



Maryland's New All-Payer Hospital Demonstration

Interview with John Colmers, Donna Kinzer, and Josh Sharfstein

Robert A. Berenson

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Maryland, the only state that continues an all-payer rate setting system for hospitals, embarked on an ambitious plan in 2014 to transform its approach under the authority of a new Medicare demonstration. The five-year demonstration will test all-payer global budgets for hospitals while attempting to use the platform of hospital payments to shift to population-based payments for most health care services. To learn more about the genesis of this demonstration approach, experience to date, and challenges faced, Robert Berenson, an Institute fellow at the Urban Institute, interviewed John Colmers, chairman of the Maryland Health Services Cost Review Commission (HSCRC), Donna Kinzer, executive director of the HSCRC, and Joshua Sharfstein, former secretary of the Maryland Department of Health and Mental Hygiene.

During the 1970s and 1980s, statewide all-payer rate setting programs were enacted in four states, including Maryland, through a Medicare waiver. These programs intended to constrain hospital price and cost increases while providing greater uniformity in hospital prices and payment methods across the system. Though the other states abandoned rate setting with the rise of managed care in the 80s, Maryland has continuously maintained and evolved its rate-setting program, now in its 41st year and administered by the HSCRC, an independent state agency governed by appointed, volunteer Commissioners and administered by a professional staff of about 40.

Maryland's rate setting system's performance record is mixed. It has successfully restrained per service growth in prices, moving from an average cost per hospital admission that was 25 percent above the US average to the middle of the pack. However, the cost growth in per capita hospital services has grown rapidly, largely because hospitals have responded to unit price constraints by increasing the volume of services more than other states. For details about the history of the Maryland hospital

payment system and the reasons for moving to the new demonstration approach, see *Revisiting State Rate Setting for Hospitals: Promises and Pitfalls* (Murray and Berenson 2015).

Before 2014, the various public and private payers paid hospitals on the basis of approved charges for units of service. The current approach, explored in the following interview, relies on global budgets. Under the terms of the demonstration, hospital revenue must meet two tests based on (1) a limitation on all-payer per capita hospital charge growth of Maryland residents and (2) a limitation on the growth in hospital expenditures per Maryland resident traditional Medicare beneficiaries. The demonstration also requires hospitals to maintain or increase quality-based pay-for-performance programs and reduce the currently high Medicare readmissions rate to be at or below the national rate.

Interview

Berenson: What is the purpose of the demonstration that the state and CMS [the Centers for Medicare & Medicaid Services] negotiated? What do you hope to accomplish during its five years?

Colmers: The hypothesis is that by applying an all-payer approach to controlling the aggregate spending per capita for hospitals services, we can accelerate movement toward the *three-part aim*. The incentives established under this system will begin to align the direction and activities of other components of the health care system in support of improved health of the population, improvements in the patient experience of care, and lower per capita cost.

Sharfstein: I'd say what John is getting at in a slightly different way. By leaving behind fee-for-service [FFS] across all payers, the state can achieve greater gains in cost control and outcomes.

Berenson: So, in a sense, it's unit pricing with a ceiling that is based on DRGs [diagnosis-related groups]?

Colmers: That's how it was in the past. The new program is focused on holding the increase in per capita hospital spending for all payers to the long-term per capita growth of the state economy. In addition, Maryland has committed to controlling Medicare per capita spending for hospitals such that it generates \$330 million in savings for Medicare over the next five years.

Berenson: Since the demo began in January 2014, what progress have you made?

Colmers: The single most important progress, to HSCRC staff's great credit, was getting all 46 hospitals in the state on a global budget of some form by July of last year. It essentially means locking down a hospital's revenue to a known dollar amount irrespective of the volume generated. So, all 46 hospitals have entered into a contractual relationship with the state, an evergreen¹ contract with specific components to it. The first and most important step was to lock down the revenue, which has been accomplished. Work groups are ongoing on a variety of topics, like data infrastructure, care management activities that might be done across hospitals, and physician engagement activities. These are all essential because while this is a system that is designed initially around hospitals, the ultimate goal is to align those incentives with other health care providers in the system.

Getting everyone on a global agreement was essential, as was having workgroups with payers and providers of all stripes. Consumers are participating in an open and collaborative fashion to develop the techniques and approaches to make this sustainable in the long run. It's been going well and the results are encouraging— we're not resting on our laurels, but they are certainly encouraging.

Per capita spending in the state for hospital services has gone up, but less than the 3.58 percent per capita rate of increase that was established as the all-payer test. We believe, that on the Medicare component Maryland's per capita spending for hospital services has increased less rapidly than the country as a whole, thereby generating Medicare savings.² We've made substantial improvement in reducing hospital-acquired conditions. One area in which we haven't made as much progress is readmissions. We've seen a reduction in readmissions in the state, but not at the level we need to get to in order to match the national Medicare readmissions rate.

Kinzer: We also capped revenue while we were doing a massive Medicaid expansion and an exchange enrollment. So we have 200,000 expansion enrollees and we kept revenue caps in place. We were able to absorb those enrollees in the system without increasing the spending in the state by pressing down on utilization in other areas.

Berenson: The idea of a global hospital budget irrespective of volume, how does that work operationally? What if a hospital is getting volume because it is excelling such that people want to go there? Or if there is a large enrollment of the eligible population because they finally have insurance and have needs that are getting met? How do you distinguish between “good” and “bad” volume?

