Exploring Global Budgets and All-Payer Rate Setting Approaches: How Does it Impact Rural Providers?

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NORC AT THE UNIVERSITY OF CHICAGO

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

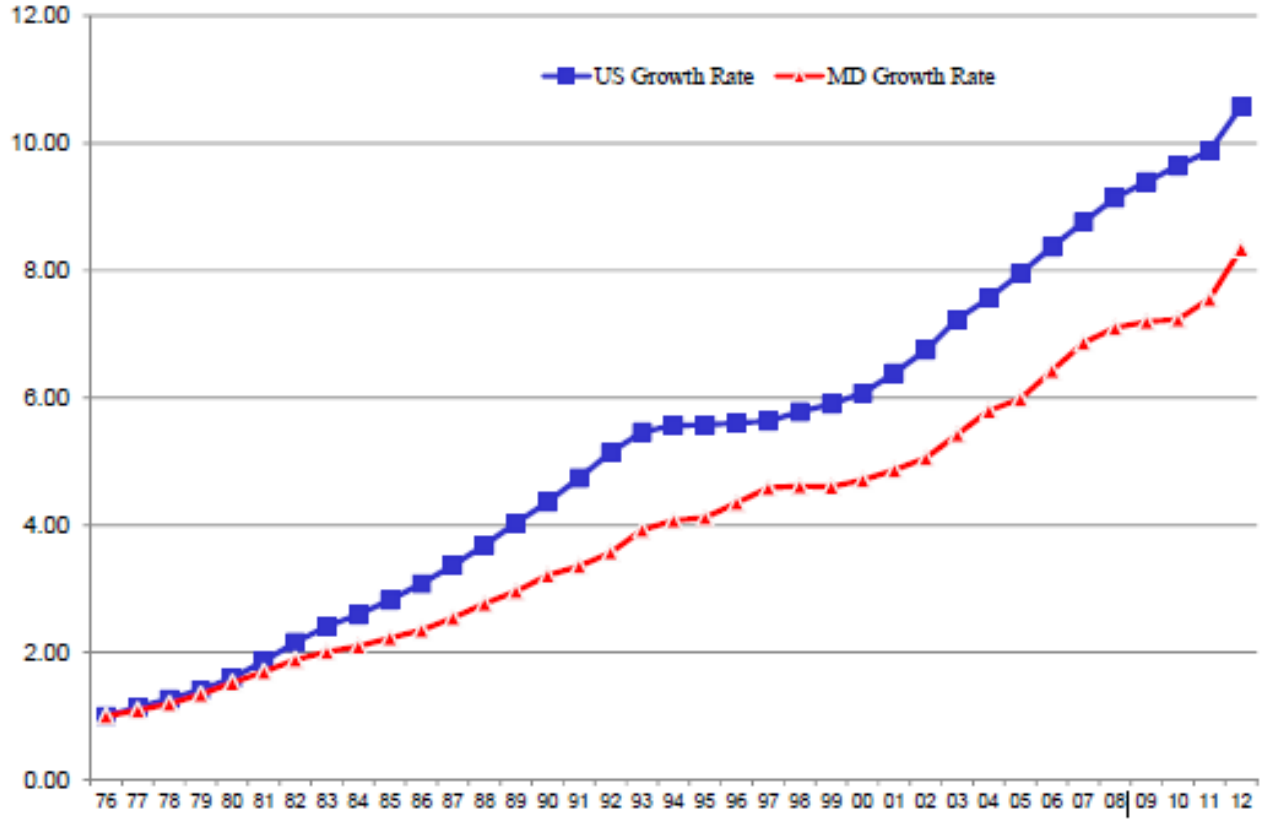
- Cost containment
- Equitable funding of uncompensated care
- Stable and predictable payment system for hospitals
- All payers fund fair share of GME
- Links hospital quality to payment

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

Indexed Growth Rates in Hospital Cost per Adjusted Admission, Maryland vs. U.S. 1976-2012



