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## The Future of Population-Based Reimbursement

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# Future of Population-Based Reimbursement

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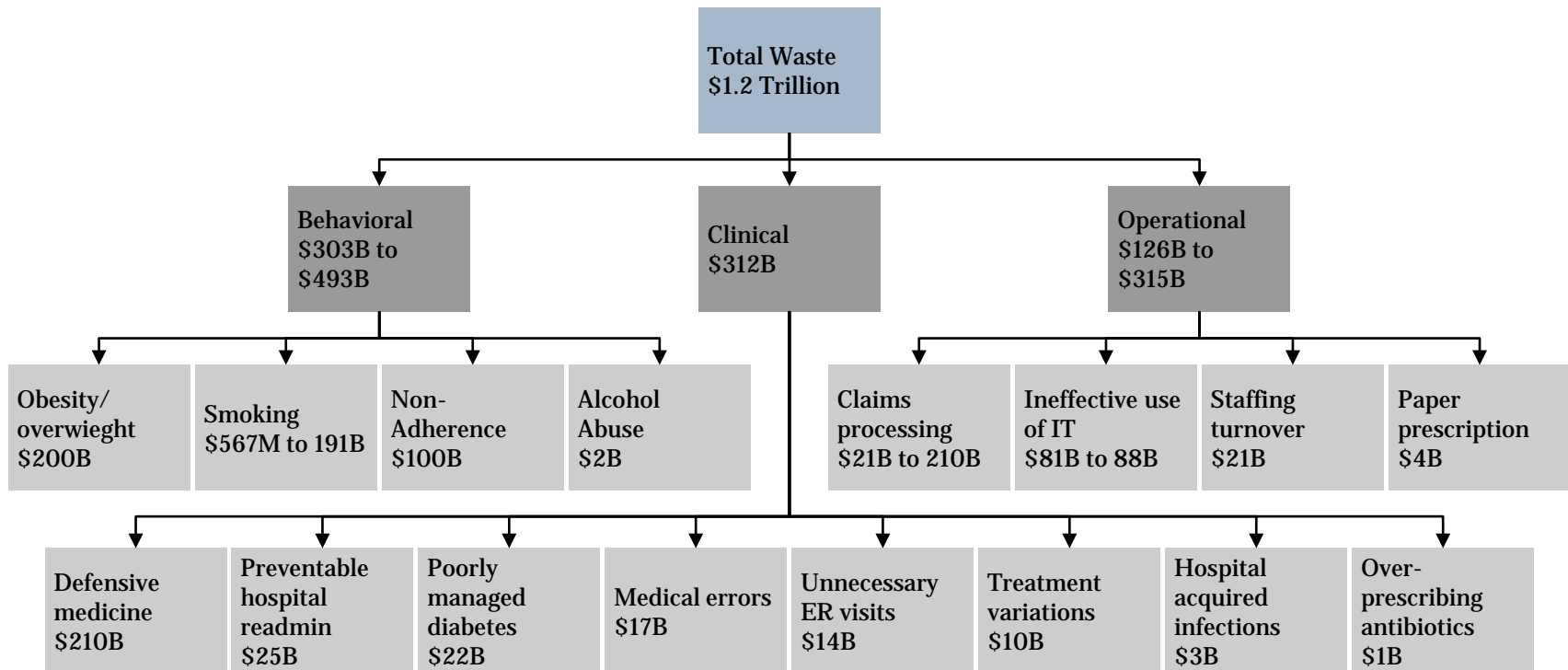
# Agenda

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- **FFS Context**
- **Maryland – 2014 CMS Waiver**
- **Implications**
- **Summary**

# Waste in US Healthcare

**Opportunities to eliminate wasteful spending in healthcare add up to \$1.2 trillion of the annual \$2.2 trillion spent nationally; these categories overlap**

