Guiding Principles for Implementation of Population-Based and Patient Centered Payment Systems:

A Report from the Advisory Council to the Maryland Health Services Cost Review Commission

January 31, 2014

Introduction and Statement of Purpose

The State of Maryland is leading a transformative effort to improve care and lower the growth in health care spending in the State. Stated in terms of the "Three Part Aim," the goal is a health care system that enhances patient care, improves health, and lowers total costs.

To achieve this goal, the State of Maryland worked closely with the Centers for Medicare and Medicaid Services (CMS) throughout 2013 to craft an innovative plan that would make Maryland a national leader in achieving the Three Part Aim and permit the federal government to continue to participate in the four-decade long all-payer hospital payment system that has proven to be both successful and enduring. The federal government approved Maryland's new Model Design application and implementation began in January 2014.

The Advisory Council

As the State's rate setting authority, the Health Services Cost Review Commission (HSCRC) will play a vital role in the implementation of this innovative approach to health reform. In order to implement and develop such an ambitious effort, HSCRC created an Advisory Council to enlist the guidance of stakeholders and health care leaders from across the State and with a national perspective. A list of Advisory Council members appears at the end of this report.

The Advisory Council is charged with advising the Commission on implementing the Model as approved by the federal government. The Council is offering real-world advice and practical guidance to support the successful implementation of this comprehensive and complex initiative. Council membership represents a variety of sectors in health care including hospitals, payers, and physicians, as well as outside experts. Following an initial meeting with the Commission on November 13, 2013, the Council held four public meetings from December 2013 through January 2014, and took suggestions from members of the public, including patient advocacy groups. The public was invited to share their thoughts during the public meetings of the Advisory Council and to email their comments to the Council through the HSCRC website.

The Council stands ready to make more specific recommendations upon the request of the HSCRC.

The Model Requirements

Building on the Commission's existing authority to regulate and set hospital rates across all payers, including Medicare, the State is preparing to expand its efforts to control growth in total hospital cost per capita. New health care delivery and payment models will be aligned with other initiatives underway to help meet the goals.

Maryland has committed to meeting the following key requirements:

Cost Requirements of the Model

- The all-payer per capita total hospital revenue growth will be limited to 3.58% per year over the first three years (plus an adjustment for population growth), which is the 10-year compound annual growth rate in per capita gross State product.
- Medicare per beneficiary total hospital cost growth over five years shall be at least $330 million less than the national Medicare per capita total hospital cost growth over five years.[1] This represents a savings level of about one-half of one percent per year under the national Medicare spending growth rate beginning in year two of the model.

Quality Requirements

Maryland will achieve a number of quality targets designed to promote better care, better health and lower costs. Under the model, the quality of care for Maryland residents, including Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries, will improve as measured by hospital quality and population health measures.

Specific requirements of the model to improve quality include:

- The aggregate Medicare 30-day unadjusted all-cause, all-site readmission rate will be reduced to the corresponding national rate over five years.

- An annual aggregate reduction of 6.89% in Potentially Preventable Conditions (PPCs) over five years will result in a cumulative reduction of 30% in PPCs over the life of the model.

This report provides the Advisory Council's recommendations to the HSCRC on how best to meet these goals through the implementation of the new Model.[2]

Advisory Council Recommendations

1. Focus on meeting the early Model requirements

1.1 The Advisory Council recommends that the HSCRC prioritize implementation initiatives that contribute to meeting the All Payer Target hospital per capita spending growth rate and the Medicare savings target in the first two years of the proposed model.

1.2 To ensure that the State is on track in meeting the tight goals, it will be necessary to develop a clear timetable, interim milestones, key benchmarks, and periodic assessments of progress.

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[1] The target includes inpatient services and outpatient hospital services under Medicare definitions for beneficiaries residing in Maryland, regardless of where the care is provided. HSCRC regulates outpatient hospital services located at the hospital. The Medicare definition is broader and will include some freestanding outpatient facilities owned and operated by hospitals.

[2] This report reflects a general consensus of Advisory Council members; agreement on the various recommendations reflects the consensus of opinions, but that should not be taken to mean unanimous agreement on each point.

