Maryland All Payer Model Comprehensive Primary Care

January 2017

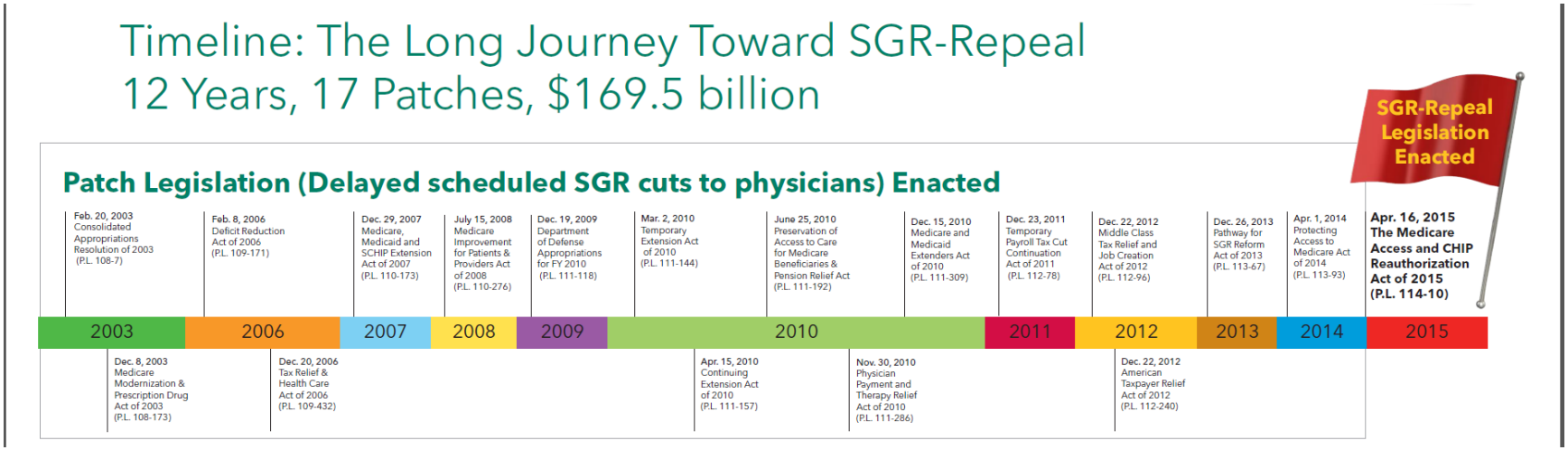
HSCRC
Health Services Cost Review Commission

Agenda

- Describe the progression from FFS Medicare to SGR and then to MACRA
- Describe MACRA elements of MIPS and APMs
- Describe the States progression from FFS Medicare hospital payments to the All Payer FFS and then to the All Payer Global Budget
- Describe the Advanced APM- Maryland Patient Centered Home model in development
- Questions and Answers

SGR Progresssion

- 1997 Balanced Budget Act-Sustained Growth Rate replaces Medicare Volme performance Standard
- 2015 Medicare Access and CHIP Reauthorization Act replaces SGR



