Maryland Health Model: Lessons for Other States

Oct. 9, 2019

Agenda

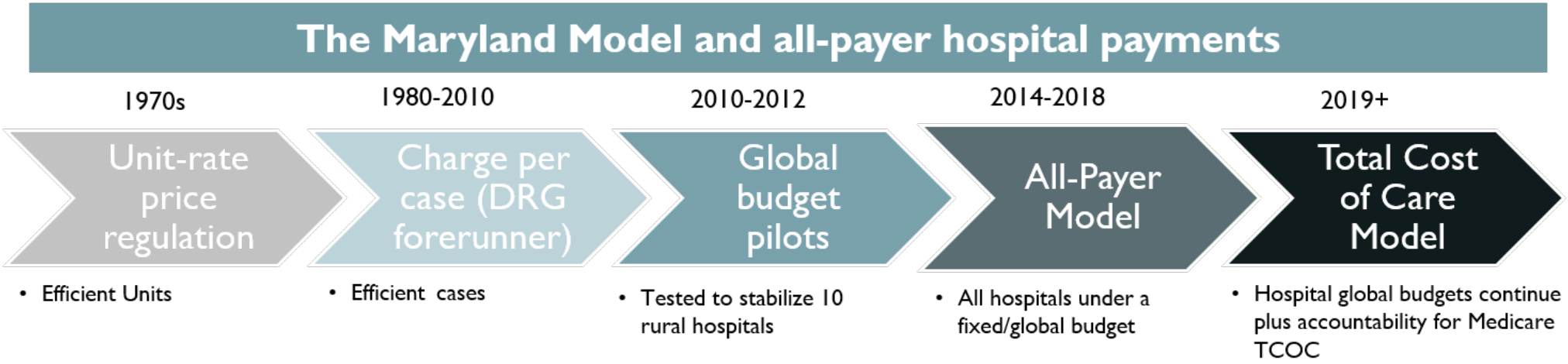
- Describe Maryland Health Model
  - Results from All-Payer Model (2014-2018), in which hospital global budgets were the primary innovation
  - Pivoting to TCOC Model (2019-2026+), building on the chassis of hospital global budgets with voluntary payment programs
- Pitch: Applying hospital global budgets in other states
  - Why other states (hospitals and payers) might/should be interested in hospital global budgets, especially in rural areas
  - How: Tools/options for setting global budgets
  - NOTE: Maryland has a lot of bells and whistles that are not essential, particularly for implementing global budgets in rural areas

Overview of Maryland Health Model

HSCRC: Who We Are

- Health Services Cost Review Commission (HSCRC) responsible for regulating the quality and cost of hospital services to ensure all Marylanders have access to high quality healthcare services
  - 7 Commissioners
  - ~40 staff
- Help lead the State's efforts to transform the delivery system and achieve population health improvement goals under the Maryland model, incentivizing value not volume
- Under this Model, built on the chassis of Maryland's unique all-payer hospital rate-setting system, we aim to improve health outcomes, enhance the quality of care, and ultimately reduce the total cost of care for Marylanders

Evolution of the Maryland Model



- Since 1977, Maryland has had an all-payer hospital rate-setting system
  - A given acute care hospital's charge is the same regardless of payer
  - Charges ("prices") differ across hospitals
- In 2010, ten rural hospitals were placed on Total Patient Revenue (TPR) systems
  - TPR was a pilot for what became Global Budget Revenue (GBR) for all hospitals in 2014
- In 2014, Maryland moved to the All-Payer Model with CMMI, focused on controlling hospital costs through GBR
- In 2019, Maryland moved to the Total Cost of Care (TCOC) Model, focusing on (Medicare) TCOC through system-wide alignment

Application of hospital global budgets in MD: Will NOT be the same if other states adopt

- Definitely since 2014, no longer focus on setting/scrutinizing the price of individual hospital services
  - This is not the 1970s
- Rather, we set each hospital's Global Budget Revenue (GBR) from all payers
  - GBR also known as Population-Based Revenue (PBR) to reflect the block/per capita nature of the approach
  - At any given hospital, charges are the same for all payers
  - Payers still pay claims on a fee-for-service basis
  - But hospitals are given flexibility to dial their charges in order to hit their annual GBR. For example, if volumes falls, prices must rise!
  - Hospital's price increases since 2014 may be a good thing: reducing hospital volume, moving low-value care out of hospitals, etc.
    - **Key experience from Maryland's unique approach: It is not (just) the prices, stupid, but the total cost of care**

What changes in move to hospital Global Budgets?