Kinzer: We're developing a sophisticated approach. We apply an age-adjusted population adjustment to each hospital based on demographic changes in its service area. This accounts for expected changes in utilization resulting from population and demographic changes. We are doing a “market shift adjustment.” We are focusing on isolating patients that shift from one institution to another at zip code and service line level so that we can move money from one hospital to another as patients move. So we will make market shift adjustments to keep hospitals responsive to consumers and keep hospitals from shedding service lines at the expense of another hospital's or of good service. We are also making an adjustment to increase hospitals' budgets for estimated growth in utilization from the enrollment expansions, while also reducing the uncompensated care funding for those individuals that had previously been provided in hospitals' revenues. We are able to do this in a sophisticated manner by linking Medicaid IDs to pre- and postenrollment hospital claims, using a master patient identifier generated through our Health Information Exchange. This allows us to look at utilization growth for the 200,000 new Medicaid enrollees in a very sophisticated way, and to estimate the impact on each hospital.

The Challenge of Assessing Changes in Hospital Volume

Berenson: Do you have to make a judgment about whether the shift is warranted? Or is it just a formula that if volume is going up there is a shift of a certain amount?

Kinzer: To make a shift, volume has to go down at one place then up at another. If you have volume going up everywhere, there isn't a shift. We limit the shift adjustment to balance the volume decrease and the volume increase. If there is no down and up, there is no shift.

Colmers: There is a value judgment in the sense that what we term as "potentially avoidable utilization"³ isn't subject to that market shift calculation. If what's going down at one place is avoidable admissions and what's going up at another place is avoidable admissions, there is no shift that takes place.

For example, if someone reduces readmissions, we pull those cases out of the market shift adjustment. We've pulled out admissions for ambulatory care-sensitive conditions. We've done a lot of work to reclassify patients on a consistent basis for shifts from observation to inpatient to make sure we aren't just moving money around inside a hospital and not changing the cost of the delivery. So we are just completing a fairly sophisticated model. We also have an approach to effectively allow the volume growth in highly specialized services, to "pass through," if you will. It's part of the global budget, but we allow for an annual adjustment to the global budget, so we aren't capping certain things like transplants, high end burn patients, and highly specialized cancer care.

Berenson: It seems to be a balancing act between not undoing the incentive to reduce volume and not paying for volume that goes elsewhere.

Kinzer: Right, and we have very good data. We get detailed monthly abstracts on all of their bills for inpatient and outpatient care from each hospital every month. Within 60 days of the point of service we can turn the data around. We will continue to modify the approach to improve it once it has been implemented.

Berenson: What happens on the other side if there is a very bad flu season and hospitals can argue that that's the reason for the volume growth. Can you adjust the budget?

Kinzer: Yes, we can adjust for flu season, if it's very unusual and volume is higher than the base.

Berenson: If there is a generalized reduction in volume that isn't a shift, the objective is to not penalize hospitals, but to assure them of their budget for the next year, right? Because if you reduce their budget because their volume declined, they have less incentive to actually reduce the volume. Do I have that right?

Kinzer: Yes.

Berenson: So that's why there isn't an automatic adjustment for reduced volume. What happens when you have a hospital losing volume because there is less demand for services? Do you have authority to adjust their budget?

Colmers: Yes, there would be an opportunity to reestablish a global budget based on a new reality. We wouldn't say a priori it happens every year. But if we see the demand down significantly, there can be an adjustment. Remember, how it works is you're operating on a fixed budget, say \$100 million. If your volume declines 10 percent, you're still charging on a fee-for-service basis so you don't get \$100 million.

So, if your volume declines 10 percent, you have to raise rates 10 percent to keep \$100 million.⁴ In the scenario you described, you would see unit rates go up significantly. But they are still in a competitive market and may not want to have rates that high. So there may be good reason from a hospital's perspective to shed additional revenue.

Kinzer: We do have two quality adjustments that provide for reduced volumes. One is an adjustment for readmissions and the other is a reduction for avoidable utilization. These adjustments are calculated on a hospital-specific basis.

We have the ability to limit rate changes if there are very significant volume reductions. We start looking at volume reduction once they would require a 5 percent rate increase to keep a hospital's revenue on budget. If volumes go down, hospitals have to raise unit rates in order to reach the revenue budget. They are allowed to do this automatically until they reach a 5 percent rate change overall. If the rates need to increase by more than 5 percent, they must communicate with HSCRC staff to increase the corridor for rate changes. The HSCRC staff will generally grant a rate adjustment up to 10 percent so long as it is satisfied with the explanation of the volume reduction.

Beyond 10 percent, staff has an additional review process to ensure it understands the reduction—for example, to ensure avoidable utilization is being reduced, and that patients are not just being shifted to another setting. Depending on the magnitude of the decline, there may be an opportunity to share savings. However, hospitals are making large investments to improve care to reach the savings, and the Commission wants to ensure that savings are retained to reinvest in additional interventions and improvements.

We have two other routine adjustments for volume changes. One for quaternary care, so we aren't constraining volume for transplants and some highly specialized cancer services, for example. We adjust the budgets once a year for changes in these services. We wanted to ensure that funds would be available for these highly specialized services.

