Jefferson
Thomas Jefferson University
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

Thomas Jefferson University
Jefferson Digital Commons

College of Population Health Forum
Jefferson College of Population Health

11-12-2014

The Future of Population-Based Reimbursement

David Chin, MD, MBA
Johns Hopkins Bloomberg School of Public Health and Johns Hopkins School of Medicine, dchin@jhsph.edu

Follow this and additional works at: https://jdc.jefferson.edu/hpforum

Part of the Health Services Research Commons

Let us know how access to this document benefits you

Recommended Citation
Chin, MD, MBA, David, "The Future of Population-Based Reimbursement" (2014). *College of Population Health Forum.* Presentation 86.
https://jdc.jefferson.edu/hpforum/86

This Article is brought to you for free and open access by the Jefferson Digital Commons. The Jefferson Digital Commons is a service of Thomas Jefferson University's Center for Teaching and Learning (CTL). The Commons is a showcase for Jefferson books and journals, peer-reviewed scholarly publications, unique historical collections from the University archives, and teaching tools. The Jefferson Digital Commons allows researchers and interested readers anywhere in the world to learn about and keep up to date with Jefferson scholarship. This article has been accepted for inclusion in College of Population Health Forum by an authorized administrator of the Jefferson Digital Commons. For more information, please contact: JeffersonDigitalCommons@jefferson.edu.

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

Future of Population-Based Reimbursement

Nov 12, 2014

David Chin, MD, MBA

Distinguished Scholar

Department of Health Policy and Management

Johns Hopkins Bloomberg School of Public Health

dchin5@jhu.edu

© 2003, Johns Hopkins University. All rights reserved.

Agenda

- FFS Context
- Maryland – 2014 CMS Waiver
- Implications
- Summary

Waste in US Healthcare

Opportunities to eliminate wasteful spending in healthcare add up to $1.2 trillion of the annual $2.2 trillion spent nationally; these categories overlap

