The Maryland Global Budget Experiment: Insights from a Maryland Rural Hospital Under Total Patient Revenue

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Welcome to the All-Payer System World

• What is an All-Payer system?
  • Health care system in which all insurers use the same fee schedule
    • Private and public insurers pay the same rate
    • Uninsured pays the same rate
  • Rates are negotiated by an independent rate commission
  • Provides transparency of rates
  • Eliminates cost-shifting
Value of an All-Payer System

- Cost containment
- Equitable funding of uncompensated care
- Stable and predictable payment system for hospitals
- All payers fund fair share of GME
- Links hospital quality to payment

The Maryland Reimbursement Model

Health Services Cost Review Commission (HSCRC), an independent Commission with seven Commissioners appointed by the Governor
- Set rates for all payers, including Medicare and Medicaid, since 1977
- Hospitals must charge Commission approved rates to all payers – otherwise incur significant penalties
Incentive to pursue a new waiver…

- Focused on cost per case constraint
  - Each hospital was constrained to case-mix/severity adjust $/case
- A “Volume Adjustment System” (VAS) limited incentives to increase volumes --- the VAS was scaled back and eventually removed in 2001
- Hospitals responded to tight cost per case growth limits and elimination of the VAS by greatly increasing case volumes and other service use
Unique New Model: Maryland’s All-Payer Model

- Maryland is implementing an All-Payer Model for hospital payment
  - Approved by Center for Medicare and Medicaid Innovation (CMMI) effective January 1, 2014 for 5 years
  - Modernizes Maryland’s Medicare waiver and unique all-payer hospital rate system

  Old Waiver
  Per inpatient admission hospital payment

  New Model
  All-payer, per capita, total hospital payment & quality

- Key provisions of the new Model:
  - Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least $330 million to Medicare over 5 years
  - Patient and population centered-measures to promote care improvement
  - Payment transformation away from fee-for-service for hospital services
  - Proposal covering all health spending due at the end of Year 3 for 2019 and beyond

Source: Maryland Health Services Cost Review Commission

New Global Model: Moving Away from Volume

Former Hospital Payment Model:
Volume Driven

- Units/Cases
- Rate Per Unit or Case
- Hospital Revenue
  - Unknown at the beginning of year
  - More units creates more revenue

New Hospital Payment Model:
Population and Value Driven

- Revenue Base Year
- Updates for Trend, Population, Value
- Allowed Revenue for Target Year
  - Known at the beginning of year
  - More units does not create more revenue

Source: Maryland Health Services Cost Review Commission
CMS is Focused on Increasing Value Based Payment Approaches—Consider Impact on Maryland Providers

Category 1: Fee for Service – No Link to Value
- Payments are based on volume of services and not linked to quality or efficiency

Category 2: Fee for Service – Link to Value
- At least a portion of payments vary based on the quality and/or efficiency of health care delivery

Category 3: Alternative Payment Models
- Some payment is linked to the effective management of a population or an episode of care
- Payments are triggered by delivery of services, but opportunities for shared savings over 2-year risk
- Aged care organization
- Medical homes
- Bundled payments
- Comprehensive primary care initiatives
- Comprehensive DSRD
- Medicare-Medicaid financial alignment initiatives

Category 4: Population-based Payment
- Payment is not directly triggered by service delivery so volume is not linked to payment
- Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., 21 year)
- Maryland All-Payer Hospital Model (fits into this category)


Global Budget Model

- The Global Budget Model: revenue budget with annual adjustments
  - The initial revenue budget was based on historical revenue
  - Budgets can be enhanced or reduced based on hospital efficiency and utilization
  - The budget is adjusted annually for utilization changes related to market shift, population, service mix etc.

Source: Maryland Health Services Cost Review Commission
GBR Adjustments

Source: Maryland Health Services Cost Review Commission

HSCRC Model Implementation Timeline

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<th>Phase 1 (to 6/30/14)</th>
<th>Phase 2 (7/1/14 - 3/30/15)</th>
<th>Phase 3 (4/1/15 - 3/30/16)</th>
<th>Phase 4 (2016-Beyond)</th>
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<td>Bring hospitals onto global revenue budgets</td>
<td>Identify, monitor and address clinical and cost improvement opportunities</td>
<td>Implement additional population-based and patient-centered approaches</td>
<td>Develop proposal to focus on the broader health system beyond 2018</td>
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<td>Begin public input process; advisory council and work groups</td>
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<td>Secure resources, and bring together all stakeholders to develop approach</td>
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How is the new model working?

Per-person revenue growth reduced to 1.47% (target 3.58%)
Medicare saved $116M compared to growth in the rest of the U.S.
Complications (e.g., infections) 26%
Medicare readmissions more than U.S., but did not meet state goals

Source: CMS Find Success Reducing Cost Growth, NEJM, November 12, 2015

“Maryland’s new all-payer model provides Maryland with a unique opportunity to reduce health care costs to consumers, insurers and businesses by improving quality and by addressing patients’ needs more holistically.”

Van T. Mitchell, Maryland Health and Mental Hygiene Secretary
McCready Health – Crisfield, Maryland

- Implemented in 2010 in 8 rural hospitals
- Available to hospitals without or limited overlapping service areas
- Provided strong incentives to treat its community of patients in the most efficient and clinically effective way
- HSCRC monitored hospital performance, such as readmissions
What is Total Patient Revenue?

- Revenue constraint system
- Each hospital’s total annual revenue is known at the beginning of each fiscal year
  - Determined using historical base period
- Provides hospitals with a financial incentive to manage their resources efficiently and effectively in order to slow the rate of increase in the cost of health care (hospital and outpatient services*)
  - Provide the highest value of care possible to the community it serves

Rural Hospital View

- Prefer TPR
  - Rates are set at beginning of year
  - Fluctuations in volume less noticeable
- Very transparent
- Negotiation is more straight-forward based on formula
- Have found HSCSC staff to have a “caring attitude”
  - Focused on reasonableness of charges for patients
- Still deal directly with insurance companies
  - Payments are very timely
Shifting from Volume to Value

More focus on population health
  – Participating in HSCRC grant to address population health
Maryland waiver includes quality metrics
  – Change culture
  – Added community care workers
  – Nursing staff on board to document
Need to provide education internally and externally
Data is key
  – CRISP (Chesapeake Regional Information System for our Patients)

Words of Wisdom

Need to be open to possibilities
No system is perfect
We have to make health care system more efficient
  – Need to figure out a way to work together
One system may not be better for all providers and payers
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