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Policy Research

A New Hospital Payment Model:

Maryland's Global Budgeting System

Assembly California Legislature, Informational Hearing Universal Healthcare Delivery Systems and Cost Containment Efforts in the United States

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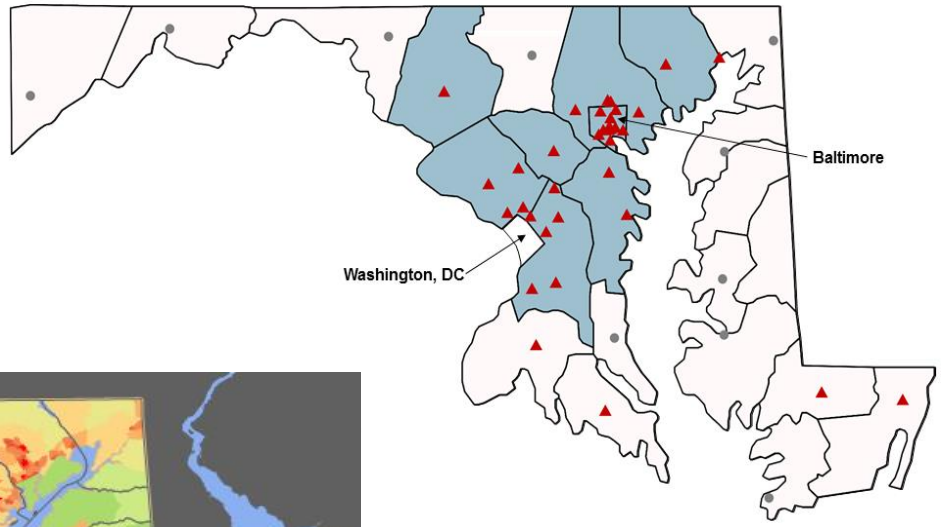
Unique All-Payer Hospital Payment System in Maryland

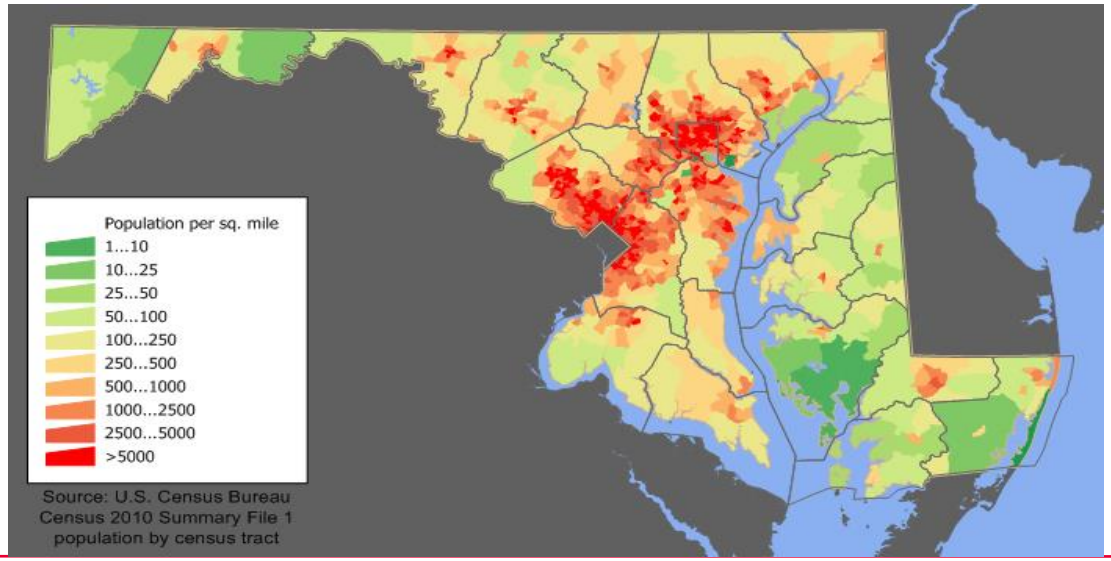
- Since the late 1970s, Maryland sets hospital rates for all public and private payers
- Essentially, hospitals receive a rate for each of their services from the state, and all payers, including Medicare, Medicaid, Private, and Uninsured pay off of the same rate
  - Medicare and Medicaid pays higher than other states
  - Private payer and uninsured pays less
- Rates are updated annually on a prospective basis and differ for each hospital
  - Higher cost hospitals such as academic medical centers have higher rates
- Claim processing and benefit coverage are determined by each payer

