

# **Understanding Maryland's Unique Medicare Waiver**

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# 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

# Health Services Cost Review Commission

- Oversees hospital rate regulation in Maryland
- Independent 7 member Commission
  - Decisions appealable to the courts
  - Balanced membership
  - Experienced staff
- Broad statutory authority
  - Has allowed Commission methods to evolve
- Broad support

# HSCRC Sets Hospital Rates for All Payers

- Medicare waiver granted July 1, 1977 as demonstration
  - Allows HSCRC to set hospital rates for Medicare—unique to Maryland
  - State law and Medicaid plan requires others to pay HSCRC rates
- Old Waiver test (2 parts)
  - Lower cumulative rate of increase in Medicare payment/admission from 1/1/81
  - Must remain all payer
- All payers pay their fair share of full financial requirements
  - Uncompensated Care
  - GME/IME
  - Capital
- Considerable value to patients, State and hospitals

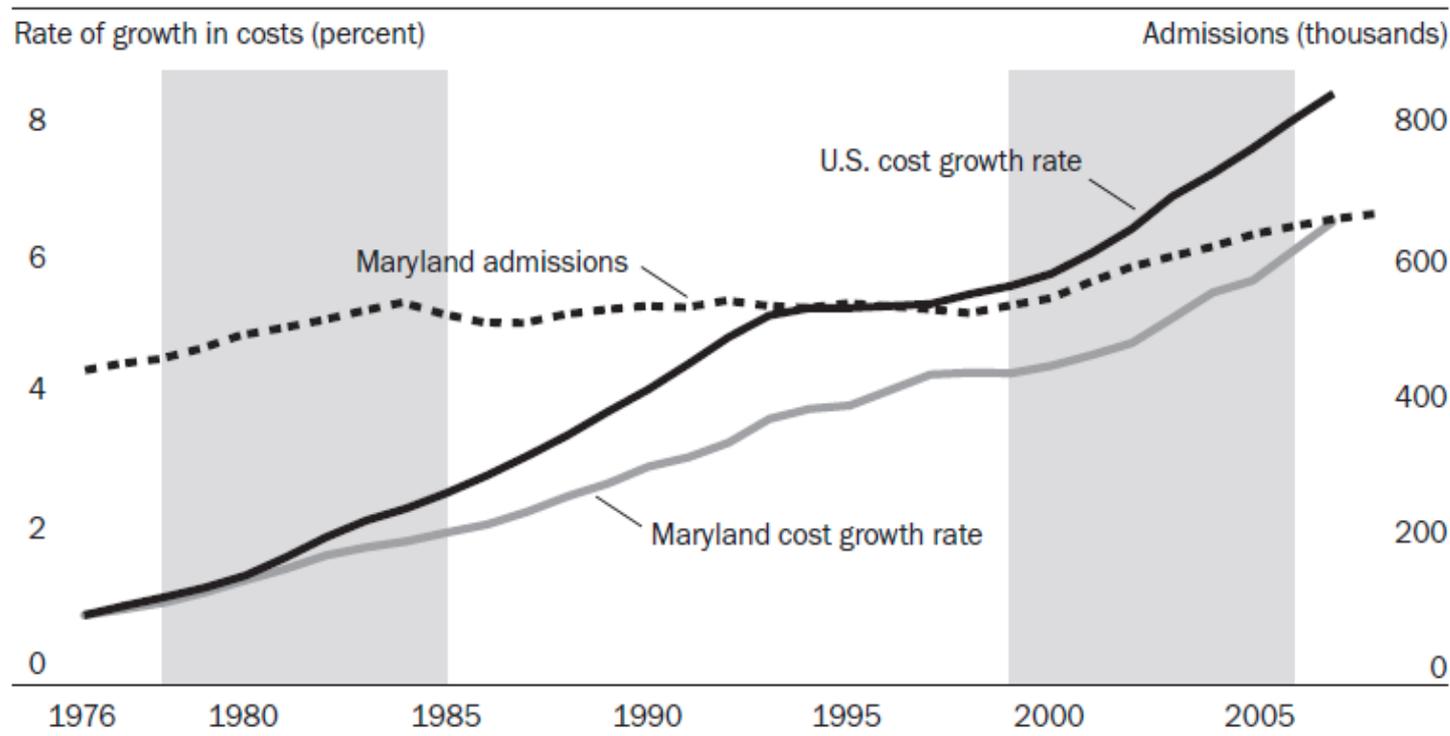
# HSCRC Sets Prices Per Unit of Service

<u>Functional Center</u>	<u>Approved Rate</u>	<u>Unit</u>		<u>Units of Service</u>	<u>Charge</u>
Medical/Surgical Unit	\$500	Per day	X	5	\$ 2,500
Intensive Care Unit	\$1,000	Per day	X	2	2,000
Admission	\$100	Per case	X	1	100
Operating Room	\$15	Per minute	X	150	2,250
Radiology	\$20	RVU	X	25	500
Pulmonary	\$3.00	RVU	X	10	30
Blood	\$15	RVU	X	5	75
Lab	\$2.00	RVU	X	25	50
Physical Therapy	\$16	RVU	X	5	80
Cost of Drugs Sold	\$1,200	Invoice cost	X	patient	1,200
<u>Medical Supplies</u>	\$2,100	Invoice cost	X	patient	<u>2,100</u>
<b>Total Charge Per Case</b>					<b><u>\$10,885</u></b>

# HSCRC Cost Accomplishments

- Cost containment (all payer)--From 26% above the national average cost per case in 1976 to 2% below in 2007

**Indexed Growth Rates In Hospital Cost Per Adjusted Admission, Maryland And United States, 1976-2007 (2008)**



# Challenges of the Old Waiver Model

- Emphasis on cost per case kept focus only on hospital inpatient services, not over all health care spending
- Not well fitted to innovations in health care

# Approved Model Timeline

## ■ Phase 1 (5 Year Model)

- Maryland all-payer hospital model
- Developing in alignment with the broader health care system

