The Maryland All-Payer Hospital Rate Setting System:

A Look Back – How did we Get Here?

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Controlling Maryland Hospital and Health Care Spending in the Era of Budget Caps
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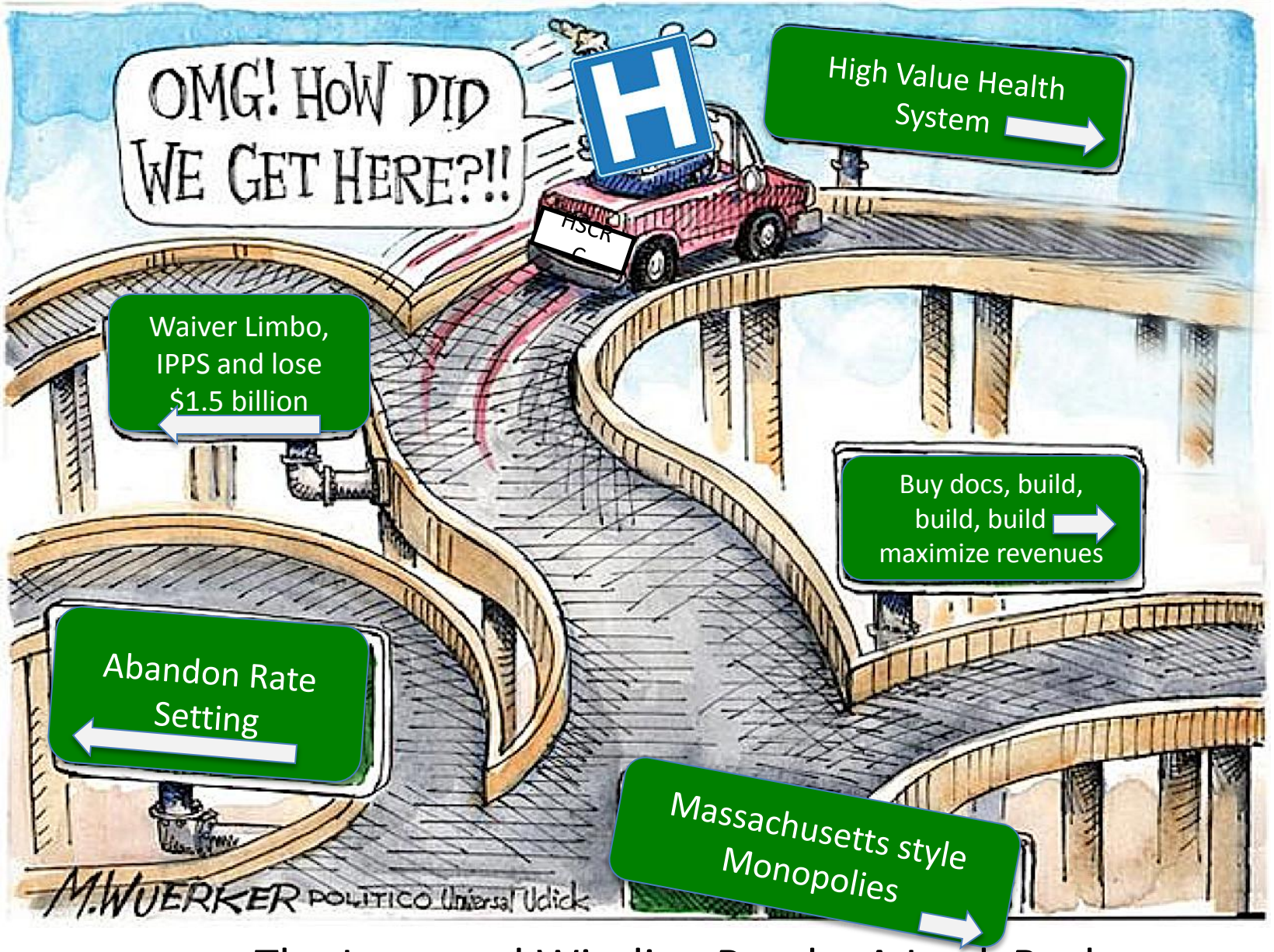
Presented by Robert Murray (former Executive Director, Maryland HSCRC)