The State of Maryland

- 47 Acute general hospitals, all nonprofit
  - The Johns Hopkins Hospital
  - The University of Maryland
- 54 % of population with employer coverage, 16% in Medicaid, 14% in Medicare. Major commercial payers:
  - CareFirst, Blue Cross Blue Shield
  - Aetna
  - United
  - Kaiser
- HMO penetration rate 34%*

Maryland Acute Care Hospitals



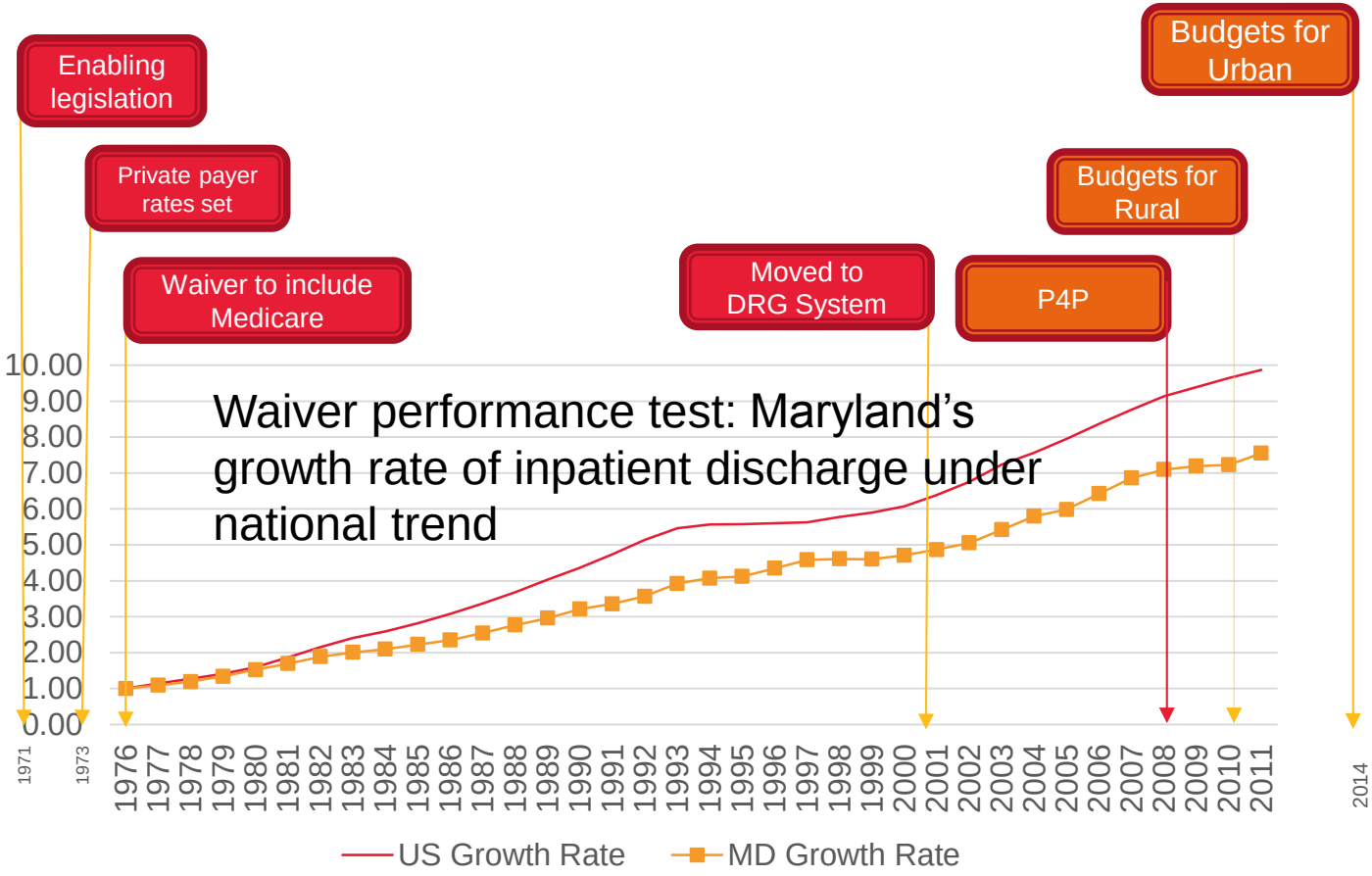


- 6 Million people
- 18% of population > age 64
- 3rd highest income per capita state
- High poverty rates (urban and rural)