## ■ Phase 2

- 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

# 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

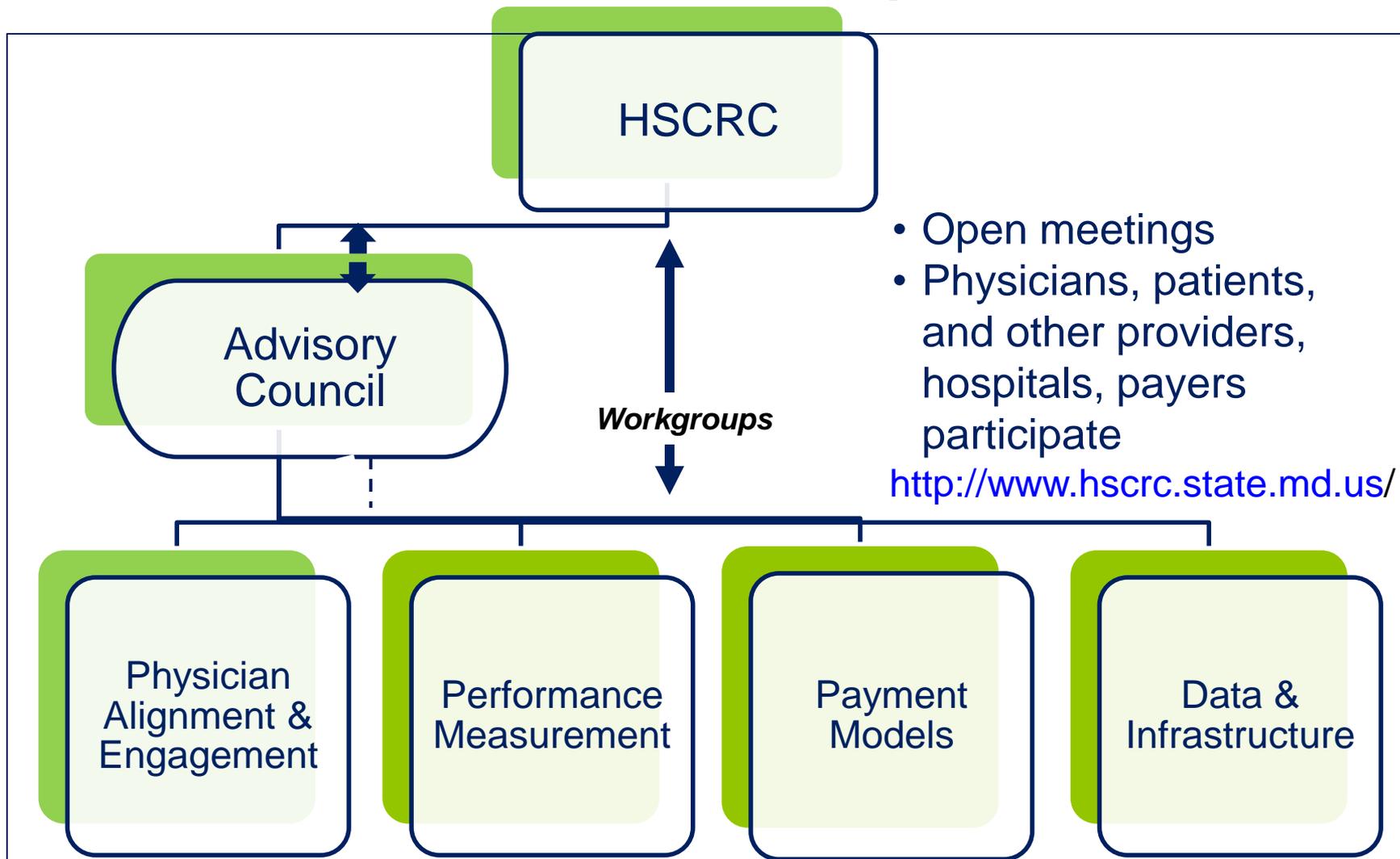


Updates for Trend,  
Population, Value

Allowed  
Revenue Target Year

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

# Stakeholder Input



# MHA Gainsharing Steering Committee

- Provide overall direction
- MedChi representatives are Ramani Peruvemba, MD, Doug Mitchell, MD & Gene Ransom
- Non-binding participation
- MHA has engaged Applied Medical Software to implement a program to help hospitals align incentives with Physicians



# Program Highlights

- **Large scale** program – all DRGs, all costs
- Methodology incorporates robust **protections and safeguards**
- **Customize at local level** – Internal steering committee, composed of at least 50% physicians; conditions incentive payments on specific quality and care redesign initiatives
- **Direct link** between physician and institutional success

# HSCRC Developing Another Gainsharing Model



# Waiver Results: Year One

		Maryland Performance	Annual Target	
<b>ALL-PAYER HOSPITAL SPENDING GROWTH PER CAPITA</b> <small>(compared to prior year Maryland)</small>		<b>1.47%</b> <small>spending growth</small>	<b>3.58%</b> <small>spending growth or below</small>	PERIOD <small>Jan-Dec 2014 vs. Jan-Dec 2013</small>  DATA <small>HSCRC monthly financial data</small>