HSCRC – the "Board Game" by Milton Bradley

The Game has a lot of twists and turns and some very suspenseful moments

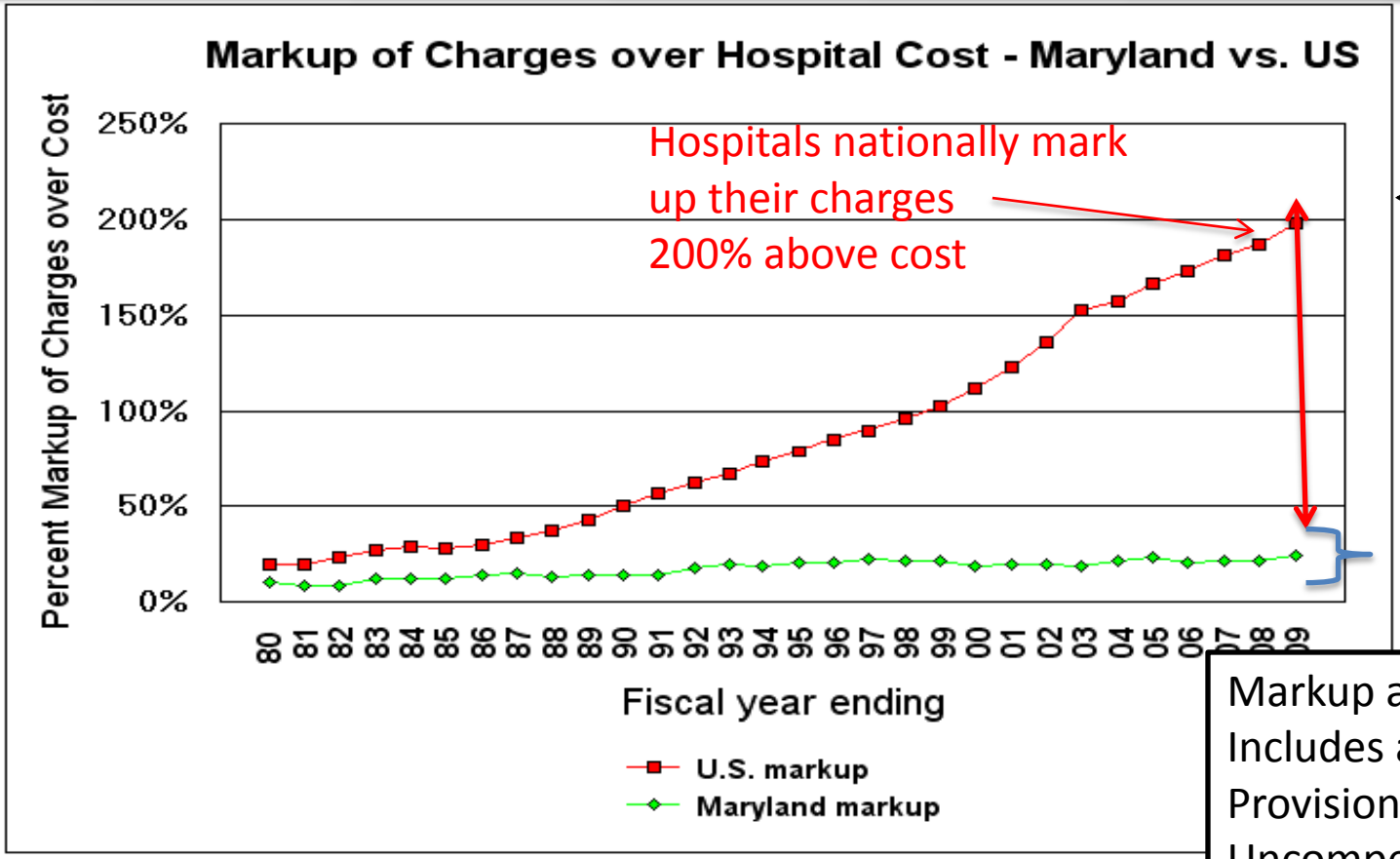


The Long and Winding Road – A Look Back

First: a Quick Overview of Hospital Rate Setting

- HSCRC created in 1971 with jurisdiction over hospital costs (IP & OP facility only) with rate setting authority for commercial payers
- Began negotiations with Medicare (HCFA) in 1972 for an all-payer waiver (in effect when all hospital rates set: 1977)
- The "Medicare waiver" (initially a demonstration waiver) made the system "all-payer" allowing for Medicare and Medicaid
- System was based on historical costs – (but a focus on outliers)
- Established a prospective rate setting system - annual rate updates
- Initially a system of "Unit rates by Revenue Center"
- Uniform Markups of Charges over Cost
- System of Financing "reasonable" Uncompensated Care"

