A Journey Together: Making the new All Payer Hospital Model Work for You and Your Patients

Maryland Health Services Cost Review Commission

January 2015

Health Services Cost Review Commission

- Oversees hospital rate regulation in Maryland
- Independent 7 member Commission
  - Small professional staff of 37
- All payers pay on the basis of rates set by HSCRC
  - Medicare, Medicaid, Commercial payers
- Unique system in place since 1977 under a set of “waivers”
  - Considerable value to patients, business, providers
  - All payers contribute to pay for uncompensated care
- Need for waiver modernization to reflect change in focus to quality and total hospital cost

New All-Payer Model

- Maryland is implementing a new All-Payer Model for hospital payment
  - New Model contract approved by CMS/CMMI effective January 1, 2014
  - Modernizes Medicare waiver in place since 1977 and maintains benefits
  - Health Services Cost Review Commission leading the implementation

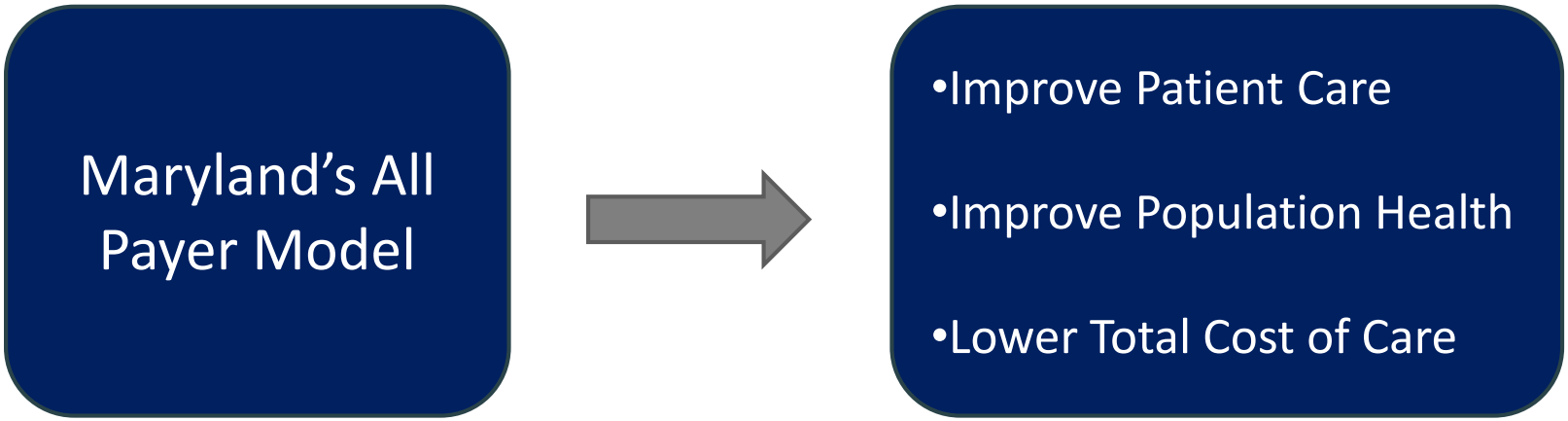
- The All-Payer Model shifts focus
  - From **per inpatient admission** hospital payment
  - To **all payer**, **per capita,** total hospital payment and quality

New Model Agreement 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% maximum annual growth rate for first 3 years
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered measures** and targets to assure care and population health improvement
  - Medicare readmission reductions to national average
  - Continued aggressive reductions in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC)
  - Other care improvements