<b>MEDICARE HOSPITAL SPENDING GROWTH PER BENEFICIARY</b> <small>(compared to national)</small>		<b>-1.12%</b> <small>spending decrease</small>	<b>0.50%</b> <small>spending growth or below</small>	PERIOD <small>Jan-Dec 2014 vs. Jan-Dec 2013</small>  DATA <small>HSCRC monthly financial data (used as proxy)</small>
<b>MEDICARE ALL PROVIDER SPENDING GROWTH PER BENEFICIARY</b> <small>(compared to national)</small>		<b>COMING SOON</b>	<b>1%</b> <small>no more than above national growth</small>	PERIOD <small>Coming soon</small>  DATA <small>Coming soon</small>
<b>MEDICARE READMISSION RATE</b> <small>(compared to national)</small>		<b>-0.80%</b> <small>decrease</small>	<b>-1.86%</b> <small>decrease or more</small>	PERIOD <small>Jan-Oct 2014 vs. Jan-Oct 2013</small>  DATA <small>CMMI data</small>
<b>MARYLAND HOSPITAL ACQUIRED CONDITIONS RATE</b> <small>(compared to prior year Maryland)</small>		<b>-25.97%</b> <small>decrease</small>	<b>-6.89%</b> <small>decrease or more</small>	PERIOD <small>Jan-Dec 2014 vs. Jan-Dec 2013</small>  DATA <small>HSCRC inpatient case-mix data, final</small>

# 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