



July 18, 2019

Maryland's Experience and Progress in Implementing Value-Based Healthcare Reform

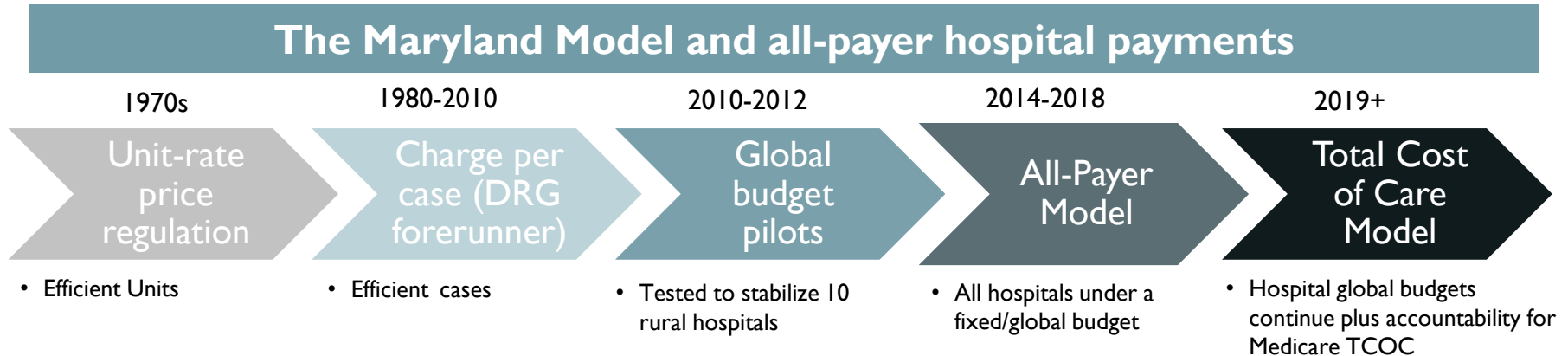
Health Services Cost Review Commission
Katie Wunderlich (Executive Director) & Chris Peterson (Principal Deputy Director)



Agenda

- ▶ **Background: Maryland's unique approach**
 - ▶ Overview of Maryland's all-payer hospital rate-setting
 - ▶ All-Payer Model, 2014-2018
 - ▶ Maryland's Total Cost of Care (TCOC) Model, 2019-2028
- ▶ **TCOC Model**
 - ▶ Improving all-payer hospital payment system
 - ▶ Flexibility for coordination across care continuum, especially via Medicare
 - ▶ Maryland Primary Care Program (MDPCP)
 - ▶ Population health
- ▶ **MHCC-HSCRC collaboration**

Evolution of the Maryland Model



- ▶ Since 1977, Maryland has had an all-payer hospital rate-setting system
 - ▶ A given acute care hospital's charge is the same regardless of payer
 - ▶ Charges ("prices") differ across hospitals
- ▶ In 2010, ten rural hospitals were placed on Total Patient Revenue (TPR) systems
 - ▶ TPR was a pilot for what became Global Budget Revenue (GBR) for all hospitals in 2014
- ▶ In 2014, Maryland moved to the All-Payer Model with CMMI, focused on controlling hospital costs through GBR
- ▶ In 2019, Maryland moved to the Total Cost of Care (TCOC) Model, focusing on (Medicare) TCOC through system-wide alignment

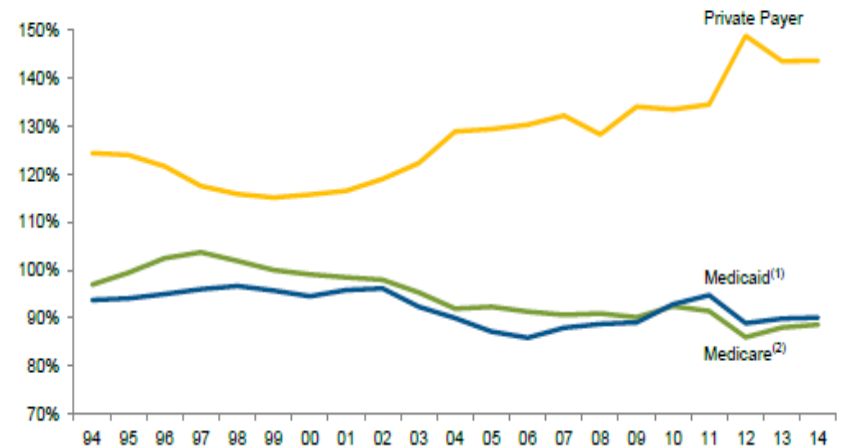
Value of Maryland's All-Payer Hospital Rate Setting System

