# New All-Payer Model for Maryland Population-Based and Patient-Centered Payment Systems*

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** Information Provided by Donna Kinzer and Steve Ports, HSCRC*

# Outline of Presentation

- Overview
- History of Maryland Rate Setting
- Overview of New Maryland All-Payer Model
- Opportunities for Success
- Implementation Approach
- Questions

# MedChi Facts

- MedChi is the seventh oldest medical society, formed in 1799 in Annapolis, MD

- The Mission of MedChi, The Maryland State Medical Society, is to serve as Maryland's foremost advocate and resource for physicians, their patients,  and the public health of Maryland

- Largest physician organization in Maryland
  - Physicians – primary care and specialists
  - Medical residents and students
  - Practice managers and medical staff

# MedChi Works to Enhance Health Care for All Marylanders

- Set up Accountable Care Organizations in three regions to meet growing health care demand
- Offering CME and working with specialty societies to enhance medical knowledge
- Fighting to prevent decreases in Medicaid and Medicare payments to physicians, which significantly affects their patients
- Meeting the needs of both independent practices and employed physicians
- Free Rx drug cards to help uninsured and underinsured with prescriptions

# Approved New All-Payer Model

- Maryland is implementing a new All-Payer Model for hospital payment
  - Updated application submitted to Center for Medicare and Medicaid Innovation in October 2013
  - Approved effective January 1, 2014
- Focus on new approaches to rate regulation
- Moves Maryland
  - From **Medicare**, **inpatient, per admission** test
  - To an **all payer**, **total hospital** payment **per capita** test
    - Shifts focus to population health and delivery system redesign

# 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 Sets Prices Per Unit of Service

| Functional Center | Approved Rate | Unit | | Units of Service | Charge |
|---|---|---|---|---|---|
| Medical/Surgical Unit | $500 | Per day | X | 5 | $ 2,500 |
| Intensive Care Unit | $1,000 | Per day | X | 2 | 2,000 |
| Admission | $100 | Per case | X | 1 | 100 |
| Operating Room | $15 | Per minute | X | 150 | 2,250 |
| Radiology | $20 | RVU | X | 25 | 500 |
| Pulmonary | $3.00 | RVU | X | 10 | 30 |
| Blood | $15 | RVU | X | 5 | 75 |
| Lab | $2.00 | RVU | X | 25 | 50 |
| Physical Therapy | $16 | RVU | X | 5 | 80 |
| Cost of Drugs Sold | $1,200 | Invoice cost | X | patient | 1,200 |
| Medical Supplies | $2,100 | Invoice cost | X | patient | 2,100 |
| Total Charge Per Case | | | | | **$10,885** |

# HSCRC Administers Quality-Based Payment Initiatives for Hospitals

## QBR
(Quality Based Reimbursement)

- Clinical Process of Care Measures
- Patient Experience of Care (HCAHPS)
- Mortality

