August 22, 2019

Maryland's Experience and Progress in Implementing Value-Based Healthcare Reform

Health Services Cost Review Commission

Agenda

- Background: Maryland's unique approach
  - Overview of Maryland's all-payer hospital rate-setting system
  - All-Payer Model, 2014-2018
- TCOC Model
  - Maryland's Total Cost of Care (TCOC) Model, 2019-2028
  - Statewide Integrated Health Improvement Strategy
    - Hospital Quality & Pay for Performance
    - Care Transformation
    - Population health

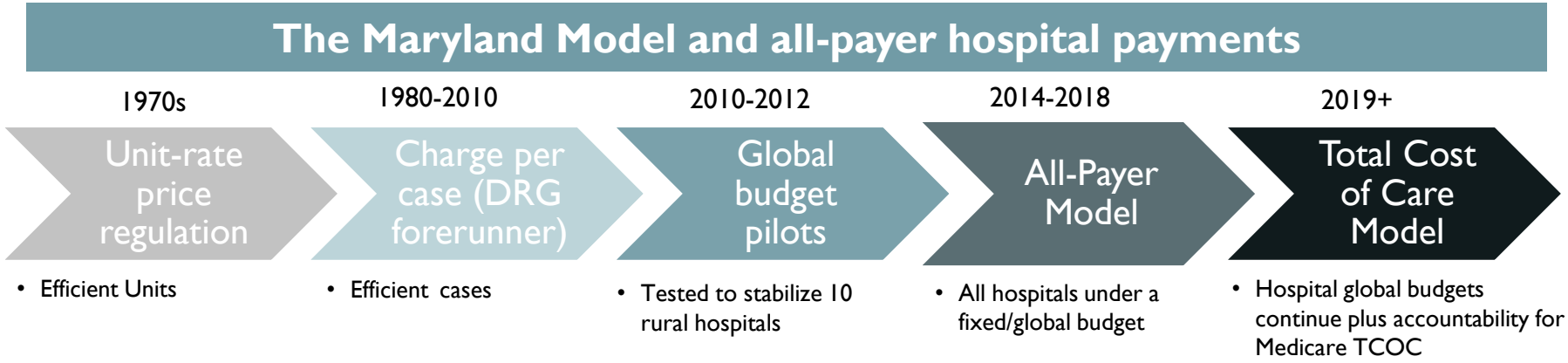
HSCRC - Who We Are

The State of Maryland Health Services Cost Review Commission (HSCRC) is the State agency responsible for regulating the quality and cost of hospital services in order to ensure all Marylanders have access to high quality healthcare services.

We lead the State's efforts to transform the delivery system and achieve population health improvement goals under the Total Cost of Care Model.

Under this model and through our previous All-Payer Model, we aim to improve health outcomes, enhance the quality of care, and ultimately reduce the total cost of care for Marylanders

Evolution of the Maryland Model



- Since 1977, Maryland has had an all-payer hospital rate-setting system
  - A given acute care hospital's charge is the same regardless of payer
  - Charges ("prices") differ across hospitals

- In 2014, Maryland moved to the All-Payer Model with CMMI, focused on controlling hospital costs through GBR

- In 2019, Maryland moved to the Total Cost of Care (TCOC) Model, focusing on (Medicare) TCOC through system-wide alignment

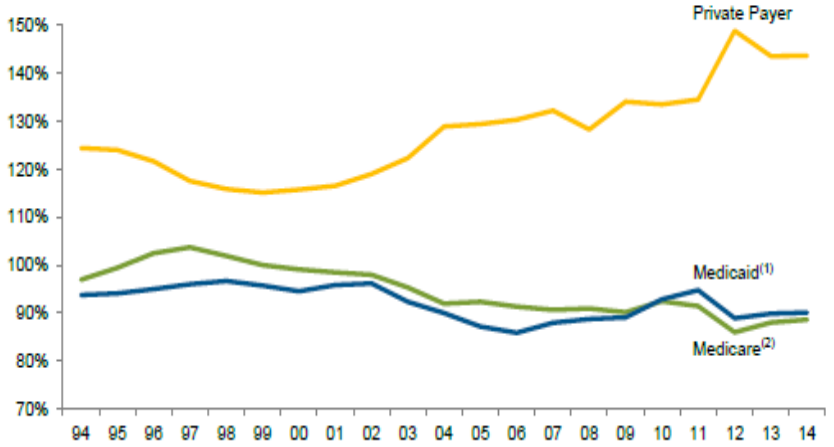
Value of Maryland's All-Payer Hospital Rate Setting System