Our second routine adjustment is for transfers. There was initially some concern that more of the high-needs patients would be transferred to the academic medical centers out of the other hospitals. We put in a transfer policy to provide additional money to academic medical centers when they get transfers in. Correspondingly, we don't want community hospitals to think twice about transferring for medical reasons, so we provided a buffer zone for transfer increases where the transferring hospital is not charged for the increased transfers. But if transfers increase beyond a relatively high threshold, reflecting a major shift in service delivery, we will charge the community hospital budget. An example of this is a hospital that decides to transfer ventilator patients instead of keeping them in their own facility.

Berenson: Are there other potential epidemiologic or technology changes—or policy changes—that would justify you accepting volume increases and raising budgets?

Colmers: We are able to look at such exogenous events and consider if we want to make adjustments. Some of these types of events were specifically identified in the agreement we have with CMS and others were left purposefully vague. We consider them public health anomalies. With Ebola, because of

the way the care is being localized, if we have particular facilities that become hubs for treatment, we might want to make an adjustment. One other adjustment, which we contemplated in the agreement with CMS, is that if as a state if we were doing a better job of having people enrolled, whether it was in Medicaid or exchange products, the Commission could make adjustments to hospital budgets.

Kinzer: Because if hospitals had some unlimited potential for increase of Medicaid patients, they wouldn't want to agree to a global budget. We have pretty sophisticated calculations. We've taken new Medicaid enrollees and can look at their utilization from the base year and compare it to the current year and do it by quarter. It's fascinating because we were told by the actuaries that by the end of the year most excess utilization would drop. That you would get pent up demand, then it would drop. That's exactly what we are seeing. By the end of the year the excess utilization was down to 15 percent above the base.

Berenson: Does the demo apply to spending and quality just for residents of Maryland or to all patients seen in Maryland hospitals?

Colmers: The rate setting authority of the Commission is over hospitals. It applies to all people who go to hospitals in Maryland. Hospitals have to charge these rates and payers pay them. The all-payer Maryland test is for Maryland residents. But regardless of meeting the test, if you're an out-of-state patient and you come into Maryland, you're subject to paying the rates set by the Maryland Commission. But the Medicare test is Medicare hospital spending regardless of where beneficiaries get care. They can get hospital care in Florida or Hawaii, it doesn't matter.⁵

Berenson: Even Arab sheiks?

Colmers: Yes.

Berenson: So some rate setting continues, according to your previous methodology. How fast and complete will the shift from rate setting on individual services to a global budget and then to population-based payment be?

Sharfstein: The global budget approach was supposed to encompass 80 percent of payments by the end of the five years, and it's 95 percent already. But there is still rate setting. If your budget is \$100 and we expect you to have 10 admissions, we will let you charge \$10 per admission.

Colmers: The reason we set the goal of 40 to 50 percent payment by global budgets in year one is we thought it would take some time for hospitals to move off of fee-for-service. One thing that was of interest with CMS was "why isn't this going to turn into a doc fix problem?" Where you have an overall goal but everyone's individual interests don't align with the goal. So we wanted to get somewhere where hospitals were essentially facing financial incentives similar to the overall system as they were shifting from fee-for-service, but we thought it would take time. What happened was that the hospitals came to the realization that the future was going to require a different approach to their finances—and they would do better if they could transform their systems to meet it rather than be living in a volume world. Changing now was the better long-term strategy.

Kinzer: If you're going to try to transform, it's desirable to have a stable budget while you're shifting directions in a major way to respond to the new payment approach tied to what you're trying to accomplish.

Colmers: In reality the alternative was made unpalatable. People saw fewer variables and moving parts by going to fixed budget. And to be honest, the market shift adjustment is something we are in the midst of adopting. It will be interesting to see how people fare and how that will work. But by and large the hospital community has embraced this new model and many of them, as I can attest from my day job, are working very hard to understand and work within it.

Sharfstein: We had one hospital CEO say to us as we were developing the new approach, "To get a 1 percent margin, I have to do 5 percent more volume. So if you can give me a 1 percent margin and I can reduce my volume, we all win." That's the world he wanted.

Berenson: A recent book, *Diagnosis Related Groups in Europe* (Busse et al. 2011), describes how many European countries have moved to what they call "activity-based payment"—DRGs. They found that hospitals with fixed budgets didn't have to work very hard and queues for services resulted. They did not have to compete for patients. So many countries have adopted DRGs, but some have maintained global budgets as well.

Kinzer: There are limits to how much they can raise their prices if their volumes fall and if other hospitals pick up the patients, we are focused on moving revenues. We have very detailed timely data and we can closely monitor changes in volumes at a macro and micro level. The French have been to visit us already, and they are saying "Our volumes are flying through the roof since we went into a DRG system. What should we do?" And we said, it's funny you come to visit us now. There's no question that you have to adjust and make decisions on what levers you're going to pull based on what the needs are. Right now we need to focus on reducing avoidable utilization and moving away from paying based on volumes. The French are looking at volume adjustments to reduce the variable revenue provided for growth. You can't pull on the price and the volume levers at the same time. So we're focused on reducing avoidable utilization and having hospitals reinvest that money into care improvements and coordination, which are very expensive to institute.

The History of Maryland Rate Setting

Berenson: Maryland has been the only all-payer rate setting program that has survived the broad movement to more competitive health care markets. The other all-payer states gave up.

Colmers: The notion of rate setting being antithetical to competition is wrong. Prices are important to attract patients and payers. Prices matter here and the hospitals have to have reasonable prices to compete—a payer can decide not to contract or to steer elsewhere.

