Maryland's All-Payer and Medicare Waiver Requirements and the Potential Implication for Vermont
House Ways and Means Committee

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Update on Maryland's All-Payer "per capita" Demonstration

- Background on Maryland's Payment System & the existing Medicare waiver and waiver test
- Factors leading to Maryland seeking a new waiver
  - Driven by a need to focus on constraining unnecessary and marginal hospital service volumes as the way to achieve accountability for cost in the system
- CMMI Authority and Negotiations with Maryland
- Key Features of the Demonstration

Update on Maryland's All-Payer "per capita" Demonstration

- Required Expenditure Limitations
- Other Programs Complimenting the Demonstration
- Changes in Financial Incentives Facing Hospitals
- CMMI Receptivity to Granting Similar All-Payer waivers to other States
- Why This May be Relevant to Vermont

Background on the Maryland All-Payer System

- Maryland is the last remaining "All-Payer" hospital rate system (Rate Setting Authority pertains to facility-based charges for inpatient and outpatient care -- not physicians)
- Original waiver limited increases in Medicare (and all payer) payments **per inpatient case** to the national rate of increase since 1981
- "All-Payer" hospital system administered by the Health Services Cost Review Commission (HSCRC) since 1977 (**Last Remaining All Payer System**)
- In Maryland the HSCRC regulates the "markup" of charges over cost resulting in a tight link between charges and Net Patient Services Revenue (NPSR) and less variation in hospital payments (**payment equity**)
- Mechanism to pay for "reasonable" levels of Free Care and Bad Debt is built into the rates paid by All-Payers

Factors Leading to the New Waiver Proposal

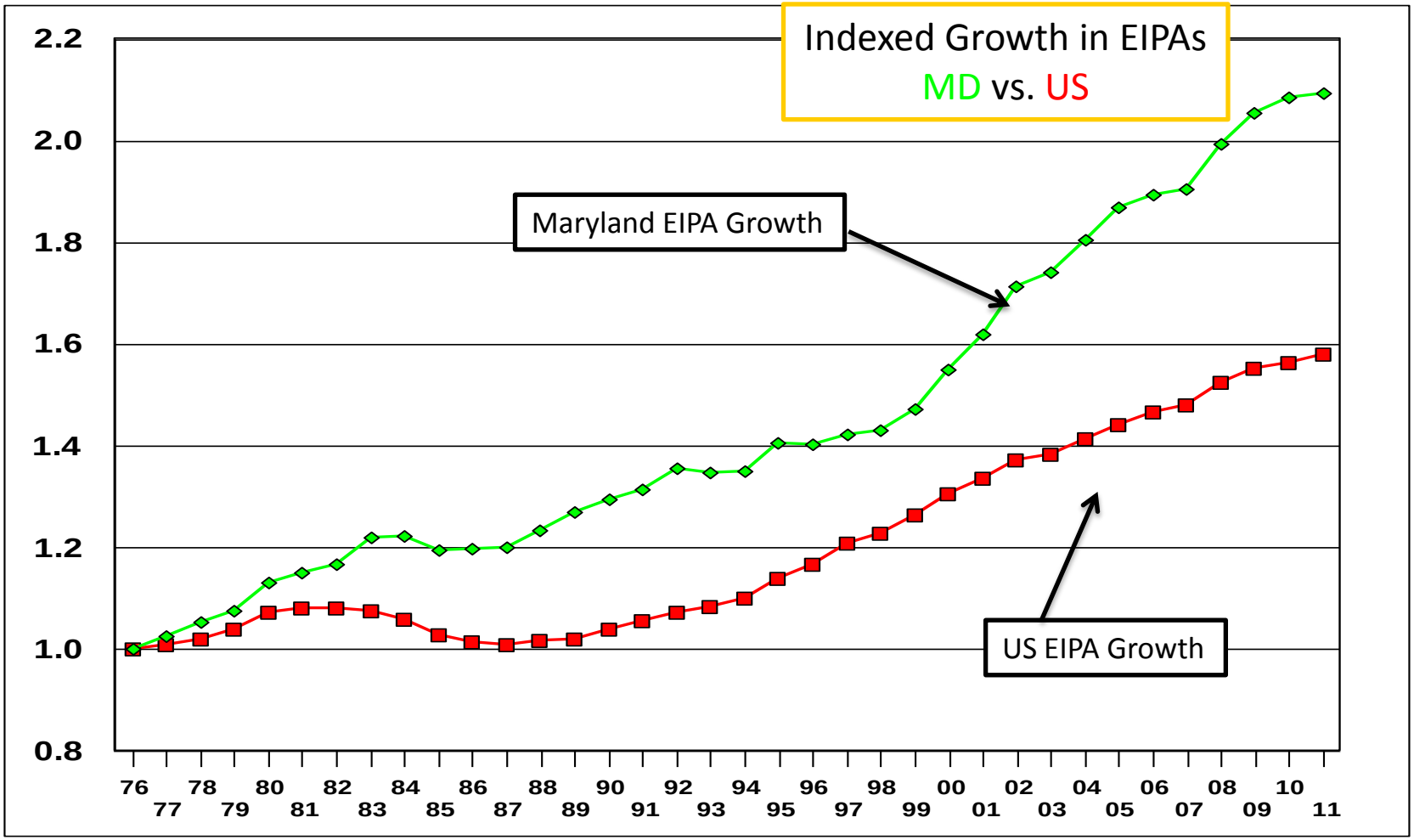
- Maryland system limited the growth in cost per case, but not cost per capita
- The State had a "Volume Adjustment System" (VAS) that limited incentives to increase volumes --- the VAS was scaled back and eventually removed in 2001
- Hospitals responded to tight cost per case growth limits and elimination of the VAS by greatly increasing case volumes and other service use
- So while Maryland did well on limiting cost per case growth, rapid growth in services provided undermined overall "affordability"