Maryland's approach:

- Avoids cost shifting across payers
- Cost containment for the public
- Equitable funding of uncompensated care
- Stable and predictable system for hospitals
- All payers fund Graduate Medical Education
- Transparency
- Leader in linking quality and payment

While the rest of the nation sees:

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



Source: American Hospital Association
(1) and (2). Includes Disproportionate Share Hospital (DSH) payments.

Maryland's Unique Healthcare Delivery System: All-Payer Model (2014-2018)

All-Payer Model: Expansion of Hospital Global Budgets

- From 2014, all general, acute care hospitals in Maryland went under Global Budget Revenues (GBRs) set by the HSCRC
  - Fixed revenue base for 12-month period, with annual adjustments
  - Adjustments for variables including population growth, readmissions, hospital-acquired conditions, etc.
  - Reimbursement still administered on fee-for-service basis, but only for attaining GBR
  - Hospitals have flexibility to dial charges up or down (within constraints) so that, by year end, they have attained their GBR
    - Penalties for being too high or too low
- Sometimes use term: Population-Based Revenue (PBR) instead of GBR

Move from Volume to Value Transforms Hospital Incentives

- No longer chasing volumes on pressured prices
- Incentivized
  - Reduced readmissions
  - Reduced hospital-acquired conditions
  - Reduced ambulatory-sensitive conditions, or Prevention Quality Indicators (PQIs)
  - Better managed internal costs
- Results
  - Improved health care quality, lower costs, better consumer experience

But more to be done …

All-Payer Model Performance 2014-2018: Met or Exceeded CMS Contract Requirements

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ $330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

*** $273 million in Medicare TCOC savings in 2018 alone – aka Medicare savings run rate** (vs. 2013 base)

Maryland Total Cost of Care Model (2019-2028)