Kinzer: Even with a global budget, the hospitals are focused on competition. Their focus has turned more to attracting and retaining patients and less toward volume growth. However, if their avoidable volumes go down a lot and they do not attract more patients or provide some new services, their prices

may go up too high. They're concerned about high prices because the payers and purchasers are concerned about it. At some level there will be excess capacity, and we will need to reduce excess capacity as it develops.

Berenson: What about the previous, long-standing regime of rate setting led you to seek the new demonstration? What were the successes? What were the failures?

Colmers: It was relatively straightforward. There are many advantages to all-payer rate setting, as payers and hospitals would agree. Cost containment had generally worked. Per admission increases in payments per admission in Maryland had fallen from being very high relative to the rest of the country to at or below the national average. It funded a mechanism for uncompensated care so there were no hospitals of last resort, a fair mechanism for funding graduate medical education resulted, it produced lots of really good data, featured transparency, and all the rest. Those were all really good things.

The problem was our ability to continue the waiver depended on a test that required us to hold Medicare payment per admission in the state to a rate of increase less than the rate of increase nationally as measured from a fixed point in time. What happened over the last number of years, was that by doing the right thing it was becoming increasingly difficult for us to meet that Medicare test. We were in danger of failing it.

So imagine for a moment reducing readmissions or one-day stays, which were incentives under the old system the Commission developed. If you do that, the remaining admissions in the hospital are more expensive. By doing the right thing your rate of increase per admission goes up more rapidly. And we were seeing ourselves deteriorating relative to the rest of the country. It was clear that if we were to lose the waiver we would lose all the benefits that have accrued to the state and to the purchasers. A core understanding was that we wanted something to continue. The challenge Josh and I had in getting everyone around the same table was creating a common vision of what the future would be like.

Sharfstein: When we did a road show, I started by saying that my dad is a psychiatrist who divides everything in the world into one of two groups: pleasure-seeking and pain-avoiding. I would say that for this meeting, I would be playing the pleasure-seeking role and John would be playing the pain-avoiding role. I would talk about the potential benefits of switching from fee-for-service, and then John would come in and say, "Do you have any idea the misery we would be facing if we lost the waiver?"

Berenson: The Medicare test in the past was based on a rate of increase. But Maryland started as the second-highest per capita hospital-spending state in the country. So it starts with a much higher base that can't be made up by meeting a rate of increase target. The basic question is, "Doesn't Medicare inherently lose money by participating in the All-Payer Demonstration in Maryland?" It subsidizes uncompensated care, it's helping pick up shortfalls from Medicaid, it has in the past paid for increased volume because the test was based on per-discharge, not total hospital spending?

Colmers: What you're asking—and it's a fair question—is, "Did Medicare get the results it wanted based on a new judgment of how the system is successful, or are we going to look at if it was successful based

on what it was required to do under the old test?” And I think we did what we were supposed to do and acted the way we were supposed to act under the old test. The world has changed.

If you want to compare us to the three other all-payer states—New Jersey, Massachusetts, and New York—one of the things that is a hallmark in Maryland is that the enabling statute was broadly established. It allowed the Commission to modify the rate setting over time, whereas the other states had their rate setting methods embedded in the statute. You can imagine how much fun it was, each and every year, to modify statutes. In Maryland it was left largely to the regulatory agency, the hospitals, and the payers on an annual basis figuring it out, and a system evolving over time.

Berenson: Why did Maryland see higher rates of readmissions and higher admissions per capita than other states? Hospitals there also have volume incentives. So why was the response in Maryland so different than in other states?

Sharfstein: The pressure down on prices to meet the Medicare test took away one tool hospitals have—seeking higher prices from other payers—and pushes them toward increasing the volume of admissions. If you can only sell pants for \$2, you will need to sell a lot of pants.

Berenson: So it’s the safety valve—in other places their safety valve is high prices from commercial payers, but they don’t have that option in an all-payer state, here so their safety valve is volume. The Europeans using DRGs have a volume problem, which Medicare hasn’t had. Medicare has high readmission rates, but they didn’t have the anticipated response to raise volume when DRGs came in the mid-80s.

Kinzer: Also, there are a number of issues we don’t know the answers to. The federal government is trying to study the impact of socioeconomic factors on readmissions. We have a high number of vulnerable populations in Maryland and high risk factors for hospitalization. In addition, there are some measurement issues we are exploring. For example, there are “distinct part” units for psych and rehab in other places that are excluded from readmission calculations, but we don’t have distinct psych and rehab units so all of our readmissions for psych and rehab are counted.

Utilization on the commercial side isn’t particularly high in Maryland. It’s very average. And for Medicaid it is always very difficult to compare service use rates—the populations are so variable. The Medicare utilization is high, but not higher than a lot of other places. Not higher than a lot of the urban populated areas. Maryland has one of the highest population densities in the country.

Berenson: People are correctly pointing out that the Medicare readmission penalty policy, in which hospitals are competing with each other in what is called an “attainment model,” is unfair (Joynt and Jha 2013).

Sharfstein: That’s exactly right. Maryland’s approach is different from the Medicare readmission penalty. Even under the previous system, the hospitals agreed to an approach that in essence included a 30-day readmission as part of the index admission—essentially creating an episode and not generating a new payment for the readmission.

Kinzer: We resisted putting in an attainment model because we believe that you would have to adjust for socioeconomic status, and Josh resisted any socioeconomic status adjustment, because we should be investing to overcome that, not accepting it as a reason for poor outcomes.

