Maryland Health Services Cost Review Commission

New All-Payer Model

Steve Ports, Principal Deputy, Policy & Operations
Sule Calikoglu, Ph.D., Deputy Director, Research & Methodology

06/05/2014

HSCRC
Health Services Cost Review Commission

Overview of Health Services Cost Review Commission

- **Enabling Legislation 1971**
  - Enabling statute – very broad authority and language
  - Created a politically/legally independent agency ("HSCRC" or "Commission")
  - Unique governance structure - 7 volunteer Commissioners
  - Small experienced staff 33 FTEs (core analytic staff of 10-12)
- **Jurisdiction**
  - Inpatient and outpatient hospital services (no Part B)
  - 46 Acute Care Hospitals - $16 billion in revenue
- **Regulation**
  - Regulatory Authority remains the same
  - New Approaches to Regulation

New All-Payer Model

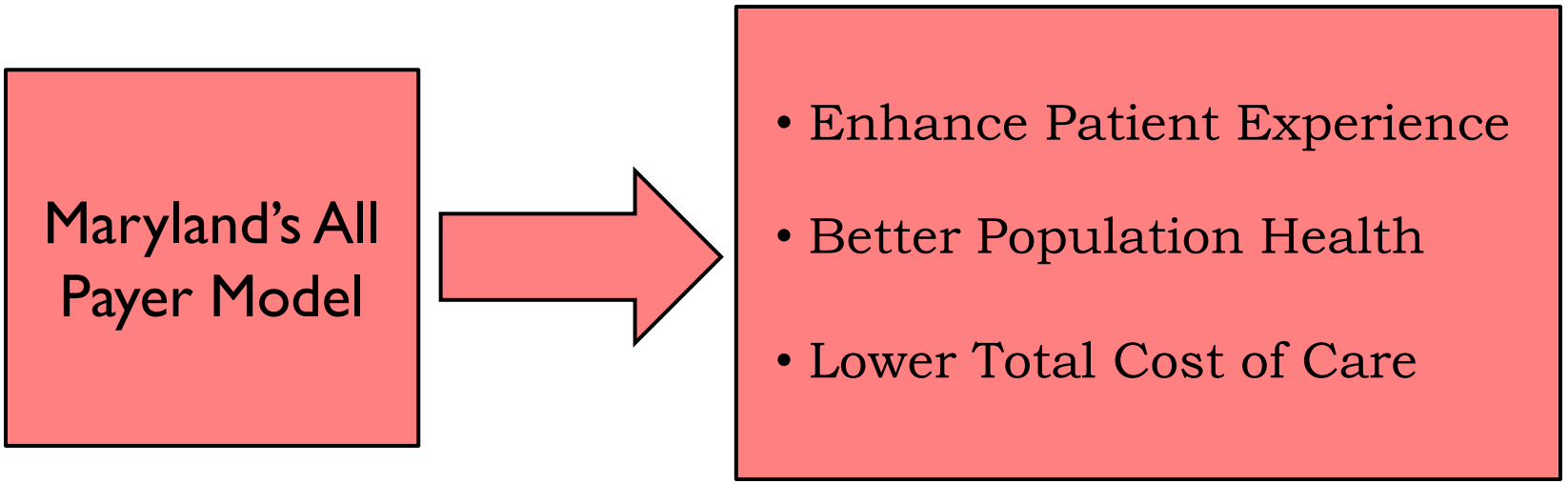
- New Model Approved by CMS January 1, 2014
  - Implementation effective January 1, 2014
- Phase 1 (5 years)
  - 2014-2018
  - Hospital inpatient and outpatient
- Phase 2
  - Proposal submitted end of 2016
  - Focus on controlling growth in total health spending
  - If approved, would begin in 2019

History

But 40-year-old waiver “test” was out of date

OLD		NEW
Inpatient care		All hospital care
Medicare only		All payers
Cost of care per hospital stay		Cost of care per person overall

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.

Lower Cost

Annual hospital SPENDING CAP – 3.58% per capita

Medicare SAVINGS TARGET – $330 million over 5 years

GROWTH in Maryland spending per capita cannot exceed nation

Improve Care

REDUCE READMISSIONS: patients who return to the hospital within 30 days of discharge

Maryland ranks poorly (almost last) – 49 of 51 states and D.C.

Bring Maryland readmission rates to NATIONAL AVERAGE in 5 years

Better, SAFER care

Safer Care

REDUCE INFECTIONS AND COMPLICATIONS:
patients who get sicker while in the hospital

