Advisory Council Meeting Agenda

April 18, 2016
12:00 pm to 3:00 pm
Maryland Hospital Association
6820 Deerpath Rd, Elkridge, MD 21075

12:00 – 12:10 **Welcome and Introductions**
Donna Kinzer, Executive Director, HSCRC

12:10 – 12:25 **Overview of MACRA**
Sule Gerovich, Director, Center for Population-based Methodologies, HSCRC

12:25 – 1:00 **Maryland's All-Payer Model Progression**
Donna Kinzer, Executive Director, HSCRC

1:00 – 2:45 **Maryland Priorities: Feedback from Advisory Council**
Jack Meyer, Principal, Health Management Associates

2:45 – 3:00 **Public Comments**
Jack Meyer, Principal, Health Management Associates

All meeting materials available at
http://www.hscrc.maryland.gov/hscrc-advisory-council.cfm

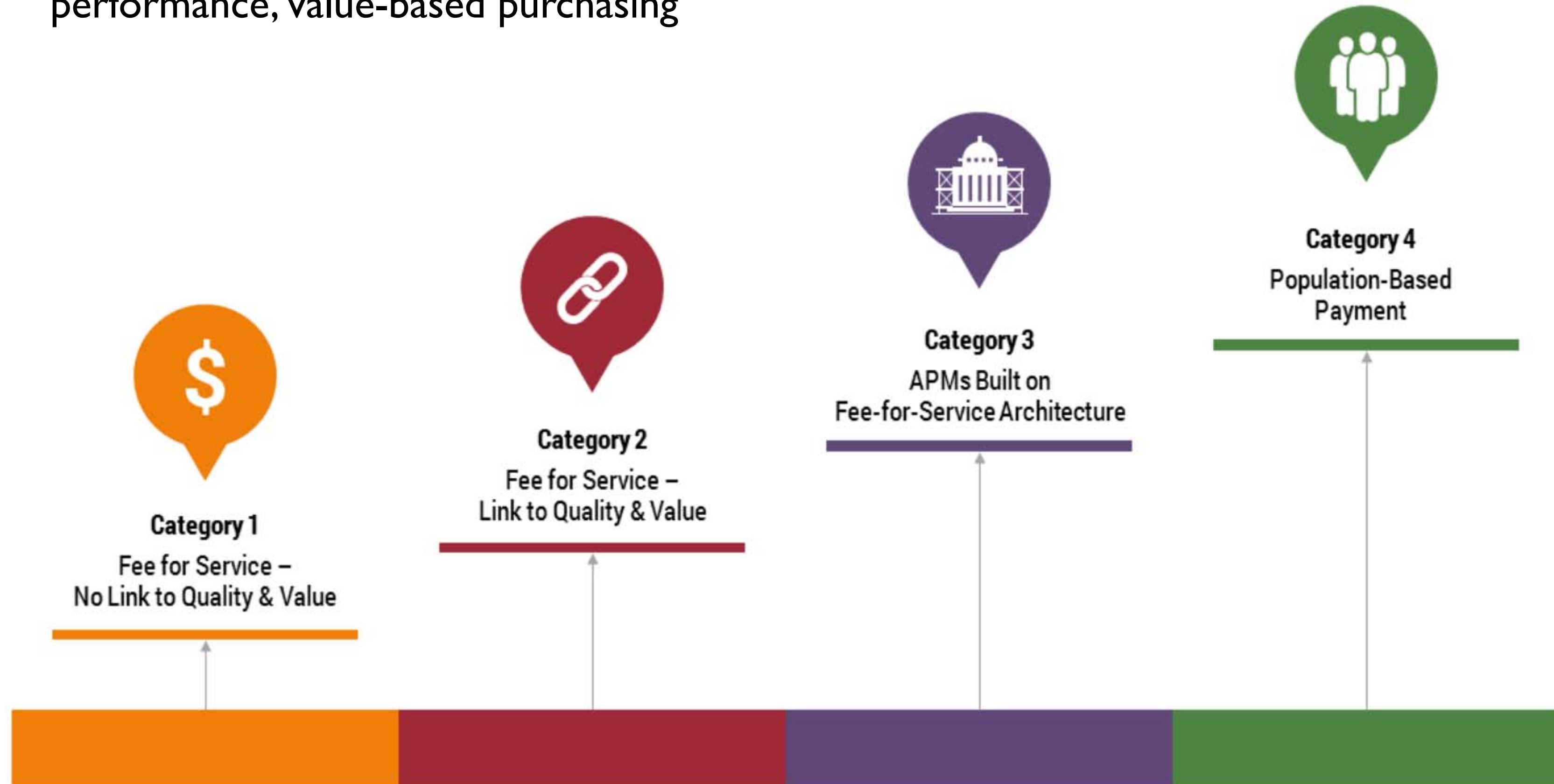
MACRA Overview

April 2016

HSCRC
Health Services Cost Review Commission

CMS is Focused on Progression from Volume-Based to Value-Based Payments

- Hospitals have some value-based payment via Hospital VBP, readmissions, and HAC programs
- Other provider groups (e.g. physicians, post-acute care) are moving to pay-for-performance, value-based purchasing



Source: Health Care Payment Learning & Action Network Alternative Payment Model (APM) Framework Final White Paper, 2016

MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

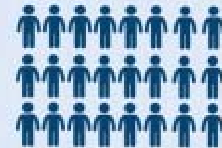
Medicare Fee-for-Service

GOAL 1:

Medicare payments are tied to quality or value through **alternative payment models** **(categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

Medicare fee-for-service payments are **tied to quality or value** **(categories 2-4)** by the end of 2016, and 90% by the end of 2018



STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

Set **internal goals** for HHS

Invite **private sector payers** to match or exceeed HHS goals

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

Accelerating Movement via MACRA

- MACRA is formally known as the H.R.2 Medicare Access and CHIP Reauthorization Act of 2015
  - Signed into law by Obama in April 2015

- MACRA Highlights
  - Repeals use of the Sustainable Growth Rate (SGR) Formula
    - Cut Medicare physician fees for all services if total physician spending exceeded a target, penalizing individuals who did control their costs
    - Was volume-based- did not reward improvements in quality
  - Replaces SGR with new quality-driven payment systems for providers

- ***Still many unknowns- Regs coming out this summer

MACRA: Provider Reimbursement Changes

- 2019-2025: Move to value-based payments via involvement in either of two tracks:

1) MIPS: Merit-Based Incentive Payment System	2) APMs: Alternative Payment Models
• Continues traditional FFS track • BUT a portion of Medicare provider payment at risk will gradually increase up to **-9% to +9%** based on their performance on quality and outcomes measures	• Medicare providers can opt out of MIPS and **receive +5% bonus** in rates if a substantial portion of their revenue is through APMs • Qualifying APMs definition TBD based on rulemaking.

- 2026+: All Medicare providers receive 0.25% update
  - APM providers will receive an additional 0.5% update, thereby receiving a 0.75% update overall for Medicare services

Source: Summarized from Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

Track 1: MIPS

- Performance Areas
  - Quality (e.g. preventive care, safety, etc.)
  - Resource use (e.g. Medicare spending per beneficiary)
  - Meaningful use of EHRs
  - Clinical practice improvement activities
    - Care coordination
    - Expanded access (e.g. same day appointments)
    - Patient safety and practice assessment (e..g surgical checklists)
    - Beneficiary engagement (e.g. use of shared decision-making)
    - Population management
    - APM participation
- Each category will have an underlying set of activities or measures
  - Measures used for the evaluation of provider performance can be based on all payer data (not only Medicare)

Source: Summarized from Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

Track 2: Alternative Payment Models (APMs)

- Poviders will receive **+5% bonus**, in addition to payments otherwise made under the APM, if they have a minimum amount of revenue at risk through an APM
  - To qualify for the bonus in 2019, providers may need to be in an APM in 2017
  - See Appendix

- To qualify as an eligible APM, providers must:
  - Use certified EHR technology
  - Meet quality measures (comparable to MIPS measures)
  - Assume more than "nominal" financial risk
    - Not yet sure what this means– definition TBD based on rulemaking

