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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

Dear Acting Administrator Slavitt:

Thank you for the opportunity to provide input to CMS as it considers how it could create payment systems to support higher quality, more affordable care for the residents of a geographic region, using lessons derived from the Maryland All-Payer Model for hospital services.

Problems in Current Hospital Payment Systems That Need to Be Solved

The payment methodologies used in the Medicare Inpatient Prospective Payment System (IPPS) and the Medicare Outpatient Prospective Payment System (OPPS) create financial rewards and penalties for hospitals that conflict with efforts to reduce avoidable admissions and readmissions, unnecessary testing and imaging, etc. Although the case rate structure in IPPS encourages hospitals to deliver care during each hospital stay as efficiently as possible, it creates large financial penalties for a hospital when admissions decline, and it can create excessive financial rewards when admissions increase. This is because the majority of costs in a hospital are fixed, at least in the short run, and even if the DRG payment amounts to the hospital match the average cost per case at the hospital's current volume of patients, the same DRG payment amounts will create a large profit for the hospital when it has more admissions and large losses when the hospital has fewer admissions, because the payments are much larger than the hospital's marginal cost for the services. Similarly, the OPPS pays for outpatient care on a partially-bundled per-service/per-visit basis, where the payment rates may be higher or lower than a hospital's costs depending on the volume of services. Clearly, these kinds of financial penalties and rewards make it difficult for hospitals to cooperate with efforts to reduce hospital admissions, readmissions, testing, and other services.

Hospitals are both required by law and expected by their communities to have certain essential services available to residents and visitors in the community. Community residents need 24/7 access to an emergency department, a cardiac catheterization center, imaging and laboratory services, a surgical suite, etc. in order to avoid preventable deaths and complications from

accidents, heart attacks, strokes, etc. However, the Medicare IPPS and OPPS do not provide direct support for the costs associated with maintaining these standby services; hospitals must support those costs using the revenue derived from payments for actual emergency room visits, cardiac catheterizations, CT scans, surgeries, and even unrelated procedures and services. Consequently, when there are fewer ED visits, tests, procedures, and admissions, Medicare will spend less, but the hospital will have a more difficult time maintaining its standby services. Under the structure of the current payment system, improving the affordability of care can decrease access to care.

Teaching hospitals are doubly penalized by the structure of the current hospital payment system, because they rely on revenues from admissions not only to pay for their standby services (the costs of which may be higher than in a community hospital because of the unique, specialized standby services delivered by an academic medical center) but also to pay for their medical education and research costs. Although Medicare pays teaching hospitals more than other hospitals to cover the costs of their teaching functions, these payments are explicitly tied to the number and types of admissions to the hospital. Most commercial payers do not explicitly support teaching costs, but they do so implicitly by making higher payments to teaching hospitals for an admission or service than they do to other hospitals, so as a practical matter, all of the teaching hospital's payments for teaching and research are tied to the number of patients it treats. These explicit and implicit ties between patient admissions and teaching/research revenues mean that admitting fewer patients to an academic medical center jeopardizes the hospital's ability to pay for teaching and research as well as its ability to sustain its standby services.

These problems are not unique to Medicare's hospital payment systems. DRG payment systems used by commercial payers create similar problems, as do payment systems that pay per diems or a percent of charges for individual services.

How Maryland Has Addressed These Problems, With CMS Support

The State of Maryland has a unique regulatory structure that has enabled it to mitigate the problematic rewards and penalties current payment systems create for hospitals. Maryland has the ability to require all payers to adjust payment rates to hospitals in order to avoid high profits when patient volumes increase and to avoid large losses when volumes decrease. This includes the ability to set Medicare payment rates, which ensures that both Medicare and other payers pay their fair shares of what is determined to be an appropriate overall level of revenue to support the hospital's services. When Maryland began aggressively encouraging efforts to reduce avoidable admissions and complications, it recognized that the average payments per service and per admission would need to *increase* for Medicare and other payers even though the payers' total spending would *decrease* because covering the hospital's essential fixed costs with fewer admissions and services would mean the average cost per admission would be higher.

However, the waiver that authorized Maryland to set Medicare payment rates was premised on its ability to hold the amounts Medicare paid *per hospital admission* below the amounts it paid in other states, not based on whether the Medicare program was spending less on *hospital care per beneficiary*. CMS wisely recognized that controlling overall spending was the true goal, and so it revised the waiver structure for Maryland accordingly.

