Uncompensated Care Policy
Year 2017

Payment Work Group
05/2/2016

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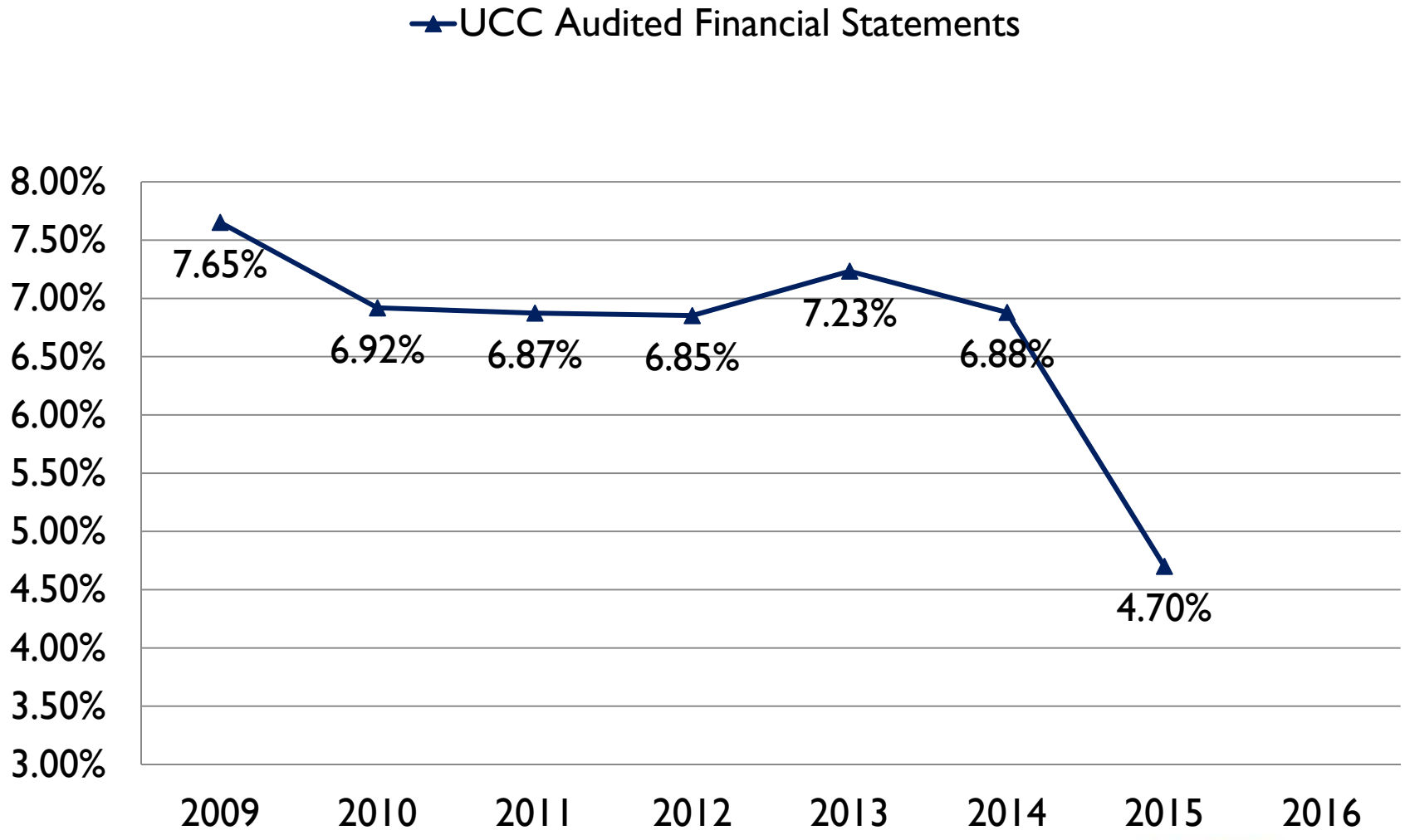
What is Uncompensated Care (UCC) in Maryland?

- 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.

Uncompensated Care as a Percent of Gross Patient Revenue Fiscal Years 2009- 2015



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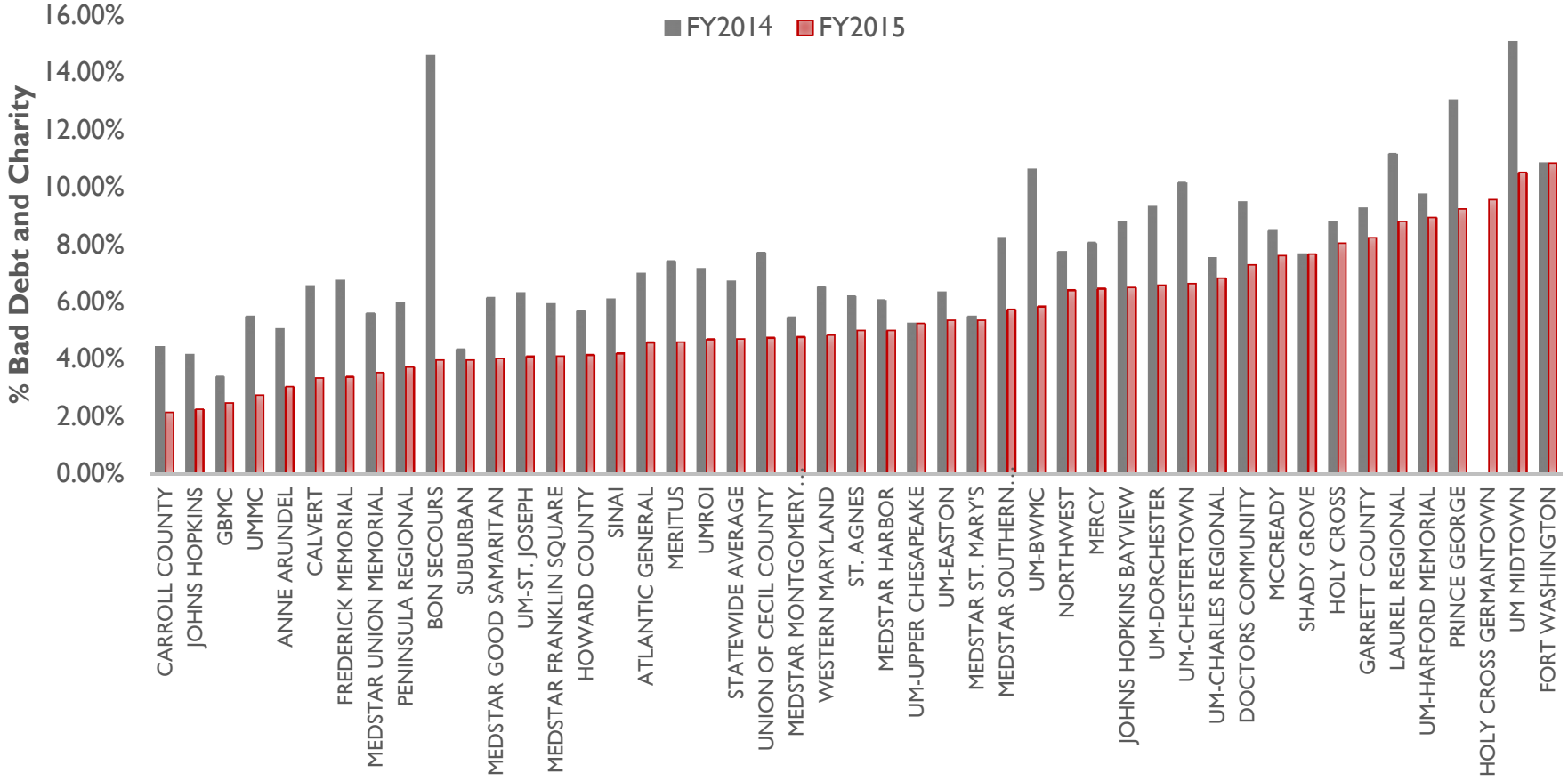
HSCRC UCC Adjustments for ACA