Source: Summarized from Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

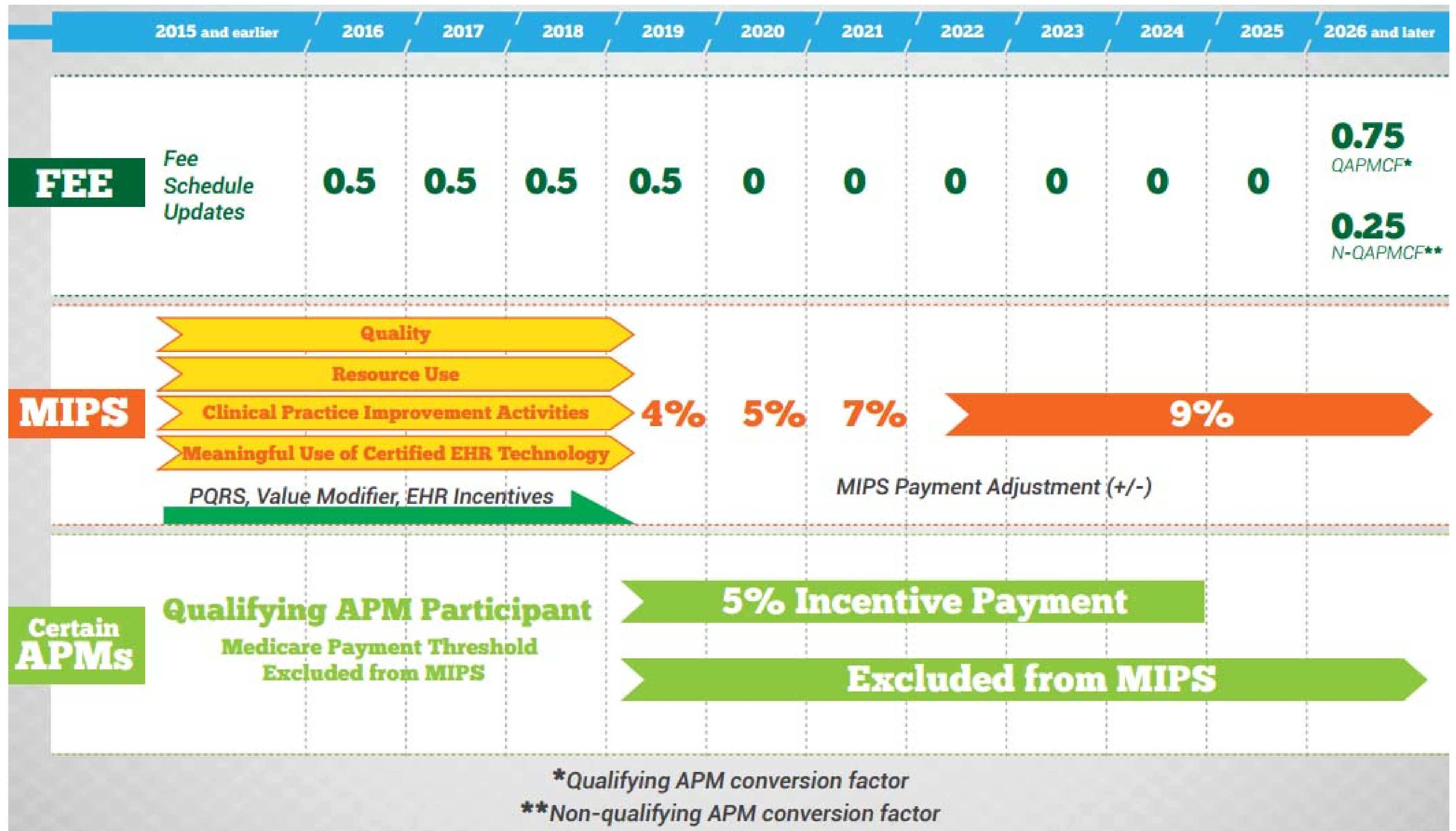
Strategic Implications for Maryland

- MACRA demonstrates the federal movement to two-sided risk and alternative payment models (e.g. ACO, PCMH, bundled payment, etc.) and focus on efficiency, outcomes, and financial responsibility
- Maryland's next steps may include:
  - Assess current state, identify gaps, analyze opportunities and develop roadmap
  - Develop and implement physician partnership strategy

Source: Summarized from Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

Appendix

MACRA: MIPS & APM Timeline Overview



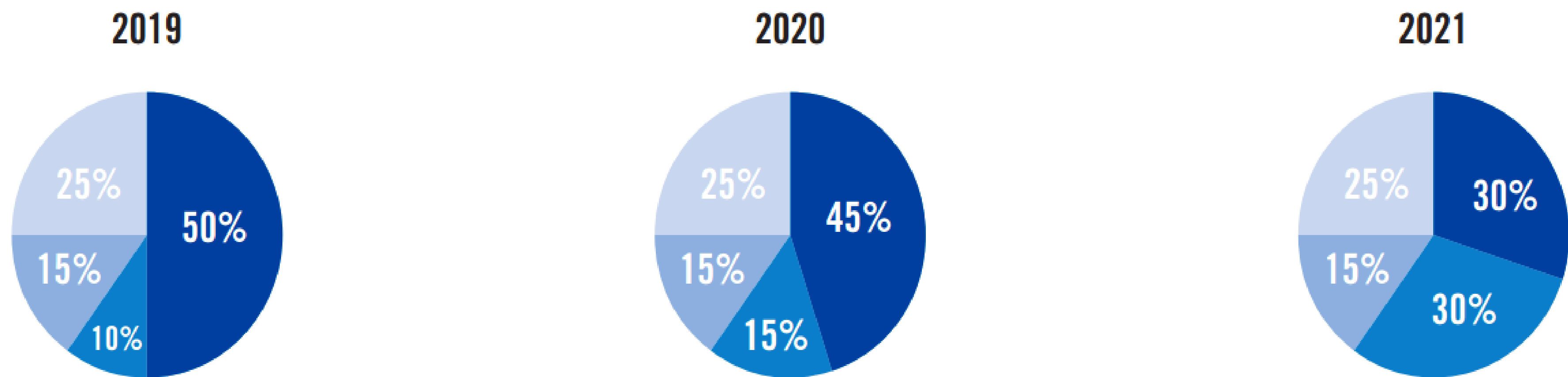
Source: CMS.gov Merit-Based Incentive Payment System (MIPS) & Alternative Payment Models (APMs) website, 2015

MIPS & MACRA Eligibility

	TRACK 1		TRACK 2
TYPES OF ELIGIBLE PROFESSIONALS	Value-Modifier	MIPS	APM
Medicare Physicians: Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, Doctor of Chiropractic	**2017** (2015 performance)	**2019**	**2019**
Practitioners: Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist	**2018** (2016 performance)	**2019**	**2019**
Practitioners: Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologists	**N/A**	**2021**	**2019**
Therapists: Physical Therapist, Occupational Therapist, Qualified Speech-Language Therapist	**N/A**	**2021**	**2019**

Source: Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

MIPS Performance Measures



QUALITY	Physician Quality Reporting System measures
RESOURCE USE	Value-based Payment Modifier measures
MEANINGFUL USE OF EHR	EHR incentive payment measures
CLINICAL PRACTICE IMPROVEMENT ACTIVITIES	Expanded access, population management, care coordination, beneficiary engagement, patient safety, and alternative payment models

