maryland
health services
cost review commission

Revenue for Reform Workgroup

June 23, 2021

Agenda

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1. Analysis of Retained Revenue & Population Health Spending
   - Quantifying the Hospital Retained Revenue
   - Responses to the Population Health Surveys
2. Examples of the ICC and the Safe Harbor Implications
3. Process for R4R Safe Harbor
   - Overview of the R4R Safe Harbors
   - Submission and Approval Process
   - Year 1 Timeline

Retained Revenue and Population Health Spending

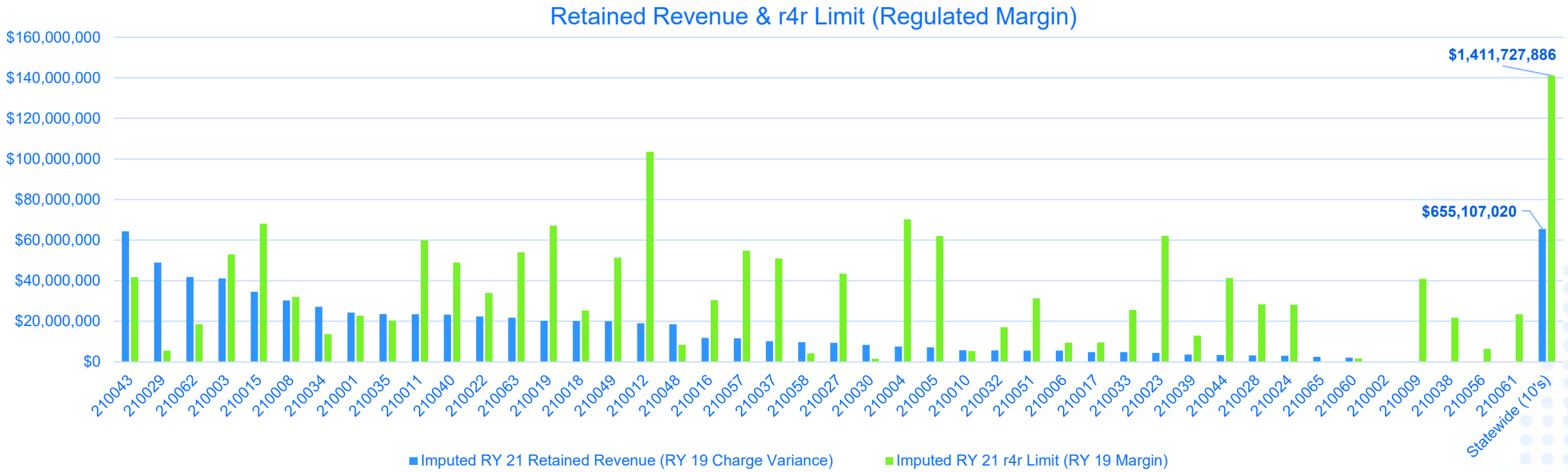
Comparison of Retained Revenue and Population Health

Staff calculated the amount of Retained Revenue under the global budgets and compared it to the amount of population health expenditures incurred by the hospitals.

- Staff estimate that there is approx. $655 million in retained revenue statewide;
- Hospitals reported non-physician population health expenditures of approx. $215 million on their Population Health Reports;
- Hospitals indicated that most of the physician expenditures were for general subsidies, rather than physicians engaged in community health or addressing community health needs.

Revenue for Reform is intended to incentivize hospitals to invest some of their retained revenues in 1) community health investments; or 2) primary care in underserved areas.

Retained Revenue & R4R Opportunity



- Method: multiply RY 19 charge variance by RY 21 permanent revenue to quantify retained revenue (negatives excluded); multiply RY 19 regulated margin to impute R4R limit (negatives excluded)
- If the opportunity for R4R was limited to retained revenue it would still be quite substantial ($655 million). To maximize the incentive, staff proposes extending the opportunity to regulated margin ($1.4 billion).
  - Staff contends that safe harbors beyond regulated margin would misappropriate revenue related to actual hospital costs

