Maryland's Proposal to Modernize All-Payer Rate Setting: Enhancing Patient Experience, Controlling Costs, and Improving Health

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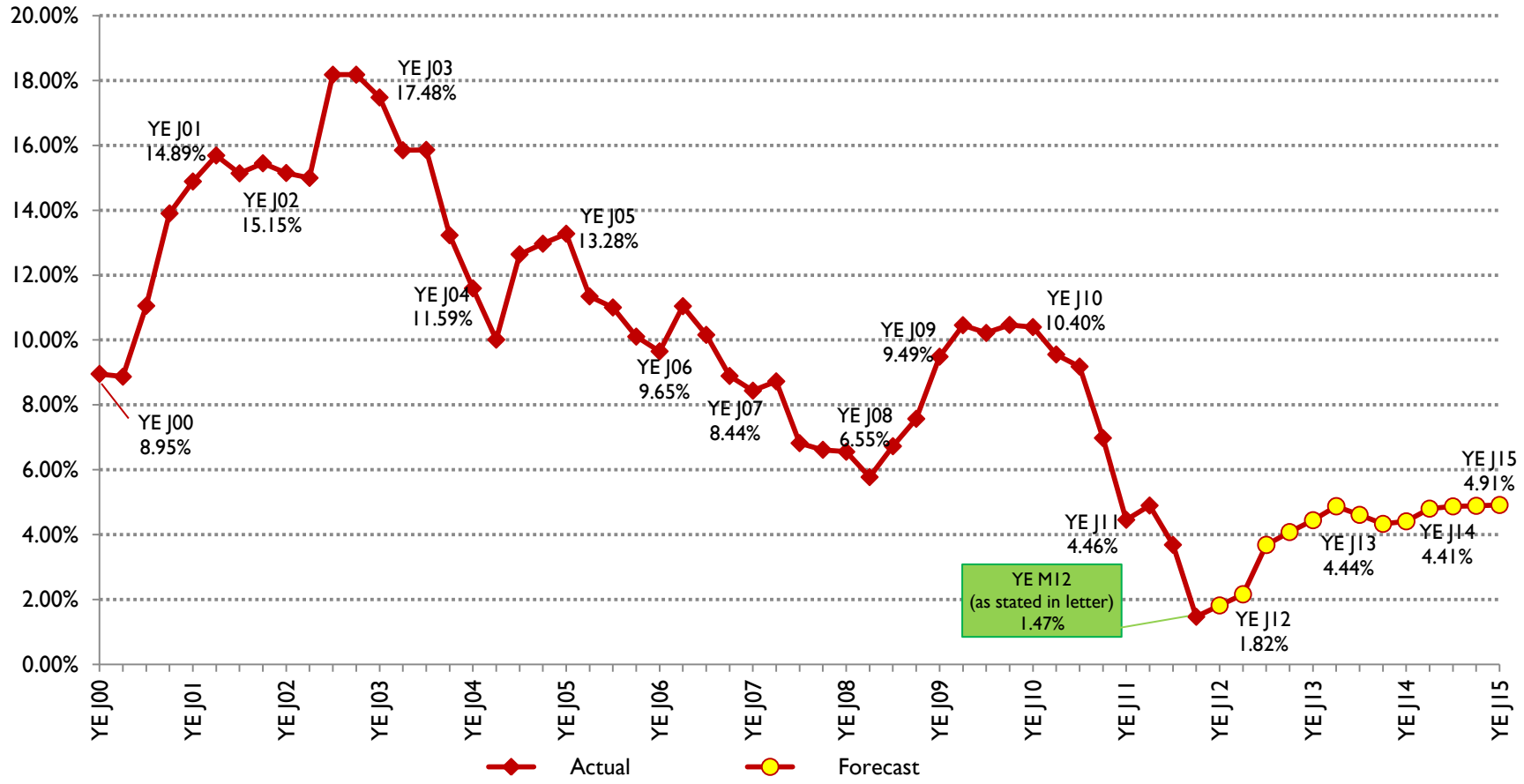
Background

