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

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A Consortium of

Center *for* Rural Health
The University of North Dakota
School of Medicine & Health Sciences

The Walsh Center
for Rural Health Analysis
NORC AT THE UNIVERSITY OF CHICAGO

Maryland's All-Payer System: A Foundational Building Block

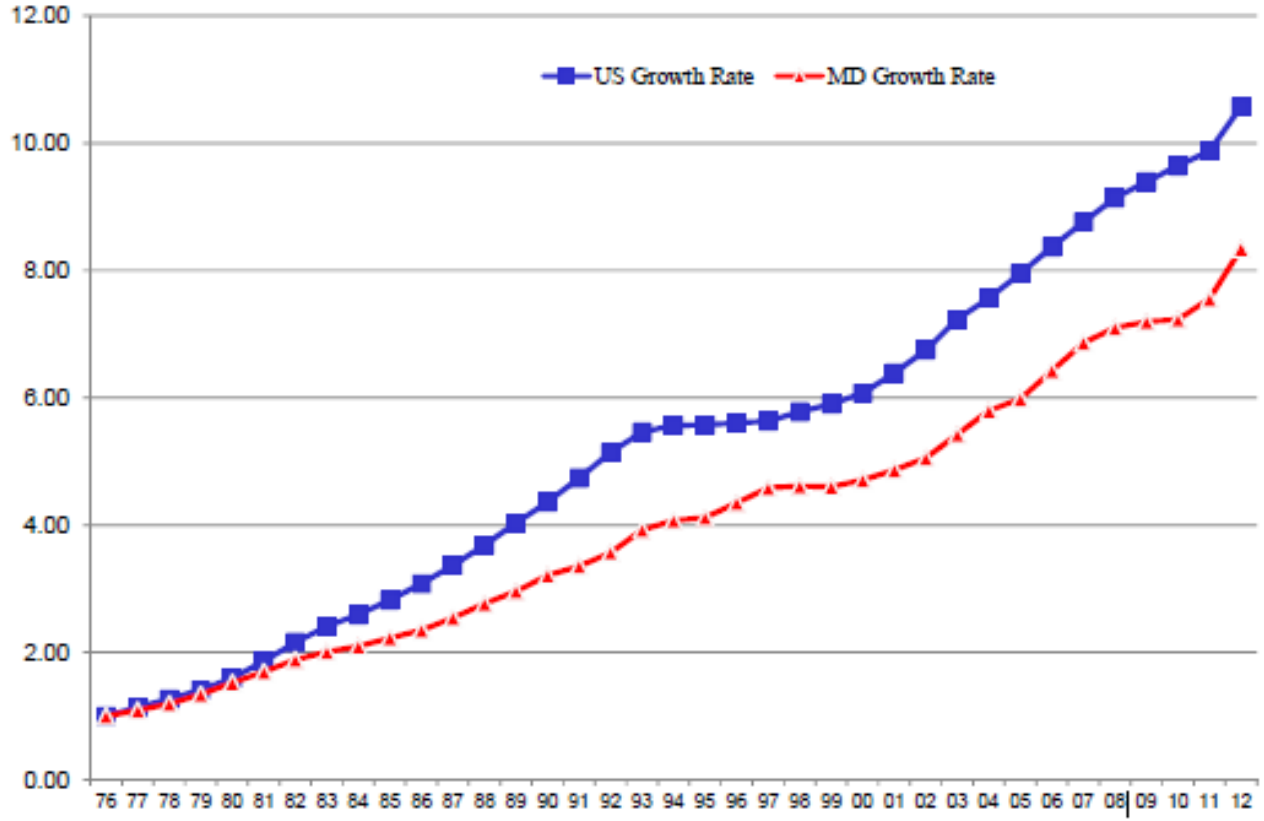
- What is an All-Payer system?
  - Health care system in which all insurers use the same fee schedule
    - Private and public insurers pay the same rate
    - Uninsured pays the same rate
- Rates set by independent state commission
- Provides transparency of rates
- Eliminates cost-shifting

The Maryland Reimbursement Model

Health Services Cost Review Commission (HSCRC), an independent Commission with seven volunteer 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)

Total Patient Revenue – Rural Maryland

- Implemented in 2010 in 10 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 manner
- HSCRC monitored hospital performance, such as readmissions and ED visits

