Maryland All-Payer Model Overview

Rural Health Care Delivery Workgroup

August 2016

HSCRC
Health Services Cost Review Commission

Overview

- The Nation's Evolving Healthcare Landscape: Major Pressures Leading Shift to Value
- Unique Changes in Maryland's Healthcare Delivery System
- Model Progression

The Nation's Evolving Healthcare Landscape: Shifting to Value

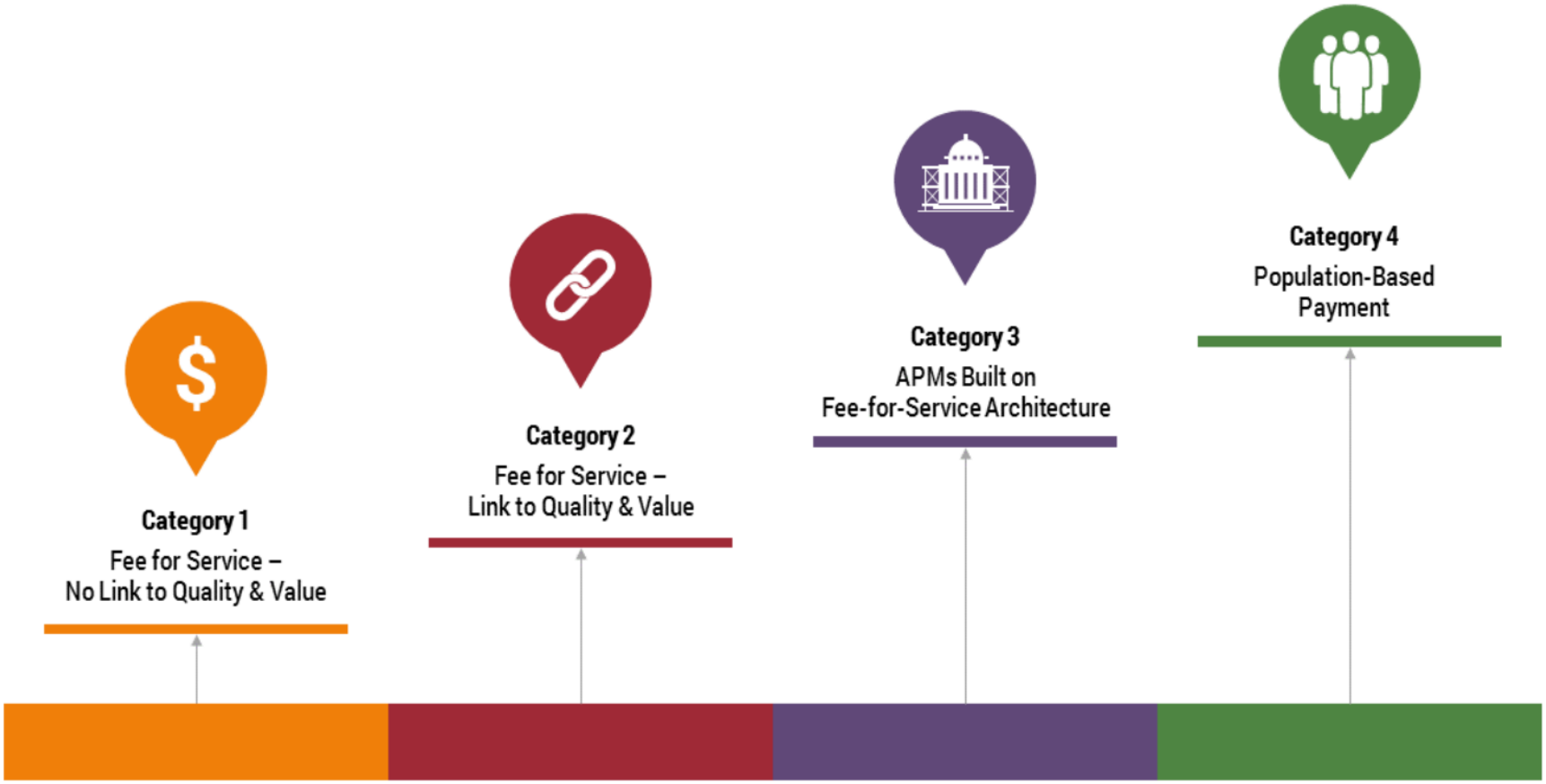
CMS and National Strategy--Change Provider Payment Structures, Delivery of Care and Distribution of Information