1.3 Global payment methods for Maryland hospitals should be the tool of preference to assure revenue controls.

1.4 Success under global payment methods will feature the ability to reduce avoidable utilization through better care.

1.5 It will also be important to monitor access and quality challenges regarding health services that will likely shift from hospitals to other settings, such as skilled nursing facilities, ambulatory surgery centers, and others that are not under the HSCRC authority to regulate.

Discussion

Meeting the targets will require a strong work plan and continuous vigilance to ensure that interim milestones are being met. The HSCRC should track and report on progress in meeting the benchmarks. Particularly in the first two years, it will be important to measure progress toward the endpoint—is the State as far along, for example, after six months, as it should be to meet targets for the first year and the second year? All this translates simply into having a good business plan and a series of specific milestones toward fulfilling it.

The Advisory Council believes that the new model design presents near-term tight revenue constraints that can only be met with quick and strong reforms in both the health care delivery system and the payment systems. While long-term reforms are needed to improve population health, there is a risk that Maryland will miss the opportunity to achieve these ultimate goals if spending exceeds the limits in the model design or if the promised savings to Medicare do not materialize.

The following steps are necessary to achieve the targets:

Identifying opportunities for controlling avoidable utilization

HSCRC should work with providers and consumers to analyze data to identify the types of utilization of health services that could be reduced with better access to primary care and care coordination, such as inpatient admissions for ambulatory-sensitive conditions, readmissions, and emergency department visits presenting needs that could be served in lower-cost settings. Reducing this type of volume may yield significant savings and also likely improve patient care and health outcomes. It also will be important to reduce avoidable complications in areas such as infections, respiratory and renal failure, and medical errors.

Identifying high-need patients

Improving the health care delivery system requires the careful identification of high-need patients. The HSCRC should work with other State agencies with expertise and data resources, as well as with stakeholders *to identify and secure data* that can be helpful in targeting care coordination to high-need patients. Health care leaders can use predictive modeling, claims analysis, health status questionnaires, and other techniques to identify patients (using secure and confidential approaches to data access and management) with complex medical needs who are frequent users of the health care system, particularly in high-cost settings. In order for care coordination interventions to be cost-effective, they need to be targeted carefully to patients who could really benefit.

Implementing care coordination reforms

Another important step is to inform the development of care coordination programs targeted to these patients with complex medical conditions. Both public and private payers as well as providers would benefit from obtaining objective and evidence-based information on promising care coordination initiatives.

Multi-disciplinary teams including physicians, nurses, nurse practitioners, and individuals outside the medical model such as nutritionists, social workers, and community health workers can work with high-need/high-resource patients and their families to manage chronic conditions. Effective care coordination can help avoid ambulatory-sensitive use of emergency departments, inpatient admissions, and hospital outpatient care.

The State and private sector leaders should coordinate the new model design with efforts already underway involving Patient Centered Medical Homes (PCMH), Accountable Care Organizations (ACOs), SIM projects, and team-based care. Both public and private payers in Maryland are already engaged in some of these activities. What is needed is to bring the scattered initiatives to scale and share evidence related to program impact. HSCRC could play a useful role in helping to gather leaders and data to facilitate discussions about promising strategies and practices.

Focusing on the opportunity to improve care for the Medicare fee-for-service population

An important challenge involves the Medicare population. Nearly three of four Medicare enrollees in the standard fee-for-service setting receive largely uncoordinated, highly fragmented care. It is vitally important to bring the tools of improved care management to this population. This includes identifying Medicare patients whose care is not well managed and coordinating their care.

The Advisory Council believes that it would be helpful to have a concise and user-friendly compilation of the evidence base and best practices in both the identification of high-need patients and effective care management for this population.

Developing payment reforms

Payment system reform will require moving away from fee-for-service payments, toward payment models that reward better patient outcomes, quality of care improvements, and overall cost containment.

The HSCRC anticipates that nearly all Maryland hospitals will be operating under global payment models in the near future. The Council believes that these models hold the most promise for meeting the revenue targets in the early years because they move away from incentives in fee-for-service payment that foster a greater volume of services, and offer strong budget discipline. In addition, global payments provide clear and simple revenue targets with flexibility for hospitals to manage within these macro goals.

2. Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation

2.1 The Advisory Council urges the HSCRC to strike a balance between near-term cost control, which is paramount, and making the required investments in physical and human infrastructure necessary for success. If we do not meet the near-term targets, there will be no long-term program. But if we fail to make the needed infrastructure investments, we will not have the toolkit of reforms necessary to achieve lasting success.