Source: American Hospital Association Statistics Cost per Equivalent Inpatient Admission (EIPA)

MARYLAND

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 2000
- Hospitals responded to tight cost per case growth limits and elimination of the VAS by greatly increasing case volumes and other service use

	All Payer Total Cost Per Capita	All Payer Hospital Cost Per Capita	Medicare Total Cost Per Beneficiary	Medicare Hospital Cost Per Beneficiary
Maryland	$7,492	$2,767	$11,449	$6,352
U.S.	$6,815	$2,475	$10,365	$4,847
MD/U.S.	**1.10**	**1.12**	**1.10**	**1.31**

MD Rapid Increases in the "Total Cost" of Hospital Care

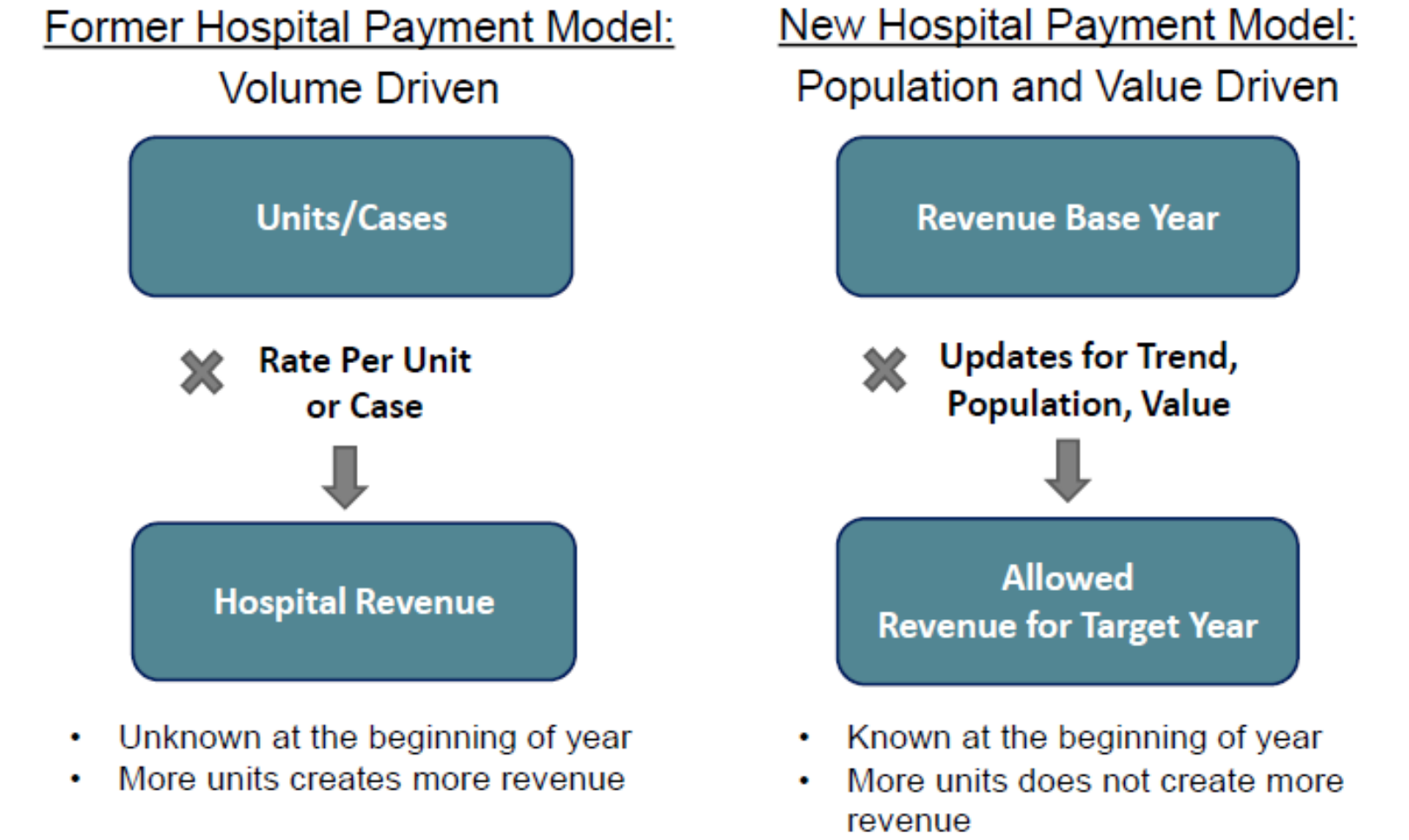
Unique New Model: Maryland's All-Payer Model

