All Payer Hospital System Modernization
Payment Models Work Group / Performance Measurement Work Group

Meeting Agenda

March 2, 2015
Payment Models Work Group 9:30 am to 12:30 pm
Performance Measurement Work Group 11:00 am to 1:30 pm
Health Services Cost Review Commission, Conference Room 100
4160 Patterson Avenue, Baltimore, MD 21215

9:30	1.Introductions and Meeting Overview Donna Kinzer, Executive Director
9:40	2.FY 2016 Update Factor David Romans, Director
10:05	3.Market Shift Update Sule Calikoglu, Deputy Director
10:30	4.Preliminary Capital Policy Principles Jerry Schmith, Deputy Director

10:50 Break to allow the Performance Measurement Work Group Members to join the meeting or connect to the webinar

10:55	Welcome Performance Measurement Work Group Members Sule Calikoglu, Deputy Director
11:00	5.Readmission Scaling and Aggregate Revenue at Risk for Quality Programs Sule Calikoglu, Deputy Director
12:25	6.Readmission Statewide Target and Performance Measurement Sule Calikoglu, Deputy Director
12:55	7.QBR Measures and Scaling Alyson Schuster, Associate Director
1:30	Adjourn

ALL MEETING MATERIALS ARE AVAILABLE AT THE MARYLAND ALL-PAYER HOSPITAL SYSTEM MODERNIZATION TAB AT HSCRC.MARYLAND.GOV

Balanced Update Model

Maximum allowed growth

Maximum revenue growth allowance		A	3.58% per capita
Population growth		B	0.71%
Maximum revenue growth allowance ((1+A)*(1+B)		C	4.32%

Components of revenue change-increases

	Proportion of Revenues	Allowance	Weighted Allowance
Adjustment for inflation/policy adjustments			
-Global budget revenues			2.40%
			2.40%
Adjustment for volume			
-Population Growth			
-Categoricals			
-Transfers ($1 M to $5 impact)			
-Market shift adjustments ($4 M estimated impact)			
			0.57%
Infrastructure allowance provided			
-Global budget revenues except TPR	80%		
CON adjustments-			
-Opening of Holy Cross Germantown Hospital			0.23%
Net increase before adjustments			3.20%
Other adjustments (positive and negative)			
-Set aside for unknown adjustments			0.50%
-Reverse prior year's shared savings reduction			0.40%
-Positive Incentives (Readmissions and Other Quality)			0.15%
-Shared savings/negative scaling adjustments			-0.60%
Net increase attributable to hospitals			3.65%
Per Capita			3.06%
Components of revenue changes-net decreases not hospital generated			
-Uncompensated care reduction, net of differential			-0.77%
-Utilization Impact of Medicaid Expansion			**TBD**
-MHIP adjustment			-0.27%
-Other assessment changes			
Net decreases			-1.04%
Net revenue growth			2.61%
Per capita revenue growth			2.03%

Market Shift Adjustment Update

Payment Work Group

March 2nd, 2015

HSCRC
Health Services Cost Review Commission

Market Shift Adjustments (MSAs) Draft Principles--Purpose

- Purpose of MSAs is to provide a basis for increasing or decreasing the approved regulated revenue of hospitals operating under global revenue arrangements to ensure that revenue is appropriately reallocated when shifts in patient volumes occur between hospitals.
  - Support objectives of Triple Aim
  - Fundamentally different than a volume adjustment
  - Independent of general volume increases
  - Focus is on "shifts" rather than share

Market Shift Adjustments (MSAs) Draft Principles--Application

- Applied as part of global budget mechanism.
- Only one of many mechanisms.
- Examples of other situations where global budgets might be adjusted for changes in volumes include;
  - Opening of a new hospital,
  - Increases in transfers of patients,
  - Discontinuation of services, changes in levels of services,
  - Shifts to unregulated settings,
  - Shifts from/to out of state hospitals or
  - Actions that undermine the Triple Aim.