The Need to Create Similar Outcomes as Maryland, But Using Different Approaches

Payment reforms are needed that can address the problems in current hospital payment systems in states other than Maryland. I do not believe it is either feasible or desirable to try and replicate the Maryland approach in other states, however. The payment methodology in Maryland is dependent on having a state regulatory body with the authority to dictate the amounts that all payers – Medicare, Medicaid, and private payers – will pay hospitals for services received by the insured beneficiaries of those payers. Maryland's approach is also dependent on that regulatory body having the skills and expertise to make fair and effective judgments about whether changes in the number of patients treated by a hospital justifies a change in the hospital's revenues. It is unlikely that most other states will be willing or able to implement a comparable system.

Fortunately, there are other ways to change hospital payment systems in ways that would address the problems described earlier without requiring the type of regulatory structure that Maryland uses. One approach will be described later in these comments.

Global Budgets for Hospital Services vs. Global Budgets for All Healthcare Services

Although the RFI states that it is explicitly designed to build upon lessons learned in Maryland, the questions in the RFI are all narrowly framed in the context of a "prospective global budget for a region." The "global budgets" in Maryland are global budgets for *hospital services*, not for *all healthcare services* in any community. Maryland only regulates payments for hospital services, it does not regulate payments for physician services, for nursing home services, home health services, etc.

One of the challenges that Maryland currently faces is that while payment systems for hospitals in Maryland no longer penalize hospitals for reducing hospital admissions and services, payment systems for *physicians* in Maryland still penalize physicians for delivering fewer services and do not give them adequate resources to help patients avoid the need for hospitalizations and procedures. This makes it difficult for physicians to support hospitals' efforts to reduce avoidable admissions and other services.

However, I do not believe that it is necessary, feasible, or desirable to go even farther than the Maryland payment system and try to establish a "global budget" for ALL healthcare services to address this, as the RFI suggests that CMS wants to do. Appropriate physician-focused payment reforms in the Medicare program and appropriate payment reforms for other healthcare providers could address this problem. Creating a true regional global budget is difficult and problematic for the following reasons:

- **Difficulty of forecasting total healthcare spending.** No one knows how to accurately project the healthcare needs and spending for a population of patients. Prospective risk adjustment models can only predict about 20% of the variation in healthcare spending even for large groups of patients. The accuracy is even lower for smaller populations of patients, simply because small changes in the number and types of patients can result in large changes in spending; for example, significant in-migration or out-migration during the year, a special event that attracts tourists, or a flu outbreak could result in the need for significantly higher expenditures on healthcare services in a small community than any budgeting process could ever plan for. Concurrent risk adjustment models are less

inaccurate because they take into account changes in the patient population and unexpected health problems that occur during the course of the year, but one cannot use a *concurrent* risk adjustment model to establish a *prospective* budget. (Concurrent risk adjustment *can* be used to provide adequate payments and achieve spending levels that are based on patient needs rather than unnecessary utilization, which is how CMS should define the goal of its initiative, rather than establishing budgets.)

- **Risks of inappropriate rationing of care.** If it is impossible to accurately predict how many services and how much spending will be needed to address the healthcare needs of a population of patients, then a fixed prospective budget could result in rationing of healthcare services, i.e., forcing healthcare providers to deny services to patients who need them because the "budget" has been exceeded. This can be avoided by allowing adjustments to the budget when patient needs are higher than expected, but if the budget can easily be changed, then it really is not a prospective budget. (If the budget is going to be routinely adjusted for changes in the needs of the community, it is better to simply create a predictable payment system that is based on patient needs.)
- **Challenges in allocating the budget.** Creating a single "global" budget for all healthcare services begs the question of whether, when, and how much individual healthcare providers will be paid for their services. If every healthcare provider is paid the same way they are paid today, then nothing has really changed about the healthcare payment *system*; the problem of deciding payment *amounts* for individual providers has simply been pushed from CMS to each individual community. Someone either has to receive the total budget and then pay individual providers (which is the equivalent of "single payer healthcare" at the local level) or some method has to be established for determining who should give back part of what they've already been paid when the overall budget is exceeded. (This is not necessary if each provider can be paid under an alternative payment system that enables and encourages them to deliver care in ways that will achieve lower overall spending levels.)

Instead of trying to establish a global budget for a community, it would be both desirable and feasible for CMS to create an alternative payment model for hospitals and alternative payment models for physicians and other healthcare providers in the community that can achieve the same kinds of positive impacts that one might hope to achieve through a comprehensive global budget but without the problems associated with that approach. If CMS creates payment systems in which physicians, hospitals, and other providers are paid based on patients' health conditions rather than based solely on what services were delivered and if CMS provides payments designed specifically to support essential standby services and healthcare service infrastructure in a community, it would create the benefits equivalent those envisioned by having a regional budget for Medicare spending, but with the added benefits of an automatic method of adjusting the budget for changes in patient needs and an automatic way of allocating the budget fairly among participating providers.