- 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

- 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

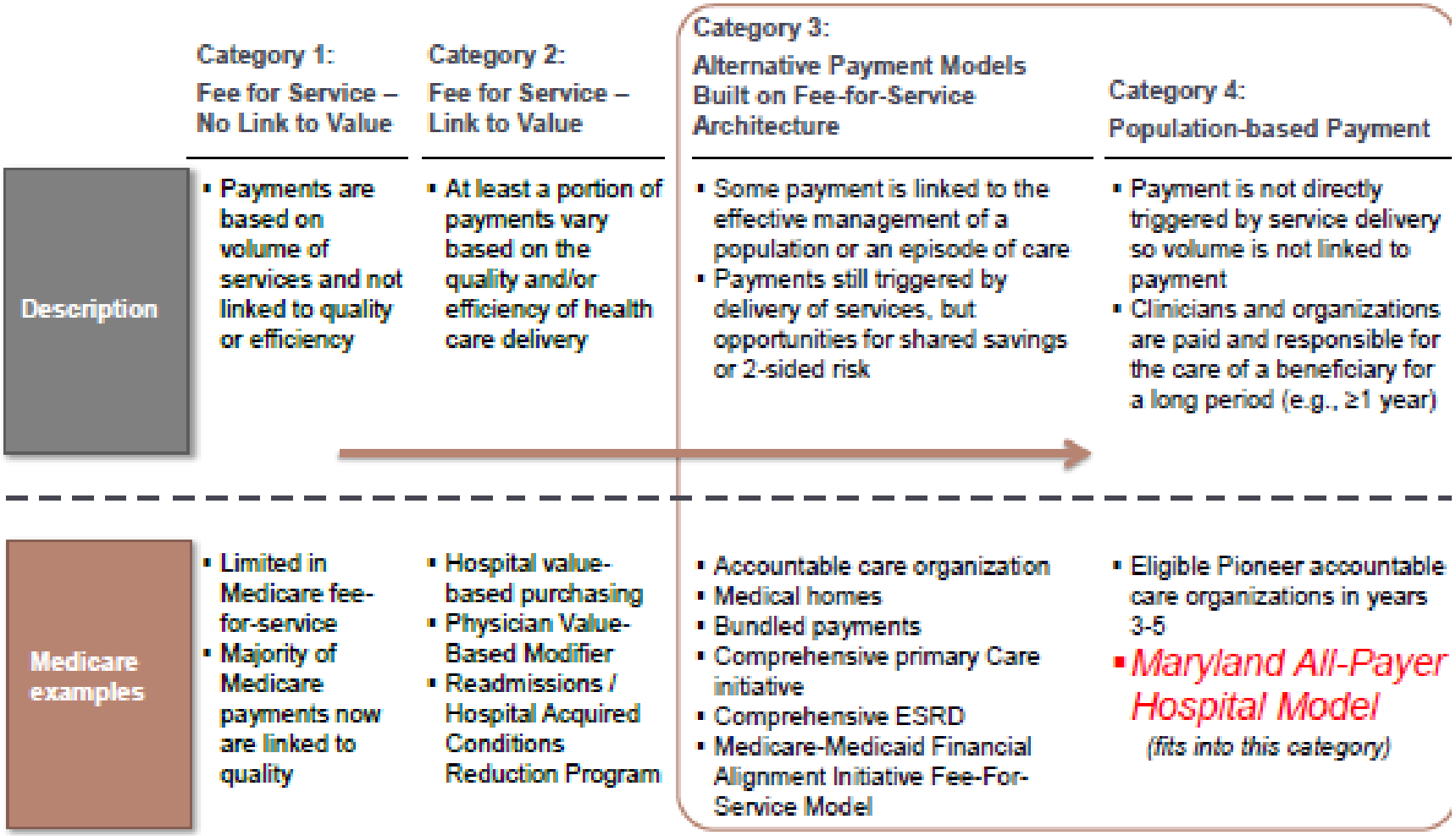
Source: Maryland Health Services Cost Review Commission