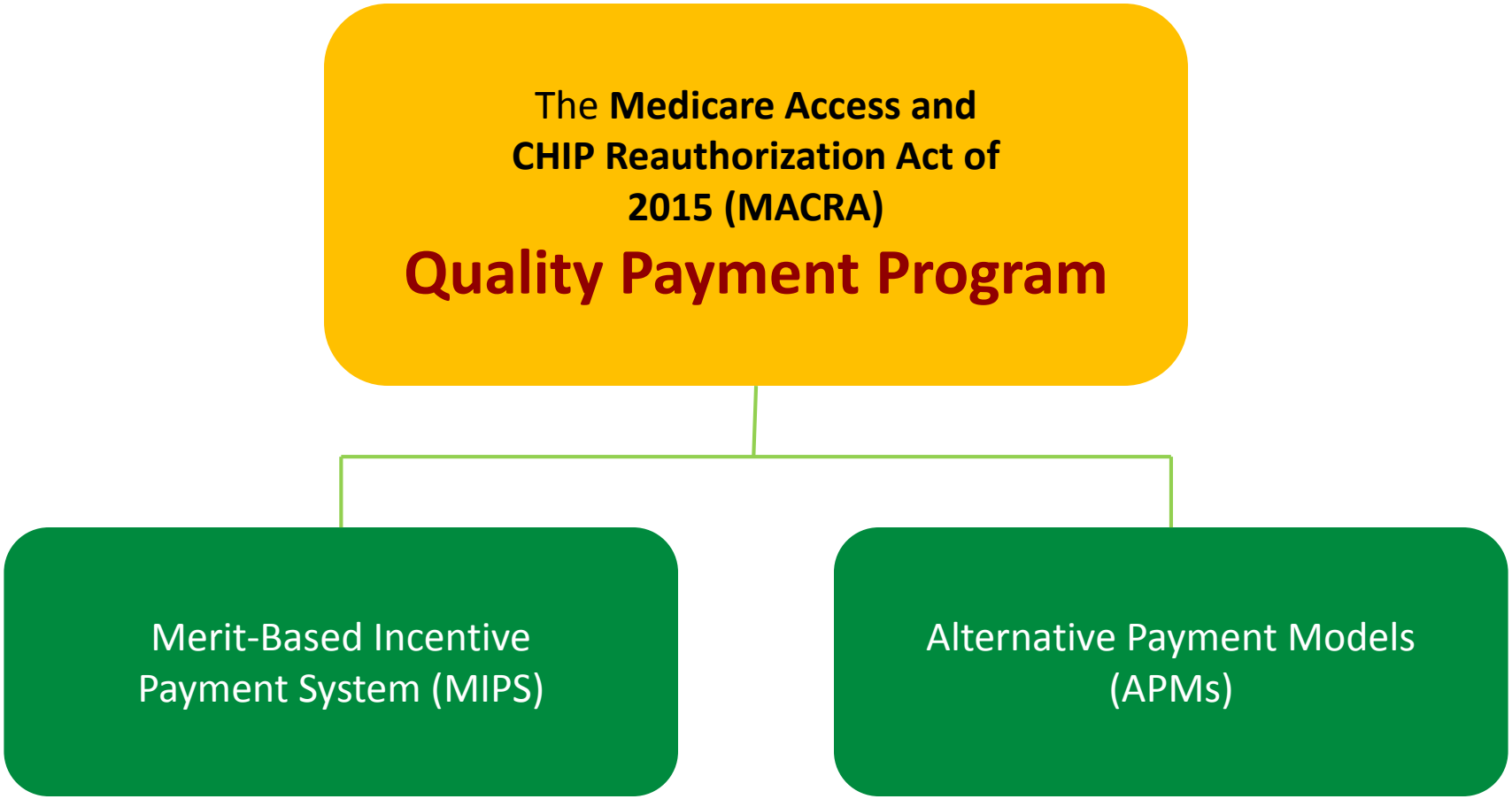
CMS and National Strategy-Change Provider Payment Structures, Delivery of Care and Distribution of Information

Focus Areas	Description
Pay Providers	• Increase linkage of payments to value • Alternative payment models, moving away from payment for volume • 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) presentation

MACRA Elements

Law *intended* to align physician payment with *value*



Two pathways: MIPS versus APMs (2019)