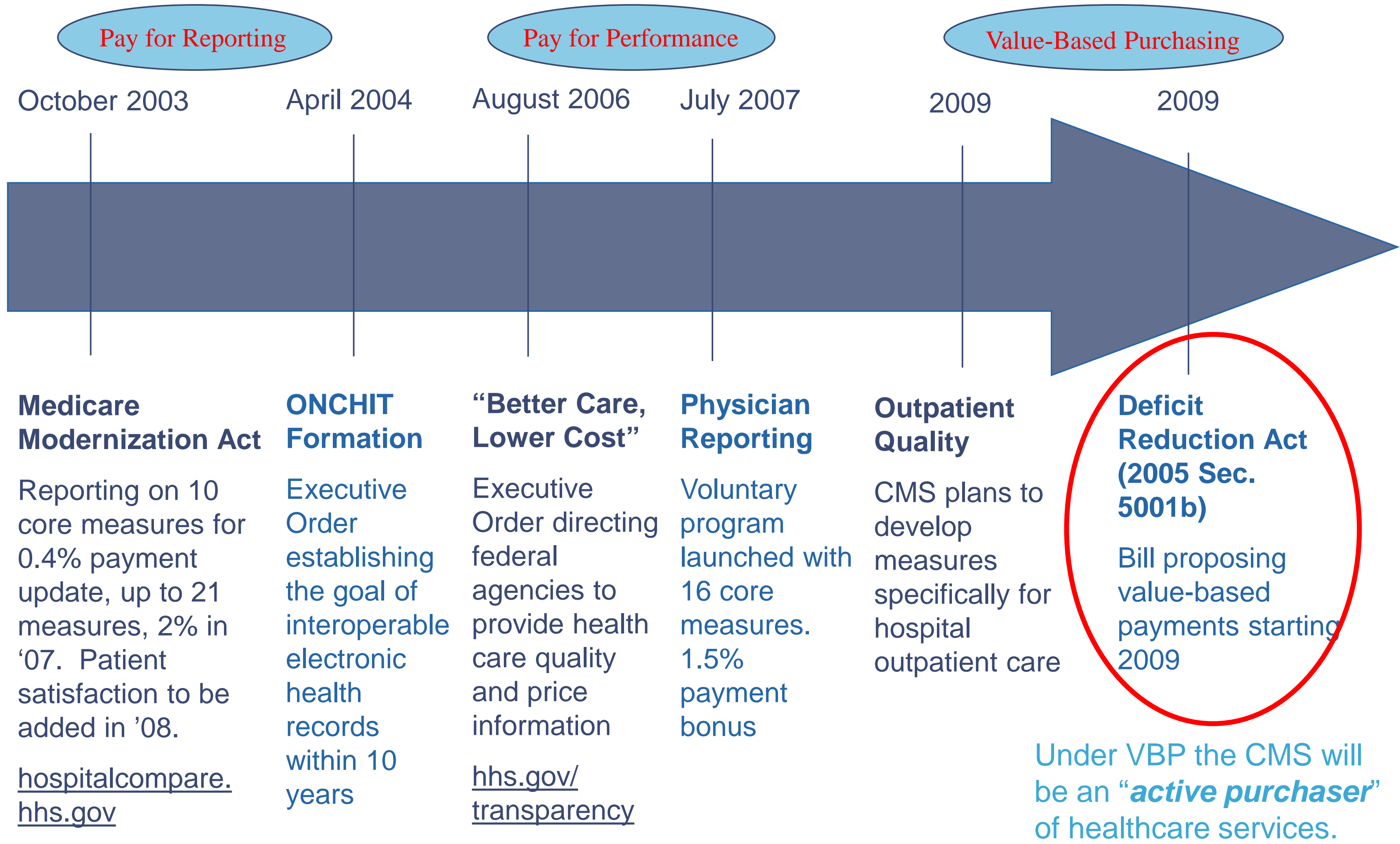
- Total Waste $1.2 Trillion
  - Behavioral $303B to $493B
    - Obesity/ overweight $200B
    - Smoking $567M to 191B
    - Non-Adherence $100B
    - Alcohol Abuse $2B
  - Clinical $312B
    - Defensive medicine $210B
    - Preventable hospital readmin $25B
    - Poorly managed diabetes $22B
    - Medical errors $17B
    - Unnecessary ER visits $14B
    - Treatment variations $10B
    - Hospital acquired infections $3B
    - Over-prescribing antibiotics $1B
  - Operational $126B to $315B
    - Claims processing $21B to 210B
    - Ineffective use of IT $81B to 88B
    - Staffing turnover $21B
    - Paper prescription $4B

Waste cannot be eliminated immediately. However, by viewing waste in these baskets, the size of opportunities can be prioritized and rewarded. Like health spending itself, these categories overlap. Reducing one basket can affect the size of the others.

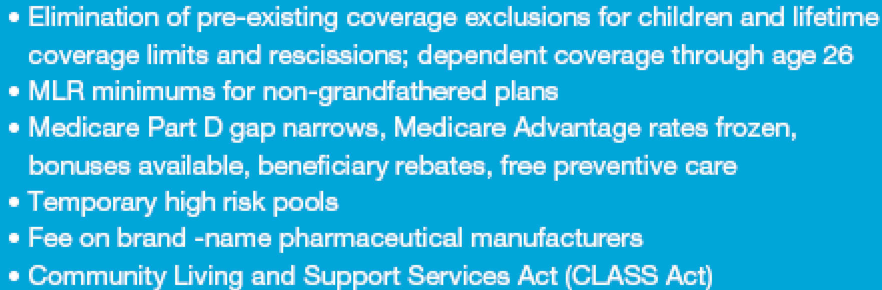
Source: Analysis by PwC's Health Research Institute based on published studies on inefficiencies in healthcare.