Payment Equity

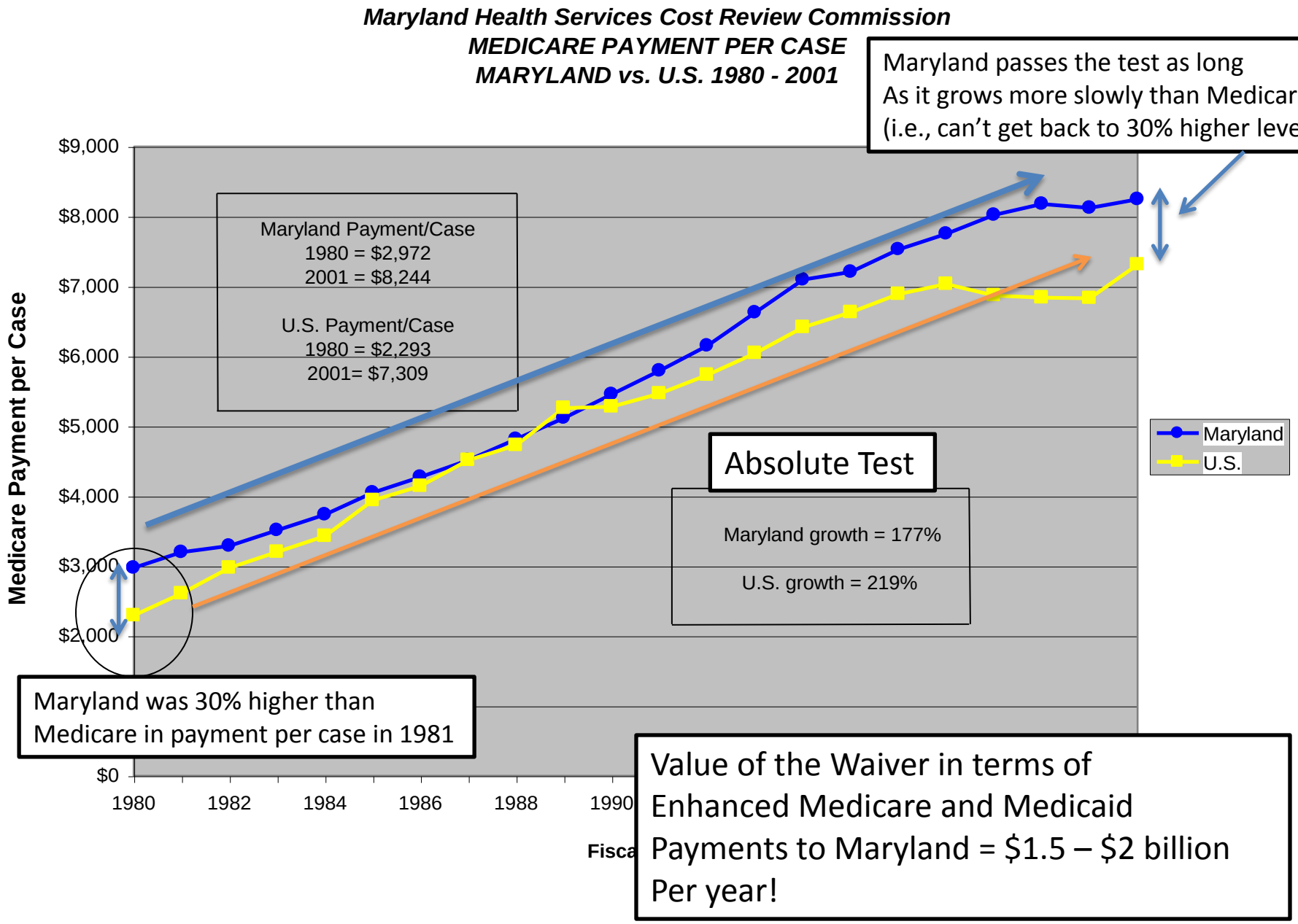


Markup also Includes a "reasonable Provision" for hospital Uncompensated Care

- HSCRC controls the "markup" of price over cost
- HSCRC also prohibits price-discrimination/cost-shifting
- Maryland has the lowest markups and lowest charges in U.S.

Source: American Hospital Association statistics 1980 - 2009

Original Waiver test was a "per case payment relative rate" of Growth Test"



Other Features of the Baseline System

- Extensive data collection clinical and financial (inpatient case mix data set the best in the world)
- 1977 HSCRC changed the Basis of Payment to DRGs
  - First DRG-based payment system in the world
- Focus on outliers led to development of the "Screens" – identifying high cost providers for corrective action
- Outpatient payment – still unit rates
- Strong Cost control mechanisms/policies 1977-1989 but no quality-related P4P
- Maryland and all State-based Rate Setting Systems had a System of Volume Adjustments

Volume Adjustment System (VAS)

- Under DRG System, Hospitals have 3 Primary Incentives:
  - Minimize Cost Per Case
  - Maximize Revenue Per Case (Coding has an impact here)
  - **Maximize Case Volumes**

- Volume Adjustment System: Reflect Hospital Fixed/Variable Costs
  - Over the Short Term (in general) Hospital Fixed Costs are about 40-60%
  - In absence of a Volume Adjustment, New cases: Marginal Revenue > Marginal Cost
  - Marginal case hospital retains 100 cents on the $ when cost is 50 cents on the $
  - New Volumes add substantially to Profitability and Cash Flow

Implication: Large incentive to admit more cases; Greatly Undermines Cost Control

- All State Based Rate Systems in US had Volume Adju
  - Economically Sound: Reflects Fixed and Variable Components of
  - Acts as a "Break" on incentive to do unnecessary volume

Oddly – Medicare didn't contemplate the use of a Volume Adjustment

Question this now
Given most CMS
Experiments are all
About controlling
Unnecessary volume

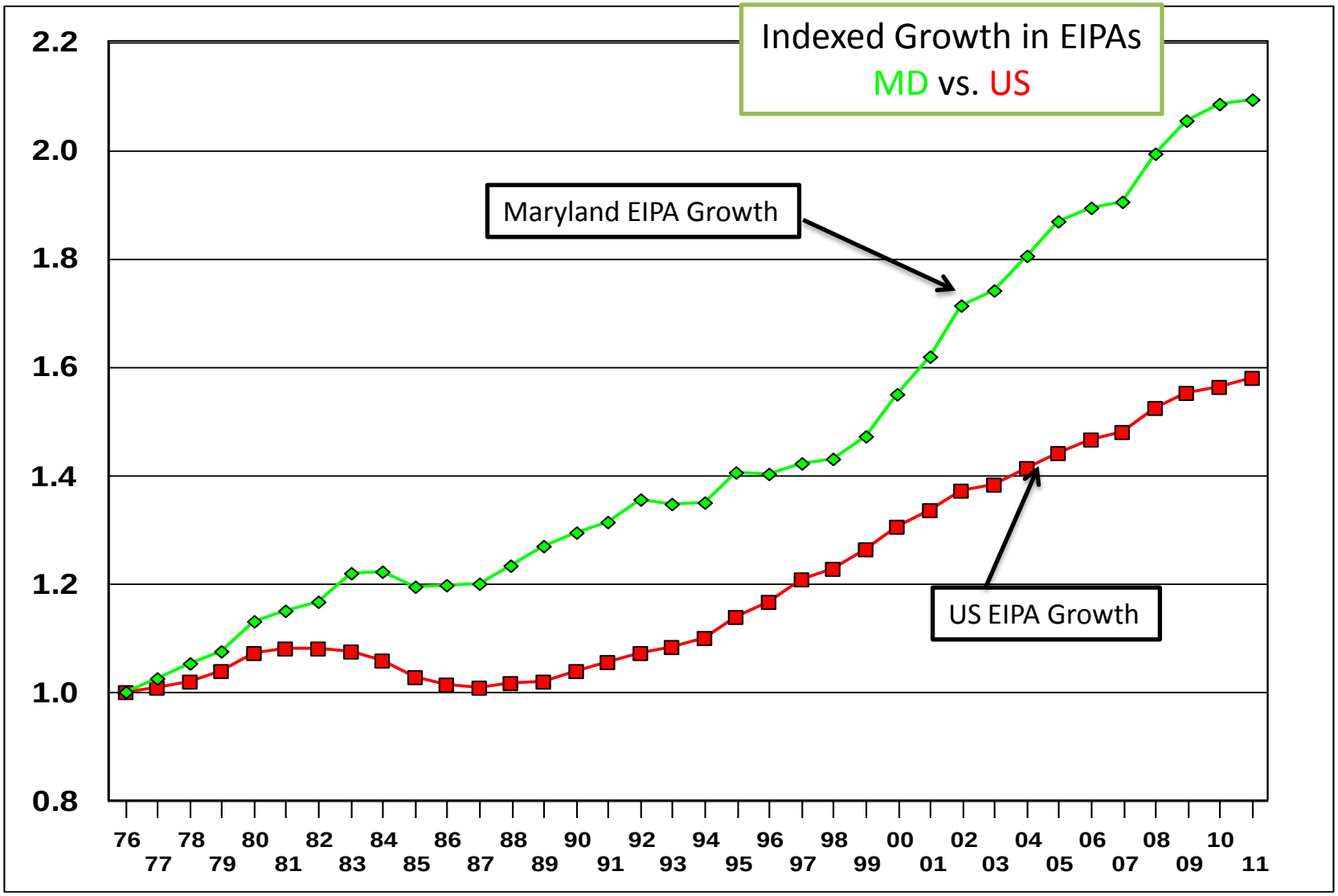
Volume Adjustment System (continued)

