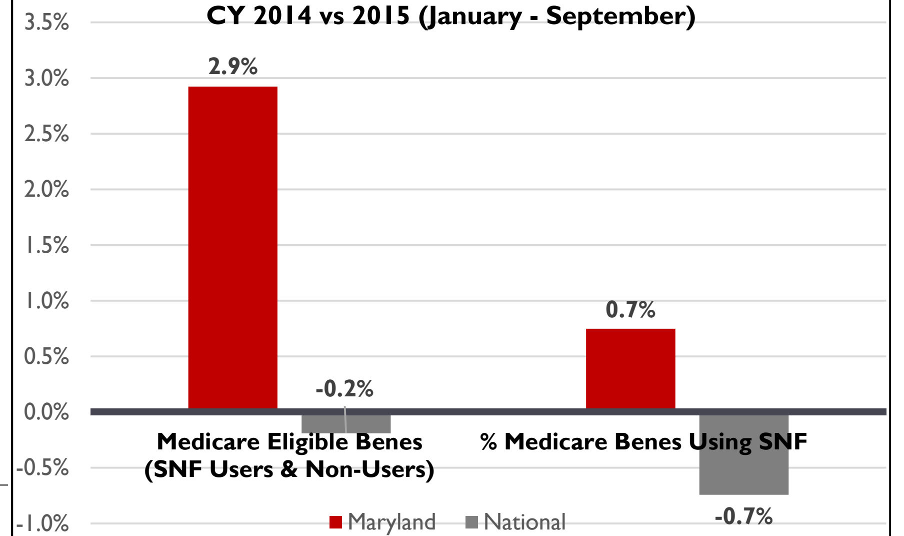
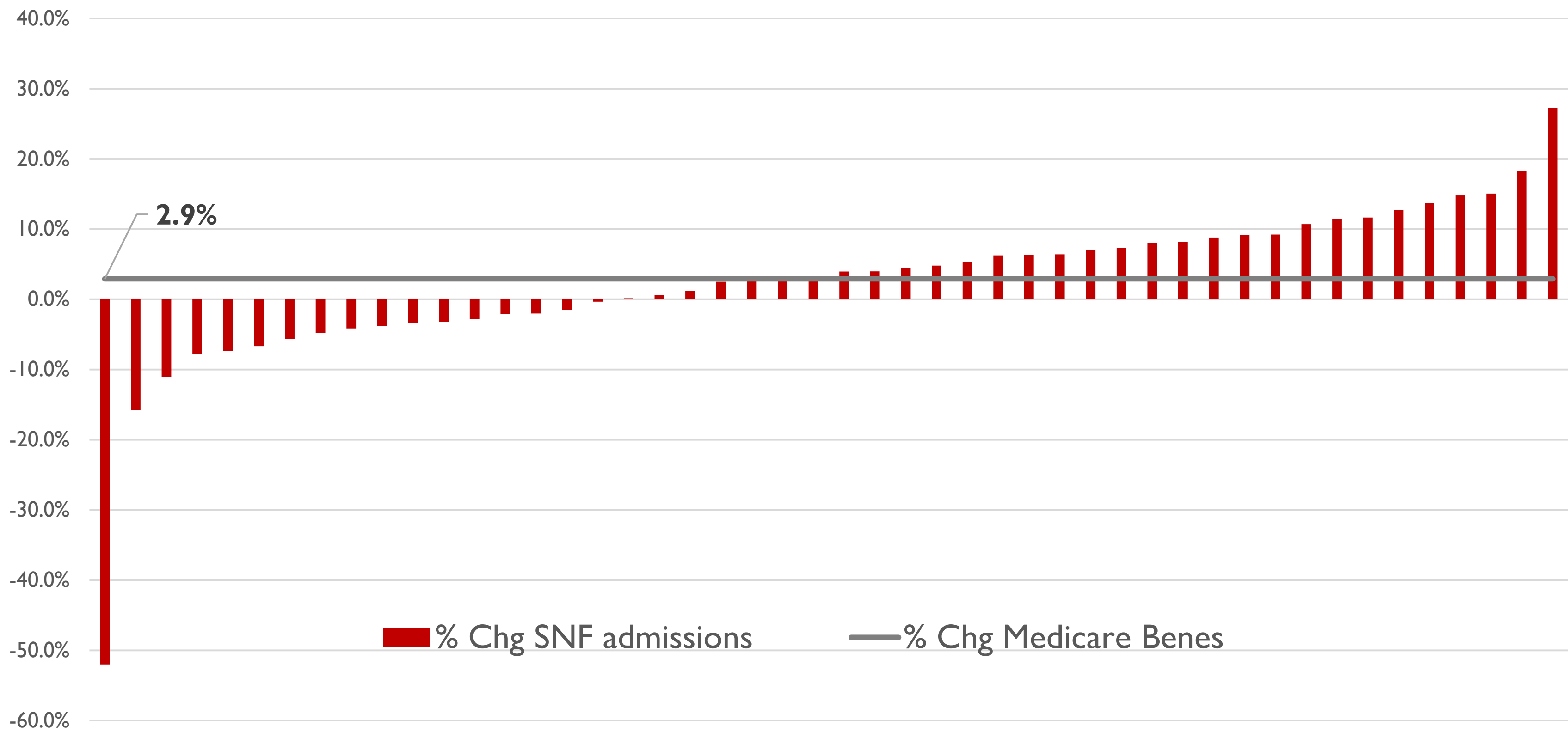


CHART 4: Percent Change in Eligible Medicare Beneficiaries and Percent of Medicare Beneficiaries Using SNF
CY 2014 vs 2015 (January - September)
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
-0.5%
-1.0%
2.9%
-0.2%
0.7%
-0.7%
Medicare Eligible Benes (SNF Users & Non-Users)
% Medicare Benes Using SNF
Maryland
National

Percent Change in SNF Admissions from Inpatient Discharges By Hospital CY 2014 vs 2015 (January - September)



Data Note: This graph represents a subset of SNF admissions for MD Medicare Beneficiaries and includes discharges from out-of-state hospitals to MD SNFs and discharges from MD Non-Regulated IP Hospitals to MD SNFs

Data Caveats

- Data contained in this document represent analyses prepared by HSCRC staff based on data provided by the Federal Government.
- Maryland data represents a subset of SNF admissions and does not include admissions from inpatient discharges during which substance abuse treatment was provided ("SAMSHA claims").
- National data is based on analysis of a 5% sample of national SNF claims and also excludes SAMSHA claims.
- The intent of this analysis is to provide early indications of the spending trends in Maryland for Medicare patients, relative to national trends.
- This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation could have an impact on claims lags.
- These analyses should be used with caution and do not represent official guidance on performance or spending trends.