- Traditionally staff prospectively calculates the rate of uncompensated care at each regulated hospital by combining historical uncompensated care rates with predictions from a regression model over three years.
- The Commission adjusted this methodology to incorporate a prospective yet conservative adjustment for the expected impact of the ACA's Medicaid expansion on uncompensated care.
  - For FY 2015, results of the historic trend and regression model were adjusted down from 7.23% to 6.14% to capture the expected impact of the State extending full Medicaid benefits to people previously enrolled in the PAC program.
  - For FY 2016, results were adjusted further down to 5.25 % based on estimated impact for higher enrollment rates in Medicaid due to woodwork effect and expansion.

Reductions in UCC vary by Hospital in post-ACA period



Source: HSCRC Financial Audited Data

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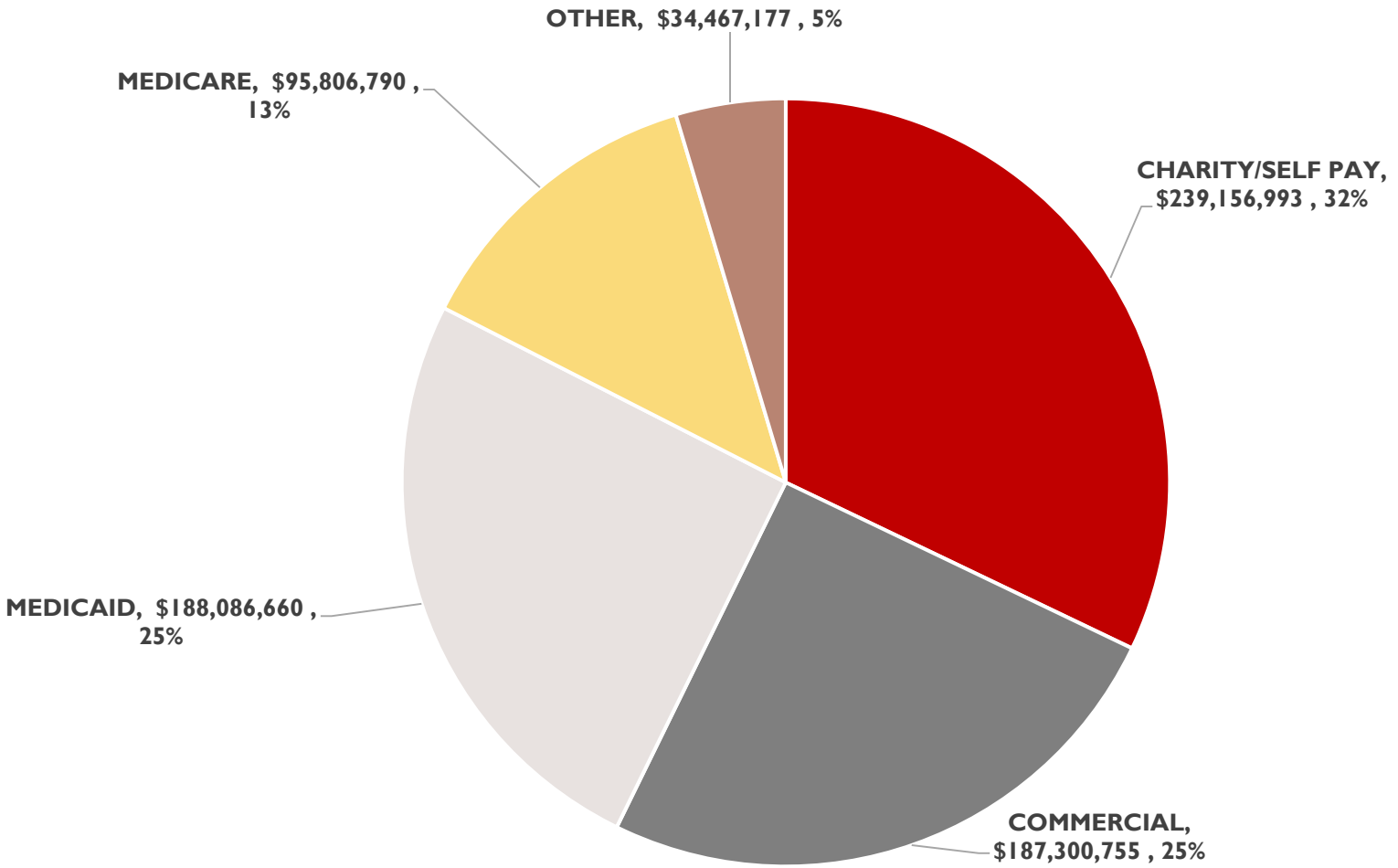
HSCRC started collecting account level write-off data

