



Global Budget Revenue

October 8, 2015

HSCRC

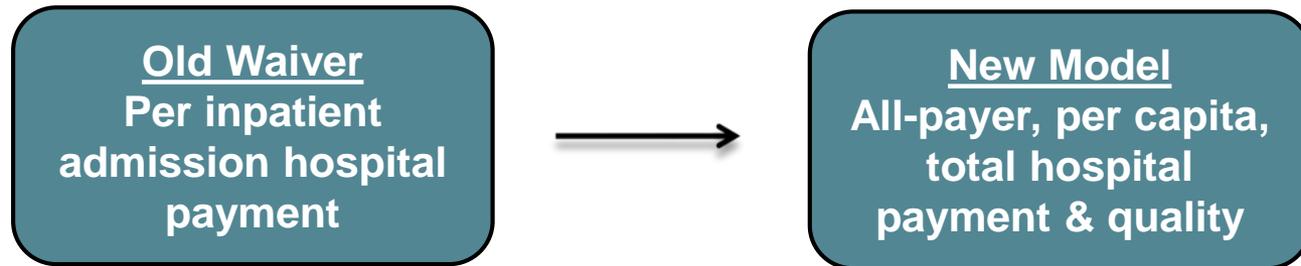
Health Services Cost
Review Commission

Goals

- ▶ Understand GBR's connection to the goals of Maryland's Demonstration
- ▶ Understand impact on budgeting and planning for RFP and future phases
- ▶ Answer questions that have frequently arisen over the past year

Unique New Model: Maryland's All-Payer Model

- ▶ Maryland is implementing an All-Payer Model for hospital payment
 - ▶ Approved by Center for Medicare and Medicaid Innovation (CMMI) effective January 1, 2014 for 5 years
 - ▶ Modernizes Maryland's Medicare waiver and unique all-payer hospital rate system



- ▶ Key provisions of the new Model:
 - ▶ Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least \$330 million to Medicare over 5 years
 - ▶ Patient and population centered-measures to promote care improvement
 - ▶ Payment transformation away from fee-for-service for hospital services
 - ▶ Proposal covering all health spending due at the end of Year 3 for 2019 and beyond

New Global Model: Moving Away from Volume

Former Hospital Payment Model:

Volume Driven



× Rate Per Unit
or Case



- Unknown at the beginning of year
- More units creates more revenue

New Hospital Payment Model:

Population and Value Driven



× Updates for Trend,
Population, Value



- Known at the beginning of year
- More units does not create more revenue

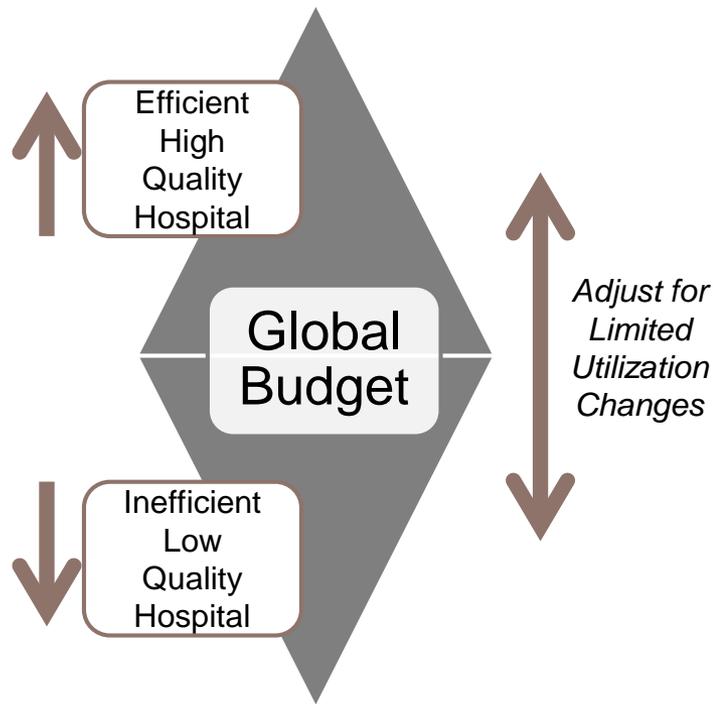


CMS is Focused on Increasing Value Based Payment Approaches—Consider Impact on Maryland Providers