- No longer chasing volumes on pressured prices
- Incentivizing and encouraging investment in:
  - Better managed internal costs (focus on costs, not revenue)
  - Reducing readmissions
  - Reducing hospital-acquired conditions
  - Reducing ambulatory-sensitive conditions, or Prevention Quality Indicators (PQIs)
- Results
  - Improved health care quality, lower costs, better consumer experience

But more to be done …

What challenges under Global Budgets? What is Maryland doing about it?

- Access: Ensure no stinting on necessary care
  - Readmissions and other quality measures capture inadequate hospital care
  - HSCRC looks into big volume drops/price increases
  - Plenty of opportunity to reduce Potentially Avoidable Utilization (PAU) rather than necessary care
- Shifting volumes and potentially "double-paying"
  - From Hospital A to Hospital B, not really desirable (Market Shift)
    - Less of a concern in rural areas
    - HSCRC generally takes 50% of volumes moved out of Hospital A, gives 50% to Hospital B but only up to the amount moved out of Hospital A
    - HSCRC can customize based on unique circumstances (e.g., hospital shut down service but did not inform HSCRC, as required in GBR contract)

What challenges under Global Budgets? What is Maryland doing about it? P. 2

- From hospital to non-hospital setting, desirable
  - HSCRC generally takes 50% of volumes moved out of hospital A
- Innovations (e.g., high-cost drugs)
  - HSCRC has carved out certain drugs from global budget (i.e., payers pay on a volume basis)
- New challenges five years in
  - Excess capacity: Hospitals to eliminate fixed costs? Repurpose capacity? Remove money from GBR?
  - Capital funding
  - Vision: What should be hospitals' role moving forward? What mix of hospital services versus population and health management? What should global budgets be paying hospitals to do, and how do we make sure that is happening?

All-Payer Model Performance 2014-2018: Met or Exceeded CMS Contract Requirements

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ $330M cumulative (Lower than national average growth rate from 2013 base year)	$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

*** $273 million in Medicare TCOC savings in 2018 alone – aka Medicare savings run rate** (vs. 2013 base)

Maryland Model's Story of Success: Medicare FFS Savings vs. National Growth from 2013 to 2018

- Biggest savings (that is, Maryland difference from national growth) from hospital spend, increasing over time
  - Primarily from volume declines, not price (although ~0.2% removed annually from hospital GBRs for potentially avoidable utilization (PAU))
  - Hospital Outpatient is largest source of savings
  - Hospital Inpatient also produced savings
- Dissavings: Increase in Part B non-hospital. For example:
  - Moving certain surgeries from inpatient to outpatient/community
  - Moving from ED to community settings
  - Incentivizing more community care and follow-up to avoid readmissions
- Dissavings: Increase in home health and hospice
- Savings overwhelm dissavings
- **All indicate success of the Model**