MIPS

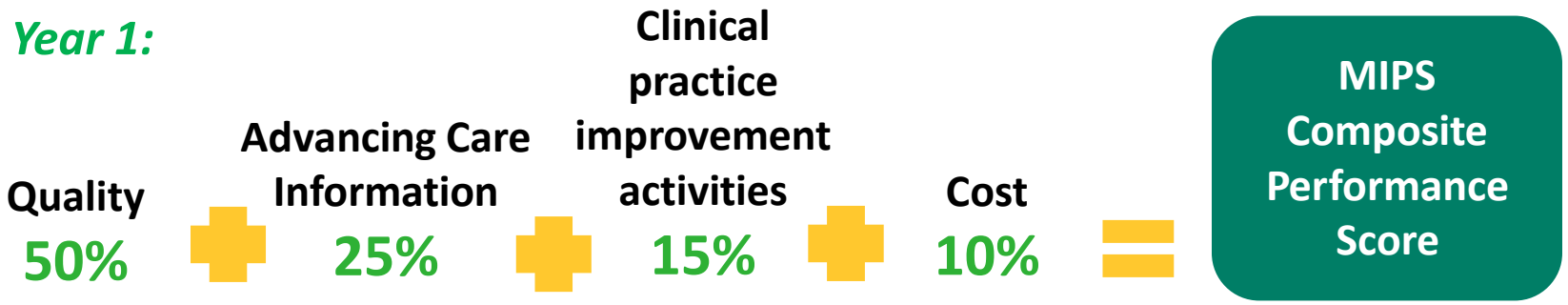
- MIPS adjusts traditional fee-for-service payments upward or downward based on new reporting program, integrating PQRS, Meaningful Use, and Value-Based Modifier
- **Measurement categories (composite score of 0-100):**
  - **Clinical quality (30%)**
  - **Meaningful use (25%)**
  - **Resource Use (30%)**
  - **Practice improvement (15%)**

APMs

- **Supported by their own payment rules, plus**
- **5% annual bonus FFS payments for physicians who get substantial revenue from *alternative payment models*** that
  - Involve upside and downside financial risk, e.g. ACOs or bundled payments
  - OR
  - PCMHs, if ↑ quality with ↓ or ↔ cost; ↓ cost with ↑ or ↔ quality (e.g., CPCI)

How will Clinicians Be Scored Under MIPS?

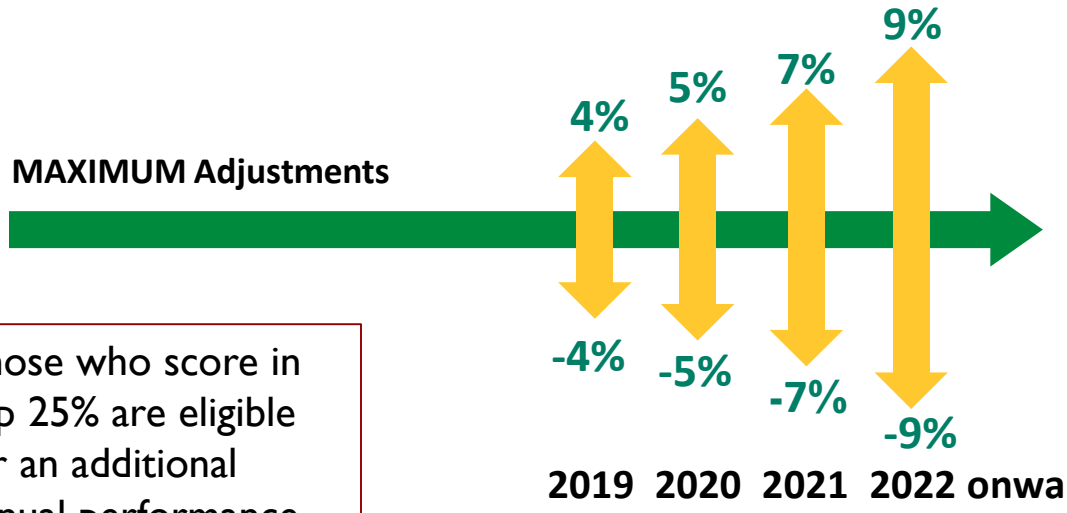
A single MIPS **composite performance score** will factor in performance in **4 weighted performance categories**:



Source: www.lansummit.org/wp-content/uploads/2015/09/4G-00Total.pdf

How Much Can MIPS Adjust Payments?

