

**Maryland's Proposal to Modernize All-Payer Rate Setting:
Enhancing Patient Experience, Controlling Costs, and Improving Health**

John M. Colmers
Chairman
Health Services Cost Review Commission

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health and Mental Hygiene

Testimony before the Finance Committee, Maryland State Senate
March 26, 2013

Summary

Health care in the United States is facing critical challenges in access to care, cost, and outcomes. To address these challenges, Maryland has recently submitted an initial proposal to the Center for Medicare & Medicaid Services that to build on the strengths of our health care system and modernize our unique approach to all-payer hospital rate-setting.

This proposal will complement other critical efforts underway to strengthen primary care and community health, enhance the sharing of medical information, and expand access to care through the Maryland Health Connection.

In our testimony today, we will outline the key elements of Maryland's proposal and discuss the next steps in the process towards adoption.

Background

Since the late 1970s, Maryland's independent Health Services Cost Review Commission (HSCRC) has set hospital rates for all public and private payers.

This structure has provided major benefits to Maryland residents. It has:

- eliminated cost-shifting between payers;
- allowed for creative uses of incentives to improve quality and outcomes;
- substantially limited the growth of hospital per-case costs;
- provided for lower costs on an all-payer basis within our region;
- provided a stable and predictable payment system for hospitals;
- promoted financial stability for efficient and effective hospitals; and
- supported equitable funding of uncompensated care and medical education.

Maryland's current rate-setting system, however, has important limitations. The rules date back to a time when inpatient services were predominant, and cost per discharge and average length of stay were the only measures for efficiency. The current system's focus on per-case costs does not provide the incentives aligned to population health and comprehensive coordinated care across different settings.

In addition, the current system depends on maintaining per-case costs below a national trend. This condition, however, is in jeopardy. Our "waiver cushion" is the lowest that it has been in many years, in part, because the system has begun to focus on reducing

unnecessary inpatient services. The loss of the waiver would undermine Maryland's all-payer system and create disruption in the health care system.

In this model design proposal, Maryland intends to modernize the rate-setting system to overcome these limitations and provide an innovative and creative solution to critical health care challenges.

Our overarching hypothesis is that an all payer system that is accountable for the total cost of care on a per capita basis is an effective model for establishing policies and incentives to drive system progress toward achieving the three-part aim of enhanced patient experience, better population health and lower costs.

Model Design

Maryland's proposal starts with accountability for the total cost of care on a per capita basis.

For Phase 1, over the next five years, the state commits to limiting inpatient and outpatient hospital costs for all payers to a trend based on the state's long-term Gross State Product (GSP). There would be a separate guarantee of inpatient and outpatient hospital per beneficiary cost growth below a Medicare benchmark.

In order to organize around the goal of constraining per capita cost growth, Maryland will accelerate a broad range of delivery reform efforts. These include:

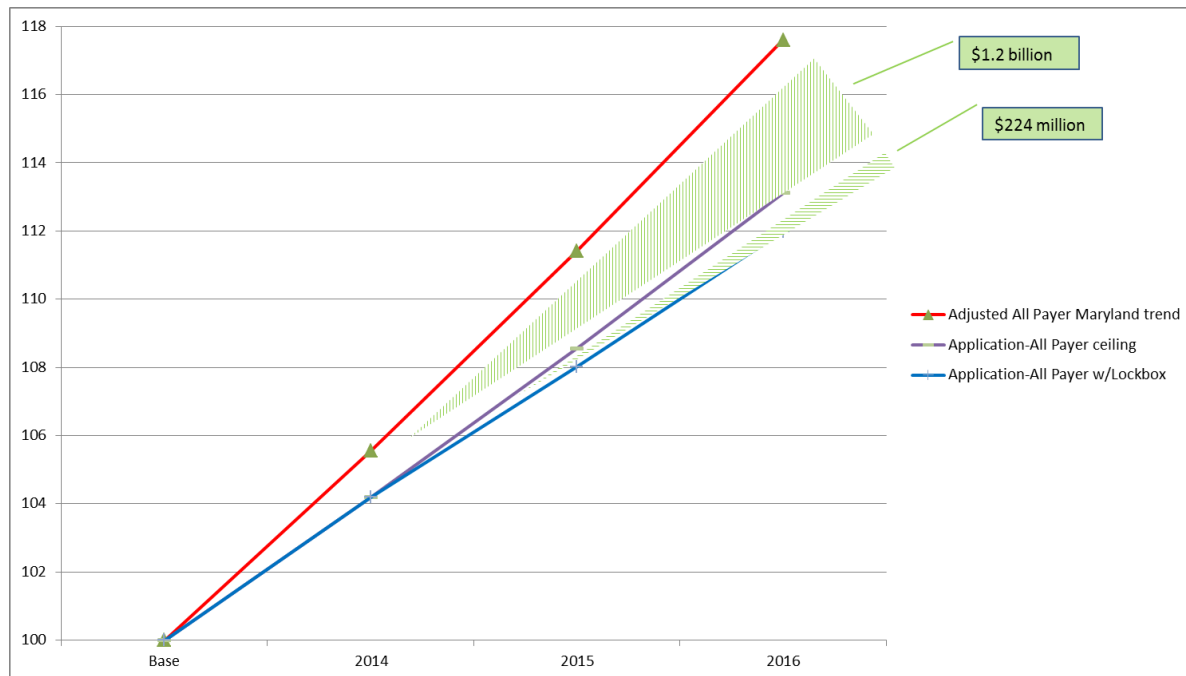
- Gain-sharing between hospitals and physicians as patient outcomes improve and overall costs decline.
- Accountable Care Organizations, with rules that can be established in Maryland on an all-payer basis.
- Readmission programs, which provide powerful incentives for improved coordination of care.
- Global budgeting, for rural hospitals that can gain net revenue with innovative partnerships with community physician and public health agencies.
- Population-based budgeting, for suburban and urban hospitals shifting out of fee-for-service payment to accountability for health outcomes and cost.

To encourage savings below the guaranteed expenditure ceiling, Maryland's proposal introduces the concept of the shared savings lockbox. When hospitals participate in innovative payment and delivery reform programs and achieve savings, the portion of savings returned to payers is set aside to lower overall expenditures. There will also be savings for health care providers that will support the financial stability of efficient and effective health care systems. The rules governing the shared savings lockbox and other

elements of the proposal will be set by the Health Services Cost Review Commission through a transparent and public process.

Specifically, Maryland is proposing a hard expenditure ceiling targeted to the state's trend for Gross State Product, with savings underneath of at least 0.5% per year. We anticipate that this will save payers \$1.4 billion off of potential current trends by 2016 (Figure).

Figure: Health Care Costs Under Proposed Model



Maryland's model design proposal integrates with other critical health reforms underway in the state. It aligns hospital incentives with those of medical homes, a key feature of Maryland's State Innovation Model proposal. It aligns with major investments made in information technology, including the state's Health Information Exchange. It also aligns with the public health goals of the State Health Improvement Process.

These efforts will all come together in a Phase 2 proposal, to be submitted in Year 4. This proposal will further advance the three-part aim, including better health, improved patient experience, and constrained overall cost of care per Maryland resident.

Measuring Success

This proposal includes detailed measures of success:

- For the patient experience of care, Maryland will measure patient satisfaction, the effectiveness of care transitions, physician participation in public programs, and complication rates.

- For population health, Maryland will measure life expectancy, hospitalizations for ambulatory care sensitive conditions, primary and secondary prevention for cardiovascular disease, and behavioral health emergencies, including racial and ethnic disparities in these measures.
- For health care costs, Maryland will measure overuse of diagnostic imaging, inpatient and outpatient costs, and total costs. The state will track expenditures for specific payers, including Medicare, Medicaid, CHIP, the federal employee program, and subsidies through the Maryland Health Benefit Exchange.

Next Steps

Maryland's submission of this proposal is an important step in a deliberate process that is far from over. We anticipate several months of review within CMS and other federal agencies before the proposal is finalized and approved. We also anticipate further dialogue with stakeholders in Maryland throughout this time. In addition, the Health Services Cost Review Commission will begin collaborative discussions with the goal of developing an implementation plan.

At this point, given the broad statutory authority that currently exists, we are not aware of a need for changes in the law. However, should such a need be identified during the months to come, the HSCRC and DHMH will come back during the legislative session in 2014 with a proposal.

Thank you for the opportunity to testify at this critical moment for Maryland's health care system. Working together, we can build upon our unique strengths to address key challenges of cost and outcome and provide a model for the nation.