Summary of Reported Population Health Costs, Statewide

$ in Millions	Regulated Hospital	Unregulated Hospital	System	Total
Non-Physician Direct	152.2	30.9	14.7	197.8
Non-Physician Indirect	27.3	11.1	2.7	41.2
Total Non-Physician	179.5	42.1	17.4	239.0
Non-Physician Revenue	10.8	9.5	4.0	24.3
Net Non-Physician Cost	168.7	32.6	13.4	214.6
Physician Direct	198.9	612.9	206.6	1018.5
Physician Indirect	31.6	226.3	172.0	429.8
Total Physician Cost	230.5	839.2	378.6	1448.2
Physician Revenue	18.3	444.2	260.7	723.2
Net Physician Cost	212.2	395.0	117.9	725.1

To date, non-physician expenditures on population health are limited. The majority of population health spending is in the regulated setting ($150M out of $198 M direct)

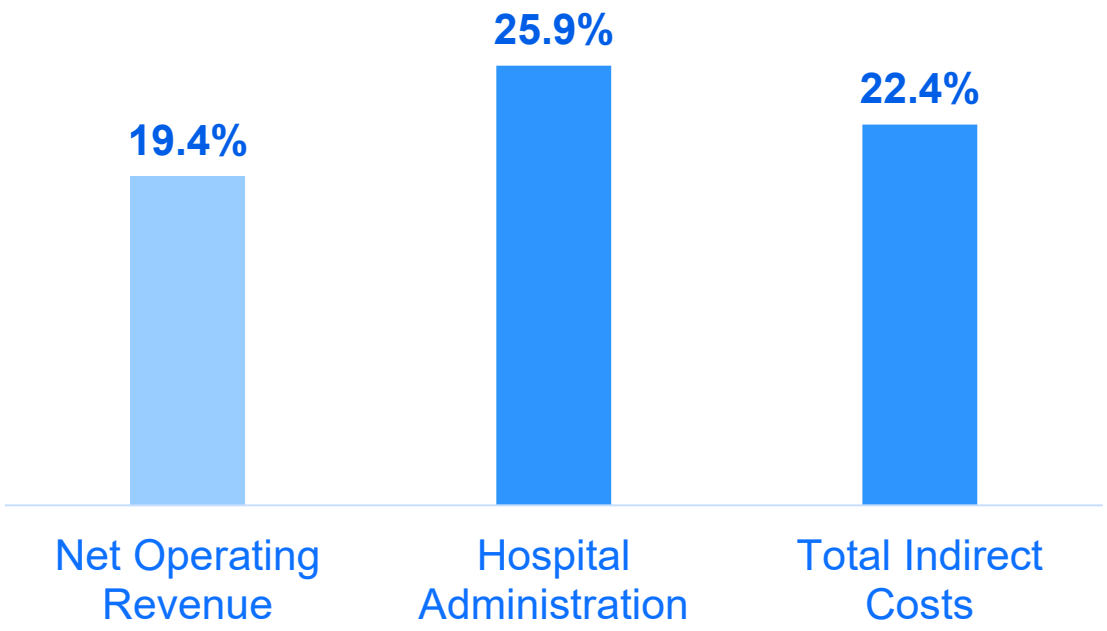
Non-Physician Population Health Spending Reflects a Small Portion of Regulated Spending in Most Cost Centers (2020)

Table reflects regulated non-physician population health costs reported by June YE hospitals as a share of their total regulated spending in that category.

