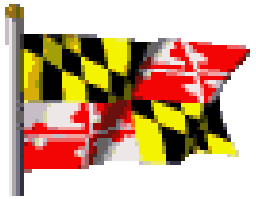


# New All-Payer Model for Maryland Population-Based and Patient-Centered Payment and Care

## Maryland Health Services Cost Review Commission

**December 2014**

# Focus and Opportunities of New Model

MARYLAND

# Approved 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

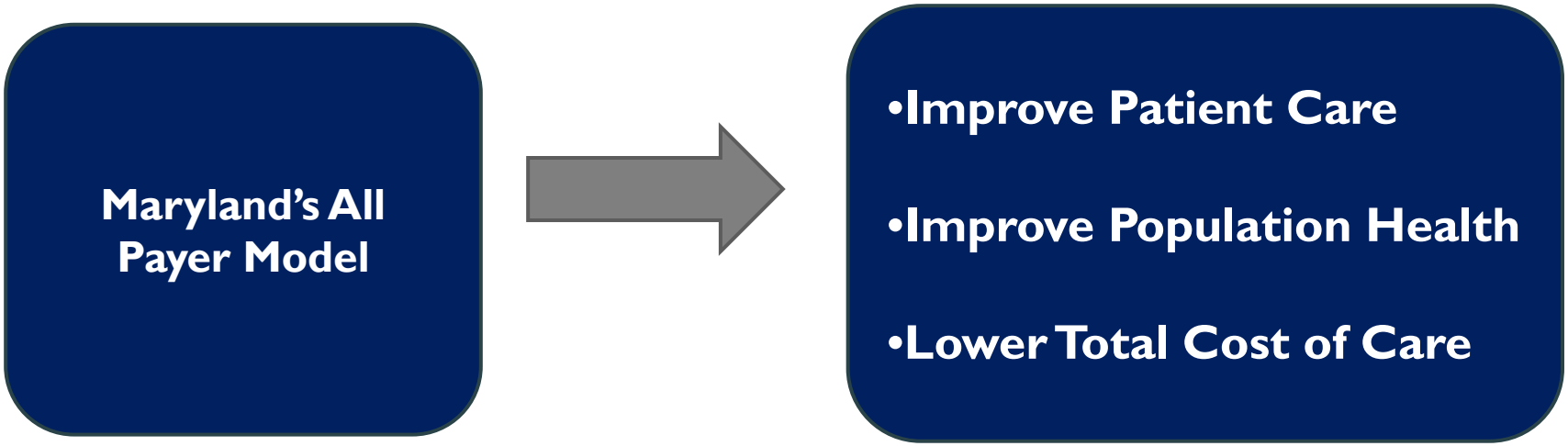
- The All-Payer Model shifts focus
  - From **per inpatient admission** hospital payment
  - To **all payer**, **per capita,** total hospital payment and quality

# 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)
  - Many others

# Shifts Focus to Patients

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



# Creates New Context for HSCRC

- Align payment with new ways of organizing and providing care
- Contain growth in total cost of hospital care in line with requirements
- Increase focus on patients and quality of care

**Better care**

**Better health**

**Lower cost**

# New Hospital Model Facilitates Change

- CMS contract required population based or global models for hospital rate setting by the end of 5 years
- All hospitals elected to adopt global budgets by July 1, 2014 (~95% of hospital revenues under global budgets)

What is a global budget?

- A revenue budget for the hospital covering all of its services, set at the beginning of the year
- Budget is not dependent on volume—as a result, it supports needed delivery improvements

# Hospitals 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
  - 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

# Expected Outcomes

- Better care and lower costs benefitting consumers, business, and government

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

# Appendix

# Background

# Health Services Cost Review Commission

- Oversees hospital rate regulation in Maryland
- Independent 7 member Commission
  - Small professional staff of 35
- 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, State and hospitals
  - All payers contribute to pay for uncompensated care
- Need for waiver modernization to reflect change in focus to quality and total cost