	Category 1: Fee for Service – No Link to Value	Category 2: Fee for Service – Link to Value	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-based Payment
Description	<ul style="list-style-type: none"> Payments are based on volume of services and not linked to quality or efficiency 	<ul style="list-style-type: none"> At least a portion of payments vary based on the quality and/or efficiency of health care delivery 	<ul style="list-style-type: none"> Some payment is linked to the effective management of a population or an episode of care Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk 	<ul style="list-style-type: none"> Payment is not directly triggered by service delivery so volume is not linked to payment Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)
Medicare examples	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions / Hospital Acquired Conditions Reduction Program 	<ul style="list-style-type: none"> Accountable care organization Medical homes Bundled payments Comprehensive primary Care initiative Comprehensive ESRD Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3-5 Maryland All-Payer Hospital Model <i>(fits into this category)</i>



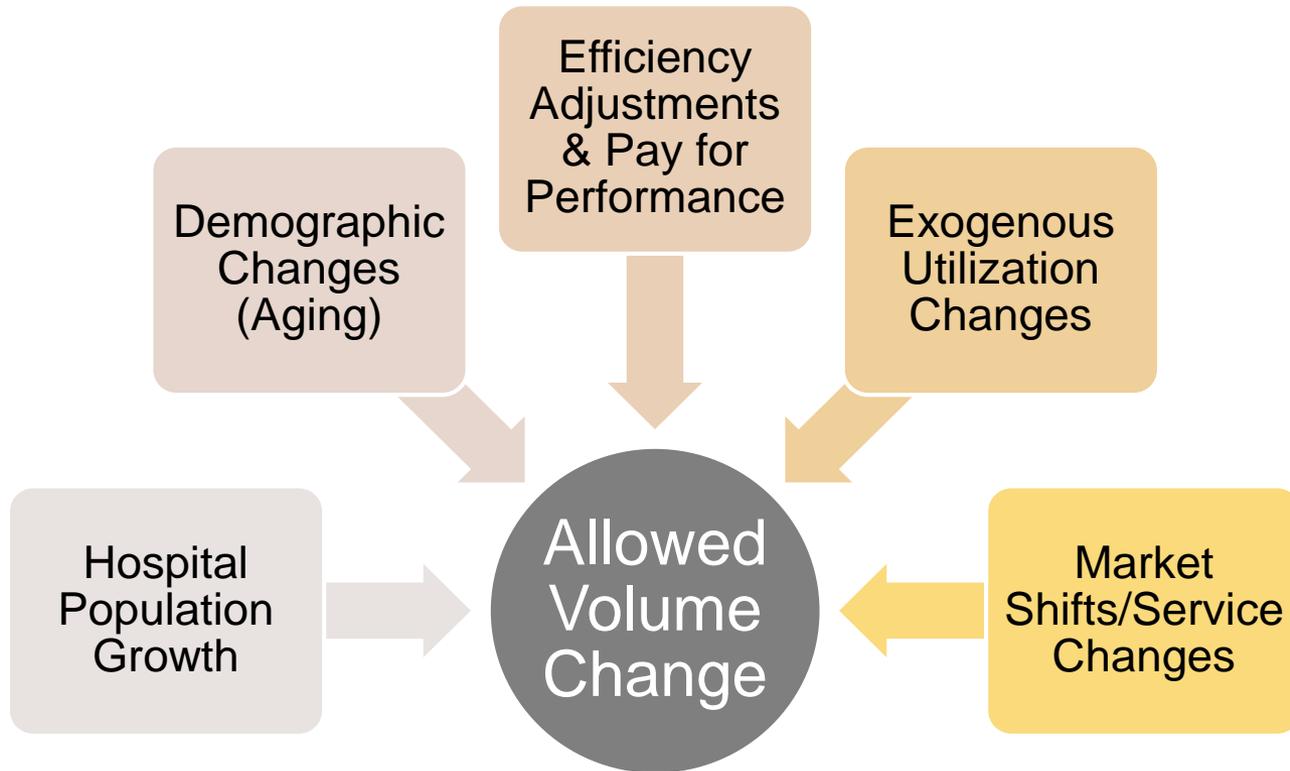
Global Budget Model



▶ **The Global Budget Model: revenue budget with annual adjustments**

- ▶ *The initial revenue budget was based on historical revenue*
- ▶ *Budgets can be enhanced or reduced based on hospital efficiency and utilization*
- ▶ *The budget is adjusted annually for utilization changes related to market shift, population, service mix etc.*