Addressing the Needs of Rural Communities and Rural Hospitals

The smallest hospitals in the most rural communities in the country are classified as Critical Access Hospitals and are paid by Medicare through a "cost-based reimbursement system" rather than the case rates and service payments under the Inpatient and Outpatient Prospective Payment

Systems. Although it would seem on the surface that cost-based reimbursement would avoid the problems of payments being higher or lower than costs as patient volumes change, this would only be true if a hospital were paid for *all* of its patients based on its costs. Because Medicare's cost-based payment system for Critical Access Hospitals only pays the hospital 101% of its costs for *Medicare* patients, the hospital cannot generate an adequate operating margin to cover the costs of services delivered to uninsured patients. Moreover, every *non-Medicare* patient the hospital treats *reduces* the Medicare payments the hospital receives to cover its fixed costs, because Medicare only pays for the proportion of the hospital's costs that are allocated to Medicare beneficiaries.

Even more significantly, under sequestration, Medicare only pays Critical Access Hospitals 99% of their actual costs allocated to Medicare beneficiaries, not 101% of their costs. In other words, today, if a Critical Access Hospital only treated Medicare beneficiaries, it would go bankrupt because the law requires that the hospital receive less revenue than its costs, no matter how low those costs are. This creates significant pressures for a Critical Access Hospital (CAH) to treat or admit commercially-insured patients and it creates financial penalties for a CAH if it encourages efforts to reduce avoidable admissions and readmissions for Medicare beneficiaries. However, even if sequestration were revoked for Critical Access Hospitals, a 1% margin would not be sufficient to allow the hospital to cover the costs of treating uninsured patients, to make capital investments in equipment and facilities, etc.

RECOMMENDATIONS FOR CMS ACTION

How to Establish a Hospital Payment System That Supports Regional Population Health

Goals for a Better Medicare Payment System for Hospitals

What is needed is a new payment system that could be used by both Medicare and other payers to support services delivered by both urban and rural hospitals that achieves the following goals:

- Provides adequate financial support for essential standby services, such as an emergency department, based on the size of the community and the age and health of the population;
- Provides adequate financial support for sufficient hospital medical and surgical care capacity to address the number and types of admissions and services needed based on the health problems of the community residents;
- Provides adequate financial support for any incremental costs the hospital incurs over and above the hospital's fixed costs for treating additional patients or treating more complex patients;
- Provides adequate support for medical education services based on the size of the medical education program rather than the number of patients treated or the number of services delivered in the hospital; and
- Enables and encourages the hospital to be as efficient as possible in the delivery of care to patients who do need to come to the hospital and to support community efforts to improve the health of the residents and avoid the need for hospital services, thereby controlling the total cost of care in the community.

Structure of a Better Payment System for Hospitals

These goals could be achieved through a five-part payment system structured as follows:

1. Annual Per-Resident Payments

The costs of standby services, i.e., services that must be available regardless of whether any patients are seen, such as the cost of having an emergency department or cardiac catheterization services staffed and ready to go on a round-the-clock basis, could best be supported through a fixed annual payment for each resident in the community. A Per-Resident Payment could also support general population health services, such as education about prevention and wellness and support for general wellness services in the community, and could help cover the costs of care for uninsured residents. The payment could potentially be stratified by age to reflect differences in the likely rates of utilization of standby services by different population groups.

The Per-Resident Payment would be paid directly to the hospital by Medicare and other payers (i.e., Medicaid and commercial health insurance plans) for each of the payer's covered members. For uninsured residents, the Per-Resident Payment could either be paid directly by the residents as a "membership fee" (which would in turn entitle them to receive individual services at lower rates than otherwise) and/or it could be supported through local or state government tax revenues for low-income residents (e.g., through a tax rebate for those with sufficient income to pay taxes or through direct payments to the hospital for those who are unemployed).

In communities with one hospital that delivers all of these standby services, the Per-Resident payment would be paid to that hospital for all of the residents in the community. In communities where two or more hospitals deliver these kinds of services, the payment amounts for each hospital could be determined through a two-step process. First, an aggregate payment level per resident would be determined as though there were only one hospital in the community delivering all of the standby services. Then an allocation of that payment between the hospitals would be determined based on past relative utilization of each hospital's standby services by the community (or based on other factors determined by the community, such as whether the hospitals focused their services on different parts of the community). Each hospital would receive that Per-Resident Payment amount for a year, and then the amount could be adjusted in the subsequent year based on actual utilization patterns over the course of the year.