# Approved New All-Payer Model

- Maryland is implementing a new All-Payer Model for hospital payment
  - New Model approved by CMS/CMMI effective January 1, 2014
  - Health Services Cost Review Commission leading the implementation

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

# Long Standing Medicare Waiver

- Medicare waiver granted July 1, 1977
  - It's what makes the system "all-payer"
  - Old waiver test was based on rate of increase in Medicare payment per admission
  - New waiver based on total hospital revenue per capita, Medicare savings, and quality improvements

- Considerable value to patients, business, hospitals, government

# Support from Stakeholders

MedChi
The Maryland State Medical Society

October 7, 2013

The Honorable Joshua Sharfstein, MD
Secretary, Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Sent via email to joshua.sharfstein@maryland.gov

RE: Medicare Waiver Application

Dear Dr. Sharfstein:

As you are aware, MedChi has been actively involved in discussions relevant to the design of t
MedChi is committed to assuring that the adoption of new payment models and system des
the intended incentives for increased efficiency and quality but do not negatively affect pa
professional services or create tension between hospitals and physicians. MedChi along w
physician organizations identified its top priorities and concerns with the waiver in a letter su
you in July 2012 (See attached).

MedChi appreciates this opportunity to provide comment on the revised waiver application
submission to CMS. As stated in our previous letter and throughout our involvement in th
MedChi has been opposed to any bundling of physician professional fees in this waiver a
MedChi applauds the HSCRC for clearly limiting this waiver's applicability to facility fees for t
years. MedChi believes this will ensure that the State can address issues relative to gain-s
other mechanisms for system reform in a manner that balances the risks and benefits
approaches in an environment that does not create tension between facilities and ph
otherwise causes unfair and an unjustified leverage by hospitals over the practice of medicine.

MedChi, would like to raise two specific issues/recommendations relative to this application.

- The waiver document fails to provide a funding mechanism for the loan assistance

HEALTH CARE for All
MARYLAND CITIZENS' HEALTH INITIATIVE
2600 ST. PAUL STREET BALTIMORE, MD 21218 P:14101235-9000 F:14101

October 7, 2013

Secretary Dr. Joshua Sharfstein
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

Dear Secretary Sharfstein,

The Maryland Citizens' Health Initiative commends the O'Malley-
for this proposed amendment of Maryland's landmark Medicare waiver m
unique all-payor hospital payment system. Although this system, which i
kind in the nation, has been working well to help contain rising health car
need of being updated to address modern health care needs. Most importa
wholeheartedly with the Administration that the present system which inc
keep patients in their care needs to be changed in order to put the incentiv
healthy and out of the hospitals. The global payment structure envisioned
long way to achieving this goal. We also commend the Maryland Hospital
understanding the need to make these changes and for their commitment t
decisions that will be necessary to implement them.

We believe that the details of how the incentives, needed under the
will be critical to the success of the program. We encourage robust public
the incentives early in the process. We also urge you to build in a formal s
consumer engagement in the implementation and monitoring of the waive
serves consumer interests.

MCHS
Maryland Community Health System

October 7, 2013

Joshua M. Sharfstein, M.D., Secretary
Department of Health and Mental Hygiene
201 West Preston Street, Fifth Floor
Baltimore, MD 21401

John M. Colmers, Chairman
Health Services and Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Secretary Sharfstein and Chairman Colmers:

Thank you for the opportunity to submit public comments on the draft application for "
Payer Model" from the Department of Health and Mental Hygiene (DHMH) to Centers
and Medicaid Services. The application reflects a bold, innovative approach to reshap
health care system through its hospital financing system. We strongly agree that Mary
steadily towards reforming its health care delivery system, as we can achieve better pat
by redesigning the relationship between hospital and community-based care. The five-
seems ambitious, given the complexity of the health care system and the historic lack o
allocated to the community-based health care system however, we are fully supportive
changes outlined in the waiver proposal.

