History and Overview of the HSCRC
(Health Services Cost Review Commission)

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University of Maryland Medical System

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University of Maryland Medical System

January 30, 2015
Discussion Topics

I. Before the HSCRC

II. The Formation of the HSCRC and the “All Payor” System

III. Impact

IV. Current & Future Initiatives

V. Other General Information
General Overview

• Uncertainty
  – Status of Healthcare Reform
  – Accountable Care Organizations

• Challenge
  – Performance Improvement
  – Re-capitalization
  – Maintaining acceptable operating margins

• Opportunity
  – Chance for this era of healthcare workers to make a profound and lasting change
Maryland Healthcare Environment
Pre-HSCRC (Late 60’s – Early 70’s)

- **Significant amount of in-efficiency in delivery system**
  - Over utilization
  - Length of stay for patients exceeded national averages
  - Excess capacity

- **Weak financial performance for Maryland Hospitals**

- **Inconsistent access to hospital care for the poor and uninsured**

- **By 1971, hospital cost per case in Maryland exceeded the National average by 25%!**
The Formation of the HSCRC

• **1971 - Initial legislation enacted by the General Assembly**
  – Independent body within the Department of Health and Mental Hygiene
  – HSCRC given the authority to establish hospital rates

**Legislative Mandate**

• **Contain Hospital Costs**
  ➢ Total costs are reasonable

• **Ensure Equity / Stability**
  ➢ Charges (unit rates) are reasonably related to costs.
  ➢ Fair and equitable rates to everyone
  ➢ Hospitals are compensated fairly (Provide financial stability)
  ➢ Predictability for payors and hospitals

• **Maximize Access to Care**
  ➢ All hospitals and payors share in responsibility of caring for the poor and uninsured

• **Provide Accountability**
  ➢ System checks and balances
  ➢ Public disclosure
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**Regulatory Jurisdiction (Rates)**

**Includes:**
- Inpatient services
- Outpatient services “at the hospital”

**Excludes:**
- Physician/Professional Fee/Part B Activity
- Other operating revenue
- Non operating revenue

**Provide Accountability**
- System checks and balances
- Public disclosure
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Maryland becomes an “All Payor” state
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  - Continue to be the only state with this “waiver”
HSCRC’s Mandate

• Ensure Equity / Fairness / Stability

• Maximize Access to Care

• Contain Hospital Costs / Total Costs are Reasonable

• Provide Accountability
HSCRC’s Mandate

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• Provide Accountability
“All Payor” Hospital Rate Setting System

Unit Rates

• **HSCRC**
  – Establish and approve rates for each unit of service (Room and Board, imaging, lab, etc…)
    • Hospital specific
  – Unit rates are to be reasonably related to underlying costs
    • Including social costs of uncompensated care (bad debt / charity)

• **Hospitals**
  – Required to charge **all payors** at HSCRC approved unit rates

• **Payors (All)**
  – Required to pay hospitals based on each hospitals approved unit rates
    • Payors given the ability to deny payment of care for lack of medical necessity
### (Non-Medicare)

Dear Mr. Jones

35 year old Pneumonia Patient

<table>
<thead>
<tr>
<th>Services</th>
<th>Units</th>
<th>Unit Rates</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board</td>
<td>4 Days</td>
<td>$500</td>
<td>$2,000</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>1 Visit</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td>Operating Room</td>
<td>50 Mins.</td>
<td>$20</td>
<td>$1,000</td>
</tr>
<tr>
<td>Lab</td>
<td>40 Tests</td>
<td>$10</td>
<td>$400</td>
</tr>
<tr>
<td>X-Ray</td>
<td>5 Tests</td>
<td>$100</td>
<td>$500</td>
</tr>
</tbody>
</table>

Please pay this Amount $4,025

### (Medicare)

Dear Mr. Smith

75 year old Hip Fracture

<table>
<thead>
<tr>
<th>Services</th>
<th>Units</th>
<th>Unit Rates</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board</td>
<td>8 Days</td>
<td>$500</td>
<td>$4,000</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>1 Visit</td>
<td>$125</td>
<td>$125</td>
</tr>
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<td>$10</td>
<td>$50</td>
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<td>X-Ray</td>
<td>10 Tests</td>
<td>$100</td>
<td>$1,000</td>
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Please pay this Amount $7,175
Hospital Reimbursement
Maryland vs. Rest of Nation

[Bar chart showing hospital reimbursement costs for Medicare/Medicaid, Community, SelfPay, and average for the nation.]
Hospital Reimbursement
Maryland vs. Rest of Nation

5% Margin
Hospital Reimbursement
Maryland vs. Rest of Nation

Charge to Cost Ratio (Illus.)

Mostly attributable to pricing needed to maximize reimbursement given need to cost shift.
Hospital Reimbursement
Maryland vs. Rest of Nation

Charge to Cost Ratio (Illus.)

2.5 to 1

Nation

Maryland
Hospital Reimbursement
Maryland vs. Rest of Nation

Charge to Cost Ratio (Illus.)

