The Maryland All Payer Hospital Rate Setting System Experience

"Looking Beyond DRGs"

Provider Payment Reform in the Philippines – Toward Universal Health Coverage (Policy Forum)

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March 7, 2018

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Maryland All Payer Hospital Rate Setting

- Maryland is the last of 5 states to have State-based Hospital Rate Setting Systems – applied to All Payers including Medicare
- Requires a “Waiver” from the Federal Medicare rules
- Maryland keeps this Waiver from Medicare as long as it pass a financial “Waiver Test”
- System applies only to Facility charges and not to Physicians
- Goals: Control Cost Growth; Improve Payment Equity across payers; Improve Access to Care; Improve Quality; Improve Accountability/Transparency and provide for Hospital Solvency
- Initial System a per case DRG system (first in the world in 1977) applied to Medicare, Medicaid and Commercial patients
- Administered by the Health Services Cost Review Commission – a State Regulatory Agency with broad legal authority to set rates
- $7 million budget and 30 FTEs health economists, accountants and research staff

DRG System Performance

- Per Case Cost growth – lowest in the nation 1977 – 2006
- Volume Adjustment System designed to eliminate any incentive to do additional inpatient or outpatient volumes
  - Hospital have high fixed costs ~ 50%+ and thus Variable costs for incremental volume are about 50%
  - Incremental payment in absence of a Volume Adjustment System = 100% for each new case or new outpatient procedure/test
  - This Economic Equation creates large incentives for hospitals to purchase physicians, build new buildings and technology to increase volumes of care
  - HSCRC's Volume Adjustment System reduced inpatient and outpatient payments by this Variable Cost factor (50%) if volumes increased
  - Hospitals received their fixed cost component (50%) if volumes decreased
- 1977-1990 Maryland experience little volume growth and also controlled the growth in hospital cost per case
- In 1992 HSCRC reduced the "break" on volume growth – diluted the Volume Adjustment System and eliminated it in 2001
- As a result, inpatient and outpatient **volumes explode**d 2001-2009[3]

HSCRC - Implication of and Responses to Provider Volume Growth

- Maryland continued to do well in control of cost per case
- But increased number of cases and outpatient volume meant per capita hospital costs increased rapidly
- HSCRC changed the structure of payment – to adopt broader payment bundles
  - HSCRC adopted Global Budgets for 10 isolated Rural hospitals
  - Adopted combined admission/readmission payment for 31 hospitals
  - The HSCRC reinstituted the Volume Adjustment System for others
- Broader Payment Structures such as Global Budgets – transfer more Financial Risk from the Payer to the Provider
- Create stronger overall Incentives for Cost Control
- HSCRC also implemented Quality Pay-for-Performance Initiatives to counter incentives to "stint on care" under new payment structures

Policy Responses 2008-2011: Quality of Care Initiatives

- These Quality programs provided incremental incentives (both penalties or rewards) for hospitals to maintain or improve quality
- Programs implemented in part due to concerns that hospitals might "stint" on quality of care under the incentives of more fixed payment mechanisms
- Quality-Based Reimbursement (QBR)
  - Implemented an incremental P4P incentive program for various process/quality metrics
  - Measured performance on use of Process Measures correlated with higher quality
  - Later incorporated clinical care, patient safety, mortality and ED wait times and patient satisfaction measures
- Maryland Hospital Acquired Conditions (HAC)s
  - Implemented an incremental P4P incentive program for hospitals to reduce HACs
  - Much broader than the Medicare HAC program (incentivized performance on 64 different "Potentially Preventable Conditions") e.g., infection rates, falls, never events
- Readmission Programs
  - Implemented an incremental incentive program for hospitals to reduce Readmission rates

Maryland New Model Demonstration 2014

- Medicare Waiver test Performance – which was a average payment per case growth test – started to erode
  - As hospitals reduced numbers of admissions under New Model caused average cost per case to increase
- Maryland wanted to change its waiver test from a per case test to a per capita growth test to parallel the new payment structure
- With National Health Reform 2010 - federal government wanted States to experiment with payment that moved away from incentivizing volumes to payment emphasizing better "value"
- Emphasis was also on Population Based Payment initiatives
- Hospital Global Budget payment arrangements are compatible with these goals
- Maryland negotiated a New Medicare Waiver with the federal government in 2014 which put all hospitals under Global Budgets

Hospital Global Budgets - Characteristics

- Establishes a fixed budget for a hospital regardless of the number of patients seen
- The Fixed Budget is meant to cover a "Reference Population"
  - Reference Population easy to identify for isolated rural hospitals – where 50-75% of population uses the local hospital
- Budget are usually based on a hospital's Historical Costs in some "Base Year"
- Budget is Trended to the first Performance Year by a "Trend Factor" that takes into account input inflation and demographic changes
- There may be Adjustments to the Budget (Maryland added extra funding to the trend to assist with investment in population health)
- HSCRC could enforce Compliance with the Budget – i.e., a Hard Cap (if over, next year's budget reduced and penalties applied)
- Reinsurance may apply (certain types of services or high cost cases excluded and/or Aggregate Stop Loss applied to reduce risk)