Changes from All-Payer Model (2014-2018) to Total Cost of Care Model

All-Payer Model
Contract Expired on Dec. 31, 2018

Total Cost of Care Model
Began Jan.1, 2019

System-wide focus

Total cost of care savings

Hospital quality *and* population health metrics

Maryland Primary Care Program (MDPCP) and other care transformation tools

Provider alignment via MACRA-eligible programs and post-acute programs

Total Cost of Care (TCOC) Model Overview

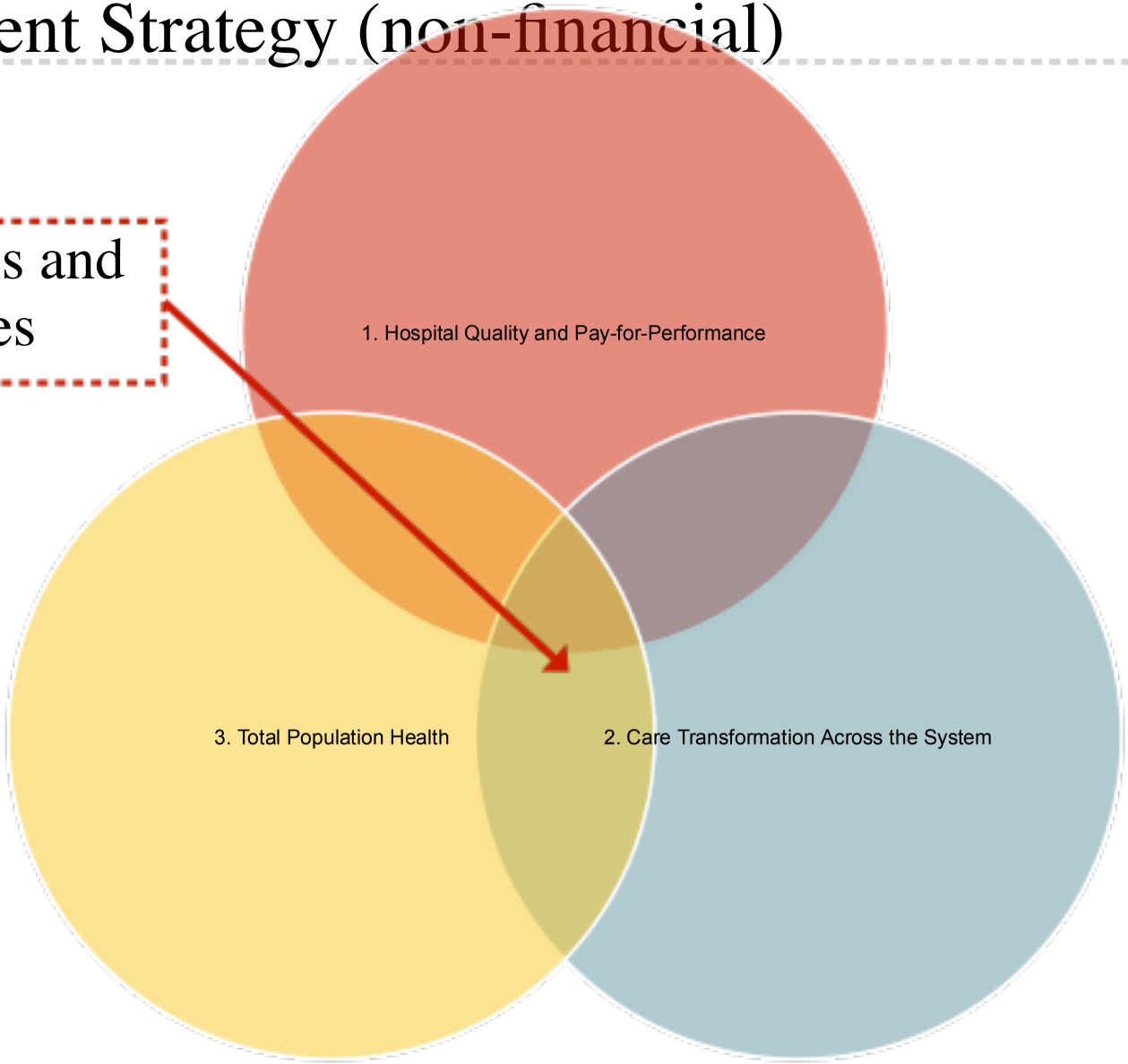
- A 10-year agreement (2019-2028) between Maryland and CMS
  - Five years (2019-2023) to build up to cost savings and five years (2024-2028) to maintain Medicare cost savings and quality improvements
  - Opportunity to "expand" the model (that is, to make it permanent) based on how we perform over the next 3-5 years
- Limits growth in total cost of care per capita and improves quality and population health by:
  - Continuous quality improvement in setting hospital global budgets
  - Engaging non-hospital providers in care transformation and TCOC responsibility
  - Targeting specific population health goals and interventions