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 2/5/18

By: _____

Adam Boehler, Director, Center for Medicare and Medicaid Innovati

GOVERNOR OF MARYLAND

Date: 12/9/18

By: _____

Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: _____

Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

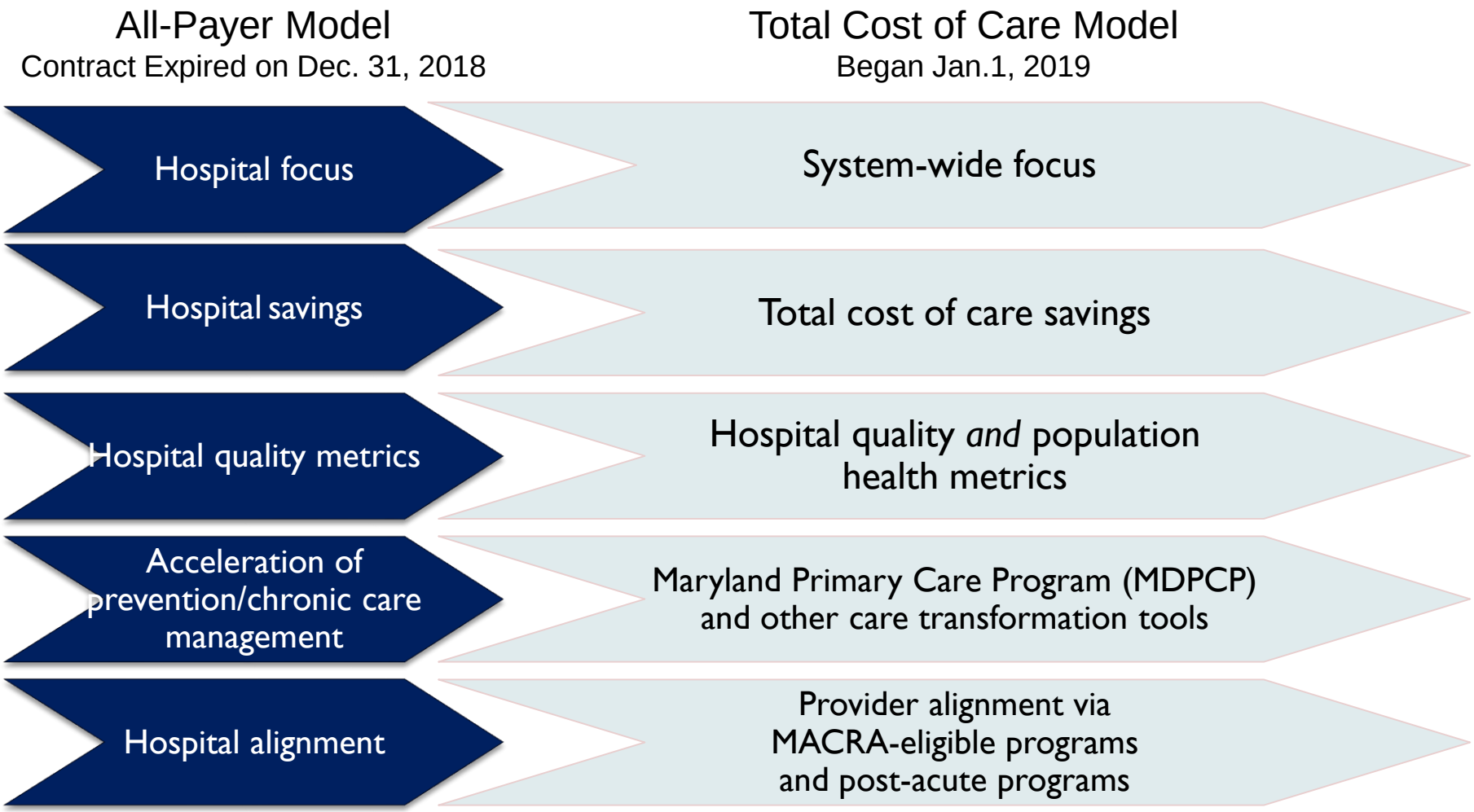
By: _____

Nelson Sabatini, Chairman

TCOC Model Agreement

Signed on July 9, 2018

Changes from All-Payer Model to Total Cost of Care Model

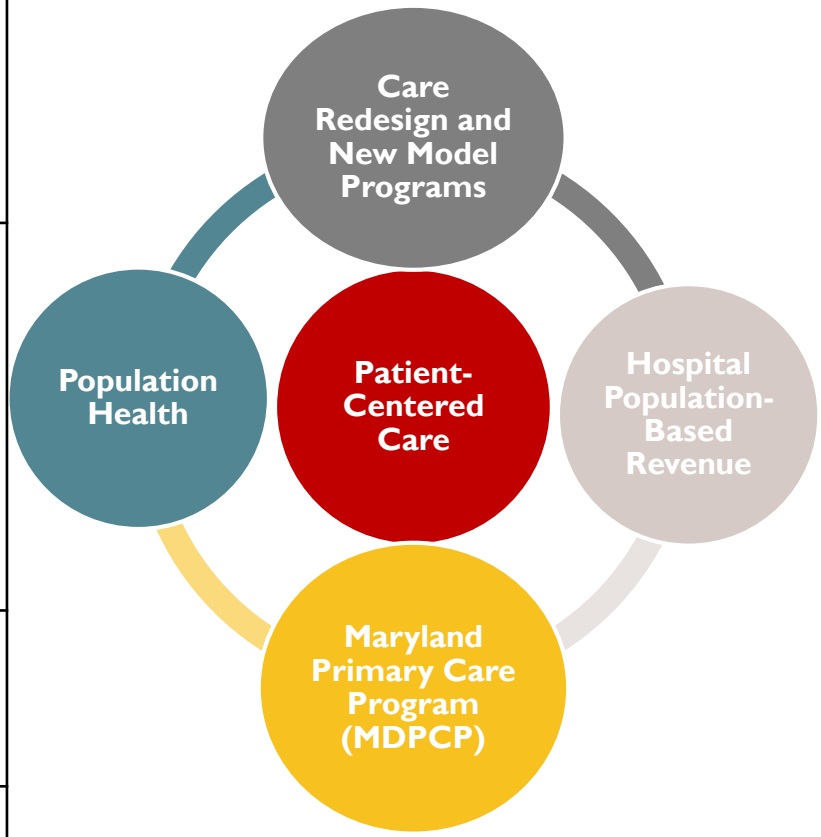


Total Cost of Care (TCOC) Model Overview

- New contract is a 10-year agreement (2019-2028) between MD and CMS
  - 5 years (2019-2023) to build up to required Medicare savings and 5 years (2024-2028) to maintain Medicare savings and quality improvements
- Designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes and constrain the growth of costs
- Total Cost of Care (TCOC) Medicare savings building to $300 million annually by 2023 (from 2013 base)