1.2 to 1

2.5 to 1

Mostly attributable to the cost of uncomp. care, contractual allowances, and profit

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Maryland

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HSCRC Approved Discounts

- Medicare/Medicaid
  - 6.0%
- MCare/MCaid HMO’s
  - 4.0%
- Advance Financing
  - 2.25%
- Prompt Pay
  - 1%-2.25%

Medicare/Mcaid
Comm.
SelfPay
Avg.
Reimbursement Maryland vs. Rest of Nation

Maryland mostly attributable to the cost of uncomp. care, contractual allowances, and profit.

1.2 to 1
2.5 to 1

Charge to Cost Ratio (Illus.)

Pillar of HSCRC System

✓ Ensure Equity and Fairness
HSCRC’s Mandate

• Ensure Equity / Fairness / Stability

• **Maximize Access to Care**

• Contain Hospital Costs / Total Costs are Reasonable

• Provide Accountability
HSCRC Impact – Maximizing Access

Statewide Actual Uncompensated Care
1977 - 2010

Fiscal Year

Percent of Total Gross Patient Revenue

Amount in Uncompensated Care (Millions)

$ UCC (millions)  % Total Revenue
The Statewide UCC pool fund

• The Statewide UCC % is built into all hospitals’ rates; the UCC Pool acts as a settlement methodology to account for hospitals that experience more or less UCC than the State.

- Low UCC Funding: Hospital pays into UCC Pool.
- High UCC Funding: Hospital receives payments from UCC Pool.

Statewide UCC Included in all hospital rates.
HSCRC’s Mandate

- Ensure Equity / Fairness / Stability
- Maximize Access to Care
- **Contain Hospital Costs / Total Costs are Reasonable**
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HSCRC Impact – Control Costs

Difference in Cost per Case: Maryland vs. Nation

Model of Success

Maryland costs per case had improved dramatically from 25% higher than nation to 12% below in 1992

Source: Maryland Hospital Association
HSCRC Impact – Control Costs
Difference in Cost per Case: Maryland vs. Nation

Illustration

<table>
<thead>
<tr>
<th>Year</th>
<th>MD</th>
<th>Nation</th>
<th>% Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>'76</td>
<td>$1,000</td>
<td>$800</td>
<td>+25%</td>
</tr>
<tr>
<td>'92</td>
<td>$1,640</td>
<td>$1,865</td>
<td>-12%</td>
</tr>
</tbody>
</table>

Source: Maryland Hospital Association
Inpatient Charge Per Case System (CPC)

Hospitals continue to charge at HSCRC established unit rates but are also must comply with its HSCRC established Charge Per Case Target.

Patient Bill
(Unit Rates)

Dear Mrs. Jones

<table>
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<tr>
<th>Services</th>
<th>Units</th>
<th>Rates</th>
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<td>5 Tests</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Supplies/Drugs</td>
<td>Usage</td>
<td></td>
<td>$540</td>
</tr>
</tbody>
</table>

Please pay this Amount $4,565

Must Average

Charge per Case Target $6,800

$13,830

$4,565

$2,005
The Making of the HSCRC

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- 1980 - Medicare exemption became permanent (with stipulations) in Maryland
  - Continue to be the only state with this “waiver”

**There’s a “Catch” – There’s always a “Catch”?**

**“The Waiver Test”**

On-going demonstration that the cumulative rate of growth in Medicare payments to Maryland hospitals is no greater than the cumulative rate of growth in Medicare payments to hospitals nationally over the same time period.

- 1980 – Medicare exemption
  - Continue to be the only state

<table>
<thead>
<tr>
<th></th>
<th>National Medicare Pmt/Case</th>
<th>Maryland Medicare Pmt/Case</th>
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<tbody>
<tr>
<td>Base Period (1981)</td>
<td>$2,293</td>
<td>$2,972</td>
</tr>
<tr>
<td>Measurement Period (Sept 2010)</td>
<td>$10,557</td>
<td>$12,488</td>
</tr>
<tr>
<td>Cumulative Growth Rate (Absolute Test)</td>
<td>360.4%</td>
<td>320.2%</td>
</tr>
<tr>
<td>Relative Margin Waiver Cushion (HSCRC Calc)</td>
<td></td>
<td>9.57%</td>
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</tbody>
</table>
The Making of the HSCRC

Relative Margin Waiver Cushion
June 2006 – Projected June 2013

Maryland Relative Waiver Test
2006 - 2013

- Actual
- Forecast
- Last Waiver Letter 09/2010
- Estimated Current Position 9/30/11

Projected Future Deterioration
Potential adjustments to national trend would improve results

Source: HSCRC
The Making of the HSCRC

Overarching Concern for Maryland Hospitals

Changes to the healthcare delivery system will challenge the current waiver test.

