Health Services Cost Review Commission: Budget Analysis

February 22, 2018

HSCRC
Health Services Cost Review Commission

Maryland's Unique Healthcare Delivery System and Transformation

Background: Maryland's All-Payer Model

- Since 1977, Maryland has had an all-payer hospital rate-setting system
- In 2014, Maryland updated its approach through the All-Payer Model
  - 5-year state innovation between Maryland & federal government (2014 through 2018) focused on hospital payment transformation
  - Each hospital receives fixed Global Budget Revenue (GBR)
    - Shifts from volume to value-based payments
    - Greater focus on patients and working with providers across the care continuum

Value of the All Payer System

- Contains costs for businesses, private payers, public payers, and consumers
- Equitable funding of uncompensated care
- Stable and predictable payment system for hospitals
- All payers fund GME
- Transparency
- System links quality and payment
- Avoids cost shifting across payors

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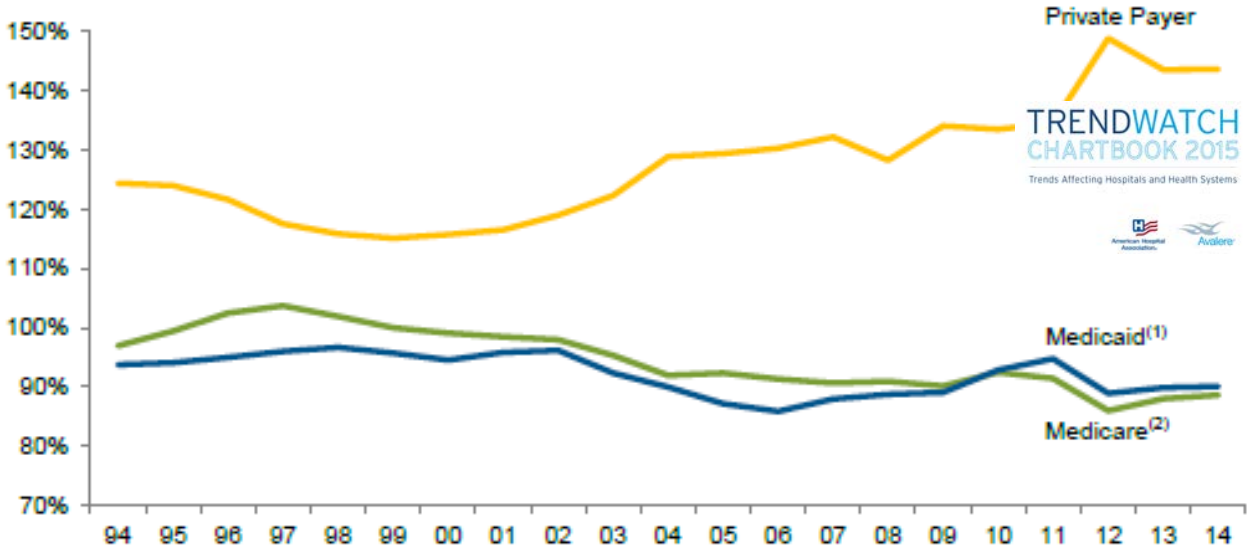
Nationally, Cost-Shifting Occurs Between Private and Public Payers

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1994 – 2014



Source: American Hospital Association

Outside of Maryland, Medicare costs are shifted onto businesses and consumers

- In Maryland, hospitals are paid using a common rate structure by ALL payers, which eliminates cost shifting

HSCRC Staffing and Resources

- 7 Commissioners, including a Chair and Vice Chair
  - Day jobs of commissioners have included hospital executives, physicians, executives of long-term care facilities, and health policy consultants, experts, and economists
- Budget consists entirely of special funds
  - FY 19 Budget Allowance : $16.1 million operations
  - $120 million for UCC
- HSCRC regulates $17 billion hospital industry
- 39 full-time staff plus analytic support from contractors
  - FY 19 Budget requests 8 new PINs to support the work of the All-Payer Model and the preparation for the Total Cost of Care All-Payer Model

