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Center for Rural Health Policy Analysis

Rural Health Value

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Rural Innovation Profile

Global Budget Process as an Alternative Payment Model

What: A rural hospital faces challenges and opportunities in the context of annual, individualized, pre-set global budgets.

Why: Maryland and the Centers for Medicare & Medicaid Services (CMS) are evolving the State's all-payer hospital rate-setting system to increase the use of population-based payment models and limit total annual hospital spending growth to 3.58 percent.

Who: McCready Health, Crisfield, Maryland.

How: McCready Health negotiates with the State commission to set the hospital's annual budget based on historic volume and costs and service patterns, and regularly monitors and adjusts fees to achieve budget goals.

Key Points

- Today's alternative payment models emphasize care quality and population health, as well as cost. Future payment focus will be on total cost of care, with hospital care as a component.
- Hospitals must closely monitor the fluctuation in cost of services and utilization, and must regularly adjust charges within a set range to hit pre-set global budget targets.
- CMS waiver requirements are prompting increased care coordination.
- Rate structures are set to prevent one service line from subsidizing another, and to prevent cost shifting between public and private insurers.

Cooperative Agreement funded by the
Federal Office of Rural Health Policy:
1 UB7 RH25011-01

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MCCREADY HEALTH

McCready Health is a hospital and long-term care health system serving the Lower Eastern Shore of Maryland. Its service area of about 7,000 people includes several island communities. Edward W. McCready Memorial Hospital, Crisfield, Maryland, has three acute care beds and an average daily census of 2.7. The next smallest hospital in Maryland has 40 beds. Due to its waterfront location on Chesapeake Bay, McCready may be the only hospital in Maryland with a dock at its emergency department. The system also includes a 76-bed long-term care and short-term rehabilitation center, a 30-bed assisted living center, and an immediate care and imaging center. McCready Health's workforce totals 208 FTEs.

MARYLAND'S HOSPITAL PAYMENT MODEL

All-Payer Rate Setting

Maryland has had an all-payer rate-setting system since 1977. An independent State commission, the Health Services Cost Review Commission (HSCRC), sets hospital service reimbursement rates for all payers, including Medicare and Medicaid. A Medicare waiver exempts Maryland from the Inpatient Prospective Payment System and the Outpatient Prospective Payment System and allows the State to set rates for these services. No Maryland hospitals are designated as critical access.

The HSCRC establishes hospital-specific and service-specific rates for all inpatient, hospital-based outpatient, and emergency services. Annual rates vary between hospitals based on hospital population changes, demographic changes, efficiency adjustments, pay for performance, external utilization changes, and service changes. Unusual circumstances, such as volume shifts due to extreme weather, may allow for rate adjustments during the year. All payers (Medicare, Medicaid, and commercial) reimburse a hospital for services at the same amount. No discounts are available to the different payers, which eliminates cost shifting between payers.

The model has evolved over time. For Maryland to retain its Medicare waiver from CMS reimbursement rates, in 2014 the state committed to new provisions that shift reimbursement from volume to value.

These included:

- Hospital per capita revenue growth ceiling of 3.58 percent per year, with savings of at least \$330 million to Medicare over five years
- Quality metrics, with patient- and population-centered measures to promote care improvement
- Payment transformation away from fee-for-service to global hospital care budgets





Set Annual Budgets

Starting in 2014, all Maryland hospitals are given a fixed annual revenue cap for providing hospital services. The caps are established by the HSCRC at the beginning of the fiscal year through either the Total Patient Revenue (TPR) system—for hospitals with easily defined market areas—or Global Budget Revenue (GBR) system—for hospitals with overlapping markets. Both systems aim to control increases in total hospital revenue per capita and encourage hospitals to focus on population-based health management. Both systems provide minimum/maximum rate ranges for service lines (5 percent above and 10 percent below unit rate compliance charge corridors). Seasonal variation is taken into consideration. Hospitals can adjust their own rates, as needed, within the range. The rate range gives hospitals some flexibility to respond to environmental changes—such as spikes in demand—without allowing cost shifting between service lines.

Rural hospitals in Maryland have operated with global revenue budgets longer than other hospitals in the state. The TPR system, which applies to rural hospitals, began in 1980 and expanded to all 10 rural hospitals in 2010 (FY 2011). As part of the 2014 CMS waiver updates, Maryland created the GBR system to provide a similar budget cap structure for all other hospitals. The HSCRC is transitioning TPR hospitals to the newer GBR system.