The application proposes a broad outline of a new five-year model for the all-payer sy
success of the new model will depend on separate but related initiatives including the el

BARBARA MARX BROCATO & ASSOCIATES

October 7, 2013

Joshua M. Sharfstein, M.D.
Secretary of Health & Mental Hygiene
Office of Secretary
Department of Health & Mental Hygiene
201 West Preston St.
Baltimore, MD 21201 - 2399

John M. Colmers, Chair
Health Services Cost Review Commission
4201 Patterson Ave.
Baltimore, MD 21215

Dear Secretary Sharfstein and Chairman Colmers,

Thank you for the opportunity to comment on the CMS waiver application that was publicly released on Friday, September 27th. We are writing on behalf of our clients: the Maryland Society of Anesthesiologists (MSA), Medical Emergency Professionals (MEP), the Maryland Society of Otolaryngology (MSO), First Colonies Anesthesia Associates (FCAA) and Advanced Radiology. Both of you have long known and understood our interest and efforts in this matter and we appreciate your attention to our concerns.

From reading the document we understand that physician fees are not immediately brought under the auspices of the waiver. It is very important that physicians have a decision making role in key aspects of the new waiver system. A decision making role is of particular importance with regard to the allocation of funds in global payment models, governance structure of ACOs, establishing parameters of gainsharing, exposure to liability and assumption of risk, and very many other issues.

We respectfully request that you consider additional language indicating that resources and incentives should be available to physicians for the development of innovative care models that extend across the continuum of care, and to the extent allowable under law, integrates other specialties and care providers.

We are sure you are aware that physicians wish to share in shaping any policies under which ultimately they must operate. We realize that in the future dramatic changes will occur among relationships all parties to

Maryland Hospital Association

MHA
6820 Deerpath Road
Elkridge, Maryland 21075-6234
Tel: 410-379-6200
Fax: 410-379-8239

October 10, 2013

The Honorable Martin O'Malley
Governor of Maryland
100 State Circle
Annapolis, MD 21401-1925

Dear Governor O'Malley:

On behalf of Maryland's hospitals, the Maryland Hospital Association supports the state's updated draft application to the Centers for Medicare & Medicaid Services to modernize Maryland's all-payer model and hospital rate setting system.

The proposal seeks to make care more affordable by limiting the rate of growth in spending on hospital care in Maryland over the next five years. Improved coordination of patient care and overall population health are at its heart, and will be accomplished by groups of hospitals, doctors and others who come together to ensure that patients, especially the chronically ill, get the right care at the right time and in the right setting.

The goals of the proposal will be very challenging for hospitals as the ideas included have never been tried nor tested before on this scale. Hospitals will have to find ways to provide care at a lower cost than today. Important tools will be needed to help hospitals achieve new spending targets that are tied to the state's economic growth. And we need to ensure the time necessary to thoughtfully implement the changes required to be successful. If approved, important aspects will still need to be clarified, and we look forward to working with the state as we progress.

For four decades our unique system of paying for hospital care, and our partnership with state officials, the state rate setting commission, insurers, and others, has put Maryland at the forefront of health care innovation and equity. The key to meeting this new challenge and making the system a success will be an even closer collaboration among all our partners and our patients and communities as we embark upon a path that promises lower costs, higher quality and a healthier Maryland.

We look forward to working with you, Health Secretary Sharfstein and hospital rate setting commission chairman Colmers as we move ahead on this historic effort.

Sincerely,

Carmela Coyle

Carmela Coyle
President & CEO

HFAM
Health Facilities Association of Maryland
Partners in Quality Care

October 7, 2013

The Honorable Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health & Mental Hygiene
201 West Preston Street
Baltimore, MD 21201 – 2399

Dear Secretary Sharfstein,

It has been productive and a pleasure to work with you on the Maryland Hospital Waiver over this last year on behalf of the majority of Maryland's skilled nursing, rehabilitative and post-acute care providers.

We have had the opportunity to review the most recent and updated waiver application and are encouraged by the continued focus and advancement on issues related to the 3-day hospital stay and observation days.

We look forward to continuing to work with you on the details and are hopeful for the success of this important work.