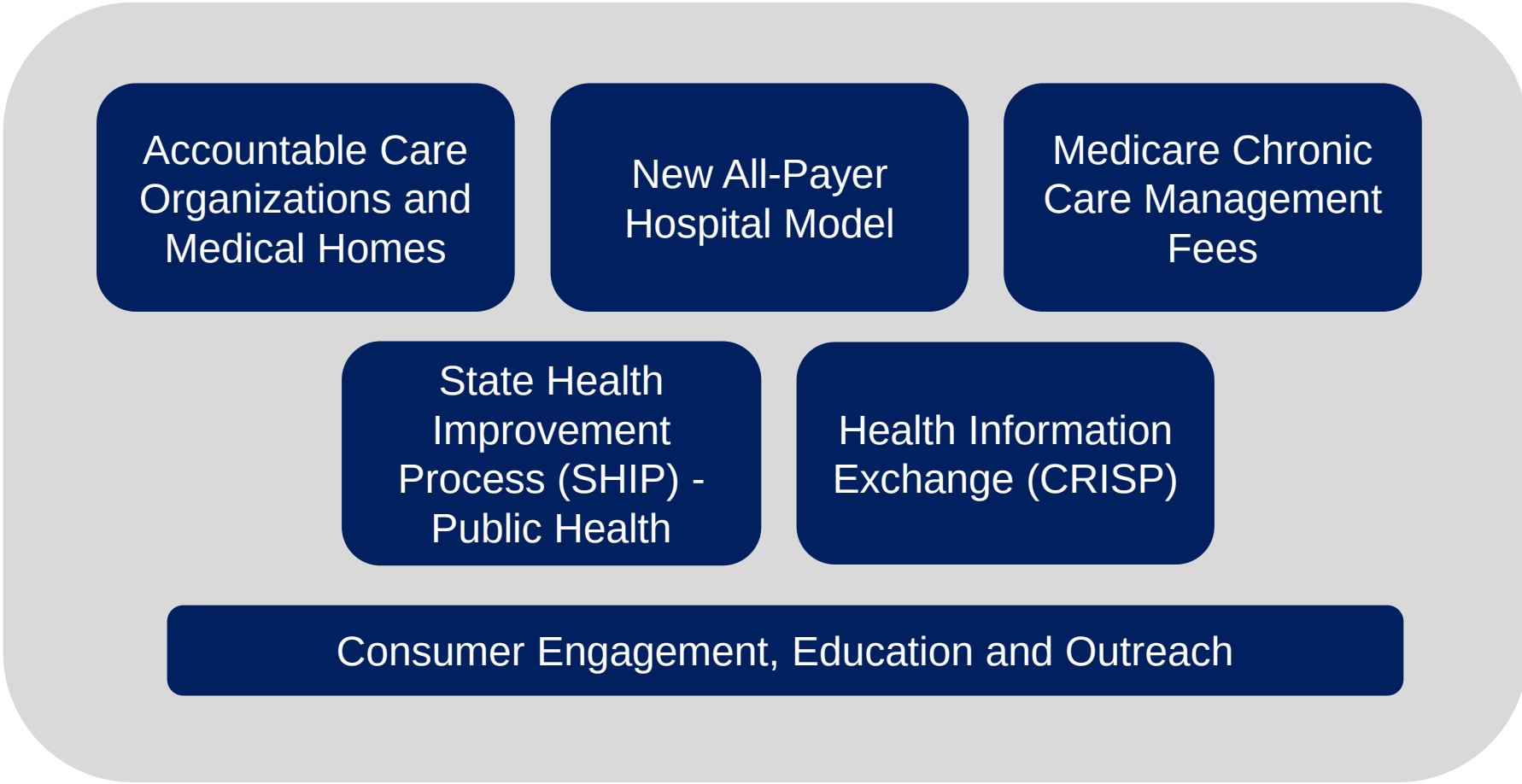
Shifts Focus to Patients

- Unprecedented effort to improve health and outcomes, and control costs
- Focus on providing the right services and reducing utilization that can be avoided with better care
- Change delivery system together with all providers



Coordination of Efforts is Essential to Success of the All-Payer Model

- Creates a new context for Health Services Cost Review Commission



HSCRC Model Implementation Timeline

Bring hospitals onto global revenue budgets with enhanced quality requirements	Identify, monitor, and address clinical and cost improvement opportunities	Implement additional population-based and patient centered approaches	Develop proposal to focus on the broader health system beyond 2018
Begin public input process: advisory council and work groups	• Enhance models, monitoring and infrastructure • Formalize partnerships for engagement and improvement	• Evolve alignment models and payment approaches • Increase focus on total cost of care	Secure resources, and bring together all stakeholders to develop approach

Complete

In Progress

Phase 1: 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 Budget are as follows:
  - 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

