Maryland All-Payer Model: Hospital Global Budgets

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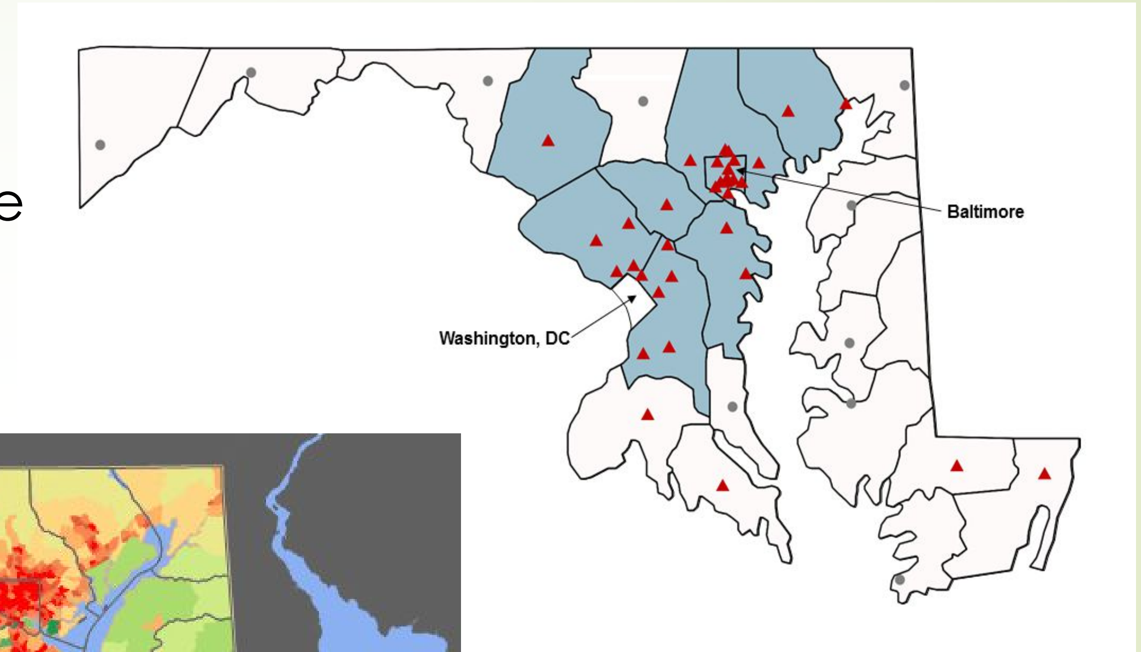
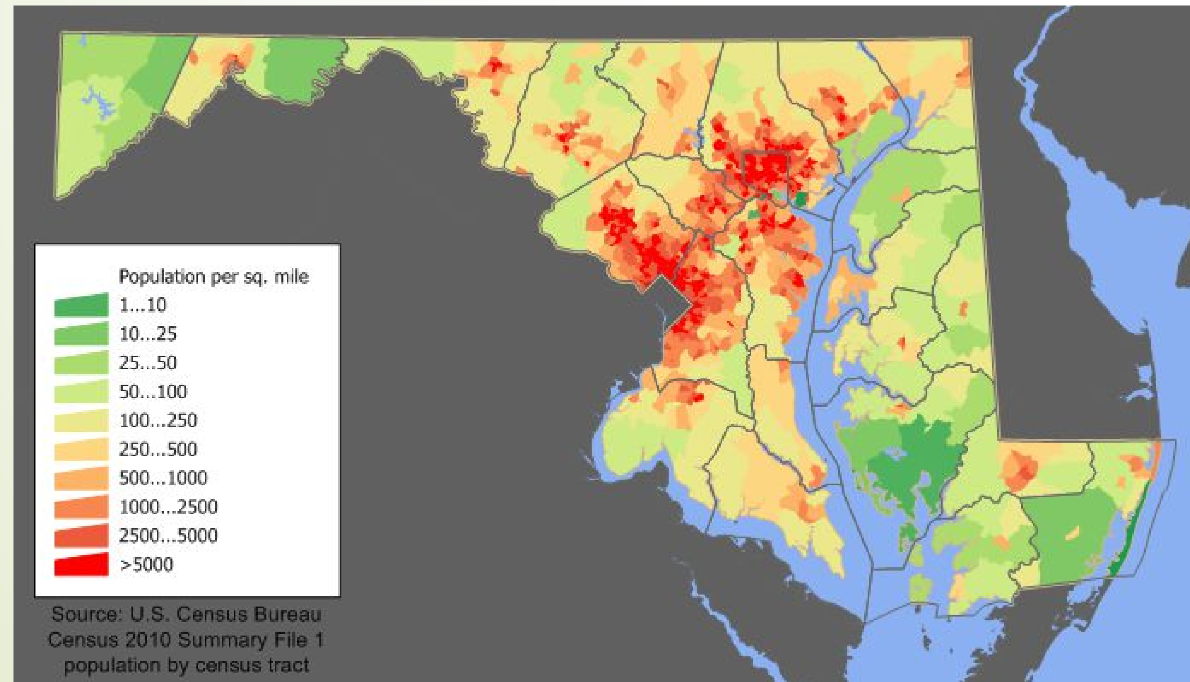
Unique All-Payer Model: Health Services Cost Review Commission (HSCRC)