- 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

UCC Distribution by Payer: Self-Pay/Charity and Medicaid comprise more than half of UCC (Jan report results)



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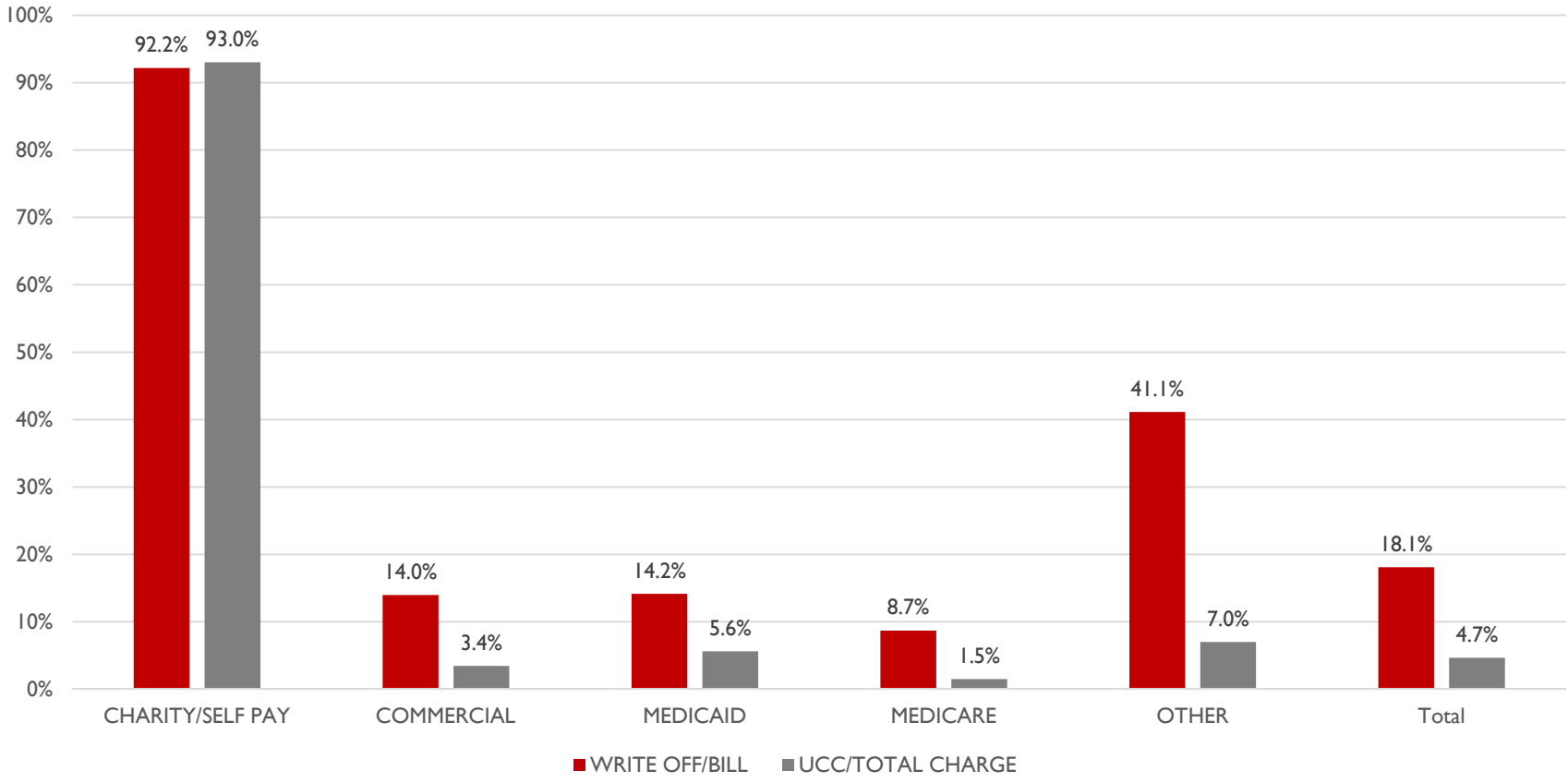
Payer Source is Still A Strong Predictor