Maryland's Proposal to Modernize
All-Payer Rate Setting:
Enhancing Patient Experience, Controlling
Costs, and Improving Health

Senate Finance Committee and Budget and Tax Committee Briefing
March 27, 2013

John M. Colmers
Chairman
Health Services Cost Review
Commission

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health
and Mental Hygiene

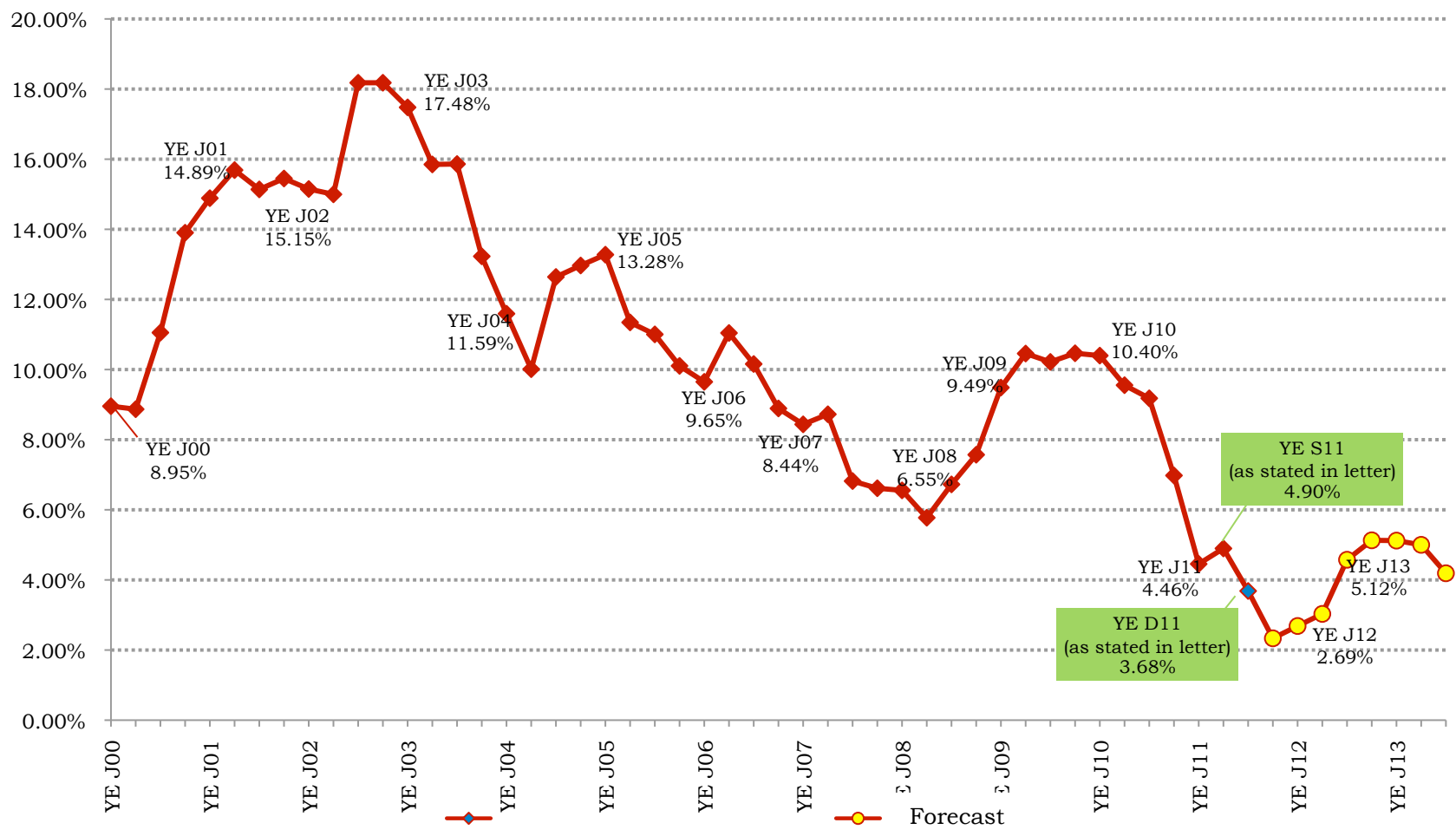
Background

- ▶ Since the late 1970s, the independent Health Services Cost Review Commission sets inpatient and outpatient hospital rates for all public and private payers.
- ▶ In the last 35 years, Maryland's hospital finance system has:
 - ▶ Eliminated cost-shifting among payers
 - ▶ Provided for the sharing of public goods (e.g., uncompensated care and medical education) among all payers
 - ▶ Allowed usage of creative of incentives to improve quality and outcomes