Focus Areas	Description
Pay Providers	• Increase linkage of payments to value • Alternative payment models, moving away from payment for volume (MACRA) • Bring proven payment models to scale
Deliver Care	• Encourage integration and coordination of care • Improve population health • Promote patient engagement
Distribute Information	• Create transparency on cost and quality information • Bring electronic health information to the point of care

Source: Summarized from Sylvia Burwell (US Secretary of Health & Human Services) presentation

CMS is Focused on Progression to Alternative Payment Models (APMs)

MACRA is expected to have extensive fee schedule effects on physicians in 2019 based on participation in APMs

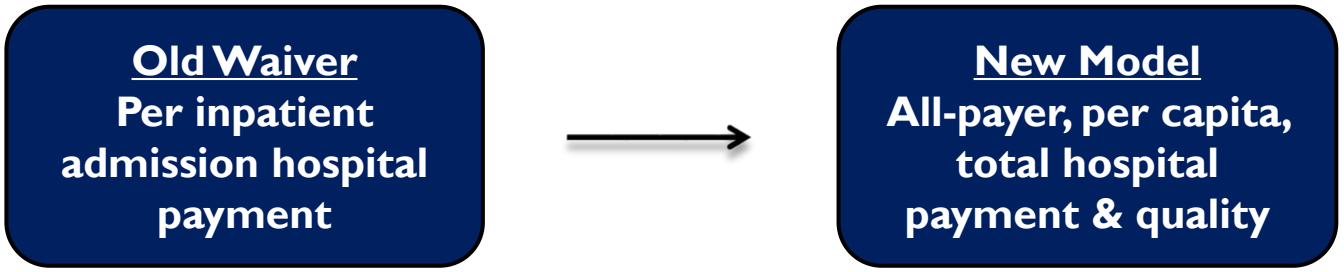


Source: Health Care Payment Learning & Action Network Alternative Payment Model (APM) Framework Final White Paper

Unique Changes in Maryland's Healthcare Delivery System

Unique New Model: Maryland's All-Payer Model

- Maryland is implementing an All-Payer Model for hospital payment
  - Approved by Centers for Medicare & Medicaid Services (CMS) effective January 1, 2014 for 5 years
  - Modernizes Maryland's Medicare waiver and unique all-payer hospital rate system
  - Health Services Cost Review Commission (HSCRC) is leading the effort



- HSCRC back drop:
  - Oversees hospital rate regulation for all payers
  - Rate setting authority extends to all payers, Medicare waiver
    - Granted in 1977 and renewed under a different approach in 2014
  - Provides considerable value
    - Limits cost shifting- all payers share in medical education, uncompensated care, etc.

Unique New Model: Built on Maryland's Approach for Funding Rural Hospitals

- Total Patient Revenue Model established with many rural hospitals in beginning with Garrett Memorial and expanding to 10 hospitals in 2011.
- TPR provided sole community provider hospitals, and hospitals operating in regions of the State without competing hospitals with financial incentive to manage their resources efficiently and effectively to slow the rate of increase in the cost of health care.
- TPR provides the assurance of a certain amount of revenue each year independent of the number of patients treated and the amount of services provided to these patients.
- Most qualifying hospitals were successful under TPR based on both quality and financial metrics.
- The New Model uses many TPR principles and expands that approach by including specific spending and quality targets that Maryland must meet.
- CMS has proposed regulations for rural hospitals that are based on the Maryland TPR concept which is seen as a safety net for such hospitals that are experiencing volume declines.

