

As reported in earlier editions of *Management Rounds*, students in the Hopkins MHA program are introduced to the Maryland model of health care shortly after they arrive in Baltimore. In this edition of *MR*, we share with you what has been happening in Maryland via our Q&A with John Colmers, senior vice president for health care transformation and strategic planning at Johns Hopkins Medicine. Before joining Hopkins, Mr. Colmers was secretary of the Maryland Department of Health and Mental Hygiene (2007–11) and held various positions within the state, including commissioner of the Health Services Cost Review Commission (2013–17).

**MR: Mr. Colmers, as someone who has been involved in the development and evolution of the Maryland Model, can you speak a bit about how the current Maryland All-Payer Model came to fruition?**

Maryland has had an all-payer hospital rate setting system since 1977, made possible by a waiver granted to the state by the federal government. For most of its existence, the system focused its attention on holding down only hospital costs, with an initial focus on departmental unit rates and eventually shifting to case-mix adjusted admissions. In those earlier years, however, there was no constraint on overall hospital spending. That waiver was continued so long as the state held the rate of increase in Medicare payments per admission in Maryland to a level lower than the rate of increase in Medicare payments per admission nationally, as measured from January 1, 1981. It was becoming increasingly difficult to pass that old test, due to steps that were being taken in Maryland to reduce unnecessary admissions and readmissions. As the unnecessary admissions were reduced, the resulting remaining admissions were more expensive. Thus, the payment per admission in Maryland was increasing more rapidly, making it more difficult to pass the old test. We began negotiating with the federal government for a new demonstration with a focus on holding down total hospital spending. We reached an agreement with the federal government and that model of the waiver started January 1<sup>st</sup>, 2014. We are just about to conclude the fifth year of that demonstration, which prepared us for the latest round of negotiations and the total cost of care model that will go into effect this coming January.

**MR: The successful negotiation with CMS for a new version of the Maryland Waiver seems indicative of the State's performance under the All-Payer Model. Can you speak to the outcomes of the State over the lifetime of the current model and how that influenced the conversations with CMS for the new model?**

The 2014 model had a number of performance measures, on which the state has performed quite well. The first measure was that we had to hold hospital spending per capita for all payers to a rate of increase less than the rate of growth in the economy as a whole, or a rate of 3.58 percent. In fact, the rate of increase in Maryland over the first three years of the model was held to less than half of that (1.53%). Maryland was also required by CMS to focus specifically on Medicare hospital spending, where we had to produce \$300 million in cumulative savings over the 5-year demonstration by comparing what per capita spending would have been had it gone up at the national rate of increase. Over the first 3 years Maryland hospitals produced \$586 million in Medicare hospital savings, and by the end of the 5-year period estimated savings will be well over \$1 billion. The state was also required to reduce hospital readmissions for Medicare patients to the national rate over five years. Over the course of the first four years, Maryland has already met that goal. There have also been significant declines in health care-acquired conditions, and the state held Medicare total cost of care spending – not just hospital spending – below the national rate of increase. In regards to total cost of care, there was an increase in non-

hospital spending but it did not outweigh the savings that were realized on the hospital side. All in all, Maryland was able to demonstrate some pretty impressive results. Consequently we were able to begin negotiating a model to focus not just on hospital spending, but on total cost of care.

**MR: What are some of the major changes in the new Maryland Model? How long is this iteration of the model and what are the target savings?**

The new model will cover a 10 year period of time. Eight years associated with performance and then two years of transition. For eight years Maryland will need to demonstrate completed improvement of holding Medicare total cost of care savings below that of the rest of country. As part of the negotiations we were able to keep the original base year of 2013, so the savings that we have accrued thus far do not disappear. In this iteration of the model, the state will have to demonstrate by the end of 2023 annualized savings of \$300 in Medicare total cost of care (Part A and Part B) – in contrast to cumulative hospital only savings in the previous demonstration. By the end of the fourth year of the current model, the HSCRC estimates we are at about \$140 million of annual savings. So we have \$160 million in improvement still to make going forward. There is still a fair amount of work to do, but there have been considerable achievements over the first four years of this demonstration, so we remain optimistic. CMS will still require Maryland to hold all payer hospital spending in line with the aforementioned 3.58 percent. Additionally, there will be population health outcome measures, which are currently being finalized, and the federal government provided the state some new tools to assist in aligning incentives between hospital and non-hospital providers.

