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The Maryland Model: Implementing Value-Based Healthcare Reform

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Center for Payment Reform and Provider Alignment (PRPA)

AKA "paying too much"

HEALTH AFFAIRS > VOL. 38, NO. 1: SUBSTANCE USE, PAYMENT & MORE

It's Still The Prices, Stupid: Why The US Spends So Much On Health Care, And A Tribute To Uwe Reinhardt

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AFFILIATIONS

Executive Summary: Insights from a Commission whose job was/is to regulate hospital prices

- Holding down prices may just incentivize volume increases
  - Q: Is that desirable -- for spending (total cost of care) and health care outcomes?
  - A: No!
- How can payers incentivize and empower providers to reduce total cost of care while improving quality – that is, to move from volume to value?
  - Capitate or approximate capitation
  - Fix payments in advance for a particular population or a particular set of services
  - Adjust payments for desired outcomes
  - Consider opportunities for providers to offer changes, share incentives, collaborate across the care continuum

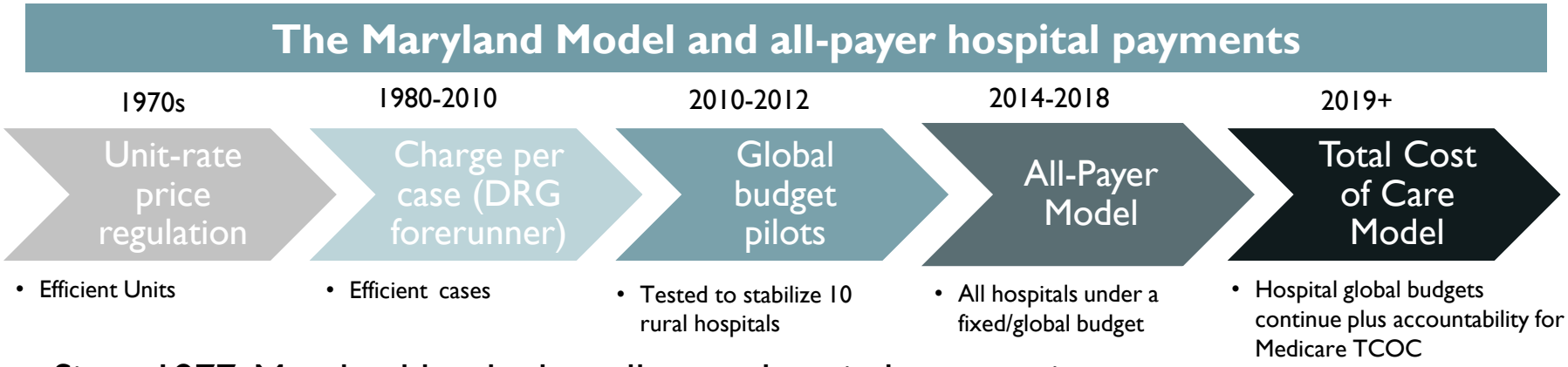
Executive Summary: How does HSCRC incentivize move to value-based care?

- Definitely since 2014, no longer focus on setting/scrutinizing the price of individual hospital services
- Rather, we set each hospital's Global Budget Revenue (GBR) from all payers
  - GBR also known as Population-Based Revenue (PBR) to reflect the block/per capita nature of the approach
  - At any given hospital, charges for all payers are the same
  - Payers still pay claims on a fee-for-service basis
  - But hospitals are given flexibility to dial their charges in order to hit their annual GBR
    - If volumes rise, prices must fall
    - If volumes decrease, prices must rise
  - Hospital's price increases since 2014 may be a good thing: reducing hospital volume, moving low-value care out of hospitals, etc.
    - **Key experience from Maryland's unique approach: It is not (just) the prices, stupid, but the total cost of care**

Agenda

- Background: Maryland's unique approach
  - Overview of Maryland's all-payer hospital rate-setting
  - All-Payer Model, 2014-2018
  - Maryland's Total Cost of Care (TCOC) Model, 2019-2028
- TCOC Model: What's in it for doctors?
  - Maryland Primary Care Program (MDPCP)
  - Hospital-led Care Redesign Program (CRP), with track of HCIP, ECIP …
  - Future state: NON-hospital led Enhanced Episode Program (EEP)
- Final Thoughts