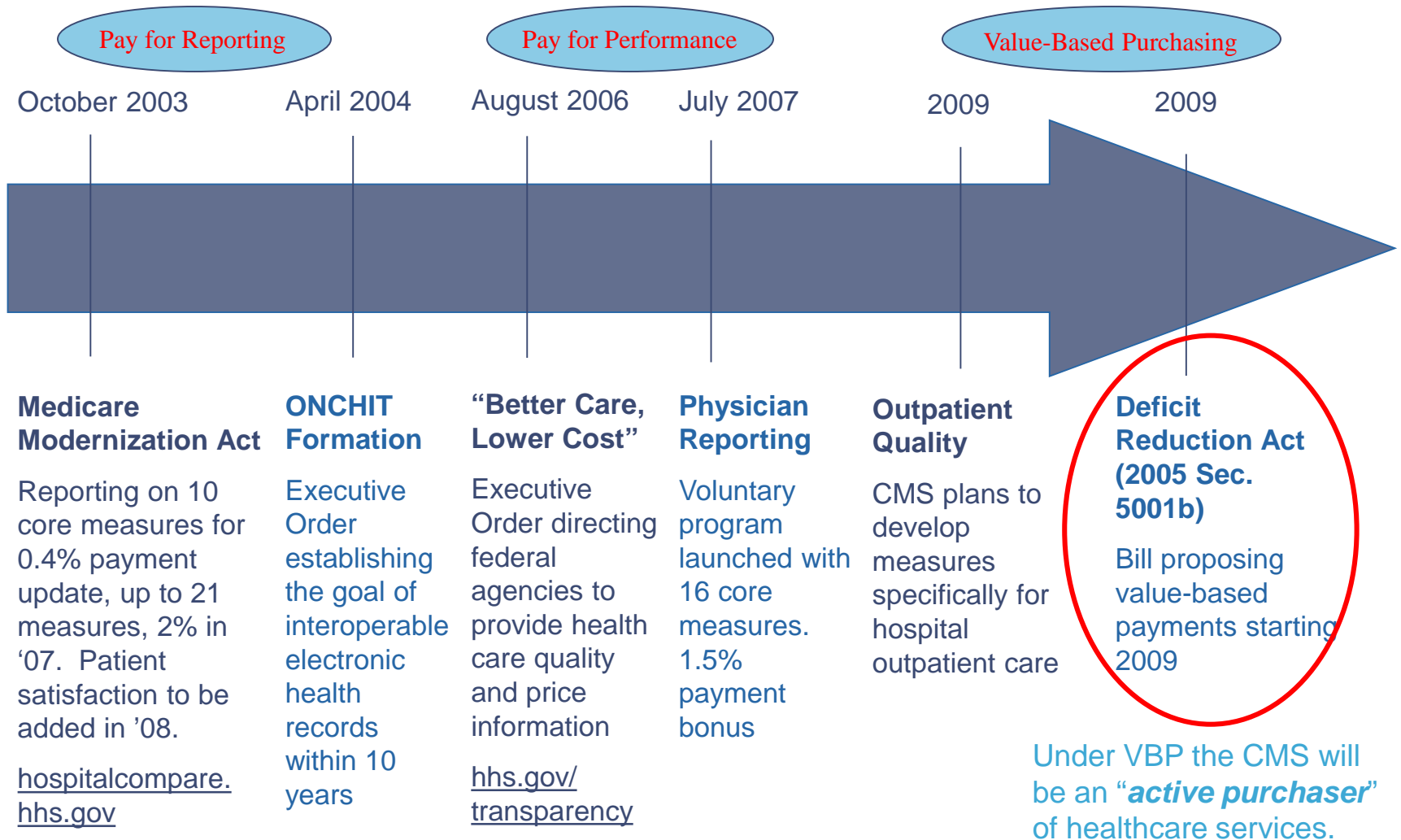


Waste cannot be eliminated immediately. However, by viewing waste in these baskets, the size of opportunities can be prioritized and rewarded. Like health spending itself, these categories overlap. Reducing one basket can affect the size of the others.

Source: Analysis by PwC's Health Research Institute based on published studies on inefficiencies in healthcare.




# Quality and Payment Reform in FFS




# Three tranches of health reform

## Regulation and coverage (2010-2013)

- Elimination of pre-existing coverage exclusions for children and lifetime coverage limits and rescissions; dependent coverage through age 26
  - MLR minimums for non-grandfathered plans
  - Medicare Part D gap narrows, Medicare Advantage rates frozen, bonuses available, beneficiary rebates, free preventive care
  - Temporary high risk pools
  - Fee on brand -name pharmaceutical manufacturers
  - Community Living and Support Services Act (CLASS Act)
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## Major expansion of coverage (2014)

- Mandates for individuals
  - Employer penalties for those that do not provide coverage
  - Health insurance exchanges
  - Small employer and individual subsidies
  - Health insurer industry fee
  - Guaranteed issue, rating bands, and risk adjustment
  - Medicaid expansion
  - Disproportionate share payment reductions to hospitals
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## Bending the cost curve (2015-2020)

- Penalty for not adopting electronic medical records
- Independent Payment Advisory Board (IPAB)
- High-cost plan excise tax
- Medicare Part D “Doughnut Hole” closes
- Reduced payment for hospital-acquired conditions

# Ambulatory Sensitive Conditions

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- Uncontrolled diabetes w/o complications
- Short-term diabetes complications
- Long-term diabetes complications
- Lower extremity amputation among diabetics
- Congestive Heart Failure
- Hypertension
- Angina without a procedure
- Adult Asthma
- Pediatric Asthma
- Chronic Obstructive Pulmonary Disease
- Bacterial Pneumonia
- Dehydration
- Urinary tract infection
- Perforated appendix
- Pediatric gastroenteritis
- Low-weight birth



# Change in Chicago ACSAs 2010 – 2012

Service Line	% ACSAs	% All Other Cases in the Service Line
Cardiology, Interventional	(23.5%)	(12.7%)
General Medicine	(13.6%)	(5.7%)
Gastroenterology	(12.8%)	(6.2%)
Endocrine	(12.0%)	(1.4%)
Thoracic Surgery	(11.1%)	(9.0%)
Neurology	(7.8%)	(5.6%)
General Surgery	(6.8%)	(3.2%)
Pulmonary	(2.4%)	0.3%
Cardiology	(10.2%)	(11.5%)
Vascular Surgery	(5.8%)	(9.3%)
Urology	(3.8%)	(12.1%)



