Staff Evaluation of and Response to the MHA/Payer Update Proposal

Introduction

On June 23, 2010, the HSCRC's Chairman received a letter signed jointly by representatives from the Maryland Hospital Association ("MHA"), CareFirst of Maryland, United Health Care, and the Maryland Secretary of Health indicating that they had privately developed a "consensus proposal" for consideration by the Health Services Cost Review Commission ("HSCRC," or "Commission") on the magnitude and structure of the FY 2011 update to hospital rates. In this proposal, the payers and MHA presented a structure for the Update Factor involving a readmission reduction project, and making a portion of the update contingent upon the success of that readmission reduction program.

The HSCRC staff support the goals of the proposed readmission reduction project, which could be structured to reinforce other efforts on readmissions, and are suggesting as an option for Commission consideration some modifications to the MHA/payer proposal that will provide more accountability, and would actually provide more funding to hospitals that achieve the goal of reducing readmissions.

During follow-up discussions with hospital and payer representatives about their proposal, it appears that there remains a disagreement between the payers and hospitals over the precise handling of the portion of the update related to the readmission reduction program. The staff's proposed modifications also provide a potential solution to this remaining and unresolved issue between the hospitals and payers.

This evaluation paper starts with a discussion of the strengths of the MHA/payer proposal. Section 2 of the paper discusses the staff's concerns about that proposal, and section 3 describes the modification being suggested by staff and the rationale for these suggestions. The paper concludes with a summary of the advantages of the staff's modified proposal that is being presented as another option for Commission consideration.

1. Description of the MHA/Payer Proposal

Description of the Proposal

The letter from the MHA and payers is attached as Appendix 1 to this paper. The proposal was that the Update Factor for Fiscal year 2011 should be 2.44%, 0.44% of which is intended to be for the readmission program, with 0.22% for the funding of the infrastructure required, and a 0.22% "incentive or at-risk" component, contingent upon achieving the goal of reducing readmissions by 10% in the 4th quarter of FY 2011. The additional 0.44% funding is equivalent to about $60 million of additional revenue (and higher payments by the paying public) that the hospitals would generate in FY 2011 if their proposal were adopted.

The MHA/Payer letter further states that the "0.44 percentage points are specifically targeted to fund readmission reduction programs to be implemented in Maryland hospitals through efforts coordinated by the Maryland Hospital Association." During further discussions with payer and hospital representatives, MHA provided a clarification to this statement and indicated that the additional 0.44% in the FY 2011 update was intended to provide hospitals with adequate funding in the coming year, such that they would be in a position to develop initiatives to begin reducing readmissions. Thus, the proposal did not intend that hospitals would be expected to dedicate either the initial 0.22% component or the "at-risk" 0.22% component specifically to building a readmission reduction infrastructure.

Remaining Area of Disagreement between Hospital and Payer Representatives

Following submission of the June 23rd letter to the HSCRC, hospital, MHA, and payer representatives met with HSCRC staff and members of the HSCRC payment work group to describe and clarify the details of their proposed update. During these discussions, it became clear that the parties disagreed on the handling of the 0.44% add-on to rates. While both parties agreed that this proposal is a "one-year" proposal and applies only to the hospital rate update for FY2011, they disagreed over whether funding related to the readmission reduction effort would continue into future years. Hospital representatives believed that these amounts were to be provided to hospitals permanently in their rate structure, while payer representatives believed that these amounts were to be provided only on a "one-time" basis – that is, provided up-front in the FY 2011 update (effective July 1), but then removed from hospitals' on-going rate structures in FY 2012. As of this writing, this issue has not yet been resolved.