Source: Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

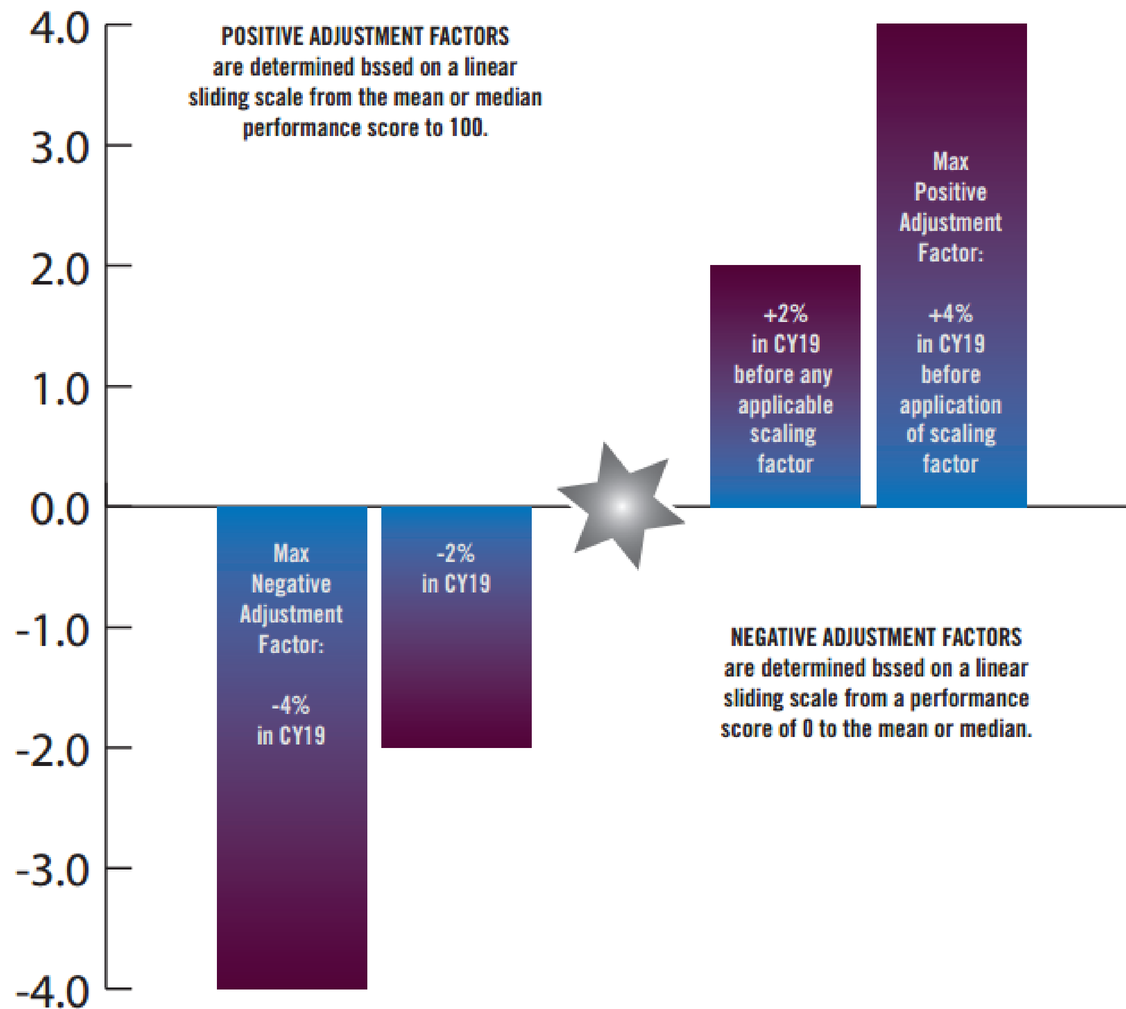
MIPS Payment Adjustment Factors

Figure 6 – MIPS payment adjustment factors

	Maximum positive adjustment before budget neutrality scaling factor	Maximum negative adjustment factor	Maximum positive adjustment after budget neutrality scaling factor
CY 2019	4%	-4%	12%
CY 2020	5%	-5%	15%
CY 2021	7%	-7%	21%
CY 2022	9%	-9%	27%

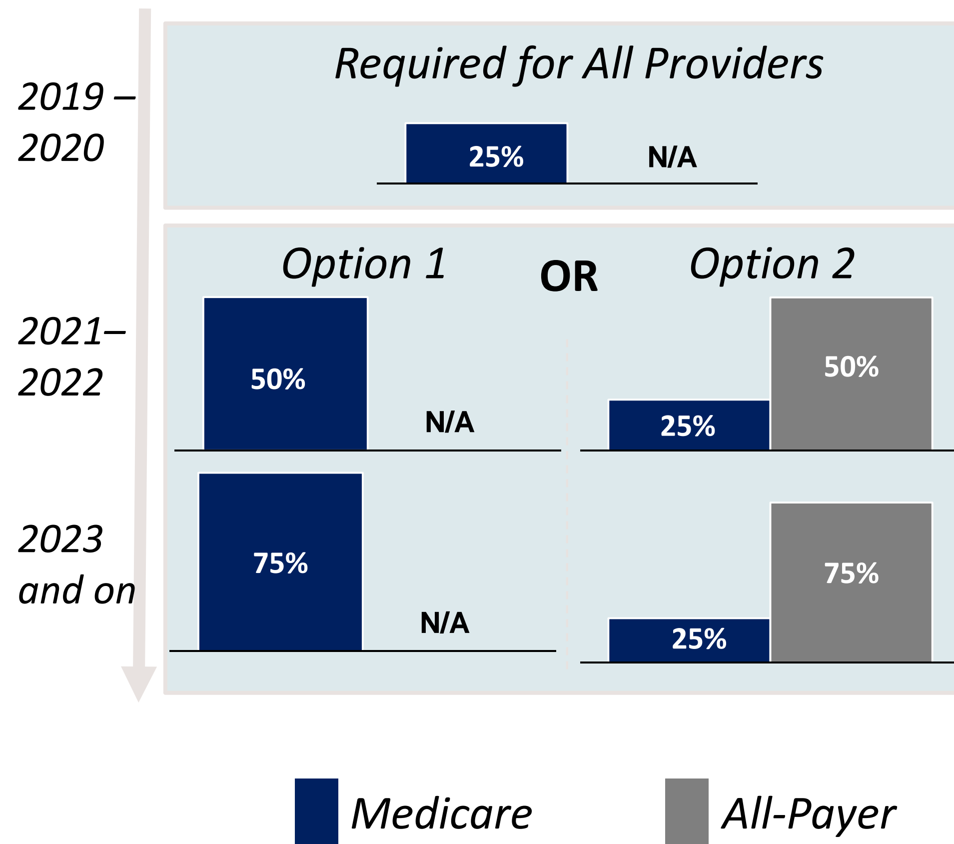
Source: Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