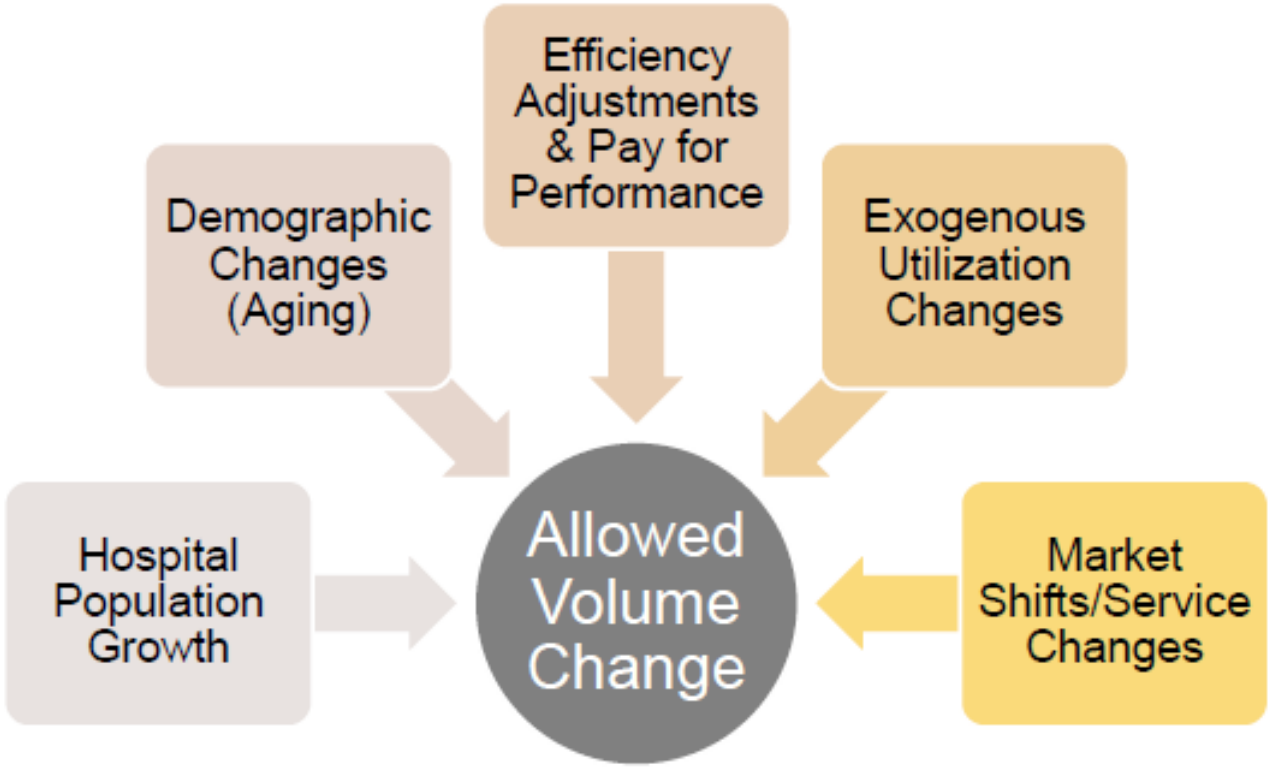
Unique New Model: Maryland's All-Payer Model

