May 15, 2014
Joshua M. Sharfstein, M.D.

Maryland All-Payer Hospital Model

Context: Innovation in Maryland

CRISP
State Health Improvement Process

Maryland Department of Health and Mental Hygiene

Josh Sharfstein, MD

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April 18, 2014
BACKGROUND OF MARYLAND RATE REGULATION

Health Services Cost Review Commission

- Oversees hospital rate regulation in Maryland
- Independent 7 member Commission
  - Decisions appealable to the courts
  - Balanced membership
  - Experienced staff
- Broad statutory authority
  - Has allowed Commission methods to evolve
- Broad Support
HSCRC Sets Hospital Rates for All Payers

- Medicare waiver granted July 1, 1977 as demonstration
  - Allows HSCRC to set hospital rates for Medicare—unique to Maryland
  - State law and Medicaid plan requires others to pay HSCRC rates
- Old Waiver test (2 parts)
  - Lower cumulative rate of increase in Medicare payment/admission from 1/1/81
  - Must remain all payer
- All payers pay their fair share of full financial requirements
  - Uncompensated Care
  - GME/IME
  - Capital
- Considerable value to patients, State and hospitals
HSCRC Cost Accomplishments

- Cost containment (all payer) -- From 26% above the national average cost per case in 1976 to 2% below in 2007

Indexed Growth Rates In Hospital Cost Per Adjusted Admission, Maryland And United States, 1978-2007 (2008)

Rate of growth in costs (percent)  

<table>
<thead>
<tr>
<th>Year</th>
<th>U.S. cost growth rate</th>
<th>Maryland cost growth rate</th>
<th>Maryland admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>0</td>
<td>8</td>
<td>400</td>
</tr>
<tr>
<td>1980</td>
<td>2</td>
<td>6</td>
<td>420</td>
</tr>
<tr>
<td>1985</td>
<td>4</td>
<td>4</td>
<td>440</td>
</tr>
<tr>
<td>1990</td>
<td>6</td>
<td>2</td>
<td>460</td>
</tr>
<tr>
<td>1995</td>
<td>8</td>
<td>0</td>
<td>480</td>
</tr>
<tr>
<td>2000</td>
<td>6.5</td>
<td>3</td>
<td>500</td>
</tr>
<tr>
<td>2005</td>
<td>5</td>
<td>1</td>
<td>520</td>
</tr>
</tbody>
</table>

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Challenges of the Old Waiver Model

- Medicare participation premised on Maryland keeping cost per case increase below increase in national rate of growth per case
- Emphasis on cost per case kept focus only on hospital inpatient services, not overall health care spending
- Not well fitted to innovations in health care

Diminishing “Waiver Cushion”

Exhibit 5
Medicare Waiver Cushion
Fiscal 1998-2014

Source: DLS
Total Patient Revenue (TPR)

- Voluntary three-year rate arrangements
- Establishes fixed global revenue levels for hospitals for all inpatient and outpatient revenues regardless of volume
- Revenues subject to adjustments for quality and performance standards
- Hospitals invest and develop approaches to improve population health, coordinate care, and reduce hospital utilization
- Savings from improved performance are retained by the hospital
- Provides strong incentives for care coordination and ensuring that care is provided in less expensive and more appropriate settings
- Requires the hospital to work collaboratively with community providers
- Ten hospitals began operating under this structure in FY 2011, mostly in isolated rural facilities with defined catchment areas

### TPR Hospitals

- 10% of net revenue
- Mostly rural

### TPR versus non-TPR Hospitals Before and After TPR Implementation in 2011

<table>
<thead>
<tr>
<th></th>
<th>TPR</th>
<th>Non-TPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Admissions</td>
<td>0.686</td>
<td>0.356</td>
</tr>
<tr>
<td>% Change</td>
<td>-57.7%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Same Hospital Readmissions</td>
<td>4.940</td>
<td>5.440</td>
</tr>
<tr>
<td>% Change</td>
<td>-8.9%</td>
<td>-10.3%</td>
</tr>
<tr>
<td>Available Admissions/Population</td>
<td>12.2%</td>
<td>20.5%</td>
</tr>
<tr>
<td>% Change</td>
<td>-37.0%</td>
<td>-37.1%</td>
</tr>
</tbody>
</table>

Source: RCHC, May 2013
Note: FY2013 is based on 6-month data and annualized.
Overview of New All-Payer Model
Model Hypothesis

- Maryland is the only state in the nation with an all-payer hospital rate setting system.
- Our hypothesis: By aligning all-payer rate setting with other critical reform efforts, Maryland can become a model for cost control, improved health outcomes, and a better patient experience for patients.