Shifts Focus from Rates to Revenues

Former Hospital Payment Model: Volume Driven

Units/Cases

× **Rate Per Unit or Case**

↓

Hospital Revenue

- Unknown at the beginning of year
- More units creates more revenue

New Hospital Payment Model: Population and Value Driven

Revenue Base Year

× **Updates for Trend, Population, Value**

↓

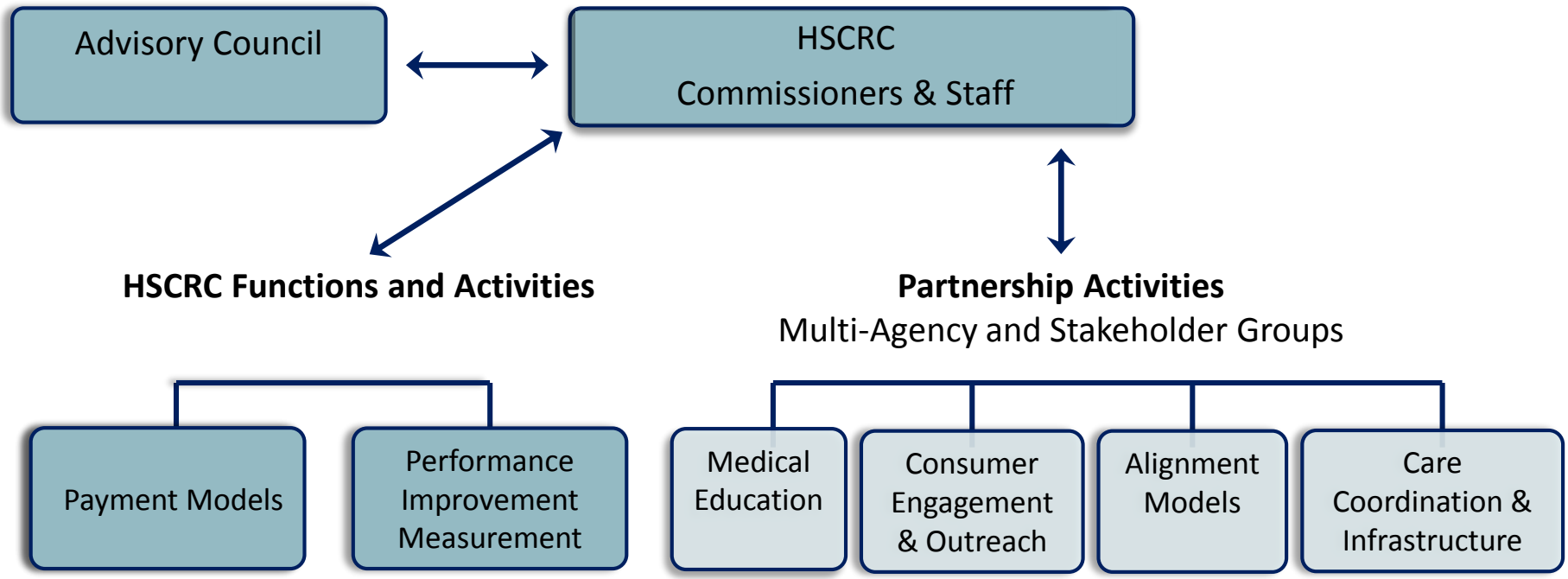
Allowed Revenue for Target Year

- Known at the beginning of year
- More units does not create more revenue

Phase 2: Focus on Clinical Improvement and Infrastructure

- HSCRC has completed its initial hospital payment model changes with enhanced quality and outcomes requirements.
- The focus now is on clinical improvement and coordinating and integrating care.
- Solutions should be patient focused, and approaches to engage and educate patients will be needed.
- Partnerships with physicians and practitioners, long term and post acute care providers, and community health and service organizations are critical to creating effective and workable strategies, infrastructure, and operations.