- **Oversees hospital rate regulation for all payers**
  - Unique governance structure - 7 volunteer Commissioners consist of stakeholder representatives appointed by the Governor
  - Rate setting authority extends to all payers, Medicare waiver since 1980s
  - Inpatient and outpatient hospital services (no Physicians services)
  - 47 Acute Care Hospitals - $15 billion in revenue
- **Provides considerable value**
  - Limits cost shifting--all payers pay their share, including uncompensated care and graduate medical education
  - Innovates with stakeholders and regulates on a local level
  - Uses all payer metrics to measure outcomes and guide care improvement

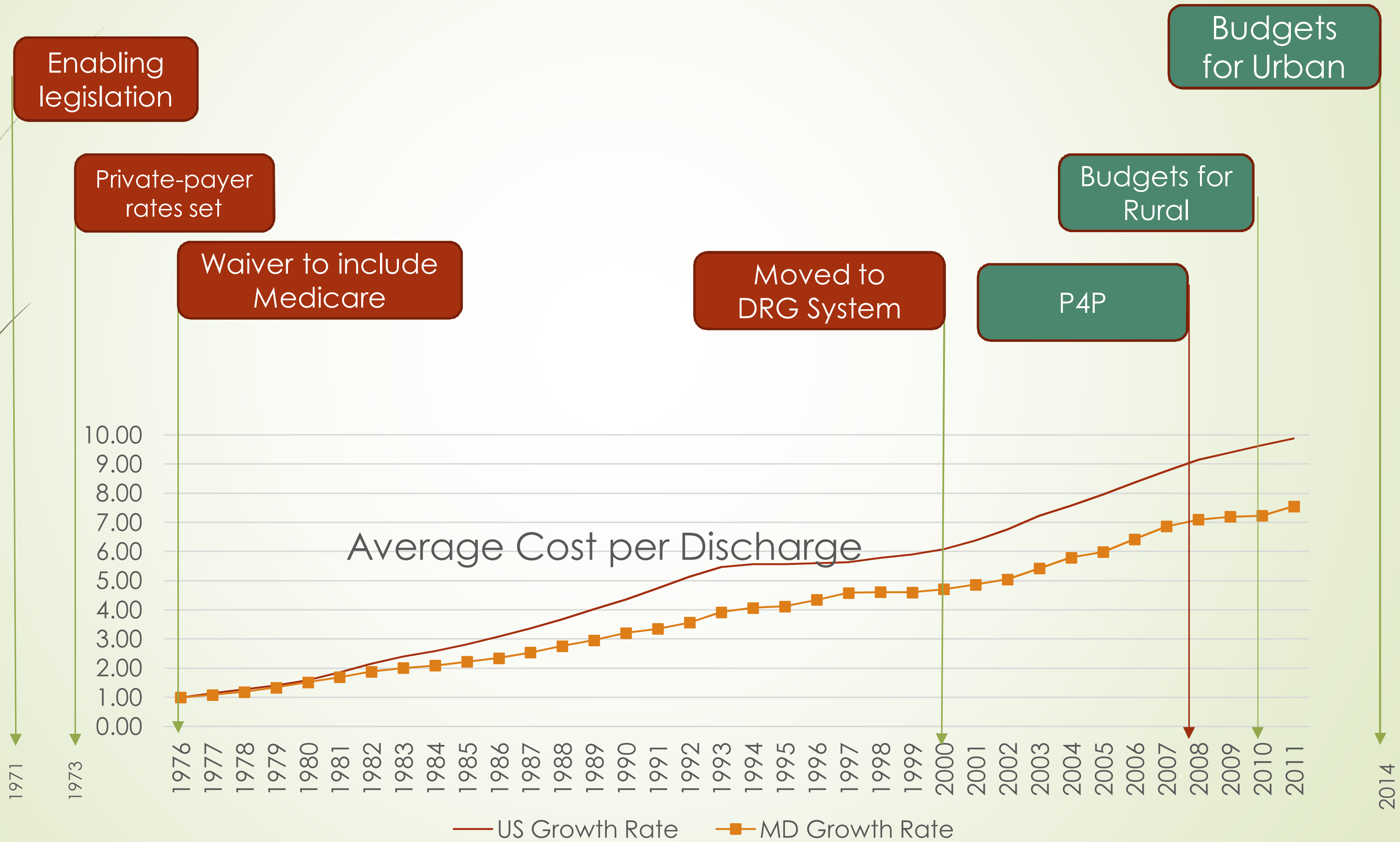
The State of Maryland