MIPS Payment Adjustment Factors



Source: Premier Medicare Payment Reform: Implications and Options for Physicians and Hospitals, 2015

APM: Provider Eligibility



Source: The Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board analysis.

Maryland's All-Payer Model Progression

April 18, 2016

HSCRC
Health Services Cost Review Commission

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

Examples of National Changes

- **CMS Chronic Care**
  - Chronic Care Management Fee, effective January 2015
  - CPC+ (new model)
    - Revenue for practices that effectively deliver the appropriate care coordination services for their chronically ill patients
- **Medicare Access & CHIP Reauthorization Act (SGR Relief Law):**
  - Requires Medicare providers [physicians] to have a substantial proportion of their revenue under alternative payment models (i.e. ACOs, medical homes, bundled payments, etc.) in order to receive an additional 5% Medicare payment update in 2019-2024
- **Geographic Population-Based Model**

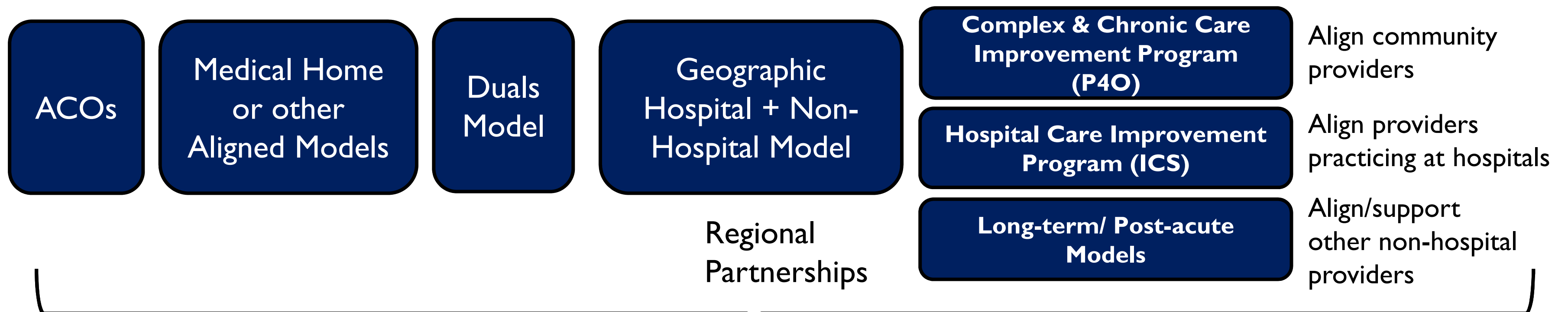
Current All-Payer Model Agreement Term

- “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”.

Potential Approach for the Proposal on the All-Payer Model Progression

- Submit a proposal to CMS on the All-Payer Model progression that lays out a timeline for Maryland Innovations that take on increased accountability over time
  - For what is Maryland is taking responsibility?
    - Services
    - Financial accountability
    - Quality
  - When?
    - Sequence of innovations
    - 2017-2024 plan
  - How?
    - High-level concepts
    - Starting with Medicare, but encourage all payer principles for system transformation
      - Maintain All-Payer Hospital Model
      - Medicare TCOC concepts

Potential Long-Term Developments



Shared savings
Additional financial and outcomes responsibility across the system over time
Develop infrastructure/governance to support alignment and model activities
Engage and support consumers

Models Supported By the Delivery System's:

- Data & Financial Incentives for Providers
(Alignment tools and data for P4O, ICS, , etc.)

- Common Technology Tools
(Via CRISP: risk scores, care histories, etc.)

- Care Coordination Resources

Common Goals:

- Reduce Potentially Avoidable Utilization
- Improve Quality, Outcomes
- Person-Centered Care
- Reduce Spending Growth
- All-Payer Hospital Model
- Aligned Non-hospital Models

(Ideas Staff Developed and Collected From Stakeholders)

What Might be in the Plan?