- Volume inducing feature of FFS payment has undermined cost containment in Maryland and Nationally
- Major factor behind Hospital expansionary strategies (building projects, questionable new technologies, buying docs, etc.)
- Increase volumes = excess Marginal Revenues over Marginal Costs and this surplus is reinvested in expansionary strategies that again increase volumes
- Particularly true for non-profit hospitals (no need to distribute profits to owners – instead use increased cash flow from volume increases to expand and generate more volumes)
- Responsible for the view that "Hospitals are self-fueling, ever-expanding machines" (James Robinson, UC Berkeley)

Implications: Collapse of Managed Care & Removal of VAS

- Maryland VAS was effective – but policy changed over time
  - 1977-89: Costs treated 50%/50%: VC/FC (hospital retains 50 cents on $ for volume)
  - 1990-2001: Some hospitals negotiated 100% VC arrangements
  - Rest of the system placed on 85%/15% VC/FC (hospitals retained 85 cents on the $)
  - 2001: 100% VC (eliminated Volume Adjustment in 2001)
- During Rate System "Redesign" – HSCRC negotiated very low update factors 2001-2004
- In exchange for low updates hospitals requested elimination of VAS
- Managed care was still relatively strong in 2000 and it was thought that HMOs would continue to provide a break on unnecessary volumes
- HSCRC was wrong and Hospitals responded to the changed incentives and disappearance of Managed Care by greatly increasing volumes

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



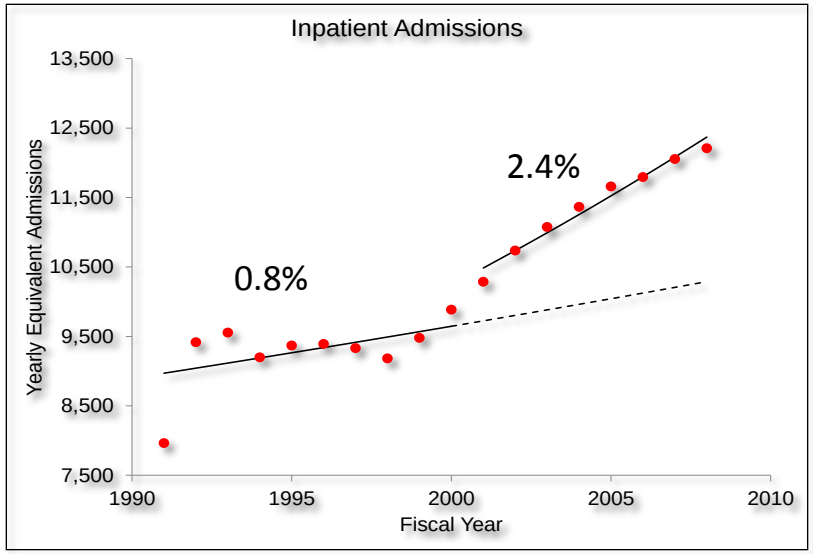
From the American Hospital Association Annual Statistical Guide 1976-2011

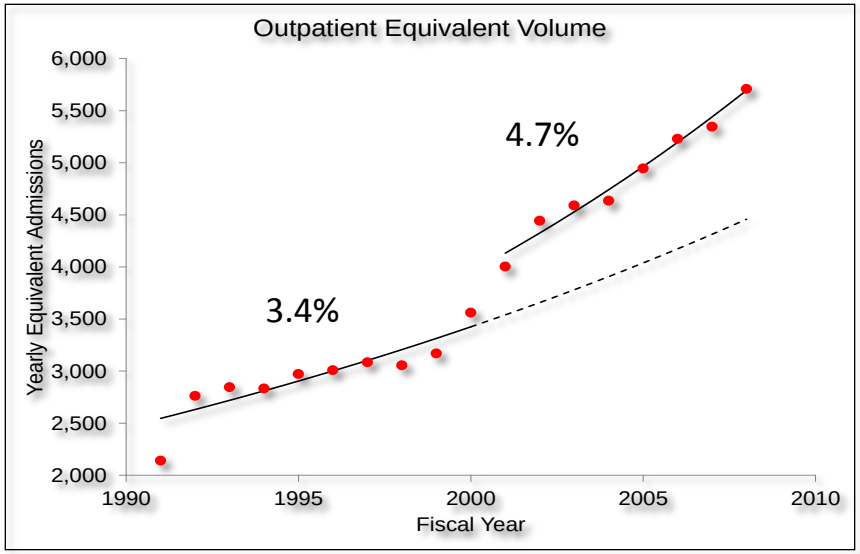
Findings from "Kalman et al."