# Old vs. New Maryland Waiver

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- Old Model

$$\text{Rate} \times \text{Volume}_x = \text{Revenue}_x$$

- New Model

$$\text{Revenue} = \text{Rate}_x \times \text{Volume}_x$$

# Original Maryland CMS Waiver

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- All payer including Medicare/Medicaid
- Cumulative Spending Growth Targets
  - Hospital Admission Costs
    - 26 % above national average in 1977
    - 4% **below** national average in 2011
- Uncompensated Care Pool
- Regulated and Unregulated Space

# New Maryland Waiver from CMS

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- 5 year demonstration – Global Budget Revenue (GBR)
- Per capita tests
  - Annual increase in total hospital costs for Maryland residents in Maryland hospitals per capita must be less than 3.58%
  - Increase in Medicare total hospital costs for Maryland beneficiaries per capita over 5 years must beat national per beneficiary trend by \$330 million

# Other Parts of the CMS Waiver

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- Quality improvements
  - Readmissions
  - MHACs
  - Other quality measures
- Other Guardrails
  - Total cost of care
  - Non-Maryland Medicare hospital spending

# Health Services Cost Review Commission

## GBR Agreements

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- All hospitals have reached agreement
- 95% of all revenue in the state is under GBR
  - Most of what is not in GBR is JHHS out of state
- Agreements are posted on HSCRC web site.
- Contracts automatically renew

# HSCRC FY15 Update

## 3.58% ≠ Update

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Maximum per capita revenue growth	3.58%
Population growth	0.71%
Maximum revenue growth	4.32%

### Inflation

- |           |       |
|-----------|-------|
| • GBR     | 2.41% |
| • Non GBR | 1.71% |

+/- Adjustment for Volumes

+ CON Adjustments

+ Infrastructure Allowance

+/- Uncompensated Care

+/- Quality Metrics

+ Contingency

+/- Other Assessments

Has to add up  
to well less  
than 4.32%

# Quality Measures and Targets

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Measures focus on patient and population health improvement

- Medicare readmission reduction to national average
  - FY2015 target is 6.76% reduction per Maryland hospital
- Potentially preventable hospitalizations
- Reduce potentially preventable complications by 30% over 5 years
  - State target = 8% aggregate reduction per year

# Regulated to Unregulated

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- “When services covered by the GBR model are moved to an unregulated setting, an adjustment will be made to ensure the shift provides savings”
- Precise calculation not known
- Annual disclosure of changes in services provided

# Rate Compliance

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- Unit rate compliance
  - Hospitals must charge HSCRC rates or face penalties
  - In order to hit revenue target, hospitals must alter rates as volume fluctuates
  - Allowed corridor increased to +/- 5%
    - Generally to all rate centers
    - May request up to +/- 10%
- Overall compliance
  - Total GBR compliance +/- 0.5%
  - Opportunity to move revenue/services within a hospital system

# Overall Compliance

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- Overall compliance
  - Total GBR compliance +/- 0.5%
  - Opportunity to move revenue/services within a hospital system

# Market Share

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- HSCRC will monitor volume changes
- Policy still under development, but some general statements
  - Will separately consider reductions in avoidable volumes
  - Upward volume adjustment only to extent there is corresponding reduction elsewhere
  - Will monitor inappropriate shifting of cases
- Will consider one-time ACA volume impact
- Will consider other one-time exogenous factors

# Transfers

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- Under development
- Will apply to in-state transfers among hospitals
- Monitored relative to base
- Expect that an amount will be charged to transferring hospital and credited to recipient

# HSCRC

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- Established in 1971 to set hospital rates
- All-payer waiver in 1977
- Governed by 7 commissioners – maximum of three providers
- All acute, specialty, and mental health hospitals in Maryland
- Free-standing ambulatory and physician offices excluded

# CRISP

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- Established in 2009 as an HIE
- All Maryland and 6 DC Hospitals
- Regional Extension Center for HIT for 1000 primary care providers
- Real time ADT, ER visits, lab, radiology, discharge summaries, Rx, H&P, Consultations, and Operative Notes

# Challenges

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- Virtual “Medicare Advantage Plan” for 750,000 Maryland Medicare recipients
- Attribution for Population Denominators for Global Budgets
  - Western Maryland Experience
- Physicians and Unregulated Space

# Care Management

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- **Primary Care MDs**
- **Specialists**
- **Sites of Care**

Pham, et al; Ann Intern Med 2009;356(11) 236-42

# Near Term Success Factors

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- Need to maintain volumes at FY 2013 levels by reducing inappropriate (readmissions, hospital acquired conditions, avoidable admissions) and increasing appropriate volume
- Reduce operational costs
- Need to optimize utilization of all assets
- Maximize Out of State/International volume

# Summary

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- FFS Context
- New Waiver is a call to action
- Creates a “glide path” for change
  - Alignment of Incentives
  - Alignment of Infrastructure
- Value is the new gold standard
  - Quality
  - Appropriate hospital care
  - Cost efficiency
  - Population health focus