Maryland's Current All-Payer Model

Maryland's All-Payer Model Agreement Results to Date

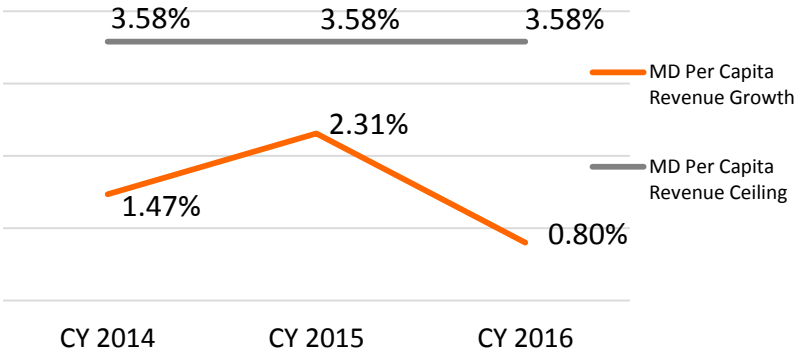
Current Hospital Model Features (2014-2018)

- ✓ 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
- ✓ Sustains rural health care with stable revenue base

Future Model Features (2019 and beyond)

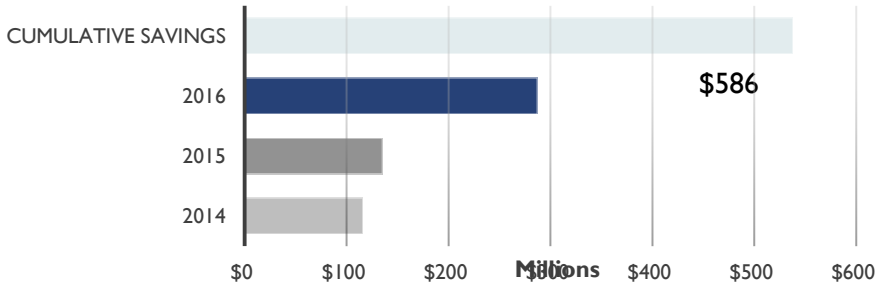
- ✓ Complex and chronic care improvement, population health
- ✓ Provider-led innovations in primary care, nursing homes, other care settings, fostering delivery innovation and flexibility
- ✓ Limit growth in Medicare Total Cost of Care (A&B) for 800k FFS beneficiaries

Maryland hospital growth contained for all payers



SOURCE State of Maryland .

Medicare savings of $500+ million in hospital payments in 3 years, relative to national growth rates



Total Cost of Care and Quality Results

- ✓ Medicare total cost of care $461 million savings
- ✓ Readmissions (-79%)
- ✓ Hospital Acquired Conditions (-44%)

SOURCE State of Maryland analysis of data from CMS.