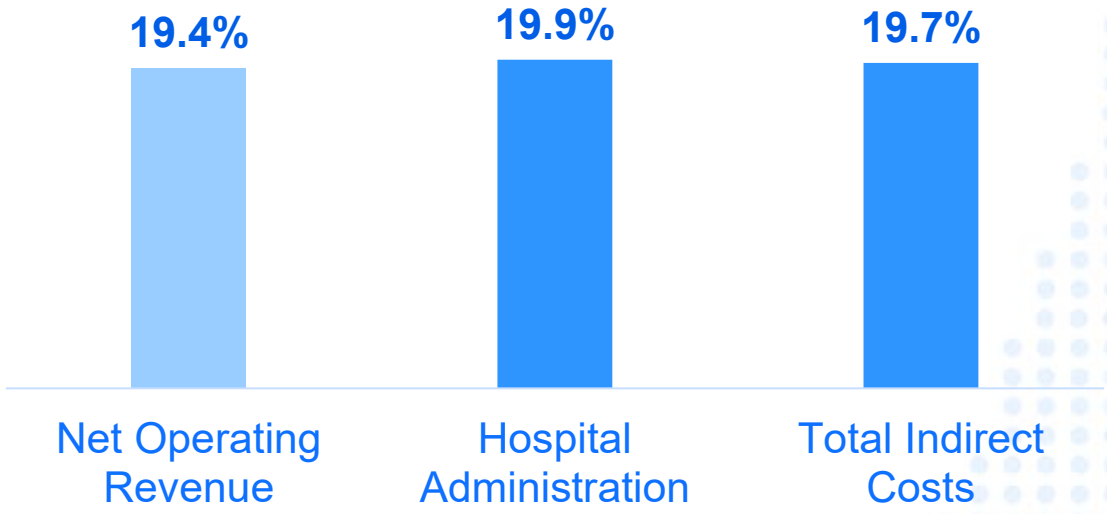
	Population Health Attributed	Total Cost	% of Spending
Hospital Admin	51,872,803	1,224,107,000	4.2%
Social Services	29,528,234	81,595,000	36.2%
Malpractice Insurance	8,572,987	260,968,890	3.3%
Med Surg Acute	8,452,370	1,001,669,000	0.8%
Medical Care Review	5,826,415	127,159,560	4.6%
Nursing Admin	5,222,197	191,834,000	2.7%
Clinic	4,881,372	212,320,000	2.3%
Community Health Education	4,005,706	38,391,000	10.4%
Pharmacy	3,361,984	256,154,000	1.3%
Data Processing	3,013,091	609,890,000	0.5%
All Other	18,971,476	9,081,224,550	0.2%
Total	143,708,636	13,085,313,000	1.1%

Regulated Non-Physician Pop. Health Spending Explains Overhead Cost Growth Since 2013

2013 to 2019 Regulated Growth, Selected Categories



2013 to 2019 Regulated Growth, **Excluding Population Health Costs (assumed to be 0 in 2013)**



2019 Amounts are shown due to the impact of COVID on 2020 administrative costs. Since population health reporting was for 2020, amounts in 2019 are assumed to be the same as those reported for 2020. Includes only June YE hospitals.

Direct Physician (Losses) Gains

$ in Millions	Regulated Hospital	Unregulated Hospital	System	Unregulated + Non-Regulated	% of Total	Total	% of Total
Hospital Coverage	-88.0	-110.2	-2.6	-112.8	98%	-200.8	68%
Population Health focused clinics	-10.8	-13.5	-4.9	-18.4	16%	-29.2	10%
Community Physicians in specialties identified in CHNA	-13.6	22.7	-0.5	22.2	-19%	8.7	-3%
Community Physicians - Primary Care, not in CHNA	0.0	0.7	11.2	11.9	-10%	11.9	-4%
Community Physicians - All Other, not in CHNA	-68.2	-68.5	50.9	-17.6	15%	-85.9	29%
Direct Physician (Losses) Gains	-180.6	-168.7	54.1	-114.7	100%	-295.3	100%
Indirect physician Costs	-31.6	-226.3	-172.0	-398.2		-429.8	
Losses (Gains)	-212.2	-395.0	-117.9	-512.9		-725.1	

- All date slide amounts are preliminary – do not tie to physician costs on Annual Filing
- Staff to review tie out of Regulated amounts and revenue

Integrated Efficiency Examples & Safe Harbor Examples

Revenue for Reform in the ICC

The Revenue for Reform safe harbor will be subtracted from the hospital's approved revenue that is compared to the peer group standard.