*Source: Kaiser Family Foundation State Health Facts

Medicare Waiver

Federal Law (section 1814(b) of the Social Security Act) established a waiver for Maryland for Medicare and Medicaid to pay 94 % of the state regulated rates.



Health Services Cost Review Commission (HSCRC)

- **Oversees hospital rate regulation for all payers**
  - **Independent quasi-public commission**
  - **Unique governance structure - 7 volunteer Commissioners consist of stakeholder representatives appointed by the Governor**
  - **Authority- Inpatient & outpatient hospital services (no Physicians services)- 47 Acute Care Hospitals - $15 billion in revenue**
  - **Small technical staff**
    - 40 FTEs
    - $8 million operating budget
    - Funded by user fees

Benefits of All-Payer System

- **Provides considerable value**
  - **Limits cost shifting--all payers pay their share, including uncompensated care and graduate medical education**
  - **Innovates with stakeholders and regulates on a local level**
  - **Uses all payer metrics to measure outcomes and guide care improvements**
  - **Creates financial stability for hospitals (higher bond ratings despite smaller margins)**
  - **Provides policy levers for health care market**
    - Bond indemnification program for hospital closures
    - Nurse support program
    - State health information exchange
    - Population health workforce support

Impetus for Reform

- **Total health spending increase**
  - Price X Utilization
- **Waiver metric focused on average price, which would go up under reform activities**
- **Population health**
  - Hospital finance vs. prevention
- **Rural hospital viability**

New All-Payer Model Agreement with CMS Phase I: 2014-2019

- Moved from unit price to total cost per capita measure

- All-Payer limit is set for 3.58 % for the first three years with an option to update afterwards.
- Quality and performance targets to promote care improvement
  - 30-day readmissions
  - Hospital complication rates (such as infections, adverse events)
- Payment transformation away from fee-for-service for hospital services
  - Expanding global budgets to urban/suburban hospitals
  - Models to focus on total health spending and transformation

A Pilot: A Global Budget Across All Payers for Rural Hospitals

- Expanded rural hospital global budgets to 10 hospitals on July 1, 2010
  - The goal of was to incentivize hospitals to provide high quality and reduce utilization and provide financial stability for rural hospitals

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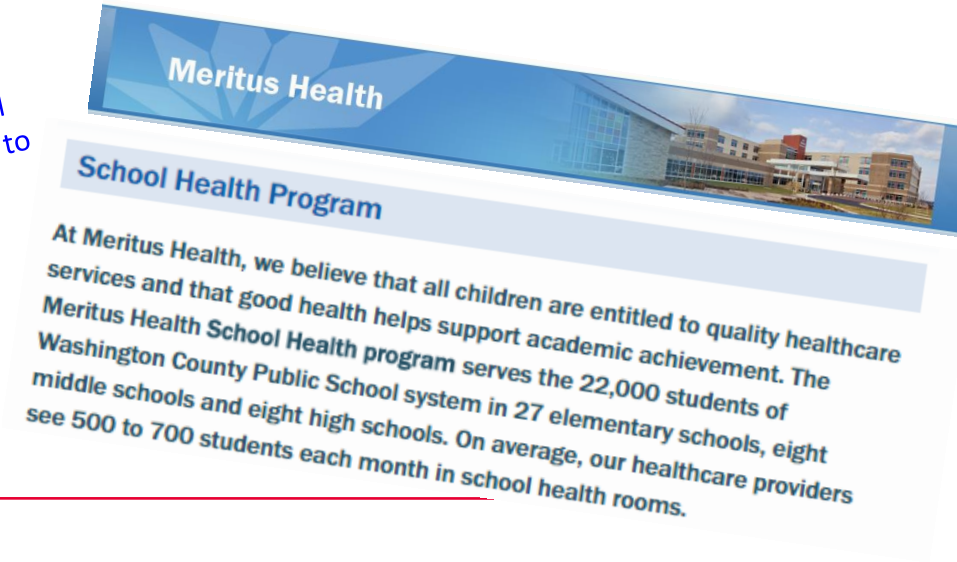
Maryland Hospital's Innovative Approach to Community Health

