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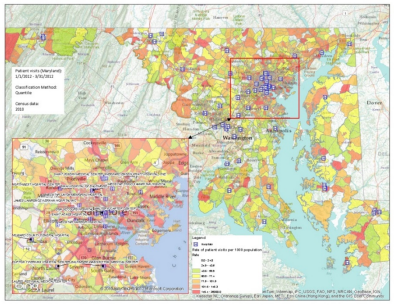
May 15, 2014

Joshua M. Sharfstein, M.D.

Maryland All-Payer Hospital Model

Context: Innovation in Maryland

CRISP



State Health Improvement Process

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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

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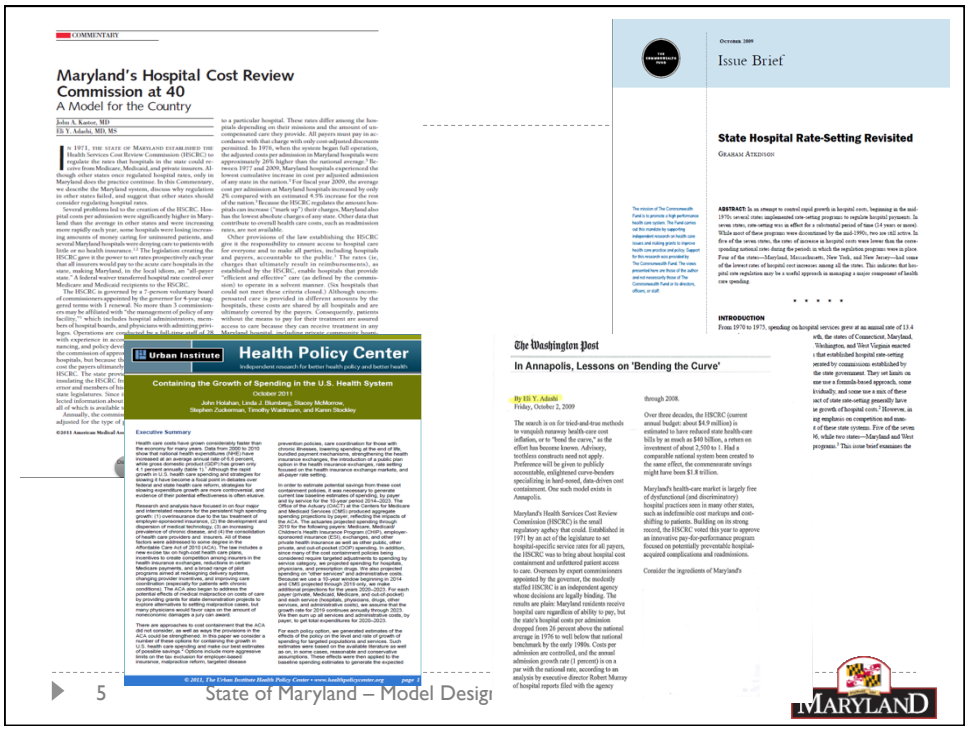

HSCRC Sets Hospital Rates for All Payers

- 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

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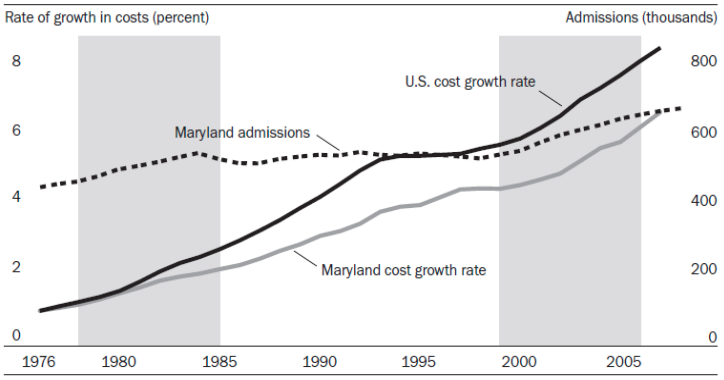
HSCRC Cost Accomplishments

- 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)



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PAYMENT REFORM

By Uwe E. Reinhardt

ANALYSIS & COMMENTARY

The Many Different Prices Paid To Providers And The Flawed Theory Of Cost Shifting: Is It Time For A More Rational All-Payer System?