Market Shift Adjustments (MSAs) Draft Principles--Features

- Specified population
  - Staff is using a virtual service area based on zip codes for urban and suburban hospitals. More defined service area used for rural areas.
- Defined set of covered services
- Budget neutral to maximum extent practicable
- Generally excludes reductions in potentially avoidable utilization

Market Shift Adjustment Work in Progress

- A work in progress
  FY2015 Q1 and preliminary Q2 data released on Feb 27th
  - Data cleanup (possible resubmissions)
  - Understanding the service line trends
- Outpatient weights
  - Weight methodology
  - Oncology, drugs and radiation therapy methodology
- Turning to define the calculation of the revenue transfer
  - Intend to utilize 50% variable cost in routine calculations
- Approach to payer/MSO driven market shifts

Implementation Timelines

- Measurement Period for FY2016 GBRs (July 2015)
  - July-Dec 2014 Discharges -
  - July-Dec 2013 Discharges
- Measurement Period for FY2017 GBRs (July 2016)
  - Jan-Dec 2015 Discharges -
  - Jan-Dec 2014 Discharges

See Excel Sheet:

3b- Market Shift Analysis FY15 Q1 –Preliminary Q2

DRAFT

Notes Regarding HSCRC Role in CON Review Process and Adjustments for Capital

I. Law outlines role and coordination with MHCC
II. Two types of request
    a. The pledge (no additional revenue)
    b. Regular CON review
III. Global budget required to docket CON
IV. Pre docketing review questions
V. Staff frequently meets with MHCC staff and applicant evaluates underlying volume projections
    a. Focus on any growth or shift assumptions, and implications for duplication
    b. Incremental revenues
    c. Incremental global budget requirements requested
    d. Assumptions regarding cost and financing
    e. Focus on potentially avoidable utilization
VI. For CONs with a revenue increase
    a. Applicant needs to file a rate application unless they can prove feasibility without it
    b. Application review approach needs to be updated--old method of review needs updating
    c. Once approved, revenue is earmarked for removal from statewide revenue availability under new all payer model

Preliminary Thoughts Regarding for Major Capital Projects and Rate Adjustments

Context:

Prior to the expansion of global budget models under the All-Payer Model, major capital projects were funded in part through increased marginal revenue from expected volume increases. Global budget hospitals operate under a fixed annual revenue cap. While the variable cost associated with volume increases due to demographic changes and market shift recognized under the global budget methodology, marginal revenue from expected volume increases is no longer a viable source of funding for major capital projects. Therefore, the HSCRC must create a policy to address major capital projects that does not rely on volume expansion for funding. Hospital rates include provisions for capital costs.

Guiding Principles

- Promote the advancement of the Triple Aim: enhance patient care, improve health, and lower total costs
- Supports the goals and requirements of the All-Payer Model
- Capital should not be treated as a pass thru, but an integral element of per capita costs. Like any other cost, there are trade offs among investments. The additional funds that should be provided for major capital projects should be limited and considered in the context of overall per capita costs.
- Rate increases should not pay for growth and replacement of excess capacity or capacity for avoidable utilization in the Maryland health care system
- Policies should support hospitals in reducing excess capacity in the Maryland health care system while maintaining or improving quality and access to care
- The approach should provide hospitals and health systems with fair and reasonable financing opportunities for major capital projects, while recognizing the responsibility of hospitals and systems to plan for major replacements,
- Recognize the responsibility of hospitals and systems to attain additional funding sources
- Integrate with State CON approval process

Matters to Address

- Define “Major Capital Projects”
- Develop process to assess and adjust hospital global budgets to finance major capital projects
    - Establish method to assess efficiency and charge reasonableness within the context of a population-based health payment system
    - Determine the extent of rate variation that should be considered appropriate to finance major replacements
    - Develop process to consider avoidable utilization in the system
    - Consider including hospital quality performance an evaluation criteria
    - Work with MHCC to develop new policies and processes for CONs
- Address already submitted CON applications in a timely manner

See Excel Sheet:

5. Quality Programs Scaling and Aggregate Revenue at Risk v2

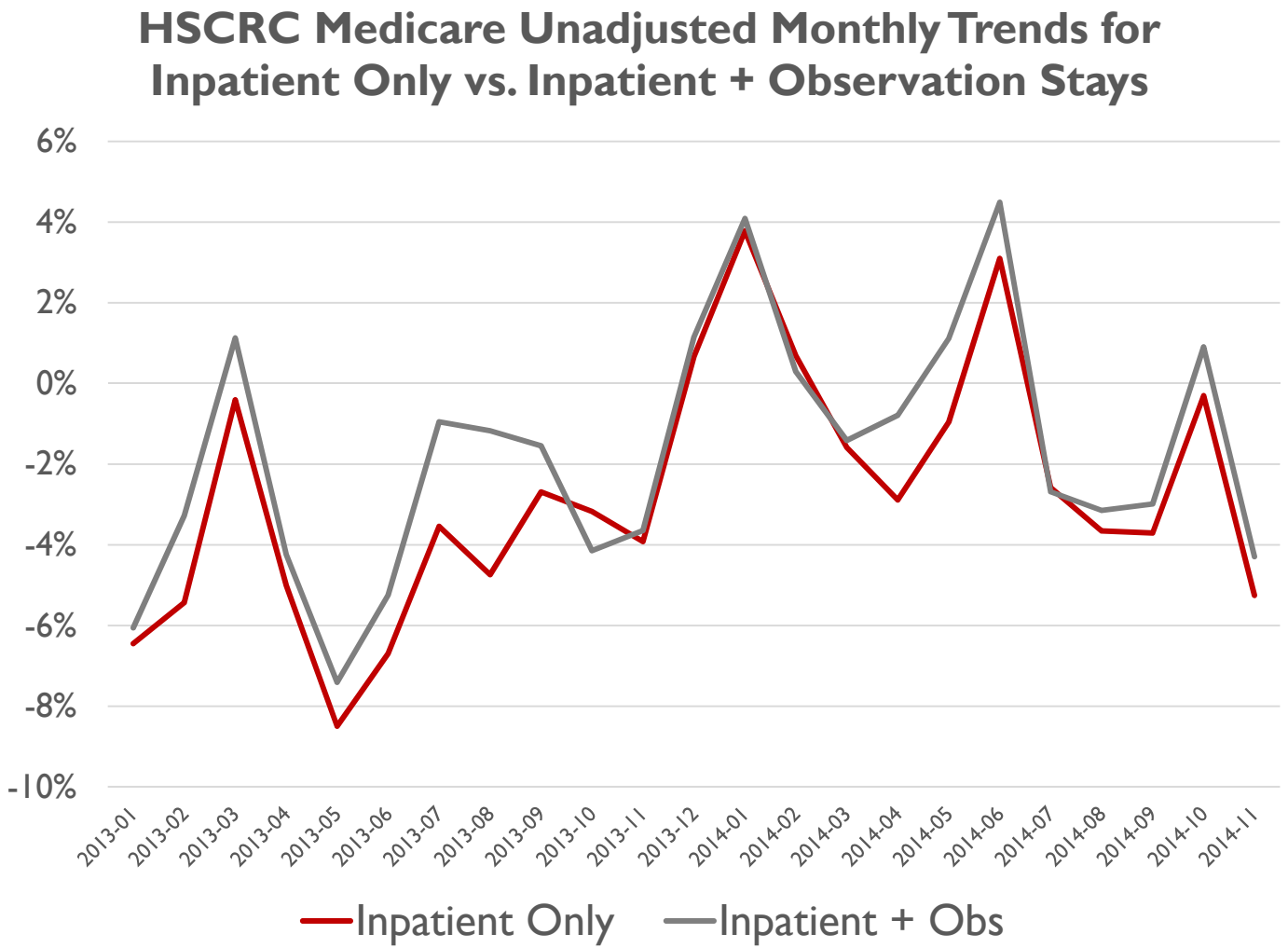
Readmissions State Target and Performance Measurement

Performance Measurement 3/2/2015

MD vs National Readmission Trends

	Nation		MD		MD- US Difference
	% Readmissions	Percent Change in Rate of Readmits	% Readmissions	Percent Change in Rate of Readmits	% Readmits
CY2011	16.68%		18.60%		11.51%
CY2012	16.16%	-3.10%	17.82%	-4.20%	10.24%
CY2013	15.78%	-2.34%	17.08%	-4.14%	8.21%
CY2014*	15.73%	-0.35%	16.94%	-0.80%	7.72%
CY 2014 Target			16.76%	-1.86%	6.57%

MD Trend with Observation Cases



CMMI Medicare Readmission Target

	National		MD		MD- US Difference
	% Readmissions	Percent Change in Rate of Readmits	% Readmissions	Percent Change in Rate of Readmits	% Readmits
CY2011	16.68%		18.60%		
CY2012	16.16%	-3.10%	17.82%	-4.20%	10.2%
CY2013	15.78%	-2.34%	17.08%	-4.14%	8.2%
CY2014*	15.73%	-0.35%	16.94%	-0.80%	7.7%
CY2015	15.52%	-1.34%	16.28%	-3.90%	4.9%
CY2016	15.31%	-1.34%	15.81%	-2.89%	3.3%
CY2017	15.10%	-1.34%	15.35%	-2.91%	1.6%
CY2018	14.90%	-1.34%	14.90%	-2.94%	0.0%