  - Includes Medicare Part A and Part B fee-for-service expenditures, as well as non-claims based payments
  - In 2017, Maryland was at ~$135M – not quite halfway to $300M
  - By end of 2018, we are at $273M
- Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually

Total Cost of Care Model Components

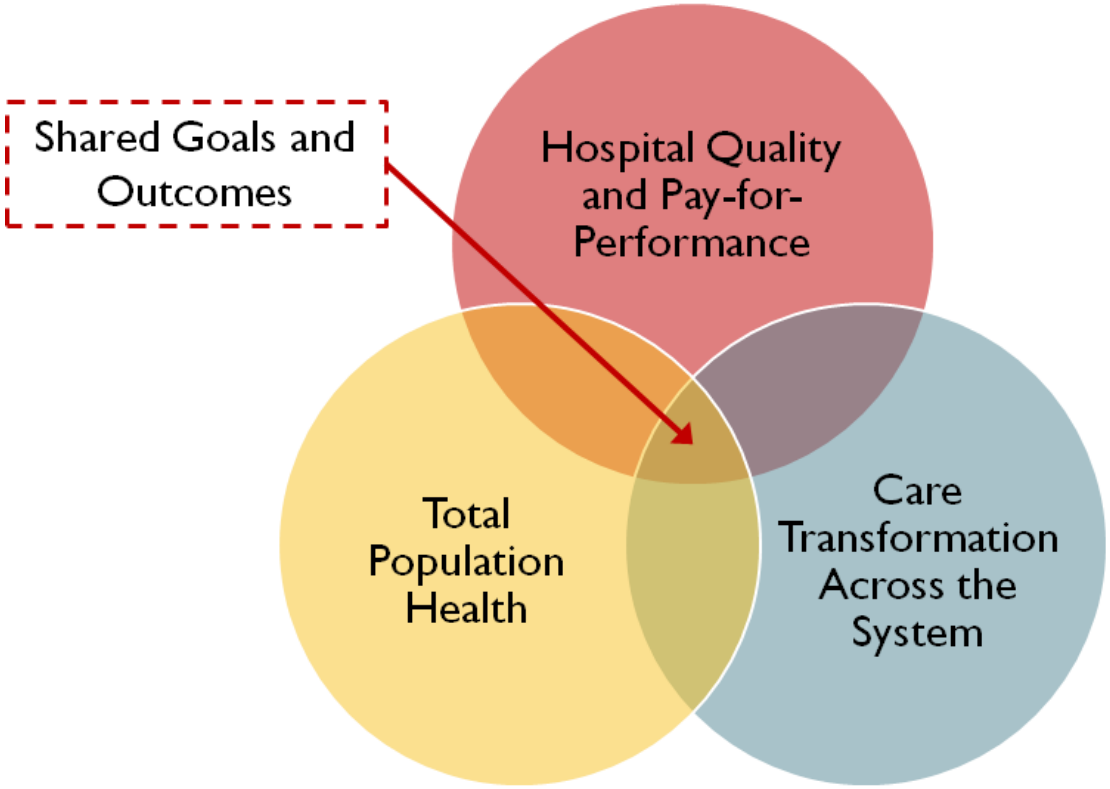
Component	Purpose	Status
Hospital Population-Based Revenue	Expand hospital incentives and responsibility to control total costs through limited revenue-at-risk (±1% of hospital Medicare payments) under the **Medicare Performance Adjustment (MPA)**	Expands
Care Redesign and "New Model" Programs	Enable private-sector led programs supported by State flexibility, "MACRA-tize" the model and expand incentives for hospitals to work with others, and opportunity for development of "New Model Programs"	Expands
Maryland Primary Care Program	Enhance chronic care and health management for Medicare enrollees	New
Population Health	Programs and credit for improvement in diabetes, addiction, and other priorities	New