- Maryland has significant responsibility already
  - 56% of Medicare payments are for hospital services—Maryland has full responsibility for these costs under the All-Payer Model
  - For the remaining costs, Maryland has a guardrail to protect against cost shifting. Cost growth above national growth by more than 1%, or two years in a row above the national growth rate requires a corrective action plan from the State
- Concept in 2019 and beyond: Test several accountability approaches to ensure a range of flexible models are available for providers to consider adopting—build on existing models
  - Continue all payer hospital model
  - Have hospitals and non-hospital providers in shared savings models for Medicare
  - Use common outcomes measures across the system (e.g. population health, outcomes, avoidable utilization, cost) for Medicare
  - Add two sided models (upside savings and down side risk) and/or annual savings requirements– date TBD
  - Pay particular attention to MACRA requirements
  - Add specific provider responsibility under agreed approach (e.g. post acute and long term care, dual-eligibles, etc., medical home)
  - Develop common outcomes measures, value approaches across models and across payers to the extent possible, to help drive system transformation

Potential Approach for Model Progression

- High-level principles:
  - Continue with the All-Payer Hospital Model
  - Develop models for Medicare to progress on taking responsibility for the Medicare TCOC and improving health and outcomes
  - Maintain commitment to all payer principles of developing things in concert with one another (e.g. performance measures that could be used across the system)
- High-level timelines for discussion:
  - 2014: Global budgets
  - 2015: Model refinements
  - 2016: Add care redesign and alignment tools to existing All-Payer Model (Model Amendment)
  - 2016: Prepare long-term plan to file Jan 1, 2017
  - 2016-2017: Develop MACRA strategies
  - 2017: Implement care redesign and alignment tools
  - TBD:
    - Post-acute and long-term care model
    - Geographic, shared savings model, medical home, ACO
  - 2019: Test drive/implement shared savings models
  - Expanded TCOC progression –timeline and approach TBD
  - Time frame TBD- Duals Model

Care Redesign & Alignment Progression

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
  - MACRA affects potential models and timing
- 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

Two Potential New Programs: Creating Alignment Across Hospitals & Other Providers

Hospital Care Improvement, or Internal Cost Savings (ICS), Program	Complex and Chronic Care Improvement, or Pay for Outcomes (P4O), Program
• **Who?** For providers practicing at hospitals • **What?** Designed to reward improvements in hospital care that result in care improvements and efficiency	• **Who?** For community providers • **What?** Incentives for high-value activities focused on high needs patients with complex and rising needs, such as multiple chronic conditions; Leverages Medicare Chronic Care Management Fee

- Through these voluntary programs, hospitals would be able to share resources with providers, and potentially provide them incentive payments
  - Quality targets must be met, costs should not shift, and the total cost of care should not rise above a benchmark

Appendix

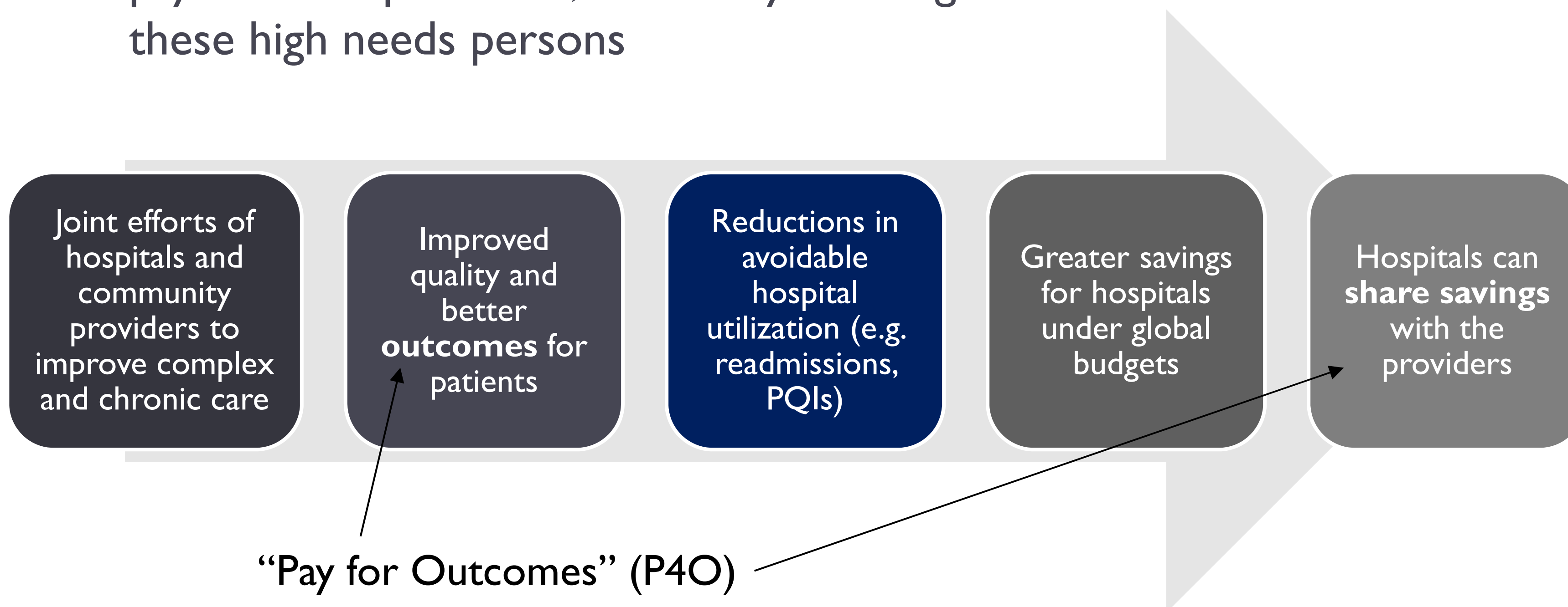
Appendix - Model Amendment

1. Hospital Care Improvement ("Gainsharing" or "Internal Cost Savings") Program

- Goal: Reward improvements in the quality of hospital encounters and transitions in care that will create internal hospital cost savings
- Activities that may be included:
  - Care coordination and discharge planning
  - Evidence-based practice support
  - Patient safety practices
  - Harm prevention such as self-reporting adverse events
  - Staff development such as CPOE training
  - Efficiency and cost reduction such as discharge order by goal time