Evolution of the Maryland Model



- Since 1977, Maryland has had an all-payer hospital rate-setting system
  - A given acute care hospital's charge is the same regardless of payer
  - But charges ("prices") do differ across hospitals
- In 2010, ten rural hospitals were placed on Total Patient Revenue (TPR) systems
  - TPR was a pilot for what became Global Budget Revenue (GBR) for all hospitals in 2014
- In 2014, Maryland moved to the All-Payer Model with CMMI, focused on hospital costs
- In 2019, Maryland moved to the Total Cost of Care (TCOC) Model, focusing on (Medicare) TCOC through system-wide alignment

All-Payer Model Performance 2014-2018: Met or Exceeded CMS Contract Requirements

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ $330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

*** $273 million in Medicare TCOC savings in 2018 alone – aka Medicare savings run rate** (vs. 2013 base)

Maryland's Story of Success: Medicare FFS Savings vs. National Growth since 2013

- Biggest savings (that is, Maryland difference from national growth) from hospital spend
  - Primarily from volume declines, not price (although ~0.2% removed annually from hospital GBRs for potentially avoidable utilization (PAU))
  - Hospital Outpatient is largest source of savings
  - Hospital Inpatient also produced savings
- Dissavings: Increase in Part B non-hospital. For example:
  - Moving certain surgeries from hospital to community settings
  - Moving from ED to community settings
  - Incentivizing more community care and follow-up to avoid readmissions
- Dissavings: Increase in home health and hospice
- Savings overwhelm dissavings
- All potentially positive effects of the Maryland Model

Maryland Total Cost of Care Model (2019-2028)

