



Maryland Total Cost of Care Model

Update on Key Activities

Health Services Cost Review Commission
Katie Wunderlich – Executive Director



HSCRC - Who We Are



The State of Maryland Health Services Cost Review Commission (HSCRC) is the State agency responsible for regulating the quality and cost of hospital services in order to ensure all Marylanders have access to high quality healthcare services.

We help lead the State's efforts to transform the delivery system and achieve population health improvement goals under the Total Cost of Care Model.

Under this Model and through our previous All-Payer Model, we aim to improve health outcomes, enhance the quality of care, and ultimately reduce the total cost of care for Marylanders.

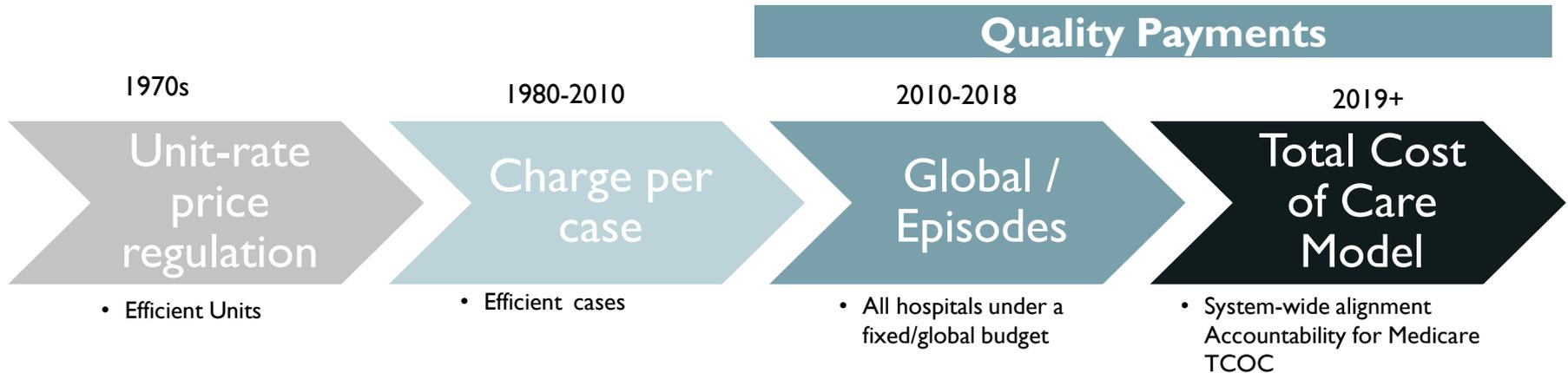
Agenda

- ▶ **Maryland's Unique Healthcare Delivery System**
 - Overview of Maryland's All-Payer Hospital Rate Setting
 - All-Payer Model, 2014-2018
- ▶ **Maryland's Total Cost of Care (TCOC) Model, 2019-2028**
 - Model Overview
 - Model Components
 - Statewide Integrated Health Improvement Strategy
- ▶ **Partnering with MHBE and other stakeholders**

Maryland's Unique Healthcare Delivery System:
Overview of All-Payer Hospital Rate Setting



Evolution of the Maryland Model



- ▶ Since 1977, Maryland has had an all-payer hospital rate-setting system
- ▶ In 2014, Maryland updated its rate setting approach through the All-Payer Model:
 - ▶ Contractual agreement between Maryland and federal government
 - ▶ Patient-centered approach that focuses on improving care and outcomes
 - ▶ Per capita, value-based payment framework for hospitals
 - ▶ Stable and predictable revenues for hospitals, especially those providing rural healthcare
 - ▶ Hospital-led efforts to reduce avoidable use and improve quality and coordination