TCOC Model Targets at a Glance

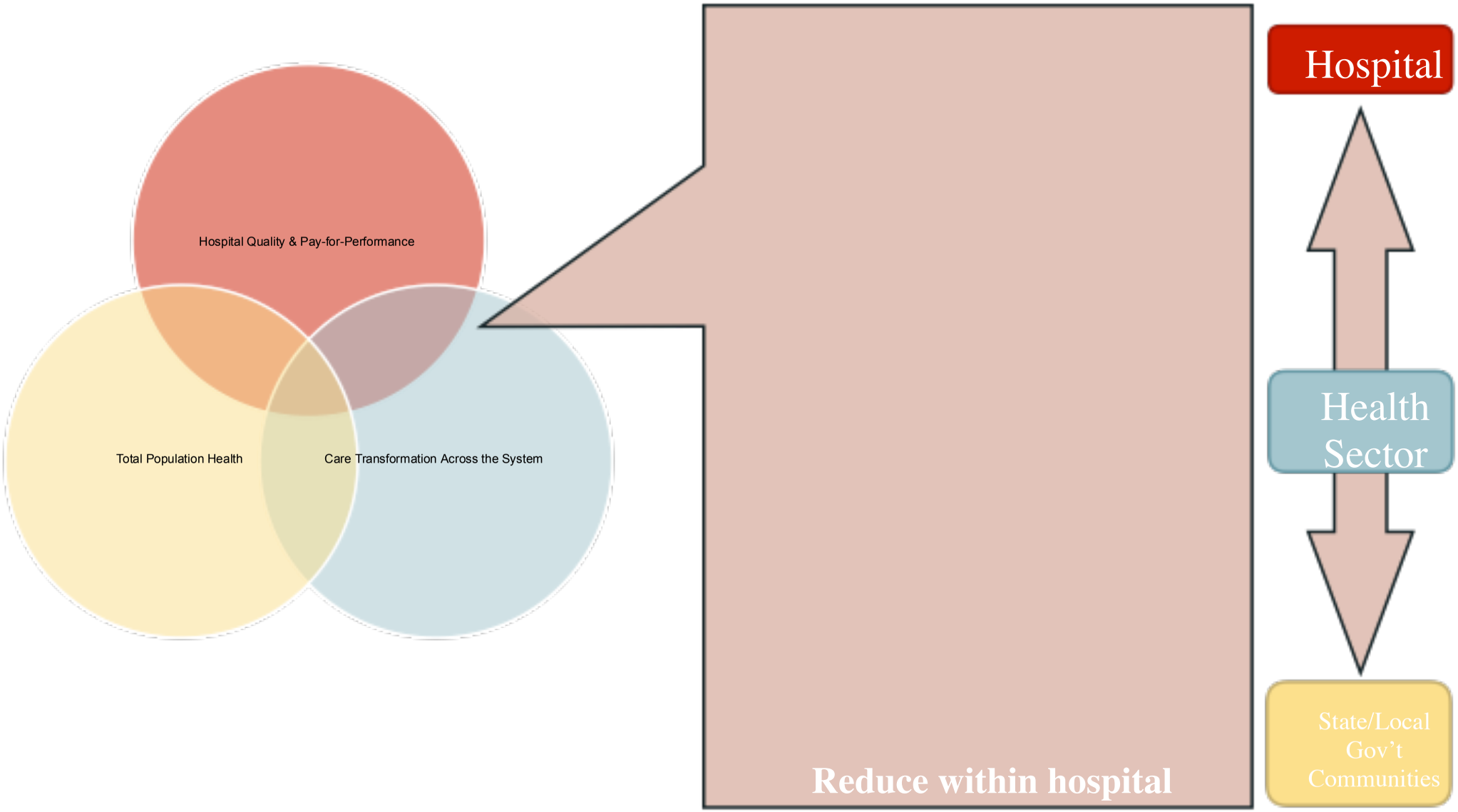
- Continue All-Payer total hospital per capita revenue growth ceiling of 3.58% annual growth
- Medicare annual TCOC savings of $300 million by end of Year 5 (2023)
- Year-over-year Medicare TCOC Per Capita Guardrails:
  - Maryland Medicare TCOC cannot exceed national growth for two consecutive years
  - Cannot exceed national growth by more than 1% in a single year
- Sustain and further progress on patient and population-centered quality measures
- Address population health. State to focus on:
  - Diabetes
  - Substance Use Disorder
  - TBD

Domains of Maryland's Statewide Integrated Health Improvement Strategy (non-financial)