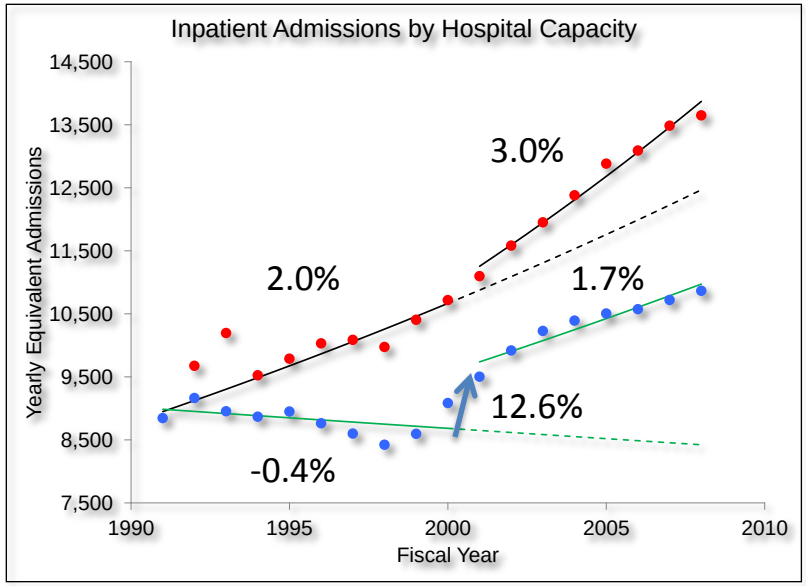
- Researcher from Duke University published a study on the "volume response by Maryland hospitals" over the period 2001-2008
- Findings:
  - With the repeal of the 85% volume adjustment, inpatient admissions had a significant relative increase from baseline of 7.8% and a significant acceleration in yearly growth from 0.8% to 2.4%
  - Similarly, outpatient equivalent volume experienced a significant relative increase from baseline of 16.7% and a non-significant acceleration in yearly growth from 3.4% to 4.7%
  - Similarly, outpatient equivalent volume experienced a significant relative increase from baseline of 16.7% and a non-significant acceleration in yearly growth from 3.4% to 4.7%
  - Operating revenue and operating costs increased significantly over baseline by 4.2% and 7.6%, respectively
  - The operating revenue yearly growth rate, which had previously outpaced the growth in operating costs (5.3% vs 4.8%), converged after the repeal (8.7% vs 8.4%)

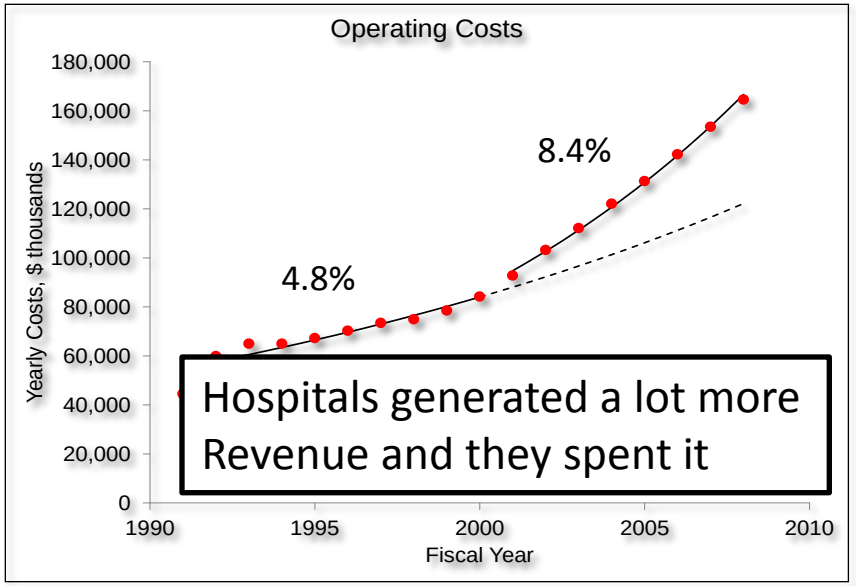
http://www.ajmc.com/publications/issue/2014/2014-vol20-n6/Removing-a-Constraint-on-Hospital-Utilization-A-Natural-Experiment-in-Maryland

Findings from “Kalman et al.”