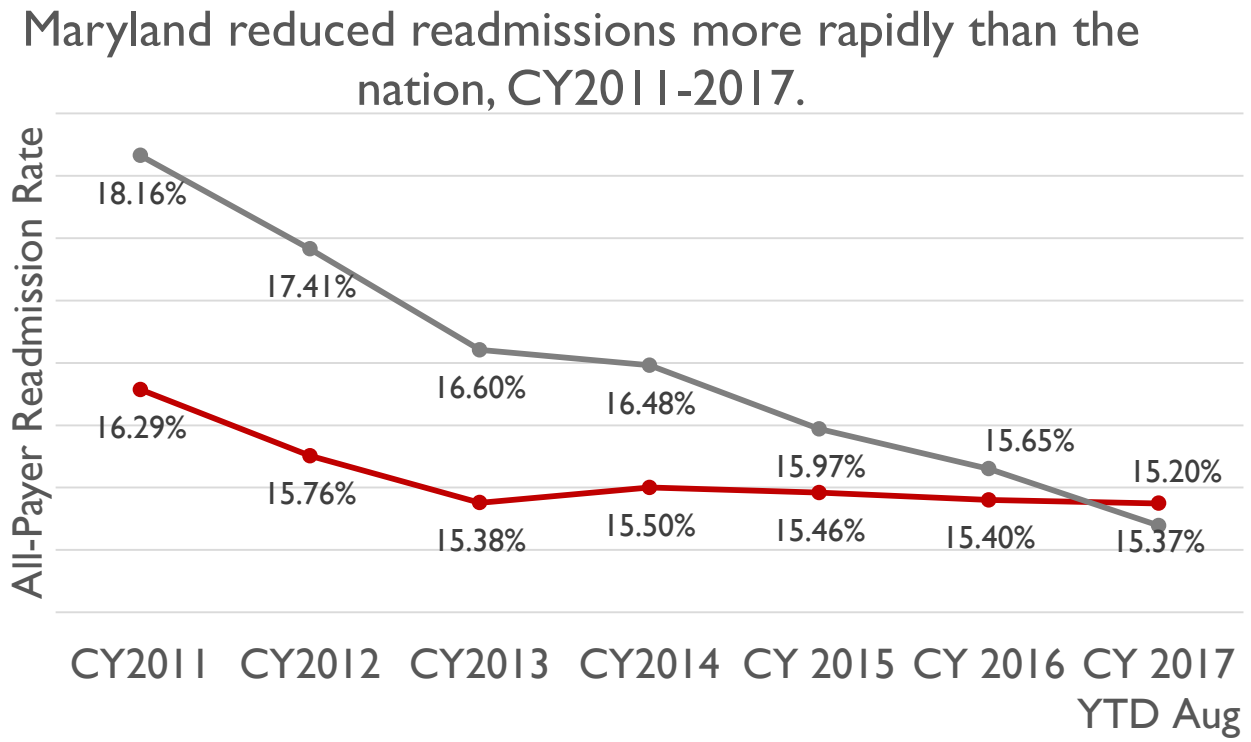
All-Payer Model: Performance to Date

Performance Measures	Targets	2014 Results	2015 Results	2016 Results	2017 Results (preliminary)[1,3]
All-Payer Hospital Revenue Growth	**≤ 3.58% per capita annually**	**1.47% growth per capita**	**2.31% growth per capita**	**0.80% growth per capita[2]**	**3.05% growth per capita[2]**
Medicare Savings in Hospital Expenditures	**≥ $330m over 5 years** (Lower than national average growth rate from 2013 base year)	**$120 m** (2.21% below national average growth)	**$155m** **$275 cumulative** (2.63% below national average growth since 2013)	**$311m** **$586m cumulative[2]** (5.50% below national average growth since 2013)	**$270m** **$856m cumulative[2]**
Medicare Savings in Total Cost of Care	**Lower than the national average growth rate for total cost of care from 2013 base year**	**$142m** (1.62% below national average growth)	**$121m** **$263m cumulative** (1.31% below national average growth since 2013)	**$198m** **$461m cumulative[2]** (2.08% below national average growth since 2013)	**$118m** **$579m cumulative[2]**
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	**30% reduction over 5 years**	**25%** reduction	**34%** reduction since 2013	**44%** reduction since 2013	**Unavailable**
Readmissions Reductions for Medicare	**≤ National average over 5 years**	**19%** reduction in gap above nation	**58%** reduction in gap above nation since 2013	**79%** reduction in gap above nation since 2013	**Under the National Average**
Hospital Revenue to Global or Population-Based	**≥ 80% by year 5**	**95%**	**96%**	**100%**	**100%**

[1] [1]Preliminary results for calendar year 2017, these have not been validated by CMS.
[2]Actual revenues were below the ceiling for CY 2016 and these numbers have been adjusted to reflect the hospital undercharge of approximately 1% that occurred in the second half of CY 2016.
[3] This Medicare financial data is through October 2017. Performance may change in the final two months of CY 2017.

