HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY (SHPDA)
1177 Alakea Street, Suite 402 • Honolulu, HI 96813 • Phone: (808) 587-0788 • www.shpda.org
Universal Access Advisory Council - Plan Development Committee

Meeting Minutes

January 19, 2024 | 12:00 PM Hawaii Time
Virtually via Zoom and Physical Meeting Location at
The Keoni Ana Building, 1177 Alakea Street, Suite 402

MEMBERS: Mark Alexander, Rick Bruno, Jonathan Ching, Jenn Diesman, Beth Giesting, Lawrence Nitz, Gary Okamoto, Michael Robinson, Linda Rosen Melvin Sakurai, Marilyn Seeley, Paul Roeder
MEMBERS ABSENT: Sheri Daniels, Victoria Fan, John McComas, Rae Seitz, Malia Tallett, Nadine Tenn Salle
GUESTS: Robert Berenson (Presenter), Jon Ching, Paige Heckathorn Choy, Haley Hsieh, Robyn Kuraoka, Dew-Anne Langcaon, James Lin, Jennifer Lo, Judy Mohr Peterson, Robert Murray (Presenter), Gary Okamoto, Hilton Raethel, Matt Sasaki, Joy Soares, Charlene Takeno, "WillB", Charlene Young
SHPDA: John Lewin, Wendy Nihoa

ATTENDANCE RECORD OF MEMBERS

Date	11/16/23	12/20/23	1/19/24	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Mark Alexander	X	X	X							
Rick Bruno	X	O	X							
Jonathan Ching	O	X	X							
Sheri Daniels	O	O	O							
Jenn Diesman	X	O	X							
Victoria Fan	X	X	O							
Beth Giesting	X	X	X							
John McComas	X	X	O							
Lawrence Nitz	X	X	X							
Gary Okamoto	X	X	X							
Michael Robinson	X	X	X							
Linda Rosen	X	O	X							
Melvin Sakurai	X	X	X							
Marilyn Seeley	X	X	X							
Rae Seitz	X	X	O							
Malia Tallett	O	O	O							
Nadine Tenn Salle	X	X	O							
Paul Roeder*	X	X	X							

Legend: X=Present; O=Absent; /=No Meeting | *-Chair, **-Vice Chair

TOPIC	DISCUSSION	ACTION
Call to Order	The meeting was called to order at 12:01 p.m. by P. Roeder Chairperson, Universal Access Advisory Council (UAAC) presiding.	
Welcome	P. Roeder welcomed new members. Followed by member, guest, and staff introductions.	
Educational Session	"The Maryland All-Payer Reimbursement Model" by Robert Murray, MBA, President, Global Health Payment LLC and Robert Berenson, MD, Institute Fellow, The Urban Institute. A copy of the "Rate Setting in Maryland and Hospital Global Budget Discussion, Presentation for the State of Hawaii and Interested Parties" are hereby attached to these minutes. The presentation was followed by a question & answer period and discussion.	
Next Meeting	January 22, 2024, 12:00 p.m. (via Zoom).	
Adjournment	The meeting was adjourned at 1:08 p.m.	

Rate Setting in Maryland and Hospital Global Budgets Discussion

Presentation for the State of Hawaii and Interested Parties

Robert Murray
January 19, 20224

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Agenda

- My Background
- Background on the Maryland Hospital Rate Setting System & Evolution
- Key Success Factors of the Early Maryland system
- Past Hospital Global Budget (HGB) Applications
- HGBs: General Characteristics
- Evolution of Maryland Hospital Payment System
- Advantages and Weaknesses of Global Budgets and Rate Regulation
- Results from Current MD Global Budget Demonstration
- Final Observations

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My Background

- BA and MA in Economics and MBA from Stanford University
- Management Consultant for Amherst Associates, Ernst and Young
- Deputy Director and Executive Director, Maryland Health Services Cost Review Commission (HSCRC) 1993-2011
- During my time with HSCRC implemented several new payment initiatives:
  - A pay-for-performance hospital quality initiatives providing incentives for hospitals to reduce unnecessary readmissions and hospital acquired conditions (HACs)
  - Implementation of a severity-adjusted DRGs for payment of MD hospitals
  - Implementation of a pilot hospital global budget (HGB) model for 10 more isolated rural hospitals
- Since leaving the HSCRC – served as a Consultant to the World Bank and States, along with Health Services Research activities