Shared Goals and Outcomes



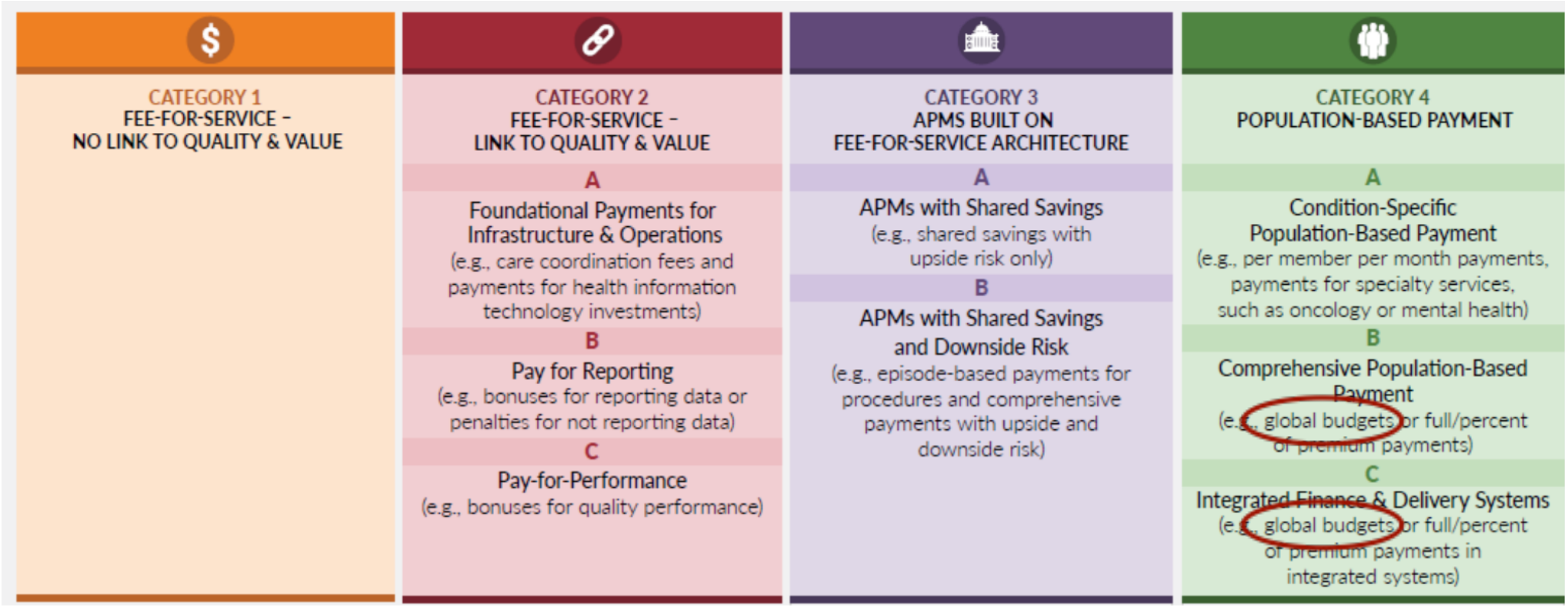
Potential Examples of Shared Model Goals: State and CMMI to Agree on Targets



Pitch to Other States to Consider Hospital Global Budgets

Payers and consumers want value for their health care dollar

Less value, more volume → **More value, less volume**



Source: HCP-LAN Alternative Payment Model (APM) Framework

Incentives of FFS vs. Global Budgets: Paid for volume vs. value

Less value, more volume ⟵ ⟶ **More value, less volume**

- Revenue = Price * Quantity
- Payers fight providers over prices and utilization (quantity)
- Medicare PPS does not pay for every individual service/item, but hospitals are still incentivized to bring in more volume – that is, more cases
  - CAHs under volume incentive

- Revenue = Base year revenue + trend ± value-based adjustments
- Hospitals no longer incentivized to bring in (marginal) cases; instead, turn their attention to keeping people well, avoid (re)admissions
- Consumers should benefit most
- Payers/providers should have less haggling
- 180-degree change

What problem do Global Budgets address, particularly in rural areas?

Examples:

- Hospitals with financial hardship because declining FFS volume
  - Multiple drivers: declining number of cases, declining demand for hospital-based services, declining population
  - Hospital pressured to provide care that may be of marginal benefit
  - Trying to run up the Down escalator
- Payers pressured to pay higher and higher prices ("cost shifting") on those declining volumes
  - Raises questions about what payers are paying for

Considerations for Other States.