New Global Model: Moving Away from Volume



Source: Maryland Health Services Cost Review Commission

CMS is Focused on Increasing Value Based Payment Approaches—Consider Impact on Maryland Providers



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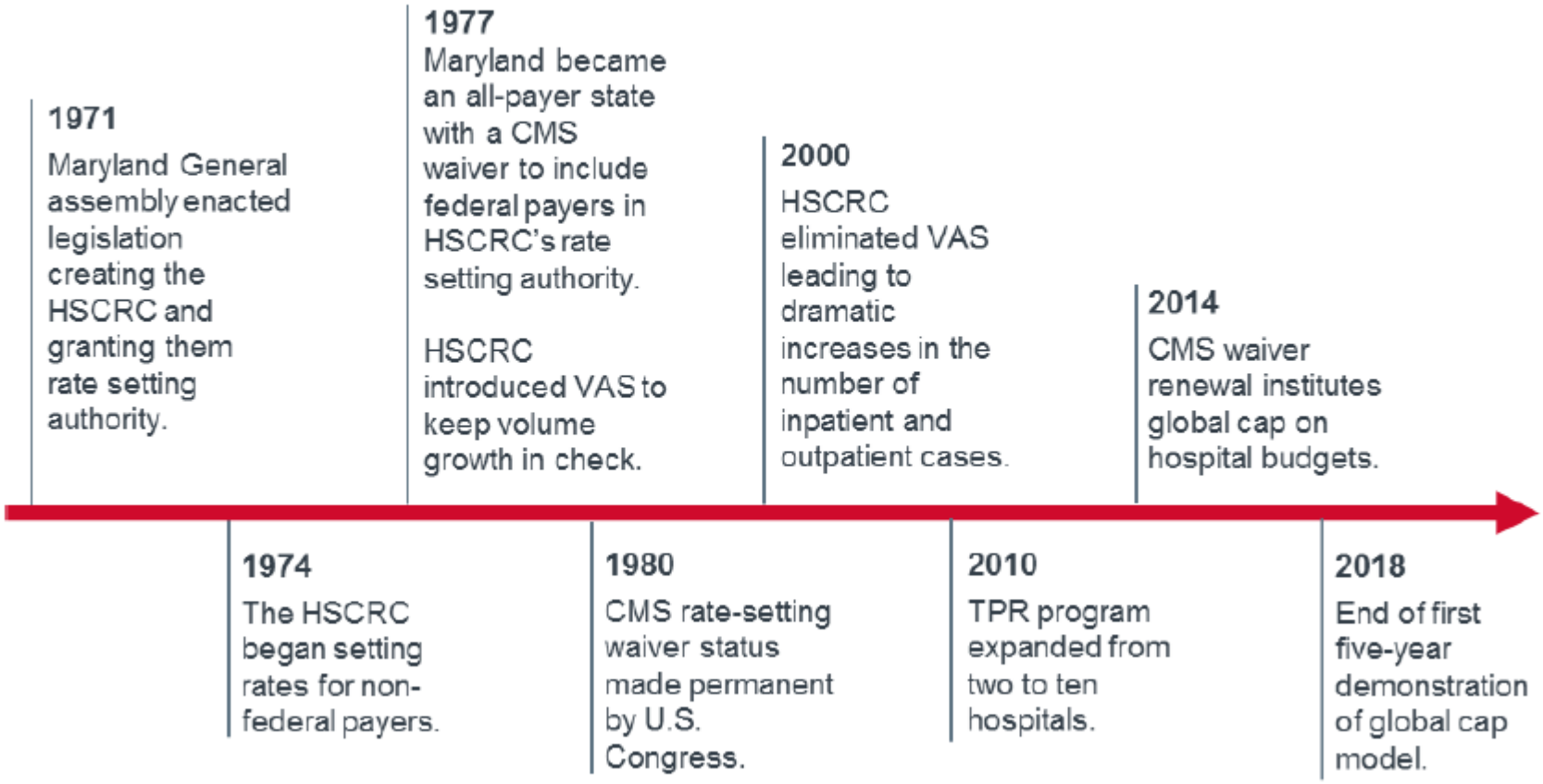
Source: Adapted from Rajkumar R, Conway PH, Tavenner M. CMS – engaging multiple payers in payment reform. JAMA 2014; 311: 1967-8.