All-Payer Model Performance – CY 2014 and 2015

Maryland Year 1 & Year 2 Performance

All-Payer Model Metrics

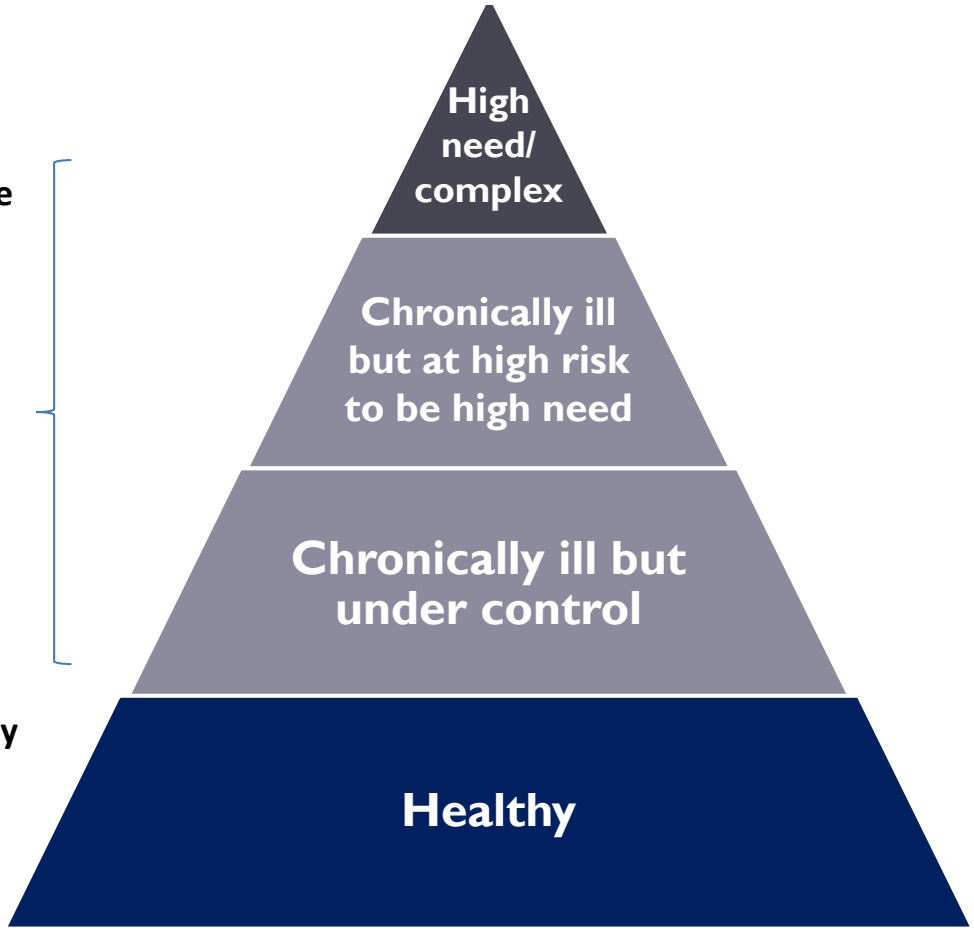
Performance Measures	Targets	CY 2014 Results	CY 2015 Results
All-Payer Revenue Growth	≤ 3.58% per capita	1.47% per capita	2.31% per capita
Medicare Savings in Hospital Expenditures	≥ $330m over 5 years	$116m in CY14	$135m in CY15 $251m aggregate
Medicare Savings in Total Cost of Care	Lower than the national average	$133m in CY14	$80m in CY15 $213m aggregate
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	30% reduction over 5 years	26% reduction in CY14	33.34% reduction in CY15
Readmissions Reductions for Medicare	≤ National average over 5 years	0.21% gap decrease between Maryland & the Nation in CY14	0.70% gap decrease between MD & the Nation in CY15
Hospital Revenue to Global or Population-based	≥ 80% by Year 5	95% in CY14	96% in CY15

Opportunities for Patients—Tailoring Care Delivery to Persons' Needs = Better Outcomes & Quality of Life, Fewer Hospitalizations

Utilizing EHRs, analytics, health information exchange, and care coordination resources to improve care and health.

