Maryland Health Services Cost Review Commission

New All-Payer Model for Maryland
Population-Based and Patient-Centered Payment Systems
May 2014

Outline of Presentation

- Introductions
- Overview of New Maryland All-Payer Model
- Opportunities for Success
- Implementation Approach
- Questions

Overview of New All-Payer Model

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

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 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

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
- Focus is on patients and quality of care

Better care

Better health

Lower cost

Focus Shifts from Rates to Revenues

Old Model

Volume Driven

Units/Cases

Rate Per Unit or Case

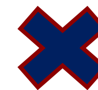
Hospital Revenue

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

Challenge for Integration of Efforts

Medical Homes Accountable Care Organizations

Health Enterprise Zones (HEZ)

Enrollment Expansion

-Medicaid

-Private

Health Information Exchange--CRISP

State Health Improvement Process-Public Health

Timeline of All-Payer Model Development

Phase 1 (5 Year Model)

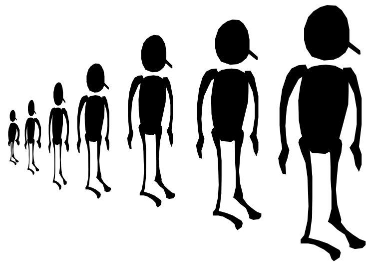
- Hospital global model
- Population-based
- Preparation for Phase 2 focus on total costs of care model

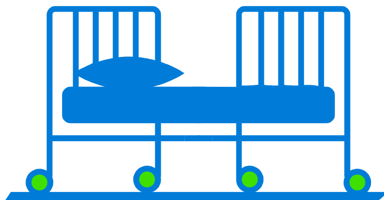
Opportunities for Success Under the New All-Payer Model

History Provides Example

DRGs and New Technology Reduced Length of Stay and Admissions and Freed Up $$$ for Major Improvements in Cardiac Care, Minimally Invasive Procedures, Advanced Imaging, New Medications and Other Care

	1980	2010	% CHG
U. S. Population	227M	309 M	+36%
Occupied beds	755,000	473,000	-37%





What Does This Mean?

- New Model represents most significant change in nearly 40 years
- Focus shifts to gain control of the revenue budget and focus on gaining the right volumes and reducing avoidable utilization resulting from care improvement
- Potential for excess capacity will demand focus on cost control and opportunities to optimize capacity
- Opens up new avenues for innovation
- Increased efficiency creates opportunities for improved care and better population health

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

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

Near Term Revenue Models

Global Budget Revenues (GBR, TPR)	Non-GBR Revenues
• Inflation Adjustment • Demographic Shift Driven Volume	• Inflation Adjustment • Volume Governor • 50% variable cost factor

- Quality-based adjustments
- Other statewide policy adjustments

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

HSCRC Administers Quality-Based Payment Initiatives for Hospitals

QBR
(Quality Based Reimbursement)

- Clinical Process of Care Measures
- Patient Experience of Care (HCAHPS)
- Mortality

MHAC
(Maryland Hospital-Acquired Conditions)

- 65 Potentially Preventable Complications

Readmissions

- 30-day bundled episodes
- Shared Savings and Improvement programs

Aligning Quality-Based Programs with the Model

- 30% reduction target in Hospital Acquired Conditions (HAC)
  - Linked the financial impact of hospital performance to statewide progress
    - If state improvement rate is below or equal to 8%, maximum revenue at risk is 4%
    - If state improvement exceeds 8%, maximum revenue at risk is 1%
- Readmission target
  - Positive incentive for hospitals that achieve 6.8% improvement in all cause all hospital readmission rate

Medicare Focus: GO FOR "0"