- 5.65 Million people
- 18% of population > age 64
- 3rd highest income per capita state
- High poverty rates
- Two major Academic Medical Institutions





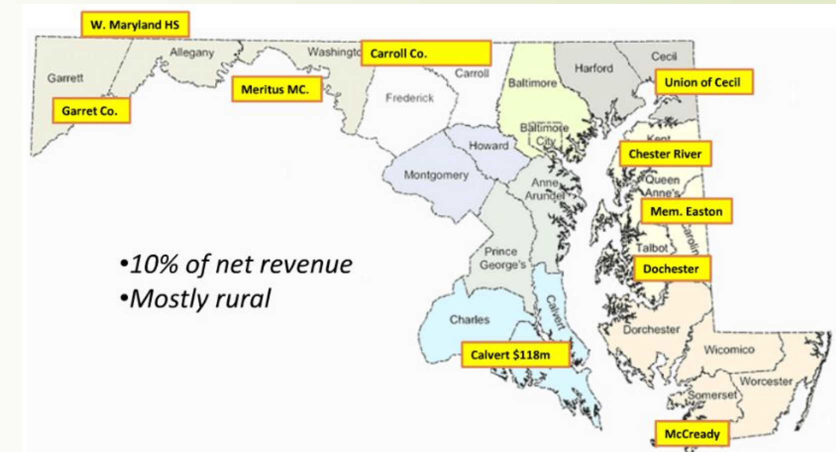
Payment Innovation Timelines



Payment Innovations

- **Pay for Performance Programs**
  - July 2008- Hospital Value-Based Program
  - July 2010- Hospital-Acquired Conditions

- **Alternative Payment Programs**
  - **July 2010-Global budgets for 10 rural hospitals**
    - Population health focus
    - Stability for the rural hospital finances to reorganize services
  - **July 2011-Hospital episode payments that incorporated all cause readmissions for all others**
    - Strong incentives to reduce readmissions and improve care