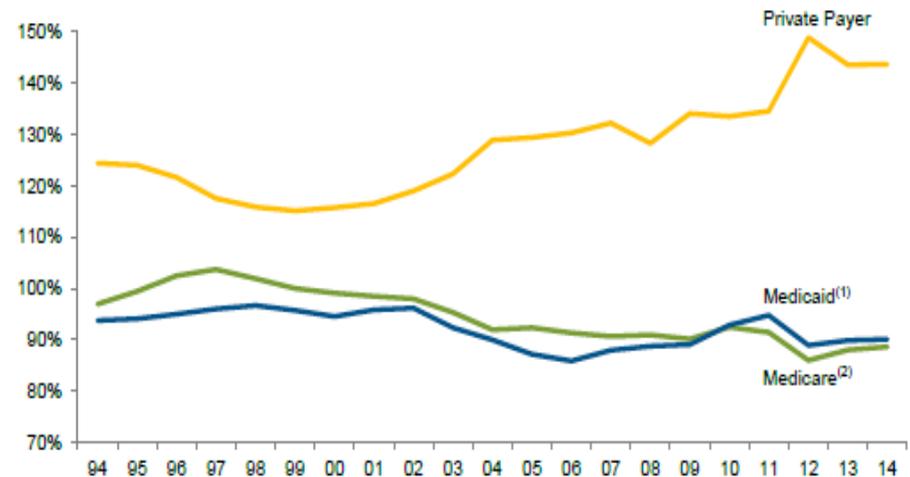
Value of Maryland's All-Payer Hospital Rate Setting System

Maryland's approach:

- ▶ Avoids cost shifting across payers
- ▶ Cost containment for the public
- ▶ Equitable funding of uncompensated care
- ▶ Stable and predictable system for hospitals
- ▶ All payers fund Graduate Medical Education
- ▶ Transparency
- ▶ Leader in linking quality and payment

While the rest of the nation sees:

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1994 – 2014



Source: American Hospital Association
(1) and (2). Includes Disproportionate Share Hospital (DSH) payments.

Other Advantages of the Maryland Model

- ▶ Hospitals do not negotiate charge masters with various insurers or focus on “upcoding”
- ▶ Lower prices for private insurance creates a healthy marketplace for competition
- ▶ Maryland’s health system is on track for sustainable and transparent health spending growth
- ▶ The system benefits private insurance spending while controlling Medicare growth with the federal agreement

Move from Volume to Value Under All-Payer Model Transforms Hospital Incentives

- ▶ **No longer chasing volumes on pressured prices**
- ▶ **Incentivized:**
 - ▶ Reduced readmissions
 - ▶ Reduced hospital-acquired conditions
 - ▶ Reduced ambulatory-sensitive conditions, or Prevention Quality Indicators (PQIs)
 - ▶ Better managed internal costs
- ▶ **Results**
 - ▶ Improved health care quality, lower costs, better consumer experience

But more to be done ...

All-Payer Model Results, CY 2014-2018

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ \$330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	\$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	\$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓

* \$273 million in Medicare TCOC savings in 2018 alone – aka Medicare savings run rate (vs. 2013 base)

Maryland's Story of Success: Medicare FFS Savings vs. National Growth since 2013

- ▶ Savings overwhelm dissavings
- ▶ Biggest savings (that is, Maryland difference from national growth) from hospital spend
 - ▶ Primarily from volume declines, not price (although ~0.2% removed annually from hospital GBRs for potentially avoidable utilization (PAU))
 - ▶ Hospital Outpatient is largest source of savings
 - ▶ Hospital Inpatient also produced savings
- ▶ Dissavings: Increase in Part B non-hospital. For example:
 - ▶ Moving certain surgeries from hospital to community settings
 - ▶ Moving from ED to community settings
 - ▶ Incentivizing more community care and follow-up to avoid readmissions
- ▶ Dissavings: Increase in home health and hospice
- ▶ All potentially positive effects of the Maryland Model

Maryland Total Cost of Care Model (2019-2028)

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/9/18

By: Adam Boehler, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF MARYLAND

Date: 7/9/18

By: Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

By: Nelson Sabatini, Chairman



TCOC Model Agreement
Signed on July 9, 2018



Changes from All-Payer Model to Total Cost of Care Model

**All-Payer Model
2014 - 2018**

Hospital Focus



**Total Cost of Care Model
2019 - 2028**

System Wide Focus

Hospital Savings



Total Cost of Care Savings

Hospital Quality



Hospital Quality & Population Health

Total Cost of Care (TCOC) Model Overview

- ▶ **A 10-year agreement (2019-2028) between Maryland and CMS**
 - ▶ Five years (2019-2023) to build up to cost savings and five years (2024-2028) to maintain Medicare cost savings and quality improvements
 - ▶ Opportunity to “expand” the model (that is, to make it permanent) based on how we perform over the next 3-5 years
- ▶ **Limits growth in total cost of care per capita and improves quality and population health by:**
 - ▶ Continuous quality improvement in setting hospital global budgets
 - ▶ Engaging non-hospital providers in care transformation and TCOC responsibility
 - ▶ Targeting specific population health goals and interventions