Maryland's approach:

- ▶ Avoids cost shifting across payers
- ▶ Cost containment for the public
- ▶ Equitable funding of uncompensated care
- ▶ Stable and predictable system for hospitals
- ▶ All payers fund Graduate Medical Education
- ▶ Transparency
- ▶ Leader in linking quality and payment

While the rest of the nation sees:

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1994 – 2014



Source: American Hospital Association
(1) and (2). Includes Disproportionate Share Hospital (DSH) payments.

Maryland's Unique Healthcare Delivery System:
All-Payer Model (2014-2018)



All-Payer Model: Expansion of Hospital Global Budgets

- ▶ From 2014, all general, acute care hospitals in Maryland went under Global Budget Revenues (GBRs) set by the HSCRC
 - ▶ Fixed revenue base for 12-month period, with annual adjustments
 - ▶ Adjustments for variables including population growth, readmissions, hospital-acquired conditions, etc.
 - ▶ Reimbursement still administered on fee-for-service basis, but only for attaining GBR
 - ▶ Hospitals have flexibility to dial charges up or down (within constraints) so that, by year end, they have attained their GBR
 - ▶ Penalties for being too high or too low
- ▶ Sometimes use term: Population-Based Revenue (PBR) instead of GBR

Move from Volume to Value Transforms Hospital Incentives

- ▶ **No longer chasing volumes on pressured prices**
- ▶ **Incentivized**
 - ▶ Reduced readmissions
 - ▶ Reduced hospital-acquired conditions
 - ▶ Reduced ambulatory-sensitive conditions, or Prevention Quality Indicators (PQIs)
 - ▶ Better managed internal costs
- ▶ **Results**
 - ▶ Improved health care quality, lower costs, better consumer experience

But more to be done ...

All-Payer Model Performance 2014-2018: Met or Exceeded CMS Contract Requirements

Performance Measures	Targets	2018 Results	Met
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.92% average annual growth per capita since 2013	✓
Medicare Savings in Hospital Expenditures	≥ \$330M cumulative over 5 years (Lower than national average growth rate from 2013 base year)	\$1.4B cumulative (8.74% below national average growth since 2013)	✓
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	\$869M cumulative* (2.74% below national average growth since 2013)	✓
All-Payer Reductions in Hospital-Acquired Conditions	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	All Maryland hospitals, with 98% of revenue under GBR	✓





Maryland Total Cost of Care Model
(2019-2028)



CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/9/18

By: Adam Boehler, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF MARYLAND

Date: 7/9/18

By: Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

By: Nelson Sabatini, Chairman



TCOC Model Agreement Signed on July 9, 2018



Changes from All-Payer Model to Total Cost of Care Model

All-Payer Model

Contract Expired on Dec. 31, 2018

Hospital focus

Hospital savings

Hospital quality metrics

Acceleration of prevention/chronic care management

Hospital alignment

Total Cost of Care Model

Began Jan. 1, 2019

System-wide focus

Total cost of care savings

Hospital quality *and* population health metrics

Maryland Primary Care Program (MDPCP) and other care transformation tools

Provider alignment via MACRA-eligible programs and post-acute programs

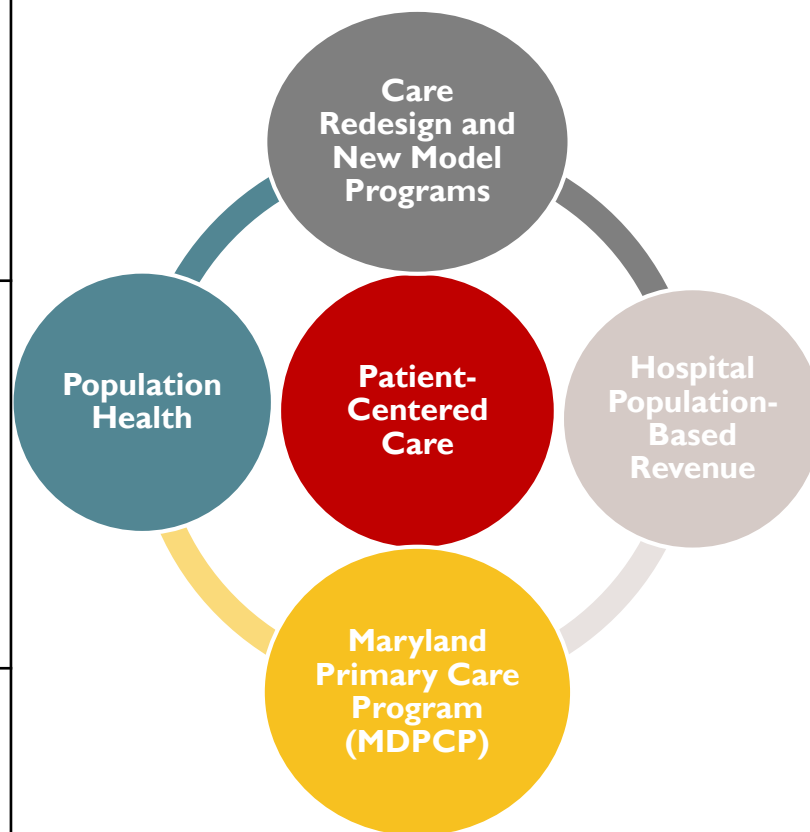


Total Cost of Care (TCOC) Model Overview

- ▶ New contract is a 10-year agreement (2019-2028) between MD and CMS
 - ▶ 5 years (2019-2023) to build up to required Medicare savings and 5 years (2024-2028) to maintain Medicare savings and quality improvements
- ▶ Designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes and constrain the growth of costs
- ▶ Total Cost of Care (TCOC) Medicare savings building to \$300 million annually by 2023 (from 2013 base)
 - ▶ Includes Medicare Part A and Part B fee-for-service expenditures, as well as non-claims based payments
 - ▶ In 2017, Maryland was at ~\$135M – not quite halfway to \$300M
 - ▶ By end of 2018, we are at \$273M
- ▶ Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually

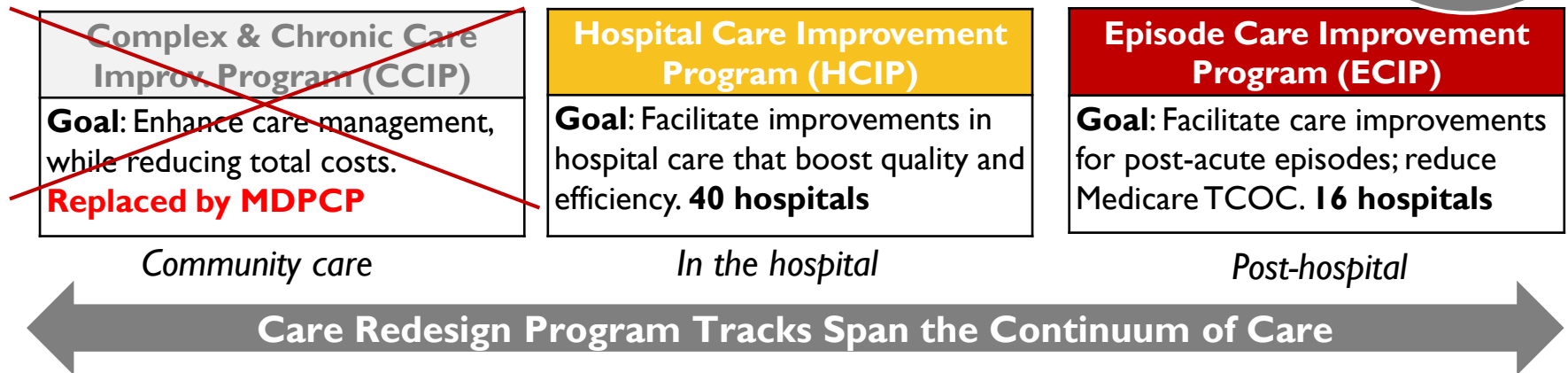
Total Cost of Care Model Components

Component	Purpose	Status
Hospital Population-Based Revenue	Expand hospital incentives and responsibility to control total costs through limited revenue-at-risk ($\pm 1\%$ of hospital Medicare payments) under the Medicare Performance Adjustment (MPA)	Expands
Care Redesign and “New Model” Programs	Enable private-sector led programs supported by State flexibility, “MACRA-tize” the model and expand incentives for hospitals to work with others, and opportunity for development of “New Model Programs”	Expands
Population Health	Programs and credit for improvement in diabetes, addiction, and other priorities	New
Maryland Primary Care Program	Enhance chronic care and health management for Medicare enrollees	New



Care Redesign Program (CRP): Aligning hospitals with non-hospital providers

Care Redesign and New Model Programs



▶ Under CRP, hospitals:

- ▶ Convene the program,
 - ▶ Bear financial risk (under GBRs and the MPA, which MACRAtizes Care Partners),
 - ▶ Obtain Medicare data (CCLF like ACOs), and
 - ▶ Choose whether or not to participate and, if so, whether or not to share incentives or resources with Care Partners
- ▶ ECIP assesses 90-day post-acute (PAC) episodes triggered in inpatient
- ▶ If hospital achieves 3% Medicare savings in PAC, hospital receives payment for savings – and can share with Care Partners

Other Hospital-Led Care Transformation Initiatives

- ▶ **West Baltimore EMS Collaborative – Mobile Integrated Health Community Paramedicine Program**
 - ▶ Aim is to comprehensively improve the health of Baltimore citizens; address gaps in the delivery of health care services to patients; and reduce the need for emergency medical services (EMS) transport, emergency department evaluations, and hospital readmissions.
 - ▶ Transitional Health Support pilot provides in home and chronic disease management services for 30 days after hospital discharge using a multidisciplinary team, including RN, NP, pharmacist, social worker, community health worker, and EMT
 - ▶ Minor Definitive Care Now pilot provides on-scene care from an NP and BCFD community paramedic for low-acuity 911 callers
 - ▶ Partners include University of Maryland Medical Center, Baltimore City Fire Department, HSCRC

New Model Program: Enhanced Episode Program (EEP) Under Development

Care
Redesign and
New Model
Programs

- ▶ Maryland is developing a non-hospital convened episode-based payment program
- ▶ The State of Maryland will administer the program
- ▶ Program will be developed to have multiple tracks, each with specialty or clinical care specific grouped episodes
- ▶ Conveners must take downside risk and will aggregate risk across engaged providers/episode initiators:
- ▶ Targeted start date of January 2021
- ▶ At the outset:
 - ▶ Would begin with 3 episodes triggered in Hospital Outpatient Department (HOPD) mirroring BPCI Advanced
 - ▶ Provider-led reform: Working with SIG and provider groups to determine what additional track and episodes may be added