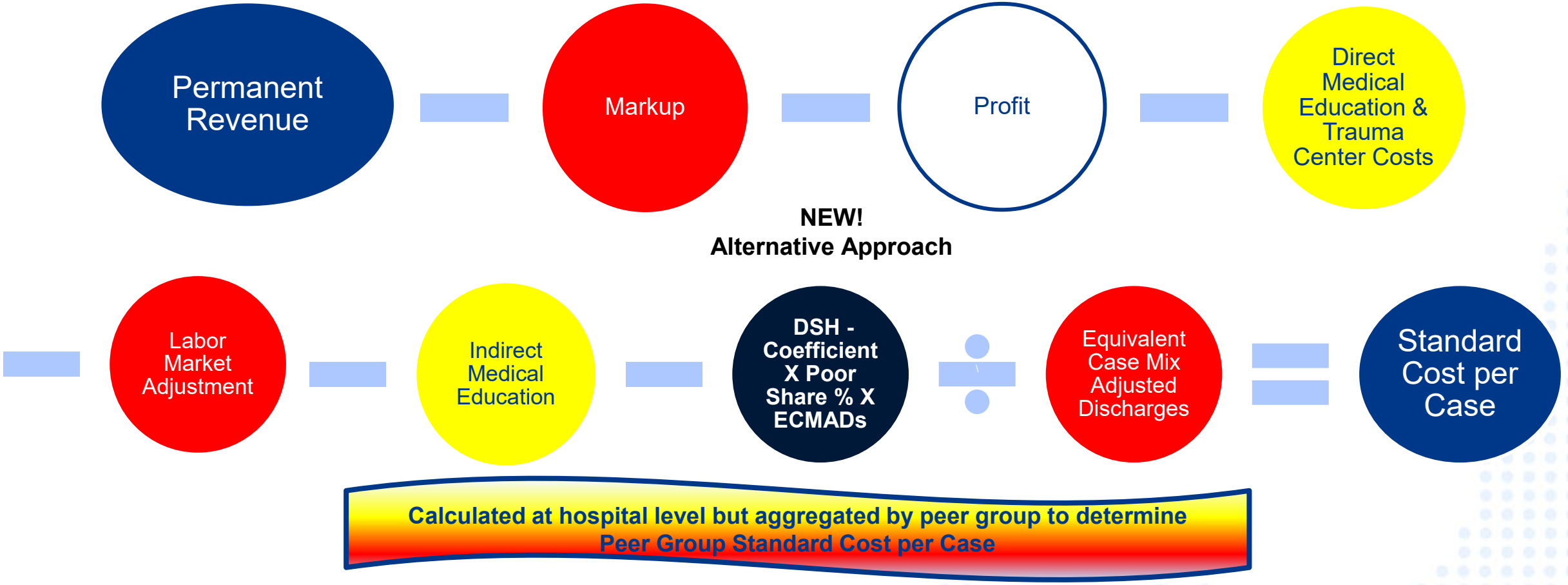
- Staff elected to implement the safe harbor as a straight addition at the end of the ICC methodology, versus removing safe harbor revenue from the ICC evaluation;
- This results in a 1:1 safe harbor. Every dollar added to the safe harbor will reduce the amount of the efficiency adjustment by an equal amount;
- This also means that one hospital's safe harbor will not impact the peer group standard, and thus other hospital's efficiency relative to the peer group standard.
- However, a hospital that drops out of the least efficient quintile may result in other hospitals falling into the least efficient quintile.

The R4R Safe Harbor benefits the hospital in two respects:

1. It lowers the amount of revenue that will be removed under the Efficiency Adjustment; and
2. It lowers that amount of revenue that is scaled by the Efficiency Adjustment.