- 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

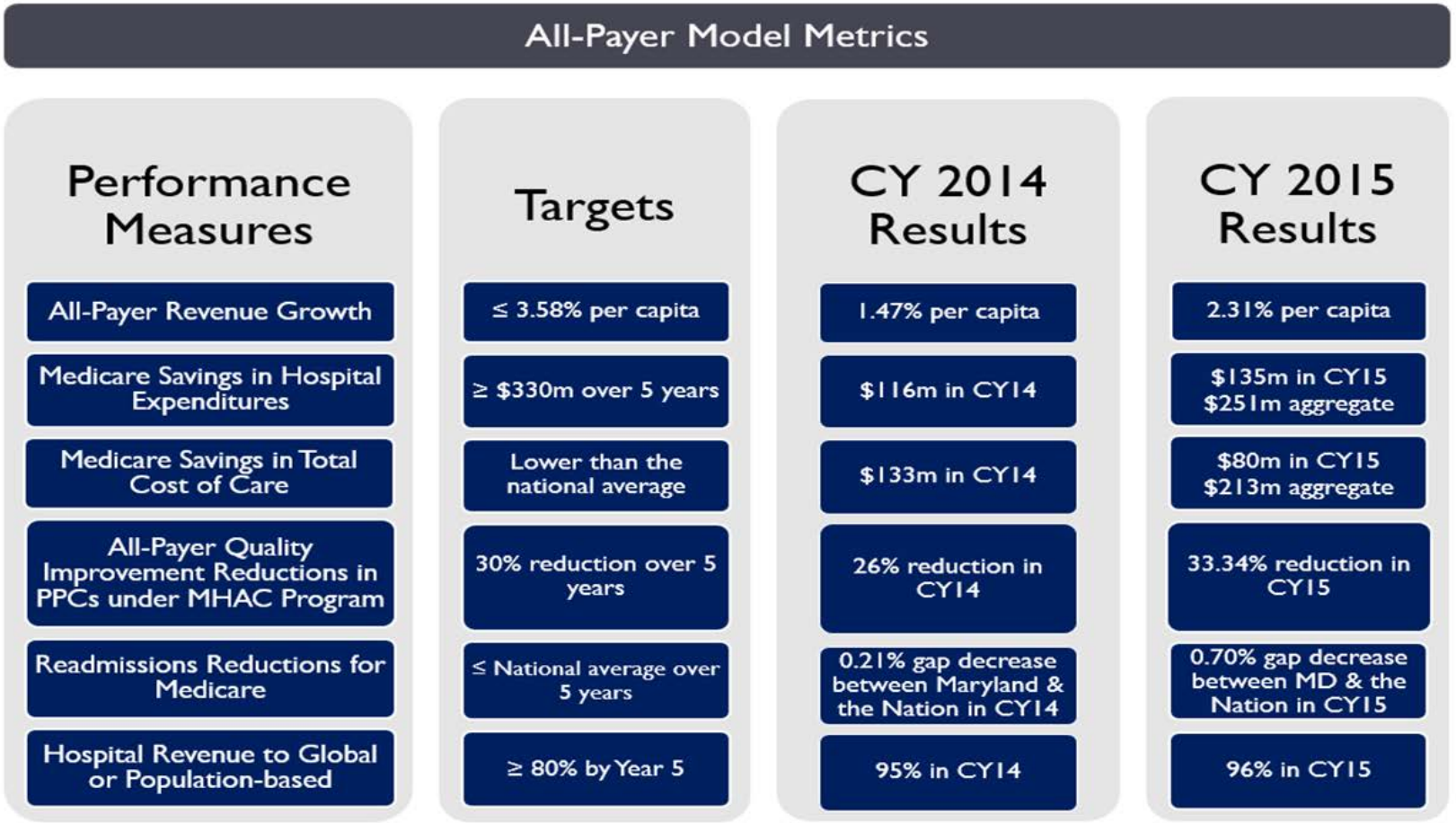
Source: Maryland Health Services Cost Review Commission

GBR Adjustments



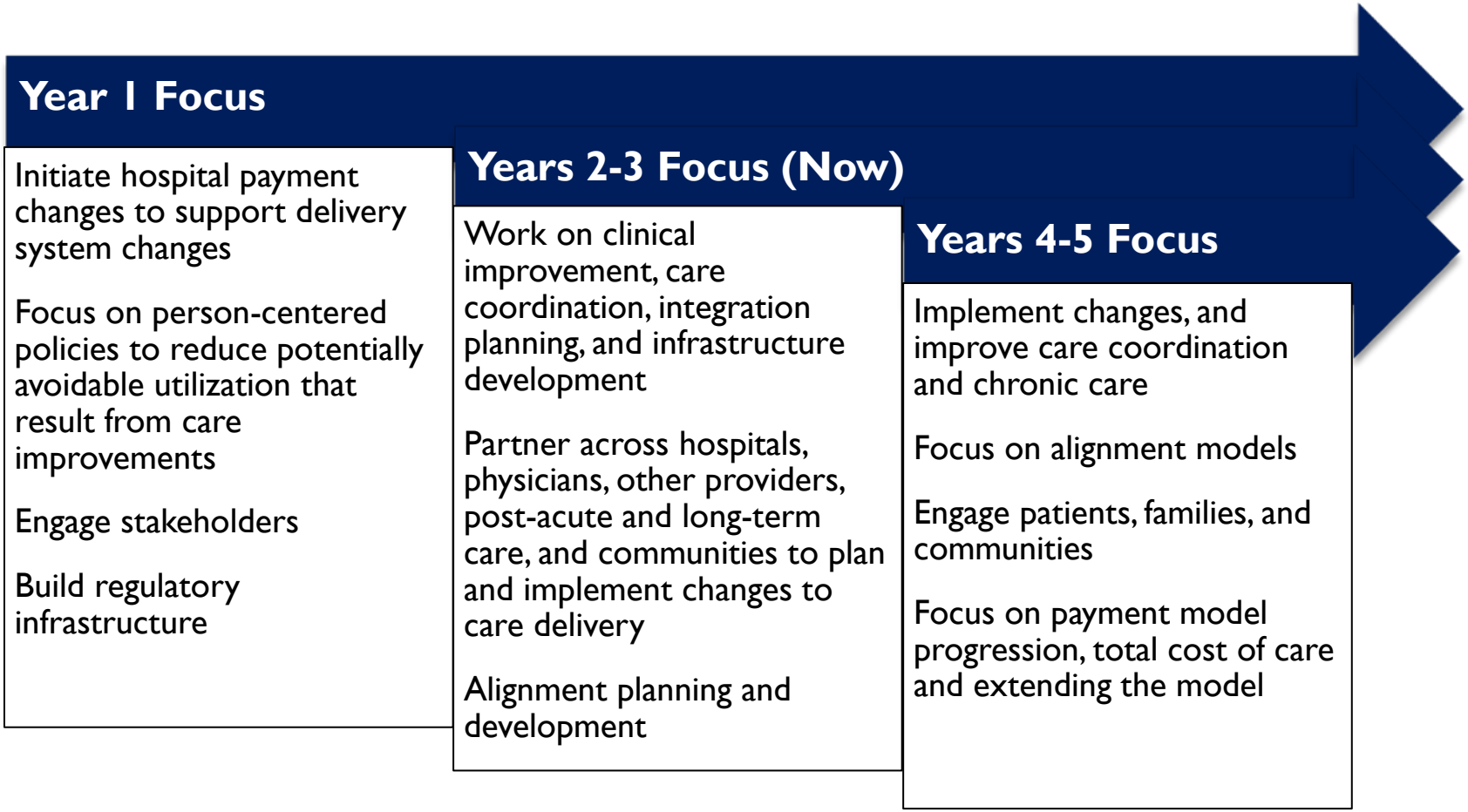
Source: Maryland Health Services Cost Review Commission