MCCREADY HEALTH'S EXPERIENCE WITHIN THE TPR SYSTEM

Edward W. McCready Memorial Hospital was the second hospital to participate in Maryland's TPR system, starting in FY 2008. All services provided on the McCready Hospital campus are regulated under TPR. Services provided off campus are not regulated and fall under traditional payment methods. CEO Joy Strand joined McCready Health in 2013. After working at a critical access hospital and a prospective payment system hospital in other states, Strand had a steep learning curve in adjusting to the TPR system. She says that regardless of the specific revenue reimbursement system, supporting a hospital that serves a population of less than 10,000 is a challenge.

Rate Setting

Rate setting with HSRC is a complicated and lengthy negotiation process. In Strand's three years at McCready, rate setting is rarely finalized by the start of the fiscal year when it takes effect. The budget year begins based on last year's performance and is revised later if necessary. Historic volumes are used when the HSCRC sets the TPR for the year; seasonal fluctuations are considered as well. Many hospitals, including McCready, hire a

“CMS, the state, and the hospitals have the same goals. They want communities to have access to the hospitals they need and to get the health care they need. They just come at it from different angles.

***Joy Strand, CEO
McCready Health***





consultant for guidance in completing the complex rate-setting worksheet. Consultants can help project additional growth in certain areas or see where a hospital did not receive the market basket update in a certain corridor.

Given the impact of utilization variability on the hospital's tight margins, Strand and her chief financial officer meet every two weeks throughout the year to make timely decisions about rate adjustments. They review status against their annual budget and compare charges against the allowable TPR for that time frame. For each service corridor, they analyze volume and charge data to assess whether McCready is within the corridor and the percentage of spending for the time. They adjust rates up or down within each corridor to stay under, but as close as possible, to the annual budget cap. If McCready is ahead of spending, they decrease rates; if behind, they increase rates. Because of its small size, McCready is challenged to modulate charges when volumes fluctuate. Larger hospitals have more ability to absorb volume fluctuations.

One year McCready Memorial Hospital experienced significant, unexpected growth in surgery volumes, and it struggled to stay within its TPR budget. Reviewing data from Maryland's regional health information exchange, which serves the entire state and the District of Columbia, the HSCRC noticed the volume increase and approached McCready about making adjustments to its current TPR to accommodate the unpredicted volume growth.

Service corridor rate adjustments are reflected in consumer costs. For example, patients who need periodic complete blood counts (CBC), they might have one cost in January and a different price in June. Patient copay amounts change depending on the current price. The biggest complaint McCready has had from consumers is the facility charge for outpatient visits. This allowable charge that payers are required to pay applies to hospital-based physician practices but not to private, nonhospital physician practices.

Planning Implications

McCready sets annual, organization-wide goals based on four categories: financial, quality, growth, and community. The targets and activities of every facility and department in the McCready Health system link to the organizational goals. As a Maryland hospital, McCready's performance contributes to the many requirements and goals of the CMS Medicare waiver. Accordingly, McCready's organizational goals are built primarily around the waiver. The switch from volume payment to value payment is driving McCready to understand and improve the health status of its populations. Built-in quality performance incentives have prompted the hospital to further focus on reducing inappropriate readmissions and managing chronic disease.





The eligibility of a planned service line for reimbursement under TPR influences McCready Health's strategic planning. For example, McCready opened an immediate care center in a town 14 miles away from the McCready hospital campus to expand needed services in this community. Understanding this service would not be paid under TPR was an important part of the planning. For McCready, expanding nonregulated services outside of the TPR program contributes additional revenue that cannot be earned on the hospital campus.

As with all value-based reimbursement systems, Maryland's all-payer rate setting system requires health care organizations to have analytical expertise to understand and manage the complex billing, utilization, and clinical data. McCready, like other rural health care systems, is challenged to find and support analytic staff as part of its workforce.

Increased Coordination

The new phase of the CMS waiver starts in 2017. Hospitals will be partially responsible for the nonhospital care that people in their service areas receive. The goals of the waiver include increased collaboration and care coordination of shared patients. Strand is approaching area nursing homes and hospitals about working together so patients receive the greatest benefit at the lowest cost.

With additional funding through the HSCRC for regional planning, McCready is working with two larger area hospitals to address emerging requirements for population health and care management. The joint project will focus on care coordination for high utilizers and people with chronic care needs. The project also seeks to improve health care access on the small, remote Smith Island through physician assistant visits and telehealth. The two larger hospitals will analyze patient data available through Maryland's health information exchange. Lacking staff with the analytic skills to mine and use the data, McCready will be able to leverage the analytic skills of its collaborators.

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