Berenson: I coauthored an article, citing Maryland, arguing that Medicare should not pay for readmissions—or pay at the variable cost rate—within a defined period—say, 15 or 30 days, rather than relying on marginal incentives of a couple of percentage points based on measuring readmission rates and comparing hospitals to each other (Berenson, Paulus, and Kalman 2012). No need for a socioeconomic adjustment. I should add that the paper has been totally ignored.

Sharfstein: What you proposed is not only a more fair incentive, it's a stronger incentive.

Berenson: John, in distinguishing Maryland from the other all-payer rate setting states you mentioned the independence of the Commission. To what extent does having an independent Commission, rather than having the function embedded in a health agency within government, make a difference?

Colmers: We have thought and talked about this for a long time. There are several factors that I would suggest. The first and most important factor is the “Hal Cohen Effect.”⁶ The culture Hal instilled in the state, in terms of the independent commission, which has been passed on through multiple generations and is now instilled in Donna [Kinzer], is really important. Having competent, thoughtful, knowledgeable staff who know every bit as much about hospitals and how they operate is part of that. And having incredibly good data, which allows the system to operate.

As you suggested, it is important to have an independent commission that, also, includes people who are part of the hospital industry. I'm the chairman of the Commission, but my day job is at Hopkins. People ask if it's a conflict of interest. And the answer is absolutely, but the enabling statute envisions that up to three of the seven members could represent hospitals. The first chairman of the Commission was a hospital executive, Alvin Powers. When I was the executive director my chairman, Charles Fisher, was a hospital trustee. The law allows it. I recuse myself on matters directly related to Hopkins' hospitals, but my experience informs our work, without having the decisionmaking majority. It keeps the discussions and folks engaged in it.

Also, having only seven members means you have to take a broad view of the world. There aren't any seats at the table that represent only one segment of the world. The fact that Maryland has a hospital association run by hospital trustees rather than hospital administrators has meant over time that that organization has tended to have a public policy bent that comes from volunteer trustees' participation. Finally, as I mentioned before, it is helpful not having the operational policies laid out in it in statute so they aren't rigid and can be modified over time.

Sharfstein: I would add that we have learned a lot from our earlier experience in rate setting. The global budgets were piloted for three years in 10 rural hospitals. That was essential, both to have flexibility and foresight to build on that experience. Then when we got into a pickle with the waiver, there were people who had experienced the global budget approach and could say it's not the end of the world. When I visited the recently built Western Maryland Regional Hospital, which the *New York Times*

wrote about,⁷ it was remarkably quiet. It was only 60 percent occupied. The CEO showed me the wards that were shutting down. In their place, he showed me a clinic for asthma and diabetes, which was free to patients. With this approach, you have hospitals that aren't just in the hospital business. They're more or less integrated delivery and see a business line and sustainability of running a health system. The visitors from France that Donna referred to were focused on how their hospitals are just hospitals and not thinking about global budgets or population-based payment.

Berenson: One of the concerns some express about all-payer approaches to hospital payment is that the regulatory approach can freeze innovation, both of new payment approaches such as risk-sharing with providers, and benefit design, such as narrow or tiered provider networks. Is that a legitimate concern?

Colmers: I don't believe so. I expect that there will continue to be a lot of innovation in other payment approaches and benefit design. That being said, I'm not a fan of narrow networks or reference pricing. Often times, the payers will end up doing it in ways that are antithetical to the triple aim. You can create a narrow network around the hospital and physicians who have the lowest joint replacement price, but if you pay for lots of surgeries that aren't needed, that's not a bargain.

Our greatest innovation challenge is how we get ourselves ready for the next phase and how we engage physicians both primary care and specialists. How do you do it in a way that doesn't lead only to employment by a health system? There isn't enough money in the world to do it. I worry about people competing over physicians in ways that are antithetical to our goals for improving quality and reducing costs. We must develop ways to align people in a way, that independent physicians can remain independent and have access to an infrastructure that helps them manage patients without necessarily having to be in a hospital system. Donna is working on care coordination in ways that don't require hospital employment.

The Demonstration Tests

Berenson: Josh, you were very involved with the state test tying the growth target to the growth in the gross state product, which for the last 10 years averaged 3.58 percent, so that was picked as one of the tests for demo. What is the history of that decision?

Sharfstein: That benchmark was emerging in the health policy world as a reasonable approach if applied to health care. We were able to adopt it because the alternatives were unacceptable. If you said we're just going to bend the cost curve from the historic trajectory of outrageous health care inflation, that wasn't good enough for people who were focused on controlling cost. At the same time, if you said the state needed to hit an arbitrary, fixed, and aggressive goal, that would be a nonstarter for hospitals. We needed something between what the hospital was hoping for and what the payers were hoping for. And this worked out well. It's a low number and an aggressive goal, but we were able to convince people it was achievable.

Berenson: The Medicare sustainable growth rate for the physician fee schedule, which is about to be repealed, is based on a similar concept of a gross domestic product target on a national basis. The incentive on the entire profession backfired because the individual physician had different incentives

from the group. The difference here seems to be that the incentives apply at the individual hospital level, rather than hospitals as a whole.