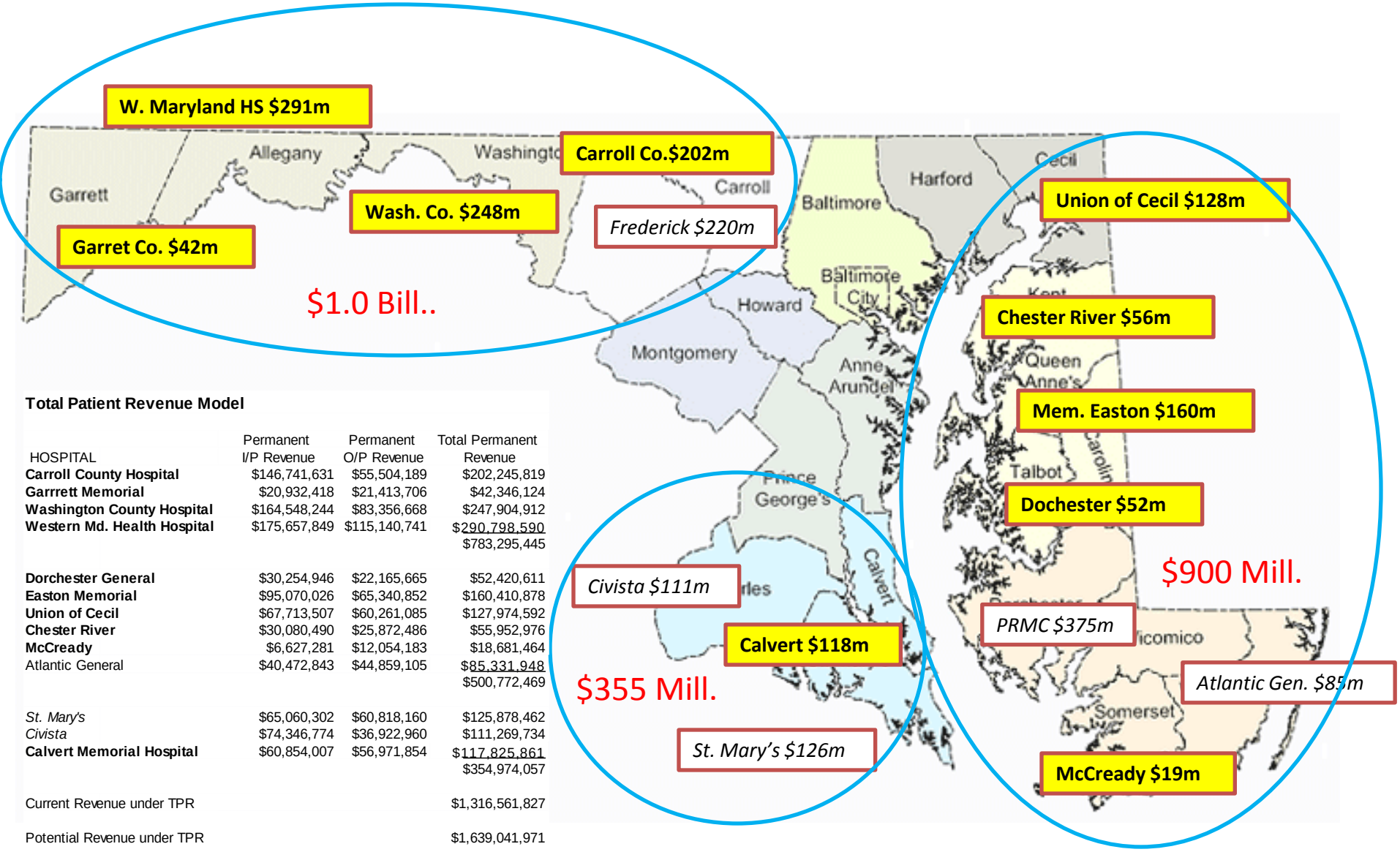




Payment System Changes & Addressing our "Value" problem

- Emphasis on Quality and Payment Changes nationally spurred a round of similar change in Maryland 2003-2011
- Quality Related Programs:
  - Quality-Based Reimbursement (P4P system of rewards and penalties for performing evidence-based process measures)
  - Maryland Hospital Acquired Conditions Policy (P4P system of significant rewards/penalties for risk adjusted rates of complications across 64 categories)
- Cost/Utilization Programs:
  - Admission-Readmission Revenue (ARR) policy which bundled admissions and all-cause readmissions (31 of 46 hospitals adopted)
  - Re-instituted VAS at 85% VC and 15% FC over large opposition by hospitals
  - Negotiated 14 Total Patient Revenue (TPR) agreements (10 were finalized)

Total Patient Revenue (HSCRC first Prospective Global Budget Model)



Total Patient Revenue Model

HOSPITAL	Permanent I/P Revenue	Permanent O/P Revenue	Total Permanent Revenue
Carroll County Hospital	$146,741,631	$55,504,189	$202,245,819
Garrrett Memorial	$20,932,418	$21,413,706	$42,346,124
Washington County Hospital	$164,548,244	$83,356,668	$247,904,912
Western Md. Health Hospital	$175,657,849	$115,140,741	$290,798,590
			$783,295,445
Dorchester General	$30,254,946	$22,165,665	$52,420,611
Easton Memorial	$95,070,026	$65,340,852	$160,410,878
Union of Cecil	$67,713,507	$60,261,085	$127,974,592
Chester River	$30,080,490	$25,872,486	$55,952,976
McCready	$6,627,281	$12,054,183	$18,681,464
Atlantic General	$40,472,843	$44,859,105	$85,331,948
			$500,772,469
St. Mary's	$65,060,302	$60,818,160	$125,878,462
Civista	$74,346,774	$36,922,960	$111,269,734
Calvert Memorial Hospital	$60,854,007	$56,971,854	$117,825,861
			$354,974,057
Current Revenue under TPR			$1,316,561,827
Potential Revenue under TPR			$1,639,041,971