Best well,

Joseph DeMattos, Jr.
President

601 Global Way, Suite 100-103 • Linthicum, MD 21090 • www.HFAM.org
410.290.5132 • 301.490.8413 • Toll Free: 1.877.LTC.HFAM

Chet Burrell
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2668
Fax: 410-761-7606
chet.burrell@carefirst.com

CareFirst

October 7, 2013

Joshua M. Sharfstein, M.D.
Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

John M. Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Sharfstein and Chairman Colmers,

The purpose of this letter is to provide general comments regarding the updated draft application "Maryland's All Payer Model: Proposal to the Center for Medicare and Medicaid Services." In a separate letter, we offer more detailed comments on the technical aspects of the Proposal.

CareFirst is strongly supportive of the State's effort to change the current "per case" Medicare waiver test in Maryland to a "per capita" test that encompasses both inpatient and outpatient hospital services. As noted in the draft application, the existing per case test does not encourage reductions in inpatient hospital volumes, which are too high in Maryland (especially for Medicare), while it encourages cost shifting to outpatient hospital services. The move to a per capita cost test should limit increases to a level that is sustainable within available economic resources. This is a clearly desirable goal that we believe is advanced by the framework provided in the Proposal.

To be successful, this effort will require the continued collaboration of all interested parties with the openness and transparency that has characterized Maryland's Rate Setting System for the past 36 years. CareFirst is committed to assisting the State in achieving the promise inherent in the Proposal.

More specifically, a major and highly positive feature of the Proposal is the development of several Global Payment Models in addition to the existing Total Patient Revenue (TPR) payment option. These new payment models, along with a modified Charge per Case (CPC)

# 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% 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
- **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)
  - Many others

# Approved Model Timeline

## 5 Year Hospital Model

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

## After 5 Years--Total Cost of Care Model

- Proposal to be submitted by the end of the third year
- Implementation beyond Year 5 will further advance the three-part aim of better care, better health, and lower cost

# Implementation Approach and Progress

# HSCRC Model Implementation Timeline


| Phase 1 (to 6/30/14) | Phase 2 (7/1/14 – 3/30/15) | Phase 3 (4/1/15 – 3/30/16) | Phase 4 (2016-Beyond) |
|---|---|---|---|
| Bring hospitals onto global revenue budgets | 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<br>•Formalize partnerships for engagement and improvement | •Evolve alignment models and payment approaches<br>•Increase focus on total cost of care | Secure resources, and bring together all stakeholders to develop approach |

Complete

In Progress

# Phase 1--Initial Implementation Activities

# Global Budget Model for Hospitals

- Global budget for hospital covers all services, developed at the beginning of the year
- Not dependent on volume
- Advantage--supports needed delivery improvements


| | Volume | Rate |
|---|---|---|
| BUDGET | 100,000 | $1,000 |
| Actual INCREASE | 120,000 | $ 833 |
| Actual DECREASE | 90,000 | $1,111 |