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 2/5/18

By: _____

Adam Boehler, Director, Center for Medicare and Medicaid Innovati

GOVERNOR OF MARYLAND

Date: 7/9/18

By: _____

Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: _____

Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

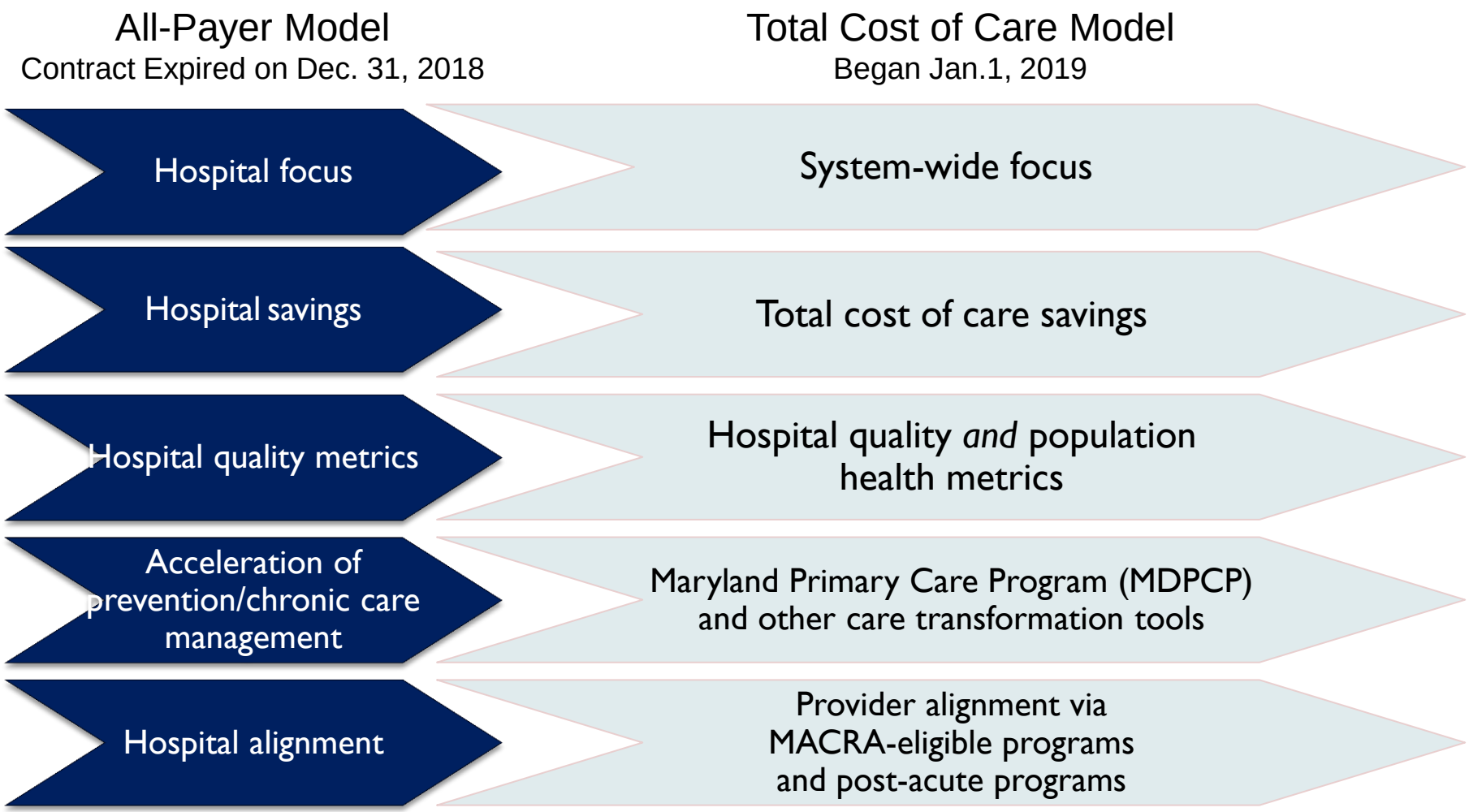
By: _____

Nelson Sabatini, Chairman

TCOC Model Agreement

Signed on July 9, 2018

Total Cost of Care Model: Still Built on Chassis of Hospital All-Payer Rate Setting But…

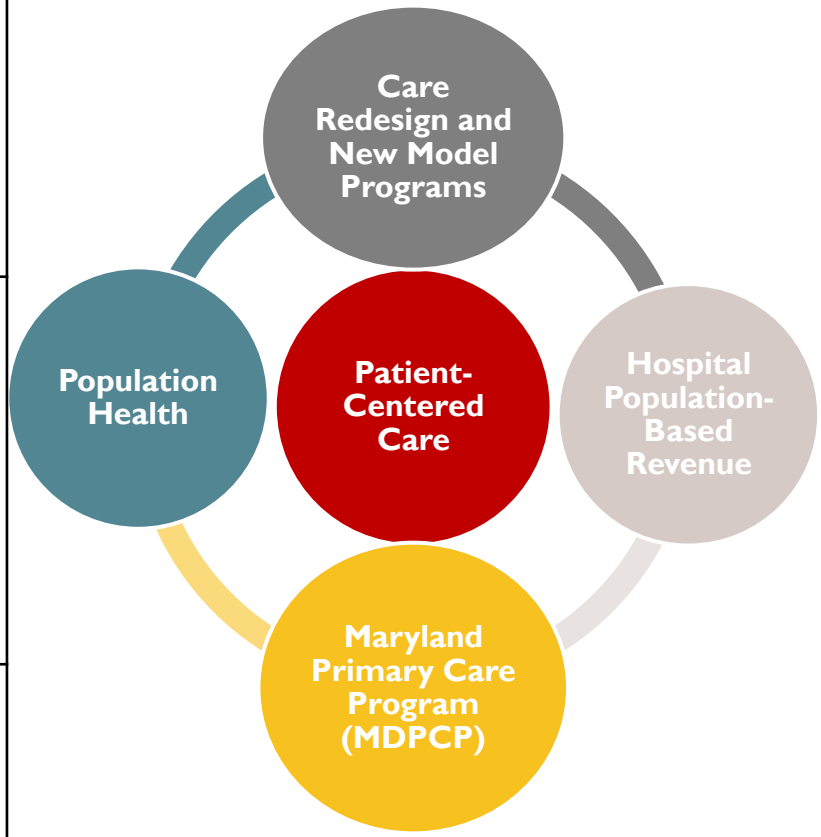


Total Cost of Care (TCOC) Model Overview

- New contract is a 10-year agreement (2019-2028) between MD and CMS
  - 5 years (2019-2023) to build up to required Medicare savings and 5 years (2024-2028) to maintain Medicare savings and quality improvements
- Designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes and constrain the growth of costs
- Total Cost of Care (TCOC) Medicare savings building to $300 million annually by 2023 (from 2013 base)
  - Includes Medicare Part A and Part B fee-for-service expenditures, as well as non-claims based payments
  - In 2017, Maryland was at ~$135M – not quite halfway to $300M
  - By end of 2018, we are at $273M
- Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually

Total Cost of Care Model Components

Component	Purpose	Status
Hospital Population-Based Revenue	Expand hospital incentives and responsibility to control total costs through limited revenue-at-risk (±1% of hospital Medicare payments) under the **Medicare Performance Adjustment (MPA)**	Expands
Care Redesign and "New Model" Programs	Enable private-sector led programs supported by State flexibility, "MACRA-tize" the model and expand incentives for hospitals to work with others, and opportunity for development of "New Model Programs"	Expands
Population Health	Programs and credit for improvement in diabetes, addiction, and other priorities	New
Maryland Primary Care Program	Enhance chronic care and health management for Medicare enrollees	New



Maryland Total Cost of Care Model: What's In It For Doctors?