2. Monthly Per-Patient Payments

In addition to true standby services, i.e., resources that are ready to deliver services for emergencies and similar conditions even if no services are actually delivered, hospitals need to have adequate capacity to address the medical and surgical care needs of the community at volumes that would be viewed as appropriate based on the level of health problems in the community and assuming effective, efficient ambulatory management and treatment of patient conditions is being delivered based on the best available evidence. For example, even with the most effective ambulatory care management of patients with chronic disease that has been achieved to date, some number of patients will have exacerbations that require hospitalization, and it will be important that a community hospital has adequate inpatient capacity to care for patients when those exacerbations and hospitalizations occur.

To support this capacity, Medicare and other payers (i.e., Medicaid and commercial health insurance plans) would make a monthly Per-Patient Payment to the hospital for each of the payer's covered members. The amount of the Per-Patient Payment would be based on the

expected rate of hospital services needed given the diagnosed conditions and risk factors among the payer's members. Since different hospitals might provide different types of services (for example, a small rural hospital might have an emergency room but very limited capacity to deliver inpatient services), the Per-Patient Payment to a hospital would also be based on the kinds of admissions and procedures it delivers. As with the annual Per-Resident Payments, in communities where two or more hospitals deliver the same kinds of services, the monthly Per-Patient Payment amounts for each hospital could be determined through a two-step process, starting with calculating an aggregate payment amount representing the cost of the total capacity needed in the community, and then allocating that amount between the hospitals based on the proportion of patients they actually serve or other factors determined by the community.

3. Per-Service Payments for Individual Services and Admissions

Although there are many problems with a payment system for hospitals that pays solely on the basis of the number of services delivered, the use of payments for individual services achieves a number of desirable goals: (1) it ensures that payers whose patients have more health problems pay a higher share of the total cost of healthcare services; (2) it enables revenues to better match providers' costs based on differences in the variable cost of healthcare services with different levels of patient volume; and (3) it enables patient cost-sharing to discourage overuse of services and reward preventive care.

If Per-Resident and Per-Patient Payments are being paid to cover the hospital's fixed costs and a subset of essential services, then the size of the Per-Service Payments can be reduced from current levels to better match the marginal or variable cost of services (rather than being set based on the average cost of services, as they are today). This would mean that a hospital would still receive higher or lower revenues if it admitted more or fewer patients or delivered more or fewer outpatient services, but the change in revenues would be much smaller than it is today, and more importantly, the change in revenues would be similar to the amount by which the hospital's costs would change with more or fewer patients, so that the hospital's operating margin would not be significantly affected. As a result, the hospital would have adequate resources to cover its costs if more patients needed care, but there would be no incentive to treat more patients simply because they would increase the profitability of the hospital.

The initial amounts of these Per-Service Payments might be set using the relative values currently embedded in the OPPS and IPPS, but with lower absolute levels. However, since the current relative values were intended to reflect the differences in *average* costs between different types of services or admissions, not the differences in *marginal* costs, it would be necessary to obtain data on the marginal costs as quickly as possible in order to revise the payment rates for each service so they match the actual differences in costs incurred when more or fewer services of a particular type are delivered.

4. Performance-Based Payments

A fourth component of the payment system would increase or decrease the payment amounts under the first three categories based on the quality of care, patient experience, and overall management of total healthcare spending relevant to the services supported by each of those other payment components. These performance-based payments should be based on aspects of cost and quality that the hospital can reasonably be expected to control.

Since the Per-Resident and Per-Patient Payment components of the payment model would not be tied directly to the number or costs of services delivered, it would be important to ensure that a

hospital did not try to avoid high-cost patients or otherwise "shift" costs to other hospitals or to other providers. This could be done by measuring the overall utilization and spending in the community on hospital services, and the utilization and spending on other services which could be viewed as substitutes for hospital services. If the utilization of the hospital's services by the community residents went down but the equivalent types of services delivered by other hospitals to the residents increased, then the payments to the hospital would be reduced in the current year through the performance adjustments. The baseline payment amounts could then be reduced in the following year by recalculating the formula that sets the payments based on the relative number of services delivered by each hospital.

5. Annual Medical Education Payments

Finally, teaching hospitals would receive an annual payment based on the number and types of medical residents at the hospital. The aggregate amount of the payment could be the same as the aggregate amount that Medicare had been paying the hospital for medical education under the current IPPS structure, but the payment would no longer be tied to the number and types of admissions. The amount of the payment could be updated each year based on inflation and could be adjusted based on performance factors relevant to the quality and efficiency of the medical education program rather than based on factors relevant to the quality of care for patients (which would be addressed through the performance-based payment category described above).