		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

(1) Compiled from "Maryland's Model Design" as submitted by the Maryland to CMS on March 26, 2013. (1)

Indexed Rates of Growth in Hospital Inpatient and Outpatient Volumes (as measured by EIPAs): 1976-2011



From the American Hospital Association Annual Statistical Guide 1976-2011

Implication of FFS Incentives & Need for Global Limits

- The features of standard FFS-based payment methods ensure that a hospital's profitability will increase with increases in volumes

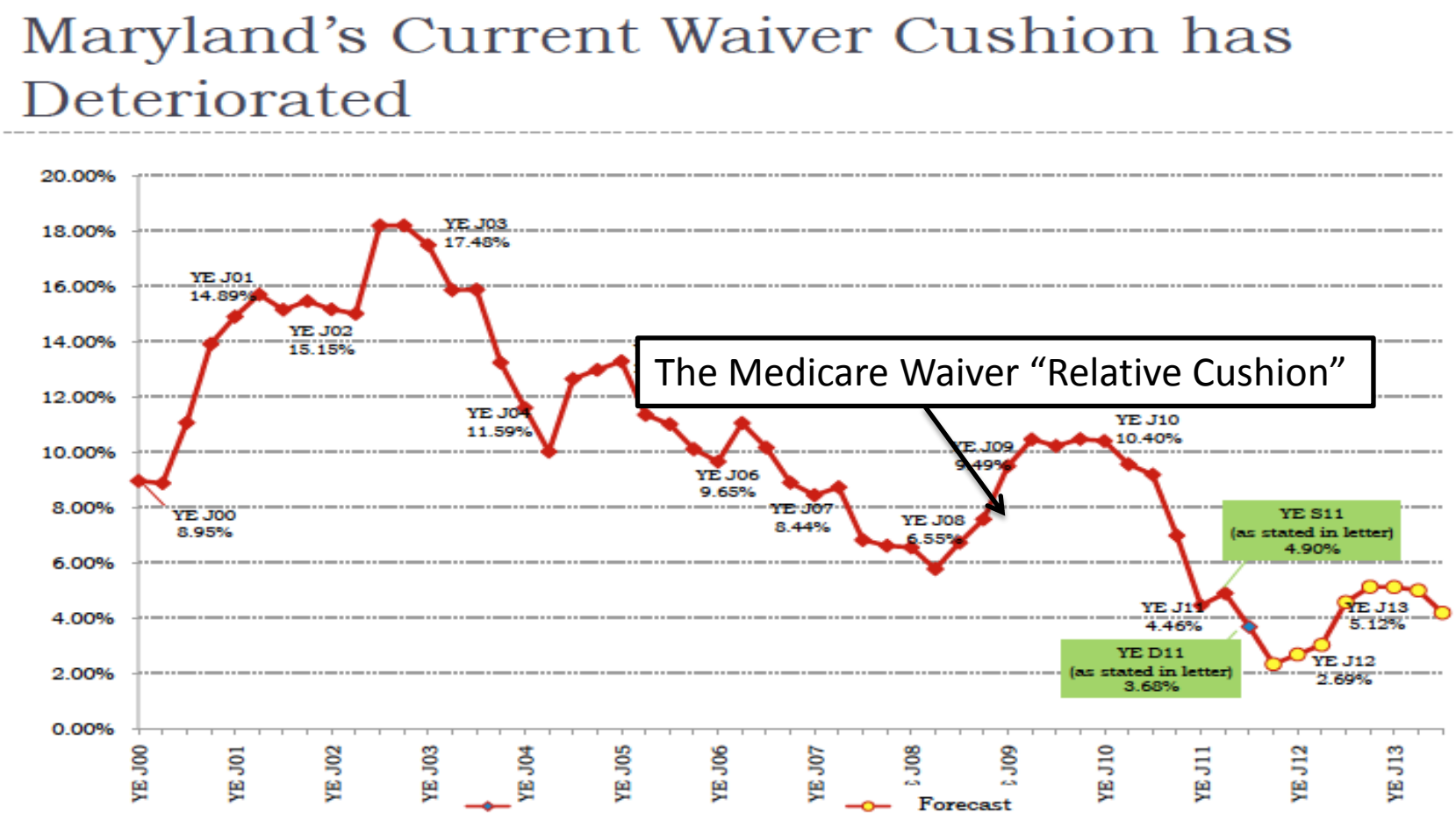
  MR > MC for incremental volumes and difference = increased cash flow under FFS