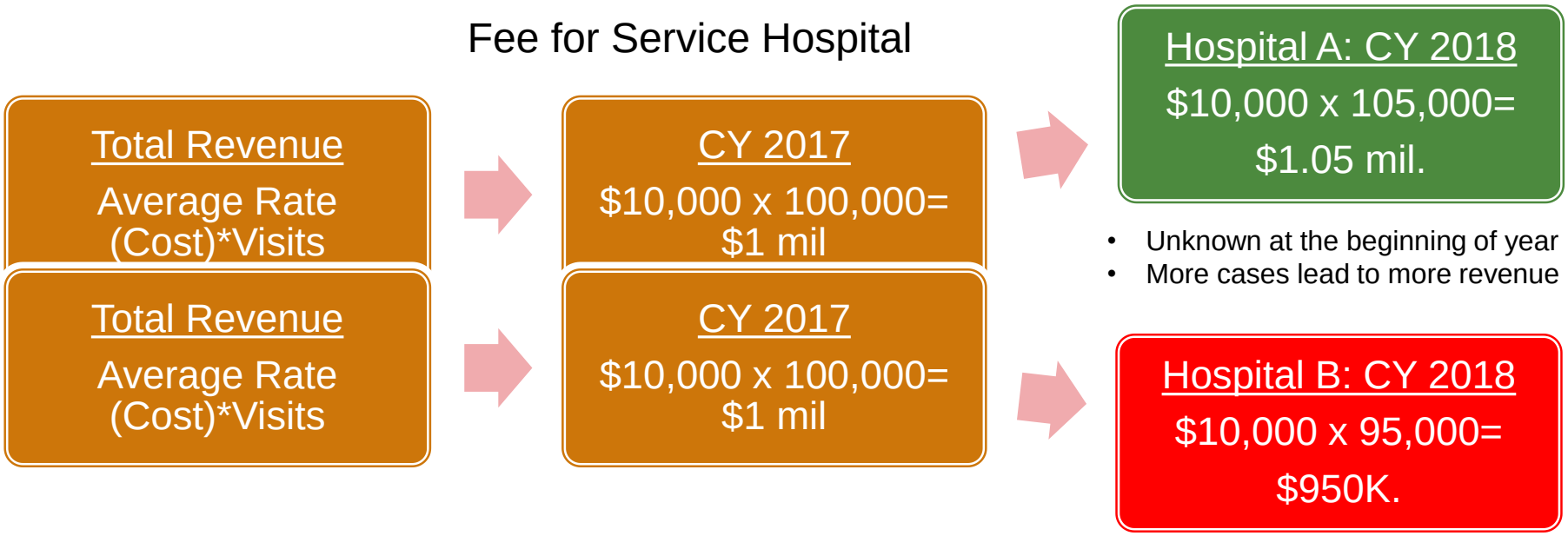
Garrett Regional Medical Center looks within its service area to hire patients as community health workers

Nurse navigators are common at many hospitals, but Garrett Regional Medical Center is taking a fresh approach by hiring patients, instead, to guide their peers through the hospital journey.