Moving Away from Volume

<u>Former Hospital Payment Model:</u>

Volume Driven

Units/Cases

Rate Per Unit or Case

Hospital Revenue

- Unknown at the beginning of year
- More cases lead to more revenue

<u>New Hospital Payment Model:</u>

Population and Value Driven

Revenue Base Year

Updates for Trend, Population, Value

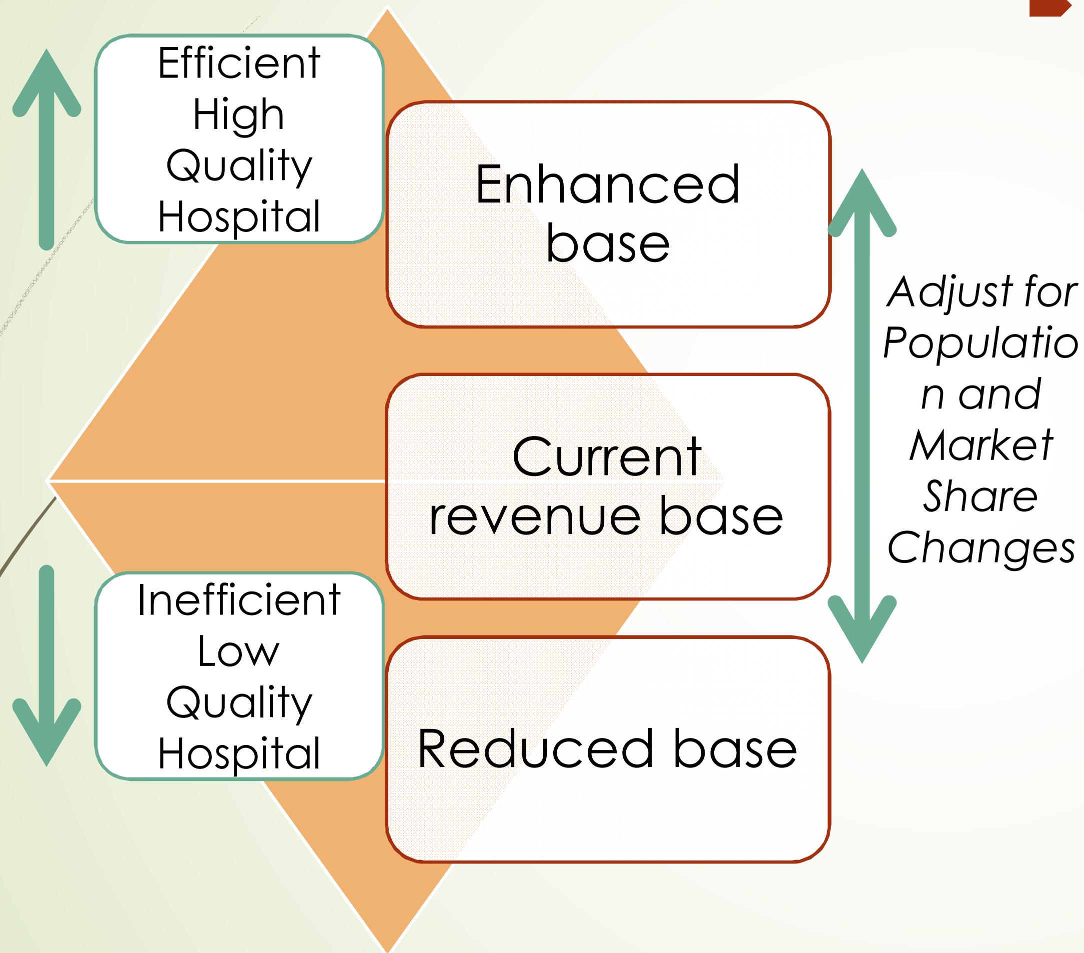
Allowed Revenue for Target Year

- Known at the beginning of year
- More cases do not lead to more revenue

Maryland’s New All-Payer Model Agreement with CMS- January 2014

- **Modernizes Maryland’s Medicare 40-year waiver**
  - Moved from inpatient average cost per discharge to per capita total hospital cost
- **Statewide All-Payer hospital per capita revenue growth ceiling tied to the long term economic growth rate**
  - All-Payer limit is set for 3.58 % for the first three years with an option to update afterword's.
- **Quality and performance targets to promote care improvement**
  - 30-day readmissions
  - Hospital acquired conditions
- **Payment transformation away from fee-for-service for hospital services**
  - Expanding global budgets to urban/suburban hospitals
  - Models to focus on total health spending and transformation

Global Budget Model



- The Global Budget Model: revenue budget with annual adjustments
  - *The initial revenue budget would be based on historical revenue*
  - *This budget could be enhanced or reduced based on hospital efficiency and utilization*
  - *The budget would be adjusted annually for changes in market share, population and quality*