- The "**flip side**" of volume inducing FFS payment is the financial discouragement associated with volume decreases (loss of 100 cents on the dollar, fail to cover fixed costs and see reduce profits)

- Volume growth in Maryland and nationally has greatly contributed to health care cost growth

- Starting in 2008 HSCRC sought to address the "volume problem" and prepare Maryland for a possible renegotiation of its Medicare waiver
  - Step 1: Negotiation of 10 Pilot Global Budget Rate Arrangements (the so-called Total Patient Revenue or "TPR" pilots)
  - Step 2: Reintroduction of a Volume Adjustment System
  - Step 3: Negotiation of Admission-All Readmission episodes for 31 hospitals
  - Preliminary discussions with CMS/CMMI re: a possible Per Capita Waiver

Policy Changes Contributed to Erosion in Maryland's Per case Waiver Test



Negotiating Process with the CMMI/CMS

- Maryland began to more actively discuss a new waiver all through 2012 – these talks helped the State formulate an actual Draft Application which was submitted September 26, 2012
- CMS/CMMI responded and raised key issues:
  - What savings should be generated for Medicare?
  - What is the nature of the Demonstration (Targets and "monitoring" only? Or prescribed payment methodologies?)
- CMS/CMMI approved a General Waiver – but with a number of specific requirements regarding payment structures and other policies
- Consistent with the purpose of "Demonstrations" – to test an idea

Background on & Terms of Maryland's Renegotiated Waiver

- New Waiver Negotiated with CMMI and approved by OMB - effective Jan 1, 2014

- **Phase I** -- Waives current statute authorizing Maryland to operate an All-Payer system with a per case growth waiver test and imposes both **All-Payer** and a **Medicare-specific** per capita growth limitations (over a 5-year period)

- All-payer per capita growth limit is linked to Maryland's 10 year average annual growth in Gross State Product (GSP) = 3.58% per resident

- The Medicare per capita limit is per a schedule devised to save Medicare at least $330 million over the 5-year Demo with growth limitations at Medicare actual growth rates per capita less 0.5% (years 2-5)

  US Medicare Growth Projections
  1.9% in 2014 and 1.6% in 2015

- **Phase II --** After Year 5 would bring all Medicare health services (not just hospitals) under a cap – Maryland must propose a plan to do this by year 4

Additional Requirements by CMMI

- HSCRC must expand system revenue covered by "**Global Budgets**"
  - Global Models can be either "population-based" (i.e., explicitly tied to a defined population) or budgets not explicitly tied to a defined population:
    - TPR Arrangements (suitable for rural hospitals with discrete patient populations) – TPR hospitals account for 10% of system revenue
    - Global Budgets for other hospitals with prescribed population-based payment provisions (i.e., annual updates and demographic volume allowances)
  - Goal of shifting at least 80% of all hospital revenue to Global Budget Payment Models by 2018

	Year 1	Year 2	Year 3	Year 4	Year 5
% Revenue Under Global Models	NA	50.0%	60.0%	70.0%	80.0%

- Hospitals can opt to stay on a modified version of the current "Charge Per Case" (CPC) payment methodology
  - Modified CPC includes a rigorous Volume Adjustment and "Volume Governor" to meet volume targets

This system is inherently less predictable and thus less attractive to the Hospitals

How the HSCRC is Administering the System

- The HSCRC is establishing hospital-specific Global Budgets within the overall expenditure cap
- The hospital budgets will reflect the following adjustments:
  - Hospital cost inflation
  - Changes in population demographics in the service areas of the hospitals
  - Special adjustments (e.g., infrastructure) and Productivity Offsets
- Hospital expenditures will be tracked on a monthly basis by hospital for Medicare and other payers
- The HSCRC has the authority to compel rate decreases as needed to ensure compliance with the budgets