2. Complex and Chronic Care Improvement or Pay for Outcomes (P4O) Program

- A voluntary, alignment program that
  - Allows hospitals to incentivize and support community providers in improving complex and chronic care, particularly for those patients who qualify for CMS' CCM fee
  - Ties resources from hospitals together with resources from Medicare payments to providers, essentially creating a chronic medical home for these high needs persons



2. Complex and Chronic Care Improvement or Pay for Outcomes (P4O) Program (cont.)

Through P4O, hospitals would be able to:		
Make shared savings payments to providers when they implement care redesign activities that result in reductions in avoidable hospital utilization and better outcomes	Share resources with providers that support these activities (e.g. care coordinators, risk stratification tools to ID high risk and rising risk patients)	Assist providers in accessing Medicare's CCM fee since P4O's design closely aligns with the CCM requirements

- Care redesign activities could include:
  - Care management (e.g. using HRAs and creating care plans)
  - Care coordination (e.g. obtaining discharge summary, updating records, reconciling medications)
  - Community activities (e.g. services outside traditional office setting)

Next Steps for the Model Amendment

- Focus on gaining approvals from CMS
  - Mid-summer target for Amendment
  - 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

Appendix - Geographic Model Concepts

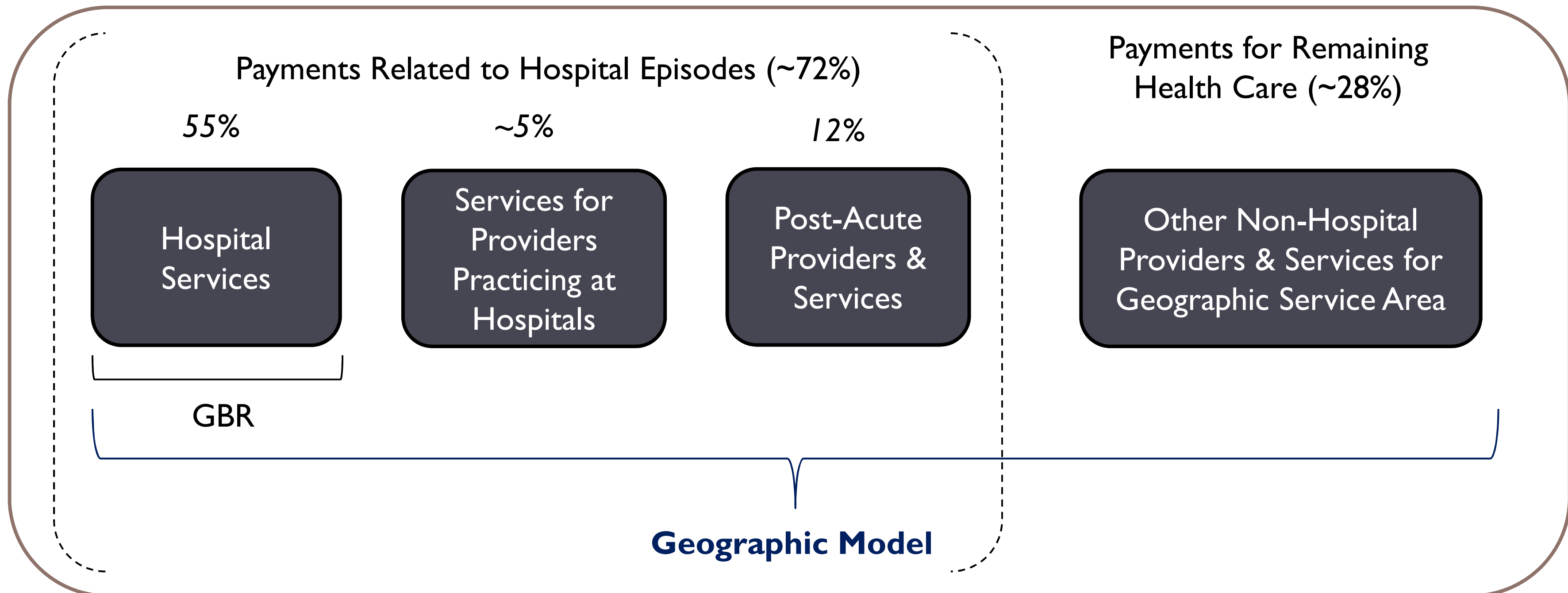
Geographic Model Concept

- Leverage Global Budget Revenue (GBR) because it provides a payment model for hospitals that moves away from volume-based to value-based payment
  - For the All-Payer Model Progression, Maryland must determine how to limit growth in Medicare total cost of care (TCOC)
  - Maryland will need a glide path to get to TCOC for Medicare over time.
- Maryland's plans for the next evolution of the All-Payer Model is due to Centers for Medicare & Medicaid Services (CMS) by January 1, 2017
  - A Geographic Model is one of several potential approaches

What is a Geographic Model?