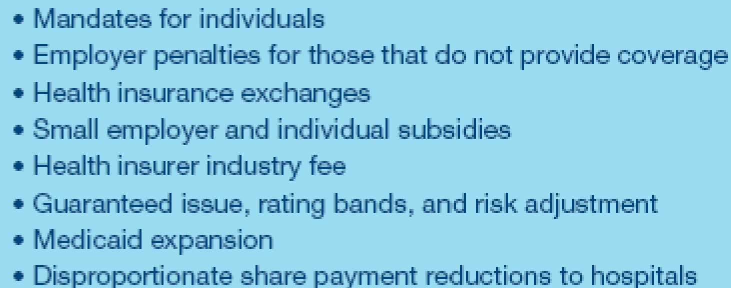
© 2003, Johns Hopkins University. All rights reserved.

Quality and Payment Reform in FFS



Three tranches of health reform





Bending the cost curve (2015-2020)

- Penalty for not adopting electronic medical records
- Independent Payment Advisory Board (IPAB)
- High-cost plan excise tax
- Medicare Part D “Doughnut Hole” closes
- Reduced payment for hospital-acquired conditions

Ambulatory Sensitive Conditions

- Uncontrolled diabetes w/o complications
- Short-term diabetes complications
- Long-term diabetes complications
- Lower extremity amputation among diabetics
- Congestive Heart Failure
- Hypertension
- Angina without a procedure
- Adult Asthma
- Pediatric Asthma
- Chronic Obstructive Pulmonary Disease
- Bacterial Pneumonia
- Dehydration
- Urinary tract infection
- Perforated appendix
- Pediatric gastroenteritis
- Low-weight birth

AHRQ Prevention Quality Indicators 2004

© 2003, Johns Hopkins University. All rights reserved.

Change in Chicago ACSAs 2010 – 2012

Service Line	% ACSAs	% All Other Cases in the Service Line
Cardiology, Interventional	**(23.5%)**	**(12.7%)**
General Medicine	**(13.6%)**	**(5.7%)**
Gastroenterology	**(12.8%)**	**(6.2%)**
Endocrine	**(12.0%)**	**(1.4%)**
Thoracic Surgery	**(11.1%)**	**(9.0%)**
Neurology	**(7.8%)**	**(5.6%)**
General Surgery	**(6.8%)**	**(3.2%)**
Pulmonary	**(2.4%)**	**0.3%**
Cardiology	(10.2%)	(11.5%)
Vascular Surgery	(5.8%)	(9.3%)
Urology	(3.8%)	(12.1%)

Kaufman, Hall & Associates , Health Affairs Blog Jan 6, 2014

© 2003, Johns Hopkins University. All rights reserved.

Old vs. New Maryland Waiver

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

- Old Model

  Rate X Volume_X = Revenue_X

- New Model

  Revenue = Rate_X X Volume_X

Original Maryland CMS Waiver

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

- All payer including Medicare/Medicaid
- Cumulative Spending Growth Targets
  - Hospital Admission Costs
    - 26 % above national average in 1977
    - 4% below national average in 2011
- Uncompensated Care Pool
- Regulated and Unregulated Space

JOHNS HOPKINS
BLOOMBERG SCHOOL
of PUBLIC HEALTH

New Maryland Waiver from CMS

- 5 year demonstration – Global Budget Revenue (GBR)
- Per capita tests
  - Annual increase in total hospital costs for Maryland residents in Maryland hospitals per capita must be less than 3.58%
  - Increase in Medicare total hospital costs for Maryland beneficiaries per capita over 5 years must beat national per beneficiary trend by $330 million

Other Parts of the CMS Waiver

- Quality improvements
  - Readmissions
  - MHACs
  - Other quality measures
- Other Guardrails
  - Total cost of care
  - Non-Maryland Medicare hospital spending

Health Services Cost Review Commission GBR Agreements

- All hospitals have reached agreement
- 95% of all revenue in the state is under GBR
  - Most of what is not in GBR is JHHS out of state
- Agreements are posted on HSCRC web site.
- Contracts automatically renew