GBR Adjustments



Market Shift Adjustments

- ▶ Market shift adjustment should not undermine the incentives to reduce avoidable utilization
- ▶ Market shift adjustment should provide necessary resources for necessary services shifted to another hospital
- ▶ Calculations are based on
 - ▶ 66 inpatient and outpatient service lines
 - ▶ Zip codes and county level
 - ▶ Excludes Potentially Avoidable Utilization (Readmissions and PQIs*)
 - ▶ Hospital service line average charge per ECMAD**
 - ▶ 50% of average cost is provided

*AHRQ Prevention Quality Indicators

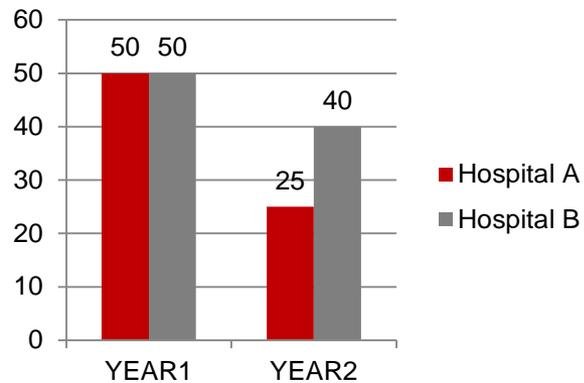
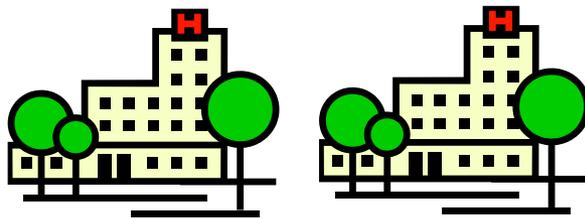
**Equivalent CaseMix Adjusted Discharges

Examples

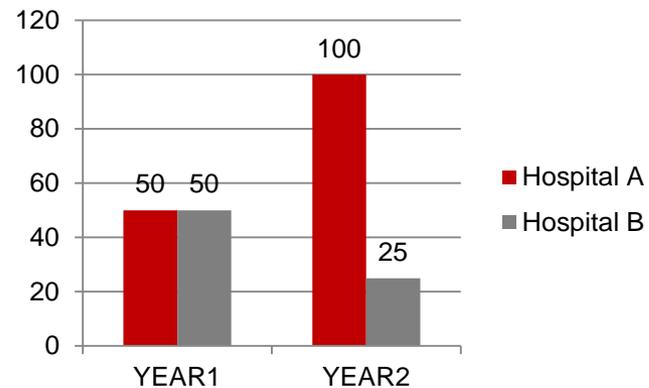
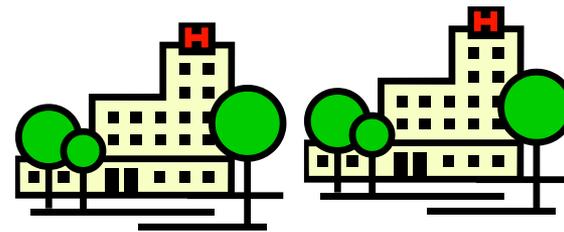
Market Share

vs.

Market Shift



Market Shift Adjustment = 0



Market Shift Adjustment = 25

Shift = the amount of “up” that was other hospitals’ “down” in particular zip and service line

HSCRC Administers Performance-Based Payment Initiatives for Hospitals



Process
of Care

Patient
Satisfaction

Outcomes

Revenue at Risk is Progressively Increased

State Fiscal Year	Complications Maximum At Risk	Patient Experience, Safety, Mortality Maximum At Risk	Readmissions State-wide impact
FY 11	0.50%	0.5%	
FY 12	1%	0.5%	
FY 13	2%	0.5%	
FY 14	2%	0.5%	-0.3%
FY15	3%	0.5%	-0.7%
FY16	4%	1.0%	-0.7%, +0.5%
FY17	4%	2.0%	-2%, 1%



Why does it work?