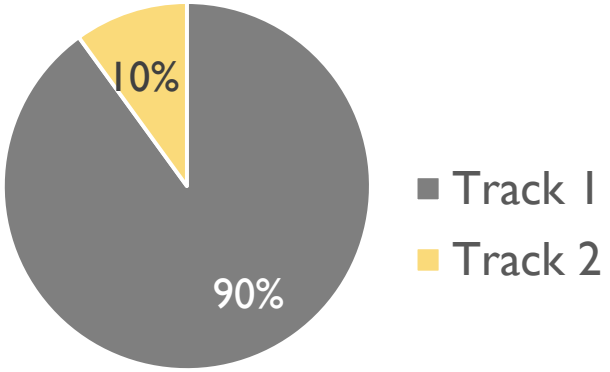
MDPCP began January 1, 2019

Maryland Primary Care Program (MDPCP)

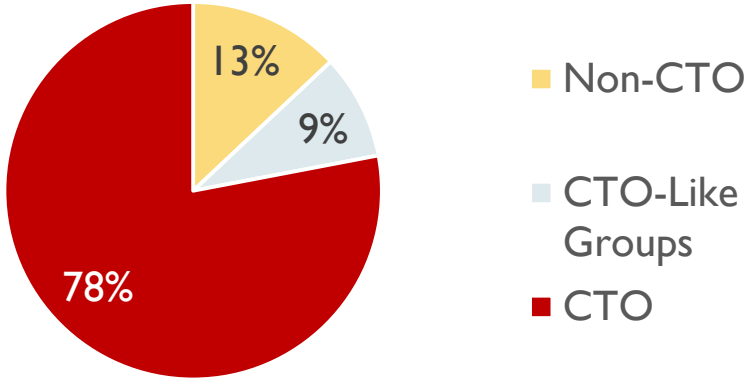
380 Practices Accepted Statewide

- ~ 220,000 beneficiaries
- ~ 1,500 Primary Care Providers
- All counties represented
- 21 Care Transformation Organizations

Practice Tracks



Practices Partnered with a CTO



- More than $60M will go to PCPs and CTOs in MDPCP Care Management Fees (CMF) in CY 2019
- MDPCP is an investment expected to pay for itself by increased chronic care management by PCPs resulting in reduced ED utilization and hospital admissions

Care Redesign Program (CRP): Aligning hospitals with non-hospital providers

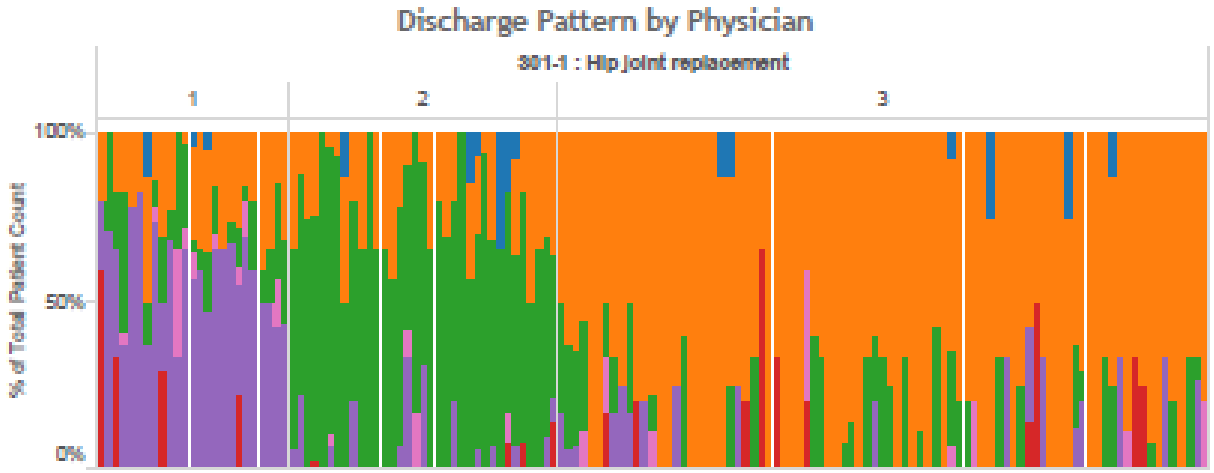
~~Complex & Chronic Care Improv. Program (CCIP)~~	Hospital Care Improvement Program (HCIP)	Episode Care Improvement Program (ECIP)
Goal: Enhance care management, while reducing total costs. **Replaced by MDPCP**	**Goal**: Facilitate improvements in hospital care that boost quality and efficiency. **40 hospitals**	**Goal**: Facilitate care improvements for post-acute episodes; reduce Medicare TCOC. **9 hospitals**
Community care	*In the hospital*	*Post-hospital*