Maryland Year 1 & Year 2 Performance



Source: Maryland All-Payer Model Overview for Rural Health Care Delivery Workgroup presentation, August 30, 2016, Steve Ports, HSCRC

Implementation Timeline



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Shifting from Volume to Value

- Increases focus on population health
  - Participating in HSCRC grant to address population health
- Includes quality metrics (Medicare waiver)
  - Changes culture
  - Add community care workers
  - Improve documentation
- Data is key
  - Chesapeake Regional Information System for our Patients (CRISP) – State Health Information Exchange (HIE)

Opportunities for Patients and Providers in Maryland

Get Connected

- Utilize CRISP encounter alerts, common care histories, and other care management tools
  - Address gaps in patients' health

Get Coordinated

- Coordinate your patients' care with other providers across clinical and community settings
- Work with case managers to address the medical and social needs of complex patients

Participate

- Use data and information to help improve outcomes and lower costs
- Join Accountable Care Organizations, medical homes, geographic initiatives, etc.
- Get involved in outcomes-based payment programs, etc.

Be Proactive

- Be a watchdog
- Contribute to the redesign of the state's healthcare delivery system

Source: Maryland All-Payer Model Overview for Rural Health Care Delivery Workgroup presentation, August 30, 2016, Steve Ports, HSCRC

Maryland Hospital CEOs' Words of Wisdom

Be open to possibilities

No system is perfect

Plan ahead

Improve efficiencies

- Create a way to work together

Provider and board education are keys to success

Relationships, relationships, relationships

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
  - Six rural hospitals to participate in pilot by end of 2016; an additional 12 to participate by 2019 with the goal of reaching 30 rural hospitals by 2020
  - Key aspects:
    - Focus on population health management
    - Role of telehealth
    - Value-based payment strategy

	Maryland	Pennsylvania	Vermont
Global Budget Model	5 years; major aims include shifting to a Medicare per capita total hospital growth target, "better care, better health and lower costs"	5 years; state is currently pursuing a Global Budget initiative pilot in an effort to develop and implement a multi-payer Global Budget in the state for rural hospitals	5 years; state plans to cap cost growth for health care providers and hospitals for Medicare, Medicaid and private insurance
Data Support	• Maryland Accountability and Reporting System • Chesapeake Regional Information System for our Patients (CRISP) • HSCRC	Rural Health Redesign Center (planned)	Green Mountain Care Board (GMCB)
Number of Hospitals Participating	All	• 6 rural hospitals in 2016-2017 • + 12 rural hospitals in 2019 • Goal: 30 rural hospitals in 2020	All
Number of CAHs	0	14	8
Population (based on 2015 census data)	6,006,401	12,802,503	626,042
Number of CAHs	0	14	8

Common Themes Across States

- Secure buy-in
  - Federal, state and local stakeholders
  - Hospital administrators and providers
  - Rural stakeholders
- Presence of a state regulatory environment
  - Certificate of Need (MD and VT)
- Establish state support
  - Independent commission – negotiate rates, monitor and oversee implementation

Common Themes Across States

- Requires a robust data infrastructure
  - Track financial and quality metrics
  - Include inflation adjustments
- Promotes care coordination
- Establish systems to support data and reporting
- Implement and monitor quality metrics

"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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