• Shift of cases to Observation increases the average charge per admission in Maryland
  • Impact of 2-midnight rule
• New payment initiatives (TPR, ARR, etc.) provide incentives to reduce utilization, increasing the average charge per admission
• Medicaid budget issues

The HSCRC Staff, MHA, Payors and CMS are reviewing the structure of the current Waiver Test.
The Triple Aim of Healthcare

• Improve Healthcare Outcomes – clinical outcomes

• Improve the Patient’s Healthcare Experience

• Reduce the Cost-of-Care – “bending the cost curve”
**Initiatives Designed to Control Growth**

- **Quality-Based Reimbursement**
  - Maryland Hospital Acquired Condition (MHAC) program
    - Identifies Potentially Preventable Complications using diagnosis and procedure data
    - Calculates actual versus expected rates of complications
    - Hospitals are reward or penalized based on performance relative to their peers
  - Quality Based Reimbursement (QBR) program
    - Process of care measures (core measure) and patient satisfaction scores (HCAHPS)
    - Similar to MHAC, hospitals are scaled based on relative performance

*Programs are changing, but even more revenue at risk*
Initiatives Designed to Control Growth

• Expansion of Total Patient Revenue (“TPR”) Methodology
  – In 2010, eight hospitals converted from CPC/CPV to TPR
    • Currently 10 hospitals on TPR agreements
  – TPR provides hospitals with a “total” revenue base that is 100% fixed
    • No change in revenue with increases or decreases in either volume or service mix
  – Overall incentive to reduce service utilization and encourage improvements in population health
  – If hospitals are successful in reducing utilization, AND, associated variable costs, profitability should increase
Current Initiatives

• Global Budget Model
  – Provides fixed revenue base on an annual basis for inpatient and outpatient regulated revenue
    • May be adjusted in the future to more accurately reflect market share
    • Receive annual inflation adjustments
    • Possibility for population and aging adjustments
  – Changes the long-standing incentives that have been in-place regarding volume
  – Forces hospitals to rethink, and possibly redesign, strategic and operating plans

❖ These agreements will be a work-in-progress
Future Initiatives

• Capitated and Other Bundled Service Arrangements
  – Provide payment upfront for a defined population of patients and/or a specific service

• Gainsharing Models
  – Have the ability to partner with physicians to share in cost savings and utilization management
HSCRC’s Mandate

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HSCRC Impact – Accountability
Reasonableness of Charges (ROC) and Rate Adjustments

- **ROC used by HSCRC and hospitals to evaluate cost effectiveness on a per case basis relative to a peer group.**
  - Adjustments to cost (CMI, Labor, Markup, Medical Education, etc.)
  - Four peer groups: Major Teaching, Minor Teaching, Non-Teaching, Academic Medical Center (JHH and UMMC)

- **HSCRC approves rate adjustments to hospitals annually**
  - Across the board inflation adjustments + Hospital specific changes in case mix
  - Other adjustments (program, prior year corrections, etc..)
  - Annual rate adjustments are “scaled,” based on relative ROC performance
    - Higher “cost” hospitals receive a lower update; Lower “cost” hospitals receive a higher update

- **Hospitals reserve the right ask for additional rates if current rate structure is not adequate. (Favorable ROC Position)**
  - File “Full” rate application or “Partial” rate application (CON approved capital)

- **HSCRC reserves the right to take corrective actions against high cost hospitals (Unfavorable ROC Position), via spenddowns or Full Rate Setting**
HSCRC Impact – Accountability
Disclosure of Information and Performance

• **High degree of availability**
  – Maryland system is based on most comprehensive and timely information available

• **Multiple reporting requirements of Hospitals**
  • Monthly revenue and utilization
  • Annual filings
  • Community Benefit Report
  • Reporting by payer and in-state vs. out-of-state
  • New data tape submission requirements – now monthly

• **Public Disclosure Report prepared annually by the HSCRC**
Additional Information
# HSCRC Current Commissioners
(Seven member panel appointed by Governor)

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Appointed</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Colmers – Chairman</td>
<td>Former Secretary, MD Dept of Budget and Management</td>
<td>2011</td>
</tr>
<tr>
<td>Herbert Wong, Ph.D. – Vice Chairman</td>
<td>Senior Economist, Agency for Healthcare Research &amp; Quality</td>
<td>2005</td>
</tr>
<tr>
<td>Stephen F. Jencks, M.D., M.P.H.</td>
<td>Institute for Healthcare Improvement</td>
<td>2012</td>
</tr>
<tr>
<td>George H. Bone, M.D.</td>
<td>Private Practice Physician</td>
<td>2010</td>
</tr>
<tr>
<td>Bernadette C. Loftus</td>
<td>Associate Executive Director, The Permanente Medical Group</td>
<td>2011</td>
</tr>
<tr>
<td>Thomas R. Mullen</td>
<td>President, Mercy Health Services</td>
<td>2011</td>
</tr>
<tr>
<td>Jack C. Keane</td>
<td>Independent Consultant</td>
<td>2011</td>
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HSCRC and Other Health Care Links

• Health Services Cost Review Commission (HSCRC)
  – www.hscrc.state.md.us

• Maryland Hospital Association (MHA)
  – www.mdhospitals.org

• Healthcare Financial Management Association (HFMA)
  – www.hfma.org

• HighMark (Medicare Fiscal Intermediary)
  – www.highmarkmedicareservices.com
Closing Comments