Care Redesign Program Tracks Span the Continuum of Care

- Under CRP, **hospitals**:
  - Convene the program,
  - Bear financial risk (under GBRs and the MPA, which MACRAtizes Care Partners),
  - Obtain Medicare data (CCLF like ACOs), and
  - Choose whether or not to participate and, if so, whether or not to share incentives or resources with Care Partners
- ECIP assesses 90-day post-acute (PAC) episodes triggered in inpatient
  - If hospital achieves 3% Medicare savings in PAC, hospital receives payment for savings – and can share with Care Partners

Hospital View into ECIP Opportunity: PAC Spending by Physician

Care Redesign and New Model Programs



Post Acute Care

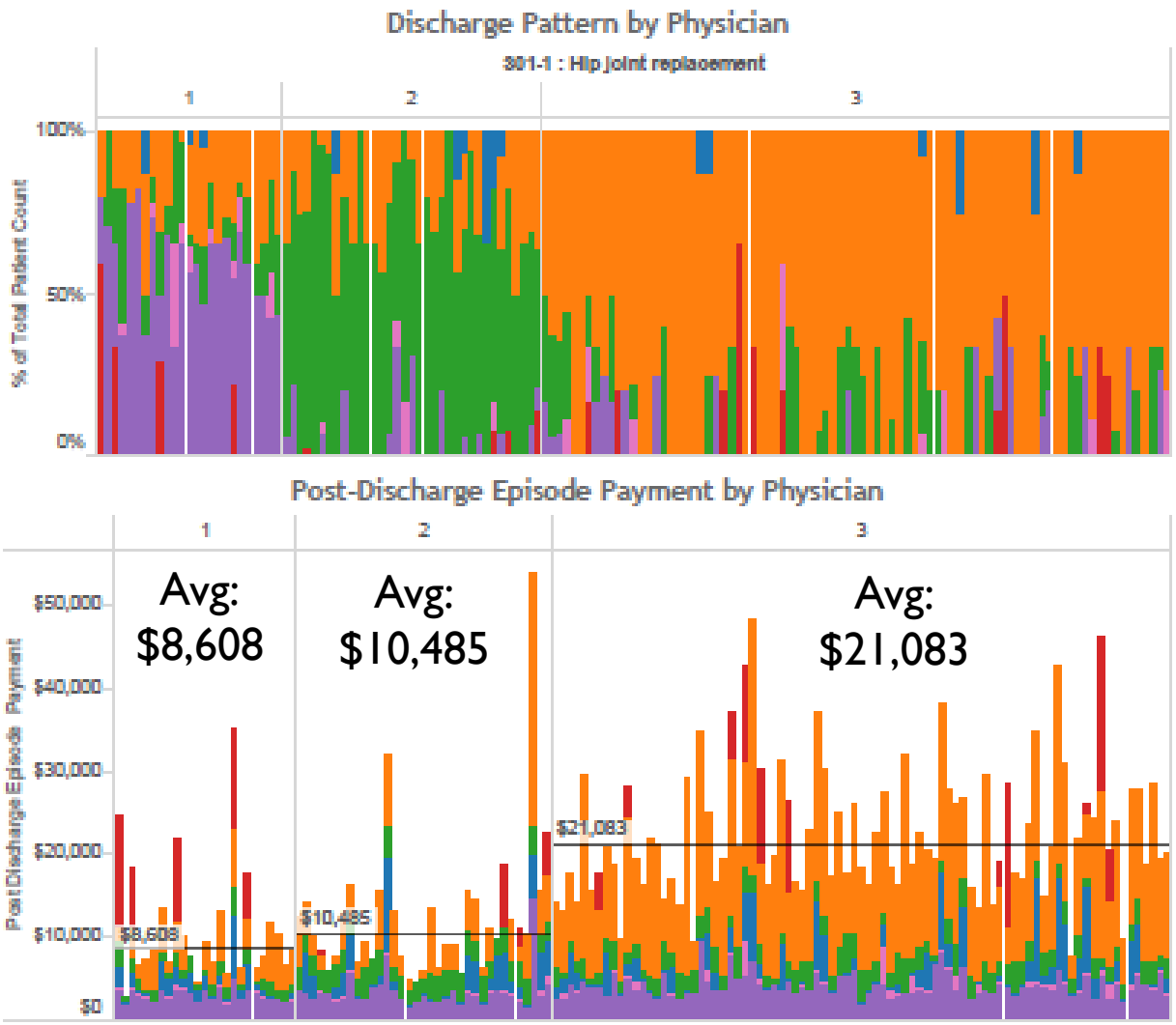
- Community
- Home Health
- SNF

i.e, nursing home

- Inpatient Rehabilitation
- Other
- Short Term Hospital

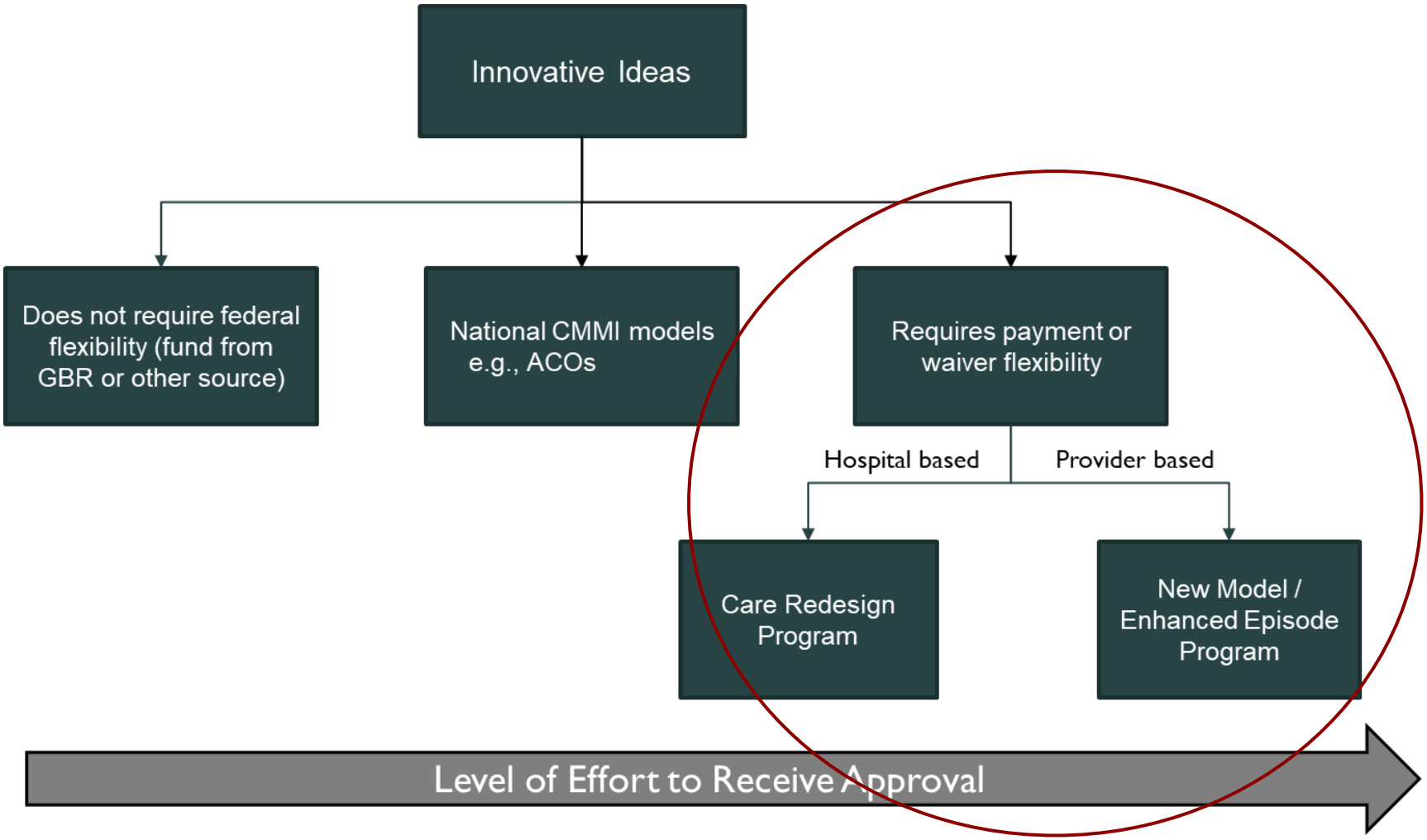
Hospital View into ECIP Opportunity: PAC Spending by Physician