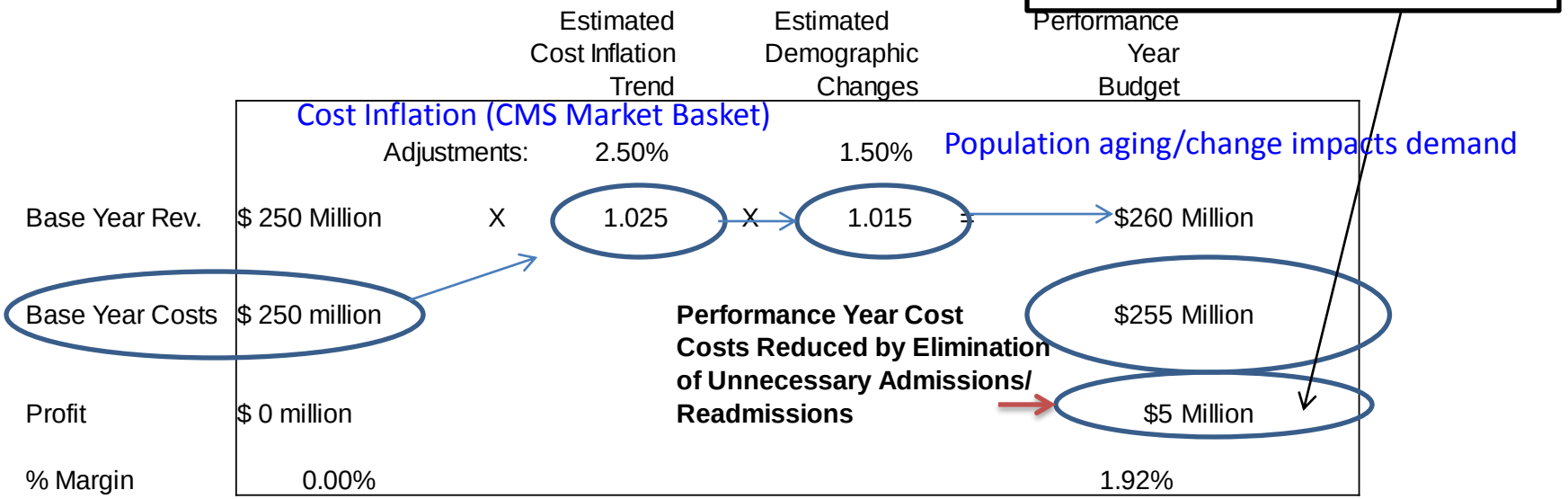
HSCRC is establishing a fixed payment now for all Hospital services in 3 large more rural regions of the State

Example of a TPR Global Budget Model and Challenges associated with non-population based Global Budgets

- Washington County Hospital (now Meritus)
  - Community hospital in a rural part of the State
  - Separated by distance and mountain ranges
  - Serves 148,000 population in Washington County
  - Limited "in-migration" from other parts of the State
  - Budget in Prior year = $250,000,000

The hospital keeps its Global Budget Revenue and associated profit – and Budgets are 100% Prospective and not "rebased" to cost

Cutting "waste" under TPR = Source of financial sustainability



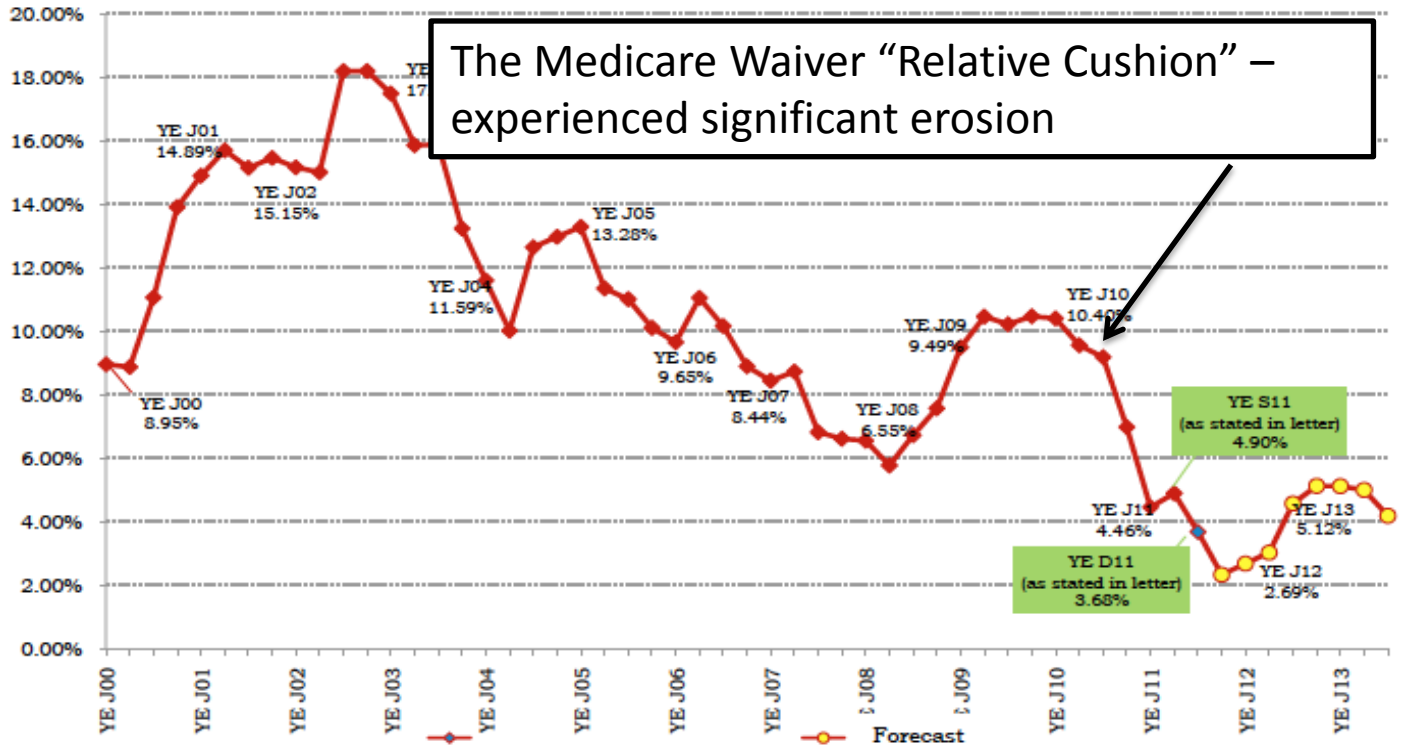
HSCRC also began developing a version of the TPR for suburban hospitals with dominant Market positions in their service area;

Challenge in establishing a Global Budget for Suburban and Urban hospitals was how to adjust for demographic change in cases, where a Hospital does not have a well-defined PSA?