Setting and Maintaining the Payment Amounts Under the New Payment System

The initial payment amounts under this system for an individual payer and hospital could be established at levels which generate the same revenue for the hospital and the same spending level for the payer as the revenue and spending level under the current payment system. Then these individual payment levels could be transitioned over time to rates that are more similar across hospitals. This is the same approach that was used when the Inpatient Prospective Payment System was first created in 1983.

The payment levels would also need to be updated annually for inflation and adjusted periodically to reflect new technologies, new evidence about the best approach to care, etc., so that hospitals would have adequate resources to deliver high quality, cutting-edge care but without the kinds of perverse incentives that exist under current payment systems.

Benefits for Both Prospective Payment System Hospitals and Critical Access Hospitals

The attachment presents a simplified example of how the payment system described above could benefit both hospitals paid under the prospective payment system used by Medicare and many Medicaid and commercial payers and also Critical Access Hospitals paid under the cost-based reimbursement systems used by Medicare and some Medicaid programs. The example shows a hospital which receives part of its payments under cost-based reimbursement and part of its payments under a prospective payment or other payment system tied to services or admissions (this mixed model is how most Critical Access Hospitals are paid), and the example shows how using a combination of per resident and per service payments instead could provide stable funding for hospital services without the significant incentives and disincentives tied to volume that exist in both the prospective payment and cost-based reimbursement systems.

Comparison of the Steps Needed to Design and Implement an Improved Hospital Payment Model to the Steps Needed to Establish a "Global Budget"

The components of the payment model described above are all equivalent to the steps that would be needed in order to establish a fair global budget for a hospital. The global budget would need to adequately support standby costs, support sufficient inpatient and outpatient capacity to meet the needs of the community, increase if more acute services were needed than expected, etc., so the same types of calculations would be needed to establish a global budget as to establish the above payment amounts. However, by incorporating those amounts into a *payment model* rather than a "global budget," adjustments to the hospital's revenue that are needed because of changes in the number of residents and patients in the community and changes in their needs could be automatically made by each payer based on information about members, patients, and services that the hospital and the payer could generate.

How to Establish Physician-Focused Payment Models That Support Regional Population Health

Since the decisions made by physicians affect the number of patients admitted to and treated at a hospital, it is problematic if physicians are not paid in ways that are designed to support the same goals as the hospital payment system. Fortunately, the Medicare Access and CHIP Reauthorization Act (MACRA) encourages the creation of physician-focused Alternative Payment Models (APMs), and many medical specialty societies and physician groups have been developing APMs that are specifically designed to give physicians the resources and flexibility needed to reduce avoidable hospital services and to have physicians take accountability for doing so. However, one of the biggest barriers physicians will face in trying to succeed under such APMs will be if their local hospital is penalized financially under the hospital payment system when the physician succeeds in reducing the number of hospitalizations.

Consequently, it is important that CMS move quickly to design and implement better payment models for hospitals and that it move quickly to approve and implement proposals for physician-focused payment models, so that payment changes can be made for both physicians and hospitals in individual communities that will enable them to work together to improve care and reduce costs.

How to Establish Payment Models for Other Healthcare Providers That Support Regional Population Health

Similar approaches can be used to design better payment models for other healthcare providers, such as post-acute care providers. To the extent that a provider maintains an essential standby service (e.g., a community ambulance service), it could be paid in part based on the number of a payer's beneficiaries or members living in the community. To the extent that a community needs to ensure adequate capacity in the community for a particular service (e.g., hospice services), the provider(s) of that service could receive a Per-Patient Payment based on the number of individuals who will potentially need that service based on their health problems. When individual services are actually received by patients, the provider could then be paid an amount per service that is based on the *marginal* cost of delivering an additional service, rather than the average cost of delivering all of the services.

Organizational Mechanisms and Data Needed to Establish Spending and Quality Targets for a Geographic Region

Rather than trying to establish a "budget" for spending in a geographic region, it would be more feasible and desirable to establish a "target" for spending that everyone in the community agrees should be feasible and that they should mutually seek to achieve. That spending target can then be used to establish the payment amounts and performance-based payment adjustments for the hospitals, physicians, and other providers in the community in a coordinated way.

These targets need to be established at the regional level – since healthcare is delivered regionally – through a collaborative process involving all of the stakeholders in the community – hospitals, physicians, employers, government, patients, citizens, etc. It cannot be done by the federal government.