Care Redesign and New Model Programs



Stakeholders and State assess approaches requiring for State/Federal approval

Care Redesign and New Model Programs



New Model Program: Enhanced Episode Program (EEP) under development

- Under EEP, **non-hospital providers** will:
  - Convene the program,
  - Bear financial risk/reward from Medicare (exactly how is TBD),
  - Obtain Medicare data, and
  - Choose whether or not to participate and, if so, whether or not to share incentives or resources with Care Partners
- Likely start date is January 2021. Why so long?
  - Obtain approval from the federal government, which must adjust Medicare payments to EEP participants based on Medicare TCOC performance
  - State administers EEP with providers and approval from Feds to:
    - Choose clinical episodes
    - Develop payment methodology
    - Develop and publish a Request for Applications (RFA)
    - Review RFA submissions
    - Track provider performance
    - Reports for providers can track their own performance
    - Calculate payments based on performance

Will doctors be interested in EEP at all?

EEP: Simplified hypothetical example
Actual details TBD

- Physician group practice (PGP) elects to take responsibility for Medicare TCOC for:
  - Triggered by _[clinical episode]__ occurring in a _[HOPD, …]_
  - For spending over _[30, 60, 90]__ days
- The PGP's average Medicare TCOC is $10,000 per beneficiary
  - CMS wants its 3% savings ($9,700 target)
  - Across the PGP's patients, if the PGP's average per beneficiary spending falls below $9,700 (assuming certain quality metrics are met), PGP receives payment from Medicare
  - On the other hand, average Medicare TCOC above $10,000 (adjusted for inflation) will require a payment from the PGP
  - $ through adjusted Medicare payments for the following year

EEP: Big questions

- Policy. For example:
  - How interested are non-hospital providers?
  - Are they able to be "conveners" or do others need to fill that role (e.g., firms like Premier or Remedy? Associations? CTOs?)
  - Is it worth the effort?
  - What episodes to include? Need:
    - 1. Clear trigger
    - 2. Large eligible population (stable volume)
    - 3. Large addressable costs
    - 4. Savings are identifiable and quantifiable

  Stakeholder Innovation Group (SIG) and State staff will assess
- Operational. For example:
  - Can the State, Feds, providers effectively administer this?
  - How to account for GBR effects when calculating savings from reduced hospital Medicare spending for episodes?

Will doctors be interested in EEP at all?

Final Thoughts

The Maryland Model: Lessons Learned

- Incentives to providers are critical: Pay for what you want
  - Eliminating cognitive dissonance across providers and payment streams is difficult
  - May require payers to give up some savings or make investments (e.g., increasing hospital prices but overall decline in spend growth)
- Engaging providers in policy development is crucial
  - Don't want to "build it and they DON'T come"
  - Public, transparent policy development has improved engagement, policies, and outcomes
  - State still has lots of room for improvement to further engage providers across the care continuum
- Important not just to get data but to use it and make it usable
- Reducing growth in total cost of care means focusing on total cost of care (not just prices)

Thank you!

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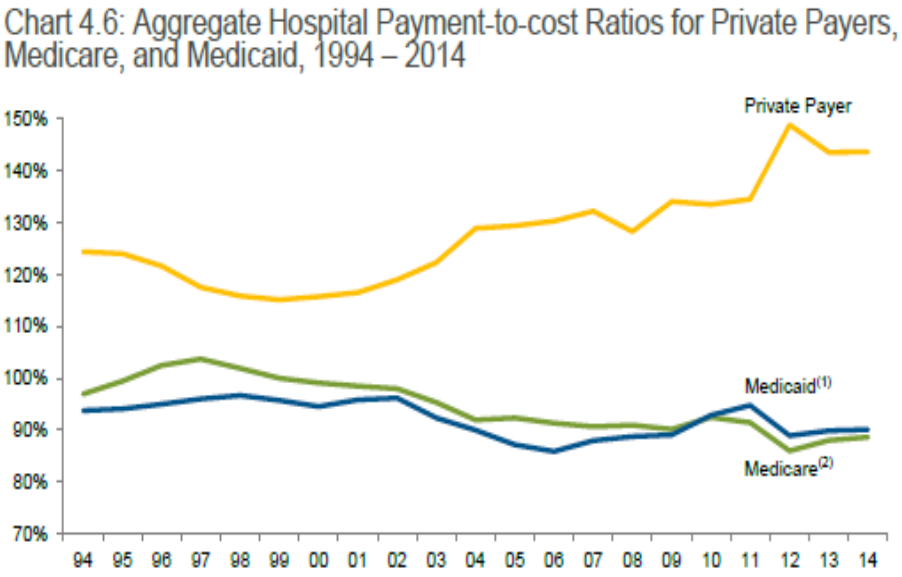
Appendix

