Discussion Document of Selected Terms of New Maryland All-Payer Model Educational Materials

October 7, 2013

Maryland Health Services Cost Review Commission

Agenda

I. Answer questions on draft application
   - Review success factors
   - Discussion of demographic adjustment

II. Financial reporting and monitoring for January
   - Data needed now
   - How it will be used
   - Monitoring and disclosure

Maryland Innovating for Better Value in Health Care

- A critical next step:

- Innovation in Maryland's unique all-payer hospital system

Better care

Better health

Lower cost

I. DRAFT APPLICATION FOR NEW ALL-PAYER MODEL

-QUESTIONS AND SUCCESS FACTOR

-DEMOGRAPHIC ADJUSTMENT

New Waiver Demonstration

- Request submitted to CMS and CMMI in March, update in October now in draft form
- Focus on new approaches to rate regulation
- Would move Maryland to an **all payer**, **total hospital** payment **per capita** test.
  - Shifts focus to population health and delivery system redesign
- Will require CMMI approval process before implementation
- Implementation activities underway for expected January 1 start date

Major Components of Draft Application

Component	
Hard cap	3.58% per capita growth for all payers for Maryland residents.
Cumulative Spending Target	Cumulative Medicare savings of $330 million over 5 years.
Length of demonstration and triggers	5 year demonstration. Trigger points on cost and quality with opportunities to correct. If terminated, 2 year transition.
Population-based and global approaches	Increased movement of revenue in global payment. At least 80% by year 5. Payments not under global payment subject to variable cost factor(s), volume governor.
Quality Metrics	Readmission, HACs, other VBP measures ✓Readmission rate for Medicare to national level within 5 years ✓Reduction in Maryland Hospital Aquired Conditions of 30% over 5 years ✓Revenue at risk in VBP measures on par with national Medicare levels

Major Components of Draft Application

Component	
Differential	Limited use. If meet all payer cap, can use if Medicare savings not met.
Adjustments	Can submit proposed adjustments for exogenous factors
Opportunity to extend/ Phase 2	Submit application at end of year 3 for extension to include total cost of care.

Approach for January 1- Transitional Hospital Revenue Model Modifications

- Approaches in place effective January 1 that assure hospital revenues within the maximum requirements for 2014
- Use existing frameworks with some modifications to allow for transitional changes effective January 1
  - Modified global budget framework used in Total Patient Revenue agreements with fixed total allowed revenue

    OR
  - Existing charge-per-episode structure with lower variable cost factor applied prospectively, and a volume governor(s) to reduce allowed revenue if maximum revenue targets are exceeded
- Add incentives/requirements for reducing avoidable volumes no later than July 1
- Revenue for non-Maryland residents have regulated rates and performance requirements but excluded from model and volume adjustment

Near Term Hospital Success Factors

- Implement
  - Work with HSCRC to implement and monitor new model
  - Manage and monitor Medicare revenue and utilization
- Reduce avoidable volumes
  - Reduce avoidable admissions, re-hospitalizations and ER visits by linking patients to more appropriate resources that prevent episodic/urgent care needs
  - Intensify efforts to reduce preventable complications/hospital acquired conditions
- Redesign/create more efficient service settings
- Critically assess investments for specific programs/services in context of community need

Short Term Success Factor: Avoidable Volumes Reduced

- In order to achieve required Medicare savings and to balance the revenue model, avoidable volumes must be reduced:
  - 30- Day Readmissions/Rehospitalizations (includes ER), with separate Medicare target
  - Preventable Admissions (based on AHRQ Prevention Quality Indicators)
  - Nursing home residents
  - ER visits than can be treated in other settings
  - Maryland Hospital Acquired Conditions (potentially preventable complications)
  - Length-of-Stay still important, with a renewed focus on Medicare patients
  - Optimize site of care with ***cost*** savings

Longer-term expectations

- Longer-term, expectations are that this New All-Payer will accelerate the movement toward other important objectives. Under this model, hospitals will need to:
  - Reduce excess capacity and reduce cost structure in line with capacity reductions; generate higher profitability from cost reductions
  - Further reduce potentially avoidable volume and make available capacity for the demographic-driven volume growth anticipated from the aging of the population

Alignment with Other Efforts

- New model designed to work together with a number of other efforts currently underway
  - Strengthen primary care,
  - Map and track preventable disease and health costs,
  - Develop public-private coalitions for improved health outcomes,
  - Establish health enterprise zones, and
  - Enroll Marylanders in health coverage through Maryland Health Connection

FAQ: Demographic Adjustment

- Q: How are you thinking about demographic adjustments?
- A: Statewide, the population increase is about .6%.
  - This is what is built into the All-Payer model ceiling
  - Full demographic adjustment with current use rates and 100% VCF yields demographic factor >1.4%
  - HSCRC will not provide full demographic adjustment.
    - Not in model
    - Medicare revenue growth rate is lower, MD and nationwide
    - Excess utilization in Maryland concentrated in Medicare and older non-Medicare
    - Capacity from falling volumes greater than growth impact in the short run (Reduction in avoidable volumes greater than .8% per year for the next three years)
    - Does not reflect VCF reduction

QUESTIONS?

II. MONITORING FOR JANUARY 1 AND THEREAFTER -FINANCIAL

-HISTORICAL DATA NEEDS

-CURRENT NEEDS

-MONITORING AND DISCLOSURE

Principles for Financial Monitoring

- Financial and utilization
  - All-Payer
    - Revenue for Maryland residents in Maryland hospitals
  - Medicare savings requirement
    - Payments for Maryland Medicare enrollees in hospitals anywhere
  - Medicare guardrail for total spending (includes all providers)
    - Growth outside of hospitals not excessive due to shifts

Monthly Monitoring

- Revenue from Maryland residents, others vs. prior year, same month
  - Same for Medicare
- Revenue versus approved revenue (seasonally adjusted)
  - Residents vs. non-residents
  - Focus on volume changes
- Short term data collection tool being updated
- Identified need for more robust and innovative data collection and monitoring tool

Data Request

- Historical and future financial and utilization data

Description	Dates Covered	Due Date
Monthly financial and utilization expansion to include break-out of residents from out-of-state patients, in total and for Medicare	From January 1, 2014 and ongoing	30 days after the end of each month
Historic monthly data (same as above).	July 1, 2012 through September 30, 2013	November 15, 2013
Historic monthly data (same as above).	October 1, 2013 through December 31, 2013	January 31, 2014

Use of Data

- Monitoring All-Payer cap
- Evaluating progress within Maryland on Medicare and savings estimates
- Rate system update (IAS) data feeds for volume adjustments

Source of Resident Status

- From financial data systems
- Primary source of resident status--zip codes
- Immigrants are residents
- International patients can be a problem (billing zip codes vs. resident zip codes)

Medicare Monitoring

- Begin process with CMMI and MHA to review data details using prior year
- Develop reconciliation process
  - Compare to data reported to HSCRC
  - Evaluate out of state
  - Non hospital data reconciliation for guardrail
  - Enrollment files and reconciliations

QUESTIONS?
COMMENTS

Next week's webinar

- Review draft policies to be introduced at November HSCRC meeting
  - Volume factor, volume governor
  - Overage
  - Monitoring
  - Other