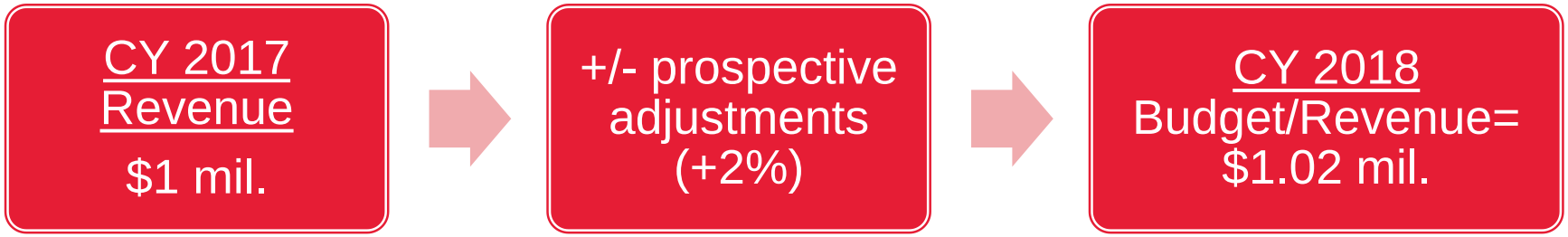
Moving Away from Volume

Fee for Service Hospital



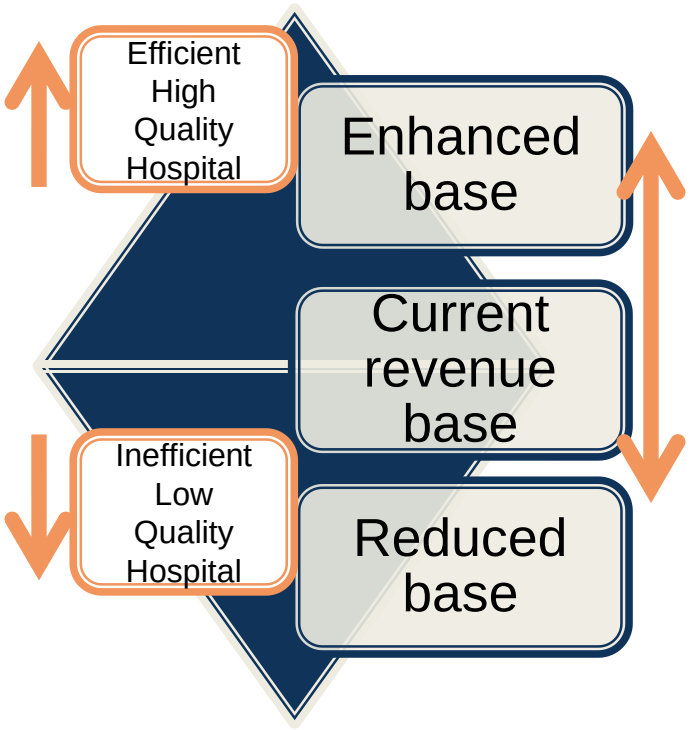
- Unknown at the beginning of year
- More cases lead to more revenue

Global Budget Hospital



- Known at the beginning of year
- More cases do not lead to more revenue

The Global Budget Model: prospective revenue budget with annual adjustments



- **Fixed revenue base for 12-month period**
  - **The initial revenue budget would be based on historical revenue**
  - **Hospitals save if they reduce hospital utilization and costs**
  - **Payers save if the budget growth is set under projected growths**
- **This budget could be enhanced or reduced based on hospital efficiency and quality**

Adjustments for Inflation and Utilization

- **Medical inflation**
  - **Market-basket Inflation Rate from a national source**
  - **Special circumstances that are beyond hospital's control**
    - New Drugs
    - Supply and drugs
- **Utilization growth**
  - **Population growth estimates**
  - **Aging**
- **Other factors**
  - **Medicaid and Exchange coverage expansions (2014)**
  - **Flu epidemic (2015)**
  - **Specialized services (transplants, specialized cancer patients)**

Policy Adjustments for New Payment System

- New policies developed for unintended consequences of budget incentives
  - Increase transfers to academic centers: Cost neutral adjustments for transfers to academic medical centers
  - Constrain access: adjustments for market shifts (annual), closure of services (contractual requirement)
  - Patient experience and quality: Up to 10 percent of revenue is at risk for performance adjustments using measures such as readmissions, complications, mortality, patient experience, population health
  - Shifting services outside of the hospital: New measures are being developed for efficiency and total cost

Approach to Moving to a More Patient-Centered System

Focus

Improving Patient-Centered Care

- Chronic Care & Care for Patients with High Needs
- Collaboration & Coordination Across Providers/Others
- Utilization of Patient Centered Measures