Phase 2: Organization of Current Activities



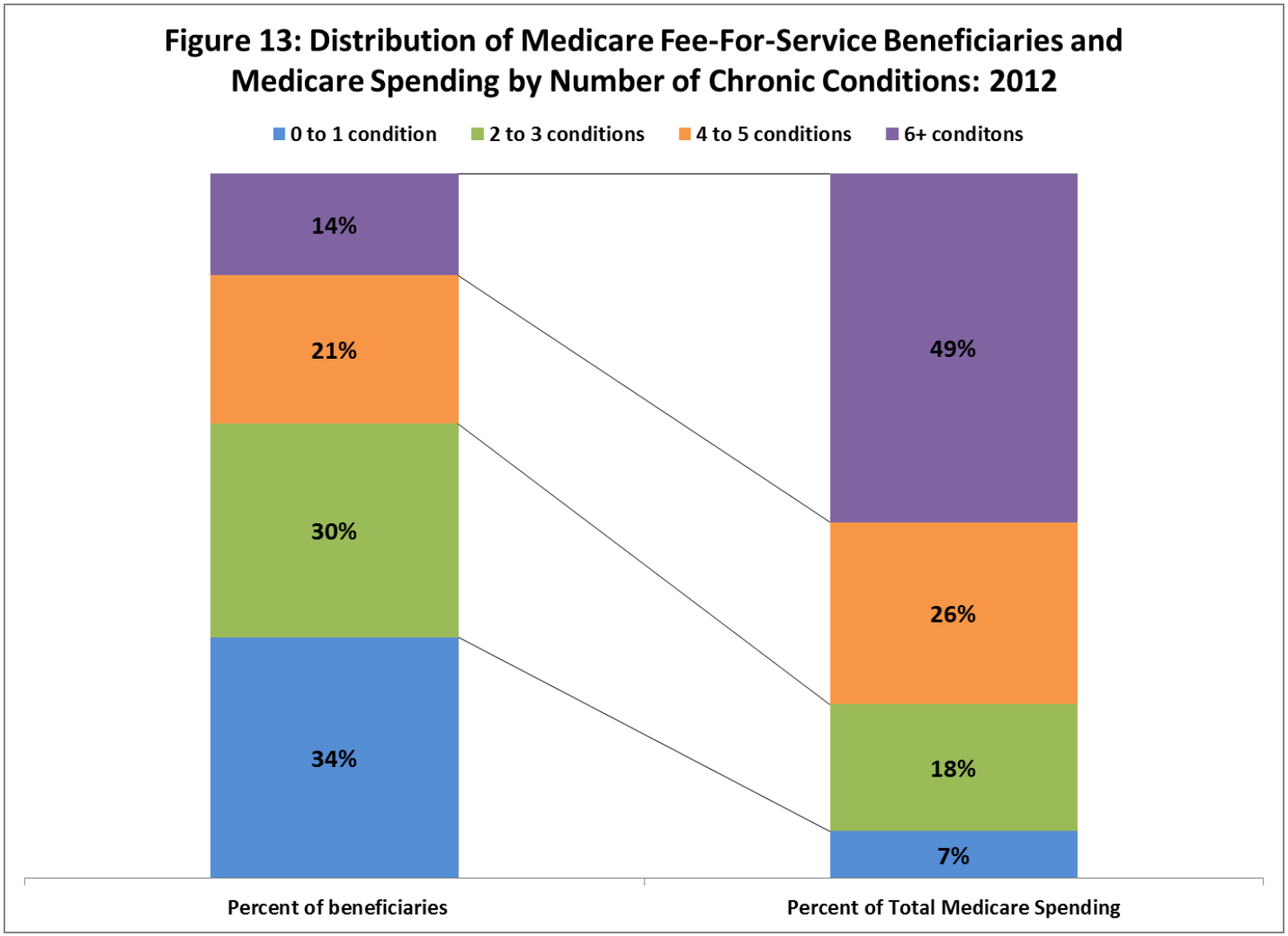
Improve Care by Reducing Potentially Avoidable Utilization (PAUs)

- PAUs are “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 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