B

Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care



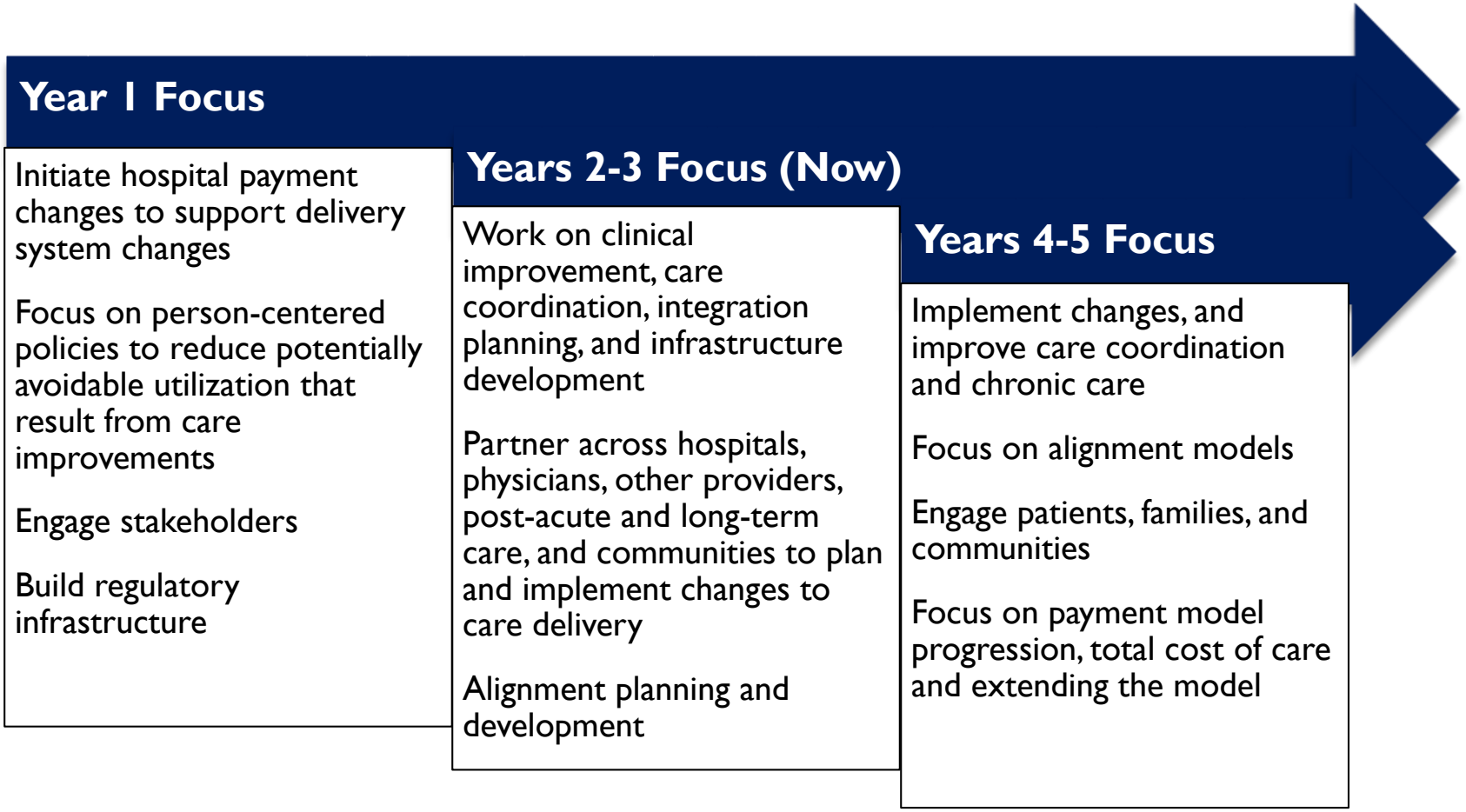
A

Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources

C

Promote and maintain health (e.g. via patient-centered medical homes)