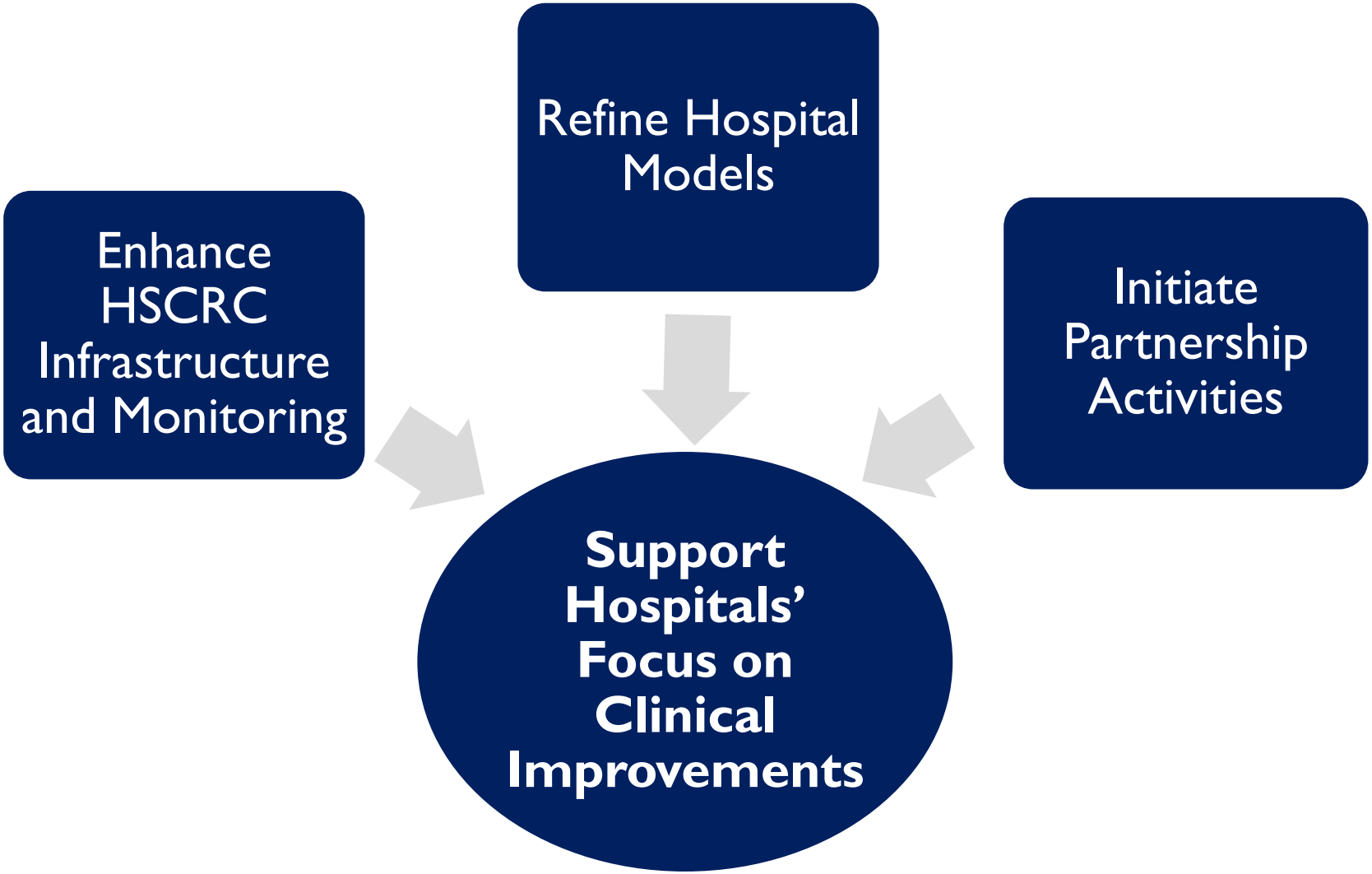
# Initial Public Engagement Process

- Engaged broad set of stakeholders in HSCRC policy making and implementation of new model
  - Advisory Council, 4 workgroups and 6 subgroups
  - 100+ appointees
  - Consumers, Employers, Providers, Payers, Practitioners
  - Technical White Papers – 19 Shared Publically

- Established processes for transparency and openness
  - Public meetings
  - Access to information
  - Opportunity for comment

# Current Phase—Partnerships for Care Improvement and Infrastructure Enhancement

# Continuing Implementation During FY 2015



# Coordination of Efforts Needed

Accountable Care Organizations and Medical Homes

State Health Improvement Process-Public Health

Enrollment Expansion

Health Information Exchange--CRISP

New All Payer Hospital Model

Consumer Engagement, Education, and Outreach

# Partnerships

HSCRC can serve as a catalyst, convener, and partner

- **Clinical & Cost Improvement:** Support selected strategies for reducing potentially avoidable utilization, practice and cost variation, and supporting high needs patients
- **Physician and Other Provider Participation:** Support development and implementation of alignment/engagement models
- **Consumer Participation:** Support consumer engagement and skill development

# Public Engagement Process – Current Phase