- Based on the MIPS **composite performance score**, physicians and practitioners will receive positive, negative, or neutral adjustments up to the percentages below.
- MIPS adjustments are **budget neutral**.



Adjustment to provider's base rate of Medicare Part B payment

Those who score in top 25% are eligible for an additional annual performance adjustment of up to 10%, 2019-24 (NOT budget neutral)

Merit-Based Incentive Payment System **(MIPS)**

Advanced Alternative Payment Models (APMs)

Initial definitions from MACRA law, APMs include:

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by Federal Law

- MACRA **does not change how any particular APM rewards value**.
- **Base payment on quality** measures comparable to those in MIPS
- **Supported by their own payment rules "plus" a 5% annual bonus on FFS payments**
- Involve upside and downside financial risk OR be a PCMH (with some caveats)
- Over time, more APM options will become available.

The Quality Payment Program provides additional rewards for participating in APMs.

Potential financial rewards

Not in APM	In APM	In Advanced APM
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
		5% lump sum bonus

If you are a **Qualifying APM Participant (QP)**

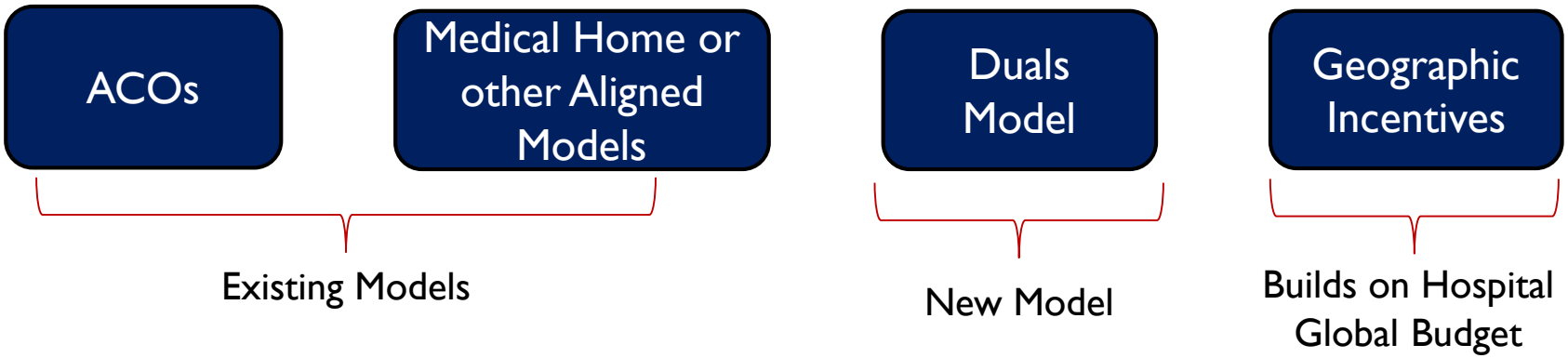
Source: CMS webinar slides, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

Key Strategies Maryland is Considering

I. Continue and strengthen All-Payer Hospital Model
II. Expand supports for high needs patients, reduce avoidable hospitalizations
III. Create a pathway for all providers to align with key goals of All-Payer Model and create opportunities for MACRA qualification bonuses for physicians
    - Begin to harmonize incentive systems
IV. Incorporate Medicare patients into a Primary Care Home Model with innovative payment that supports chronic care management and new delivery approaches (e.g. non face-to-face, telemedicine, etc.)
V. Develop other payment and delivery system changes (e.g. long-term and post-acute, other MACRA models, etc.)
VI. Develop/support models that increase system-wide responsibility for Medicare and Dual Eligible total cost of care over time
VII. Request federal waivers to enable more flexible use of post-acute and long term care resources
VIII. Support data and implementation infrastructure needs