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Background on Maryland's Unique All-Payer Hospital Rate Setting System

- Maryland's rate setting statue passed in 1971
  - The HSCRC (an independent government agency) was established and staffed 1972
  - Early year devoted to developing data collection needed for rate system 72-74
  - HSCRC started setting rates 1974 for commercial payers & applied for and received a Waiver from Medicare/Medicaid payment methods 1977 (became "all-payer")
- Impetus for Development
  - Extremely rapid hospital payment/expenditure growth 1960s/early 1970s
  - Medicaid budget over-runs
  - Potential insolvency of inner-city hospitals in the state - inability to fund hospital uncompensated care (UC)
  - Concerns re: national health reform (MD felt it was better to craft their own system)
- Characteristics of Maryland's Original Rate System

Original system a very itemized FFS payment system

  - HSCRC collected cost data and mandated a uniform accounting and reporting system for hospitals
  - Based on cost data, HSCRC set an approved "rate" for each service line (i.e., Med/surg, ICU, OR, Radiology, other Ancillary service lines, ER, ASC, etc..) some 72 different service lines
  - HSCRC had legal authority to set rates for each hospital (based on historical costs) & update them
  - So, this was a "Mandatory" rate system – applicable to all hospitals and payers in the State

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Characteristics of The Maryland System and Regulatory Approach

- Maryland payment system was "Prospective" in nature
- Once rates were set (based on reported historical hospital costs) rates were trended (updated prospectively) – this was the first prospective payment system in the US
- Early on, despite limiting the growth in HSCRC-set hospital unit rates – costs still grew rapidly because hospitals increased their volume of services
- In response, the HSCRC was first jurisdiction to make use of DRGs for inpatient payment in 1976
- Maryland also imposed a "Volume Adjustment System" (VAS) which paid hospitals on the basis of their marginal costs for producing incrementally new volumes
- The "VAS" paid hospitals on a fixed cost/variable cost basis:
  - Hospitals received 60 cents on the dollar for incrementally new volumes
  - VAS also covered hospital fixed costs (assumed to be 40-50%) when volumes declined
  - The VAS removed the excess of Marginal Revenue over Marginal Cost for volume increases (i.e., it neutralized FFS incentives to unnecessarily increase hospital volumes but provided flexibility in revenues for "needed" services)
- This VAS allowed MD to successfully control both rate growth and overall hospital per capita expenditure growth (helped moderate volume growth)
- This system is what I now refer to as a "Flexible Global Budget" payment system (will discuss later)

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Key Success Factors for Maryland's Early System and Future System Modifications

- The Medicare Waiver
  - Vital Component of the Maryland System
  - Waiver allowed for a uniformity of payment incentives across all payers
  - Also gave the HSCRC tremendous leverage over the hospitals and the rate system (elimination of the waiver would be highly disruptive to hospitals so – most all hospitals continued to support the system over time)
- System Performance
  - Controlled hospital cost per case growth very successfully (25% above US in 1976 to 1% below US by 1992)
  - Financed $1 billion of hospital uncompensated care through add-ons to rates (not a pass through however)
  - Highly equitable payment system (statutory and Medicare Waiver requirement)
- Modifications of the Maryland Rate System Overtime
  - In response to complaints by the hospitals – HSCRC greatly loosened its cost controls and removed its VAS
  - As a result, MD eroded on its Medicare waiver test (per case cost growth test) and also increased more rapidly in per capital hospital costs in 2000-2004 moving forward (volumes exploded) see Kalman et al.
  - Beginning in 2007 HSCRC brought back a more diluted VAS and experimented with Global Budgets for more isolated rural hospitals
  - This Rural Hospital HGB model was the proto-type for the Current Maryland Global Budget Demo with CMMI