Improving Population Health: Maryland's Integrated Health Improvement Strategy

- Total Cost of Care Model requires a focus on population health improvement for all Marylanders
- Maryland's Integrated Health Improvement Strategy is intended to align community health, provider systems, and other facets of the State's health ecosystem to improve population health and achieve success under the Total Cost of Care Model
- The Total Cost of Care Model encourages meaningful investments to improve the health of Marylanders to create a sustainable healthcare system.

Improving Population Health: Maryland's Integrated Health Improvement Strategy



HSCRC Regulatory Authority - Monitoring Hospital Global Budgets

- TCOC Model has broad focus across settings of care

- HSCRC has specific regulatory authority over hospital global budgets
  - Under this regulatory authority, collects extensive data on **financial statements and expenditures**
  - Under this regulatory authority, collects extensive **case-mix data**, which provide insight into patient experience and quality of care

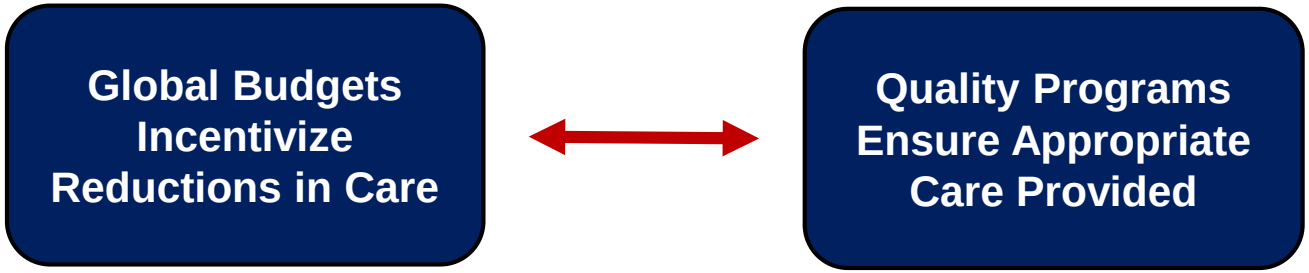
Global budgets: Impact on Quality

- Quality improvement activities can align well with a GBR system that allows hospitals to retain savings from reduced complications, avoidable utilization, etc.

- For example, let's say a hospital works with a community to help reduce pediatric asthma attacks
  - In other parts of the country, the hospital receives fewer ED visits, so the hospital generates less revenue
  - In Maryland, the hospital is under GBR so the hospital retains the revenue and saves money by reducing unnecessary utilization

Importance of Quality Measures under Global Budgets

- Financial Incentives to Reduce Unnecessary Care
- Concurrent Financial Incentives to Maintain (and Improve) Quality of Care
  - This is IMPERATIVE! Reducing Unnecessary Care should not reduce Necessary Care
  - HSCRC Monitors Quality of Care to ensure incentives of TCOC Model are properly applied



HSCRC Quality within HSCRC

- HSCRC Quality Team and Hospital Quality of Care –
  - **Monitors and Reports** various measures of hospital quality of care
  - **Incentivizes improvement** in hospital quality of care via:
    - Pay-for-Performance Programs with variety of financial incentives
    - Public reporting
    - Statewide focus on hospital-based quality improvement projects