Overview of Progression Elements

Models that Support Responsibility for Cost and Outcomes of Medicare Fee-for-Service Beneficiaries



Supporting Payment/Delivery Approaches with All Payer Applicability

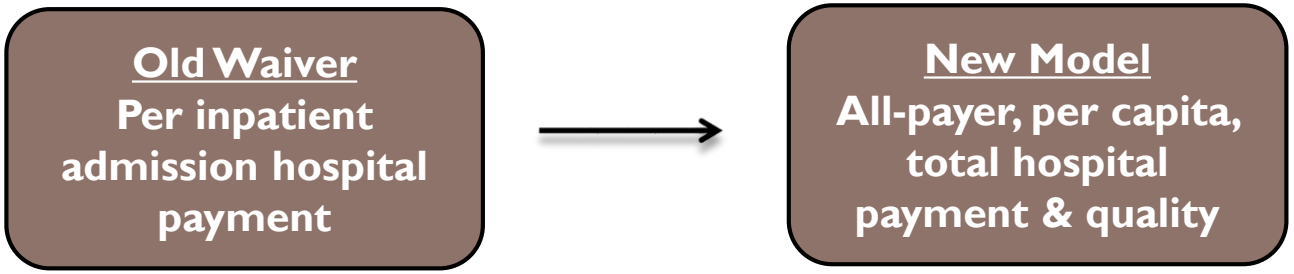
Global Hospital Budgets and Regional Partnerships
Amendment--Complex/Chronic Care, Hospital Care/Episodes
Primary Care Home--Chronic care, Visit budget flexibility
All Provider Incentive Alignment
Post-acute and Long-term Care Initiatives
Other MACRA-eligible programs

Maryland All Payer Waiver History

- 36 year old waiver from Medicare Prospective Payment System
- Rise in per capita cost recently
- Some Rural Hospitals on TPR model
- 2014 Payment Modernization Waiver and GBR
- 2019 Phase 2 of Waiver Total Cost of Care
- "Moreover, the Maryland system may serve as a model for other states interested in developing all-payer payment systems." CMS website

Overview of All Payer Model

- Approved by Center for Medicare and Medicaid Innovation (CMMI) effective January 1, 2014 for 5 years
- Modernizes Maryland's Medicare waiver and unique all-payer hospital rate system



- Key provisions of the new Model:
  - Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least $330 million to Medicare over 5 years
  - Patient and population centered-measures to promote care improvement
  - Payment transformation away from fee-for-service for hospital services
  - Proposal covering Total Cost of Care due at the end of 2016 for Phase 2 (2019 and beyond)