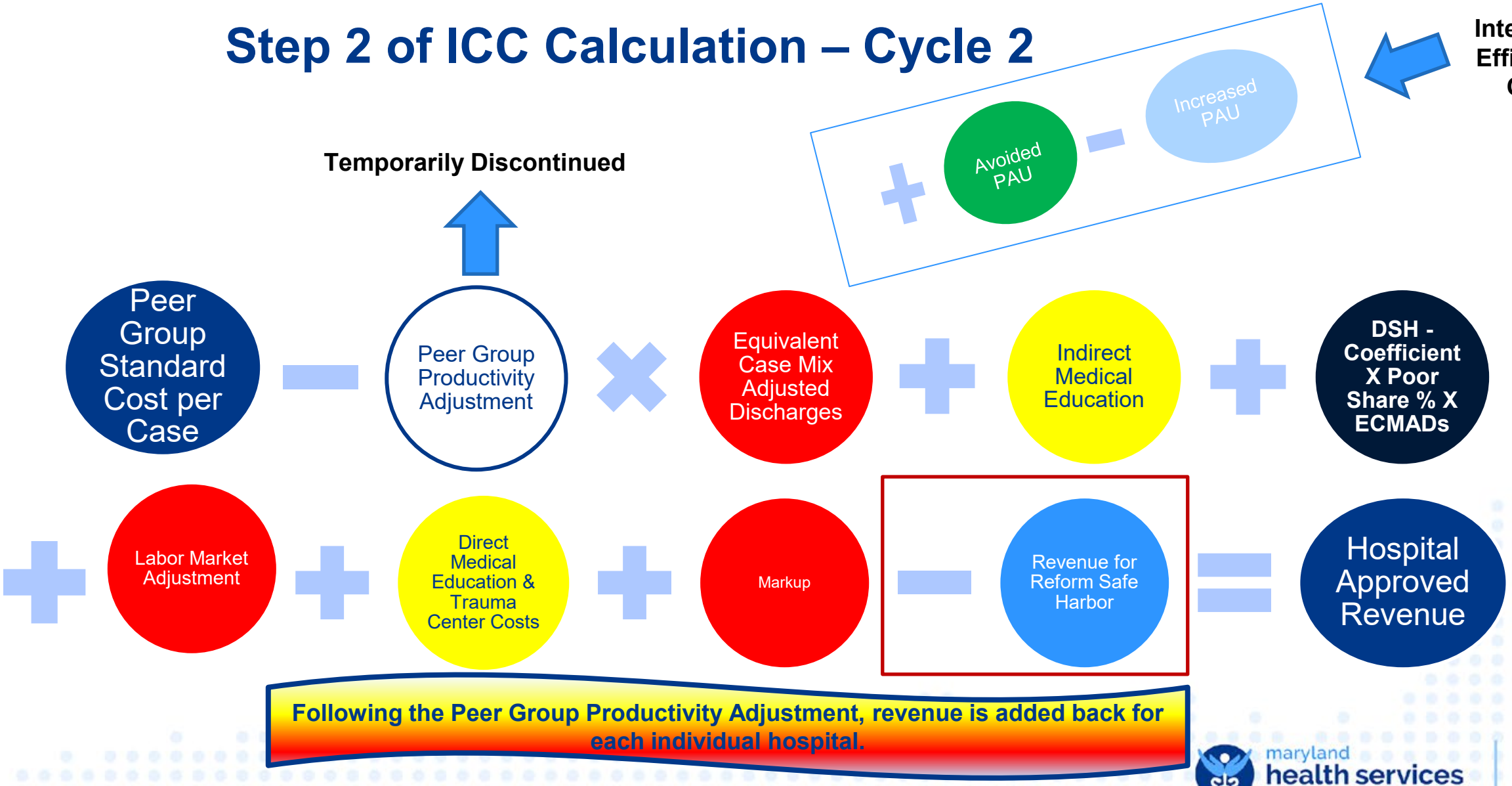
Method for Incorporating Revenue for Reform into the ICC