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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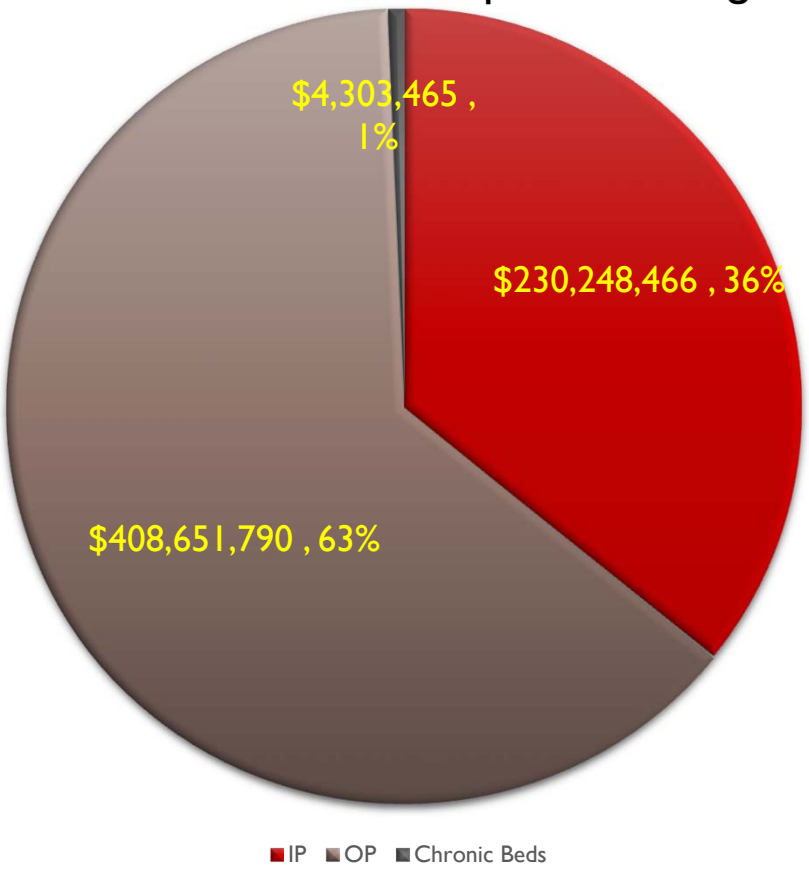
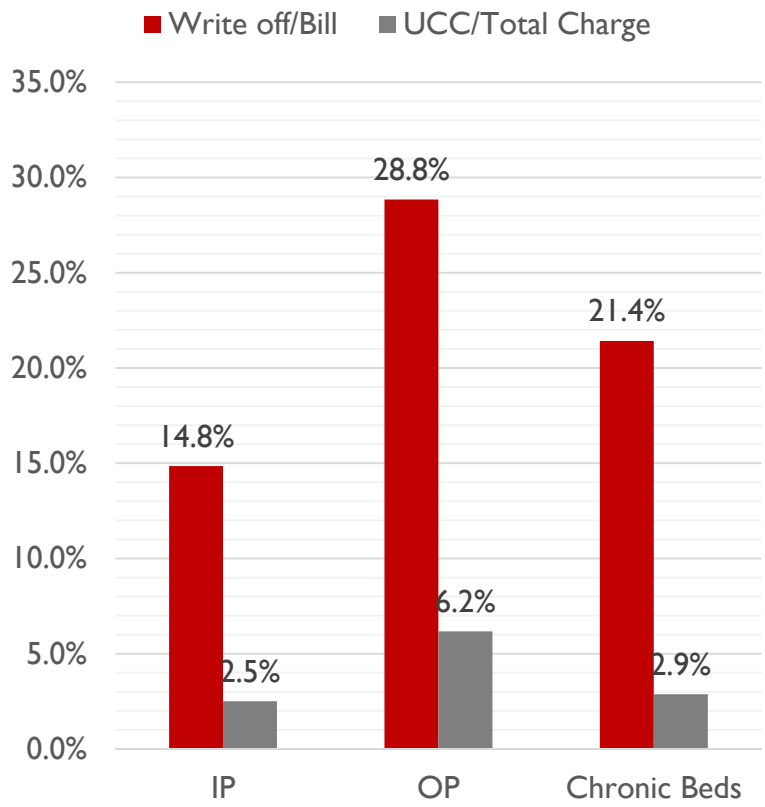
Outpatient services constitute the majority of UCC dollars.

- 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 (FY 15 experience)
- Statewide hospital level model
  - Payer source, type of service is still a strong predictor
- One year account level predictive regressions
  - Evaluate geographical statistics and other predictive models
    - Area Deprivation Index , undocumented immigrants etc.
- Continue to do 50/50 blend of FY15 audited UCC and predicted UCC
- Reduce statewide UCC provision in rates from 5.25 % to 4.70 % effective July 1, 2016

Performance-Based Payment Programs Update Shared Savings, Aggregate Revenue At Risk and Readmission Reduction Improvement

Payment Work Group

05/02/2016

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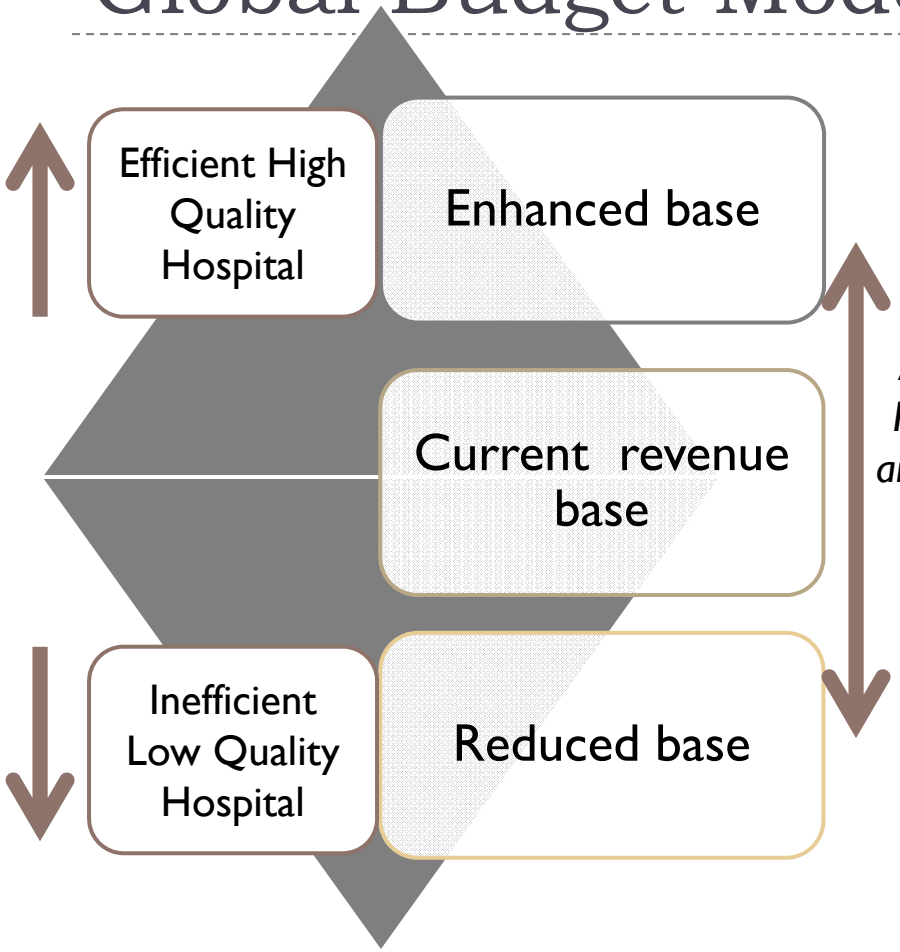
Global Budget Model