Medicare Test: At or below National Medicare Readmission Rate by end of CY 2018

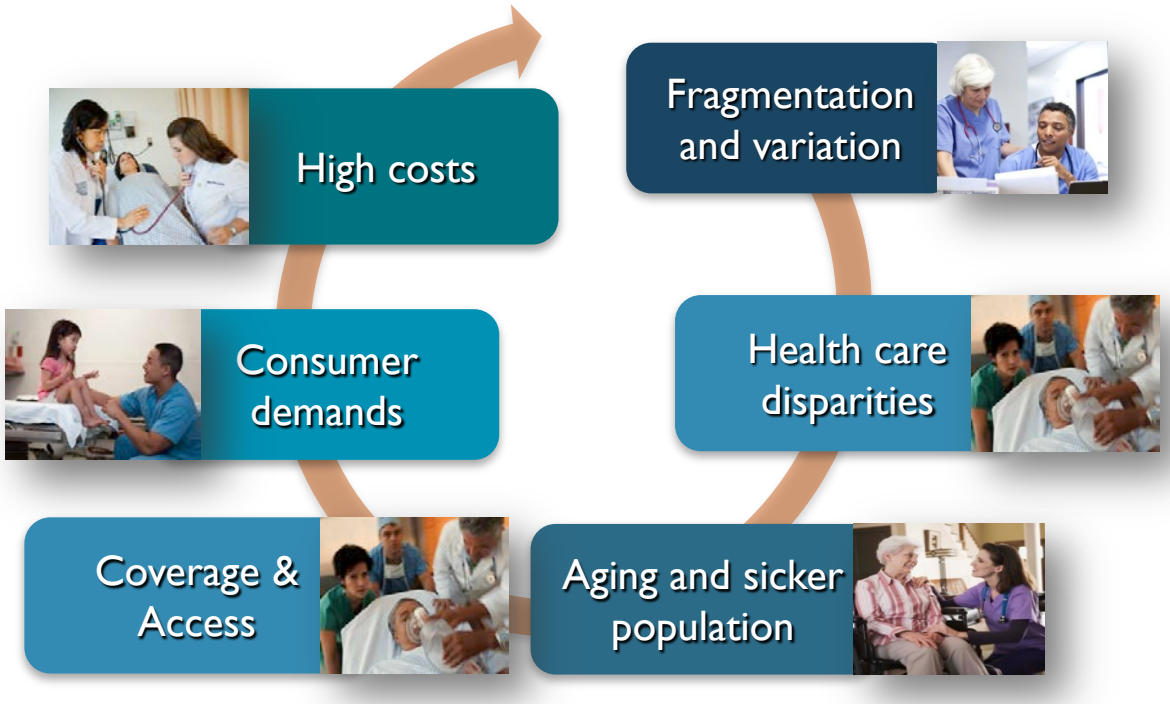
With preliminary* data for through August 2017, Maryland is meeting the current hospital model's goal.



* Data subject to change due to claims runout.

The Model Progression

Health Care System Challenges



More Ahead. . .

- Over the next decade, Maryland's population >65 years old will increase by nearly 40%
- Recent consumer polls and bipartisan focus on affordability and costs

Progression Plan: Key Strategies

I. **Foster accountability** for care and health outcomes by supporting providers as they organize to take responsibility for groups of patients/a population in a geographic area.

II. **Align measures and incentives** for all providers to work together, along with payers and health care consumers, on achieving common goals.

III. **Encourage and develop payment and delivery system transformation** to drive coordinated efforts and system-wide goals.

IV. **Ensure availability of tools** to support all types of providers in achieving transformation goals.

V. **Devote resources to increasing consumer engagement** for consumer-driven and person-centered approaches.

Steps in Maryland's Progression

- All-Payer Model Amendment
  - Enable hospitals to partner with physicians and other providers in further care improvement
  - Started with two new programs effective July 1, 2017
    - Hospital Care Improvement Program (HCIP)
    - Complex & Chronic Care Improvement Program (CCIP)
- Maryland Primary Care Program (MDPCP)
  - Increase focus on prevention and primary care
- Enhanced Total Cost of Care All-Payer Model

Care Redesign Programs – Aligning hospitals and non-hospital providers

- Two initial care redesign programs aim to align hospitals & other providers

Hospital Care Improvement Program (HCIP)	Complex and Chronic Care Improvement Program (CCIP)
• **Who?** For hospitals and Care Partners practicing at hospitals • **What?** Facilitates improvements in hospital care that result in care improvements and efficiency	• **Who?** For hospitals and Care Partners practicing in the community • **What?** Facilitates high-value activities focused on high needs patients with complex and rising needs, such as multiple chronic conditions • Leverages Medicare Chronic Care Management (CCM) fee*

- Hospitals can select which program(s) to participate in
- Through these voluntary programs, hospitals will be able to obtain data, share resources with providers, and offer optional incentive payments
- Revised Participation Agreement will address outstanding hospital issues and allow for further statewide engagement