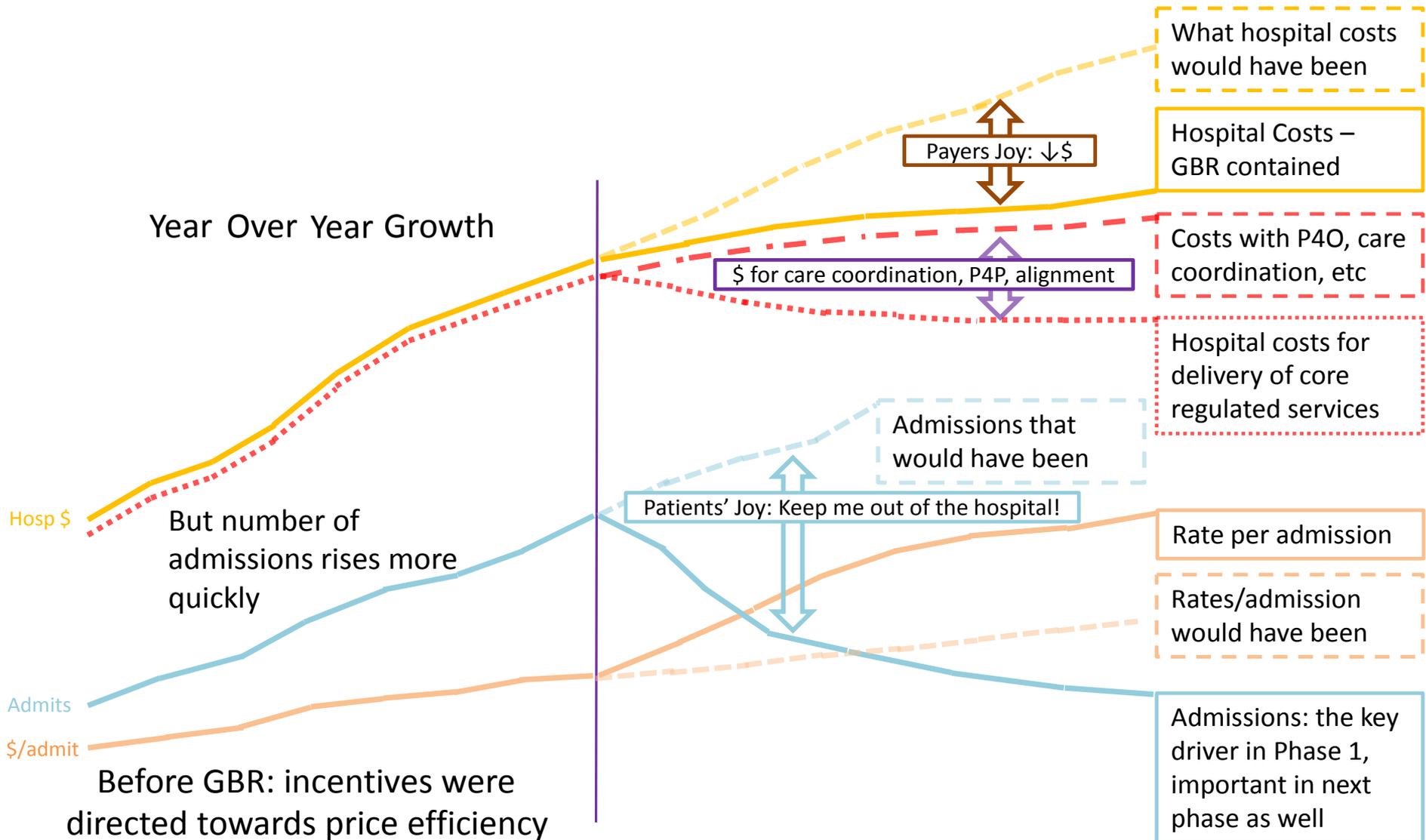
- ▶ Hospitals at risk: for first time can increase margins by decreasing number of bed-days
- ▶ Able to do well by serving cost and quality goals

What's the end game? Where are the savings going?