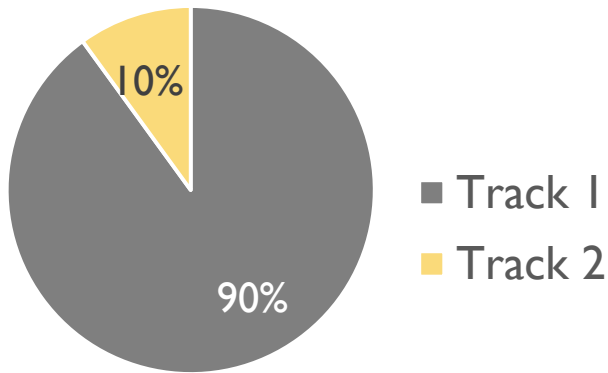
MDPCP Began January 1, 2019



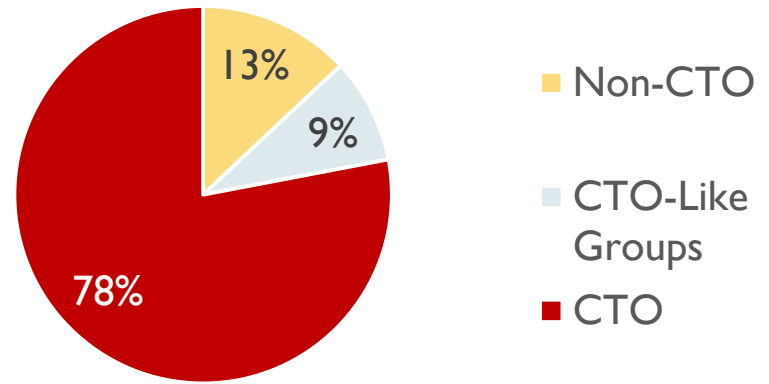
380 Practices Accepted Statewide

- ▶ ~ 220,000 beneficiaries
- ▶ ~ 1,500 Primary Care Providers
- ▶ All counties represented
- ▶ 21 Care Transformation Organizations

Practice Tracks



Practices Partnered with a CTO

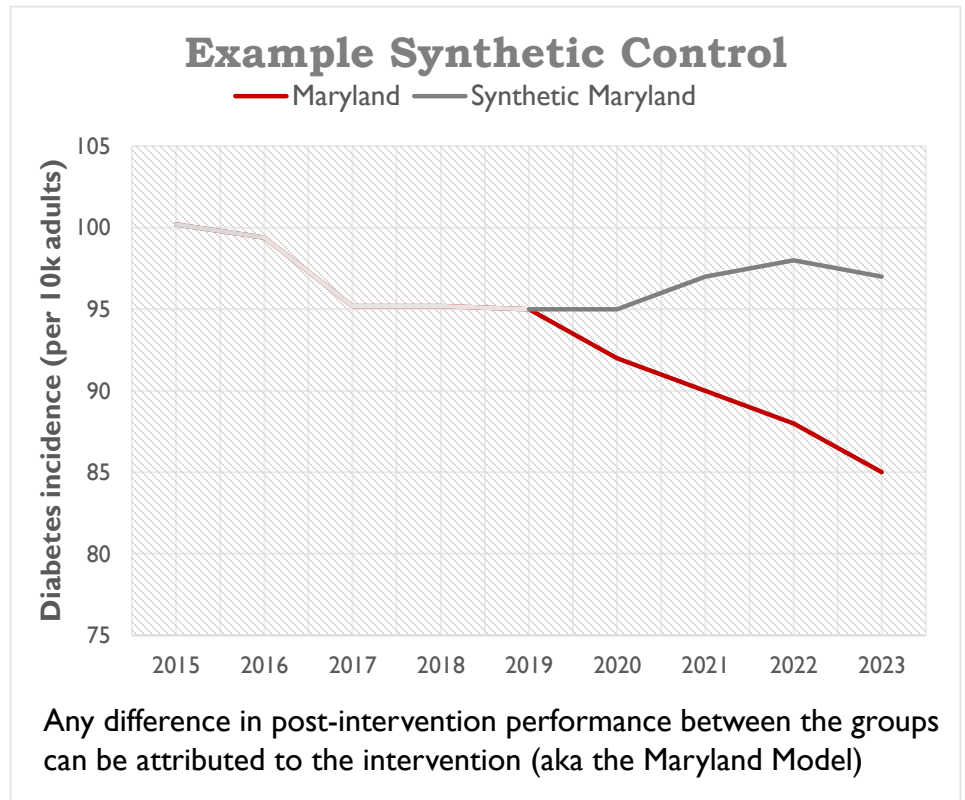
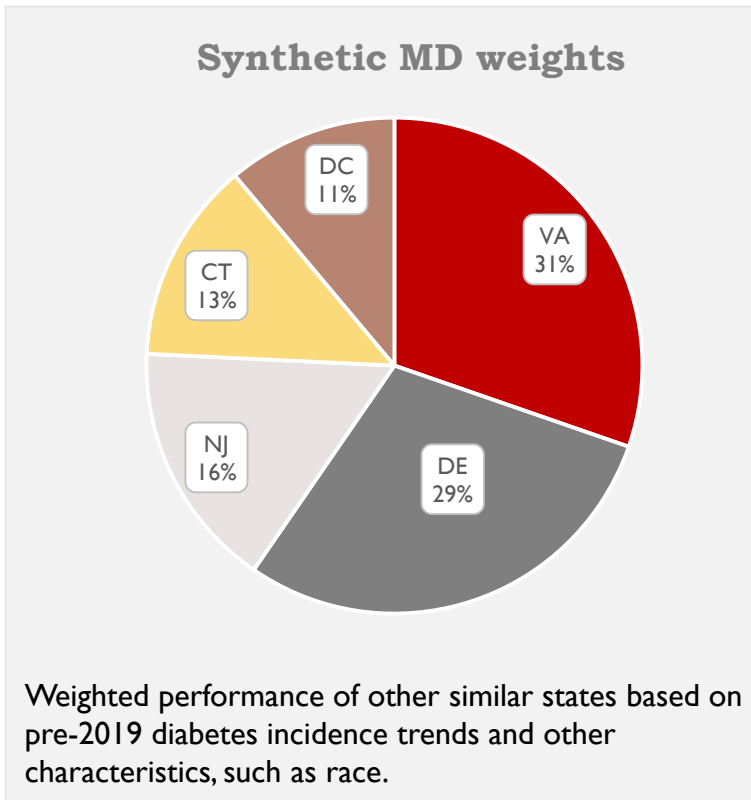