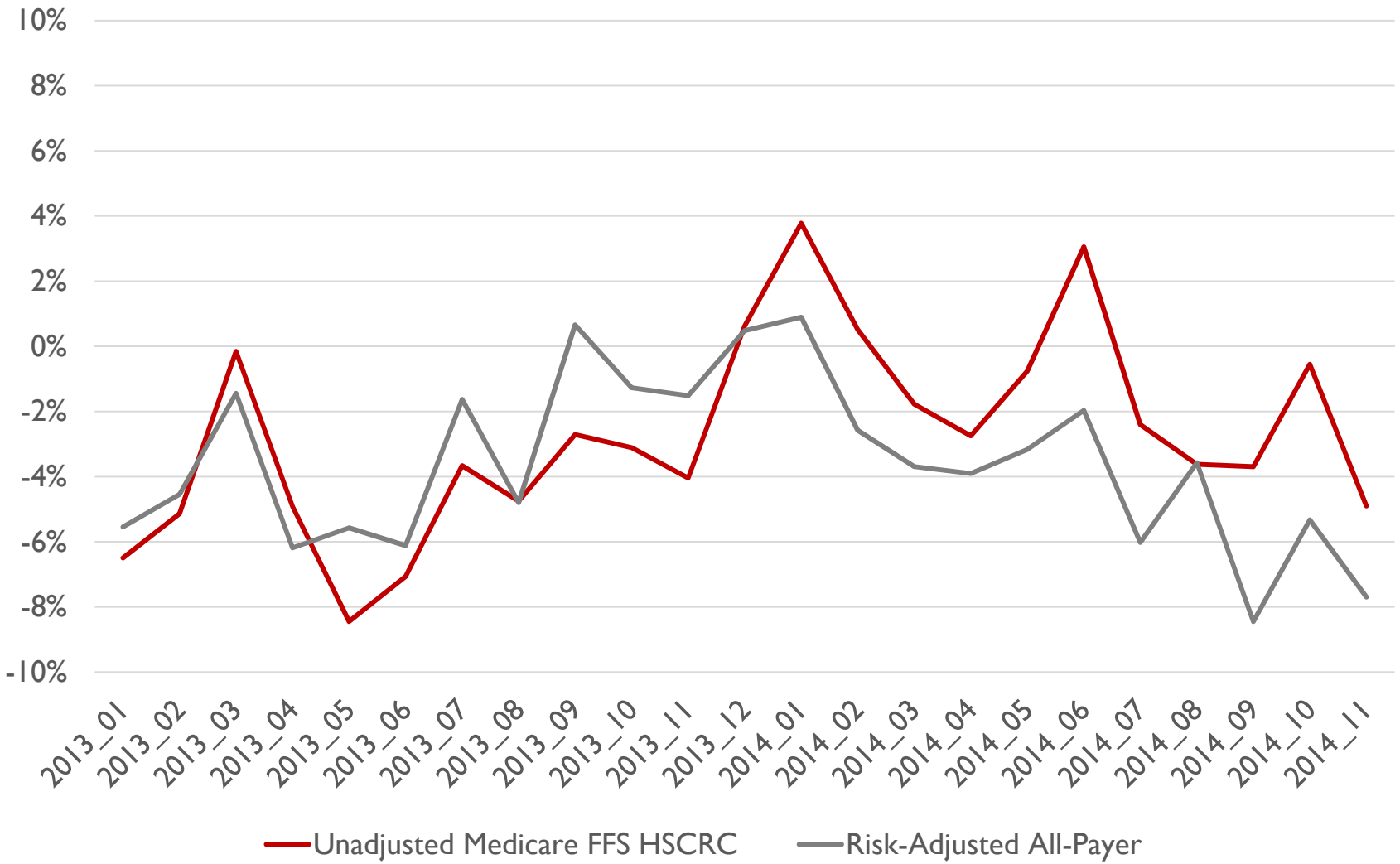
Adjustments for HSCRC Data: Medicare Unadjusted vs. All-Payer Case-mix Adjusted

