The Maryland Model: Implementing Value-Based Healthcare Reform

Chris L. Peterson, Principal Deputy Director
Health Services Cost Review Commission (HSCRC): Center for Payment Reform and Provider Alignment (PRPA)
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
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
<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Targets</th>
<th>2018 Results</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Payer Hospital Revenue Growth</td>
<td>≤ 3.58% per capita annually</td>
<td>1.92% average annual growth per capita since 2013</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Savings in Hospital Expenditures</td>
<td>≥ $330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)</td>
<td>$1.4B cumulative (8.74% below national average growth since 2013)</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Savings in Total Cost of Care</td>
<td>Lower than the national average growth rate for total cost of care from 2013 base year</td>
<td>$869M cumulative* (2.74% below national average growth since 2013)</td>
<td>✓</td>
</tr>
<tr>
<td>All-Payer Reductions in Hospital Acquired Conditions</td>
<td>30% reduction over 5 years</td>
<td>53% Reduction since 2013</td>
<td>✓</td>
</tr>
<tr>
<td>Readmissions Reductions for Medicare</td>
<td>≤ National average over 5 years</td>
<td>Below national average at the end of the fourth year</td>
<td>✓</td>
</tr>
<tr>
<td>Hospital Revenue to Global or Population-Based</td>
<td>≥ 80% by year 5</td>
<td>All Maryland hospitals, with 98% of revenue under GBR</td>
<td>✓</td>
</tr>
</tbody>
</table>

* $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)
TCOC Model Agreement
Signed on July 9, 2018
Total Cost of Care Model: Still Built on Chassis of Hospital All-Payer Rate Setting But...

<table>
<thead>
<tr>
<th>All-Payer Model</th>
<th>Total Cost of Care Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Expired on Dec. 31, 2018</td>
<td>Began Jan. 1, 2019</td>
</tr>
<tr>
<td>Hospital focus</td>
<td>System-wide focus</td>
</tr>
<tr>
<td>Hospital savings</td>
<td>Total cost of care savings</td>
</tr>
<tr>
<td>Hospital quality metrics</td>
<td>Hospital quality and population health metrics</td>
</tr>
<tr>
<td>Acceleration of prevention/chronic care management</td>
<td>Maryland Primary Care Program (MDPCP) and other care transformation tools</td>
</tr>
<tr>
<td>Hospital alignment</td>
<td>Provider alignment via MACRA-eligible programs and post-acute programs</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Component</th>
<th>Purpose</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Population-Based Revenue</td>
<td>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)</td>
<td>Expands</td>
</tr>
<tr>
<td>Care Redesign and “New Model” Programs</td>
<td>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”</td>
<td>Expands</td>
</tr>
<tr>
<td>Population Health</td>
<td>Programs and credit for improvement in diabetes, addiction, and other priorities</td>
<td>New</td>
</tr>
<tr>
<td>Maryland Primary Care Program</td>
<td>Enhance chronic care and health management for Medicare enrollees</td>
<td>New</td>
</tr>
</tbody>
</table>
Maryland Total Cost of Care Model: What’s In It For Doctors?
MDPCP began January 1, 2019

380 Practices Accepted Statewide

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

Practice Tracks
- 90% Track 1
- 10% Track 2

Practices Partnered with a CTO
- 78% CTO
- 13% CTO-Like Groups
- 9% Non-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**

<table>
<thead>
<tr>
<th>Complex &amp; Chronic Care Improvement Program (CCIP)</th>
<th>Hospital Care Improvement Program (HCIP)</th>
<th>Episode Care Improvement Program (ECIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Enhance care management, while reducing total costs.</td>
<td><strong>Goal:</strong> Facilitate improvements in hospital care that boost quality and efficiency. <strong>40 hospitals</strong></td>
<td><strong>Goal:</strong> Facilitate care improvements for post-acute episodes; reduce Medicare TCOC. <strong>9 hospitals</strong></td>
</tr>
<tr>
<td><em>Replaced by MDPCP</em></td>
<td></td>
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**Community care**

- **Under CRP, hospitals:**
  - Convene the program,
  - Bear financial risk (under GBRs and the MPA, which MACRAizes 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

i.e., nursing home
Hospital View into ECIP Opportunity: PAC Spending by Physician

**Post Acute Care**:  
- Community
- Home Health
- SNF
- Inpatient Rehabilitation
- Other
- Short Term Hospital

**Discharge Pattern by Physician**

<table>
<thead>
<tr>
<th>% of Total Patient Count</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post Discharge Episode Payment by Physician**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg: $8,608</td>
<td>Avg: $10,485</td>
<td>Avg: $21,083</td>
</tr>
</tbody>
</table>

*i.e., nursing home*
Stakeholders and State assess approaches requiring for State/Federal approval

- Innovative Ideas
  - Does not require federal flexibility (fund from GBR or other source)
  - National CMMI models e.g., ACOs
  - Requires payment or waiver flexibility
    - Hospital based
    - Provider based
      - Care Redesign Program
      - New Model / Enhanced Episode Program

Level of Effort to Receive Approval
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