*Maryland will modify program as needed to adapt to Medicare's MACRA program and the Maryland Primary Care Program

Payment and Care Delivery Alignment

- Hospitals and Providers with aligned quality targets
- Sharing information
- Driving down costs
- Improving the health of populations

Proposed Total Cost of Care All-Payer Model

Overview of Total Cost of Care Model Components

- Limits growth in total cost of care per capita for Medicare.
- Continues and enhances hospital program that limits growth per capita for all payers.
- Expands care redesign programs to enable private sector led programs supported by state flexibility.
- Initiates primary care program to enhance chronic care and health management.
- Harnesses public health and private sector population health efforts to address population health issues, including opioid use, diabetes, and other chronic conditions.

Overview of Proposed Key Elements

- **10-year Model** — Ambitious, large-scale transformation for more than 800k Medicare FFS beneficiaries. Initial five-year performance period leading to an additional five years; no turning back on transformation, focus to support the scope of transformation and continuing large investments to reduce avoidable utilization.
- **Person-Centered Primary Care Transformation** — Goal is to bring 500k Medicare beneficiaries into comprehensive primary care, increasing person-centeredness while improving chronic, mental health and preventive care. CMS will invest in care management fees.
- **Care Redesign Programs** — Bring physicians, nursing homes, and other providers into aligned programs, with State flexibility in design and implementation.
- **Population health** — The State of Maryland and providers will jointly focus on health improvement initiatives. Improved population health may offset the cost of primary care investments.
- **Total Cost of Care (TCOC) Medicare Savings** — Progressive, but aggressive savings targets. Success in reaching targets rests on driving down avoidable hospital utilization and costs. Aggressive target rests primarily on hospitals, which need timely tools, care partner engagement, and CMS/State support to succeed.

Next Steps - Total Cost of Care All-Payer Model

- Stakeholder Involvement
  - Stakeholders across the Maryland health care continuum have united in support of the TCOC Model
  - Key stakeholders formed a State Innovations Group (SIG) in 2018 to lay the foundation for making the coordinated health care improvements to deliver the first set of milestones in 2019-2023
  - Organizational discussions are currently underway
- Continuation of investments in Care Redesign Program
- State involvement
  - The Departments of Aging and Health, HSCRC, MHCC, and other state agencies will have to act as the facilitators for the industry's transformation
  - The Department of Health will focus on delivering improvements in targeted population health improvements in behavioral health, opioids and hepatitis C reduction, smoking, diabetes and obesity prevention, and targeting falls in seniors

Response to Budget Issues

All-Payer Model Contingency Plans

- Work towards TCOC Model continues as we work through negotiations
  - TCOC builds on important work started under the current hospital All-Payer Model
    - Global budget incentives
    - Focus on population health
    - Care Redesign Programs
    - MACRA-eligibility for Maryland physicians
- Results show improvements in complications and unnecessary utilization of high cost services, resulting in better care and cost savings
- Maryland negotiating team is working diligently with federal partners to clear the TCOC Model.

Hospital Operating Profits

- Regulatory oversight should focus on efficiency and better quality
- Variations in profit levels
  - Some caused by differences in reporting
  - Others may need policy adjustments
- Operating profits vs. total profits
  - Total profits include stock market gains and losses, not the focus of HSCRC
  - HSCRC reviews operating margins
- Update factors and inflation variations can affect operating margins from year to year
  - FY 19 update factor is likely to be lower
- Important health expenditures outside of traditional operating costs:
  - Physician support
  - Population health
  - Behavioral health/addiction services
  - Accountable care/care coordination/chronic care management

Uncompensated Care Fund

- Since 1984, the HSCRC has recognized the cost of uncompensated care (UCC), including charity care and bad debt.
- Through this provision, those who cannot pay for care are still able to access hospital services.
- UCC is funded by a statewide pooling system
  - Hospitals with lower levels of UCC pay into the fund
  - Hospitals with higher levels of UCC draw from the fund
- Total UCC has been decreasing in recent years due to increased health care coverage.
- FY 17 UCC fund payments totaled $98 million.
- HSCRC concurs with the recommendation to reduce the appropriation for UCC in FY 19.

Questions?