MARYLAND

All-Payer Model for Maryland Hospitals Population-Based and Patient-Centered Payment Systems

BACKGROUND OF MARYLAND RATE REGULATION

Health Services Cost Review Commission

- Oversees hospital rate regulation in Maryland
- Independent 7 member Commission
  - 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

- All Payer Rate Setting
  - Medicare waiver granted in1977 and renewed under a different approach in 2014 allows HSCRC to set hospital rates for Medicare—the elderly population.
  - State Medicaid plan (for financially and medically needy) requires payment of HSCRC rates
  - State law requires health insurers, managed care organizations, others to pay HSCRC rates
- All payers pay their fair share of full financial requirements
  - Uncompensated Care
  - Physician/other education costs
- Considerable value to patients, State and hospitals

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Overview of New All-Payer Model

Approved New All-Payer Model

- Maryland is implementing a new All-Payer Model for hospital payment
  - Approved effective January 1, 2014 for a 5 year timeframe
- Focus on new approaches to rate regulation
- Moves Maryland
  - From **per inpatient admission** regulation focus
  - To an **all payer**, **total hospital** payment **per capita** focus
    - Shifts focus to population health and delivery system redesign
- Application due at the end of 2016 to extend the model to focus on the total cost of care in year 6 and beyond

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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

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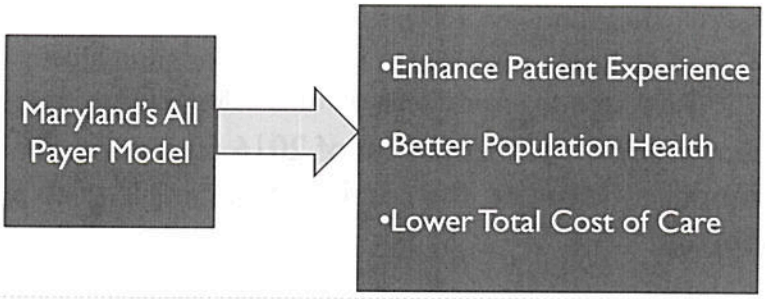
Focus Shifts to Patients

- 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



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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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Year 1 Accomplishments: Implementation of Hospital Global Budgets and Public Engagement

- Broad public engagement in initial implementation
- All Maryland hospitals are now operating under global budgets
  - More than 95% of hospital revenues under global budgets
- The key aspects of the Global Revenue Budgets:
  - Fixed revenue base for 12 month period with annual adjustments
  - Retain revenue related to reductions in potentially avoidable utilization (PAU).
    - Invest savings in care improvement
  - Annual update factor (inflation)
  - Annual quality adjustments
  - Adjustments when patients shift across hospitals and settings

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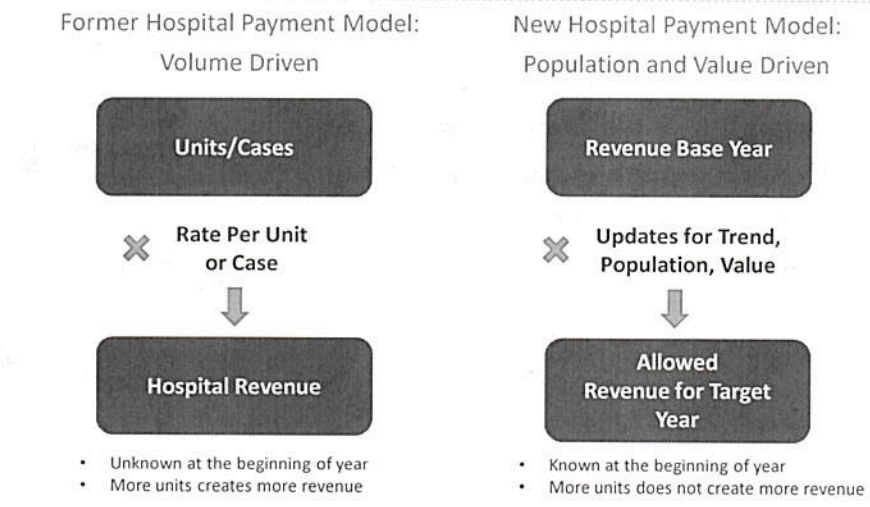
Year 1 Accomplishments: Global Model Shifts Focus from Volumes