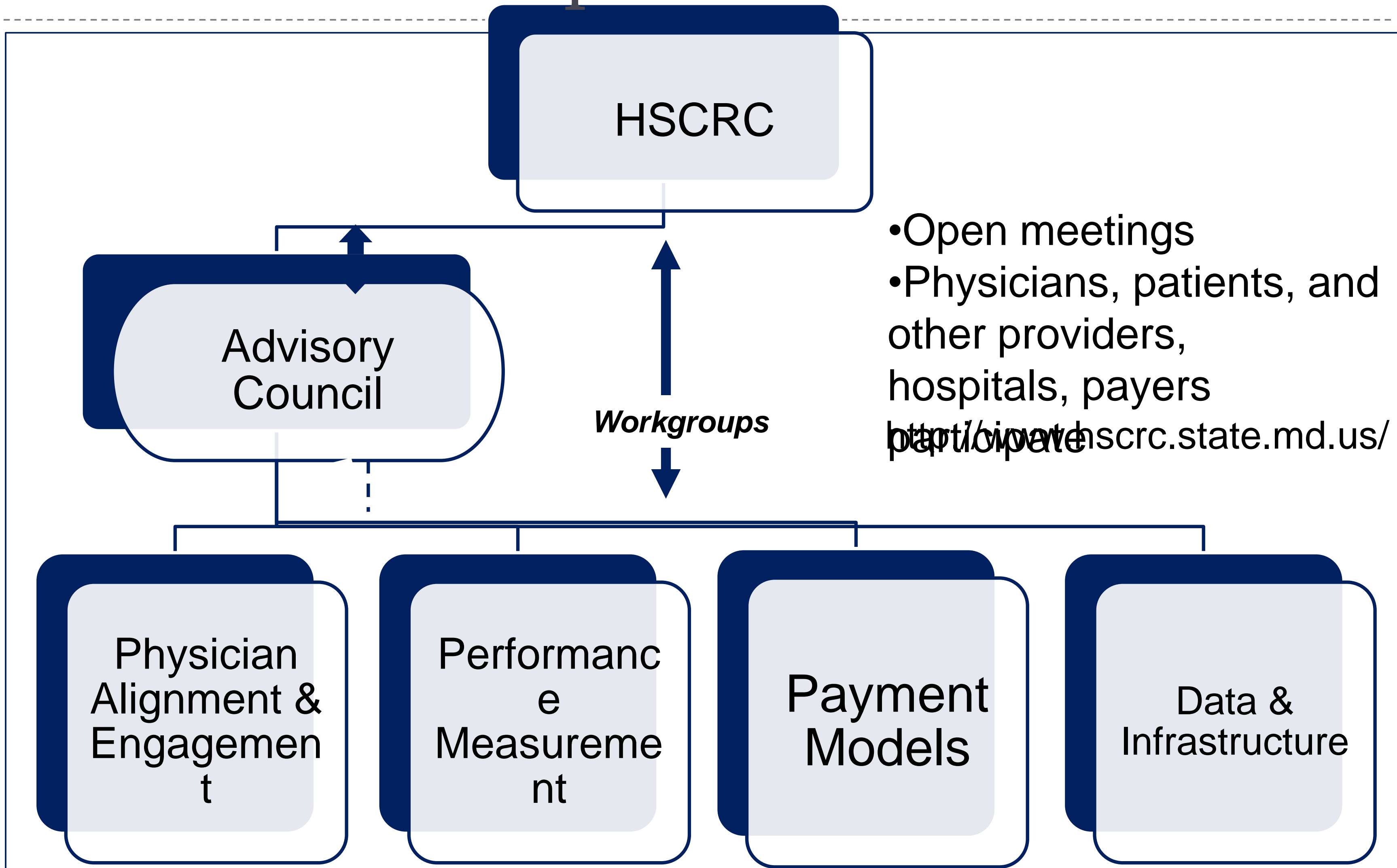
- Medicare revenue growth below national growth critical to generate savings
  - Medicare is the least managed population in Maryland
  - Focus on high need patients and avoidable utilization
  - In particular, where better care reduces costs
  - Requires improved coordination and focus among providers, patients, and families

HSCRC Implementation Approach

HSCRC Public Engagement
Short Term Process Phases

- Phase 1:
  - Fall 2013: Advisory Council - recommendations on broad principles
  - January 2014- July 2014: Workgroups
    - Four workgroups convened
    - Focused set of tasks needed for initial policy making of Commission
    - Majority of recommendations needed by July 2014
- Phase 2: July 2014 – July 2015
  - Always anticipated longer-term implementation activities
  - July Workgroup reports to address proposed future work plan
  - Advisory Council reconvening

Stakeholder input



Advisory Council

- Advisory Council was charged with offering guidance and advice on implementing Maryland's newly approved model design
- Best ways to meet the tight targets in model
- Setting priorities for implementation
- Establishing guiding principles
- Advice based on real-world experience

Advisory Council Recommendations

- 1. Focus on Meeting the Early Model Requirements
  - Focus on All-payer and Medicare tests
  - Start with Global Budgets
  - Reduce avoidable utilization
- 2. Meeting Budget Targets, Investments in Infrastructure, and Providing Flexibility for Private Sector Innovation
- 3. HSCRC as a Regulator, Catalyst, and Advocate
- 4. Consumer Involvement in Planning and Implementation
- 5. Physician and Other Provider Alignment
- 6. Transparency and the Public Engagement Process

Public Engagement Process – Work Groups

- Engaged broad set of stakeholders in HSCRC policy making and implementation of new model
  - 4 workgroups and 6 subgroups
  - 85 workgroup appointees
  - Consumers, Employers, Providers, Payers, Hospitals
- Established processes for transparency and openness
  - Diverse membership
  - Educational phase of process
  - Call for Technical White Paper Shared Publically
  - Access to information
  - Opportunity for comment

HSCRC Work Group Descriptions

Physician Alignment & Engagement

- Alignment with Emerging Physician Models
- Shared Savings
- Care Improvement
  - Care Coordination Opportunities
  - Post-Acute and Long-Term Care
  - Evidence-Based Care

Performance Improvement & Measurement

- Reducing Potentially Avoidable Utilization to achieve Three-Part Aim
  - Statewide Targets & Hospital Performance Measurement
  - Measuring Potentially Avoidable Utilization
- Value-Based Payments (integration of cost, quality, population health and outcomes)
- Patient Experience and Patient-Centered Outcomes

Note: More Detailed Work Group Descriptions reviewed by Commission January 13, 2014 and available on HSCRC website

HSCRC Work Group Descriptions

Data and Infrastructure

- Data Requirements
- Care Coordination Data and Infrastructure
- Technical and Staff Infrastructure
- Data Sharing Strategy

Payment Models

- Balanced Update
- Guardrails for Model Performance
- Market Share
- Initial and Future Models

Note: More Detailed Work Group Descriptions reviewed by Commission January 13, 2014 and available on HSCRC website

Workgroup Products (as of 5/12/14)

- **Payment Model**
  - Draft UCC Policy Recommendations
  - Draft Update Factors Recommendation for FY 2015
  - Draft Readmission Shared Savings Recommendation for FY 2015
  - Final Report – Balanced Update and Short-Term Adjustments
- **Performance Measurement**
  - Final Recommendations– Maryland Hospital Acquired Conditions
  - Final Recommendations – Readmissions
  - First Draft – Efficiency Report
- **Data and Infrastructure**
  - Final Report - Data Requirements for Monitoring All-Payer Model
- **Physician Alignment and Engagement**
  - First Draft - Current Physician Payment Models and Recommendations for Physician Alignment Strategies under the All-Payer Model