- Since the late 1970s, the independent Health Services Cost Review Commission sets inpatient and outpatient hospital rates for all public and private payers.
- In the last 35 years, Maryland's hospital finance system has:
  - Eliminated cost-shifting among payers
  - Provided for the sharing of public goods (e.g., uncompensated care and medical education) among all payers
  - Allowed usage of creative incentives to improve quality and outcomes

Maryland's Current Rate Setting System Has Important Limitations

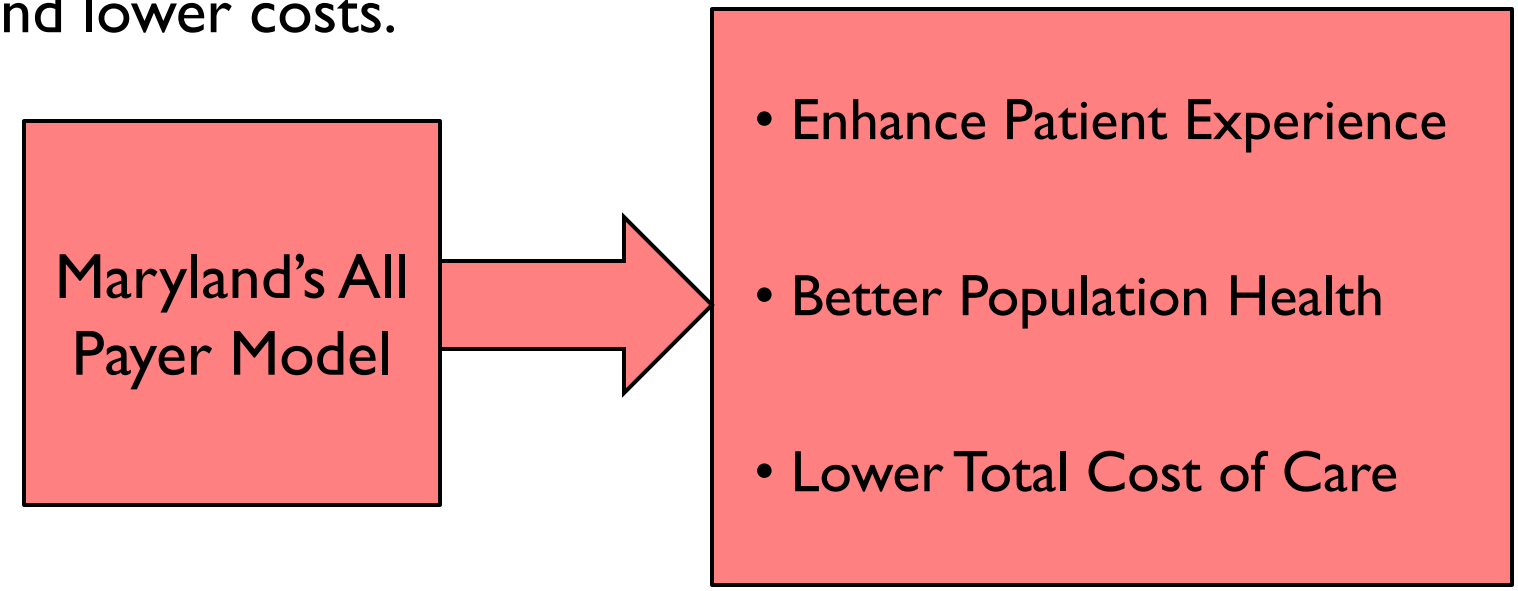
- The Medicare Waiver in the Social Security Act at 1814(b) provides Maryland authority to set payment rates for Medicare.
  - CMS evaluates Maryland's success under 1814(b) on a per discharge basis.
- Waiver test rules focus on inpatient services only
  - Reflect a time when cost per discharge and average length of stay were the only measures for efficiency
- The current system's focus on inpatient per-case costs does not provide incentives aligned to population health and comprehensive coordinated care across different settings.

Maryland's Current Waiver Cushion has Deteriorated



Maryland's Hypothesis

- An all payer system that is accountable for the total cost of care on a per capita basis is an effective model for establishing policies and incentives to drive system progress toward achieving the three part aim of enhanced patient experience (including quality and satisfaction), better population health, and lower costs.