ABSTRACT In developed nations that rely on multiple, competing health insurers—for example, Switzerland and Germany—the prices for health care services and products are subject to uniform price schedules that are either set by government or negotiated on a regional basis between associations of health insurers and associations of providers of health care. In the United States, some states—notably Maryland—have used such all-payer systems for hospitals only. Elsewhere in the United States, prices are negotiated between individual payers and providers. This situation has resulted in an opaque system in which payers with market power force weaker payers to cover disproportionate shares of providers' fixed costs—a phenomenon sometimes termed *cost shifting*—or providers simply succeed in charging higher prices when they can. In this article I propose that this price-discriminatory system be replaced over time by an all-payer system as a means to better control costs and ensure equitable payment.

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In December 2010 America's Health Insurance Plans published a report titled "Recent Trends in Hospital Prices in Oregon and California."[1] This report showed the growth in average transaction prices actually paid by the ten largest private health insurers to hospitals in Oregon during the period 2005–09, as well as the growth in net revenue per patient day paid to California hospitals by Medicaid, Medicare, and private insurers during the period 2000–09. Transaction prices—the amount of money that a hospital actually receives rather than the amount it charges—are not routinely reported by the insurance industry, which makes the report so illuminating.

Exhibit 1 presents the average annual compound growth rate in hospital transaction prices paid in Oregon for a number of well-defined procedures. The average price paid to hospitals for childbirth by a normal vaginal delivery, for example, increased from $3,800 in 2005 to $6,400 in 2009. Exhibit 2 shows data for California.

The data for Oregon raise the question: Why did the ten largest private health insurers in that state—in effect, the purchasing agents on behalf of employers and employees—not resist the steep price increases during 2005–09, in the midst of one of the deepest recessions befalling the United States since the Great Depression? This question is relevant to any strategy that relies heavily on private health insurers as agents of cost control.

In this article I explore the question at greater length, beginning with a brief discussion of the most commonly advanced explanation: the cost-shift theory. According to this theory, private health insurers have no choice but to compensate health care providers for payment shortfalls

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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 over all health care spending
- Not well fitted to innovations in health care

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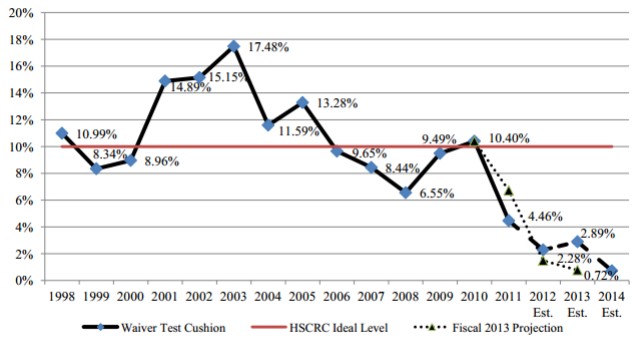
Diminishing "Waiver Cushion"

Exhibit 5
Medicare Waiver Cushion
Fiscal 1998-2014



HSCRC: Health Services Cost Review Commission

Note: Data shown are values/estimates for the end of each fiscal year. Fiscal 2012 through 2014 estimates are estimates. Fiscal 2014 estimate is based on a 2% Medicare payment cut through federal sequestration (current law) and a 0% hospital update factor.