Complete and reliable data and accurate analysis of utilization and spending in a community will be needed in order to establish spending targets, to ensure that adequate and fair payment levels can be established under a new payment model, and to assist all stakeholders in identifying and implementing opportunities for improvement.

Successfully managing the total cost of care in a community and transitioning to new payment models will require very different kinds of relationships between payers and providers, between physicians and hospitals, between purchasers and providers, and between providers and patients than exist today. Today, the only interactions many of these stakeholders routinely have with each other are negotiations over prices or compensation which often result in hard feelings on one or both sides. As a result, in many communities, there is considerable mistrust that will have to be overcome in order for the stakeholders to collaboratively redesign payment and care delivery and find win-win-win approaches.

Since there is no individual or organization "in charge" of healthcare in any region, a growing number of communities have created non-profit Regional Health Improvement Collaboratives to bring together all of the key stakeholders – physicians, hospitals, payers, and patients – to develop a common vision of how healthcare quality and value should be improved, to design win-win strategies for achieving those improvements, and to help resolve implementation problems in ways that are fair to all stakeholders. Because Regional Health Improvement Collaboratives do not deliver care, pay for care, or regulate care, they can also serve as trusted, neutral facilitators of discussion among the various stakeholders, and they can provide objective information and analysis to help overcome the lack of trust that can prevent stakeholders from reaching agreement on significant reforms on their own. Regional Health Improvement Collaboratives also represent the majority of Qualified Entities in the country so they have a unique ability to provide the data and analyses needed to design multi-payer payment models for both Medicare and other payers.

Although state governments will be playing an increasingly more central role in healthcare reform in the future, partly as a result of the programs in the Affordable Care Act, they cannot be effective substitutes for the roles that multi-stakeholder Regional Health Improvement Collaboratives play. While the regulatory powers and financial resources of state governments give them some unique strengths, such as the ability to mandate the submission of quality and cost data by providers and payers and the ability to provide anti-trust safe harbors to help

establish multi-payer payment reforms and help independent providers coordinate their services, it is difficult for state governments to support multi-year healthcare transformation efforts when changes in state administrations and changes in fiscal priorities occur, and it is difficult for states to balance regulatory enforcement powers with programs to facilitate provider improvement. In contrast, the independence and stakeholder governance of Regional Health Improvement Collaboratives provide them with greater ability to support providers through multi-year transformation efforts and to do so in a way that can be adapted to the unique needs of individual geographic regions. Consequently, the greatest success in healthcare transformation will likely come from strong partnerships between state governments and Regional Health Improvement Collaboratives.

Although many aspects of the work done by Regional Health Improvement Collaboratives are challenging, one of the most challenging tasks Collaboratives face is obtaining adequate funding to support their work. CMS will need to provide funding support to RHICs to enable them to facilitate the transition to innovative payment models in ways that meet the needs of their communities.

Moving Quickly to Refine and Try New Payment Models at the Regional Level

There is an urgent need to develop and implement new payment models for hospitals both in rural areas and in urban areas. Many communities are struggling with how to control unaffordable healthcare costs, how to help both hospitals and physician practices avoid closing, and how to correct serious problems with the quality of healthcare services. It seems obvious that if healthcare providers cannot succeed financially when healthcare spending levels are bankrupting consumers and businesses, fundamental changes are needed in the way services are paid for and those changes are needed quickly.

There are a number of communities around the country that are already working on these issues and that could serve as R&D sites to help CMS refine and test better approaches. For example:

- In Washington State, as part of Washington's State Innovation Model work, a dozen Critical Access Hospitals are working together with support from the Washington State Hospital Association, the state Health Care Authority, the state Department of Health, and the state Department of Social and Health Services to redesign the way services could be delivered in their rural communities in order to preserve access to essential services, to improve the quality of healthcare services, and to reduce the total cost of care in the communities. However, the current payment system is a serious barrier to progress, and success will depend on having significant changes to Medicare payments. Rapid action is needed, because several of the hospitals are at risk of closing, which would leave their communities without access to essential care and increase total costs for Medicare, Medicaid, and local residents and businesses.
- In Hilo, Hawaii, the physicians, hospital, employers, health plans, citizens and other stakeholders are all working together through the East Hawaii Regional Health Improvement Collaborative to improve the quality and reduce the cost of healthcare on the eastern side of the Big Island. Although HMSA has been supporting the community's efforts through payment reforms in its commercial, Medicaid, and Medicare Advantage insurance plans, a large number of patients are still covered by traditional

Medicare. Rapid action is needed because significant financial problems at the Hilo Medical Center and growing physician shortages in the community could cause loss of access to essential services and result in higher total costs for Medicare and the employers in the community.