Maryland's Current Rate Setting System Has Important Limitations

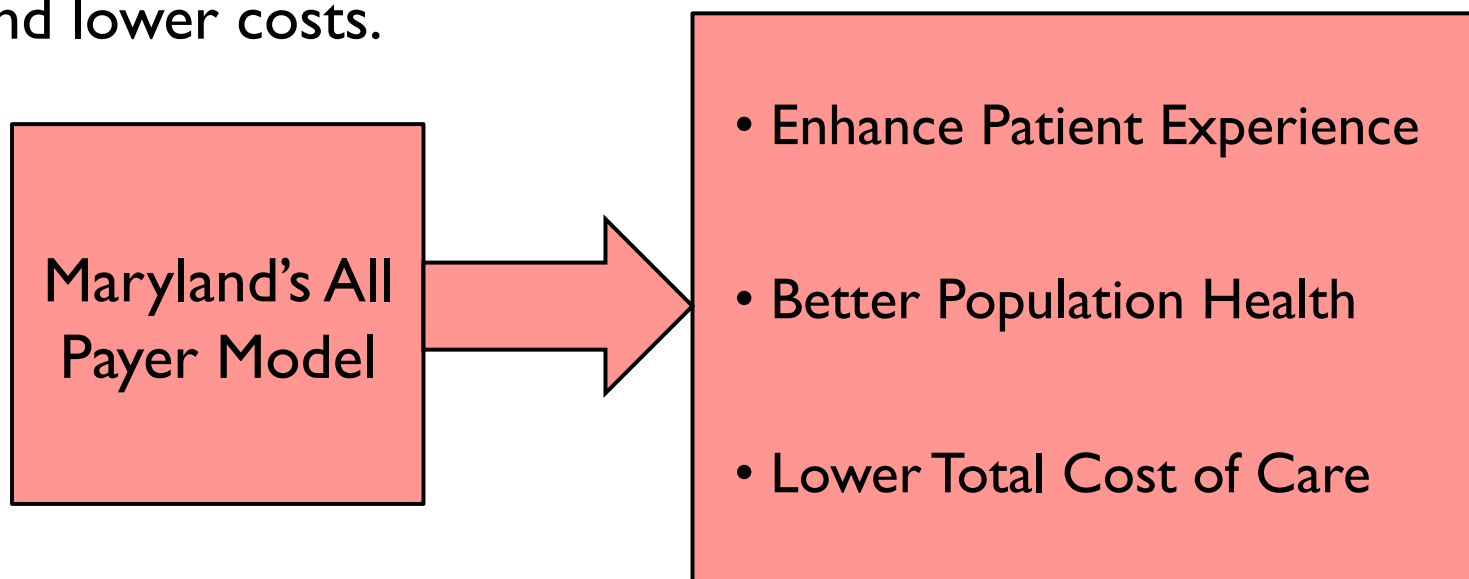
- ▶ **The Medicare Waiver in the Social Security Act at §1814 (b) provides Maryland authority to set payment rates for Medicare.**
 - ▶ CMS evaluates Maryland's success under §1814(b) on a per discharge basis.
- ▶ **Waiver test rules focus on inpatient services only**
 - ▶ Reflect a time when cost per discharge and average length of stay were the only measures for efficiency
- ▶ **The current system's focus on inpatient per-case costs does not provide incentives aligned to population health and comprehensive coordinated care across different settings.**

Maryland's Current Waiver Cushion has Deteriorated



Maryland's Hypothesis

- ▶ An all payer system that is accountable for the total cost of care on a per capita basis is an effective model for establishing policies and incentives to drive system progress toward achieving the three part aim of enhanced patient experience (including quality and satisfaction), better population health, and lower costs.