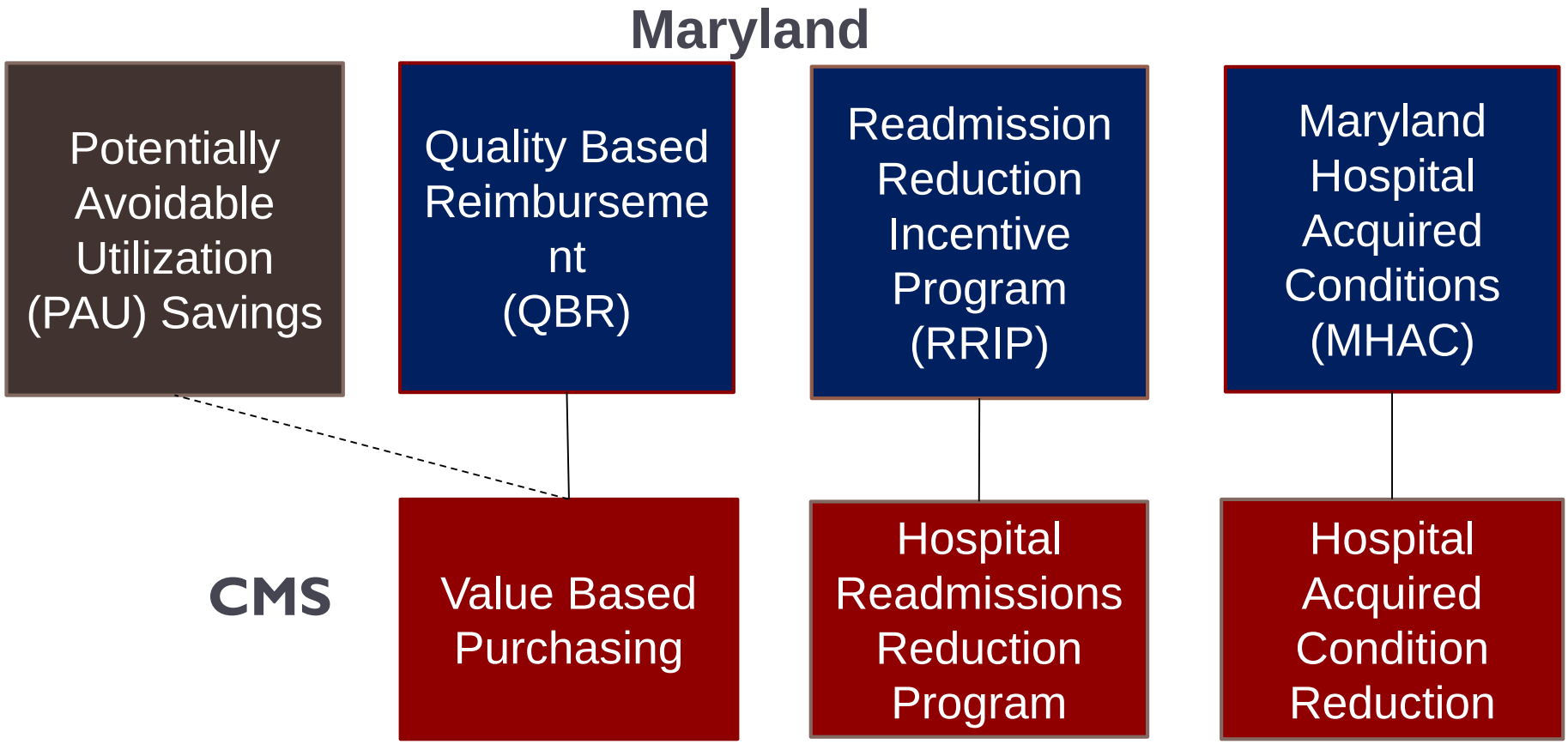
What are the Pay-for-Performance Programs?

- Pay-for-performance programs are payment arrangements where hospitals are rewarded or penalized based on meeting pre-established targets for measures of quality.

- The idea is that financial incentives are used to change provider behavior to achieve a set of specified objectives.