► **Expectation is that there are four buckets which are in order of time to start:**

1. Positive shift in hospital balance sheet through early wins in PAUs and quality (immediate!)
2. Payer savings from the reduction in number of admissions from what would have been without GBR (year one – already occurring!)
3. Investment in pay-for-outcomes and other value-based payments by hospitals to providers
4. Investments in technology and care coordination infrastructure to reduce hospitalizations and improve quality (pre-existing, but accelerating year two)

Hospital Costs: New Incentives



Investments to make it work

- ▶ Hospitals have invested with rate increases for several years, including 0.3 – 0.6% in 2014
- ▶ This year, 2015: 0.4% GBR adjustment for investing in the infrastructure that it takes to make gains in quality and cost
- ▶ 2016: 0.25% competitive award
- ▶ Years of investment in State-level IT in CRISP, now accelerating

Expectations for 0.4% rate increase and the 0.25% competitive awards

- ▶ ROI on care management of high utilizers: 0.65% input will realize >0.65% savings, captured in GBR
- ▶ Re-investment of returns will expand programs in care coordination and population management solutions
- ▶ Primary care will be bolstered to improve access and outcomes
- ▶ Through future savings (continuing ROI) payers will gain as well

How will physician alignment be created within GBR?

▶ Waivers

- ▶ P4P
- ▶ Shared savings
- ▶ Gain-sharing
- ▶ Data

Questions from the Field

Describe the intent of market shift

- ▶ Support the basic premise of GBR which is to create incentives to reduce avoidable utilization while also to:
 - ▶ Provide sufficient resources to individual hospitals if their volume of services increases as a result of shifts from other hospitals and ensure competition for high quality care
 - ▶ Avoid incentives for hospitals to seek volume increases in services
- ▶ The tight geography (zip) and the service line analysis both make it more likely that shifts will be detected and reductions in PAUs will be protected

Questions from the Field

What's a good admission?

- ▶ **FIRST ASSUMPTION:** All admissions are “GOOD”, or the admitting doctor wouldn't admit them! HSCRC is not looking for, or trying to analyze, “BAD” admissions
- ▶ There is a monitoring system for “Potentially Avoidable”: we should note the meaning of “potentially” and “avoidable”
 - ▶ Some PAUs are, in fact, not avoidable
 - ▶ Some admissions that are not PAUs are, in fact, avoidable if patient choice was more clearly discovered or alternatives explored
 - ▶ ALL admissions are assumed to be needed and “good” at the time
- ▶ Ideal state is right place at right time at the right cost
- ▶ The good thing: with GBR we **DON'T NEED TO KNOW** the “truth” of each admission's ‘avoidability’. Hospitals and doctors and their patients reduce admissions from a number that is clearly too high. Quality is monitored. Reduction is rewarded.

Questions from the Field

Should we “backfill” PAUs?

- ▶ Competition is a legitimate (particularly on quality!), so some bed-days could shift from other hospitals (and this will be recognized by market shift adjustment)
- ▶ But a losing strategy will be to increase volumes of elective admissions that could have been dealt with in another way. Why?
 - ▶ Unless increased through market shift (competition on non-reducible service lines) then the strategy will cause an increase in admissions without a commensurate increase in GBR – lower margins, lower amount to invest in other things
 - ▶ Total cost of care is coming soon. It’s time to think with the total cost of care thinking cap on

Questions from the Field

Will HSCRC reduce our GBR if we're really successful? (if our margins are high)

- ▶ No. Hospitals control their margins.
- ▶ The goal is a state-wide restraint in the growth of GBR to less than 3.58% per year. Hospitals that succeed in reducing hospitalizations can/should/will be rewarded with increased margin
- ▶ The expectation is that the reduction in admissions will take investment, including in incentives. For this reason, margins are not expected to be excessive across hospitals.

Questions from the Field

How do ACOs interact with the GBR?

- ▶ ACOs are just like a payers in the graph above: the control of hospital utilization through GBR is of great benefit in trying to reach MSR (minimal savings ratio)
- ▶ ACOs will benefit from hospitals' ability to do P4P (or "P4O": pay for outcomes) and gainshares, though these need to be aligned
- ▶ ACOs are concerned about the total cost of care and the next phase of the Demonstration is all-cost, so ACOs are potentially ahead of the game

Questions from the Field:

How will out of state patient shifts be dealt with?

- ▶ Case by case basis
- ▶ This item requires a discussion with HSCRC by the individual hospital

Conclusions:

- ▶ GBR is a nation-leading, Category 4 advanced payment model that is working
- ▶ GBR success has created the circumstances for Maryland to invest in the infrastructure of care coordination
- ▶ GBR, with adjustments for market shift and quality, provides the right incentives for the hospital component of Maryland's total cost of care to be "right place, right time, right cost"