Source:DLS

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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

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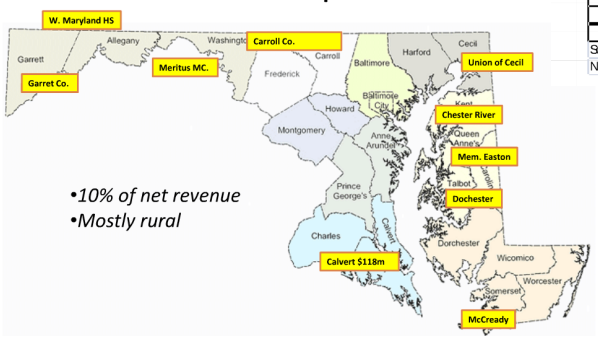
TPR versus non-TPR Hospitals: Before and After TPR Implementation in 2011

	TPR	Non-TPR
Inpatient Admissions		
FY2010	91,672	668,319
FY2013	75,478	608,166
% Change	**-17.7%**	**-9.0%**
Same Hospital Readmissions		
FY2010	9,530	64,842
FY2012	7,729	58,269
% Change	**-18.9%**	**-10.1%**
Avoidable Admissions (PQI90)		
CY2010	11,551	65,517
CY2012	9,593	57,148
% Change	**-17.0%**	**-12.8%**

Source: HSCRC, May 2013.
Note: FY2013 is based on 6 month data and annualized.

TPR Hospitals



- *10% of net revenue*
- *Mostly rural*

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ECONOMIC SCENE

Lessons in Maryland for Costs at Hospitals

J.M. Giddins Jr. for The New York Times

Dawn Snyder, a registered nurse, runs a heart failure clinic at Western Maryland Health System.

By EDUARDO PORTER
Published: August 27, 2013

CUMBERLAND, Md. — This hardscrabble city at the base of the Appalachians makes for an unlikely hotbed of health care innovation.

Economic Scene
Eduardo Porter writes the Economic Scene column for the Wednesday Business section.
Author Bio »
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Yet Western Maryland Health Systems, the major hospital serving this poor and isolated region, is carrying out an experiment that could leave a more profound imprint on the delivery of health care than President Obama's reforms.

Over the last three years, the hospital has taken its services outside its walls. It has opened a diabetes clinic, a wound center and a behavioral health clinic. It has hired people to follow up with older, sicker patients once they are discharged. It has added primary care practices in some neighborhoods.

The goal, seemingly so simple, has so far proved elusive

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Overview of New All-Payer Model

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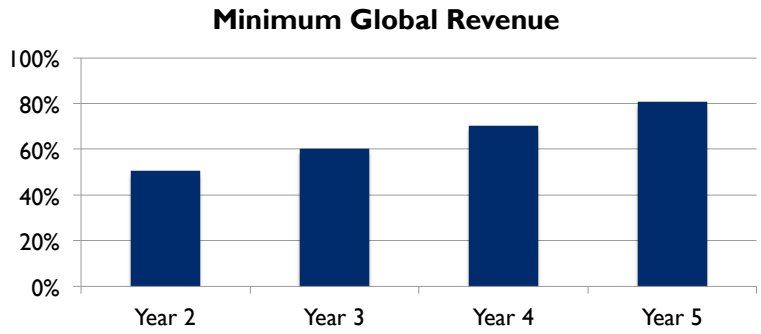
Model Hypothesis

- 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



- 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

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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

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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

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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

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Implications of Model

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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

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Focus Shifts from Rates to Revenues

Old Model Volume Driven	New Model Population and Value Driven
Units/Cases	Revenue Base Year
✖ Rate Per Unit or Case	✖ Updates for Trend, Population, Value
Hospital Revenue	Allowed Revenue Target Year
Unknown at the beginning of year. More units/more revenue	Known at the beginning of year. More units does not create more revenue

Volume targets and a variable cost factor

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

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Hospital-specific revenue adjustments

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

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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

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Acknowledgments

- Governor O'Malley and Lt. Governor Brown
- HSCRC Commissioners and Staff, including Chair John Colmers and Executive Director Donna Kinzer
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