The Need to Address Maryland's High Readmission Rate

The proposal acknowledges that there is a problem with excess readmissions in Maryland, as has been documented in several recent studies, and establishes an aggressive goal of a 10% reduction in readmissions by the 4th quarter of fiscal year 2011. In a recent article by Steve Jenks in the *New England Journal of Medicine*, Maryland was noted as having the highest readmission rate of any state on Medicare cases. Since readmissions comprise about 13% of total admissions, the MHA/Payer proposal represents a 1.3% reduction in total admissions, which is substantial. To be clear, the proposal calls for a reduction in total readmissions as opposed to subcategories of readmissions -- the HSCRC's readmission initiative has focused on providing financial incentives to hospitals to reduce "Potentially Preventable Readmissions" (PPRs). PPRs represent a subset of readmissions, which are clinically related to the initial admission and are otherwise thought to be preventable. Per previous HSCRC analysis, PPRs account for approximately 8.4% of total admissions. Achieving a goal of reducing total readmissions by 10% would require a reduction in PPRs of over 16%. The MHA/Payer proposal also defines readmissions as those occurring during a 30 day window after the discharge of the initial admission.

Staff believes that some additional amount in rates for the funding of the readmission program would be reasonable if the goal is achieved and the reduction in readmission rates is sustained over time. Under the MHA/Payer proposal, if the program does not achieve its goal of reducing readmissions by 10% in the

fourth quarter of FY 2011, then the 0.22% “incentive at-risk” component is to be reduced from the subsequent year's Update Factor.

2. Problems with the MHA/Payer proposal

First, the staff's major concern with the proposal (as originally presented) is that the incentives on the individual hospitals are not correct, and the program lacks accountability. The reward for any individual hospital is dependent upon the performance of the hospital industry as a whole, and is little influenced by each hospital’s own performance. Conversely, the impact on a hospital's revenue of a reduction in admissions is immediate and substantial. If a hospital does an outstanding job of reducing readmissions and reduces its readmissions by 20%, for a 4% reduction in total admissions, then its revenue would drop by 3.4%, but it may or may not retain the 0.22% at risk, depending upon the performance of all the other hospitals in the State. Other hospitals that do little or nothing to reduce readmissions would receive the same benefits, and could be paid for activities they did not undertake, and rewarded for performance they did not achieve.

Second, the “at-risk” amount of 0.22% is being provided up-front, and there is no meaningful mechanism to recoup it in the event the program does not achieve its goal. The Update Factor is for one year, with no specification as to how it would be calculated for FY 2012. If the hospital industry’s goal is not achievable (particularly given the flawed nature of the proposed incentive structure), the industry may well be tempted to start the negotiations for the 2012 Update Factor at a higher level to compensate.

Third, the use of statewide data for assessment of performance means that hospitals providing good data may be penalized because of other hospitals providing bad data. Some hospitals have provided data with patients having multiple medical record numbers or with dates of birth that have typographical or other errors. These errors will result in the readmission rate being underestimated in the base year, and under the MHA/payer proposal, all hospitals would be subject to a more stringent target as a result. Under the staff modifications, bad data would only hurt the hospital submitting the bad data.

Finally, a minor and easily corrected problem with the MHA/payer proposal is that the evaluation timeframe specified is not feasible. Under their proposal, the evaluation has to be completed before the final data submission is due from the hospitals for the time period being evaluated.

3. Staff Suggested Modifications to the MHA/Payer Proposal if Adopted

Given the issues noted above, the staff proposes the following modifications to the original MHA/Payer update structure. Under this modified approach, the Update Factor would be 2.00%. An additional amount intended to facilitate the development of a readmission reduction infrastructure (0.22%, or an amount determined by the Commission) would be provided up-front effective July 1, 2010. This additional amount would be provided permanently.

To address the flaws in the proposed incentive structure, staff proposes that the fixed cost factor to be provided for reductions in readmissions should be increased to 40%. Under current Commission policy, hospitals are subject to a 15% fixed cost adjustment for volume change – such that for volume reductions, the HSCRC adds back 15% to rates to help the hospital cover its fixed costs. This modified proposal would retain that 15% fixed cost adjustment for volume changes, but add 25% to the adjustment (a total of 40%) for changes, in readmission volumes. Because the fixed cost adjustment is applied on a hospital-specific basis, each hospital would be provided an additional revenue amount for its individual success in reducing readmissions. The percentage amount hospitals could recoup (the 40%) for readmission reductions would be known in advance and not contingent on the activity of other hospitals.