Reducing Avoidable Utilization

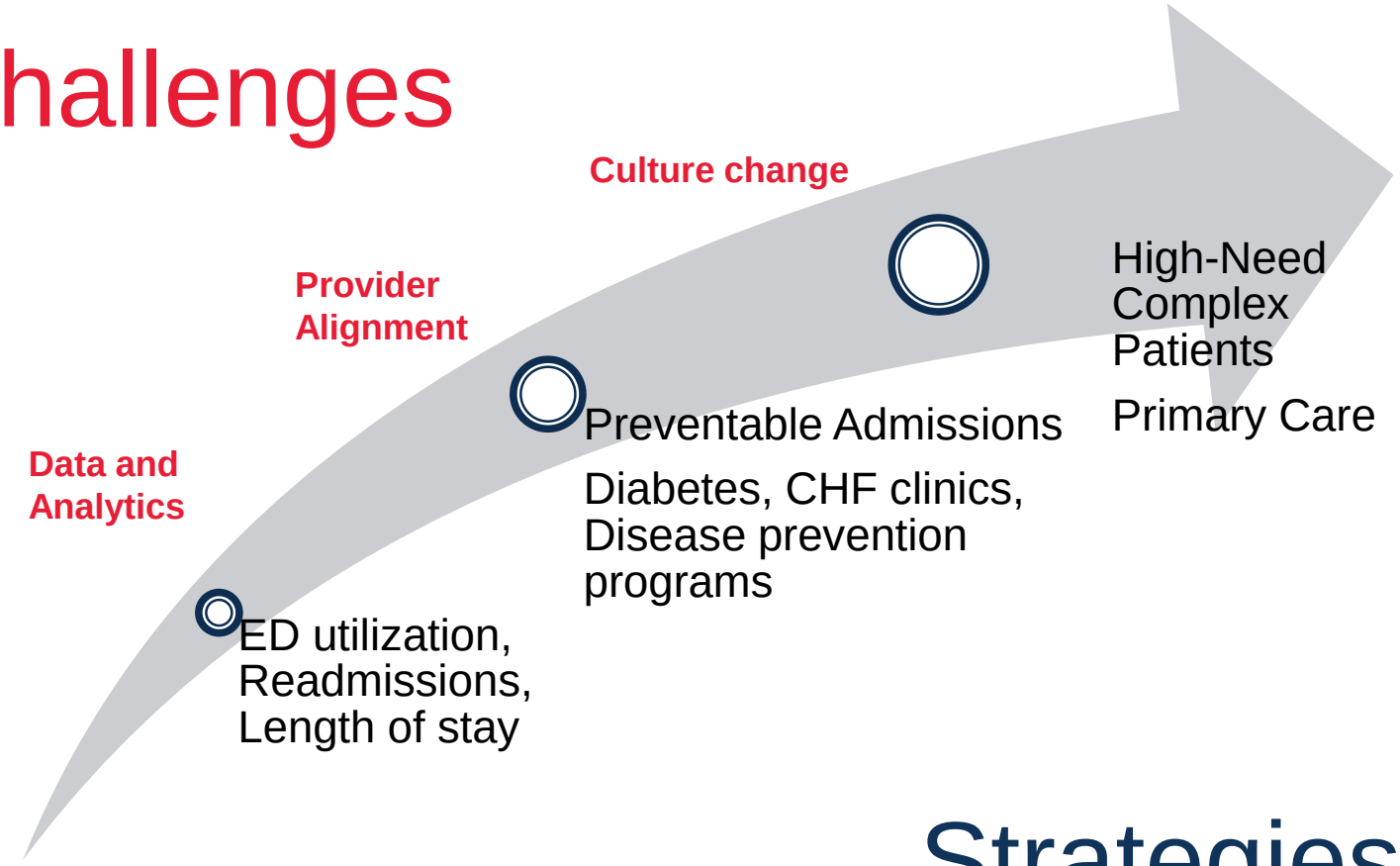
- Hospital Complications
- Population Health & Prevention Quality Indicators
- Readmissions

Ensuring Consumer Protections

- Global Budget Contracts
- Market Shift, Transfers, Transplants/Other
- Data Analytics: Detailed Monthly Reports on Volumes