Recap: Strategy for Implementing the All-Payer Model



Maryland's Strategy—Care Coordination for High Needs Patients

- Fully implement care coordination to scale, first for complex and high needs chronically ill patients
  - Organize and engage consumers, primary care, long-term care, and other providers in care coordination and chronic care management
  - Intense focus on Medicare, where models do not exist or are immature in Maryland
  - Build on growing PCMH and ACO models, global budgets and geographic areas, and Medicare Chronic Care Management (CCM) fee
- Develop financial alignment programs across hospitals and other providers, and get data and approvals needed for implementation

Care Redesign in Maryland

- The State of Maryland, in response to stakeholder input, is proposing a Care Redesign component to the All-Payer Model through a Model Amendment
  - Advisory Council, Physician Alignment work group, Care Coordination work group
- This effort aims to gain the approvals (Safe harbors, Stark, etc.) and data needed to support activities for:
  - Creating greater engagement and outcomes alignment capabilities for providers practicing at hospitals and non-hospital providers
  - Engaging patients and families
  - Care coordination, particularly for patients with high needs
  - Understanding and evaluating system-wide costs of care
- The proposed tools include:
  - Shared care coordination resources
  - Medicare data
  - Financial incentive programs for providers

Next Steps

Next Steps for the Model Amendment

- Focus on gaining approvals from CMS
  - target for Amendment approval is Fall/Winter
  - Gain access to TCOC data for providers
- Vet detail plans with providers/all stakeholders
  - Make adjustments as needed
  - Preliminary plans for a 2017 program launch
- Maryland's care redesign efforts help facilitate overall practice transformation towards person-centered care that produces better outcomes and improves quality of life
  - Collectively focusing on outcomes will help us achieve those goals and also control and reduce the growth in total health care costs

Next Steps: Model Extension

- Focus on developing Model extension concepts with stakeholder input
- Begin to prepare a plan with stakeholders that expands focus on total cost of care (due at the end of 2016 for implementation in 2019 and beyond)
  - Best approach is to focus on care redesign to reduce avoidable hospitalization costs
  - Alignment of incentives across multiple settings
  - Maryland will not propose rate-setting for other providers

How Might All-Payer Model Developments Impact Patients and Providers?

- Improved data infrastructure/exchange/tools for care management, care coordination, and community health
- Increased focus on interoperability and connection with CRISP
- Increased collaboration and coordination among providers based on patient needs
- Increased programmatic efforts by hospitals and other providers to reduce potentially avoidable utilizations (PAUs)
- Increased focus on factors affecting patients in their homes (e.g. medication reconciliation, nutrition, transportation)
- Increased opportunities for shared savings arrangements, outcomes-based payment, and other incentives when care is improved and avoidable utilization is decreased

Opportunities for Patients and Physicians in Maryland

Get Connected

- Utilize CRISP encounter alerts, common care histories, and other care management tools
  - Address gaps in patients' health

Get Coordinated

- Coordinate your patients' care with other providers across clinical and community settings
- Work with case managers to address the medical and social needs of complex patients

Participate

- Use data and information to help improve outcomes and lower costs
- Join Accountable Care Organizations, medical homes, geographic initiatives, etc.
- Get involved in outcomes-based payment programs, etc.

Be Proactive

- Be a watchdog
- Contribute to the redesign of the state's healthcare delivery system

Thank you for the opportunity to work together to improve care for Marylanders everywhere