On an annualized basis, staff estimates that this modification would provide slightly more to the hospitals than the 0.22% being requested in the MHA/payer proposal if, on average, the industry achieved the proposed goal of a 10% reduction in readmissions.

This modified approach would be implemented as follows:

1) Calculate the drop in case mix adjusted readmissions;

2) Provide the hospital with a fixed cost adjustment for this reduction of 25%. This will be in addition to the normal 15% fixed cost factor used for volume adjustments;

3) Calculate the volume adjustment for the total volume change at the hospital in the standard manner using the standard 15% fixed cost factor;

4) The readmission reduction program should be in place for at least 2 years;

5) The effective fixed cost factor for the reduction in readmissions is then 15% + 25% = 40% (note: because this methodology is untested, some reasonableness checks on the magnitude of the volume adjustments would be required);

6) Hospitals providing bad data would not be eligible for the increased payments provided through a change in the fixed cost adjustment. Staff will be receiving final (and hopefully corrected) inpatient case mix data for FY 2010 in October and will be able to determine the soundness of individual hospital data at that time.

This staff recommendation has the following benefits:

1. It provides appropriate incentives to individual hospitals - hospitals that perform well will be rewarded, while those that do not will receive only the up-front infrastructure 0.22%;

2. The reward for good performance will be greater under the staff recommendation than it would be under the MHA/payer proposal;

3. There is no issue with having to take back funds already in rates if the program is not successful -- something staff has found to be extremely difficult historically;

4. Hospitals with bad data can easily be excluded and will not distort the outcome for other hospitals;

5. Any activities planned by MHA to reduce readmissions under their proposal would be equally applicable for the staff modification;

6. These incentives would apply for future years so that hospitals will continue to be rewarded for maintaining or improving their performance over time. Under the MHA/Payer proposal, there was no financial structure to ensure continuation of activities designed to reduce readmissions. Hence, to the extent that hospitals respond to financial incentives, the staff modification continues to strongly encourage continuation of their readmission reduction activities.

If the program is not successful in reducing readmissions, the Commission should reconsider the permanent inclusion of the infrastructure 0.22% in rates, and proceed to implement other options to reduce readmissions.

4. Summary

The staff's proposed option builds on the strengths of the MHA/payer proposal, provides appropriate incentives to individual hospitals to perform and reduce readmissions, and is more generous than the MHA/payer proposal to hospitals that achieve the target. This option can be structured in a way to provide the same level of up-front funding for readmission infrastructure development; it provides reward for performance if it is achieved, but does not provide a reward if a hospital is unsuccessful; and, it eliminates the issue of an adequate recoupment method for failure to achieve the goal.

The major advantage of the staff recommendation is that it makes the individual hospitals accountable for, and rewards them based upon, their own performance and not the average performance of the hospital industry as a whole. The MHA and the hospital industry are held accountable for the success of the overall readmission reduction program. It does not change the overall direction of the effort or the activities required to ensure its success.

The staff modification also resolves the current disagreement between payer and hospital representatives regarding the disposition of the "up-front" infrastructure component and any amount "at-risk" for performance. Up-front funding would be provided permanently in rates, and any rewards earned by individual hospitals through the application of an enhanced fixed cost adjustment associated with changes in readmissions would also be permanent.

HSCRC staff is supportive of activities that promote hospital-payer cooperation and initiatives designed to reduce unnecessary cost in the health care system. The staff also is aware that such cooperation and activities must be accompanied by strong and appropriately structured financial incentives if they are to be successful. Initiatives that are not designed to incentivize desired behavior (no matter how well-intentioned they are) will not be successful.

Impact estimates

1. Using 40% fixed costs for reductions in readmissions:

Total gross revenue	$13,300 million	
0.22% of gross revenue	$29.3 million	
Overall re-admission rate	13.3%	
Reduction in re-admissions	2,308	10% reduction for 3 months
Statewide CPC	$12,932	
Total revenue associated with drop in readmissions	$29.8 million	
Additional fixed costs of 25%	$7.5 million	
Annualized additional fixed costs	$30 million	

This option would provide an ongoing addition of $30 million to the hospitals if the goal is achieved, an amount just over the $29.3 million being requested in the MHA/payer proposal, and the reward would be proportional to the degree of success for the individual hospital as well as for the hospitals as a whole.