Total Cost of Care Targets

Reduce Medicare Costs

- Achieve \$300 million in Medicare savings annually by 2023 (from 2013 base year)

Limit Hospital Revenue

- Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually

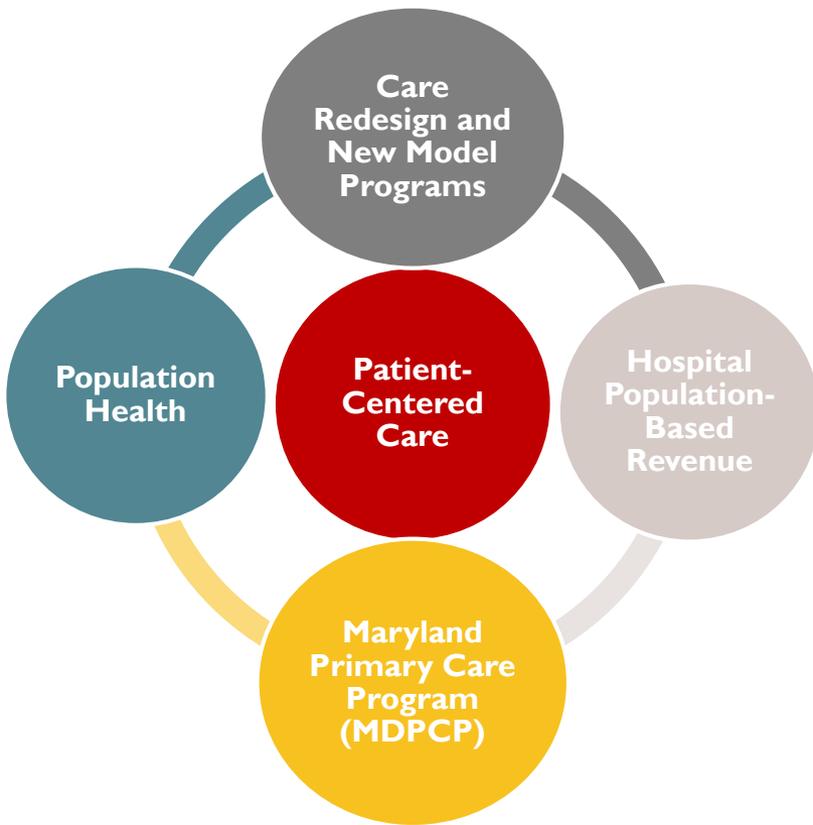
Transform Care

- Coordinate care for patients across both hospital and non-hospital settings to improve health outcomes and constrain the growth of costs