## MHAC
(Maryland Hospital-Acquired Conditions)

- 65 Potentially Preventable Complications

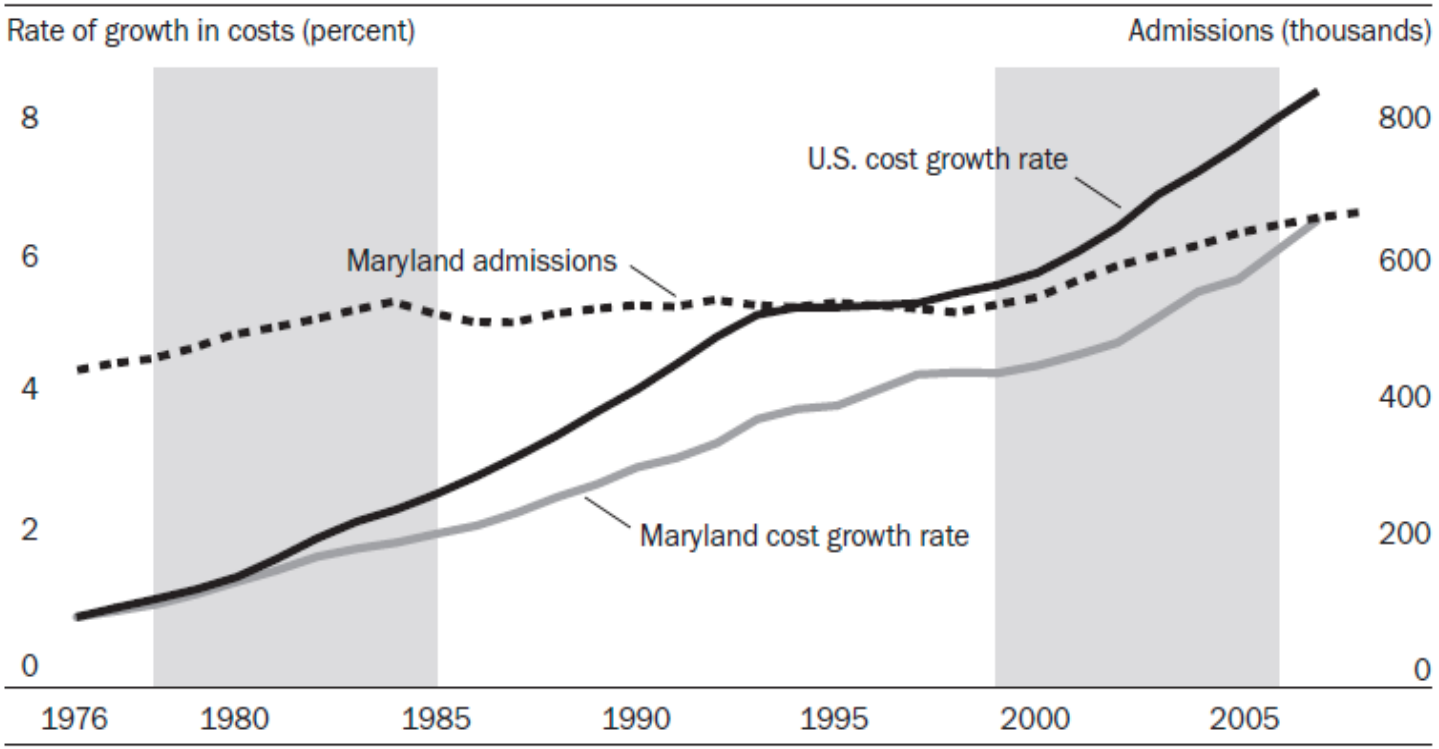
## Readmissions Reduction

- 30-day episodes
- Risk-adjusted all cause all site readmissions
- Link to payment models

# HSCRC Cost Accomplishments

- Cost containment (all payer)--From 26% above the national average cost per case in1976 to 2% below in 2007

**Indexed Growth Rates In Hospital Cost Per Adjusted Admission, Maryland And United States, 1976–2007 (2008)**



# Challenges of the Old Waiver Model

- Emphasis on cost per case kept focus only on hospital inpatient services, not over all health care spending
- Not well fitted to innovations in health care

# OVERVIEW OF NEW ALL-PAYER MODEL

# 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

# Approved Model at a Glance

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate for first 3 years
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