Note that 0.22% of revenue is about the same as the revenue associated with the drop in readmissions if the goal is achieved, so, in the first year, the cost of the proposed program (0.44%) is about twice the drop in gross revenue that would result from achieving the goal.

The staff option would provide the 0.22% for infrastructure up-front, subsequently, the hospitals would receive the additional fixed costs associated with the reduction in readmissions. This would amount to $7.5 million if the goal of a 10% reduction in readmissions were to be achieved for the 4th quarter, with no reduction in readmissions in previous quarters. For subsequent years, the additional revenue would be about $30 million if the readmission reduction was sustained, and this amount would increase if there were additional drops in readmissions.

June 22, 2010

Donald A. Young, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2299

Dear Dr. Young:

As key stakeholders in the Maryland rate setting process, we are writing to share with the Commission that, after devoting much time and effort, we have developed a joint consensus proposal for the FY 2011 hospital payment update for the Commission's consideration. Because of the late date in the Commission's decision making process, we respectfully request that you delay your scheduled decision to the July 7, 2010 Commission meeting in order to allow time for us to share the proposal in more detail and for all parties involved to better understand its implications.

We believe this joint consensus proposal does several important things: 1) provides incentives for hospitals to reduce unnecessary use of services; 2) focuses on reducing readmissions in a way that complements the work of the Commission that will be implemented later this year; and 3) acknowledges that reducing readmissions is a multi-stakeholder effort. Moreover, the spirit of this joint consensus proposal and all of the collaborative work that led to it is critical to the important task that lies ahead for all of us – reshaping Maryland's all-payor rate-setting system. That will be a complex task. The spirit in which we have reached consensus on this update proposal for FY 2011 is critical to our collective working relationship as we move forward together on reform.

As you know from Commission staff presentations, the potential for significant system savings through reductions in readmissions is clear. In reaching consensus, the parties have agreed to an update that will provide hospitals with an incentive to achieve a specific level of reduction in readmissions in 2011, with a portion of that amount to be returned in 2012 if hospitals fail to achieve the agreed-upon target.

The specifics of the consensus proposal are as follows:

- A total update of 2.44 percent, of which 0.44 percentage points are specifically targeted to fund readmission reduction programs to be implemented in Maryland hospitals through efforts coordinated by the Maryland Hospital Association (MHA).

- A goal of a 10 percent reduction in readmissions to be achieved in the fourth quarter (April 1 through June 30, 2011) across all Maryland hospitals. The methodology to be used to calculate this goal would be agreed to by the HSCRC, payors and MHA by September 1, 2010. The HSCRC would serve as the entity measuring the results achieved. Measurement would occur after June 30, 2011 and before September 1, 2011.

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- Hospitals and MHA would define and implement any program design they believe best achieves the goal; payors believe that Project RED is most promising.

- The Medicaid program would be held harmless for any impact of this update beyond what the state has budgeted for the update for FY 2011. Hospitals would pay 100 percent of that added cost through an increase to their Medicaid assessment.

- Failure to achieve the goal would result in a 0.22 percentage point reduction in the update factor to be set by the HSCRC for July 1, 2011 through June 30, 2012 rates.

- This consensus proposal would be in effect for one year.

We are pleased to present this framework to the Commission for your consideration. After spending many hours together working on an update factor, we are only asking the Commission to delay making its decision on the update until July 7, an update that would still be applied to July 1 hospital rates. Assuming you agree to delay your decision until July 7, this letter will be followed by a more detailed description of the consensus proposal and what we believe we can achieve working together. We look forward to working with Commission staff in the interim to fully brief them on our discussions and enhance their understanding of this framework. We join together in urging that the Commission consider and adopt this proposal for FY 2011.

If you have any questions, please feel free to contact any one of us.

Sincerely,

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Secretary, Department of
Health and Mental Hygiene

Chet Burrell
President and CEO
CareFirst BlueCross BlueShield

Dennis P. O'Brien
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