

January 10, 2014

Donna Kinzer, Acting Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Subject: paper on monitoring the Total Cost of Care

Dear Ms. Kinzer:

I am writing on behalf of The Johns Hopkins Health System (JHHS) and its member hospitals: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center (JHBMC), Howard County General Hospital (HCGH), and Suburban Hospital (SH) to comment on the Total Cost of Care issue. Senior management at Hopkins has participated with MHA in the development of the MHA position on Total Cost of Care. We strongly support the position MHA has taken on this issue.

The role of the academic medical center is unique in the health care system. In addition to the role of providing patient care, skilled professionals in our hospitals provide sophisticated, cutting-edge, specialized services that cannot be delivered in community hospitals. The interrelationship between patient care, the availability of newly developed technologies, the research conducted in our facilities, and the teaching mission of the academic medical system differentiate our services from the rest of the hospital system. We serve as a resource to the entire State, and the cost of fulfilling that mission must be considered as we move forward under the State's demonstration model with CMMI.

The purpose of this paper is to address issues of monitoring the total cost of care under the new demonstration model. Johns Hopkins Medicine generally agrees with the Maryland Hospital Association's paper, and this paper generally reflects the same points. We would like to emphasize the following points as the workgroups consider this issue:

- ***Hospitals should not be held responsible for changes in spending for services not under hospital control.*** For example, services for physicians not employed by hospitals are not under our control and should not affect hospital spending to correct the total spending growth for the State.
- ***At present, there is no regulatory structure to control costs outside the hospital.*** It is worth considering what policy tools on new legislation need to be developed to manage spending outside the hospital under the terms of this demonstration model.

Introduction

Under the State's new demonstration model with CMMI, hospital spending for Maryland residents will be limited to per capita growth of 3.58 percent annually with required savings for Medicare totaling \$330 million over the five year demonstration period. This agreement provides a budget for hospital system spending that the HSCRC must not exceed for the demonstration model to be successful.

From the beginning of this application process, officials from the Centers for Medicare and Medicaid Services (CMS) have consistently stated that the agency's goal in this process is to contain costs and improve quality of care, and they have viewed cost containment broadly as the total cost of care, not

simply a cost of an admission or even of hospital services alone. CMS officials publically stated early on in the process that the focus would be on total cost of care, even if subsets of care such as hospital services were the primary focus of any initial agreement. Therefore, CMS intends to monitor total healthcare spending in Maryland under the demonstration model, even if the formal demonstration is designed around hospital inpatient and outpatient spending. The goal is to be sure that the demonstration model saves Medicare money instead of shifting spending to another sector without any slowdown in cost growth.

While CMS wants to monitor Medicare spending for all services to save money, the system is an all payer regulatory system. The State and the HSCRC will have an interest in the effects of this demonstration on spending in other sectors as well to determine whether the model results in savings for all payers. Because the next iteration of this demonstration looks to address total spending, monitoring the effects in the current demonstration period will assist in developing a demonstration design and likely raise new issues that will need to be addressed.

Therefore, the State will need to measure its performance in some specific ways:

- Hospital spending per beneficiary for Maryland residents for Medicare
- Hospital per capita spending for Maryland residents for all-payers in the State
- Total healthcare spending for Medicare beneficiaries
- Total healthcare spending for all Maryland residents for all payers

The purpose of these measures is threefold:

- To monitor the flow of healthcare dollars under the new demonstration model in the short run to be sure the model is on track to accomplish its desired goal
- To provide a guarantee to CMS that total Medicare expenditures do not exceed the agreed upon conditions for the demonstration as a guard rail for Medicare program spending
- To formally evaluate the effects of the first five year demonstration

By clearly defining what needs to be measured and the level of precision required for each task, the State will be able to construct appropriate monitoring strategies.

Monitoring Medicare Spending

Because CMS is concerned about possible shifts in costs across care settings with specific requirements as a “guard rail” to avoid excessive shifting, monitoring total Medicare spending is the highest priority. It should also be the most straightforward because Medicare collects data for its beneficiaries.

Hospital expenditures per beneficiary

In the initial five year period of the waiver, CMS will evaluate the State of Maryland based on performance metrics associated exclusively with hospital expenditures. As defined above, the State of Maryland must operate with an annual growth rate in per capita hospital expenditures below 3.58% and must control hospital costs per Medicare enrollee to produce cumulative savings in hospital expenditures of \$330 million over the five year demonstration period.

The current HSCRC data are designed to measure hospital spending for particular services, but these data were developed for regulatory purposes that were considerably different. The emphasis historically has been on a charge per unit of service and later a charge per case that bundled inpatient services. The focus under the new demonstration is shifting away from the fee-for-service structure to spending per patient and to population health. The current data may be adapted to this purpose with individual identifiers

developed by CRISP, but this solution is unnecessary for Medicare beneficiaries. CMS collects complete data for Medicare beneficiaries. While Medicare data have come to the HSCRC with a considerable lag time in the past, CMS is attempting to speed up the availability of data as part of CMMI's demonstrations across the country. Agency officials have agreed to make available Medicare data with a lag of as little as three months.

For hospital services, this will allow the State to more accurately monitor its performance under the demonstration model. To monitor progress toward the \$330 million in savings, however, the baseline against which the State will be measured is not a fixed amount. The baseline measure is stated as the national growth rate in Medicare hospital expenditures, the demonstration's analog to the current waiver model's national payment per case. If final adjudicated payments are the basis of the measurement, however, a considerable time lag will continue to exist in determining the State's performance under the demonstration model. While the 3.58% per capita all-payer target was an attempt to set an objective prospective performance standard for the State, this Medicare requirement preserves the uncertainty of a retrospectively determined national standard that is only known after the performance period closed.