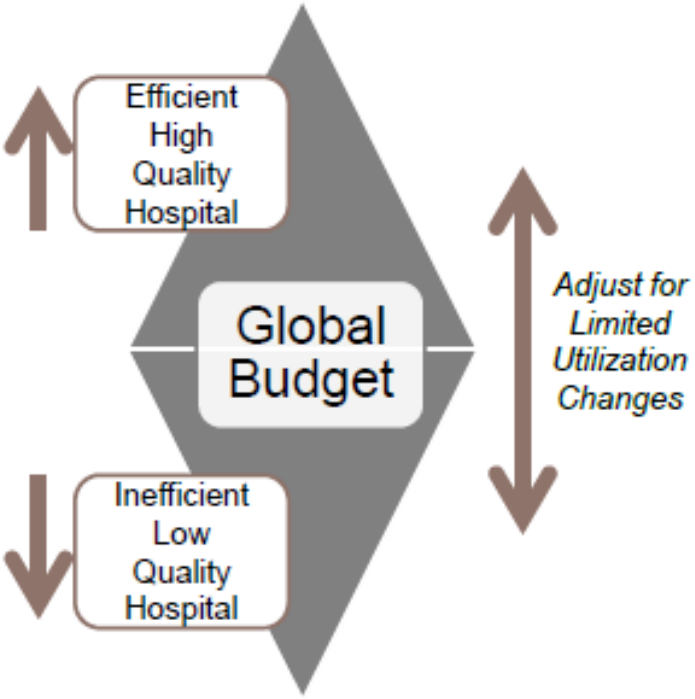
Source: Maryland Health Services Cost Review Commission

Major Milestones of Maryland's All-Payer Model



Source: Maryland's All-Payer Global Budget Cap Model and Its Implications for Providers, May 16, 2016