Value of Maryland's All-Payer Hospital Rate Setting System

Maryland's approach:

- Avoids cost shifting across payers
- Cost containment for the public
- Equitable funding of uncompensated care
- Stable and predictable system for hospitals
- All payers fund Graduate Medical Education
- Transparency
- Leader in linking quality and payment

While the rest of the nation sees:



Source: American Hospital Association
(1) and (2). Includes Disproportionate Share Hospital (DSH) payments.

Other Advantages of the Maryland Model

- Hospitals do not negotiate charge masters with various insurers or focus on "upcoding"
- Lower prices for private insurance creates a healthy marketplace for competition
- Maryland's health system is on track for sustainable and transparent health spending growth
- The system benefits private insurance spending while controlling Medicare growth with the federal agreement

Source: Health Care Cost Institute Healthy Marketplace Index https://www.healthcostinstitute.org/research/hmi

2014 Maryland All-Payer Model Agreement with CMMI

- 5-year state innovation between Maryland & federal government (2014 through 2018) focused on hospital payment transformation to global budgets
  - Per capita, value-based payment framework for hospitals
  - Provider-led efforts to reduce avoidable use and improve quality and coordination
- Savings to Medicare without cost shifting: 5-year cumulative $330 million required in Medicare FFS hospital savings
- Amendment to the Model in 2016 implemented Care Redesign Programs (CRP)
  - Granted Medicare waivers to hospitals to share incentives/resources with non-employed clinicians and facilities
  - Encourage collaboration between hospitals and non-hospital providers
  - State flexibility allows for new track introduction to meet varying system needs
  - As of July 2018, Medicare considers Maryland hospitals Advanced APM Entities, so clinicians in CRP can qualify for the 5% APM MACRA bonus

All-Payer Model: Maryland Commits to Hospital Global Budgets

From 2014, all general acute-care hospitals in Maryland went under Global Budget Revenues (GBRs) set by the HSCRC

- Fixed revenue base for 12-month period, with annual adjustments
  - Built off of each hospital's 2013 charges increased by hospital-specific adjustments
  - % adjustments for variables including population growth, readmissions, hospital-acquired conditions, etc.
- Hospital payments still administered on fee-for-service basis, but only for attaining GBR
  - Hospitals have flexibility to dial charges up or down (within constraints) so that, by year end, they have attained their GBR
  - Penalties for being too high or too low
- Before turning to our performance and moving to TCOC Model, any questions on the GBR mechanics?

Move from Volume to Value Transforms Hospital Incentives

- No longer chasing volumes on pressured prices
- Incentivized:
  - Reduced readmissions
  - Reduced hospital-acquired conditions
  - Reduced ambulatory-sensitive conditions, or Prevention Quality Indicators (PQIs)
  - Better managed internal costs
- Results
  - Improved health care quality, lower costs, better consumer experience

But more to be done …

The Maryland Model: Obstacles for Other States?

- Data: The State's data availability and capacity is phenomenal and probably hard to duplicate, especially in the short run
  - HSCRC receives detailed standardized monthly data from all hospitals:
    - Hospital claims information for all payers
    - Hospital financial information
    - This information allows us to adjust hospital GBRs for volume shifts between hospitals (50% variable cost, up to a cap), to track where volumes are declining/increasing (perhaps not shifting), to assess readmissions and other quality metrics on an all-payer basis
  - HSCRC claims level data for all Medicare FFS beneficiaries, allowing us to:
    - Attribute all 800,000 Medicare beneficiaries to hospitals and to hold hospitals accountable under the MPA for their Medicare total cost of care
    - Monitor where utilization is moved out of the hospital into community setting and, where appropriate, reduce hospitals' GBR accordingly
- Politics: Since 1977, HSCRC (seven commissioners) has evolved but has always had the power to set prices for all hospital services for all payers in Maryland