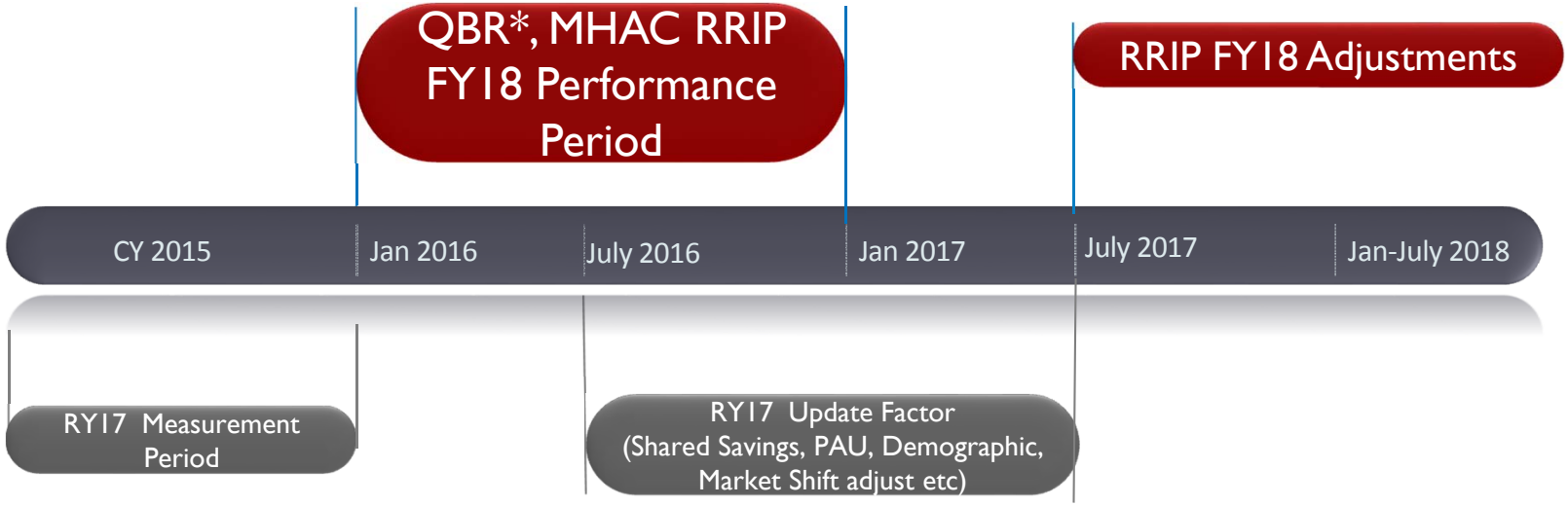


- The Global Budget Model: revenue budget with annual adjustments
  - *The initial revenue budget would be based on historical revenue*
  - *This budget could be enhanced or reduced based on hospital efficiency and utilization*
  - *The budget would be adjusted annually for changes in market share, population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

Maryland Performance-Based Payment Programs and Risk levels

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

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

FY 2017 Shared Savings Policy Draft Recommendation

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Background

- Started in FY 2014 in conjunction with the Admission Readmission Revenue (ARR) Program, which moved the inpatient payment system from average charge per case (CPC) to average charge per episode at the same hospital
- Ensure savings to the public from incentive programs and satisfy exemption requirements from Medicare Readmission Reduction Program
- All-Payer Model moved the payments to global budgets
  - FY2016 Policy remained the focus on readmissions because of concerns over progress in readmissions reductions
  - Aligned the readmission measure from same hospital readmissions to any hospital within the state
  - Capped the reductions to statewide average for hospitals that are above the 75th percaline on the percentage of Medicaid discharges for those over age 18

Proposed Changes to the Shared Savings Policy

- Align the shared savings with Potentially Avoidable Utilization
  - Add observation stays lasting 23 hour or longer to inpatient discharges
  - Add Prevention Quality Indicators (PQI)
  - Readmissions are counted at the receiving hospital

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".

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)

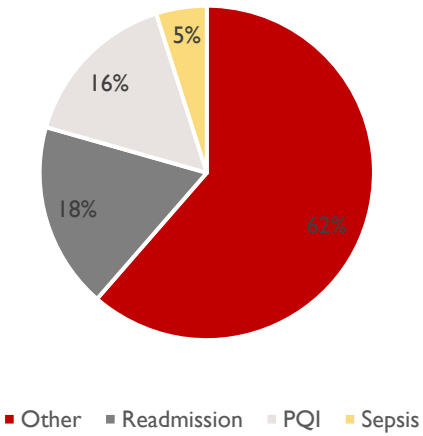
*Developed by Agency For Health Care Quality and Research
http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx
Also known as Ambulatory Care Sensitive Conditions, that is conditions for which good outpatient care can potentially prevent the hospitalization

Unplanned Admissions

- 54 % of all inpatient admissions are Medical admissions from Emergency Departments
- 61 % of all inpatient admissions are from ED

	From ED		No-ED Admissions		Total Number of Admissions	Total %
Admission Type	Number of Admissions	%	Number of Admissions	%		
Medical	**381,013**	54%	166,015	24%	547,028	78%
Surgical	48,300	7%	106,022	15%	154,322	22%
Grand Total	**429,313**	**61%**	**272,037**	**39%**	**701,350**	**100%**

PAU Distribution of Medical Cases from ED



PQI: AHRQ Prevention Quality Indicators (PQIs)*
Readmissions: 30 day all cause readmissions

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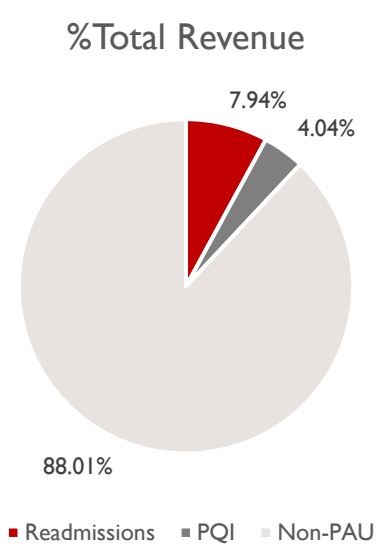
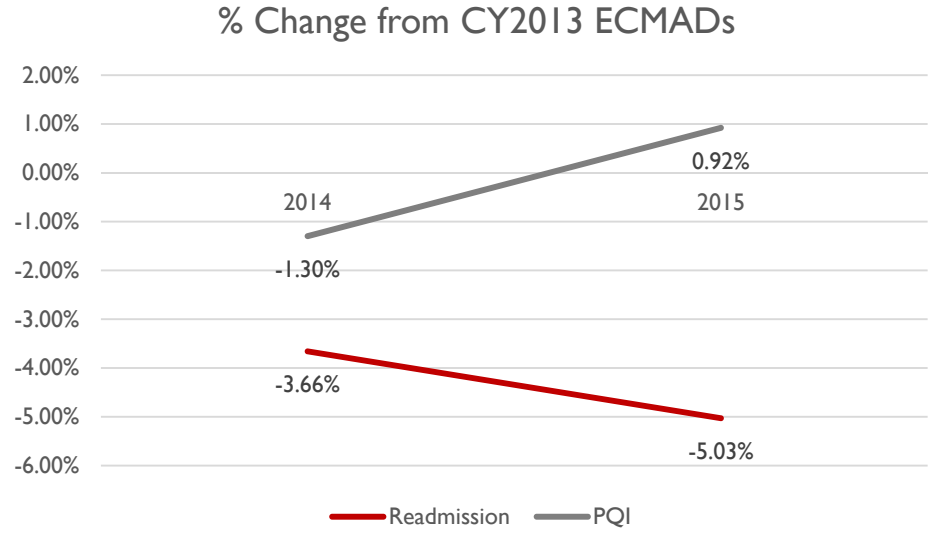
Incentivize Further PAU reductions