Improve Population Health

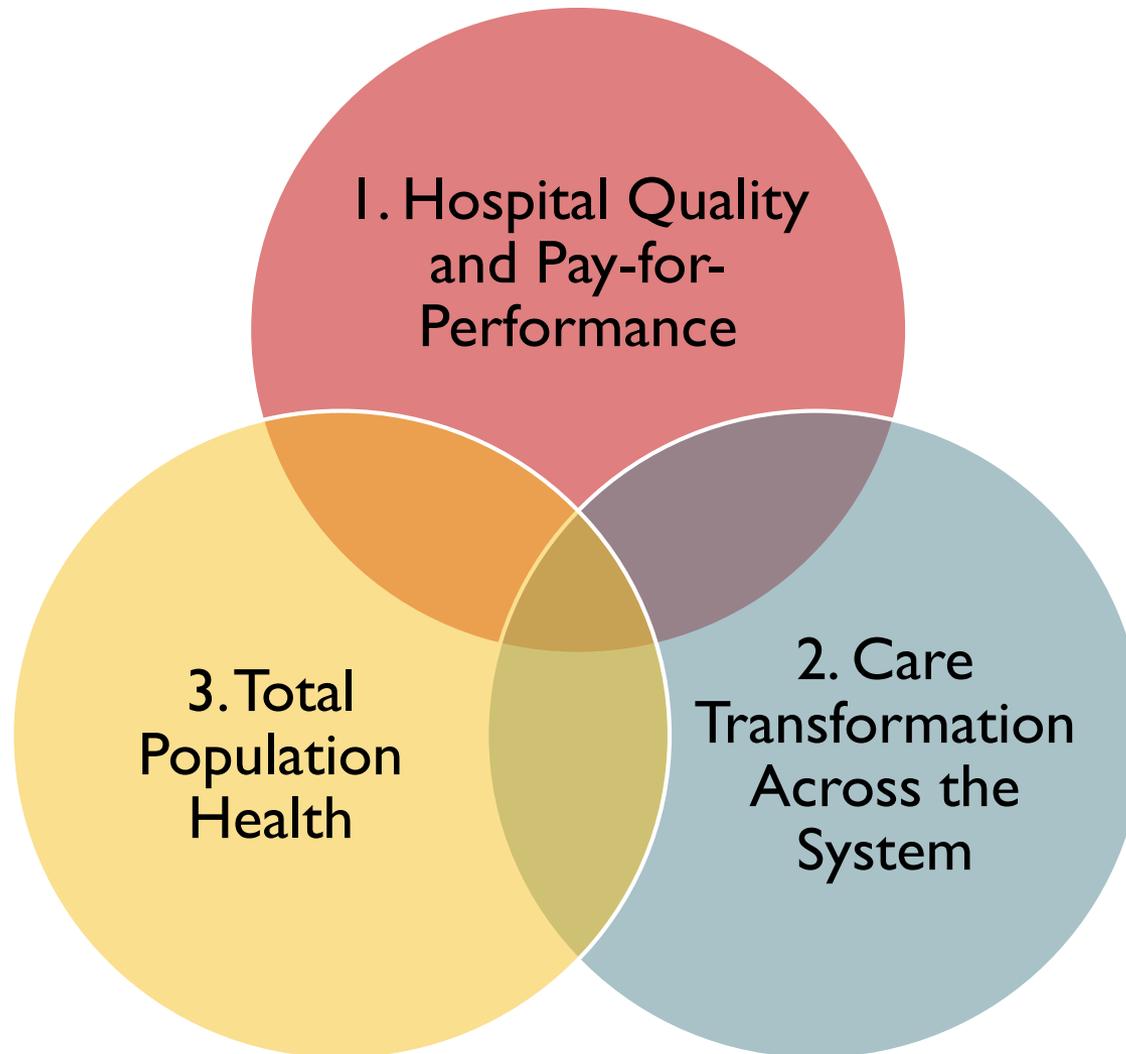
- Address Maryland's highly prevalent chronic conditions