Hospital Global Budget Experience

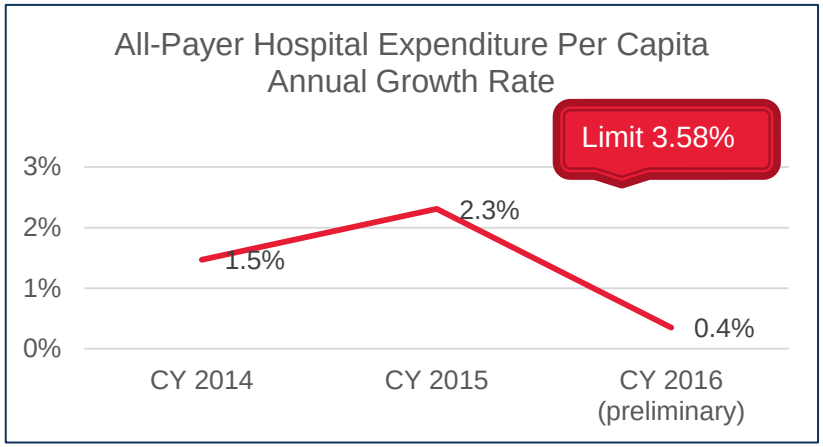
Challenges

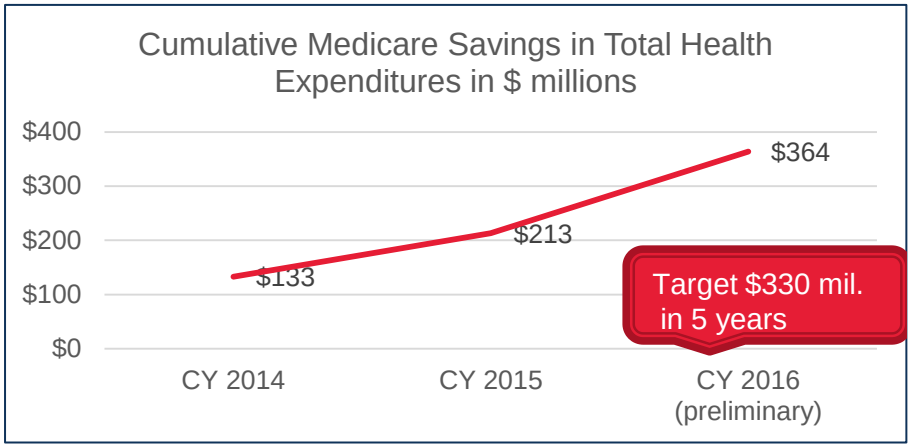


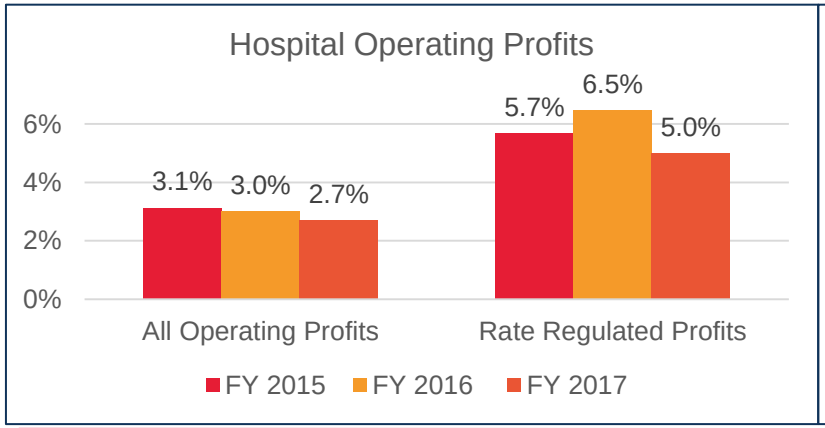
Strategies

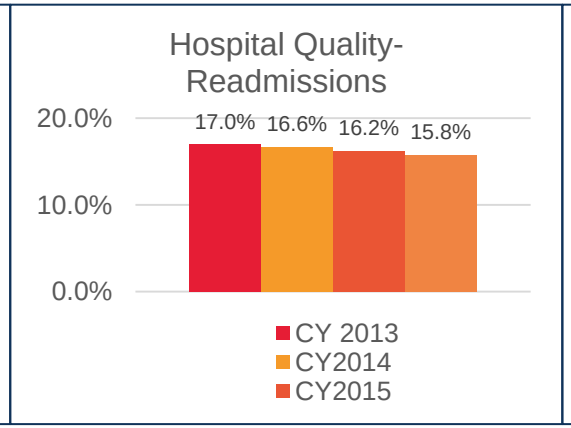
Maryland Model Results

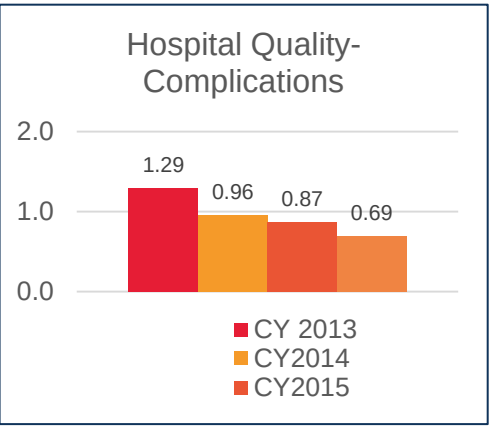
Maryland saved money for all-payers, including Medicare, while keeping healthy profit levels for hospitals and improved quality.











Sources: Maryland Health Services Cost Review Commission Monthly Monitoring Reports-November 2017
http://www.hscrc.state.md.us/documents/Quality_Documents/MHAC/RY2019/2017-03FINALRY2019MHACPolicy.pdf

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One Hospital Results- Western Maryland Hospital System

Facts About WMHS

- $330 Million in operating revenues for FY17
  - 11,556 adult admissions per year (Down from 15,521 in FY11)
  - 46,820 ED visits per year (Down from 55,183 in FY11)
  - 1,000 deliveries per year
- Over $330 million economic impact on the region annually
- $41.5 million in Community Benefit for FY2017

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ECONOMIC SCENE

Lessons in Maryland for Costs at Hospitals

Dawn Snyder, a registered nurse, runs a heart failure clinic at Western Maryland Health System.

By EDUARDO PORTER
Published: August 27, 2013

CUMBERLAND, Md. — This hardscrabble city at the base of the Appalachians makes for an unlikely hotbed of health care innovation.

Economic Scene
Eduardo Porter writes the Economic Scene column for the Wednesday Business section.
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Yet Western Maryland Health Systems, the major hospital serving this poor and isolated region, is carrying out an experiment that could leave a more profound imprint on the delivery of health care than President Obama's reforms.