Proposed Model at a Glance

- Transformational shift of hospital revenue to global payment models
  - Goal is to move virtually 100% of hospital revenue into global payments
- All-Payer total hospital per capita cost growth ceiling
  - 3.58% - tied to long term growth of state economy
- Significant savings compared to Medicare trend
  - $330 million in Medicare savings under national trend
  - Target is dynamic as Maryland must beat national spending trend
Population Health Driven by Global Revenue Models and Performance Incentives

Minimum Global Revenue

- By Year 5 virtually all revenue subject to global revenue
- Hospital revenues that are not covered under a global model will be subject to a volume adjustment system

Proposed Model at a Glance cont.

- Requirements for significant continuing progress on performance measures
- Readmission
  - Model will deliver substantially faster decline in readmissions than national rate of decline to bring Maryland into alignment with national performance
- Hospital Acquired Conditions (HACs)
  - Currently CMS targets 15 HACs, using MS-DRGs
  - Maryland targets 65 Potentially Preventable Conditions (PPCs) inclusive of the 15 CMS HACs
  - The Model will deliver a 30% reduction in hospital-acquired conditions across 65 PPCs
Approved Model Timeline

- **Phase 1 (5 Year Model)**
  - Maryland all-payer hospital model
  - Developing in alignment with the broader health care system

- **Phase 2**
  - Phase 1 efforts will come together in a Phase 2 proposal
  - To be submitted in Phase 1, End of Year 3
  - Implementation beyond Year 5 will further advance the three-part aim

Key Advantages of Model

- Leverages the broad participation of all payers, providers, and patients to result in more rapid and systemic improvements
- Fundamentally realigns hospital incentives to be consistent with three-part aim
- Aligns with other initiatives under way in Maryland for synergistic effects
- Opportunities to test new ways to make progress on readmissions and hospital acquired conditions
  - Global hospital payments, hospital episodes with all-cause readmissions, broad based HAC program
- Phase I lays the groundwork for phase II application
Implications of Model

Creates New Context for HSCRC

- Align payment with new ways of organizing and providing care
- Contain growth in total cost of hospital care in line with requirements
  - Evolve value payments around efficiency, health and outcomes
- Better care
- Better health
- Lower cost
Focus Shifts from Rates to Revenues

**Old Model**

Volume Driven

- Units/Cases
- Rate Per Unit or Case
- Hospital Revenue

Unknown at the beginning of year. More units/more revenue

**New Model**

Population and Value Driven

- Revenue Base Year
- Updates for Trend, Population, Value
- Allowed Revenue Target Year

Known at the beginning of year. More units does not create more revenue

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HSCRC Will Use Incentives to Influence Volume

- Maryland currently has volume constraints applied through a variable cost factor set at 85% and a cost-per-case constraint with a case mix governor
- Maryland will control volume payments for services not under a global budget by continuing its rate setting programs with enhanced volume controls.
  - Variable Cost Factor changes
  - Volume Governor
HSCRC Actions Can Be Targeted

- HSCRC implements policies that impact hospitals differently depending on parameters identified.
  - Revenues are scaled based on performance against quality metrics
  - The variable cost factor can be adjusted or applied differently as dictated by policy goals and performance
  - Efficiency standards applied overall as well as focusing specifically on those hospitals identified as inefficient

Looking Ahead

- Success will depend on more than hospital payment
- Model aligns hospital incentives with other key innovations in Maryland, including the medical homes in Maryland’s State Innovation Model proposal
- Model aligns with major investments made in information technology, including the state’s Health Information Exchange
- Model aligns hospital incentives with the public health goals of the State Health Improvement Process
- Model will lay the groundwork for a Phase II application that moves to a total cost of care model
  - Maryland would be the first state to assume control of total cost of care for all payers
Acknowledgments

- Governor O'Malley and Lt. Governor Brown
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