Key Aspects of Hospital Global Budgets

- **Fixed revenue base for 12-month period with annual adjustments**
  - Hospitals bill based on rates per unit which are the same for each payer
  - Hospitals raise and lower rates within corridors to stay on budget
- **Retain revenue related to reductions in potentially avoidable utilization**
  - Invest savings in care improvement
- **Annual adjustments for price and volume**

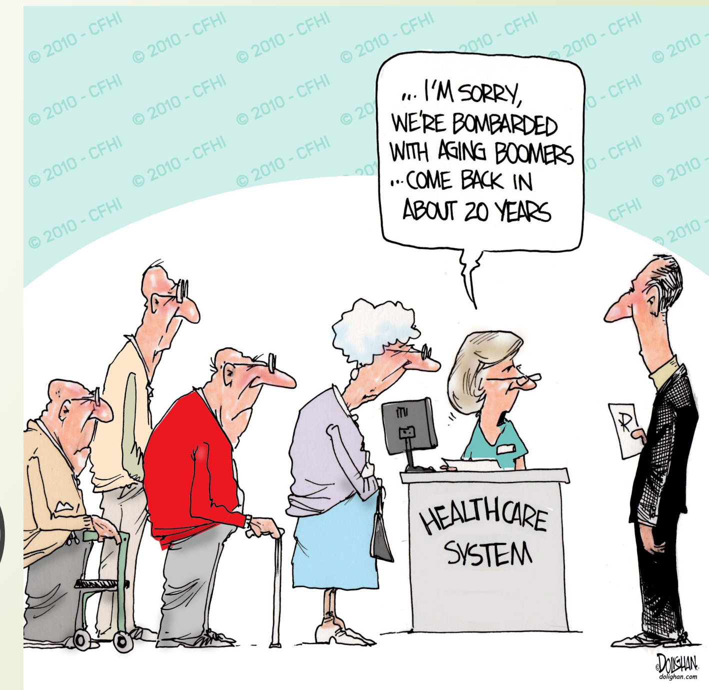
Medical Inflation Adjustment

- **Overall budget adjustment (based on single Market-basket Inflation Rate)**
- **Special circumstances that are beyond hospital's control**
  - New Drugs
  - Supply and drugs

Volume Adjustments

- **Population growth in primary service area**
  - Rural hospitals based on counties
  - Urban/Suburban based on zip codes and market share
- **Higher adjustment rates for aging**
- **Other factors**
  - Coverage expansions (2014)
  - Flu epidemic (2015)
  - Specialized services

    (transplants, specialized cancer patients)



New Incentives: Cost, Quality, Patient-Centeredness

- **Balance between incentives to reduce avoidable utilization and provide necessary resources**
  - Transfers: cost neutral adjustments to the budgets for major changes in transfer patterns (for both sending and receiving hospitals)
  - Market Shifts : encourage competition while maintaining strong incentives to reduce avoidable utilization
  - Strong pay for performance programs: readmissions, hospital acquired conditions, mortality, patient experience, population health measures