	Medicare FFS Unadjusted		Medicare FFS Case-mix Adjusted		All Payer Unadjusted		All Payer Case-mix Adjusted		
	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	% Readmits	Percent Change in Rate of Readmits	Medicare-All Payer
2012	18.65%		13.86%		12.85%		12.94%		
2013	17.86%	-4.21%	13.25%	-4.42%	12.51%	-2.63%	12.52%	-3.21%	-1.0%
2014	17.72%	-0.80%	13.07%	-1.37%	12.05%	-3.70%	12.05%	-3.76%	3.0%
2012-2014		-5.0%		-5.7%		-6.2%		-6.8%	1.9%

HSCRC Medicare and All-Payer Target

CMMI Medicare Unadjusted Targets		% Readmission Rate Reduction
CY14 Actual	A	-0.80%
CY15	B	-3.90%
Cumulative	C=(1+A)*(1+B)-1	**-4.67%**
HSCRC Medicare Casemix Adjusted Target		
CY14 Actual	D	-1.37%
CY15	E = B-0.57%	-4.47%
Cumulative	F = (1+D)*(1+E)-1	**-5.78%**
HSCRC All Payer Casemix Adjusted Target		
CY14 Actual	G	-3.76%
CY15	H = B-1.91%	-5.77%
Cumulative	**I =** (1+G)*(1+H)-1	**-9.31%**

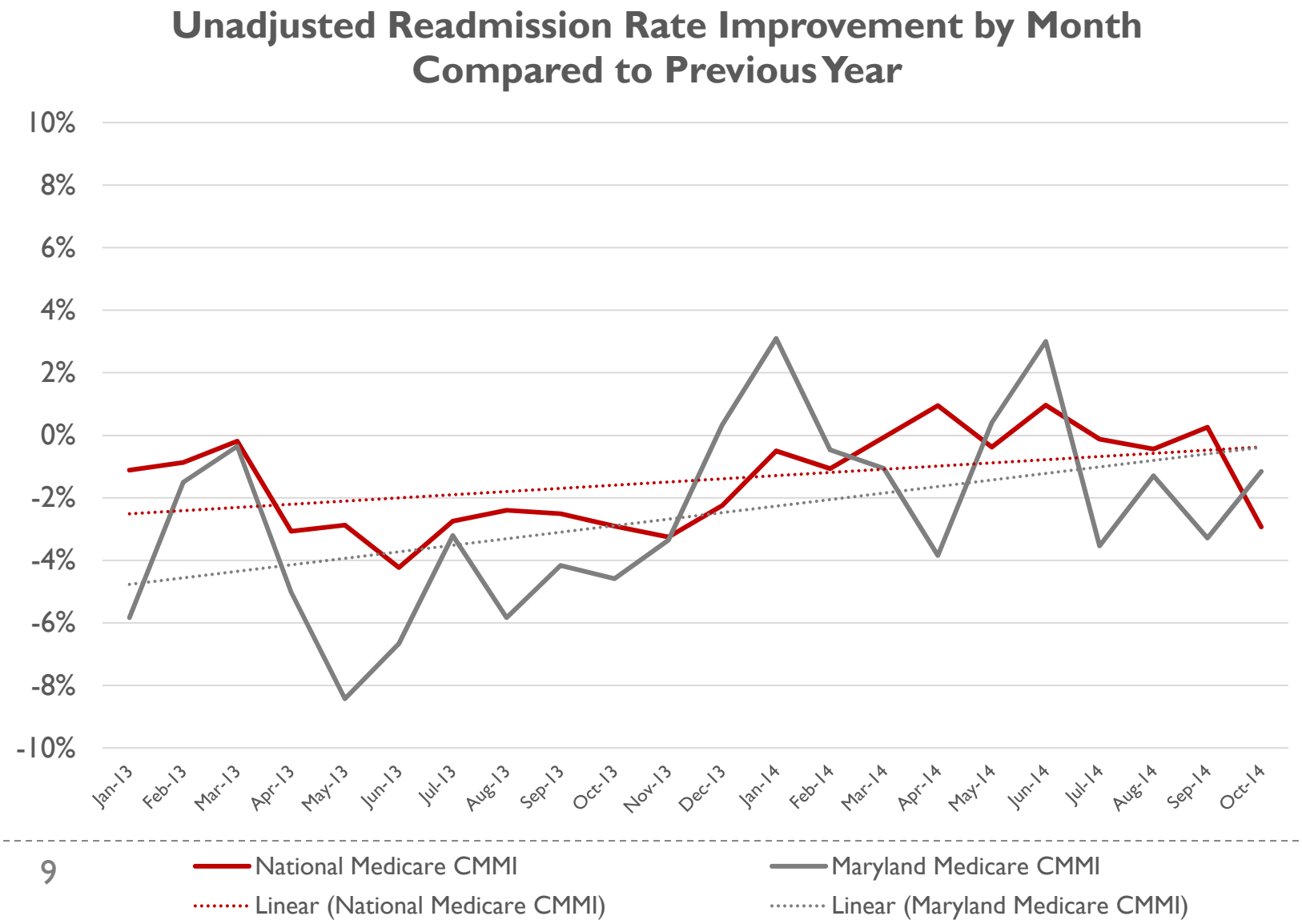
HSCRC MEDICARE AND ALL PAYER MONTLY TRENDS (ANNUAL CHANGE)