Over the last three years, the hospital has taken its services outside its walls. It has opened a diabetes clinic, a wound center and a behavioral health clinic. It has hired people to follow up

Multimedia

Overall Results

	FY2011	FY2017	Change
Inpatient Admissions	15,848	11,556	⇩ 27%
Readmission Rate	15.5%	10.7%	⇩ 26%
Inpatient Behavioral Health Admissions	1,248	1,056	⇩ 15%
Readmission Rate	20.9%	12.2%	⇩ 41%
ED Visits	55,183	46,820	⇩ 15%

Source: WHMS

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Global Budget Model Progression

- **Success and sustainability dependent on:**
  - Reducing avoidable utilization and improving population health
  - Partnering with other providers, communities, and patients to integrate and coordinate care
  - Developing effective care coordination—emergency room, transitions, addressing complex patients, disease management, long-term care and post-acute integration
  - New performance metrics for efficiency and quality
- **Phase II is currently in negotiation with CMS**

Other State Examples

- **Pennsylvania Rural Health Model**
  - Begins with 6 rural hospitals on global budgets in 2016, expanding to at least 30 of 42 rural hospitals by year 3
  - Transitions from inpatient-focused delivery to greater emphasis on outpatient services and population health
  - Focuses directly on improved quality and safety
  - Leverages technology with a common approach
- **Vermont All-Payer ACO Model**
  - Alignment across payers
  - Linking hospital budget reviews with ACO model
  - Payer differential

Going Global

Sharfstein, J.M., Gerovich, S., Moriarty, E., Chin, D. Global Budgets for Safety Net Hospitals. *JAMA.* 2017;318(18):1759-1760.

For more information

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Thank you!