Approach to Moving to a More Patient-Centered System

Focus

Improving Patient-Centered Care	Reducing Avoidable Utilization	Ensuring Consumer Protections
Chronic Care & Care for Patients with High Needs	Maryland's Hospital Acquired Conditions	Global Budget Contracts
Collaboration & Coordination Across Providers/Others	PQIs: Prevention Quality Indicators	Market Shift, Transfers, Transplants/Other
Utilization of Patient-Centered Measures	Readmissions and Rehospitalizations	Data Analytics: Detailed Monthly Reports on Volumes

Global budget model opens up new avenues for innovation

- **All-payer nature lends a greater ability to focus on common outcomes, which yields better care and outcomes for patients**
- **Success and sustainability dependent on:**
  - Reducing avoidable utilization and improving population health
  - Partnering with other providers, communities, and patients to integrate and coordinate care
  - Developing effective care coordination—emergency room, transitions, addressing complex patients, disease management, long-term care and post-acute integration

Hospital Global Budget Experience

Challenges

Data and Analytics

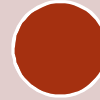
Provider Alignment

Culture change

ED utilization, Readmissions, Length of stay

Preventable Admissions

Diabetes, CHF clinics, Disease prevention programs



High-Need Complex Patients

Primary Care

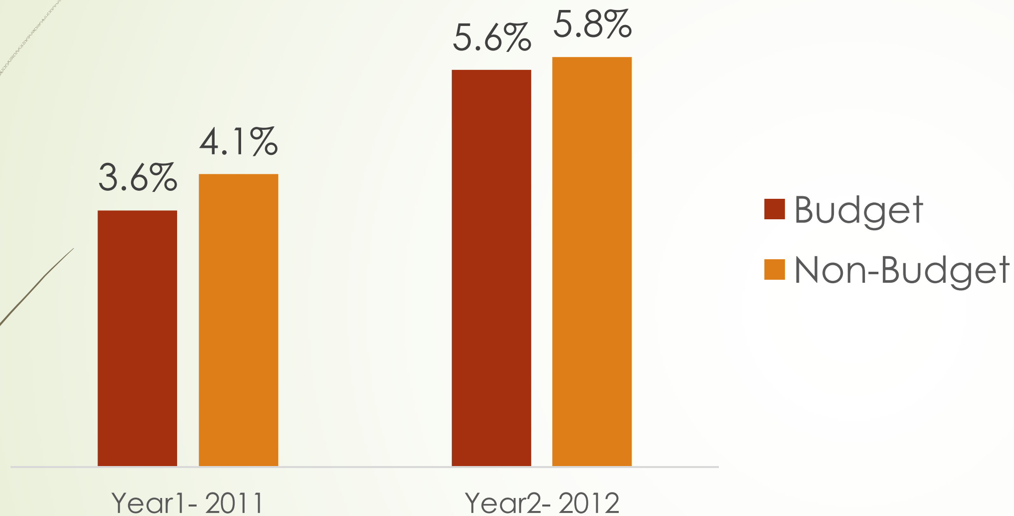
Strategies

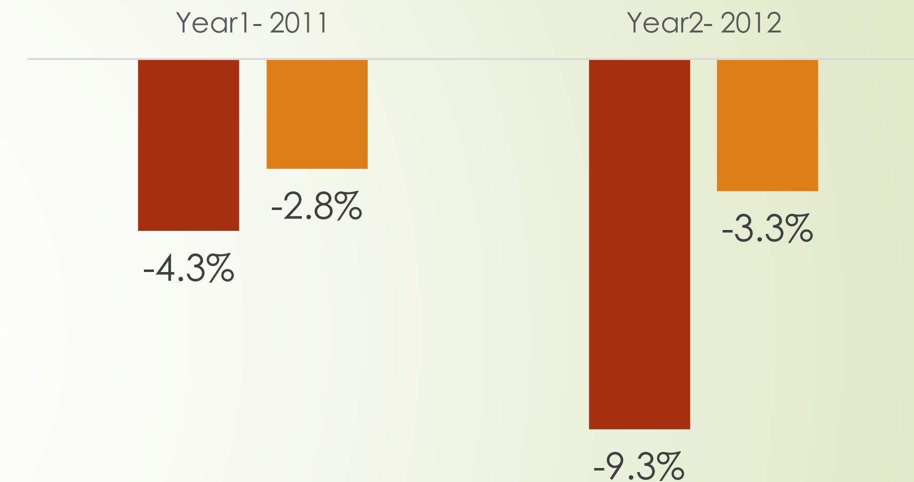
Initial Results of the Rural Hospital Budgets

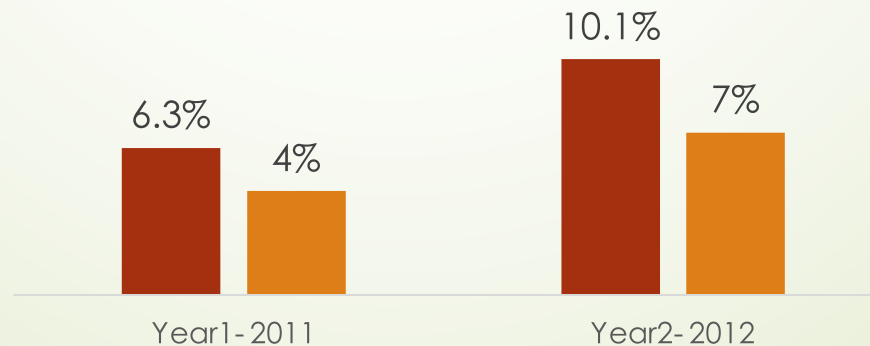
	Budget Hospitals in Maryland	Non-Budget Hospitals in Maryland
Inpatient Admissions		
FY2010	91,672	668,319
FY2013	75,478	608,166
% Change	-18%	-9%
Same Hospital Readmissions		
FY2010	9,530	64,842
FY2012	7,729	58,269
	-19%	-10%
Avoidable Admissions (PQI 90)		
CY2010	11,551	65,517