**MR: Following up on that, what challenges might the focus on total cost of care provide hospitals given that some of the total cost of care does not fall within their control? How does the new model address those challenges?**

Hospital spending for Medicare accounts for roughly 55 percent of all part A and B spending. When you begin to add in the spending coincident with that hospital visit or stay – for example, physician spending and skilled nursing costs – the total comes to close to 75 percent of the spending. The biggest challenge is aligning hospital incentives to control spending with these other providers, short of rate setting for these other providers, which is not in the plan at all. There are a couple of tools that we think will be very important in this alignment.

The first is the creation of a Medicare primary care medical home model. Medicare nationally has created a PCP Plus program for primary care physicians. As part of these negotiations, in January Maryland will roll out a primary care program for Medicare that is specifically tailored to the Maryland market. It is designed to increase care coordination fees and additional support for primary care physicians with a focus on Medicare patients with multiple chronic conditions.

The second tool was a recognition by CMS of the Maryland model as an Advance Alternative Payment Model. Under MACRA, physicians who are part of an Advance Alternative Payment Model can be eligible for an additional 5 percent bonus payment for Medicare. This will allow hospitals to encourage physicians to participate in approved care redesign programs. The state has already developed two care redesign programs that are launching: one that is hospital-based and one that is based in the community. The state also expects to have a number of bundled payment initiatives launched in January 2019.

**MR: Changing gears a bit, population health is an increasingly prominent topic in Maryland. How does the new model incorporate population health measures at the state level? Are there any priority areas or illnesses that have been identified?**

One of the features of the new model is an agreement between the state and federal government that will measure a number of population health metrics and that the federal government is willing to calculate and monetize the benefit of those improvements, and to use those calculations to offset any burdens that the state has for meeting the total cost of care target. Although the measures are not finally determined, they could include such things as the prevalence of diabetes, the prevalence of hypertension or the number of opioid deaths in a community. The state will propose a methodology to the federal government on how these improvements might be monetized and the state would then encourage programs in those particular areas to bolster results. As a former state health official it is something that is very exciting to see and I am looking forward to having that rolled out.

**MR: And do you anticipate that the focus on population health will have an impact on how healthcare organizations in the state deliver health care? If so, what impact do you anticipate it will have?**

I do think in general, whether it is because of the population health measures just discussed or the more general focus on total cost of care, the idea of hospitals forming partnerships is going to be that much more important than ever. Hospitals will likely be reaching outside their four walls to physicians, skilled nursing facilities, and other post-acute and community-based providers. Increasingly there are communities across the state where hospitals are beginning to contemplate how they might find partners to address social determinants of health. It is a little unclear how that might happen and where those partners will come from. I don't anticipate hospitals acting on their own will solve those problems, but they may serve as a catalyst in a community to address social determinants of health, such as housing, employment, or food safety.

**MR: Quality of care has always been one of the focal points of the waiver. What if anything has changed in regards to improving performance related to quality, safety, and the patient experience? How does the new model address quality of care across the state? Are there incentives in place to promote these goals?**

The rate-setting system has for quite some time placed an emphasis on quality, safety and patient experience, through incentives that have placed increasing levels of hospital revenue at risk. To reiterate, hospitals in Maryland did a remarkable job in reducing 30-day readmission rates to levels that are now below the national average. There have also been significant reductions in MHACS (Maryland Healthcare Acquired Conditions). I think it is fair to say that some of that reduction was achieved through improvements in coding, but others are clearly improvements in outcomes overall.

