SB 1073

Department of Legislative Services

Maryland General Assembly
2013 Session

FISCAL AND POLICY NOTE

Senate Bill 1073 (Senator Pipkin)
Finance

Task Force to Evaluate the Quality of Patient Care Under a Capitated Payment System

This bill establishes a Task Force to Evaluate the Quality of Patient Care Under a Capitated Payment System to study the impact of moving from a "per case" to a "per capita" payment model on the provision and quality of end-of-life care, health care services for the chronically ill, behavioral health services, and specialty care services, as well as the alignment of patient needs with the needs of hospitals. The task force must report its findings to the Governor and specified committees of the General Assembly by January 1, 2014. The Health Services Cost Review Commission (HSCRC) must provide staff for the task force. A member of the task force may not receive compensation but may be reimbursed for expenses under standard State travel regulations.

The bill takes effect June 1, 2013, and terminates June 30, 2014.

Fiscal Summary

State Effect: Special fund expenditures increase for HSCRC by $55,000 in FY 2014 only to hire a contractor to assist the task force in conducting the required study and submitting the required report and to provide expense reimbursement to task force members. No effect on revenues.

(in dollars)	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Revenues	$0	$0	$0	$0	$0
SF Expenditure	55,000	0	0	0	0
Net Effect	($55,000)	$0	$0	$0	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Current Law/Background: Maryland's hospital rate-setting system operates under a federal Medicare waiver that requires Maryland to keep growth in Medicare inpatient per-case charges lower than the national average. HSCRC's authority to standardize hospital rates for all payors, including Medicare and Medicaid, was established in 1980 by federal legislation. At this time, Maryland is the only state with an all-payor, rate-regulated system. To maintain the waiver, the rate of growth in Medicare inpatient per-case charges to Maryland hospitals from 1981 to the present must remain no greater than the rate of growth at hospitals nationally over the same time period. As of June 2011, the most recent data available, the cumulative growth of Maryland Medicare inpatient per-case charges has been 342.6%, compared to national growth of 362.3%. However, estimates for fiscal 2012 and 2013 project narrowing of this gap.

Status of Maryland's Medicare Waiver: HSCRC measures Maryland's waiver performance using the "waiver cushion" test. This represents the amount that Medicare inpatient per-case charges to Maryland could grow, assuming zero national growth, before the State failed to meet its waiver requirements. HSCRC has determined that 10.0% is the ideal level for the cushion. The larger the cushion, the more flexibility HSCRC has to adjust rates while simultaneously weathering Medicare payment trends. While the cushion has fluctuated below and above 10.0% over the past decade, in fiscal 2011, the cushion fell to 4.46%, and estimates indicate that it will continue to hover close to 0.0% in fiscal 2012 and 2013.

Efforts to Improve Waiver Performance: For the short term, HSCRC tightened control of the rate-setting system to improve the waiver cushion. In March 2012, HSCRC approved several emergency measures that have resulted in marginal improvement in anticipated waiver performance. To address erosion in the waiver cushion long term, HSCRC met with payors, the Department of Health and Mental Hygiene (DHMH), and hospitals to discuss modernization of the waiver. While all parties agree that a new waiver approach is necessary, there is not yet consensus on what that new approach should be.

Current Model Design Proposal: According to DHMH, the current waiver has important limitations. Namely, the focus on per-case costs does not provide incentives aligned to population health and comprehensive coordinated care across different settings. To address these limitations, on March 26, 2013, HSCRC submitted a 136-page model design proposal to the federal Centers for Medicare and Medicaid Services (CMS). The proposal seeks to modernize Maryland's rate-setting system to overcome current waiver limitations and provide an "innovative and creative solution to critical health care

challenges." The proposal's hypothesis is that an all-payor system that is accountable for the total cost of care on a per-capita basis is an effective model for establishing policies and incentives to drive system progress toward achieving the three-part aim of enhanced patient experience, better population health, and lower costs.

According to the proposal, the model design would begin with accountability for the total cost of care on a per-capita basis. Over the first five years, the State would commit to limiting inpatient and outpatient hospital costs for all payors to a trend based on the State's long-term gross State product (GSP). To constrain per-capita cost growth, the State would accelerate a broad range of delivery reform efforts including gain-sharing between hospitals and physicians, accountable care organizations, readmission programs, global budgeting, and population-based budgeting.

To encourage savings below a guaranteed expenditure ceiling, the model design introduces the concept of a "shared savings lockbox." When hospitals participate in innovative payment and delivery reform programs and achieve savings, the portion of savings returned to payors is set aside to lower overall expenditures. The rules governing the "shared savings lockbox" and other elements of the proposal will be set by HSCRC through a "transparent and public process."

The model design also includes a Medicare benchmark, which will be the projected 2014 through 2016 inpatient and outpatient growth rate of 2.5% per year, less the amount of minimum lockbox savings. DHMH anticipates a 3.57% overall per-capita hard expenditure ceiling will correspond to a 2.43% benchmark in Medicare expenditures. With the lockbox savings, the Medicare benchmark will grow 6.4% cumulatively over three years from the 2013 base, resulting in estimated total savings of $220 million from the projected historical trend.

HSCRC anticipates several months of review within CMS and other federal agencies before the model design proposal is finalized and approved. In the meantime, HSCRC plans to engage in further dialogue with stakeholders.

Stakeholders have expressed concern over the significant shift in policy envisioned under the model design proposal, whether sufficient time has been allocated to thoroughly review the proposal, and the potential impact of a capitated or per-capita system on the State's sickest populations who utilize the greatest amount of health care resources.

State Fiscal Effect: According to HSCRC, the task force established under the bill will convene at the same time that HSCRC, if or when the model design proposal is approved, will be seeking public comment on the proposal and considering draft recommendations to implement and achieve the goals of the proposal. HSCRC indicates that that process will require the full attention of existing staff. Thus, in combination with the complexity

of the issues to be addressed in the study required by the bill and the short timeframe given for the completion of the report, contractual services are required. Special fund expenditures for HSCRC, therefore, increase by a total of $55,000 in fiscal 2014, primarily to pay one contractor to assist the task force in completing the required study and write the report required under the bill. This amount also includes an estimated $5,000 to reimburse the 23 members of the task force for expenses, as authorized under the bill.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene, Department of Legislative Services

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mc/ljm

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