Peering over the Precipice

- Maryland Legislature Medicaid Assessment and other factors led to large erosion in the Medicare waiver
- The threat of the loss of the waiver helped to bring the hospitals on board

Maryland's Current Waiver Cushion has Deteriorated



Objectives of the Payment Reform Efforts 2003-2011

1) Address issues undermining the lack of overall cost-constraint
   - FFS Incentives and Excess Marginal Revenues
2) Develop incentives to improve hospital effectiveness (quality of care and patient safety)
3) Re-orient the system with incentives that would promote Population-Based Health
4) Position the system (given growing receptivity nationally to payment reform experiments) to replace the “Per Case” waiver test with a “Per Capita” test
5) Link system growth to growth in State Gross Product (GSP) to ensure “affordability and sustainability”
6) Sensitize CMS in 2009 and the CMMI in 2010 to the unique experiment that Maryland might provide

Implications of a Successful Maryland Model

1) Important model that demonstrates the need for direct payment mechanisms that have incentives to control volumes
   - And/or reduce hospital resistance to efforts aimed at better care coordination and elimination of unnecessary volumes

2) Model these incentives further to promote population-based health under a system that provides financial sustainability for hospitals

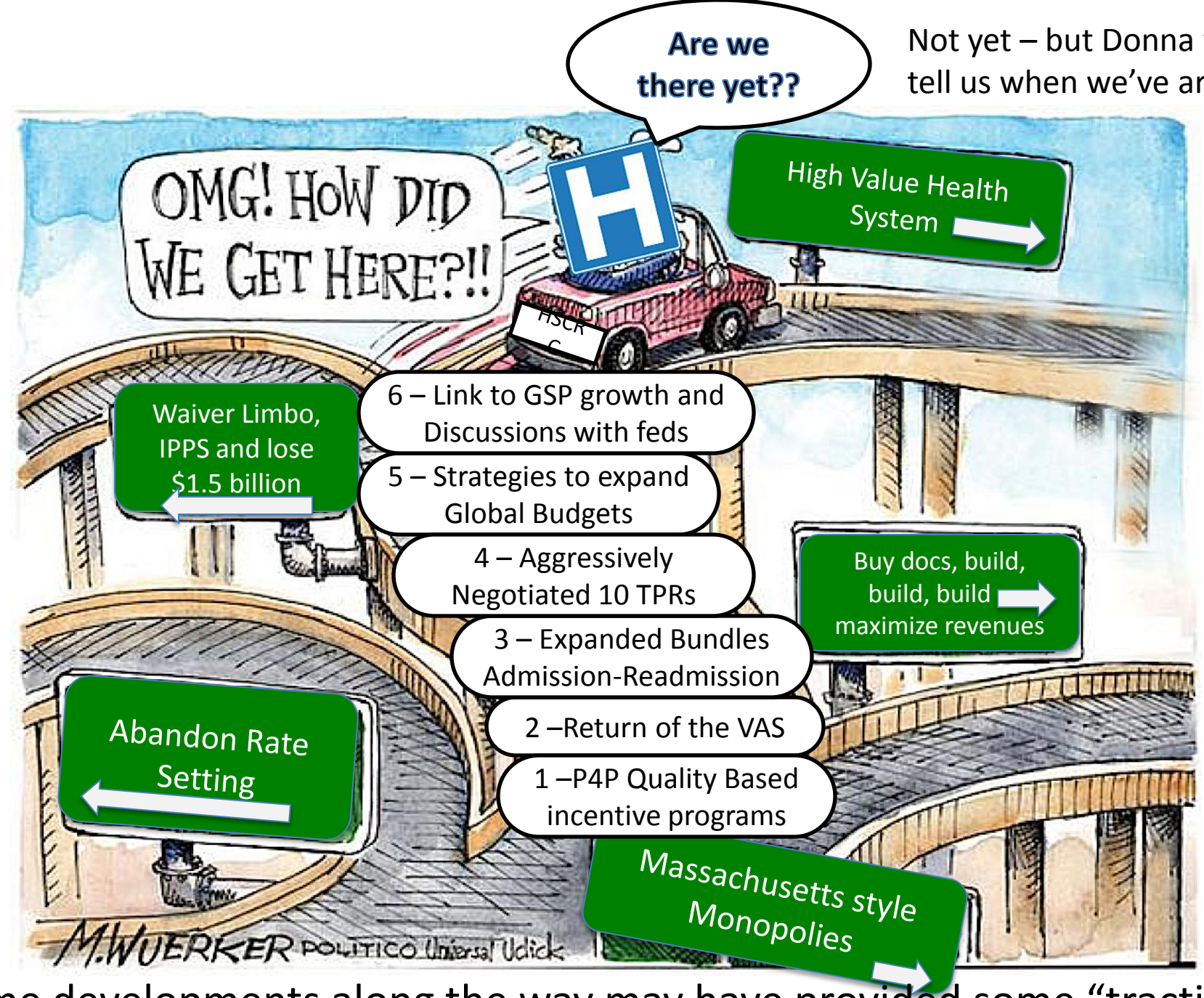
3) Linking of growth to GSP and slowing hospital cost growth to 3.58% would be a remarkable achievement (other states only dream of this)

4) Global Budgets and Volume adjustments address an inherent contradiction in the national ACO policy
   - ACOs built around hospitals with FFS incentives that will financial objectives that run counter to the goals of the ACO program
   - By contrast Maryland hospital incentives (under a VAS or Global Budgets are aligned with the incentives of ACOs and other Market inducing entities)

5) Model will reduce emphasis on specialty care & elevate Primary Care and payment models such as the CareFirst PCMH that promote better value

6) Other States may follow Maryland's lead (e.g., Vermont, West. Va., Oregon)

Not yet – but Donna will tell us when we've arrived



Some developments along the way may have provided some "traction"

We owe it all to Hal!

Harold A Cohen, Founding Executive Director of
the Maryland Health Services Cost Review Commission
1939-2012