2.2 Given the challenging targets in this initiative, goals should be set in the aggregate as close to the targets as practicable based on the degree of comfort that individual institutional targets will be met.

2.3 There should be incentives for hospitals to meet and exceed the challenging targets of the new model; hospitals should be able to retain and reinvest a high percentage of their savings.

2.4 A portion of the savings that hospitals achieve could be reinvested into "common good" investments. But given the tightness of the revenue caps under the new model, a new and secure funding source for this type of infrastructure is also essential.

2.5 HSCRC, other State agencies, and private sector leaders should build the data infrastructure needed to ensure waiver success. Specific tasks include:

- **Lead data collection efforts**
- **Ensure open access to data by all stakeholders**
- **Lead data analytics to monitor waiver metrics;**
- **Assess policy impacts;**
- **Guide clinical decision making**

Discussion

Meeting the model performance targets will require the readiness of the hospital industry. This, in turn, will require investments in infrastructure across the State. The infrastructure could include care coordination resources, data analytics, disease-focused providers and resources, and IT resources, among others.

These investments will cost money. This funding should not all come from hospital rates. The State should consider developing some type of Statewide infrastructure fund devoted to making the up-front investments needed to produce that infrastructure. Maryland needs a secure funding stream to make these investments.

The HSCRC should consider the variability in readiness among hospital systems as it plans for the phased implementation of model components. One factor is that hospitals serving complex patients will face additional challenges and expenses associated managing the care of vulnerable patients. Investments in infrastructure should also take into account the higher costs incurred by patients who experience barriers to care due to socioeconomic status, language, and other factors.

The Council notes that some of the required investments represent "public goods." These are benefits for the whole public that would likely not emerge from each individual hospital, clinic, and medical practice following its own best interest.

Data Infrastructure

The required infrastructure includes such key areas as accelerated progress toward the Health Information Exchange (HIE), with interoperable and secure data that can be used by physicians and hospitals in real time as they are treating patients. The Council believes that there should be "open access" to the data collected. In some cases, HSCRC is an "aggregator" of the data but it should be readily and publicly accessible to health care providers and others as needed within the bounds of federal and State confidentiality protections.

The progress of the Health Information Exchange to share clinically actionable information among treating providers should be accelerated. Infrastructure will also be needed to foster continued progress to reduce potentially preventable conditions and to reduce hospital readmissions. These investments should be funded primarily from a new infrastructure fund, as noted above, rather than solely by hospitals.

Supporting primary care providers

Primary care providers are at the heart of the new model of care as efforts are made to move care "upstream" to reduce avoidable use of services in high-cost settings. Primary care providers will be called upon to help avoid ambulatory-sensitive utilization of care in ER, inpatient, and hospital outpatient settings. They should be supported as they struggle to adhere to the many requirements placed on them including achieving advanced stages of meaningful use of HIT; adapting to the forthcoming ICD-10 requirements (a challenge for all providers); the demands of continuing medical education, and participating in new care delivery models such as ACOs and patient-centered medical homes.

Regulatory flexibility will help meet the goals of the model

2.6 Within the context of per capita growth ceilings on hospital spending, HSCRC should allow considerable flexibility for the health care sector to implement its own strategies for achieving the desired results while recognizing the importance of following evidence-based best practices and the potential value of some standardization.

Discussion

The Advisory Council believes that the private healthcare sector is well positioned to test and deploy innovative approaches to improve care and meet revenue and spending targets. HSCRC should *encourage, facilitate, and promote promising private sector initiatives to help meet the goals.*

Within the context of global budgets, the Council favors the use of performance standards over detailed design standards. Performance standards allow the flexibility for hospitals and other health care providers to make key decisions about how they will design specific changes in practice patterns and manage the supply chain in order to improve performance.

Thus, effective regulatory policy involves resisting the temptation to layer additional levels of detailed design standards under the overall performance standards.

Regulatory policies should also avoid protecting inefficient service providers from competitive pressures and encourage the introduction of cost-saving innovations. Tight revenue targets are important to meeting the promised targets, but it is important to let hospitals retain and reinvest their savings.

It is also important to balance the need to meet tight cost control targets with goals related to health care research and discovery, innovation, and the modernization of treatment techniques and facilities.

