Maryland Health Services Cost Review Commission

Payment Models Work Group
Draft Report on Balanced Update and Short Term Adjustments

4/9/2014

HSCRC
Health Services Cost Review Commission

Presentation Outline

I. Overview
II. Draft report
    a. Policy goals and features
    b. Requirements and considerations for balanced update
    c. Application of updates to different categories of hospital revenues
    d. Other short term adjustments and considerations
III. Next steps

Summary of Work Group Activities

- Work Group has met 4 times
  - Presentations from Maryland Hospital Association and CareFirst on proposed annual update methodologies
  - Staff reports on draft performance measurement recommendations for MHAC and readmissions, global budget contracts, payment policies, uncompensated care, and demographic adjustments
- Several Sub Groups formed to address specific issues:
  - Goals and Desired Outcomes
  - Scaling for MHAC
  - Demographic Adjustment
  - Global Budget Contract
  - Uncompensated Care/PAC
- Work Group reviewed draft report on balanced update at April 3rd meeting

Draft Report Overview

Goal

- To provide input for consideration by HSCRC in formulating policies for balanced updates to hospital revenues, taking into account the requirements of the new All-Payer Model

Recommended Goals to Guide Payment Policy

- Promotes the three-part aim as referred to in the All-Payer Model contract (better care, better health, lower costs)
- Meets the All-Payer Model requirements
- 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

Recommended Desirable Features of Payment Policies

Multiple suggested features, in four categories

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

Components and Process of Developing a Balanced Update

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Overview of Requirements for Balanced Update

- Both hospitals and payers presented approaches to balancing the update and producing an increase in allowed hospital revenues that does not exceed the limit of 3.58% per capita.
  - The MHA presented on a number of the specific components of the update
  - CareFirst focused on an approach to take into consideration the likely impact of the update on the Medicare savings requirement.
- Since all sources of patient revenue must be accounted for, the HSCRC must consider changes in revenues that are under global models (GBR and TPR) as well as those revenues that are outside a global model under a charge-per-case/episode (CPC/E) and unit rate system with new volume policies.

Components to Account for In a Short Term Update--Example

Balanced Update Model Example for Maryland Residents				
I.Maximum allowed growth				
Maximum revenue growth allowance		A	3.58%	per capita
Population growth		B	0.70%	
Maximum revenue growth allowance ((1+A)*(1+B)		C	4.31%	
II.Components of revenue change-increases				
	Portion of Revenues	Allowance	Weighted Allowance	
a. Adjustment for inflation/policy adjustments				
-Global budget revenues	80%	2.30%	1.84%	
-Non global revenues	20%	1.60%	0.32%	
			2.16%	
b. Adjustment for volume				
-Global budget revenues	80%	0.80%	0.64%	
-Non global revenues for Maryland residents	20%	1.20%	0.24%	
-Market share adjustments not revenue neutral				
			0.88%	
c. Infrastructure allowance provided				
-Global budget revenues except TPR	70%	0.33%	0.23%	
d. CON adjustments-				
-Opening of Holy Cross Germantown Hospital			0.41%	
Net increase before adjustments			3.68%	
e. Other adjustments-				
-Uncompensated care increase			0.38%	
-Set aside for unknown adjustments			0.50%	
-Reverse prior year's shared savings reduction			0.20%	
-Positive incentives			0.00%	
-Net impact of one-time adjustments				
Net increase			4.76%	
III. Components of revenue change-decreases				
a. Uncompensated care reduction			-0.80%	
b. MHIP adjustment			-0.38%	
c. Shared savings/negative scaling adjustments			-0.20%	
d. Net impact of one-time adjustments				
Net decrease			-1.18%	
Total revenue growth			3.59%	
Total revenue growth per capita			2.87%	

- The table illustrates an approach for determining the system-wide update that can be provided within the model. Figures are for illustration purposes only, and do not represent policy recommendations of HSCRC staff.