Maryland's Model Design Proposal Starts with Accountability on a Per Capita Basis

- Model Design is in two phases:
  - Phase 1: Evaluate financial success using inpatient and outpatient hospital expenditures
  - Phase 2: Proposal to be developed during Phase 1
- For Phase 1, Maryland commits to limiting inpatient and outpatient hospital costs for all payers to a **Hard Expenditure Ceiling** based on the State's long-term Gross State Product (GSP).
  - State sets a separate guarantee of inpatient and outpatient hospital per beneficiary cost growth below a **Medicare benchmark**.

Maryland Proposes to Accelerate a Broad Range of Delivery Reform Efforts

Accountable Care Organizations, with rules that can be established in Maryland on an all-payer basis.

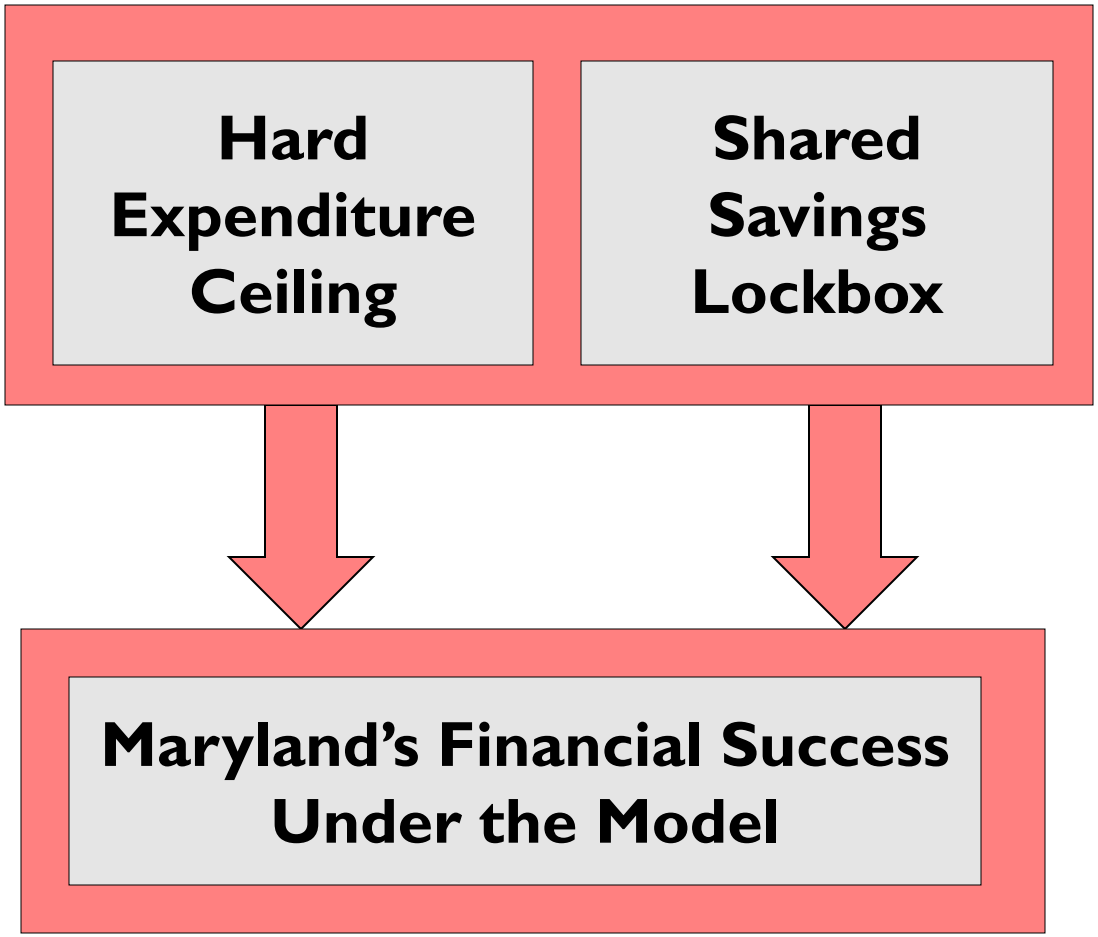
Readmission programs, which provide powerful incentives for improved coordination of care.