National Readmission Trend in CY2015?

	Lowest Improvement	2 Year Average	3 Year Average	Highest Improvement
National Trend CY12-14	-0.35%	-1.34%	-1.93%	-3.10%
CMMI Medicare Unadjusted Targets				
CY14 Actual	-0.8%	-0.8%	-0.8%	-0.8%
CY15 Target	-2.9%	-3.9%	-4.5%	-5.6%
Cumulative	**-3.71%**	**-4.67%**	**-5.24%**	**-6.36%**
HSCRC Medicare Casemix Adjusted Target				
CY14 Actual	-1.4%	-1.4%	-1.4%	-1.4%
CY2015	-3.5%	-4.5%	-5.0%	-6.2%
Cumulative	**-4.83%**	**-5.78%**	**-6.34%**	**-7.46%**
HSCRC All Payer Casemix Adjusted Target				
CY14 Actual	-3.8%	-3.8%	-3.8%	-3.8%
CY2015	-4.8%	-5.8%	-6.3%	-7.5%
Cumulative	**-8.38%**	**-9.31%**	**-9.86%**	**-10.96%**

CMMI NATIONAL vs. MD MEDICARE REDMISSION RATE CHANGE

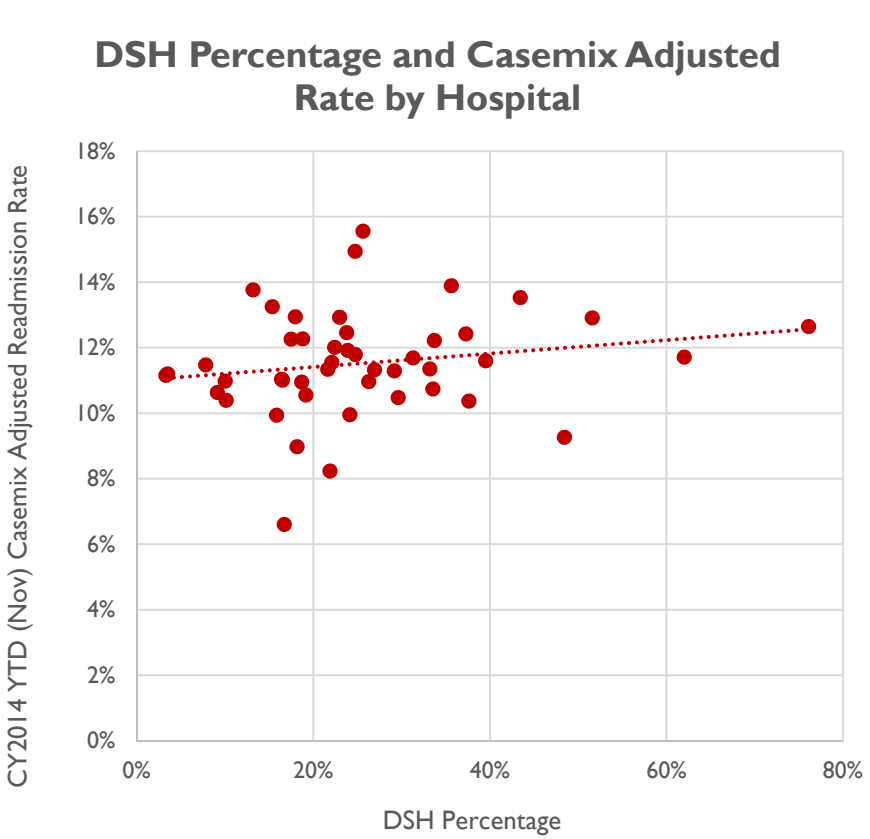


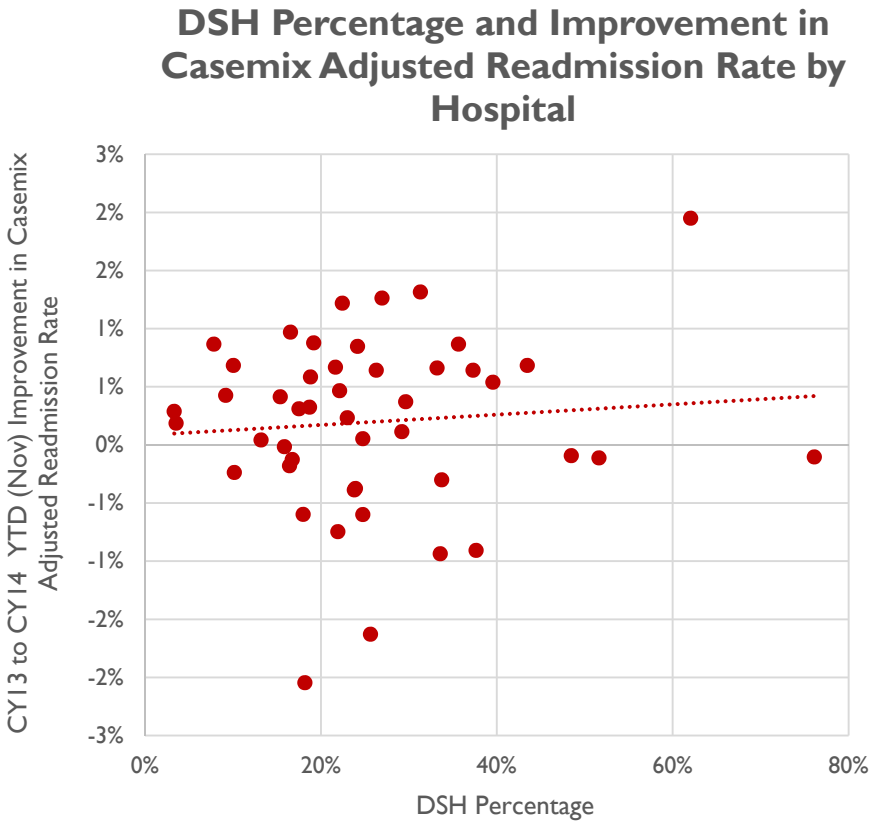
DENOMINATOR IMPACT CASEMIX ADJUSTMENT

Base Period						Performance Period					
ACTUAL TOTAL ADMITS	ACTUAL PRIMARY ADMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS / ACTUAL PRIMARY ADMITS	RISK-ADJUSTED READMISSION RATE	ACTUAL TOTAL ADMITS	ACTUAL PRIMARY ADMITS	ACTUAL READMITS	ACTUAL READMITS / ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS	RISK-ADJUSTED READMISSION RATE