Sharfstein: That's exactly right. There were two major needs. First, we needed a reasonable constraint for the whole system, and there is strong political logic to using state economic growth because it's hard to justify why health care should continue to crowd out other things. And second, we realized we wouldn't be successful unless we could shift those incentives to the people with the decisionmaking authority. We called it the "SGR [sustainable growth rate] problem." We didn't want a system with incentives at the system level that were contrary to individual-level incentives. The two biggest breakthroughs were, number one, that we could agree on a cap. Not a budget, but a spending cap. And number two, the approach to achieving that was to commit to moving away from fee-for-service payment for hospitals.

Berenson: There is a cap on growth rate at 3.58 percent, which mirrors state growth. What happens if health care inflation increases faster? Does that put unreasonable pressure on hospitals?

Colmers: There's always a possibility that hospitals can petition the commission to consider things. Generally speaking, the 3.58 percent rate of growth per capita—remember you multiply it by population growth—is a fair and healthy rate of growth. There remains a fair amount that still needs to be done to move from hospitals spending for things that could be provided in more cost effective settings. One thing I'm worried about in my day job is increases in prices for pharmaceuticals. It's a national issue, some are going up at ridiculous levels. But even in those cases it doesn't represent a sizeable portion of overall costs.

It's fair to say, the bigger question for the Commission that we need to address sooner rather than later, is how close do we want to get the actual health spending increase to 3.58 percent? Last year the updates were greater than previous year, but some would say they weren't enough. There is no thought here that we would want to see 3.58 violated.

Berenson: Wouldn't hospitals want 3.57?

Colmers: Yeah, they want 3.5798. There are lots of good reasons not to. How close do we need to get that? We had a good year this year and does it continue? 3.58 was based on a long-term growth calculation. The economy is doing better, but we aren't fully recovered from the recession so we do worry about that. But because this is a cumulative test, if we are below in some years, we have some room to allow a greater increase in another year, should inflation pressures resume.

Berenson: Medicare spending increases have been inexplicably low. What if it continues to give you less ability to generate the differential savings you are obligated to produce? Do you worry about that?

Colmers: I worry about it a lot, Bob. I worry about exogenous changes by Medicare in their payment policies that would make it more difficult for us to survive. If Congress whacks Medicare, it will make it more difficult. That being said, we think we can succeed with Medicare because for the most part it is unmanaged, as the state has low Med Advantage penetration. There are lots of opportunities for us to

succeed. While all of us stay up at night wondering what will happen, at the same time we console ourselves with the understanding that there are opportunities to improve in Medicare. In addition, there is a provision in our agreement with Medicare that says in the event we meet the all-payer test—we've met the 3.58 percent growth target and continue to do so, and we haven't met the Medicare test—we have the ability to ask CMS to consider a change in our payer differential that would allow Medicare to enjoy lower rates, which would necessarily result in somewhat higher rates for the private sector. The argument is that if we meet the 3.58 percent standard the private sector will be happy and a degree of modification in the differential would be possible. Approval is not a slam dunk.

Berenson: The price differential Medicare enjoys—and has for decades—is 6 percent?

Colmers: Yes. And it's a differential, not a discount. If the rate ought to be \$100 and half of the revenue is Medicare, you would raise the rates to \$103. Hospitals would charge commercial payers \$103 and Medicare 94 percent of 103, which is roughly \$97. So they still receive \$100.

The Next Phase

Berenson: That's where I wanted to go next. You have to move to phase two—from regulated revenue to population-based payment. You will move toward a concept of ACOs [accountable care organizations] with population accountability for all spending, right?

Sharfstein: What's required is that, by year four, we would propose an approach to controlling the growth of all spending. How that is accomplished is not specified, and it will depend in part on lessons from the first couple of years, and other elements of reform that are going on in Maryland. It doesn't necessarily mean it is going to be like five regional ACOs.

Berenson: In the Medicare demos, about half of ACOs are physician-based. I've done interviewing with primary care docs who are suspicious of hospitals' willingness to change their cultures and business models to accommodate population-based payments, which among other things should reduce reliance on hospital care. Where is the physician community? Are they threatened by the notion of hospital-based ACOs empowered by the demo?

Sharfstein: The dust hasn't settled. There are some different models and in some places in the state some might prevail over others, but there is a pretty strong model of medical homes here. Care First has been successful from a carrier perspective (Dentzer 2012). The Medicaid program is very interested in doing something with duals that would be supportive of primary care. You could potentially have an ACO model in some places that would be the dominant care delivery but in others you could have a strong medical home model paired with the hospitals on a global budget.

Kinzer: Doctors see that they have a better chance to make medical homes work because the hospitals aren't working at cross purposes; they're trying to achieve the same things the doctors are, including reducing avoidable utilization in hospitals. So they're working in the same direction even if they're under different models. Other than employed doctors in the state, most primary care doctors are in very small groups. They aren't in a position to develop the infrastructure to make the huge changes.

Nationally, some strong IPAs [independent practice associations] have evolved to large group practices, requiring a large infrastructure investment.

Sharfstein: The results of medical homes in other states have been kind of middling. One reason for that is that if hospitals are tugging in a different direction from medical homes, it can be difficult. In Maryland, hospitals and medical homes are now aligned in setting the goal of reducing preventable admissions.⁸ For example, we hear stories about hospitals in Maryland convening primary care doctors and saying, “You guys don’t do scheduling in a way that we can schedule discharged patients for follow ups, so we need to change scheduling. What would it take to do that?”