Global budgeting, for rural hospitals that can gain net revenue with innovative partnerships with community physician and public health agencies.

Gain-sharing between hospitals and physicians as patient outcomes improve and overall costs decline.

Population-based budgeting, for suburban and urban hospitals shifting out of fee-for-service payment to accountability for health outcomes and cost.

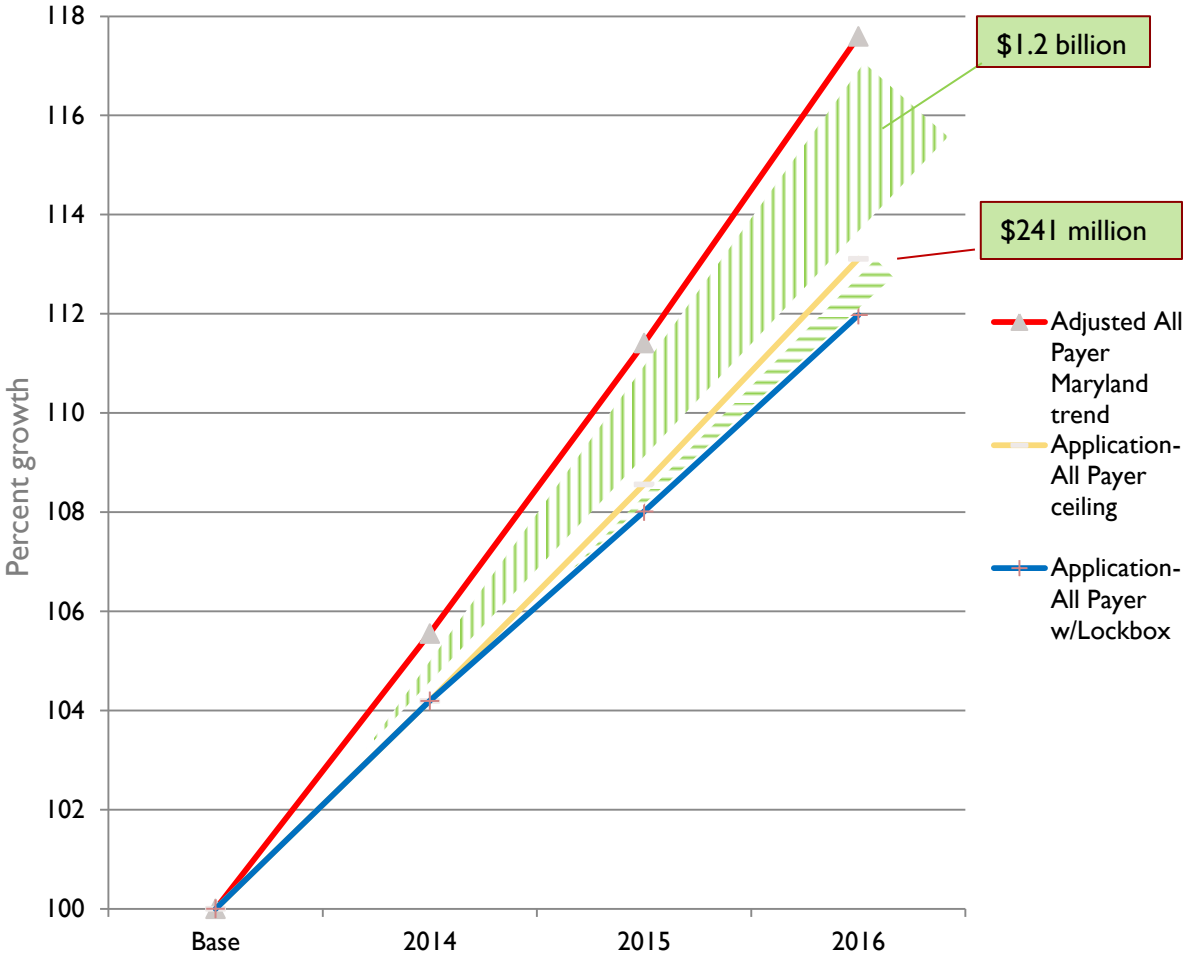
Pairing the Hard Expenditure Ceiling and a Shared Savings Lockbox Generates Financial Success



- The shared savings lockbox concept encourages savings below the guaranteed expenditure ceiling
- As innovative programs achieve savings, a portion of savings is returned to payers and ultimately the people of the State of Maryland
- Rules governing the shared savings lockbox and other elements of the proposal will be set by the HSCRC through a transparent and public process.