CY2013	9,593	57,148
	-17%	-13%

Source: HSCRC May 2013

Similar Revenue Growths, Faster Inpatient Admission Declines=Higher Average Cost







Hospital Success Story

- Development of relationships with surrounding home care facilities;
- Adoption of the Coleman Model — a discharge model that provides an in-home visit within 72 hours of discharge for patients who don't qualify for home care services;
- Addition of a full-time Emergency Department Care Manager focused on development and communication of a comprehensive discharge plan; and
- Creation of a Discharge Advocacy Center with personnel who assist patients in following the discharge plan by making follow-up doctor appointments for them, among other things.

Source: Experiment, or Our Future? Key Insights Monday, March 25, 2013 Maryland Hospital Association

Other State Solutions—Maryland Helps Provide Leadership for National Problem

- **Pennsylvania Rural Health Model**
  - Begins with 6 rural hospitals on global budgets in 2016, expanding to at least 30 of 42 rural hospitals by year 3
  - Transitions from inpatient-focused delivery to greater emphasis on outpatient services and population health
  - Focuses directly on improved quality and safety
  - Leverages technology with a common approach
- **Vermont All-Payer ACO Model**

Summary

- **Maryland's new All Payer Hospital Model tests all-payer innovation implemented at a state and local level**
- **Global budgets may provide effective mechanism to both control cost and provide resources for reorganizing care**
  - All-Payer per capita growth trend is below national average
  - $400 mil. Savings to Medicare
  - Substantial improvements in quality
  - Improved hospital finances
- **Multiple approaches can be developed to implement global budgets**

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