Maryland Health Services Cost Review Commission

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

October 2014

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

New All-Payer Model for Maryland

- Focus shifts to the patient and improvement of care
- 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

Approved Model Timeline

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

- Phase 2 – Total Cost of Care Model
  - 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
- **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
  - Quality revenue at risk to equal or exceed national Medicare programs

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

Opportunities for Success Under the New All-Payer Model

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
- Control total cost of care
- Rethink the business model/capacity and innovate
- Align with physicians and other providers

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

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

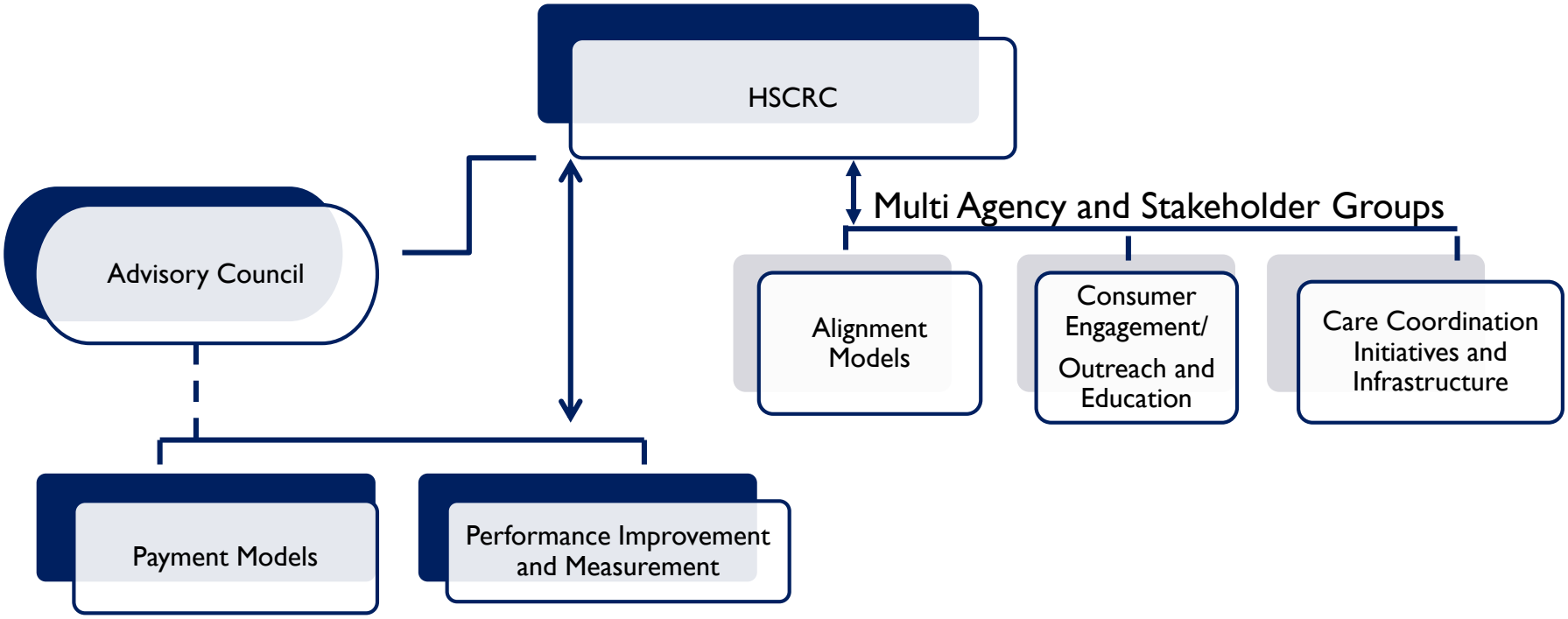
Implications for Delivery System

- **Successful hospital under a modernized waiver**
  - High quality, efficient and effective care while strategically maintaining market share
  - Partners with physicians and other practitioners, urgent care and post acute care to improve population health
  - Improves care resulting in reducing avoidable utilization freeing up funds for investments in population health and new technology and clinical services
  - High quality with reduced clinical utilization will be the most successful

Community Benefits

- The IRS requires non-profit hospitals nationally to report on their expenditures, community health needs assessments, and how community benefits programs are organized. The HSCRC receives a very similar report and makes it available to the public.
- FY 2013 was the first year that all hospitals were required to conduct a community health needs assessment.
- HSCRC Report requirements encourage collaboration with community stakeholders and other hospitals
- FY 2013 net hospital CB expenditure was 712.4 million or 5.2% of total operating expenses.

Discussion-- Initial Staff Thoughts on Possible Approaches for Next Phase of Work



Potential Ad Hoc Subgroups

Transfers	GBR Rev/Budget Corridor	GBR Template	GBR Infra. Investment Rpt.	Market Share.
Efficiency	Monitoring	Total Cost of Care	Physician Alignment	LTC/Post Acute.