Year 1 Results: Calendar Year 2014 Results

- ✓ Under all payer limit (1.47% per capita increase vs. 3.58% limit)
- ✓ Medicare savings on track (subject to review)
- ✓ Quality improvement on track—26% improvement in MHACs in CY 2014, 30% required over 5 years
- ✓ Readmissions down, but more progress needed

I. Hospital performance

- ✓ Increased profitability of hospitals overall
- ✓ Overall volume growth limited

  Absorbed 200,000 new Medicaid enrollees

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All Payer Model Implementation

Year 1 Focus

- Global budgets
- Meeting test metrics
- Monitoring infrastructure
- Potentially avoidable utilization concepts & data
- Stakeholder input

Year 2 Focus (Now)

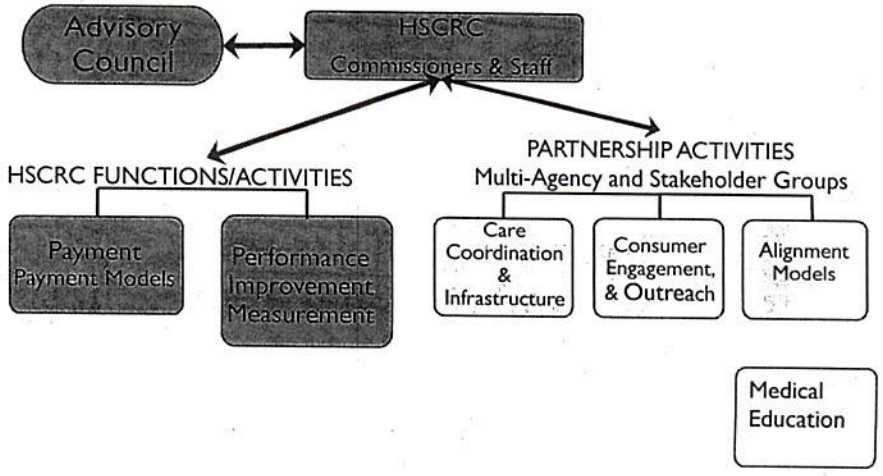
Clinical improvement
- -Better chronic care
- -More coordinated care
- -Better episodes

Payment alignment
- -Medicare chronic care fees
- -Medicare willing to innovate
- -Gain sharing and P4P
- -Dual eligible & integrated networks

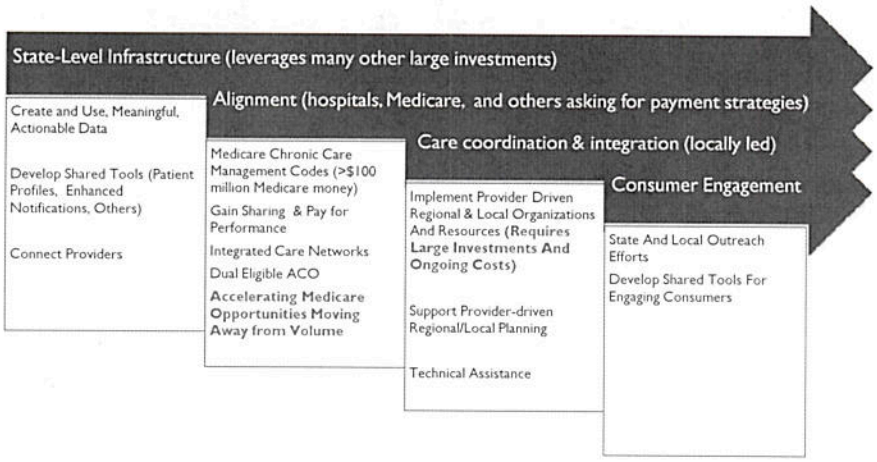
Year 3 Focus

- Implementation of infrastructure, work flows, and models
- Engage patients, families, and communities
- Focus on additional alignment opportunities