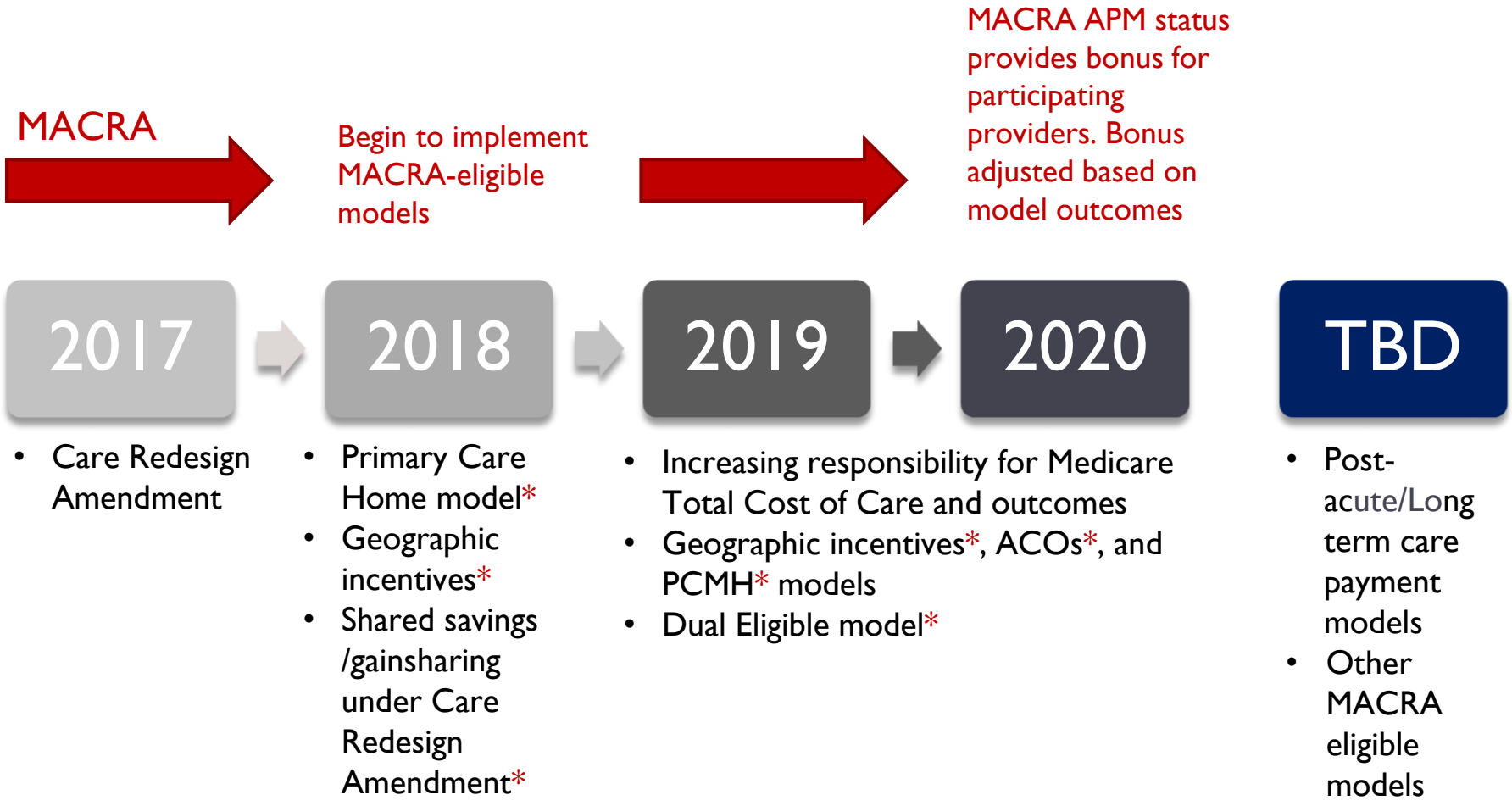
Potential Timeline-2016

- Develop progression plan for All Payer Model due to CMS by Dec 31, 2016
- Incorporate Three State initiatives:
  - Primary Care Model for Maryland to file with CMS by Dec 31, 2016 for possible implementation in Jan 2018
  - Dual Eligibles Model for implementation in 2019
  - Updated Population Health Plan due by end of 2016
- Develop incentive approach for Medicare TCOC for implementation in 2017/2018
- Align with MACRA requirements
- Obtain stakeholder input throughout