I would encourage you to contact these and other similar communities as soon as possible to learn about the work they are doing and explore forming a collaborative relationship with them in order to design and implement significant changes to both hospital and physician payment systems in a coordinated way.

Thank you again for the opportunity to offer these recommendations. I would be happy to answer any questions you may have about the recommendations or to provide any additional information or assistance that would be helpful to you in implementing them.

Sincerely,

Harold D. Miller
President and CEO

cc: CMS Deputy Administrator Patrick Conway, MD
CMMI Deputy Director Amy Bassano

Attachment: Hypothetical Example of an Improved Hospital Payment System

Hypothetical Example of an Improved Hospital Payment System

The following describes a hypothetical example of how an improved payment system for hospitals could provide more stable, adequate financial support for hospitals and more predictable spending for payers than both current payment systems in which payment is based either on the number of admissions or services or on costs.

- For simplicity, the example is focused on an "Emergency Department," but the same approach could be used for any other hospital service line for which standby capacity is needed.
- In order to illustrate how a revised payment system would work for Critical Access Hospitals as well as for hospitals paid through the prospective payment system, the example shows a hospital which receives its payments from public sector payers through a cost-based reimbursement system and its payments from private sector payers through a per-admission (or per-service) payment system (since most Critical Access Hospitals receive some payments under both approaches). However, the same results would be seen if the hospital were paid entirely on a per-admission (or per-service) basis.
- For simplicity, the new payment system shown uses only a per-resident payment and a per-service payment, but the same kinds of results would be seen with a payment system that included per-resident, per-patient, and per-service components.

The model is based on a hypothetical community with the following characteristics:

- 3,000 residents live in the community
  - 30% of residents are on Medicare and use the hospital Emergency Department at a rate of 450 visits/1000 each year. The hospital is reimbursed at 101% of costs for these visits.
  - 30% of residents are on Medicaid and use the ED at a rate of 300 visits/1000 per year. The hospital is reimbursed at 101% of costs for these visits.
  - 25% of residents have commercial insurance and use the ED at a rate of 100 visits/1000 per year. The average payment for an ED visit is $850.
  - 15% of residents are uninsured and use the ED at a rate of 200 visits/1000 per year. It is assumed that they can only afford to pay $200 for an ED visit.
- The Emergency Department costs $650,000 per year to operate. 75% of this cost is fixed cost, and 25% is variable (i.e., the variable costs are only incurred if patients are seen in the ED).

As shown in Figure 1, although the hospital is reimbursed at 101% of cost for Medicare and Medicaid patients, and although the average commercial payment is higher than the average cost per patient, the hospital still experiences a 6% loss on the operations of the ED because it does not receive a sufficient margin from Medicare, Medicaid or commercial patients to cover the full costs of serving the uninsured patients. Figure 1 also shows that a reduction in ED volume would exacerbate these losses.

Figure 2 shows that a 10% increase in the number of ED visits from insured patients would reduce the hospital's losses by 22%, but it would still not eliminate the deficit because the Medicare and Medicaid revenues do not increase in proportion to the increased volume.

Figure 3 shows an alternative way of paying for the ED services. All payers make a fixed annual payment for each of their insured members and then make a payment for each visit that averages $195 based on the marginal cost of the services delivered during a visit. The per member payment rates for Medicare and Medicaid beneficiaries are set at $240 and the commercial payment rates are set at $75 based in part on the differential rates of use for the two populations. This results in higher total payments from all of the payers so that the payments now cover the hospital's costs.

Figure 4 shows that under the new payment model, if the hospital is able to reduce the number of ED visits by 30%, the hospital ED would continue to operate with a positive margin, while reducing spending for the payers by 6-7% compared to the payments under current levels of utilization. (Under this hypothetical scenario, a 30% reduction in ED utilization would reduce spending levels for Medicare, Medicaid, and commercial payers below their original levels while leaving the hospital with a positive operating margin due to the reduction in costs needed to serve fewer patients.)