Hospital Global Budgets (continued)

- Hospital was Guaranteed to receive its Budgeted Revenue:
  1. Hospitals either paid every two weeks a fixed amount from each payer, or
  2. In Maryland hospitals still charged DRG and Outpatient rates and had to monitor volume over time
- If volumes increased over historical levels, hospital had to reduce prices
- During the Year: Prices x Volumes = Global Budget
- Goals of a Global Budget System:
  - Strong control on volumes and total cost: Incentives to reduce all costs (ancillary costs, length of stay, per day costs, number of admissions and number of readmissions)
  - Provides for predictable revenue flow for hospital & improved financial stability
  - HSCRC could trend Global Budgets at desired rate to slow cost growth and improve over all system affordability
  - Hope that hospital would become more responsive to community health needs – focus more on preventive care and population health

Requirements of New Global Budget Demonstration (2014-2018)

- CMS agreed to a New Demonstration Model/Waiver with Cost per Capita Growth Tests (replacing the cost per case growth test)
- Most of the Waiver tests required improvement vs. U.S. Performance
- Scale and Financial Requirements:
  - Convert all hospitals to Global Budgets by 2017
  - Limit all payer per resident hospital growth to no more than 3.58% per year
  - Generate at least $330 million in Medicare per capita hospital savings vs. US average growth rates over 5 years (2014-2018)
  - Limitations on Medicare Total Cost of Care growth (Total Cost of Care includes hospital and non hospital expenditures)
- Quality of Care Requirements:
  - Reduce Medicare Readmission rate to U.S. average (Maryland had one of the highest Readmission rates in the US in 2013)
  - Reduce frequency of Hospital Acquired Conditions by at least 30% over 5 years
  - Realize improvements in other clinical, patient safety and patient satisfaction measures at least equal to improvements nationally for Medicare patients

Mixed Performance Results Thus Far 2014-2018

- HSCRC shifted all 50 Maryland hospitals to adopt Global Budgets (10 had adopted Global Budgets starting in 2010)
- Growth in total All Payer hospital expenditures per Maryland resident was below the 3.58% limit in 4 out of the 5 years
- Maryland saved a little more than the required $330 million for Medicare (vs. U.S. growth rates) over 5 years (only 1.7% over 5 years)
- Maryland's Total Cost of Care (both hospital and non-hospital expenditures) was below the U.S. in CY 14 and CY16, but over the U.S. growth in CY 15, CY 17 and CY 18
  - Concern that care was shifting from hospital to non-hospital sector
- Maryland's Readmission rate declined to just below the US average
- Maryland Hospital Acquired Conditions decline by over 50% 2014-18
  - Concerns that a portion of decline was due to changes in documentation/coding
- Clinical care/Patient Safety measure performance was mixed; ED wait times increased and Patient Satisfaction worsened

Key Challenges

- Despite the very strong financial incentives of Global Budgets to reduce unnecessary volume and cost – Maryland hospital volumes remained flat and did not decline overall
- Possible reasons why hospitals did not reduce utilization:
  - The HSCRC annual updates to hospital revenue were very generous 2014-2018 and hospitals greatly improved their profitability
  - Hospital managers had less incentive to reduce volume and cost under a fixed budget as long as profit margins remained healthy otherwise
  - Hospital managers also did not want to antagonize physicians and specialists who did not face similar incentives (physicians were still paid on a FFS basis)
- Although Maryland met the key financial targets, savings produced was not very large ($500 million over 5 years = only about 1.7%)
- Evidence that care shifted from hospital to non-hospital sector
- Hospitals in urban and suburban areas found the system too rigid (i.e., it did not adjust budgets for shifts in volume across hospitals)
- Large teaching hospitals also found the fixed budgets too restrictive

Implications for Other Jurisdictions

- System is best administered by some regional or governmental entity with enforcement authority
- Hospital Global Budgets do contain very strong incentives to reduce unnecessary volumes and eliminate waste
- However, it is important to keep overall system revenue restricted to meet overall cost goals and provide strong incentives for hospitals to manage care
- Most effective if apply to an identified “Reference Population” – i.e., works best in Isolated regions
- Urban/Suburban hospitals with overlapping service areas (and reference populations) may experience problems when patients move across hospitals
- However, a Global Budget was applied successfully Regionally in Rochester NY for a group of Urban/Suburban hospitals
- Strong Quality-Based Incremental Incentive (P4P) Programs required to offset tendency to reduce quality or restrict care
- One alternative approach is a Hybrid System of Global Budgets for rural hospitals and DRGs with a Volume Adjustment System for others
- Challenges in extending Global Budgets to non-hospital services