In regards to incentives, I want to describe the way in which a portion of a hospital's revenue will be at risk for total cost of care. This is **not** an insurance model. While hospitals will need to be concerned about holding down total cost of care, only a portion of a hospital's revenue will be held at risk for the performance of total cost of care. In the first year of measurement, half of one percent of a hospital's Medicare revenue would be at risk and by year two, one percent of a hospital's Medicare revenue would be at risk for changes in total cost of care for Medicare beneficiaries who have been attributed to those hospitals from one year to the next. Again, this is not an insurance model. This is a model in which

hospitals will be incentivized, like other quality programs that have been in place over the years, but this time on improvements in total cost of care.

**MR: How might the new model impact, if at all, safety net hospitals across the state of Maryland?**

In Maryland, for many years, there have been no hospitals of last resort. That is because since the inception of the HSCRC, hospital rates have included a provision for uncompensated care, so hospitals have always had an incentive to provide needed care to the uninsured. The other thing that has made a huge difference in Maryland is the Affordable Care Act. Maryland was an early adopter of the ACA. Indeed, Maryland expanded Medicaid to certain classes of adults prior to the ACA. Moving forward, it will be interesting to see how hospitals are going to be partnering with community-based organizations and federally qualified health centers to provide care to the portion of the population that remains uninsured, which would include people who have decided not to avail themselves of care under the exchanges for whatever reason, people who have not enrolled themselves in Medicaid, or people who, because of their immigration status, cannot enroll in Medicaid. Hospitals will be thinking about how, on a population health basis, one might support such programs.

**MR: How should healthcare managers and leaders in Maryland be preparing for the Total Cost of Care Model? Where should they be placing the most attention?**

The majority of the spending of total cost of care comes from patients who are sick, which comes as no surprise. My best advice to hospitals that are thinking about total cost of care is to focus their attention on the patients that are in front of them and paying attention a bit more to those with multiple chronic illnesses, focus simply on providing the care that is necessary. This is not a model that is designed to withhold care from people, it is a model that is designed to ensure that people are receiving care that is at the right place, at the right time, and at the right price. At the front line, the focus is to provide the best care that you can and in the most compassionate and efficient way possible. And in particular for those patients who are the most vulnerable because of multiple conditions and are going to end up being more expensive, to begin wrapping around services for those individuals so as they transition from the hospital back to the community they can remain in a healthier environment than they had been previously.

**MR: One final question: How is Maryland becoming a model for other states? Furthermore, what are your views on the probability and potential impact of the model being expanded nationally?**

Frankly, I don't care. I want to make sure that we in Maryland are able to maintain the results that we have achieved. I know that the conditions in Maryland were such that it made this waiver possible and I know how difficult it would be in many other jurisdictions to even contemplate. There is neither the regulatory infrastructure nor the support that is necessary from state government to oversee this. We are fortunate in Maryland to have an outstanding health information exchange that can serve as our backbone. We have had funds made available to invest in hospital infrastructure in the state. We have had bipartisan political leadership behind this model. Hospitals in the state have seen that this is an approach that they are willing to take. I can't say that this is something that is possible in other jurisdictions.

I am a firm believer in state flexibility and the ability of states on their own to decide how they might want to address the fundamental problem of the high cost of healthcare. The good news is that if we are

successful here in Maryland, we will have done a remarkable job of bending the cost curve and making healthcare more affordable. While there are many things occurring with private employers, Medicare, and Medicaid elsewhere in the country, they are not being done on an all-payer basis and they do not have the laser focus that we are going to have to have here in Maryland. So the ways in which we are doing this, whether it is the partnerships we are developing in the care redesign programs that we have to date or if there are other care redesign activities that we develop, those may be more easily replicable in other jurisdictions.

If nothing else, we may stand as hope for others that they can devise and develop their own approach to solving that problem. We have reached a tipping point. It is no longer acceptable to think that we can live with healthcare spending continuing to take an ever-increasing share of the economy. I think, speaking now for a moment in my role at Johns Hopkins, it is a fundamental challenge for academic medicine to lead this reform to improve both the affordability and the quality of care.