Step 1 of ICC Calculation is Unchanged



Method for Incorporating Revenue for Reform into the ICC

Step 2 of ICC Calculation – Cycle 2



Benefit of Safe Harbor Part 1: Improves Efficiency Score

Current Results								
Hospital Name	Volume Adjused ICC Result	ICC Rank (50%)	2018 Medicare TCOC Relative to Benchmark	2018 Medicare TCOC Rank (25%)	2018 Commercial TCOC Relative to Benchmark	2017 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)	% Cut
University of Maryland Shore Medical Center at Easton	-16%	33	12%	18	-12.07%	38	61.00	0.04%
Johns Hopkins Bayview Medical Center	-15%	31	17%	31	-17.82%	30	61.50	0.09%
Carroll Hospital Center	-18%	36	16%	27	-21.25%	24	61.50	0.09%
Western Maryland Regional Medical Center	-13%	25	24%	41	-12.05%	39	65.00	0.38%
University of Maryland Shore Medical Center at Chestertown	-18%	35	13%	20	-12.02%	40	65.00	0.38%
Northwest Hospital Center	-14%	29	24%	40	-16.30%	33	65.50	0.43%
University of Maryland Medical Center Midtown Campus	-22%	42	19%	33	-23.21%	17	67.00	0.00%
Union Hospital of Cecil County	-18%	34	15%	26	-3.56%	42	68.00	0.64%
Sinai Hospital	-24%	43	21%	37	-14.56%	35	79.00	1.57%
Results with Cecil Safe Harbor Equal to Imputed Retained Revenue								
MedStar Union Memorial Hospital	-15%	33	14%	21	-13.68%	36	61.50	0.09%
Carroll Hospital Center	-18%	36	16%	27	-21.25%	24	61.50	0.09%
University of Maryland Shore Medical Center at Easton	-16%	34	12%	18	-12.07%	38	62.00	0.13%
Johns Hopkins Bayview Medical Center	-15%	32	17%	31	-17.82%	30	62.50	0.17%
Union Hospital of Cecil County	-14%	30	15%	26	-3.56%	42	64.00	0.30%
Western Maryland Regional Medical Center	-13%	25	24%	41	-12.05%	39	65.00	0.38%
University of Maryland Shore Medical Center at Chestertown	-18%	35	13%	20	-12.02%	40	65.00	0.38%
Northwest Hospital Center	-14%	29	24%	40	-16.30%	33	65.50	0.43%
University of Maryland Medical Center Midtown Campus	-22%	42	19%	33	-23.21%	17	67.00	0.00%
Sinai Hospital	-24%	43	21%	37	-14.56%	35	79.00	1.57%

- Method: Rerun ICC and Integrated Efficiency Matrix with Cecil having a safe harbor equal to imputed retained revenue from prior slide (Retained Revenue = $5.6 M; Margin = $17.1M)
  - Staff elected to implement safe harbor as a straight addition at the end of the ICC methodology, versus removing safe harbor revenue from the ICC evaluation. Since this results in a 1:1 safe harbor, staff will use this approach moving forward.
- Cecil's ICC ranking and Total Efficiency score improves by 4, resulting in a .30% reduction vs. a .64% reduction.

Benefit of Safe Harbor Part 2: Removes Revenue from Efficiency Analysis

Current Results					
Hospital Name	Total Rank Points (Low Score is Better)	% Cut	Permanent Revenue	$ Cut	Effective % Cut
University of Maryland Shore Medical Center at Easton	61.00	0.04%	$227,343,682	$96,710	0.04%
Johns Hopkins Bayview Medical Center	61.50	0.09%	$705,163,929	$599,941	0.09%
Carroll Hospital Center	61.50	0.09%	$236,462,593	$201,178	0.09%
Western Maryland Regional Medical Center	65.00	0.38%	$337,690,082	$1,292,854	0.38%
University of Maryland Shore Medical Center at Chestertown	65.00	0.38%	$51,014,109	$195,309	0.38%
Northwest Hospital Center	65.50	0.43%	$273,411,755	$1,163,070	0.43%
University of Maryland Medical Center Midtown Campus	67.00	0.00%	$224,425,943	$0	0.00%
Union Hospital of Cecil County	68.00	0.64%	$168,517,163	$1,075,286	0.64%
Sinai Hospital	79.00	1.57%	$835,484,664	$13,150,094	1.57%
Results with Cecil Safe Harbor Equal to Imputed Retained Revenue					
MedStar Union Memorial Hospital	61.50	0.09%	$427,877,918	$364,031	0.09%
Carroll Hospital Center	61.50	0.09%	$236,462,593	$201,178	0.09%
University of Maryland Shore Medical Center at Easton	62.00	0.13%	$227,343,682	$290,130	0.13%
Johns Hopkins Bayview Medical Center	62.50	0.17%	$705,163,929	$1,199,883	0.17%
Union Hospital of Cecil County	64.00	0.30%	$162,850,163	$484,925	0.29%
Western Maryland Regional Medical Center	65.00	0.38%	$337,690,082	$1,292,854	0.38%
University of Maryland Shore Medical Center at Chestertown	65.00	0.38%	$51,014,109	$195,309	0.38%
Northwest Hospital Center	65.50	0.43%	$273,411,755	$1,163,070	0.43%
University of Maryland Medical Center Midtown Campus	67.00	0.00%	$224,425,943	$0	0.00%
Sinai Hospital	79.00	1.57%	$835,484,664	$13,150,094	1.57%

- Method: Remove from scalable revenue Cecil Safe Harbor to ensure that associated revenue is never subject to an efficiency modification.
- Cecil's effective percentage cut ($ cut divided by permanent revenue inclusive of safe harbor revenue) is reduced from .30% to .29%.