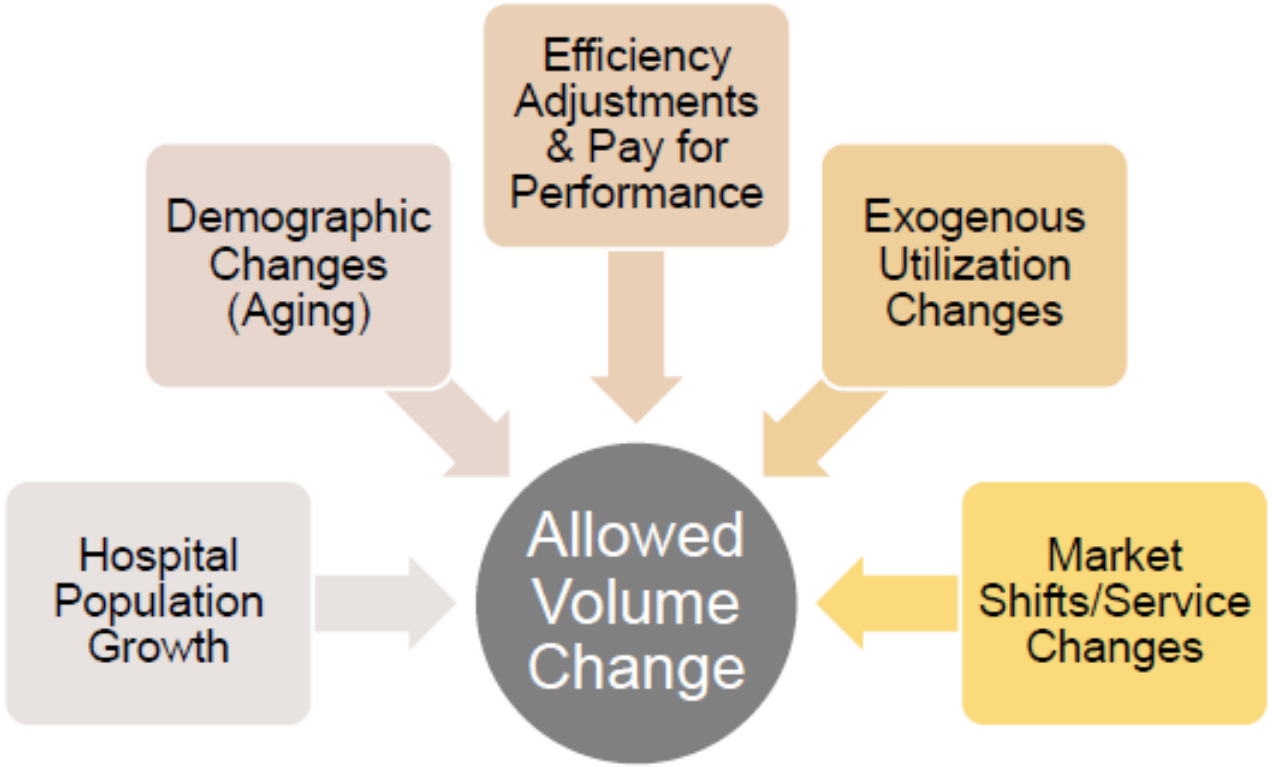
Global Budget Model



- 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

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 Complete	•Enhance models, monitoring and infrastructure •Formalize partnerships for engagement and improvement	•Evolve alignment models and payment approaches •Increase focus on total cost of care	Secure resources, and bring together all stakeholders to develop approach

MARYLAND

Critical Elements for Success

- Develop a care model that improves population health
- Engage providers beyond hospitals
- Sustain access to hospitals despite slowing payments
  - Senate Bill 707: Freestanding Medical Facilities – CON, Rates and Definitions
    - Exemption process from CON for conversion of an underutilized hospital to freestanding emergency medical center

How is the new model working based on 2014 performance?

Per-person revenue growth reduced to 1.47% (3.58%*)

Medicare saved $116M compared to growth in the rest of the U.S. ($330M*)

Complications (e.g., infections) ↓ 26% (30%*)

Medicare readmissions ↓ more than U.S., but did not meet state goals (.2% vs 1.2%*)

**5-year goal*

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

Global Budget Market Implications

- Accelerating provider efforts to improve care delivery
- Adjusting operations
- Increasing market share is path to growth
- Collaborating to address population health
- Creating actionable, timely data holds key to success
  - Maryland Accountability and Reporting System
  - CRISP

Source: Maryland's All-Payer Global Budget Cap Model and Its Implications for Providers, May 16, 2016

Maryland's Lessons for Other States

- All-payer rate setting supports full-investment in transformation
  - Evolution of system over time
- Maintaining budget predictability is motivation for revenue caps
- State and provider goals increase confidence in expectations and improve engagement

Source: Maryland's All-Payer Global Budget Cap Model and Its Implications for Providers, May 16, 2016