Establishing Hospital Global Budgets: Startup

- Explain why
  - Articulate Model goals and principles: Should be win-win-win
  - Establish policies consistent with those goals and principles
    - What hospitals are supposed to do?
    - How are hospitals incentivized to do that?
- Maximize payer participation
  - In Maryland, HSCRC has had authority to set hospital rates for all payers since the 1970s
    - Since 2014, Medicare participates via CMMI
    - States have authority to "set" hospital rates on ERISA plans based on Supreme Court decision Blues v. Travelers
  - In voluntary context, have to articulate value proposition: What's in it for them?
    - Predictable growth
    - Input into what hospitals should be doing, ensuring appropriate access to needed services at the right place, with the right trend and adjustments

Considerations for Other States.

Establishing Hospital Global Budgets: Setting the Number

- Who sets/negotiates the global budget?
  - Commission/group with representation from payers, providers, etc.
- Pick revenue Base Year (2013 in Maryland for implementation beginning in 2014)
  - What is excluded (transplants? out-of-state?)
- Set annual Update Factor and hospital-specific adjustments
  - Price inflation
  - Volume adjustment (demographics)
  - Quality adjustments
  - Haircut for Potentially Avoidable Utilization (PAU)
- Flexibility/process for ad-hoc tweaks?
  - In Maryland, there is both a formal Commissioner process, as well as a less formal staff process. HSCRC staff have flexibility to adjust GBRs, but can create "stray cat problem"

Components of Maryland's GBR Update Factor

Many of these adjustments will vary by hospital. The purpose of this table is to provide a statewide overview.

Inflation

Volume

Other Adjustments

Quality and PAU

Balanced Update Model for RY 2020

Components of Revenue Change Linked to Hospital Cost Drivers/Performance

			Weighted Allowance
Adjustment for Inflation (this includes 3.10% for compensation)			2.77%
- Rising Cost of Outpatient Oncology Drugs			0.19%
Gross Inflation Allowance	**A**		**2.96%**
Care Coordination/Population Health	**B**		**0.00%**
Adjustment for Volume			
-Demographic/Population			0.30%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.30%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.10%
- Low Efficiency Outliers	E		-0.04%
- Capital Funding -Adventist White Oak Medical Center	F		0.09%
- Categoricals & Innovation (1%)	G		0.23%
-Reversal of one-time adjustments for drugs	H		-0.03%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.34%**
Quality and PAU Savings			
PAU Savings	J		-0.30%
-Reversal of prior year quality incentives	K		0.53%
-QBR, MHAC, Readmissions			
-Positive incentives & Negative scaling adjustments	L		0.18%
Net Quality and PAU Savings	**M=**	**Sum of J thru L**	**0.41%**
Total Update First Half of Rate Year 20			
Net increase attributable to hospitals	**N=**	Sum of A+B+C+I+M	**4.02%**
Per Capita First Half of Rate Year (July - December)	**O=**	(1+N)/(1+0.30%)	**3.71%**
Adjustments in Second Half of Rate Year 20			
-Oncology Drug Adjustment	P		0.00%
-QBR	Q		-0.37%
Total Adjustments in Second Half of Rate Year 20	**R=**	P+Q	**-0.37%**
Total Update Full Fiscal Year 20			
Net increase attributable to hospital for Rate Year	**S=**	N+R	**3.64%**
Per Capita Fiscal Year	**T=**	(1+S)/(1+0.30%)	**3.33%**

* Note that once the total update is determined, a number of tests are performed to ensure the update will not breach TCOC Model guardrails and maintain Maryland's growth below national Medicare

MARYLAND

Final recap: Hospital global budgets don't have to mirror Maryland's approach

- Maryland
  - Hospital revenue still comes through a FFS system – with hospitals able to change prices to hit Global Budget amount
  - HSCRC has a lot of data sources (detailed monthly hospital case mix and financial data) and analytic capacity to capture Market Shifts, etc.
  - HSCRC is a 7-member commission empowered by state statute and recognized by the federal government (CMMI contract) to set hospital rates for all payers
- How to apply to other states?
  - Simplest approach is to take annual hospital revenue by payer for base year, increase by X%, and payers cut checks to hospital
  - CMMI is the pathway to get Medicare included. How much "savings" would CMS want in order for Medicare to participate? Any?
  - Maryland tweaks may not be necessary. For example, Market Shift may be irrelevant if focused in rural areas where no other hospital to shift to
  - Who decides annual rate update? What adjustments? How much data necessary?

Thanks!

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