Revenue 4 Reform Safe Harbors & Process

Overview of the Revenue 4 Reform Safe Harbors

Staff intends discussed two safe harbors at the previous work-group meeting:

1. Community Health Safe Harbor – The Hospital may include any spending that is directed towards an unmet community health need that is identified on the hospital's CHNA; or is spent on implementing one of the CDC's Healthy People Interventions.
2. Physician Spending Safe Harbor – The hospital may include spending on primary care, mental health providers, and dental providers that are in a Health Professional Shortage Area or a Medically Underserved Area.

Additionally, Staff intends to propose a catch-all safe harbor that allows the hospital to identify interventions that fall outside of the existing safe harbors. The hospital may only propose community health interventions to be included, and not other hospital initiatives.

Catch-All Safe Harbor

The Catch-All Safe-Harbor must include community health interventions, e.g. interventions that are conducted outside of the hospital and which focuses on the maintenance, protection, and improvement of health.

- The hospital must clearly define which populations or communities that the hospital intends to address;
- The hospital must also describe why the interventions are needed and why those interventions are not included on the hospital's CHNA.

The Hospital must also present a measure that be used to assess the ROI on the hospital's intervention.

- The hospital must propose an outcomes measures (e.g., mortality, readmission, patient experience, etc.) and not process measures (e.g., number of visitis) and a data source for collecting the measure;
- The hospital must propose a target for improvement on the relative measure and a time horizon for achieving the proposed improvement.

HSCRC staff will review the proposal and will accept it if amount of the safe harbor is comensurate with the measure and intended improvement.

Process for Assessing the Revenue 4 Reform Safe Harbor

In order to receive approval for revenue to be included in the Safe Harbor, the Hospital must submit:

- A Narrative Description of their Intervention – The hospital must explain how their intervention meets the criteria of the relevant safe harbor(s);
- A Service Area – The Hospital must indicate where the interventions will be deployed and where the served population resides;
- A Budget and Cost Model – The Hospital must include an aggregate amount that they are proposing to be included in the safe harbor and include a cost model that explains how the aggregate amount was derived.

The HSCRC will review the proposal in order to ensure that the Hospital's interventions are reasonably related to one of the safe harbors, that the service area is reasonably related to the hospital's service area, and that the cost of the intervention is reasonable.

Reporting Revenue 4 Reform Costs

The Hospital will report the amount of its safe harbored spending on its Annual Population Health Report.

- On the population health report, the hospital will be asked to report the amount of money that was spent on an approved intervention;
- The Hospital will be credited with expenditures up to the amount approved by the HSCRC but should the actual amount that they have spent;
- The HSCRC will choose a small number of hospitals / interventions to audit to ensure compliance with the safe harbor amounts.

The Hospital's approved safe harbor will be included in the next ICC run. The amount included in the Population Health Report will be reconciled with the approved amount.

- If the hospital reports less than the approved safe harbor (that was credited in the ICC), then the Hospital will be penalized in the next safe harbor after the Population Health Reports are collected;
- In future years, the HSCRC may "catch up" and use the the actual values in the Population Health Report for the ICC.

Proposed Timing for the R4R Safe Harbor

Staff will propose to incorporate Revenue 4 Reform in the ICC and the Update Factor for FY23. This anticipates the following timeline:

- Fall of 2021 – Draft Recommendation brought to the Commission
- Winter / Spring 2022 – Submission Process for FY23
  - Hospitals may submit Revenue for Reform proposals
  - Staff will review and approve Safe Harbors
- April 2022 – HSCRC runs the ICC for FY23 using the approved Safe Harbor amount.
- July 2022 – The FY23 Update Factor is scaled for the ICC Outliers.
- December 23 – The Hospitals submit their Population Health Reports for FY23.
  - The hospital spending will be reconciled with the amount included in the safe harbor.
  - A hospital that spent less than their safe harbor amount will be penalized in the FY24 ICC.

Questions?