HSCRC FY15 Update
3.58% ≠ Update

Maximum per capita revenue growth	3.58%
Population growth	0.71%
Maximum revenue growth	4.32%

Inflation

- GBR 2.41%
- Non GBR 1.71%

+/- Adjustment for Volumes

\+ CON Adjustments

\+ Infrastructure Allowance

+/- Uncompensated Care

+/- Quality Metrics

\+ Contingency

+/- Other Assessments

Has to add up to well less than 4.32%

Quality Measures and Targets

Measures focus on patient and population health improvement

- Medicare readmission reduction to national average
  - FY2015 target is 6.76% reduction per Maryland hospital
- Potentially preventable hospitalizations
- Reduce potentially preventable complications by 30% over 5 years
  - State target = 8% aggregate reduction per year

Regulated to Unregulated

- "When services covered by the GBR model are moved to an unregulated setting, an adjustment will be made to *ensure the shift provides savings*"
- Precise calculation not known
- Annual disclosure of changes in services provided

Johns Hopkins Bloomberg School of Public Health

Rate Compliance

- Unit rate compliance
  - Hospitals must charge HSCRC rates or face penalties
  - In order to hit revenue target, hospitals must alter rates as volume fluctuates
  - Allowed corridor increased to +/- 5%
    - Generally to all rate centers
    - May request up to +/- 10%
- Overall compliance
  - Total GBR compliance +/- 0.5%
  - Opportunity to move revenue/services within a hospital system

Johns Hopkins Bloomberg School of Public Health

Overall Compliance

- Overall compliance
  - Total GBR compliance +/- 0.5%
  - Opportunity to move revenue/services within a hospital system

Market Share

- HSCRC will monitor volume changes
- Policy still under development, but some general statements
  - Will separately consider reductions in avoidable volumes
  - Upward volume adjustment only to extent there is corresponding reduction elsewhere
  - Will monitor inappropriate shifting of cases
- Will consider one-time ACA volume impact
- Will consider other one-time exogenous factors

Transfers

- Under development
- Will apply to in-state transfers among hospitals
- Monitored relative to base
- Expect that an amount will be charged to transferring hospital and credited to recipient

HSCRC

- Established in 1971 to set hospital rates
- All-payer waiver in 1977
- Governed by 7 commissioners – maximum of three providers
- All acute, specialty, and mental health hospitals in Maryland
- Free-standing ambulatory and physician offices excluded

Johns Hopkins Bloomberg School of Public Health

CRISP

- Established in 2009 as an HIE
- All Maryland and 6 DC Hospitals
- Regional Extension Center for HIT for 1000 primary care providers
- Real time ADT, ER visits, lab, radiology, discharge summaries, Rx, H&P, Consultations, and Operative Notes

Challenges

- Virtual “Medicare Advantage Plan” for 750,000 Maryland Medicare recipients
- Attribution for Population Denominators for Global Budgets
  - Western Maryland Experience
- Physicians and Unregulated Space

JOHNS HOPKINS
BLOOMBERG SCHOOL of PUBLIC HEALTH

Care Management

- Primary Care MDs
- Specialists
- Sites of Care

Pham, et al; Ann Intern Med 2009;356(11) 236-42

Near Term Success Factors

Johns Hopkins Bloomberg School of Public Health

- Need to maintain volumes at FY 2013 levels by *reducing inappropriate* (readmissions, hospital acquired conditions, avoidable admissions) and *increasing appropriate* volume
- Reduce operational costs
- Need to optimize utilization of all assets
- Maximize Out of State/International volume

JOHNS HOPKINS
BLOOMBERG SCHOOL of PUBLIC HEALTH

Summary

- FFS Context
- New Waiver is a call to action
- Creates a “glide path” for change
  - Alignment of Incentives
  - Alignment of Infrastructure
- Value is the new gold standard
  - Quality
  - Appropriate hospital care
  - Cost efficiency
  - Population health focus