Other Considerations

- Impact on potential to generate Medicare savings
- Need to project both calendar and fiscal year impact since All-Payer Limit test is based on calendar years
- Global contracts will need a December 31 target and “hard stop” to match calendar year requirements

Annual Update Factor for Categories of Revenues

Three Categories of Hospital Revenues Require Updates

Two categories under All Payer-Model and/or Medicare rate setting waiver:

1. Hospitals/revenues under global budgets, including Global Budget Revenue (GBR) and Total Patient Revenue (TPR) ;
2. Hospital revenues under Medicare rate setting waiver not included under global budgets , including hospitals remaining on Charge-Per-Episode (CPE)/Charge-Per-Case (CPC) agreements and hospital revenues excluded from a global budget, such as revenues for non-residents;

One category not under Medicare rate setting waiver

3. Hospital revenues where HSCRC sets rates that are paid by non-governmental payers and purchasers, but where CMMI has not waived Medicare's rate setting authority to Maryland (psychiatric hospitals and Mount Washington Pediatric Hospital)

HSCRC Revenue Categories– Approach to Update

	#1	#2
	TPR/GBR ***Global***	**Charge Per Episode** **Other Non-Global**
Key Components of Methodology:		
1. Revenue Base	**Fixed**	**Variable**
2. Volume Changes **Residents**	**0%**	**50%** **+ Overall Governor limits hospitals growth to ~ 1% net** **N/A**
Population Adjust.	**Yes**	
3. Update factor Approach	**Inflation** **+ or - policy**	**Inflation minus productivity and policy adj.**

#3 Revenues not under Medicare waiver—Inflation minus productivity for hospital type