Maryland rates of infection HIGHER than nation

REDUCE infections and complications by 30% in 5 years

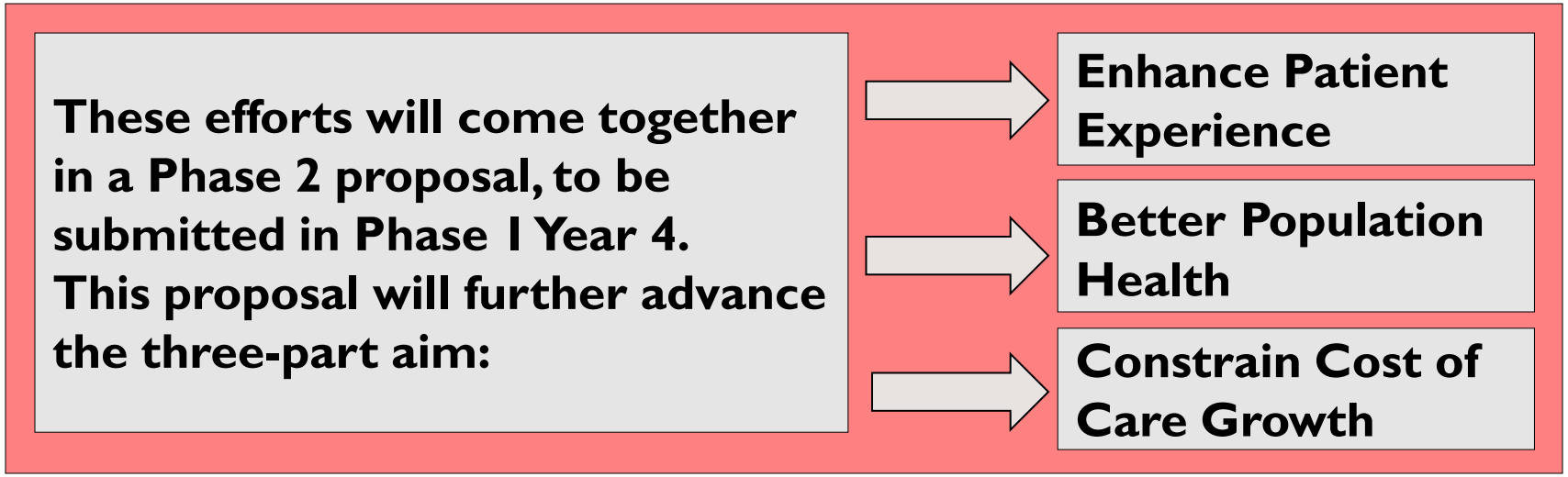
Better, SAFER care

What Does This Mean?

- New Model represents an unprecedented effort to improve health, outcomes and control costs
- Focus shifts to gain control of the revenue budget and on providing the right volumes and reducing avoidable utilization
  - Global Budgets
- Potential for excess capacity will demand focus on cost control and opportunities to optimize capacity
- Opens up new avenues for innovation
  - Population-based Hospital Payment Structures
  - Delivery System Reform

Proposal Integrates with Other Critical Health Reforms Underway

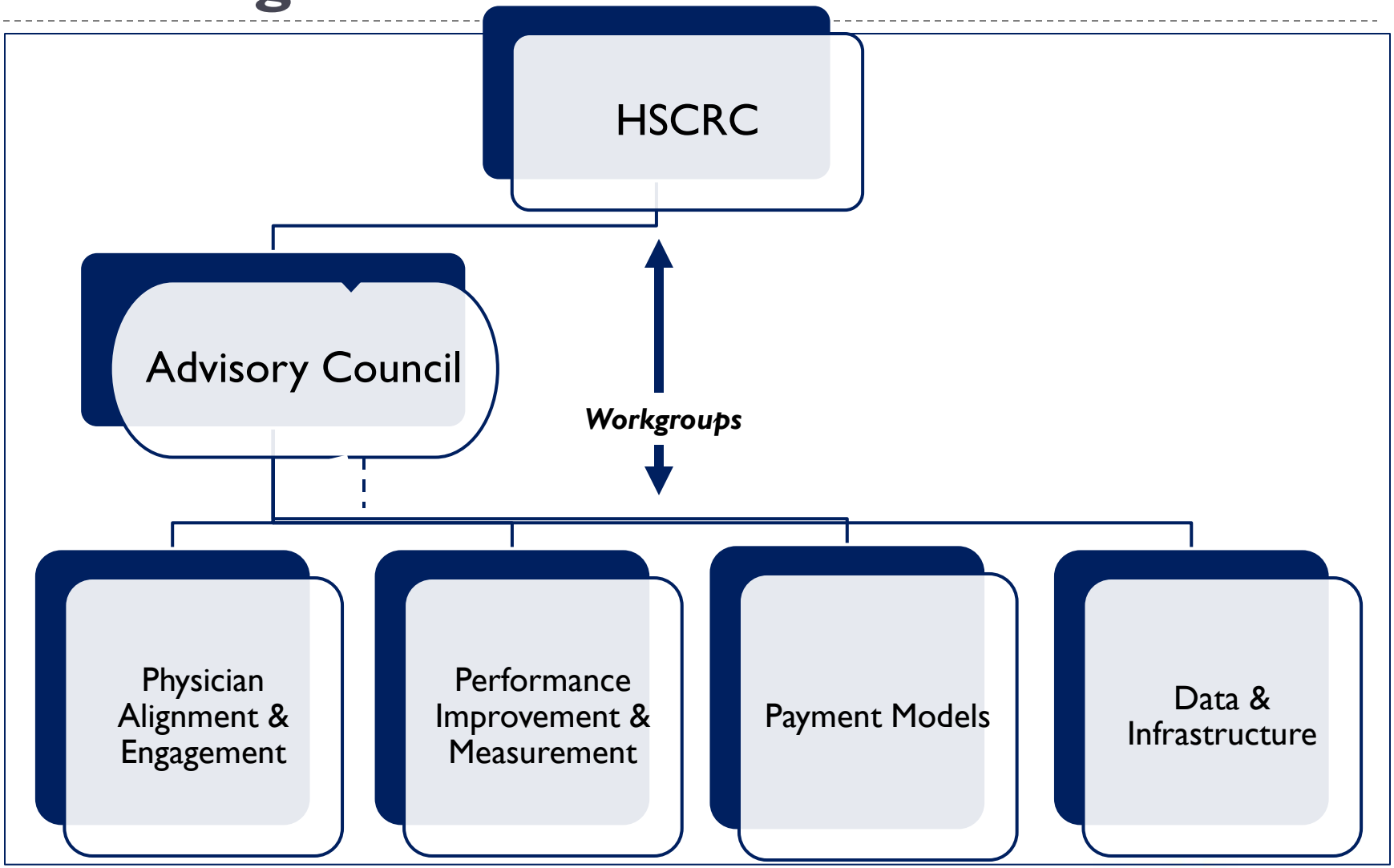
- Aligns hospital incentives with those of medical homes, a key feature of Maryland's State Innovation Model proposal
- Aligns with work of Health Enterprise Zones (HEZs)
- Aligns with major investments made in information technology, including the state's Health Information Exchange
- Aligns with public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