- Per capita savings for Medicare depends on further improvements in care coordination
- The readmission rates have declined in the last two years but PQIs have increased in CY2015





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FY 2017 Shared Savings Draft Recommendations

- Align the shared savings measure with the Potentially Avoidable Utilization definitions
- Set the value of the shared savings amount to 1.25 % of total permanent GBR revenue in the state
- Cap shared savings reduction to statewide average reduction for hospitals with higher socio-economic burden

DRAFT Recommendation for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018

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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***	Net Shared Savings***	PAU*	State Aggregate	Hospital Net
	A	B	C	D	E	F	G=Sum(A-D)	
Potential At Risk (Absolute Value)	3.00%	2.00%	1.00%	3.65%	2.00%		9.65%	
Maximum Hospital Penalty (% Inpatient Revenue)	-0.25%	-2.00%	-1.78%	-4.49%	-3.65%		-8.52%	-3.19%
Maximum Hospital Reward (% Inpatient Revenue)	1.00%	1.00%	1.00%	NA	NA	NA	3.00%	1.36%
Average Absolute Level Adjustment (% Inpatient Revenue)	**0.42%**	**0.65%**	**0.51%**	**2.64%**	**-1.66%**		**4.21%**	**1.35%**
Total Penalty	-$502,722	-$36,224,835	-$4,980,623	-$188,522,166	-$104,449,150		-$230,230,346	
Total Reward	$29,403,229	$8,358,316	$33,335,873	$0	$276,901	NA	$71,097,418	
Total Net Adjustments	**$28,900,507**	**-$27,866,519**	**$28,355,250**	**-$188,522,166**	**-$104,172,249**		**-$159,132,928**	
% Total GBR Revenue	**0.19%**	**-0.18%**	**0.19%**	**-1.25%**	**-0.69%**		**-1.05%**	

**All calculations are preliminary subject to the assessment of ICD-10 impact.*
***RRIP results are preliminary results as of December 2015 and do not reflect any potential protections that may be developed based on the approved RY 2017 recommendation.*
****QBR YTD results are preliminary estimates based on two quarters of new data due to data lag for measures from CMS. Staff will provide updated calculations for the final recommendation.*
*****Shared Savings are based on 1.25 % statewide reduction based on draft FY2017 recommendation.*

DRAFT Recommendations

- No change is recommended to FY 2017 levels

	Max Penalty	Max Reward
MHAC Below target	-3.0%	0.0%
MHAC Above Target	-1.0%	1.0%
RRIP	-2.0%	1.0%
QBR	-2.0%	1.0%

- Continue to set the maximum penalty guardrail at 3.5 percent of total hospital revenue
- The quality adjustments should be applied to inpatient revenue centers, similar to the approach used by CMS. The HSCRC staff can apply the adjustments to hospitals' medical surgical rates to concentrate the impact of this adjustment to inpatient revenues, consistent with federal policies.

Readmission Reduction Incentive Program Draft FY 2018 Policy

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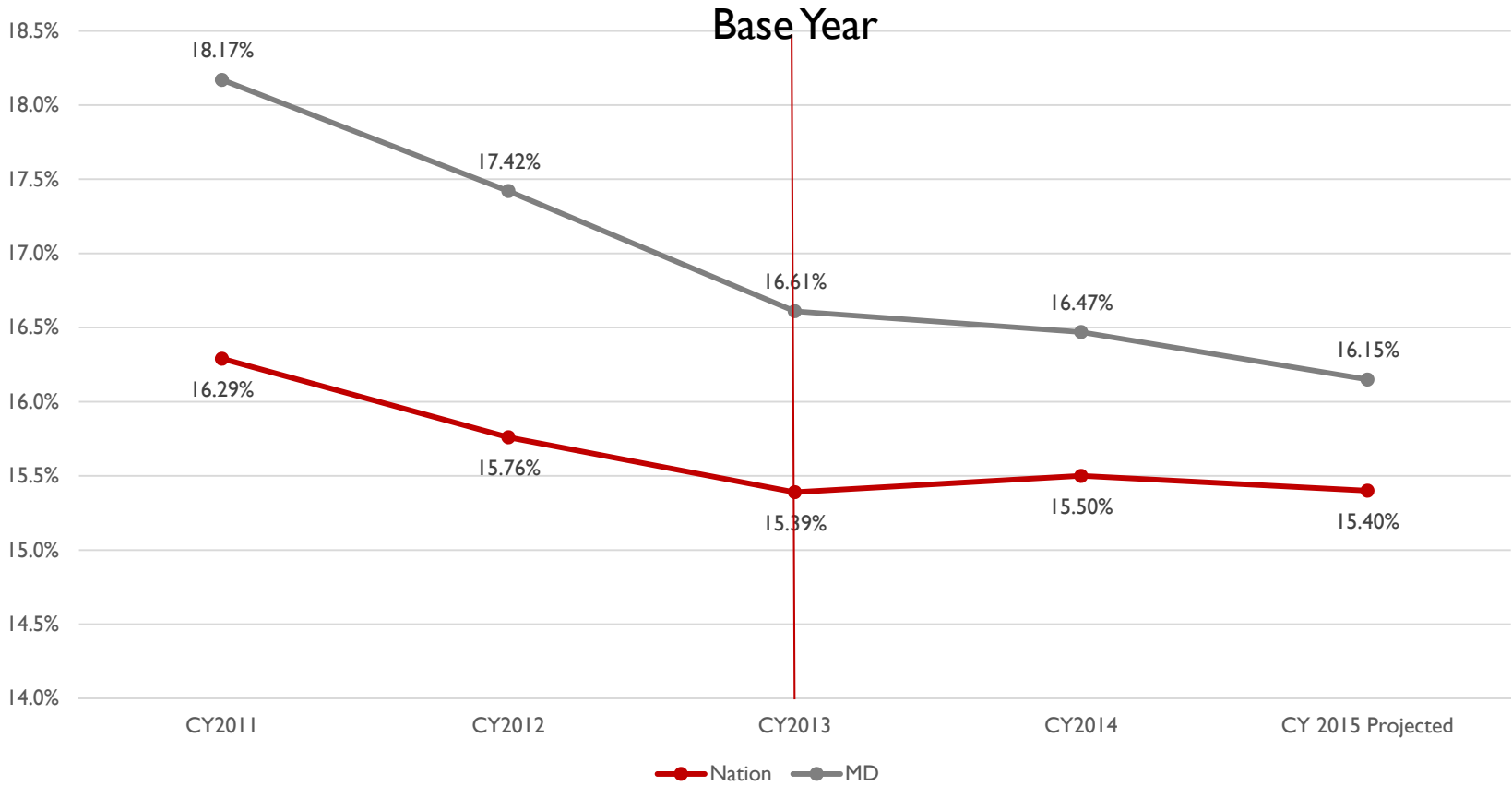
RRIP Background