Quality Terms of the Demonstration

Measures		Requirements Over the Term of the Demonstration
Readmissions		The rate of all-cause readmissions in Maryland hospitals must be cut to or below the national average by year 5
Hospital Acquired Conditions (HACs)		Maryland must reduce its rate of 65 HACs by 30%.
Evidence-Based Process measures & Patient Satisfaction		All quality-based Pay-for-Performance Initiatives must cover at least the same proportion of revenue as current Medicare initiatives and meet or exceed US Performance

CMS will closely monitor indicators of access, quality, etc. and has the right to intervene to require changes or to terminate the Demonstration if it perceives quality problems are occurring under the Demonstration.

Programs in Maryland Which Are Complementary to the Demonstration

- CareFirst Blue Cross/Blue Shield of Maryland has established a PCMH program that includes most PCPs and all products:
  - The PCPs are self-organized into Medical Panels (MPs) with 5-12 PCPs.
  - The MPs have strong financial incentives to manage costs, coordinate care and improve quality
  - They are assisted by online information, RNs/NPs and other support services. High cost members are identified and managed with care plans
  - The PCMH program has cut overall PMPM cost increases to approximately 1-2% per year
- CMS has approved an Innovation Grant that has enrolled approximately 30,000 Medicare beneficiaries in the CareFirst PCMH program
- The Maryland Demonstration now aligns the incentives of hospitals with the incentives faced by physicians under the PMCH program and other organizations under at-risk or Shared Savings Programs

Policy Implications of Maryland's Demo

- The Demo also is highly positive from an overall affordability basis – linking the growth of hospital costs to Gross State Product

- New Maryland Payment Methods (Global Budgets/Charge Per Case with a Volume Adjustment) promote Population-based Health Activities
  - Hospitals under Global Budgets now have strong financial incentives to participate in population-based health strategies that physicians under SSP arrangements are incentivized to pursue
  - In Maryland, hospitals are largely under fixed budgets or under the modified CPC with Volume Adjustments, if they lose volumes their fixed costs are covered
  - It is now in the hospitals' financial interest to support/promote better Clinical Management Activities encouraged by population based health

Policy Implications (continued)

- Fixed Global Budgets (as constructed in Maryland) are thus supportive of Population-based medicine with stable/predictable funding
  - Hospitals have increased flexibility under their approved (and guaranteed) budgets to engage in activities that best meet the unique health care needs of their populations
  - Global budgets are also inherently more predictable and provide a stable financial platform for hospitals
- Maryland's Demonstration can provide a road map for other states to apply for Similar All-payer Waiver authority

Changes in Hospital Financial Incentives & Projected Behavioral Responses Under the Demonstration

- Previously, increased admissions, procedures and tests raised hospital revenues and profits
- Under the Demonstration, volume growth will be capped at population growth: increases beyond this level will not be funded and will reduce profits
- Hospitals will be motivated to:
  - Revise "productivity-based" physician incentive agreements;
  - Adjust medical staff size and composition to meet population-based health care needs; and
  - Work with physician groups, community agencies and others to improve overall health status.
- If successful, the Demonstration may provide CMS with useful techniques and insights for national Medicare policies

Why Should Vermont Consider Global Budgets

1) Vermont's Health System configuration **lends itself to the development of regional and population-based payment arrangements** for Hospitals and their affiliated providers

2) Vermont already has **a Hospital Budget review tool** that is a key mechanism for data reporting and could be adapted to administer Enforceable Global Hospital Budgets

3) Vermont is relatively high cost on an all-payer basis, but not high cost for Medicare on a per Capita basis (less need for additional Medicare savings)

4) Several **hospitals in Vermont have expressed an interest** in adopting Global Budgets ,and there is a potential **synergy** between some hospitals and entities – such as FQHCs, with incentives to generate improved overall **Value**

5) Vermont has a high percentage of physicians employed by Hospitals – allowing for a larger proportion of health expenditures to be subject to per capita growth limits

Why Should Vermont Consider Global Budgets (Cont')

6) CMS has already indicated its desire for Population-Based payment alternatives and has expressed interest in replicating all-payer demos in other States

7) The idea of a Global Budget based system for hospitals and physicians is directly related to Vermont's stated objective of controlling health expenditure growth under a **"Unified Health Budget" tied to** growth benchmarks such as GSP

8) The State would potentially be advantaged by Maryland's recent Waiver approval – if Vermont followed the same basic principles and structures (and enhanced the model by **addressing several key weaknesses**)

9) Understanding the Maryland Waiver Model should be one of our high priorities

Questions ??