HSCRC Model Development and Implementation Timeline

- Hospital global model
- Population-based
- Preparation for Phase 2 focus on total care model and costs

Public Engagement and Implementation Planning



Focus on Meeting the Early Model Requirements

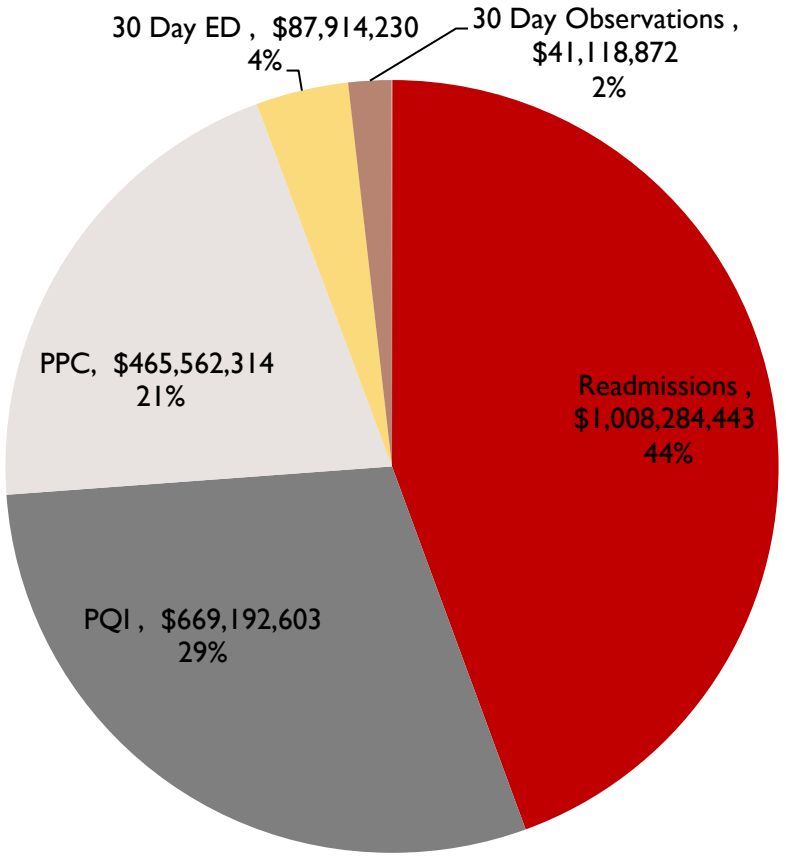
- Top priority: meeting the All Payer hospital per capita spending and Medicare savings targets
- Requires clear timetable, interim milestones, key benchmarks, periodic assessments
- Global payment is the tool of preference
- Reducing avoidable utilization through better care is the key to meeting tight targets

Potentially Avoidable Utilization: Unplanned Care

Definition of PAU:

"Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health."

Distribution of Potentially Avoidable Utilization, CY2012



Note: Categories may overlap; Readmissions are based on ARR methodology adjusted for planned admissions.

Data Needs

- HSCRC Inpatient and Outpatient Casemix Data Sets
  - CRISP Master Patient Index = Revisits, Duplicate services, Over/Under Utilization Measures
- Medicare Claims
  - Predictive Modeling-High Utilizers
  - Over/Under Utilization Measures
- HIE
  - Source of admission
  - Discharges where the 'Principal Provider of Care' was Notified"
- Population Health Management data