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Global Budget Applications

- Used widely in Canada and Europe – different iterations
- Rochester and Finger Lakes Area hospitals (New York 1980s)
- Maryland 2009 (10 rural hospitals) and 2014-present (CMM), Vermont All-Payer ACO model & Pennsylvania Rural Health Model (CMMI)
- CMMI AHEAD proposed Demonstration (proposed in 2023)
- Currently, Rhode Island, Vermont, Oregon, Washington and other states considering potential implementation
- Other state expressing interest: Massachusetts, New Mexico

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General Characteristics

- Establishment of a fixed or semi-variable ("flexible" using a VAS mechanism) budget covering all hospital services
- Initial budgets based on hospital historical revenues (eases transition)
- Annual budget usually set and enforced by a rate setting authority
- Regulator also responsible for controlling the growth of budgets over time ("Updates")
- Best if applicable to all payers (each payer contributes to the funding of global budget)
- Getting Medicare in requires negotiation of Medicare Waiver with CMMI
- Regulating aggregate budgets less complex than regulating individual service prices (as was the case with the old rate regulatory models in NY, NJ, MD and MA)
- There are different HGB approaches:100% fixed budgets or semi-variable ("flexible budgets")
- Fixed budgets set what is largely a "hard cap" – so any increases in volume (or operating cost) will cause a hospital to forego revenues above its cap, but hospital retain 100% of savings for volume drops (or improved efficiency)

Fixed budgets may provide too much risk and provide excessive incentives to reduce care

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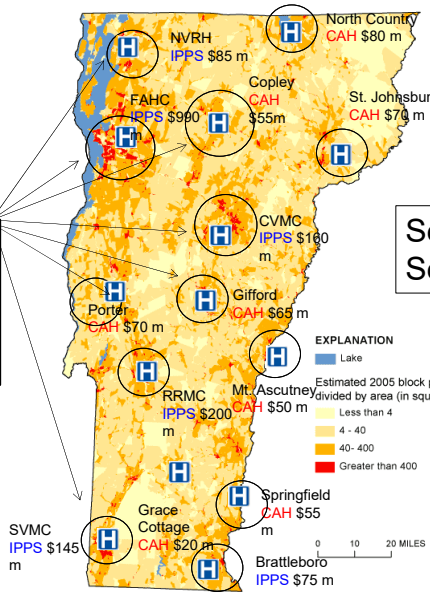
Some states Well-Suited to a System of Hospital Global Budgets

Vermont's regional system of hospitals

Populations are naturally mapped to individual Hospitals



Self-contained Hospital Service Areas

Incentives Under Different Bases of Payment

FFS MODEL	Fixed Global Budget	Flexible Global Budget
Hospital is paid 100 cents on the dollar for each service, even though cost to produce the service (i.e., variable costs) is <$1 Results in profit with volume increase and vice versa	▪ Hospitals do not receive additional revenue for volume growth ▪ May encourage stinting as hospital receives 100 cents on the dollar for volume decline	▪ Hospital receives revenue for volume growth, but only for variable costs ▪ Provides a predictable revenue source, but reduces incentive to decrease volume to increase profits and eliminates current excess FFS incentives to grow volumes

Key Advantages - hospital global budgets can:

- Removes or reduces FFS incentives hospitals current face that promotes increased volume of care
- Constrains both price and total hospital expenditure growth over time
- Encourage investments in initiatives to take savings generated by reducing unnecessary use/cost and redeploy them to invest in/improve Population Health
- Supports other Value Based Care initiatives (ACOs) – similar incentives
- Provide financial predictability and stability for hospitals – particularly small rural facilities
- Can help address untoward circumstances/events (pandemic induced volume drops) – rate agency can keep HGBs in place and guarantee adequate payment

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Key Shortcomings include:

- Fixed budgets are less responsive to shifts in volume (payer induced or other shifts)
- Fixed budgets also present a hospital with significant financial risk
- Fixed budgets may also have too strong a set of incentives to reduce service provision, shed patients or stint on care
  - Resulting in increased wait times for elective and ED care (experience in Europe and Maryland)
  - And shifts of care from acute hospitals to non-hospital and "unregulated" ASCs, imaging, etc
- Model effectiveness may be undermined by shifts of hospital care to unregulated sectors (payers then pay for shifted services "twice")
- Inequities can arise if some payer categories are not included in the Global Budget
- May get conflicting incentives if some hospitals are not under Budgets
- As with all rate models, subject to "regulatory failure" particularly if model is too complex

Note: Can discuss HSCRC's regulatory philosophy which I believe helped minimize pitfalls experienced by other state systems

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Results from the Maryland Global Budget Demo

- MD has met all of its expenditure control targets set by CMS
- 2015-2019 MD did run into trouble with meeting CMS' Total Cost of Care targets – (Medicare hospital and non-hospital growth) because of shifting of hospital care to non-hospital providers
- Again – I think "flexible budgets" would deal with this situation
- Generally, MD hospitals (including AMCs) are still supportive of the model – but this is influenced by the "Value" of the MD's Current Medicare waiver
- The Waiver currently causes MD hospitals to receive much higher Medicare payments than would exist under IPPS and OPPS (legacy of original negotiation)
- But this circumstance cannot be duplicated today – states starting out won't get enhanced Medicare payments like MD enjoys today – must start from "status quo"

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Results from the Maryland Global Budget Demo (continued)

- In recent years, the AMCs have raised concern that the fixed global budgets do not allow enough flexibility for them to innovate and adopt new technology, new high-cost drugs, etc.
- HSCRC has had to make discrete adjustments to AMC's rates to accommodate this – but viewed as "unfair" and politically motivate by other hospitals
- A flexible HGB paying on the basis of fixed and variable costs (e.g., FC/VC percentages of 50/50 or 40/60 for larger acute hospitals or perhaps 80/20 for small rural hospitals which have higher proportions of fixed costs) can handle these concerns
- Some hospitals in MD still dismayed that they are unable to pursue expansionary and so-called "empire building" strategies that many non-for-profit (NFP) hospitals pursue under the US fragmented and uncontrolled commercial payment system

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Results from the Maryland Global Budget Demo (continued)

- HGBs provide significant financial stability and predictability for hospitals
- HGBs can eliminate (or neutralized – as with flexible budgets) the FFS incentives to increase care unnecessarily
- The incentives refocuses hospitals on improving their operating cost efficiency and reducing the level of "Low Value" and unnecessary care
- Because the state imposes an overall cap on hospital expenditure growth – it can generate significant savings relative to historical trends (can share my pro-forma savings model)
- Overall hospital per capita payment cap imposed in MD = 3.58% which equaled State GDP growth over 11 years vs. MD historical growth rate of 4.58%
- We developed a pro-forma model using US National Health Expenditure data that states can use to simulate overall cost savings from a HGB model
- Hospitals under fixed or flexible HGBs now focus on improving cost efficiency and reducing low-value or unnecessary hospital care

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Final Observations

- HGBs redirect hospital incentives toward improving their operating cost efficiency, reducing levels of low value or unnecessary care and making investments in primary care and improved population health
- HSCRC Commissioner quote: "improved efficiency and reduced low value care (LVC) now become sources of financial viability under an HGB"
- Rate setting systems still vulnerable to "regulatory failure" and "regulatory capture"
- Keeping the rate system simple (regulator should devise clear incentive-based payment methods and avoid telling hospitals how to manage themselves) can help avoid Regulatory Failure
- There are structural provisions that can be established to help prevent/avoid Regulatory Capture
- My bias – the commercial health care market is replete with Market Failure – causing market-power strategies by hospitals and payers and resulting in many pricing distortions
- Rate regulation is needed to improve market function (address market failures) but rate agencies should avoid unnecessary intrusions into hospital decision-making (HSCRC philosophy)
- Also believe rate setting can induce hospitals and payers to compete on different dimensions of care

See: How Price Regulation is Needed to Advance Competition. R Berenson and R Murray, *Health Affairs*, January 2022; 41. No.1: pp 26-34. Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2021.01235

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