Global Payment: Lessons from Maryland

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Looking for a solution

High and rising health spending

Less than optimal outcomes

Considerable waste and inefficiency

FFS rewards volume

Alternative payment models hope to better align financial incentives with what we want (or claim to want)

Will payment reform lead to delivery system reform?

How global is global payment?

Global payment intends to shift incentives from volume to value

Providers financially accountable ("bear risk")—to some extent

Bundled payment: episode of care

Capitation: care for enrollee for a period of time

ACOs (FFS "shared savings") ≠ global payment

Global payment ≠ government price regulation

Global payment challenges

Risk selection

Performance measurement

Market consolidation/hospital integration with physicians

Paying downstream providers

Coordination with health insurance

Consumer expectations

The FFS anchor

Maryland's all-payer model

4+ decades of regulation

- 1971: HSCRC established
- 1974: HSCRC sets hospital rates for non-federal payers
- 1977: Federal waiver to test alternative payment models (all-payer rate regulation)
- 1980: Medicare waiver becomes permanent
- 2014: 1st new waiver moves to global hospital payment
- 2019: 2nd new waiver moves to total cost of care

Why the shift?

All-payer rate setting v. global payment

All-payer rates for each hospital, but different hospitals receive different rates

Global hospital payment: sets total hospital revenue at beginning of the year

Total cost of care: Incorporates hospital and non-hospital spending

All-Payer Model Results
CY 2014- 2016

Performance Measures	Targets	2014 Results	2015 Results[1]	2016 Results (preliminary)[2]
All-Payer Hospital Revenue Growth	**≤ 3.58% per capita annually**	**1.47% growth per capita**	**2.31% growth per capita**	**0.80% growth per capita[3]**
Medicare Savings in Hospital Expenditures	**≥ $330m over 5 years** (Lower than national average growth rate from 2013 base year)	**$116m** (2.15% below national average growth)	**$135m** **$251 cumulative** (2.22% below national average growth since 2013)	**$287m** **$538m cumulative[3]** (5.0% 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**	**$133m** (1.53% below national average growth)	**$80m** **$213m cumulative** (0.85% below national average growth since 2013)	**$151m** **$364m cumulative[3]** (1.5% below national average growth since 2013)
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	**30% reduction over 5 years**	**26%** reduction	**35%** reduction since 2013	**43%** reduction since 2013
Readmissions Reductions for Medicare	**≤ National average over 5 years**	**20%** reduction in gap above nation	**57%** reduction in gap above nation since 2013	**76%** reduction in gap above nation since 2013
Hospital Revenue to Global or Population-Based	**≥ 80% by year 5**	**95%**	**96%**	**100%**

[1] 2015 figures for readmissions are preliminary because CMS is evaluating the readmission data after ICD-10.
[2] Preliminary results for calendar year 2016, these have not been validated by CMS.
[3] Actual revenues were below the ceiling for CY 2016 and these numbers have been adjusted to reflect the hospital undercharge of approximately 1% that occurred in the second half of CY 2016.

Lessons

1. Changing payment methods does not guarantee lower cost/improved quality/transformed delivery system
2. Provider, insurer, consumer interests must be aligned—but reducing unnecessary admissions is key
3. How much is paid matters as much as how payment is made
4. Less global approaches have less risk and less reward
5. Accurate, timely, detailed clinical and financial data a must
6. Critical mass of patients necessary—including Medicare
7. Flexibility is essential