Next Steps for Maryland…

Future Areas of Focus

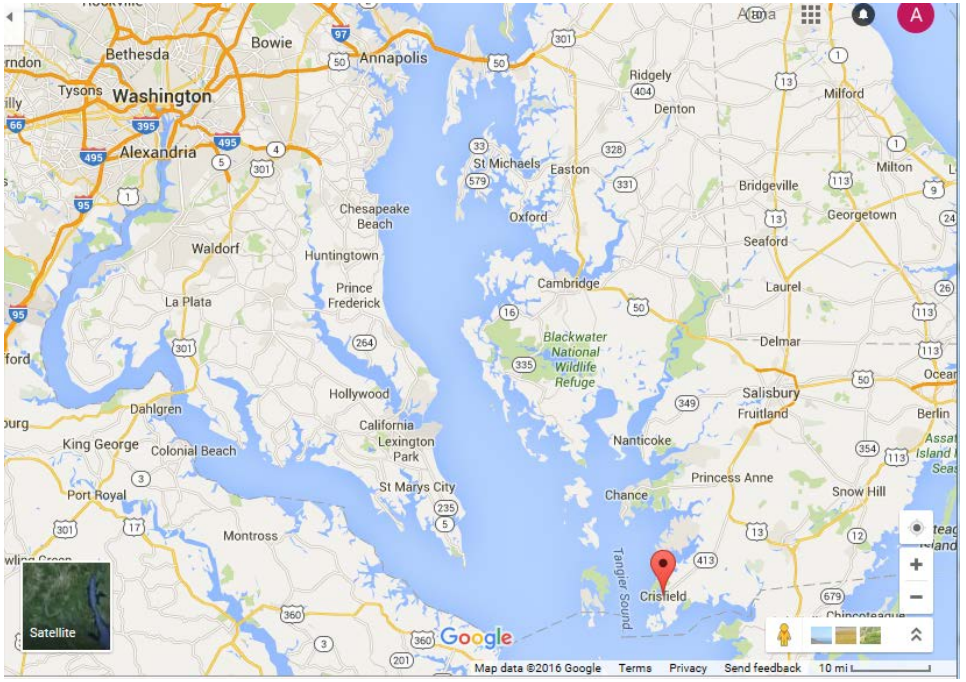
- Expand model to include accountability for total cost of care
- Reduce "potentially avoidable utilization"
- Transition 80% of primary care providers to a PCMH program

Critical Factors for Future Success

- Develop a care delivery model that successfully improves population health
- Engage providers beyond the hospital setting, especially physicians
- Sustain access to hospital services despite slowing payments to hospitals

Source: Maryland's All-Payer Global Budget Cap Model and Its Implications for Providers, May 16, 2016

McCready Health – Crisfield, Maryland



Rural Health Reform Policy
RESEARCH CENTER

Total Patient Revenue – Rural 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

Next Steps for Rural Maryland

- Senate Bill 707: Freestanding Medical Facilities – CON, Rates and Definitions
  - Exemption process from CON for conversion of an underutilized hospital to freestanding emergency medical center
- Study Report – September 2017

  Access to health care provider and services, vulnerable population needs, transportation limitations, and economic impact of closures or conversions

Vermont Timeline

- *2011* Established Green Mountain Care Board
- *2013* Set 3% target rate of increases for hospital net patient revenue
- *2014* Implemented Shared Savings Programs in Medicaid and commercial insurance markets
- *2016* Negotiating with CMS for an all-payer rate setting model

Commonwealth of Pennsylvania

- Proposal to implement a multi-payer global budget initiative in rural Pennsylvania
  - How should prospective budgets be calculated across regions?
  - How would CAHs be reimbursed?
    - 34% operate at negative total margins
  - What kind of data system will support a GB?
    - Claims, patient attributions, quality metrics
  - Role of telehealth
  - Quality measures

"It is imperative that we develop a sustainable model for rural health, not just for rural hospitals. Rural communities face different challenges than urban counterparts, and our policies should support local innovation in meeting these needs. Global hospital budgeting offers the potential to reform rural health care in alignment with better population health."

– Karen Murphy, Pennsylvania Secretary of Health

Source: Global Budgets for Rural Hospitals, Joshua M. Sharfstein, The Milbank Quarterly, Volume 94, Issue 2, 2016

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