- 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 4.87 % in CY 2015*



*HSCRC and CMMI staff identified an ICD-10 issue impacting readmission rates and are working on resolutions.

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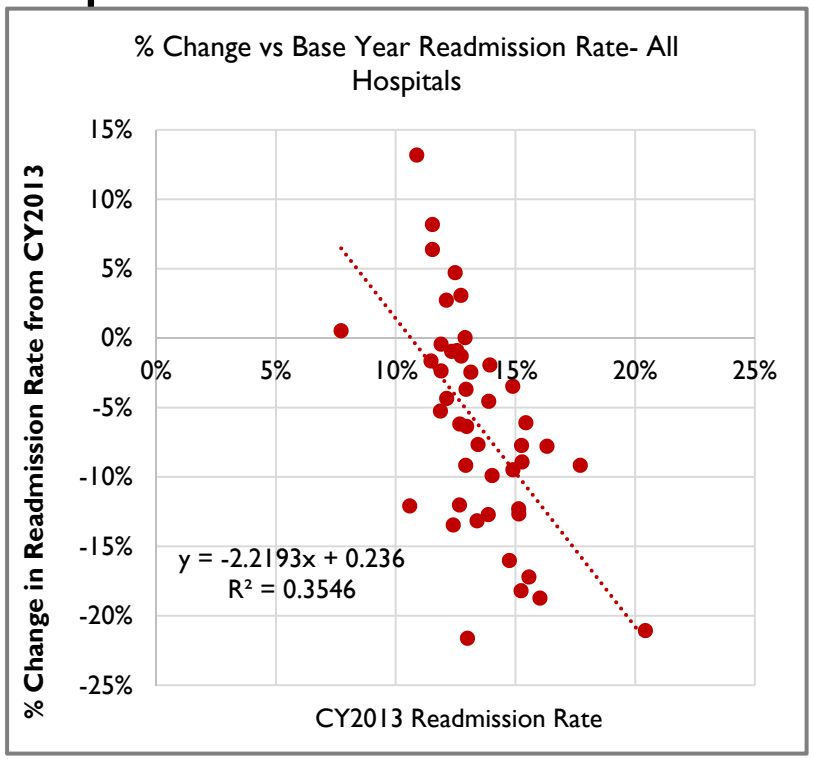
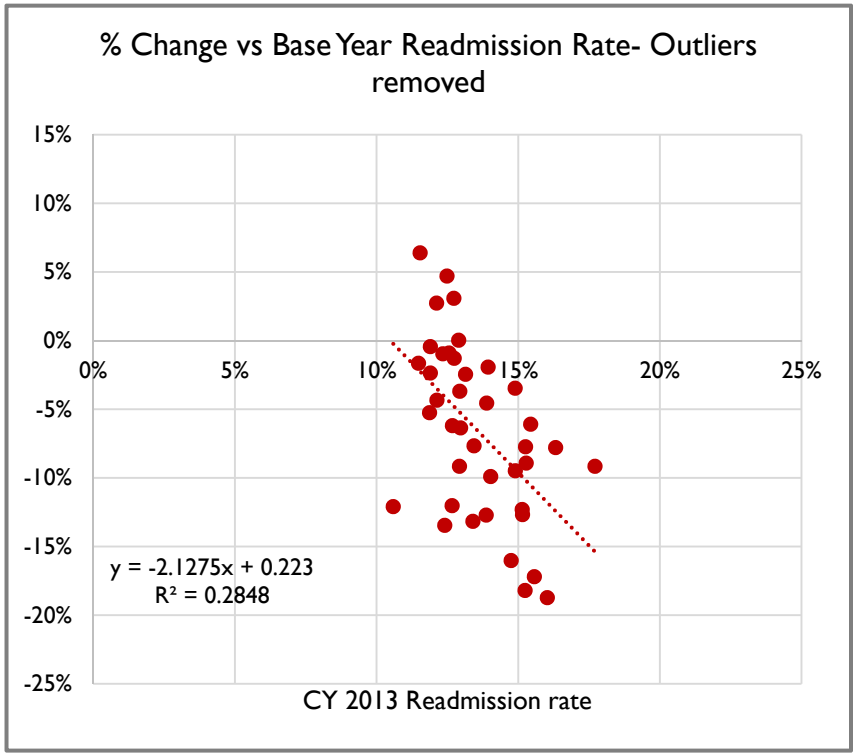
Analyses of Issues Discussed in FY 2017 Policy

- 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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RRIP proposals for FY 2018

- Payment adjustments based on readmission rates (attainment) necessaires further analysis on
  - Readmissions at out of state hospitals
  - Impact of patient's socio-economic factors
- MHA proposal combines improvement and attainment into a single payment adjustment
- Carefirst proposal blends 50/50 actual readmission rate with indigenous adjusted readmission rates

Draft Recommendations for the RRIP Policy

- For RY 2018
  - The RRIP policy should continue to be set for all-payers.
  - Hospital performance should be measured better of attainment of improvement
  - Set attainment benchmark at the state top-quartile readmission rate in CY 2013
  - Set the reduction target at 9.5 percent from CY2013 readmission rates
- For RY 2017 apply the same methodology outlined above based on 9.3 reduction target as approved by the Commission last year.
- Staff will evaluate the appropriate risk adjustment in May to finalize the recommendation.