Maryland's Model Design Proposal Starts with Accountability on a Per Capita Basis

- ▶ **Model Design is in two phases:**
 - ▶ Phase 1: Evaluate financial success using inpatient and outpatient hospital expenditures
 - ▶ Phase 2: Proposal to be developed during Phase 1
- ▶ For Phase 1, Maryland commits to limiting inpatient and outpatient hospital costs for all payers to a **Hard Expenditure Ceiling** based on the State's long-term Gross State Product (GSP).
 - ▶ State sets a separate guarantee of inpatient and outpatient hospital per beneficiary cost growth below a **Medicare benchmark**.

Maryland Proposes to Accelerate a Broad Range of Delivery Reform Efforts

Accountable Care Organizations, with rules that can be established in Maryland on an all-payer basis.

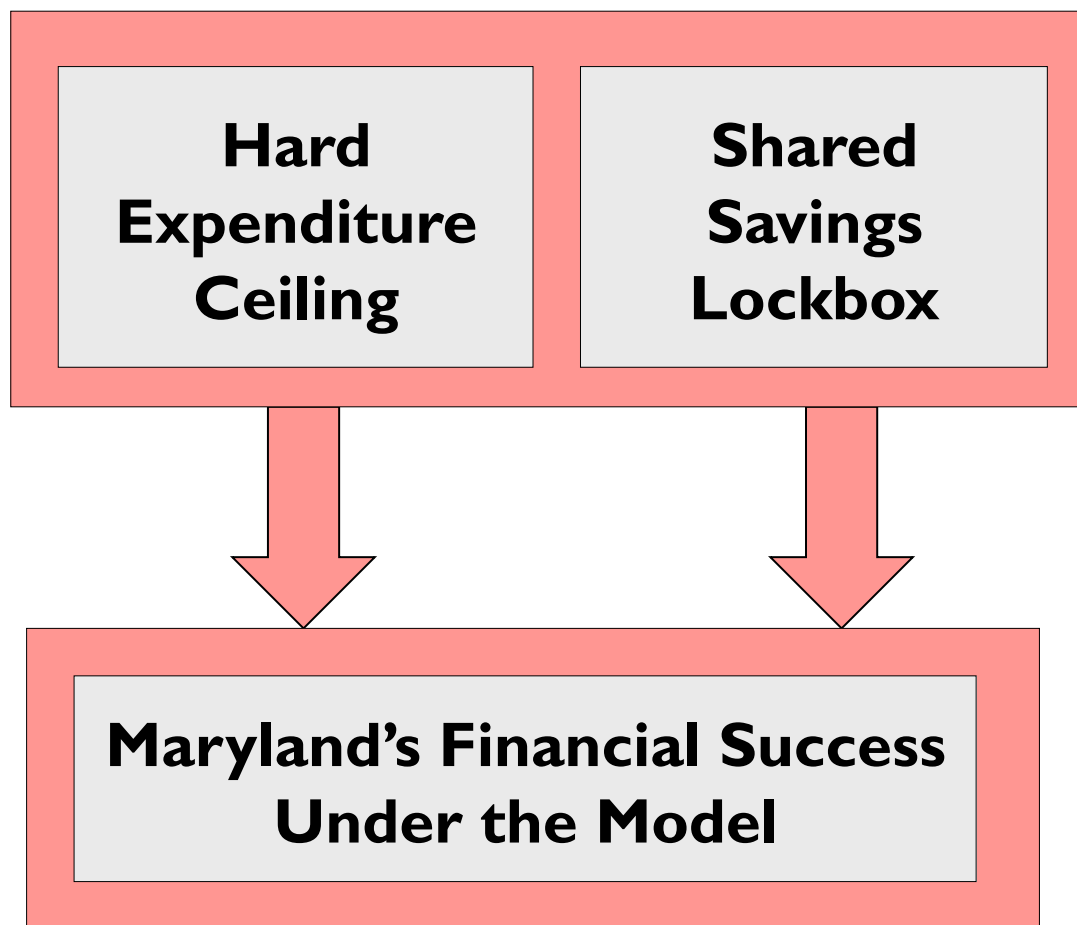
Readmission programs, which provide powerful incentives for improved coordination of care.

Global budgeting, for rural hospitals that can gain net revenue with innovative partnerships with community physician and public health agencies.

Gain-sharing between hospitals and physicians as patient outcomes improve and overall costs decline.