- P4P measures: clinical process and intermediate outcomes, patient safety measures, utilization, patient experience, outcomes, structural elements

HSCRC Administers P4P Programs similar to CMS Programs



Quality Measures that are Maternal/Pediatric Related

- Current Quality programs are all-payer in nature, with some specific maternal/child metrics of quality of care
- All-Payer Readmission Rate* [RRIP]
- All-Payer Potentially Preventable Complications (PPCs) Rate [MHAC]
  - Specific Maternal PPCs in RY 2021 MHAC Policy:
    - PPC 60 - Major Puerperal Infection and Other Major Obstetric Complications
    - PPC 61 - Other Complications of Obstetric/Surgical and Perineal Wounds
  - Maternal PPC reported in Monitoring:
    - PPC 59 - Medical and Anasthesia Obstetric Complications
  - Past OB related Complications (Discontinued for Clinical Validity Concerns)
    - PPC 55 - Obstetrical Hemorrhage without Transfusion
    - PPC 56 - Obstetrical Hemorrhage with Transfusion
    - PPC 57 - Obstetric Lacerations and Other Trauma without Instrumentation
    - PPC 58 - Obstetric Lacerations and Other Trauma with Instrumentation
- All-Payer HCAHPS Patient Experience Measures [QBR]

*Excludes newborns, but includes mothers

Quality Measures that are Maternal/Pediatric Related (Continued)

- All-Payer Prevention Quality Indicators (PQIs) [PAU]
  - Admissions for ambulatory-care sensitive conditions that may be preventable with effective primary care and population health
  - Added specific Pediatric quality indicators for 2019:
    - Admissions for Urinary Tract Infections
    - Admissions for Diabetes Short-term complications
    - Admissions for Gastroenteritis
    - Admissions for Asthma
  - Intended to include measure of low birthweight newborns, but AHRQ retired indicator in 2019

Future Initiatives

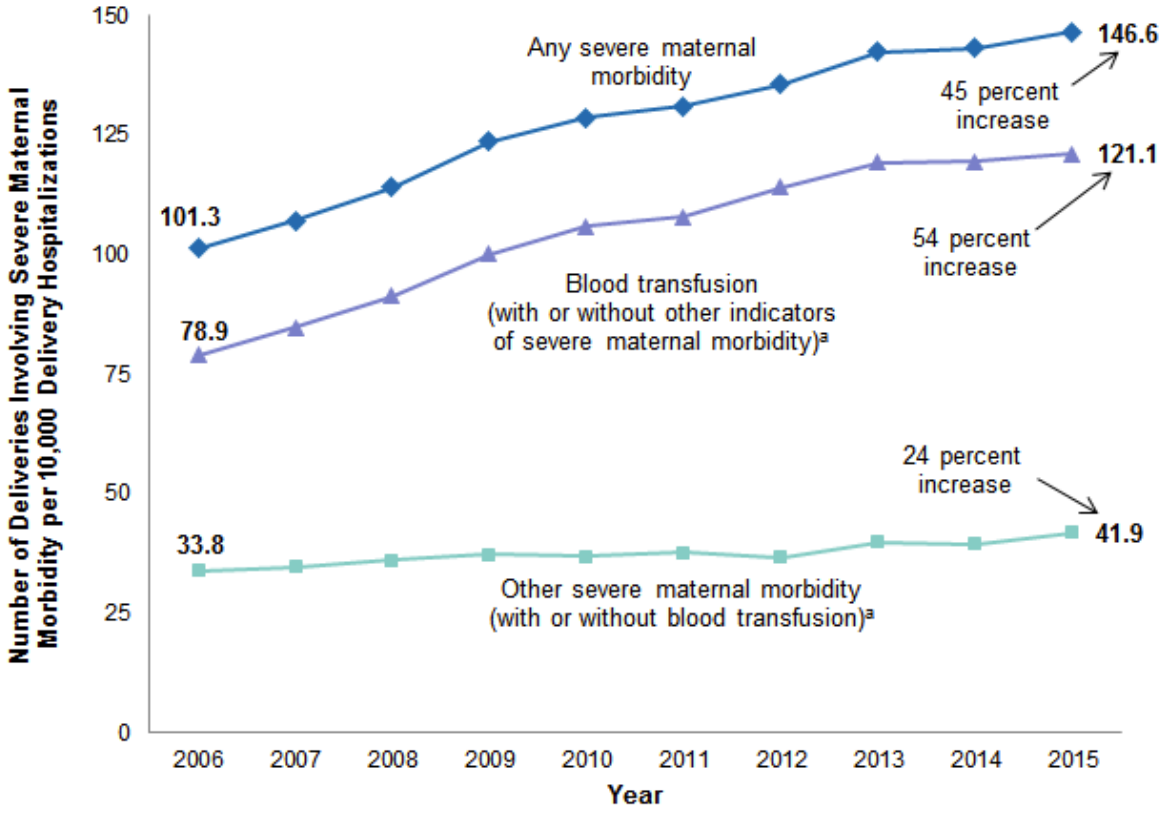
Opportunities to Expand Maternal-Child Focus under TCOC Model

