Understanding Maryland’s Unique Medicare Waiver

Gene M. Ransom, III
Chief Executive Officer
MedChi
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

<table>
<thead>
<tr>
<th>Functional Center</th>
<th>Approved Rate</th>
<th>Unit</th>
<th>Units of Service</th>
<th>Charge</th>
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<tbody>
<tr>
<td>Medical/Surgical Unit</td>
<td>$500</td>
<td>Per day</td>
<td>X</td>
<td>5</td>
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<tr>
<td>Intensive Care Unit</td>
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<td>Per day</td>
<td>X</td>
<td>2</td>
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<tr>
<td>Admission</td>
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<td>Per case</td>
<td>X</td>
<td>1</td>
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<tr>
<td>Operating Room</td>
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<td>Per minute</td>
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<tr>
<td>Radiology</td>
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<td>RVU</td>
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<td>25</td>
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<tr>
<td>Pulmonary</td>
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<tr>
<td>Blood</td>
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<tr>
<td>Lab</td>
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<td>RVU</td>
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<td>Physical Therapy</td>
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<tr>
<td>Cost of Drugs Sold</td>
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<tr>
<td>Medical Supplies</td>
<td>$2,100</td>
<td>Invoice cost</td>
<td>X</td>
<td>patient</td>
</tr>
</tbody>
</table>

**Total Charge Per Case**: $10,885
HSCRC Cost Accomplishments

- Cost containment (all payer) -- From 26% above the national average cost per case in 1976 to 2% below in 2007
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 (Crossed out)
- 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 (Crossed out)
- Allowed Revenue Target Year
- Known at the beginning of year. More units does not create more revenue
Stakeholder Input

- Open meetings
- Physicians, patients, and other providers, hospitals, payers participate

http://www.hscrc.state.md.us/

- Physician Alignment & Engagement
- Performance Measurement
- Payment Models
- Data & Infrastructure
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 vs. Annual Target

- **All-Payer Hospital Spending Growth Per Capita**
  - Maryland Performance: 1.47% spending growth
  - Annual Target: 3.58% spending growth or below
  - Data: HSCRC monthly financial data
  - Period: Jan-Dec 2014 vs. Jan-Dec 2013

- **Medicare Hospital Spending Growth Per Beneficiary**
  - Maryland Performance: -1.12% spending decrease
  - Annual Target: 0.50% spending growth or below
  - Data: HSCRC monthly financial data
  - Period: Jan-Dec 2014 vs. Jan-Dec 2013

- **Medicare All Provider Spending Growth Per Beneficiary**
  - Coming Soon
  - No more than 1% above national growth
  - Data: Coming soon

- **Medicare Readmission Rate**
  - Maryland Performance: -0.80% decrease
  - Annual Target: -1.86% decrease or more
  - Data: CMII data
  - Period: Jan-Oct 2014 vs. Jan-Oct 2013

- **Maryland Hospital Acquired Conditions Rate**
  - Maryland Performance: -25.97% decrease
  - Annual Target: -6.89% decrease or more
  - Data: HSCRC inpatient case-mix data, final
  - Period: Jan-Dec 2014 vs. Jan-Dec 2013
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