In contrast, I visited a warmer state recently, and every other billboard is advertising ERs [emergency rooms]. Here it’s a very different feeling. On one hand you don’t have the ability for primary care or a medical home to really capture an enormous amount of savings from a reduction in hospitalizations because some of the savings will be soaked into the global budget, but then on the flip side you don’t have hospitals pulling in the opposite direction. So the vision is that you have two different models with both vectors pointing in the same direction, so the medical homes and primary care can be rewarded as hospitals are seeing a reduction in volume.

I have a hard time believing that hospitals will be the ones to drive total cost of care. They’re only seeing the most expensive part, and it’s not in their expertise to keep up the various components of the health care system. But it’s an enormous value to have the biggest part of the dollar oriented in the right direction. Under traditional incentives, you can do small scale initiatives that potentially improve health and lower cost but as you scale them up you come in conflict with hospitals that want to stay full, and that makes scale difficult. In Maryland, with the hospitals seeking to reduce preventable hospitalizations, getting prevention to scale may be easier to accomplish.

Berenson: As a matter of politics, was the Maryland medical society on board?

Sharfstein: Yes. They were not big fans of the old systems. Specifically, they were concerned that the old system provided reverse incentives for locating practices in hospitals and being able to charge facility fees. Fee-for-service payment to hospitals has a particular momentum with regards to physicians that they didn’t like.

Berenson: Walk me through the “leakage” problem. If you are placing hospitals on global budgets, won’t they get into the nonhospital business and steer patients there?

Colmers: The risk is they may open up other types of facilities.

Berenson: Or joint venturing.

Sharfstein: Right. I think the fact that success of the model depends on overall cost reduction makes that a bad strategy. The hospital industry would be pursuing a path to nowhere. That’s one reason CMS wanted the proposal for population-based payment by year four. Also, CMS placed some guard rails around that for Medicare. If they see a bulge in overall Medicare costs in Maryland even as our hospital costs are going down, that could be a problem.⁹

Berenson: What are the main challenges you're facing to be successful in moving to phase two?

Kinzer: I think it is the speed of change, and making sure the infrastructure is put into place to make it sustainable and done well. It's a major shift. It's the opposite of what we were doing in terms of massive pursuit of volume, now really trying to understand what it means to focus on population health. It's just a very rapid shift and getting people moving in another direction. It's like operating an 800,000 person, full risk Medicare ACO, but you don't have the care management infrastructure in place yet.

Berenson: And hospitals need a culture shift. Can you do that in a couple years?

Kinzer: Right, the culture shift, the infrastructure. Fortunately we have one of the best HIEs [health information exchanges] in the country. We started working on it five years ago. Hospitals' real time registration of every patient who hits the hospital is there in the HIE. So that can inform physicians and insurance companies. Now we're trying to escalate that infrastructure to work with the new Medicare care management fee— to use it for what needs to be done to getting care coordination going. It is a massive opportunity with big changes needed. And the Commission has a staff of only 37, so we aren't a big agency implementing the change.

What I learned in the past is that people in a new system don't always know where to start or what to do. But we've been very helpful in giving them the five things they need to work on. We call it "potentially avoidable utilization." We've given them case-by-case, patient-by-patient potentially avoidable utilization. So they know what they need to work on, even though they might not have all the approaches to do it yet. They're working with nursing home admissions and readmissions. They are working on improving the quality of care. But no one is focusing extensively on reducing utilization of CT [computed tomography] and MRI [magnetic resonance imaging] scans to see if they are medically necessary, making patients think something is being withheld. Rather, they're working on specific quality improvements projects related to improving the quality and continuity of care.

Sharfstein: There may be more spent evaluating this than implementing it. But the economics and politics are in our favor here in Maryland. There has been a tremendous amount of outreach with the public. You have politics and economics in your favor, but then there is the sociology and the psychology, which can be harder. There's a range of how quickly the hospitals have been able to respond. One cultural issue is recognizing you aren't the master of your own destiny in the hospital field anymore; in order to reduce readmissions you have to form effective partnerships with doctors, community organizations, and, ideally, public health. A few years ago, hospitals were sending teams into the community to scan for asymptomatic carotid stenosis. Although surgery is not recommended for this condition, it was a "no vascular surgeon left behind" kind of project. And now you have hospitals, in one case, taking over the school health program, saying they can run it at break even and save money due to fewer asthma ER visits and admissions. And one hospital, Frederick, is doing a mental health project with the local mental health association to treat mental health emergencies in the community where possible.

Berenson: Will the favorable climate change with a new governor?

Kinzer: If you look at what we're doing, it is good for business. The new governor is all about what's good for business and that's what we're doing, and it's good for consumers.

Berenson: Were there any stakeholders who didn't support the demo? Consumers?

Kinzer: We have a huge amount of consumer participation in this process. It took me by surprise. I've never seen consumers so engaged. So we now have consumers leading engagement and outreach activities. They had forums, they are creating approaches for engagement and getting people into coordination and coming up with volunteer programs to get the community engaged in implementation. Prior to my work at HSCRC, I worked in consulting for 37 years. I have worked in development and implementation of payment and delivery reforms for payers and providers in various parts of the country. This is probably one of the most active consumer movements I've ever seen in my work.

Berenson: Any final thoughts?

Colmers: People always ask if this is a model for the rest of the country. My answer is, I really don't care. The precise model isn't likely to be replicable elsewhere. I can't imagine others doing it and don't care if they do. Where I think we could be of value to Medicare and to others, are understanding the types of things that hospitals and physicians and other providers do in response to an all-payer constraint. Will it lead to a more rapid and sustainable transformation of the way in which care is delivered and outcomes are produced? That is the value. It's not the precise mechanism of rate setting and all that; it's about whether you can create the incentives to create the types of things you want markets to produce and get people to do things differently. To me, that is the most interesting thing.