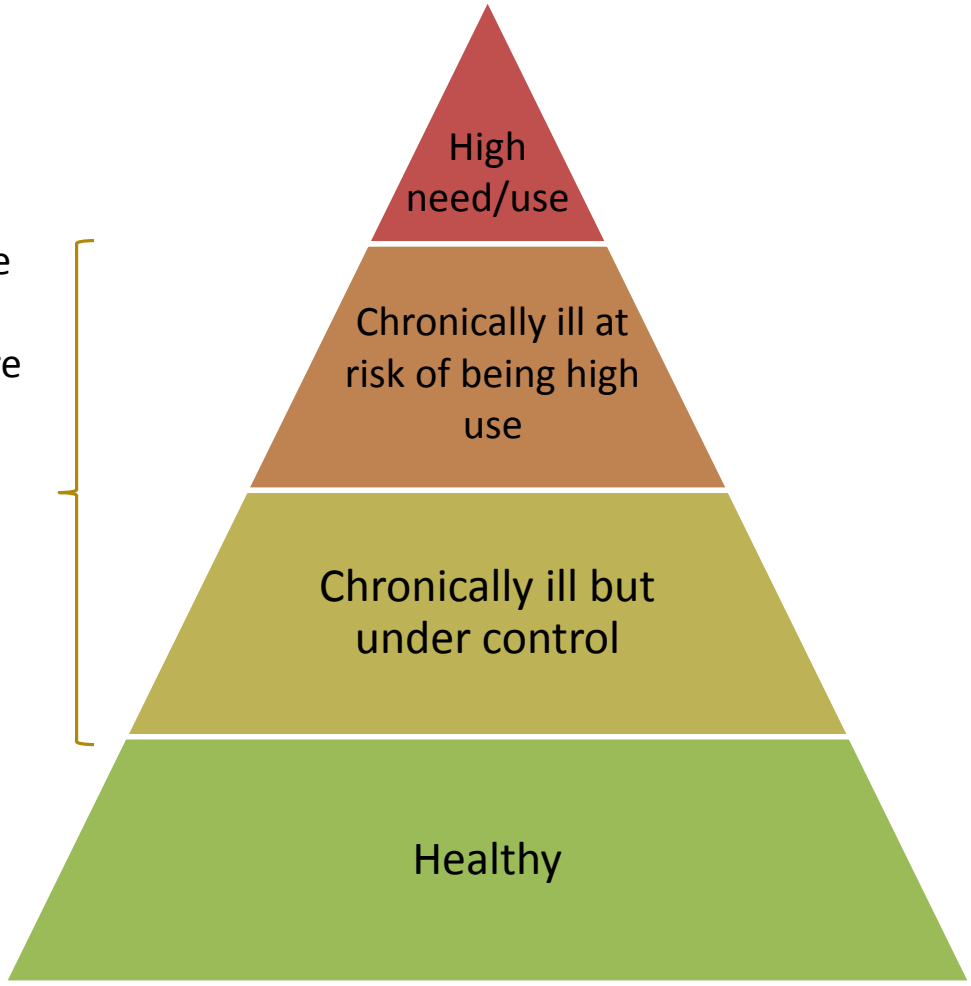
Initial Focus is Medicare

- Two thirds of high needs patients are Medicare (calculated from HSCRC data sets).
- Medicare patients have high numbers of chronic conditions. Chronic care improvement is essential for patients and also contributes to cost containment when conditions are controlled.
- Medicare patients can benefit from care coordination and customer service mechanisms that have not been supported in the fee-for-service system that is predominant in Maryland.
- The same care processes can be used for other populations, but we will need to coordinate with commercial carriers and Medicaid MCOs.

14% of Medicare Patients Drive Half of Cost



Target Resources Based on Patient Needs



A

Individual case management for individuals with significant demands on health care resources

B

Address modifiable risks and integrate and coordinate care

C

Promote and maintain health

Working Together: Partnerships to Improve Outcomes and Reduce PAU

- Numerous efforts underway with hospitals, physicians, skilled nursing facilities and long-term care, and communities
- Hospital based physicians--Partner to focus on reducing heath care acquired conditions, improve the efficiency of services provided, and on effective transitions of care
- Community based physicians—Partner to improve chronic care, access to time sensitive community based care, and care coordination
- Inform/Complain—If you see something that is not working, let MedChi leadership and HSCRC know.

How Might the New All-Payer Model Impact Physicians?

- Improved data infrastructure for care management and care coordination
- Increased collaboration and coordination between provider types
- Increased programmatic efforts by hospitals and other providers to reduce PAUs through:
  - Improved care coordination and care transitions
  - Enhanced chronic care management
  - Reduced health care acquired conditions
  - Promotion of community based health resources and patient engagement
- Introduction of shared savings arrangements

How Might the New All-Payer Model Impact Physicians?

- Reducing PAUs is good for patients
- It also frees up resources that will be needed to support investments in new hospital technology, care coordination, and community based services

Expected Outcomes

- Better care and lower costs benefitting patients, consumers, business, government *and* providers.

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