Population-based budgeting, for suburban and urban hospitals shifting out of fee-for-service payment to accountability for health outcomes and cost.

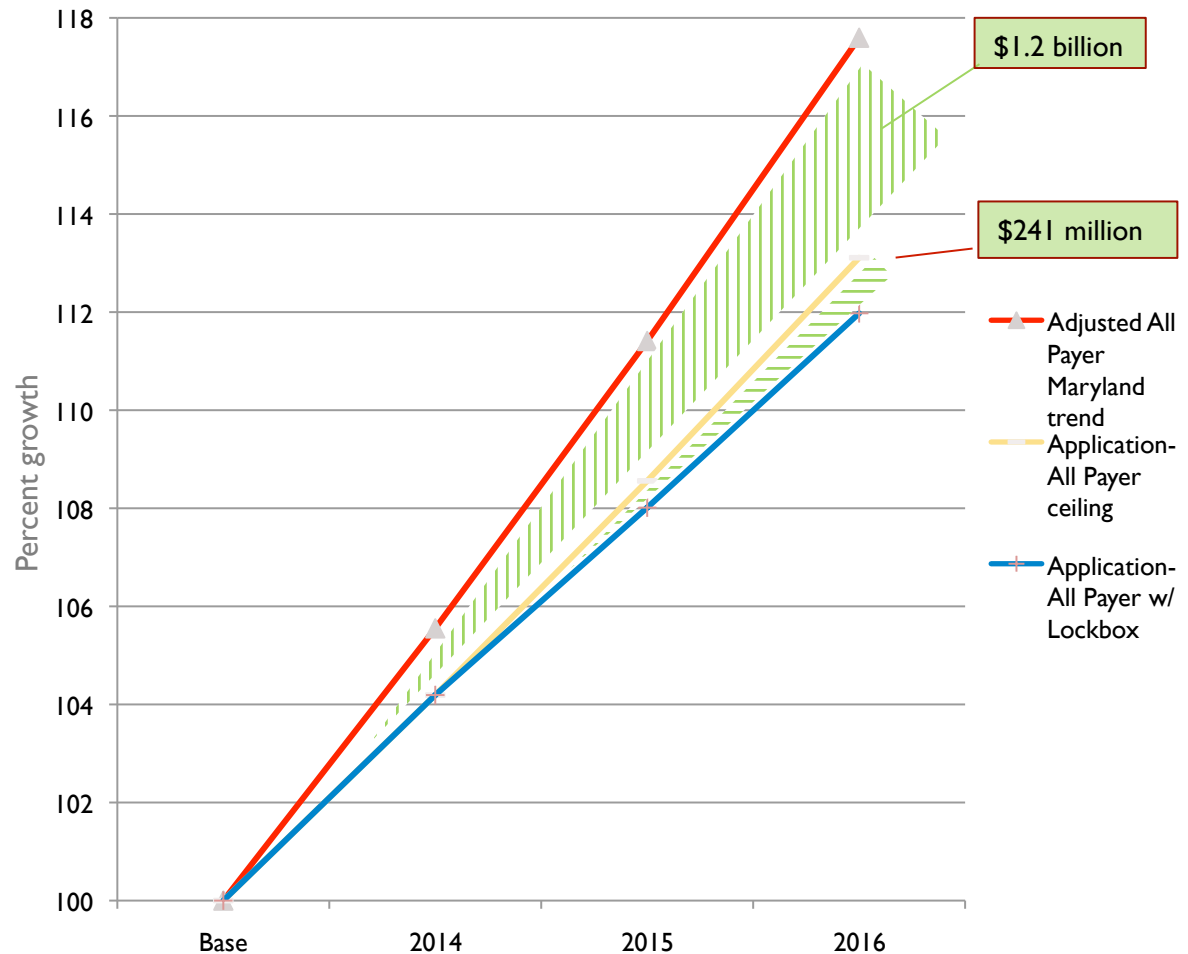
Pairing the Hard Expenditure Ceiling and a Shared Savings Lockbox Generates Financial Success



- ▶ The shared savings lockbox concept encourages savings below the guaranteed expenditure ceiling
- ▶ As innovative programs achieve savings, a portion of savings is returned to payers and ultimately the people of the State of Maryland
- ▶ Rules governing the shared savings lockbox and other elements of the proposal will be set by the HSCRC through a transparent and public process.