Market Shift Adjustments Update

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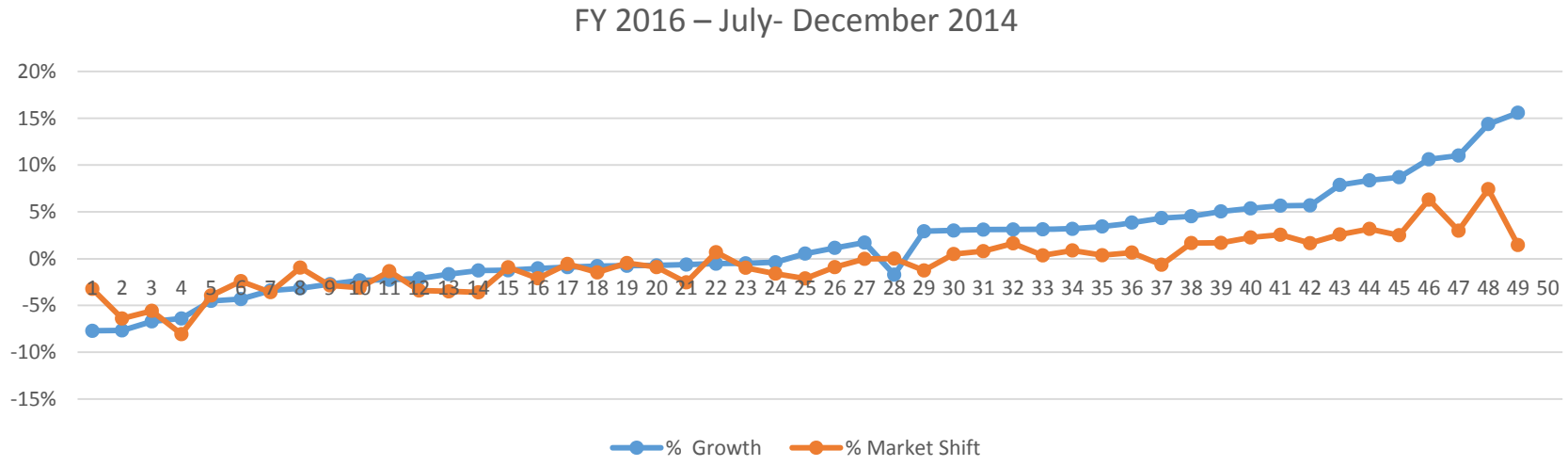
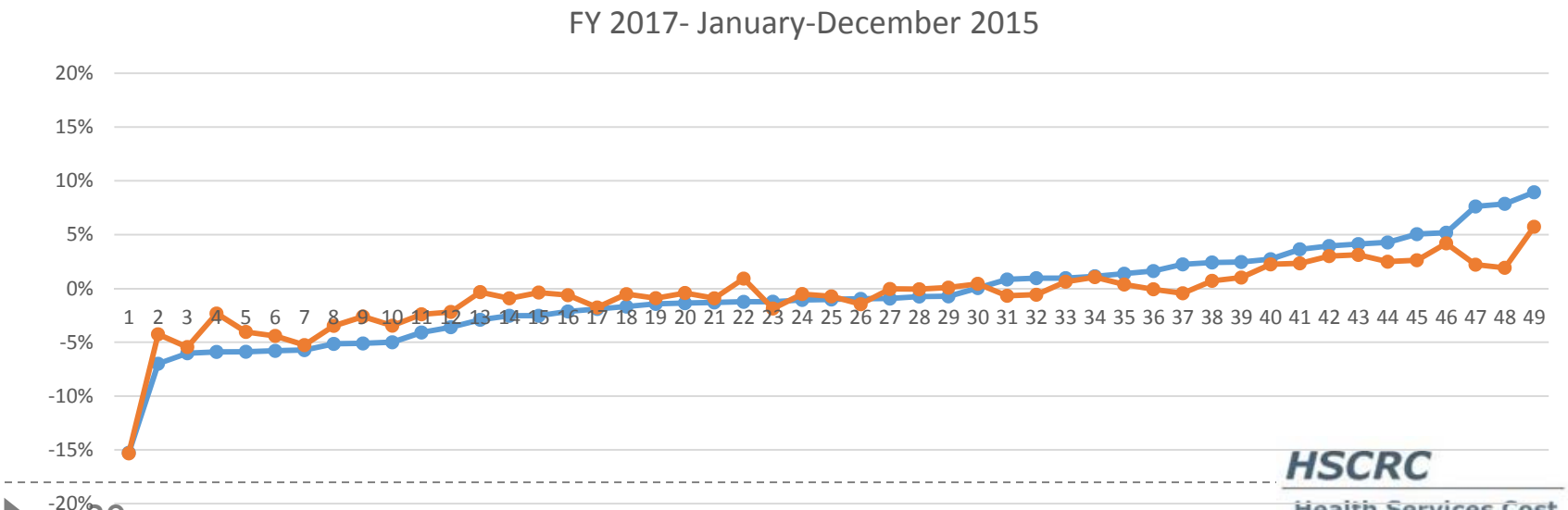
Market shift adjustments and volume growth is more closely linked in the FY 2017 period





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Market Shift - Timing

- CY 2015 period (compared to CY 2014) adjustments will be included in FY 2017 rates in July.
- For CY 2016 more timely adjustments may be needed.
- Staff has 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.
- Challenges in getting timely and accurate data inhibits regular reporting or more frequent rate adjustments.

Market Shift Outpatient Oncology and Infusion

- Staff tries several methodologies to account for variation in outpatient reporting for recurrent accounts.
- Send out results for July-December 2014 time periods to be included in FY2016 GBRs based on patient counts for different therapy combinations
- Processing Jan-December 2015 time period for FY 2017 GBR adjustments