Notes

1. Automatically renewed with annual inflators and "material impact" language to open them up for renegotiation.
2. Subsequent to the interview, Maryland HSCRC completed calculations of its first-year results. They show a 1.47 percent all-payer per capita revenue growth versus the 3.58 percent limit, and they show a -1.1 percent Maryland Medicare per beneficiary reduction (not including the impact of sequestration). In 2014, Medicare's per capita hospital costs grew 1.07 percent nationally and decreased 1.08 percent in Maryland. See Patel et al. (2015).
3. The HSCRC defines potentially avoidable utilization as hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health. Potentially avoidable utilizations include 30-day "revisits": inpatient readmissions, observation and emergency room visits, the inpatient prevention quality indications developed by the Agency for Health Care Research and Quality, and the Commission.
4. The requirement that hospitals that experience volume drops be allowed to raise their prices by an amount commensurate with the volume decline means that patients will experience some variation in pricing of the same services or supply item over the course of the year.
5. Per the Maryland model agreement with the Center for Medicare and Medicaid Innovation, the negotiated Medicare per beneficiary expenditure growth limitation applies to hospital claims associated with all Maryland Medicare beneficiaries, regardless of where they receive hospital services (either inside or outside of

Maryland). The all-payer per capita expenditure limitation applies to any patient (commercial, Medicare, Medicaid, or self-pay) who receives care at a Maryland hospital, although certain facilities, such as Johns Hopkins and University of Maryland, were allowed to exclude certain categories of out-of-state patients from their global budgets.

6. Hal Cohen was the founding executive director of the HSCRC from its inception until 1987.
7. Eduardo Porter, “Lessons in Maryland for Costs at Hospitals,” *Economic Scene*, *New York Times*, August 27, 2013.
8. Further, a recent HSCRC analysis showed Maryland was able to reduce the rate of hospitalization for “potentially preventable conditions” 23.3 percent between 2013 and 2014 (Patel et al. 2015).
9. Per the Maryland model agreement, to protect against an unanticipated and undesired shift of care for Medicare beneficiaries from the regulated hospital setting to unregulated free-standing and ambulatory facility settings, Medicare also imposed a limitation that total Part A and Part B Medicare per beneficiary expenditures in Maryland cannot grow faster than 1 percent more than total US Part A and Part B Medicare per-beneficiary expenditures.

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About the Interviewees

John M. Colmers is senior vice president, Health Care Transformation and Strategic Planning for Johns Hopkins Medicine. From 2007 to 2011 he served as the Secretary of the Maryland Department of Health and Mental Hygiene, and from 2000 to 2007 he was a senior program officer for the Milbank Memorial Fund. Before joining the Fund, Colmers spent 19 years in Maryland state government where he held various positions, including executive director of the Maryland Health Care Commission and the Health Services Cost Review Commission (HSCRC), the agency overseeing Maryland’s all-payer hospital rate-setting system.

Donna Kinzer is the executive director of the HSCRC. Kinzer took a leave from her 40-year consulting career to help lead the HSCRC staff through development and implementation of hospital payment modernizations. In that role, she assisted leadership in developing the new all-payer model for

Maryland and obtaining the new Medicare waiver. She is also leading the staff in implementation of the new model. During the first year of the new all-payer model, Kinzer led the HSCRC staff and the field in implementing global budgets for all Maryland hospitals, aligned quality-payment approaches with the new model, and implemented monitoring infrastructure. She is now developing and implementing strategies for delivery transformation needed to sustain and support the objectives of the new model.

Joshua Sharfstein is associate dean for Public Health Practice and Training and faculty in Health Policy Management at the Johns Hopkins Bloomberg School of Public Health. Previously, Sharfstein served as secretary of the Maryland Department of Health and Mental Hygiene from January 2011 to December 2014. In this position, he led efforts to align Maryland's health care system with improved health outcomes, culminating in the adoption of a revised hospital payment model.

About the Author



Robert A. Berenson is an Institute Fellow at the Urban Institute. He is an expert in health care policy, particularly Medicare, with experience practicing medicine, serving in senior positions in two presidential administrations, and helping organize and manage a successful preferred provider organization. Berenson recently completed a three-year term on the Medicare Payment Advisory Commission, serving the last two as vice-chair. From 1998 to 2000, he was in charge of Medicare payment policy and private health plan contracting in the Centers for Medicare and Medicaid Services. Previously, he served as an assistant director of the White House Domestic Policy Staff under President Carter. Berenson is a board-certified internist who practiced for 20 years, the last 12 years in a Washington, DC, group practice. While practicing helped organize and manage a successful preferred provider organization serving the Washington, DC, metropolitan area. He is coauthor, with Walter Zelman, of *The Managed Care Blues & How to Cure Them*, and, with Rick Mayes, *Medicare Payment Policy and the Shaping of U.S. Health Care* and publishes widely in journals such as the *New England Journal of Medicine* and *Health Affairs*. Berenson is a graduate of the Mount Sinai School of Medicine, a fellow of the American College of Physicians, and on the adjunct faculty of the George Washington University School of Public Health.

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2100 M Street NW
Washington, DC 20037
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