Other Short Term Adjustments

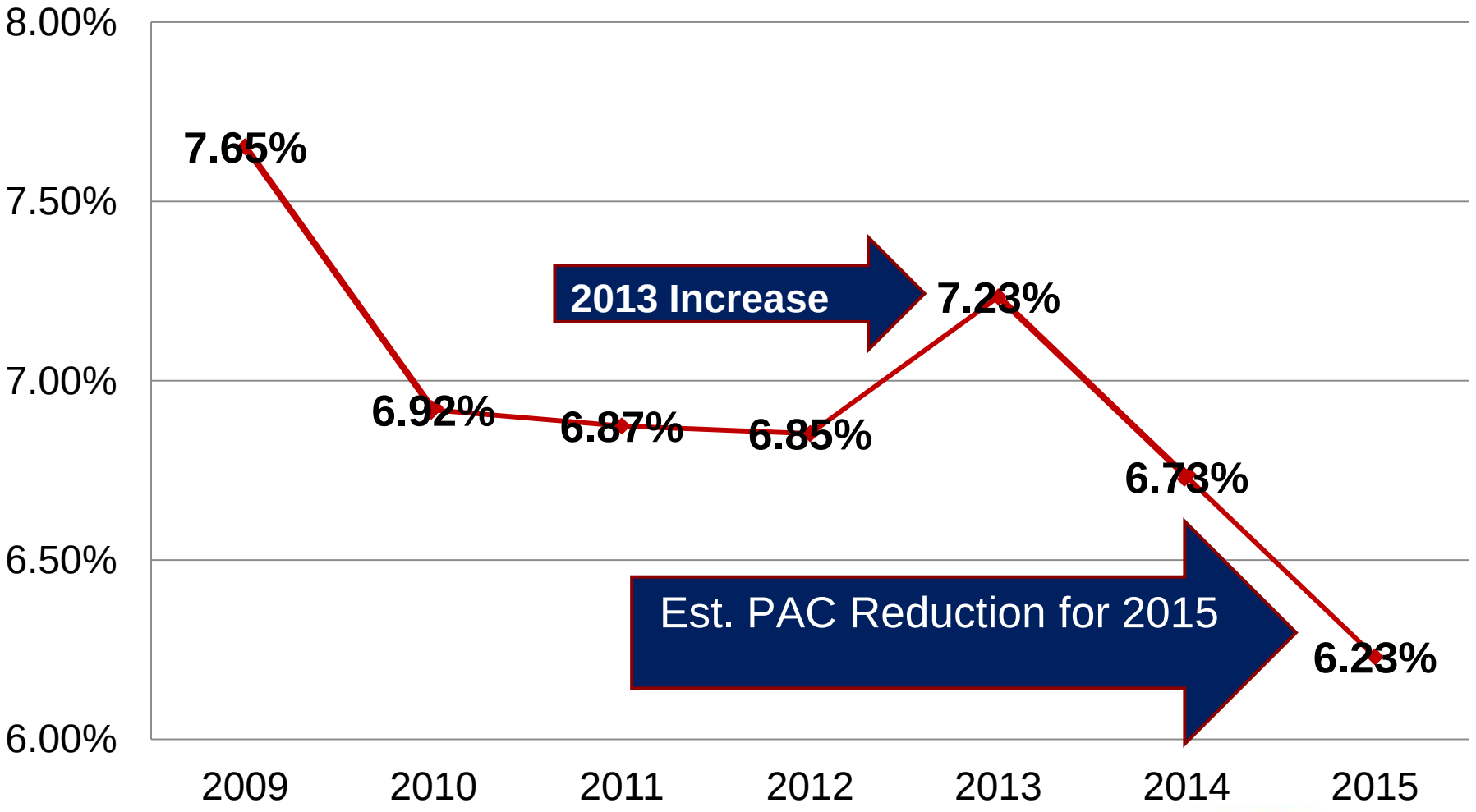
Other Short Term Issues

- Uncompensated care and ACA expansion (Medicaid and Exchange)
- Holy Cross Germantown Hospital
- Population and demographic adjustments
- Academic Medical Centers

Uncompensated Care (UCC)

- Separate report will be provided relative to UCC
- Need to fund .38% increase that occurred in FY 2013 relative to the 6.86% that was in rates from FY 2012
- Determine the level of decrease in uncompensated care to recognize relative to ACA based enrollment in January 2014
  - Focus on new full benefit Medicaid enrollees previously limited benefit (PAC) enrollees who will contribute to a sizable UCC reduction
  - Hospitals to validate the data due to significance of estimated impact on UCC provision
  - Need for monitoring and ongoing evaluation of non-PAC Medicaid enrollment and changes in payer mix reported in monthly case mix detail, to determine additional adjustments needed to UCC

Uncompensated Care as a Percent of Gross Patient Revenue with Preliminary Estimated Reduction for PAC Enrollment Fiscal Years 2009 –Proj. 2014 and 2015



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Holy Cross Germantown Hospital (HCGH)

- New hospital opening in fall 2014
- Estimated FY 2015 revenues $80 million
- Hospital's volume and related revenues will be allowed at100% variable until HCGH reaches mature revenue projections or a reasonable amount of time, then it will be converted to 50% variable or placed on a global agreement
- Volumes coming from other hospitals at 50% variable, therefore 50% of HCGH growth not funded with market share adjustment
- HSCRC staff recommends reserving 70% of growth from statewide resources against balanced update

Academic Medical Centers (AMCs)

- AMCs have a special role with referrals and highly specialized tertiary and quaternary care
  - Highly specialized cases, referred to as“Categorical” cases, were historically excluded from the Charge per Case constraint
  - Transfers in have been growing at UMMC. Growth could change as a result of incentives of the new Model.
- Recommendations
  - Include Categorical cases in Global budget at projected amounts and rebase annually
  - Adjust global budgets of referring hospital and AMC based on changing patterns at predetermined fixed amounts
  - Monitor for the need to rebase transfers
  - Begin detailed development process

Future Payment Models Work Group Activity

May

- Uncompensated care policy recommendations
- Evaluation of demographic adjustment
- Balanced update and short term adjustments recommendations

June

- Global contract review and recommended changes
- Guardrails for model performance

June and beyond

- Market share
- Capital policies considerations
- Future direction of payment models/with Physician Engagement and Alignment workgroup
- Future role and work plan for work group