The regulatory environment should encourage market shifts that involve patients moving toward high-value providers. In addition, it should reward those providers who recognize and remove excess capacity from the system. The HSCRC should seek to balance the general principle for funding to "follow the people" with the equally important desire to encourage providers to eliminate excess capacity. Finally, mechanisms for implementing this principle should not undermine the incentive for each hospital to strive for savings via reduced inpatient and outpatient volume where appropriate.

2.7 The consensus of the hospital industry should have a significant weight in policy development

Discussion

When hospitals adopt global or population-based payments, they will be taking on significant responsibility for the total cost of care under the new Model design. The performance of any one hospital will affect all hospitals and the State's ability to meet the Model requirements. The new Model will require collaboration between organizations to meet the performance goals. In order to foster collaboration, the Council recommends that the HSCRC give significant consideration and preference to policy recommendations that reflect a consensus among hospitals.

As the model implementation unfolds over time, some hospitals will hit their targets and some will not. For example, some hospitals will reduce volume, while some will see volume increase. In some sub-regions of the State, population will increase while in others it will decrease. Many factors will be in play in determining how successful hospitals are in meeting their targets, *some within their control and some outside of their control.*

As HSCRC adjusts targets over time in response to these shifts, some hospitals are rewarded and others penalized. The Council recommends that this process be transparent. While HSCRC will exercise its regulatory authority to make these adjustments during implementation, the hospital industry can provide valuable input and advice to this process.

3. HSCRC Should Play the Roles of Regulator, Catalyst, and Advocate

3.1 HSCRC should play three key roles as it strives to make the new model work: *effective regulator, a catalyst for needed reforms, and an advocate* within the State and to the federal government for the support needed to ensure success.

Discussion

In its regulatory role, within the boundaries of its mandate, the HSCRC plays a key role in payment reforms. The main challenge is to complete a significant conversion of hospitals to global budgets and then monitor and enforce the revenue caps to ensure compliance with the new model design caps on hospital spending per capita.

In its role as a catalyst for change, HSCRC should inform needed delivery system innovations, and increased data exchange. HSCRC should work with both other State agencies and the private sector to collect, synthesize, and interpret data on performance including revenues, costs, quality metrics, and patient safety.

In advocacy, HSCRC should work with CMS and collaborate with other State stakeholders to promote integrated care models and new approaches to payment under Medicare and other government programs. HSCRC, as the keeper of the system, should be a strong advocate for State budget and other actions that would support success, and against State actions that undermine it.

While data on individual hospital performance is necessary, an important goal is to move toward population-based performance metrics wherever feasible. This can facilitate both reductions in the incidence of chronic diseases such as diabetes, hypertension, and asthma, as well as improvements in the health status of people who have these diseases.

4. Consumers should be involved in planning and implementation

4.1 The HSCRC should actively engage consumers and their representatives to participate in implementation activities.

Discussion

Achieving the goals of the Three Part Aim will require the active engagement and support from consumers and their families. Patients and patient representatives should have a seat at the table in planning and developing implementation activities and provide meaningful input to the HSCRC, hospitals and others about how the implementation goals will be met. In order for individuals to make the best decisions for themselves and their families, a true working partnership should be developed between individuals and their providers. Consumers will need timely and user-friendly information and tools to increase health and illness self-management.

While tight budget caps are important, the HSCRC should also recognize the need for vulnerable populations to obtain the full complement of services and supports they need to achieve the best possible State of health and functional status. Avenues for grievances and appeals should be available to patients.

4.2 Guard against under-use of health services.

As providers begin to operate under a set of tight caps, they face incentives to reduce utilization. To the extent that this is *avoidable use, and represents unnecessary, duplicative care,* savings will be achieved without blocking access to needed services. But now concerns about over-use should be accompanied by careful monitoring and avenues for redress when there may be under-use as well. As noted earlier,

some care may shift from hospitals to lower-cost settings that are not within the model design cap. Monitoring the quality of these services is important but likely beyond the scope of HSCRC so that cooperation with other State agencies may be needed.

4.3 Incorporate quality improvement and patient safety goals into the overall plan.

Another important challenge in the new model design is that regulatory standards continue to incorporate quality and patient safety into payment formulas and focus on monitoring and reporting on the quality of care. The goal is now better care and better health along with effective cost control. HSCRC has already been engaged in patient safety and quality improvement initiatives. But now these ancillary goals have become embedded into the central objectives of the Three Part aim that are at the heart of the new all-payer model.