# 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

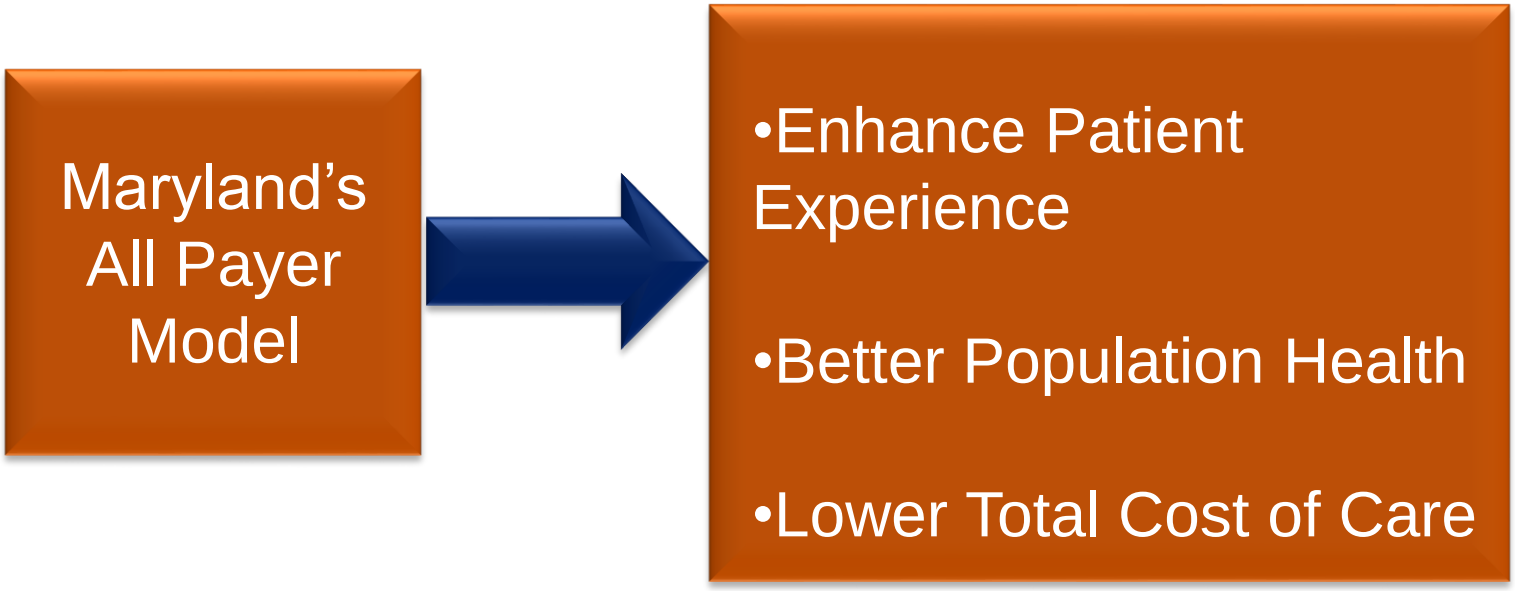
✖ Updates for Trend, Population, Value

Allowed Revenue Target Year

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

# Focus Shifts to Patients

- Unprecedented effort to improve health, improve outcomes, and control costs for patients
- Gain control of the revenue budget and focus on providing the right services and reducing utilization that can be avoided with better care



# Challenge for Integration of Efforts

Medical Homes Accountable Care Organizations

Health Enterprise Zones (HEZ)

Enrollment Expansion

-Medicaid

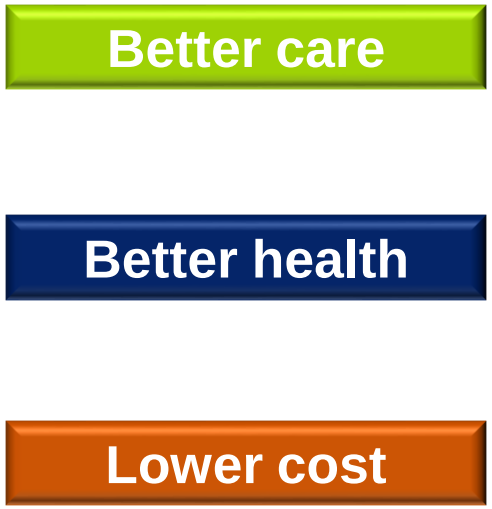
-Private

Health Information Exchange-- CRISP

State Health Improvement Process-Public Health

# Creates New Context for HSCRC

- Priority tasks:  Transition to population/global payment models and patient-centered performance targets that are tied directly to payment
- Major data and infrastructure requirements



# Timeline of All-Payer Model Development

## Phase 1 (5 Year Model)

**Near Term (2014)**

- Hospital global model

**Mid-Term (2015-2017)**

- Population-based

**Long Term (2016-Beyond)**

- Preparation for Phase 2 focus on total costs of care model

# OPPORTUNITIES FOR SUCCESS UNDER THE NEW ALL-PAYER MODEL

# What Does This Mean?

- New Model represents most significant change in nearly 40 years
- Focus shifts to gain control of the revenue budget and focus on gaining the right volumes and reducing avoidable utilization resulting from care improvement
- Potential for excess capacity will demand focus on cost control and opportunities to optimize capacity
- Opens up new avenues for innovation
- Increased efficiency creates opportunities for improved care and better population health

# Opportunities for Success

## Model Opportunities

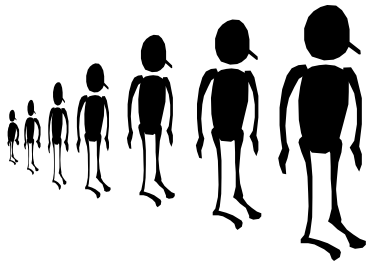
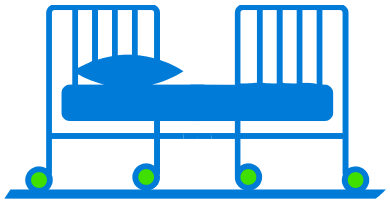
- Global revenue budgets providing stable model for transition and reinvestment
- Lower use—reduce avoidable utilization with effective care management and quality improvement
- Focus on reducing Medicare cost
- Integrate population health approaches
- Rethink the business model/capacity and innovate