Figure 1

	CURRENT PAYMENT SYSTEM			CURRENT PAYMENT SYSTEM *10% Reduced Visit Volume*			
	$	# Pts	Total $	$	# Pts	Total $	Change
Cost Reimbursement				**Cost Reimbursement**			
Cost + 1%		675	$527,545	Cost + 1%		608	$514,356	
Total Public			$527,545	Total Public			$514,356	-3%
Fee Revenues				**Fee Revenues**			
Per Visit Commercial	$850	75	$63,750	Per Visit Commercial	$850	68	$57,375	
Total Commercial			$63,750	Total Commercial			$57,375	-10%
Uninsured				**Uninsured**			
Per Visit	$200	90	$18,000	Per Visit	$200	81	$16,200	
Total Revenues			$609,295	**Total Revenues**			$587,931	-4%
Costs				**Costs**			
Fixed (75%)			$487,500	Fixed (75%)			$487,500	0%
Variable (25%)	$193	840	$162,500	Variable (25%)	$193	756	$146,250	-10%
Total Costs	$774	840	$650,000	Total Costs	$838	756	$633,750	-3%
Margin			($40,705)	**Margin**			($45,819)	-13%

Figure 2

	CURRENT PAYMENT			CURRENT PAYMENT *10% Higher Visit Volume*			
	$	# Pts	Total $	$	# Pts	Total $	Change
Cost Reimbursement				**Cost Reimbursement**			
Cost + 1%		675	$527,545	Cost + 1%		743	$544,625	
Total Public			$527,545	Total Public			$544,625	3%
Fee Revenues				**Fee Revenues**			
Per Visit Commercial	$850	75	$63,750	Per Visit Commercial	$850	83	$70,125	
Total Commercial			$63,750	Total Commercial			$70,125	10%
Uninsured				**Uninsured**			
Per Visit	$200	90	$18,000	Per Visit	$200	90	$18,000	
Total Revenues			$609,295	**Total Revenues**			$632,750	4%
Costs				**Costs**			
Fixed (75%)			$487,500	Fixed (75%)			$487,500	0%
Variable (25%)	$193	840	$162,500	Variable (25%)	$193	915	$177,009	9%
Total Costs	$774	840	$650,000	Total Costs	$726	915	$664,509	2%
Margin			($40,705)	**Margin**			($31,759)	22%

Figure 3

	CURRENT PAYMENT SYSTEM *10% Reduced Visit Volume*		
	$	# Pts	Total $
Cost Reimbursement			
Cost + 1%		608	$514,356
Total Public			$514,356
Fee Revenues			
Per Visit Commercial	$850	68	$57,375
Total Commercial			$57,375
Uninsured			
Per Visit	$200	81	$16,200
Total Revenues			$587,931
Costs			
Fixed (75%)			$487,500
Variable (25%)	$193	756	$146,250
Total Costs	$838	756	$633,750
Margin			($45,819)

	NEW PAYMENT MODEL *Same Visit Volume*			
	$	# Pts	Total $	Change
Public Revenues				
Per Member Public	$240	1,800	$432,000	
Per Visit Public	$195	675	$131,625	
Total Public			$563,625	7%
Private Revenues				
Per Member Commercial	$75	750	$56,250	
Per Visit Commercial	$195	75	$14,625	
Total Commercial			$70,875	11%
Uninsured				
Per Visit	$200	90	$18,000	
Total Revenues			$652,500	7%
Costs				
Fixed (75%)			$487,500	0%
Variable (25%)	$193	840	$162,500	0%
Total Costs	$774	840	$650,000	0%
Margin			$2,500	106%

Figure 4

	NEW PAYMENT MODEL *Same Visit Volume*		
	$	# Pts	Total $
Public Revenues			
Per Member Public	$240	1,800	$432,000
Per Visit Public	$195	675	$131,625
Total Public			$563,625
Private Revenues			
Per Member Commercial	$75	750	$56,250
Per Visit Commercial	$195	75	$14,625
Total Commercial			$70,875
Uninsured			
Per Visit	$200	90	$18,000
Total Revenues			$652,500
Costs			
Fixed (75%)			$487,500
Variable (25%)	$193	840	$162,500
Total Costs	$774	840	$650,000
Margin			$2,500

	NEW PAYMENT MODEL *30% Reduced Visit Volume*			
	$	# Pts	Total $	Change
Public Revenues				
Per Member Public	$240	1,800	$432,000	
Per Visit Public	$195	473	$92,138	
Total Public			$524,138	-7%
Private Revenues				
Per Member Commercial	$75	750	$56,250	
Per Visit Commercial	$195	53	$10,238	
Total Commercial			$66,488	-6%
Uninsured				
Per Visit	$200	63	$12,600	
Total Revenues			$603,225	-8%
Costs				
Fixed (75%)			$487,500	0%
Variable (25%)	$193	588	$113,750	-30%
Total Costs	$1,023	588	$601,250	-8%
Margin			$1,975	-21%