5. Physician and Other Provider Alignment is Essential

5.1 Physician engagement and alignment must be strong enough and occur early to support the goals of population-based and patient centered models.

5.2 The HSCRC should charge a workgroup to develop specific recommendations on strategies that align incentives among hospitals, physicians and other providers.

5.3 HSCRC should advocate for arrangements in which physicians can share in the savings achieved by hospitals under the new Model. This could involve pay-for-performance arrangements as well as formal shared-savings arrangements. The State should apply to OIG at HHS to permit shared savings arrangements between hospitals and physicians.

Discussion

The new All-Payer Model creates strong incentives for hospitals to reduce unnecessary and inappropriate care and increase efficiency. Starting in January 2014, hospitals will be benefit not only by reducing costs *during an admission,* but also by improving care in a way that results in *fewer ER visits, inpatient admissions, readmissions, and reduced hospital outpatient care.* Hospitals can be more successful in meeting these goals if their new models are complemented by aligned incentives for physicians as well. Physicians' decisions about treatment, the need for care and the venue in which it is delivered determine a large proportion of the utilization. The desired reductions in ambulatory-sensitive care will only occur if physicians are both trained and rewarded to provide the types of prevention and evidence-based care that mitigate avoidable hospital care.

Further, physicians must be made fully aware of the basis for their rewards under shared savings arrangements. They need full transparency about the basis for and the metrics of their payments, as well as assurances that proper adjustments are made to account for the wide variation in the complexity of their patient mix and that rewards account for both cost and quality of care.

Long-term care facilities must also be in synch with the redesign of health care delivery and payment. Eventually, other providers should be brought on board as well. Alignment of incentives could also cover changes in the 3-day rule and other payment modifications related to long-term care facilities.

The Physician Alignment and Engagement workgroup should consider current initiatives underway in Maryland or in development that provide opportunity for alignment among providers, including ACOs, PCMH, and other emerging models.

The Importance of Medical Malpractice Reform

The incentives in the current medical malpractice system can run counter to the key cost containment goals in the model design. The current malpractice system encourages health care providers to increase utilization (e.g. order more tests, conduct more procedures) at the same time as the model design encourages them to reduce unneeded utilization.

Physician and hospital alignment with the goals of the new model could be supported by reforms in the medical malpractice system. These reforms should go beyond the caps on awards for pain and suffering that many States have enacted, to address more fundamental restructuring of the medical malpractice system.

The Council recognizes that medical malpractice is not within the purview of HSCRC. We recommend that the Commission be aware of the dissonance between its cost containment goals and the current medical malpractice system, and lend its voice to the need for reforming it. While the Council did not reach unanimous agreement on the specific types of reforms that are needed, or the likely impact of those reforms, most of the Council believes that addressing issues around medical malpractice is important in supporting the goal of reducing avoidable utilization and should be pursued in concert with the three-part aim.

6. An ongoing, transparent public engagement process is needed

6.1 The Advisory Council supports the establishment of Work Groups to address technical and operational issues.

Discussion

The new Model represents a significant transformation of the health system in Maryland, and as such, will require ongoing engagement of hospitals, physicians, other providers, patients, and experts to build the consensus necessary for successful implementation. The technical challenges of implementing the new model require careful and thoughtful consideration. The Council supports immediately convening technical Work Groups to address the implementation issues.

Conclusion

Maryland's new all-payer model is a very advanced, cutting-edge approach to long-term cost control and health system reform. The new approach broadens and corrects limitations in the long-standing Maryland all-payer system. It commits the State of Maryland to some very tight budget controls, with near-term and long-term limits on spending. Meeting these targets will require a large-scale transformation of the Maryland health care system. The starting point is the quick adoption of global payments for Maryland hospitals. This should be accompanied by an all-out effort to reduce avoidable care in high-cost settings by identifying high-risk, high-need patients and developing effective care coordination and initiatives to manage chronic illnesses.

HSCRC can play three key roles in facilitating the success of the new model—as a regulator, a catalyst for reform, and an advocate. The Council looks forward to working with HSCRC to help make this exciting new model successful.

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