Organization of Current Activities



Strategic Roadmap



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HSCRC
Health Services Cost Review Commission

Organizing Efforts—Statewide and Regional Approaches

MARYLAND

Statewide, Regional, and Local Efforts Needed for Scaling

- HSCRC convened a partnership work group chaired by Dr. Laura Herrera Scott (DHMH) and Carmela Coyle, (MHA) to make recommendations on efforts that could accelerate care coordination and improved chronic care
- Deliberations are still in progress, but several themes are emerging.
- DHMH and HSCRC are focused on encouraging regional collaborations that can facilitate the coordination and implementation of efforts in a cost effective way, avoiding duplication and scaling resources and approaches—leading to current RFP

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Efforts that Could be Facilitated with Statewide Infrastructure—Under Discussion

- Data infrastructure and sharing
  - Leverage existing data and new sources (Medicare) to support risk stratification and identification of individuals who would benefit from care coordination
- Care planning
  - Develop patient consent process and standard forms and education materials
  - Develop care plan elements that could be visualized through CRISP
  - Organize training, engagement, and activation approaches
- Encourage collaboration
  - Promote regional efforts to organize and avoid overlap of resources
  - Encourage community and volunteer efforts
  - Develop approaches for integrating care (mental and somatic, hospital and long term/post acute
- Connecting community based providers to CRISP
  - Need to set direction, determine funding sources, and begin work

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Regional Efforts

- Develop priorities and approaches on a regional basis or with regional coordination to support high needs patients, with a focus on Medicare and dual eligible patients
  - E.g. frail elders, ESRD, patients in long term care, patients with serious mental conditions, patients with advanced chronic conditions
- Determine staffing and infrastructure needs and approaches and develop organization plans and how to integrate efforts across providers, public health, and community organizations
- Develop coordinated approaches to support practices in addressing the Medicare Chronic Care Management fee requirements

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Overview of Regional Planning Grants

- The Commission authorized up to $2.5 million from hospital rates to be used for planning of regional partnerships
- Funds are to be used for partnership planning activities
  - Funds may be used for data analysis, operational/strategic planning, health IT/analytics planning, consultants, meetings, and related expenses.
- Technical assistance will be provided to awardees
  - Utilization data, models, expert advice/consultation
- A Review Committee approved 8 of 11 proposals for funding ranging from $200,000 to $400,000

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Concluding Thoughts and Questions

- New waiver is a call to action and creates a path for change
  - Proactive, not reactive
  - Encourages more flexible and creative investments
- Medicare, Medicaid and other payers recognizing value of care coordination care improvement; prepared to pay for it
- New model is highly dependent on partnerships of providers across settings, community based organizations, and consumers—need to work together to create and accelerate the benefits that are possible
- Value is the new gold standard
  - Quality
  - Appropriate hospital care
  - Partnerships, integration and coordination
  - Cost efficiency
  - Population health focus

Thank you for the opportunity to work together to improve care for Marylanders

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Attachment 1: Potentially Avoidable Utilization (PAU)

"Hospital care that is unplanned and can be prevented through improved care, coordination, effective primary care and improved population health."

- Readmissions/Rehospitalizations that can be reduced with care coordination and quality improvements
- Preventable Admissions and ER Visits that can be reduced with improved community based care
- Avoidable admissions from skilled nursing facilities and assisted living residents that can be reduced with care integration, remote services, and prevention
- Health care acquired conditions that can be reduced with quality improvements
- Admissions and ER visits for high needs patients that can be moderated with better chronic care and care coordination

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