Stakeholder Input

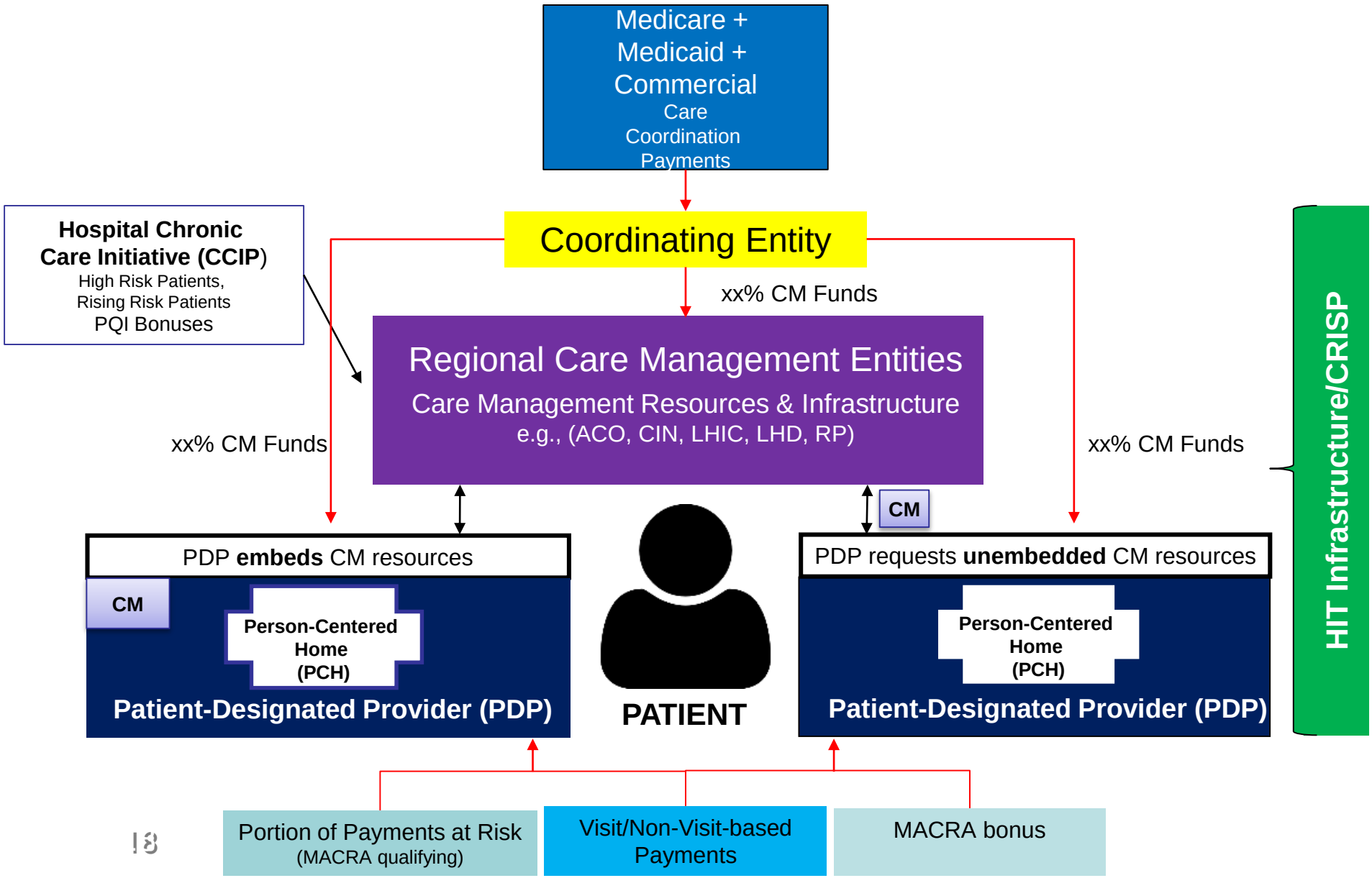
- Advisory Council
- Numerous issue oriented key stakeholder meetings
- Workgroups
  - Performance Measurement
  - Payment Models
  - Consumer
  - Care Coordination
  - Dual Eligibles
  - Primary Care Council
  - Others

Potential Timeline



Note: * Indicates anticipated MACRA-eligible models (Advanced Alternative Payment Models).

Maryland Primary Care Model



Plan Due to CMS By Dec 31

- "Prior to the beginning of PY4 (2017), Maryland will submit a proposal for a new model, which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate to take effect no later than 11:59PM EST on December 31, 2018".