Note that this provision of the demonstration is different than other CMMI demonstration models where an agreed upon reduction to spending from actuarial projections is typically established. The Accountable Care Organization (ACOs) models are typically structured with minimum expected savings built in, but the target is not determined after the performance period is complete, as is the case in this demonstration model.

Timely availability of the Medicare data will improve the HSCRC's ability to achieve other demonstration goals. The HSCRC will be able to monitor hospital expenditures per beneficiary, focus attention on key populations and cost drivers and supply data and analyses that will assist hospitals with performance improvement. The possibilities include:

- Population segmentation by utilization
- Geographic variation
- Data integration
- Need for risk adjustment

Total health care expenditures per beneficiary

While hospital costs will be the exclusive metric for Maryland's initial five years of the demonstration, CMS will be examining the total costs of care for Medicare beneficiaries to monitor the impact of this new All Payer model on costs across other service categories. As hospital expenditures are slowed or reduced in Maryland, CMS will be examining the impact on physician Part B, long term care, and home health expenditures to compare total expenditures for Medicare beneficiaries from year-to-year.

It will be critical for the HSCRC to monitor these utilization patterns and to understand these trends. The HSCRC must be attuned to shifts that may reduce hospital expenditures but do not ultimately reduce the total costs of care; the HSCRC must monitor trends and draw attention to these patterns, which may not be anticipated at the inception of the demonstration model.

For the HSCRC to prepare total costs of care analyses, far more extensive data sharing efforts will be required with CMS and Maryland agencies to obtain expenditure data across the continuum of care. CMS has indicated a willingness to do so. The HSCRC and the State will need to coordinate or develop the analytical resources to use the data for monitoring and policy development, given the HSCRC's historic focus on acute care services only. The availability of timely, accurate, verifiable "Total Cost" data is the essential first step in implementing any monitoring or control over the "Total Cost" of care. Currently data sources are not available.

What Happens if We Violate the Guard Rail?

Under the term sheet provided by CMS, the agreement will require the State to keep total expenditures in check as a guard rail against shifting costs from the hospital sector to other sectors. The term sheet calls for a CMS evaluation and a possible corrective action plan if CMS determines that total Medicare spending exceeds the national trend by more than one percent. If shifting is found, CMS could terminate the demonstration model.

Because hospital spending is the largest sector of spending and limits to hospital spending growth are in place under the demonstration model, violation of the guard rail provision under the term sheet is unlikely if the State achieves its \$330 million Medicare savings target. However, the State must monitor total spending given the theoretical possibility of such an occurrence.

Monitoring All Payer Spending

Short Term Monitoring

The State has a number of resources for collecting data that will be useful in monitoring total spending. The Maryland Health Care Commission (MHCC) collects a variety of non-hospital data for non-hospital services. However, these data come with a considerable time lag. The accuracy of the reporting is unclear given that the data have not been used for rate-setting purposes. In the long run, the State agencies may coordinate better to develop an all payer data base that would pull these data together on a timely basis for monitoring and policy development. In the meantime, cooperative arrangements could be developed to achieve short term goals for the demonstration while a more complete, timely data base is developed.

Short term measures could be developed and coordinated to monitor all payer total spending. These could be developed by payer under a common methodology and submitted confidentially to the MHCC or HSCRC to be aggregated into a statewide number. Medicare would already be providing its early data to the State, and Medicaid could provide its preliminary data as well, covering the bulk of governmental payments in the State. (Procedures for dual eligibles would need to be developed to be sure that this population did not fall between the seams of reporting for the two programs.) The largest commercial payers could also provide specific reports from their data in a manner to allow results to be aggregated across all programs. While the data would not be sufficient for a detailed, formal evaluation, it would allow reasonable monitoring of all payer progress on the total cost of care. This information could provide policy insight for future adjustments to the demonstration or for its next iteration. This short term approach would still have holes – small insurers, self-pay, and the uninsured population. However, it would provide a significant start to understand the State's performance under the demonstration model.

The MHCC is revising its regulations to speed up the submission process and to reduce the current data lag. The informal submissions discussed above may be unnecessary as these regulations come online, depending on the short run needs for information on total all-payer spending.

Long Term Evaluation of the Demonstration Model

Documenting and monitoring the total costs of care for Maryland residents will require comprehensive databases for the Medicare, Medicaid, and commercial populations. This analysis would draw on the data from the CMS data warehouse of non-confidential data to include expenditures by service category, as noted above. Additionally, Medicaid and commercial payers would need to submit data with similar detail to develop a comprehensive, confidential data base that could be used for detailed analysis of the system's performance. For a full evaluation, data would need to track individuals across service category (hospital, nursing home, physician's office, etc.) and perhaps payer status. Demographic information and patient location would also be important variables to consider along with detail information on service use, expenditures, and insurance status.

Conclusion

Clearly the data requirements are substantial and patient privacy concerns would need to be addressed with great care. However, these data would provide CMS and the State a wealth of information in understanding the effects of the demonstration over the evaluation period. To do so will require unprecedented coordination and cooperation among CMS, the State, and commercial insurers.

The final issue is the cost of this endeavor. The value of this detailed data collection and evaluation is substantial, but it will be costly and resource intensive. In the final analysis, we have to determine whether the benefits to follow are worth the resources invested in the project. Hence, a detailed evaluation plan is essential to guiding efforts at data collection at the beginning of the process to proceed in the most efficient manner.

We appreciate your consideration of our input in this process. If you have questions or require further information, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ed Beranek', with a long horizontal flourish extending to the right.

Ed Beranek
Senior Director of Finance
Johns Hopkins Health System