- Committed to population health improvement goals under TCOC Model. For example:
  - Maternal health improvement
  - Diabetes Focus
  - Opioid Use Disorder Focus
- Committed to exploring maternal-child focus within HSCRC's existing quality programs
  - New Maternal Health Measures?
  - Developing further Pediatric Focus?

Future Maternal Health:
National Severe Maternal Morbidity [CDC]

HCUP Graph on National Severe Maternal Morbidity Trends

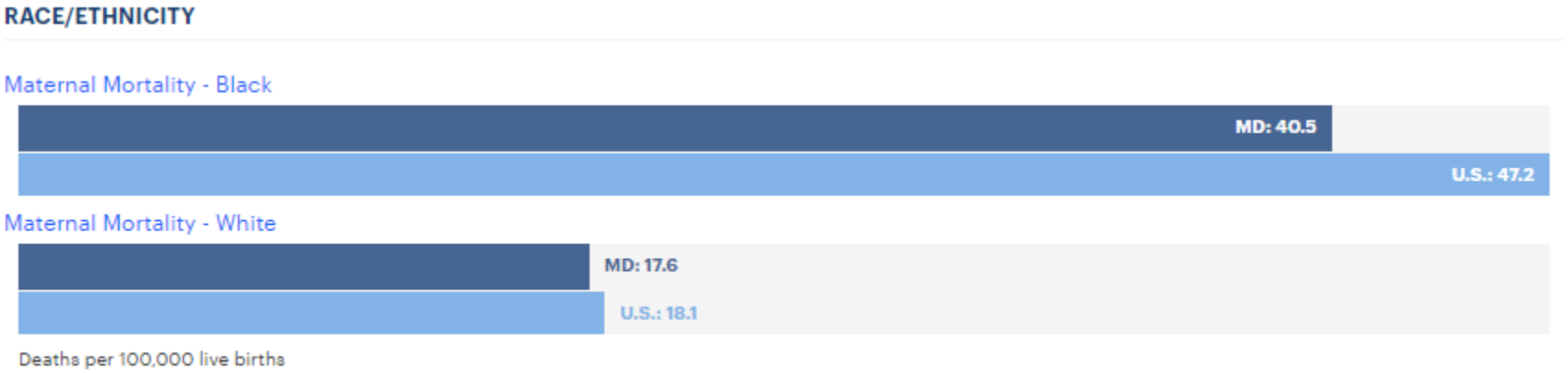
Figure 1. Trends in delivery hospitalizations involving severe maternal morbidity, 2006-2015



Future Maternal Health: HSCRC IP Data - An Opportunity to Monitor Maternal Health?

Proposal -

- Generate a monitoring report of labor and delivery measures to report divergence in process and outcome measures for pregnant women in Maryland
  - Rely on open-source, publicly available measures
  - Present static report on CRS Portal in coming seasons
    - Example measures: Maternal morbidity (transfusion, hysterectomy), c-section rates, disparities



- CDC WONDER Online Database, Mortality files, 2011-2015

Thank you!

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