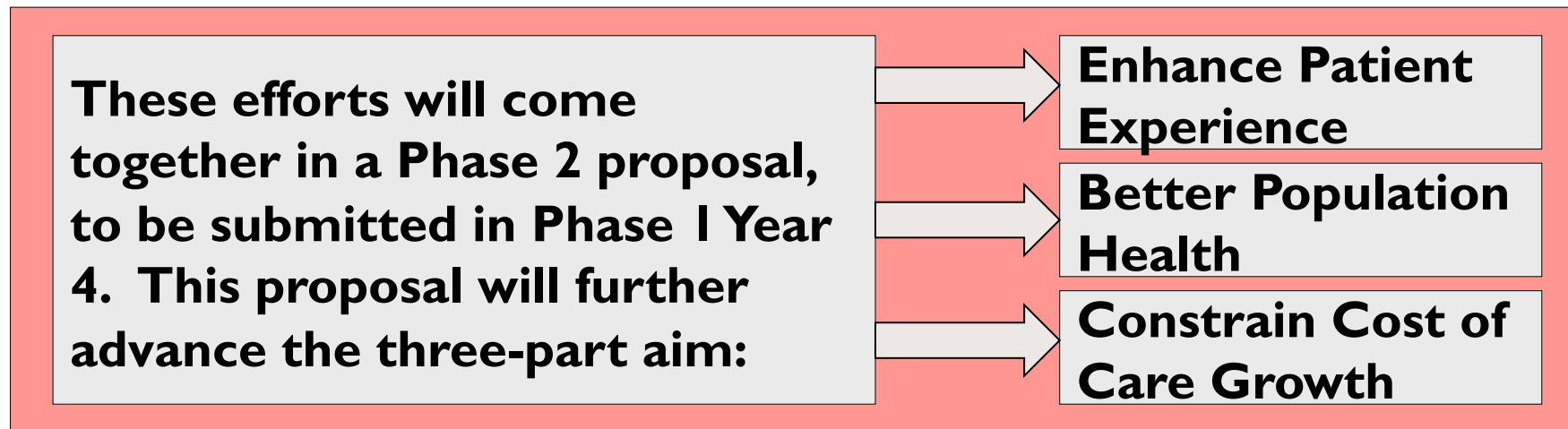
We Anticipate this Proposal Will Save \$1.4 Billion by 2016

- ▶ Maryland is proposing a hard expenditure ceiling targeted to the State's trend for GSP, with shared savings underneath of at least 0.5 percent per year



This Proposal Integrates with Other Critical Health Reforms Underway in the Maryland

- ▶ Aligns hospital incentives with those of medical homes, a key feature of Maryland's State Innovation Model proposal
- ▶ Aligns with major investments made in information technology, including the state's Health Information Exchange
- ▶ Aligns with the public health goals of the State Health Improvement Process



Maryland Will Track Numerous Performance Measures

- ▶ **Patient Experience of Care:**
 - ▶ Measures include patient satisfaction, the effectiveness of care transitions, physician participation in public programs, and complication rates
- ▶ **Population Health:**
 - ▶ Measures include life expectancy, hospitalizations for ambulatory care sensitive conditions, primary and secondary prevention for cardiovascular disease, and behavioral health emergencies, including racial and ethnic disparities in these measures
- ▶ **Health Care Costs:**
 - ▶ Measures include overuse of diagnostic imaging, inpatient and outpatient costs, and total costs

Maryland's Submission to CMS is an Important Step in a Continuing Process

- ▶ Anticipate several months of review within CMS and other federal agencies before the proposal is finalized and approved
- ▶ Anticipate further dialogue with stakeholders in Maryland throughout this time
- ▶ Given broad statutory framework, at this point, we do not see need for legal changes; if need is identified, would be an issue for 2014 session
- ▶ HSCRC will begin collaborative discussions with the goal of developing an implementation plan



Maryland's Proposal to Modernize
All-Payer Rate Setting:
Enhancing Patient Experience, Controlling
Costs, and Improving Health

Senate Finance Committee and Budget and Tax Committee Briefing
March 27, 2013

John M. Colmers
Chairman
Health Services Cost Review
Commission

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health
and Mental Hygiene