1,000	861	139	13.90%	16.14%	13.66%	855	736	119	13.92%	16.17%	13.44%
					Absolute Difference	-145	-125	-20	0.02%	0.02%	-0.22%
					Percent Difference	-14.50%	-14.52%	-14.39%	0.13%	0.15%	-1.62%

	Base Period						Performance Period					
APR DRGs (BY SOI)	ACTUAL TOTAL ADMITS	EXPECTED READMITS / ADMITS	EXPECTED READMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS	ACTUAL TOTAL ADMITS	EXPECTED READMITS/ ADMITS	EXPECTED READMITS	ACTUAL READMITS	ACTUAL READMITS/ ACTUAL TOTAL ADMITS	ACTUAL READMITS/ ACTUAL PRIMARY ADMITS
APR DRG 1	160	17.00%	27.20	27	16.88%	20.30%	150	17.00%	25.50	25	16.67%	20.00%
APR DRG 2	155	12.00%	18.60	12	7.74%	8.39%	110	12.00%	13.20	13	11.82%	13.40%
APR DRG 3	260	0.00%	0.00	0	0.00%	0.00%	220	0.00%	0.00	1	0.45%	0.46%
APR DRG 4	425	22.50%	95.63	100	23.53%	30.77%	375	22.50%	84.38	80	21.33%	27.12%
TOTALS	**1,000**	**14.14%**	**141.43**	**139**	**13.90%**	**16.14%**	**855**	**14.39%**	**123.08**	**119**	**13.92%**	**16.17%**