- ▶ More than \$60M will go to PCPs and CTOs in MDPCP Care Management Fees (CMF) in CY 2019
- ▶ MDPCP is an investment expected to pay for itself by increased chronic care management by PCPs resulting in reduced ED utilization and hospital admissions

Maryland to Receive Credit (against MDPCP Costs) for Reducing Diabetes Incidence



- ▶ Performance measure: Diabetes Incidence from BRFSS (age 35-74)
- ▶ Approach identifies a synthetic control group closely resembling Maryland
- ▶ Maryland Health Secretary and private-sector leadership now prioritizing diabetes



Bold Improvement Goals (BIGs): Statewide Strategy for Population Health Improvement



- ▶ Total Cost of Care Model requires a focus on population health improvement for all Marylanders
- ▶ Bold Improvement Goals (BIGs) are intended to align community health, provider systems, and other facets of the State's health ecosystem to improve population health and achieve success under the TCOC Model
- ▶ BIGs will leverage healthcare system focus on the TCOC Model to make meaningful investments in improving the health of Marylanders to create a sustainable healthcare system.
- ▶ Development Partners:
 - ▶ Interagency Workgroups
 - ▶ State Staff
 - ▶ Workgroups – as they are implemented into a specific program/policy
 - ▶ Commissioners, Leadership, Advisory Boards
 - ▶ Subject Matter Experts
 - ▶ Other Stakeholders





MHCC-HSCRC Collaboration



HSCRC-MHCC Collaboration

- ▶ **APCD Monitoring and Enhancements**
- ▶ **Workgroups and Legislative Deliverables**
 - ▶ Chestertown hospital and rural health delivery planning
 - ▶ EMS collaboration and reimbursement of new models of care delivery, with MIEMMS
- ▶ **New TCOC Model Program Development and Provider Alignment**
 - ▶ Stakeholder Innovation Group
 - ▶ Secretary's Vision Group
- ▶ **Communications**
 - ▶ Secretary's Vision Group Communications Subgroup
- ▶ **Statewide Planning**
 - ▶ Certificate of Need, Certificate of Exemption
 - ▶ Use of regulated space and operating room capacity
 - ▶ Analyze excess capacity and potential solutions



Thank you!