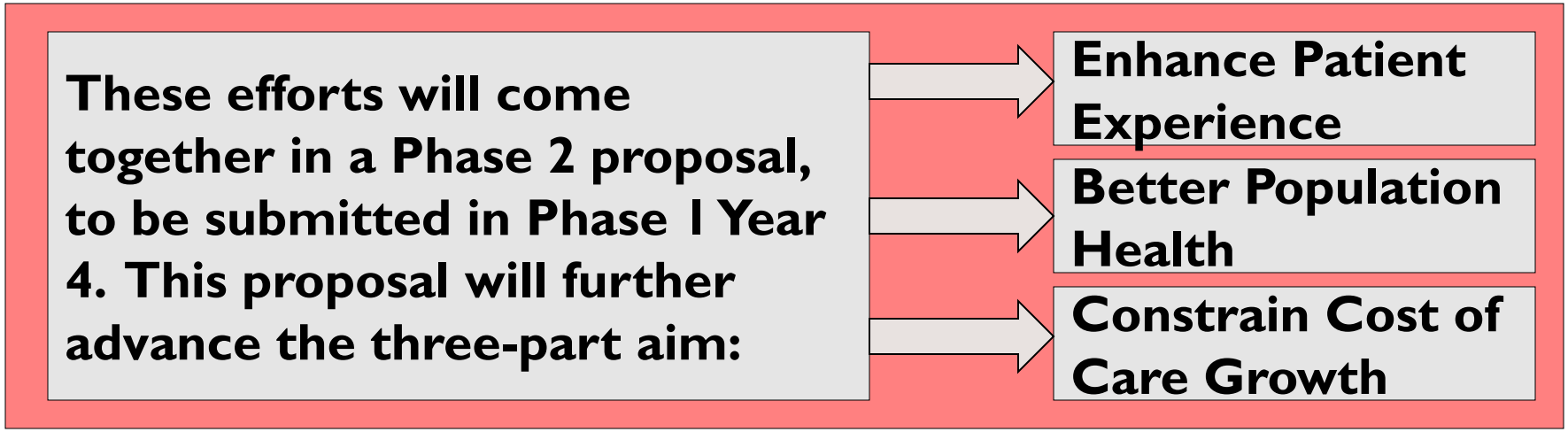
We Anticipate this Proposal Will Save $1.4 Billion by 2016

- Maryland is proposing a hard expenditure ceiling targeted to the State's trend for GSP, with shared savings underneath of at least 0.5 percent per year



This Proposal Integrates with Other Critical Health Reforms Underway in the Maryland

- Aligns hospital incentives with those of medical homes, a key feature of Maryland's State Innovation Model proposal
- Aligns with major investments made in information technology, including the state's Health Information Exchange
- Aligns with the public health goals of the State Health Improvement Process



Maryland Will Track Numerous Performance Measures

- Patient Experience of Care:
  - Measures include patient satisfaction, the effectiveness of care transitions, physician participation in public programs, and complication rates
- Population Health:
  - Measures include life expectancy, hospitalizations for ambulatory care sensitive conditions, primary and secondary prevention for cardiovascular disease, and behavioral health emergencies, including racial and ethnic disparities in these measures
- Health Care Costs:
  - Measures include overuse of diagnostic imaging, inpatient and outpatient costs, and total costs

Maryland's Submission to CMS is an Important Step in a Continuing Process

- Anticipate several months of review within CMS and other federal agencies before the proposal is finalized and approved
- Further dialogue with stakeholders in Maryland throughout this time; engagement plan submitted to the legislature in April.
- So far, we have met with:
  - Hospital executive input group
  - Consumer advocates
  - Physicians
  - Long-term care facilities
- Additional meetings planned with insurers and others.
- Given broad statutory framework, at this point, we do not see need for legal changes; if need is identified, would be an issue for 2014 session
- HSCRC is beginning collaborative discussions with the goal of developing an implementation plan