Total Cost of Care Model Components

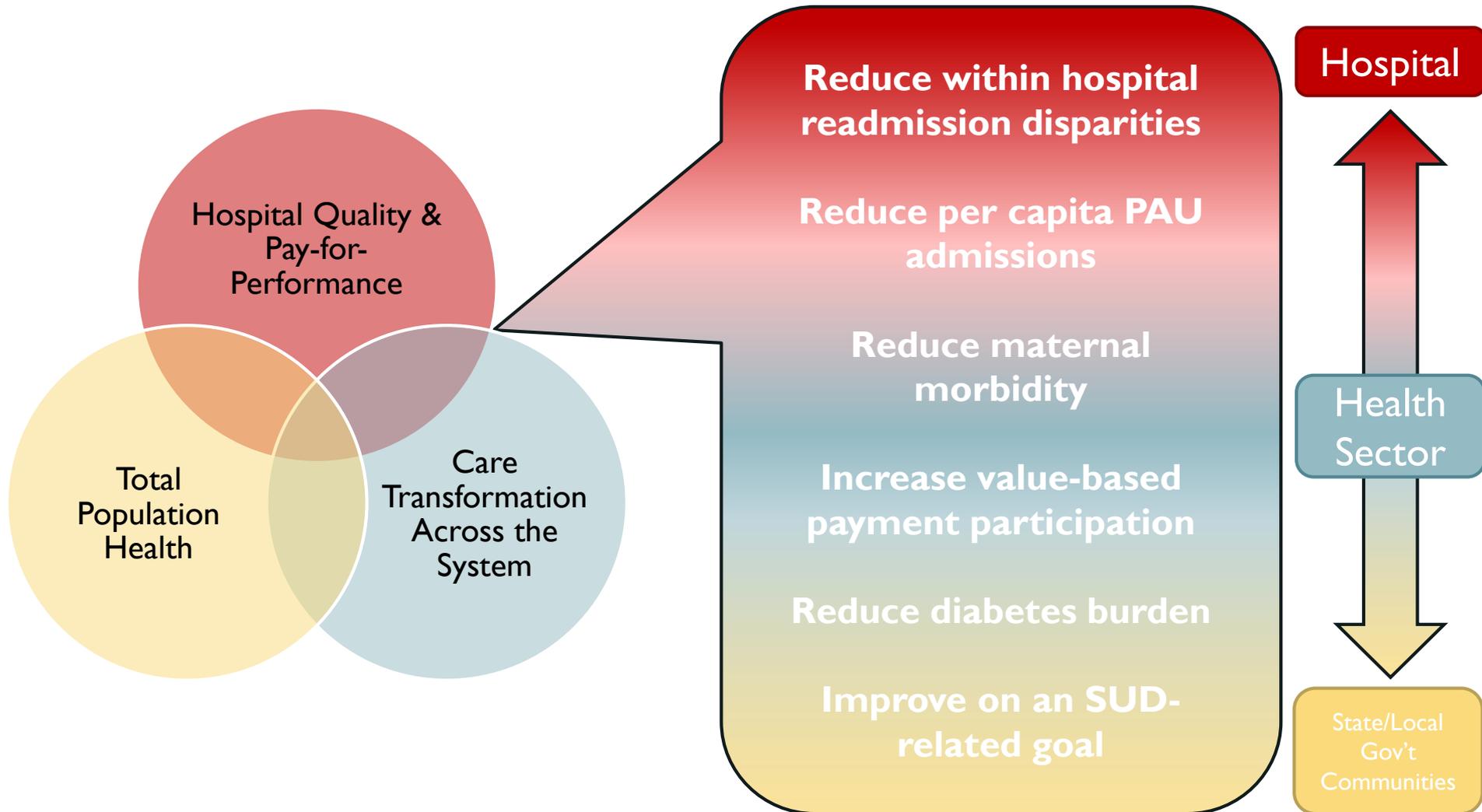


Component	Purpose
Hospital Population-Based Revenue	In addition to Global Budgets, expand hospital incentives and responsibility through revenue-at-risk.
Care Redesign and New Model Programs	<ul style="list-style-type: none"> • Enable private-sector led programs supported by State flexibility • Support MACRA payments • Expand incentives for hospitals to work with others • Develop New Model Programs (EQIP) convened by non-hospital entities and providers
Maryland Primary Care Program	Enhance chronic care and health management for Medicare enrollees
Population Health	Encourages programs and provides financial credit for improvement in statewide diabetes, opioid addiction, and other priorities

Statewide Integrated Health Improvement Strategy



Potential Examples of Shared Outcomes and Goals



First Health Improvement Area: Diabetes

- ▶ Leading cause of preventable death and disability
- ▶ Increasing prevalence reflecting significant racial, ethnic and economic disparities
- ▶ Evidence-based interventions (EBIs) can prevent or delay onset and improve outcomes
- ▶ Maryland Medicaid launching Diabetes Prevention Program (DPP) this Fall
- ▶ Diabetes/obesity cited as a priority by every jurisdiction's Local Health Improvement Coalition (LHIC) and every hospital's Community Health Needs Assessment (CHNA)
- ▶ Strong private sector support for a sustained statewide initiative
- ▶ Success provides credit in TCOC Agreement

Other HSCRC Tools - “Catalyst Grant Program”

The Regional Partnership Catalyst Grant Program is a reset of the HSCRC grant program in order to:

- Align with the goals of the Total Cost of Care model
- Support the CMMI MOU for a Statewide Integrated Health Improvement Strategy
- Meet Commission requirements to demonstrate a measurable impact of funded activities

Funding Stream I:

Diabetes Prevention & Management Programs

- Support implementation of CDC approved diabetes prevention programs
- Support diabetes management programs

Funding Stream II:

Behavioral Health Crisis Services

- Support implementation or expansion of behavioral health models that improve access to crisis services

Funding Stream III:

Population Health Priority Area #3

- To be defined

Partnering with the Maryland Health Benefit Exchange

HSCRC

Health Services Cost
Review Commission

HSCRC and MHBE working together

- ▶ Statewide Population Health Improvement Strategy requires concerted effort by a wide variety of State stakeholders, both public and private
 - ▶ Diabetes prevention and management
 - ▶ Behavioral health management and outcome improvements
- ▶ Maryland Model emphasizes sustainable growth in health care costs, coupled with quality improvements, as leading measures for success
 - ▶ HSCRC and MHBE should work together to ensure savings accrued by Maryland Model through hospital savings are available to consumers



Thank You!

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