## Delivery System Objectives

- Improved care and value for patients
- Sustainable delivery system for efficient and effective hospitals
- Alignment with physician delivery and payment model changes

# History Provides Example

***DRGs and New Technology Reduced Length of Stay and Admissions and Freed Up $$$ for Major Improvements in Cardiac Care, Minimally Invasive Procedures, Advanced Imaging, New Medications and Other Care***

| | 1980 | 2010 | % CHG |
|---|---|---|---|
| U. S. Population  | 227M | 309 M | +36% |
| Occupied beds  | 755,000 | 473,000 | 37% |

# Reduce Avoidable Utilization By Improving Care

**Examples:**

- 30- Day Readmissions/Rehospitalizations
- Preventable Admissions (based on AHRQ Prevention Quality Indicators)
- Nursing home residents—Reduce conditions leading to admissions and readmissions
- Maryland Hospital Acquired Conditions (potentially preventable complications)
- Improved care coordination: particular focus on high needs/frequent users, involvement of social services

# Medicare Focus: GO FOR “0”

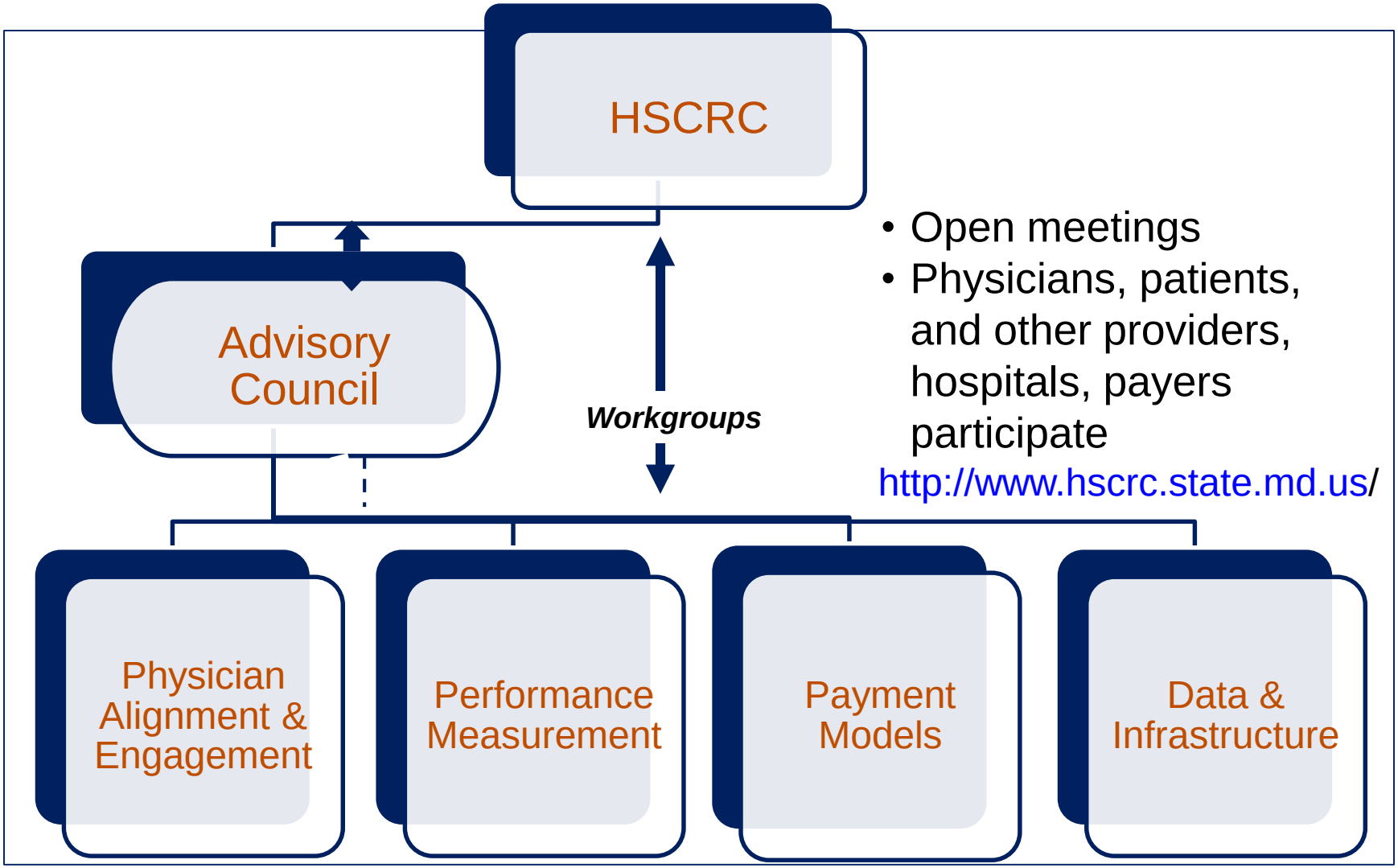
- Medicare revenue growth below national growth critical to generate savings
  - Medicare is the least managed population in Maryland
  - Focus on high need patients and avoidable utilization
  - In particular, where better care reduces costs
  - Requires improved coordination and focus among providers, patients, and families