Socio-economic Adjustment





Hold Harmless/Reduce Penalties for Performance

- Hospitals who prove:
  - Denominator changes impacting casemix adjusted rates negatively
  - High performance on attainment
  - Performed better on Medicare risk adjusted rates

Overview of Maryland's QBR FY2017 Measures and Reporting

Performance Measurement 3/2/2015

Guiding Principles

- Measurement used for performance linked with payment must include all patients regardless of payer.
- Measurement must be fair to hospitals and allow the ability to track progress.
- **Measures and targets(benchmarks and thresholds) used should be consistent with those used by the CMS VBP program to the extent possible.**
- Emphasis on outcomes should increase going forward.
- The new Model contract requires participation in all Inpatient and Outpatient Quality Reporting requirements, and reporting to CMMI to maintain exemption from the VBP program.

Domain Weights

Measures	MD QBR Weights	CMS VBP Weights
Safety	35%	20%
Clinical Care	20%	30%
Process	5%	5%
Outcome	15%	25%
HCAHPS	45%	25%
Efficiency	NA	25%

FY2017 Measures

FY2017 Comparison of Measures between CMS VBP and Maryland QBR			
FY2017 List of Measures	Definitions of Measures	CMS VBP	MD QBR
Safety Measures			
PSI-90	Complication/patient safety for selected indicators (composite)	Yes	Yes
CLABSI	Central Line-Associated Blood Stream Infection	Yes	Yes
CAUTI	Catheter-Associated Urinary Tract Infection	Yes	Yes
SSI - Colon	Surgical Site Infection - Colon	Yes	Yes
SSI - Abdominal Hysterectomy	Surgical Site Infection - Abdominal Hysterectomy	Yes	Yes
C. Difficile	Clostridium difficile Infection	Yes	
MRSA bacteremia	Methicillin-Resistant Staphylococcus aureus Bacteremia	Yes	
Clinical Care - Outcomes Measures			
30-Day Mortality - AMI	Acute Myocardial Infarction (AMI) 30-day mortality rate	Yes	
30-Day Mortality - HF	Heart Failure (HF) 30-day mortality rate	Yes	
30-Day Mortality - PN	Pneumonia (PN) 30-day mortality rate	Yes	
All cause , inpatient Mortality	All Cause, 3M-Risk of Mortality (inpatient)		Yes
Clinical Care - Process Measures			
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	Yes	
IMM-2	Influenza Immunization	Yes	Yes
PC-01	Elective Delivery Prior to 39 Completed Weeks Gestation	Yes	
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems	Yes	Yes

Issues – Safety Measures

CLABSI

- Data from Hospital Compare is incomplete (10 hospitals not reporting)
- MHCC also receives CLABSI data from NHSN, however for CY2013 the data is slightly different than the CMS CY2013 data.
- **Recommendation:** Since majority of hospitals have data on Hospital Compare, we will use CMS data for both FY2016 and FY2017. Hospitals with missing data will be contacted to obtain the data submitted to NHSN or MHCC data will be used to supplement.

Issues – Safety Measures

CAUTI, SSI-colon, & SSI-abdominal hysterectomy

- Because data collection began CY2014, no base period CY2013 data available.
- MHCC can provide CY2014 data but data will not be available for thresholds/benchmarks until May 2015 at the earliest.
- **Recommendation:** Because very few hospitals have data on Hospital Compare, we will use MHCC for an additional year. However benchmarks and thresholds will be set based on FY2017 VBP (CY2013) so that hospitals have that information now, and can use internal data until base period data is available.

Issues – Clinical Care Process Measures

AMI-7a

- Not required by MHCC / HSCRC.
- No data collected by MD hospitals, so this measure cannot be included to the list of QBR measures.

PC-01

- Because data collection began CY2014, no base period CY2013 data available
- Delay in data so will not be included

IMM-2

- CMS data not posted yet for base period CY13,Q4 – CY14,Q1.

On-Going QBR Monitoring

- HSCRC will provide a calculation sheet for hospitals to calculate their own QBR scores.

- Data sources for the calculation sheet:
  - NHSN Safety Measures and HCAHPS – Hospitals can use internal data or data available on NHSN/Hospital compare.
  - Mortality and PSI-90 –Quarterly reports will be provided by HSCRC CY2015.