# HSCRC IMPLEMENTATION APPROACH

# HSCRC Public Engagement Short Term Process Phases

- Phase 1:
  - Fall 2013:  Advisory Council - recommendations on broad principles
  - January 2014- July 2014:  Workgroups
    - Four workgroups convened
    - Focused set of tasks needed for initial policy making of Commission
    - Majority of recommendations needed by July 2014
- Phase 2: July 2014 – July 2015
  - Always anticipated longer-term implementation activities
  - July Workgroup reports to address proposed future work plan
  - Advisory Council reconvening

# Stakeholder Input




- Open meetings
- Physicians, patients, and other providers, hospitals, payers participate

http://www.hscrc.state.md.us/

# Advisory Council

- Advisory Council was charged with offering guidance and advice on implementing Maryland's newly approved model design
- Best ways to meet the tight targets in model
- Setting priorities for implementation
- Establishing guiding principles
- Advice based on real-world experience

# Advisory Council Recommendations

- Focus on Meeting the Early Model Requirements
  - Focus on All-payer and Medicare tests
  - Start with Global Budgets
  - Reduce avoidable utilization
- Meeting Budget Targets, Investments in Infrastructure, and Providing Flexibility for Private Sector Innovation
- HSCRC as a Regulator, Catalyst, and Advocate
- Consumer Involvement in Planning and Implementation
- Physician and Other Provider Alignment
- Transparency and the Public Engagement Process

# Public Engagement Process – Work Groups

- Engaged broad set of stakeholders in HSCRC policy making and implementation of new model
  - 4 workgroups and 6 subgroups
  - 85 workgroup appointees
  - Consumers, Employers, Providers, Payers, Hospitals
- Established processes for transparency and openness
  - Diverse membership
  - Educational phase of process
  - Call for Technical White Paper Shared Publically
  - Access to information
  - Opportunity for comment

# HSCRC Work Group Descriptions

## Physician Alignment & Engagement

- Alignment with Emerging Physician Models
- Shared Savings
- Care Improvement
  - Care Coordination Opportunities
  - Post-Acute and Long-Term Care
  - Evidence-Based Care

Mid-Term
FY 2015 - 17

## Performance Improvement & Measurement

- Reducing Potentially Avoidable Utilization to achieve Three-Part Aim
  - Statewide Targets & Hospital Performance Measurement
  - Measuring Potentially Avoidable Utilization
- Value-Based Payments (integration of cost, quality, population health and outcomes)
- Patient Experience and Patient-Centered Outcomes

Note: More Detailed Work Group Descriptions reviewed by Commission January 13, 2014 and available on HSCRC website

# HSCRC Work Group Descriptions

## Data and Infrastructure

- Data Requirements
- Care Coordination Data and Infrastructure
- Technical and Staff Infrastructure
- Data Sharing Strategy

Mid-Term
FY 2015 - 17

## Payment Models

- Balanced Update
- Guardrails for Model Performance
- Market Share
- Initial and Future Models

Note: More Detailed Work Group Descriptions reviewed by Commission January 13, 2014 and available on HSCRC website

# Workgroup Products (as of 5/12/14)

- **Payment Model**
  - Draft  UCC Policy Recommendations
  - Draft  Update Factors Recommendation for FY 2015
  - Draft Readmission Shared Savings Recommendation for FY 2015
  - Final Report – Balanced Update and Short-Term Adjustments
- **Performance Measurement**
  - Final Recommendations– Maryland Hospital Acquired Conditions
  - Final Recommendations – Readmissions
  - First Draft – Efficiency Report
- **Data and Infrastructure**
  - Final Report - Data Requirements for Monitoring All-Payer Model
- **Physician Alignment and Engagement**
  - First Draft - Current Physician Payment Models and Recommendations for Physician Alignment Strategies under the All-Payer Model

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