- Global budget(s) + non-hospital costs
  - Focuses on services provided in a particular geography
- Creates responsibility for a patient population in an actionable geographic area
  - Includes services provided in local geographic area (e.g. excludes tertiary and quaternary care provided in other hospitals)
  - Allows for local control, instead of taking responsibility for a set of patients across providers in various geographies like ACOs do

Geographic Model: Relationship of Hospital & Non-Hospital Costs



Key Discussion Points for the Advisory Council

The following document includes an amalgamation of comments provided by Advisory Council members, and does not purport to represent a consensus of group comments. It is provided to support follow-up discussions of the Advisory Council.

Roadmap and Progression

The Advisory Council believes that we need a clear roadmap going forward, with key milestones and a timeline. Maryland has stated goals related to the Triple Aim. The Advisory Council can help develop a consensus definition and description of the destination that we seek in Maryland. One view of that destination expressed by a Council Member is “to improve the health status of the residents of Maryland while reducing the cost of health care, improving the quality of and consumer satisfaction with care, and making the entire health care system work more efficiently.”

The first step in the progression is to better understand where we are today with almost thirty months of operation under the All-Payer Model Agreement. We should strive to understand both what is working well—so that we can expand our tools that have enabled the positive results—and where we believe there are gaps in our performance—so that we can design appropriate interventions to fill those gaps. We will need to resist the urge to embrace potential solutions that appear to be “shiny and new,” and instead focus on what will enable us to meet our targets expeditiously. As we do this, we should remind ourselves that more focused efforts are likely to yield the best results. We should also recognize that one approach is unlikely to be the appropriate solution for all situations.

We need to demonstrate that the current All-Payer Model is both successful and sustainable. The Advisory Council can offer advice about the measures that could determine if those outcomes are achieved. To ensure that we are making real progress toward this goal, we will need to define what constitutes success at particular points along the timeline, and the Advisory Council can play a useful role in this endeavor. We should evaluate the current model annually to determine progress toward success and sustainability.

This should involve setting concrete quantitative goals for managing the cost and quality of care for particular populations. The All-Payer Model agreement places a strong emphasis on controlling the growth of Medicare spending, and there are specific targets in the Model agreement related to Medicare, such as saving Medicare a cumulative $330 million over five years and reducing hospital readmissions. This implies an overriding focus on identifying and better managing high-need, high-cost Medicare patients during the early phase of implementation. The Commission can set the goals, keep score, and provide the ground rules under which providers operate. At the same time, providers will want the flexibility to manage their business most effectively.

There is a need to set out a progression from the initial focus on the Medicare fee-for-service population with complex care situations, to all populations. A sequential approach would spend more time defining

accountability, responsibility, program design, outreach and coordination of care for all populations, across the full continuum of care from the well, to those with moderate support and service needs, to the chronically ill, and those in need of greatest care and services; utilizing health education, promotion and use of care pathways such as care and case management, nursing care, and hospice care that would offer a benefit across an entire population. This will help ensure the program's longer-term success.

Thus, the first milestones could be sequenced as follows: (1) getting secure access to patient-identifiable data from CMS to provide a complete picture of the health services used by the more than 800,000 Medicare patients in fee-for-service arrangements; data security and privacy includes prior notice to consumers, opportunities for them to opt out, and consumer rights to access and correct their records; (2) identifying those in this population with the most complex needs, including those already incurring or most at risk for high utilization; (3) from what the data tells us about these high-need people, the next step is to design interventions tied to their greatest needs (for example, if the data indicates a very high incidence of mental health problems, then we would benefit from addressing how adequate mental health services can be provided, and what it would take to ensure that there are sufficient amounts and types of services to meet the identified needs); (4) develop intensive intervention strategies to improve their care, optimize their health and reduce avoidable utilization and cost.

Success will depend on setting goals that are achievable, getting clarity on these goals, and drawing a roadmap that focuses laser-like on achieving them. This roadmap should include the sequence and scale of actions and reforms that are needed.

We also need a good sense of the *progression* of the work, with one set of accomplishments leading to another set of activities—a map in which we build successively on early accomplishments. This development of a roadmap and a plan for progression are important to the transformation of the delivery system and how that will take place. These milestones should relate to periodic assessments or evaluations of progress in meeting the goals and targets related to the All-Payer Model Agreement.

Engagement, Alignment, and Accountability

The Council suggests that accountability will be fostered by first, defining the target population in a way that is based on the data showing the greatest potential for avoidable utilization with the fewest unknowns about the intervention. Next, the Council wants to focus on the aspects of care of that population that allow for the greatest reduction of potentially avoidable utilization, and determine whether existing policies are sufficient to incentivize that reduction. The Council wants to establish a limited number of achievable goals; define the care delivery change desired, and avoid multiple, overlapping policies that might micromanage the system. We should also create focus by sequencing provider engagement and accountability.

Understanding who is responsible for what, and developing a clear system of risks and rewards related to these responsibilities, is important to the success of the All-Payer Model. It seems likely that we will need aligned responsibilities to achieve system-wide accountability. This is preferable to a situation in which each party is accountable only within its own silo. If risks and rewards are aligned across hospitals,

physicians, post-acute care providers, behavioral health, and payers, we are more likely to get system-wide accountability.

Consumer engagement

Two years ago, the Advisory Council issued its first report, including this passage:

Maryland leaders should strengthen their efforts to educate consumers about the All-Payer model and strive to communicate model goals, implementation steps, and accomplishments in plain, understandable terms that demonstrate the impacts on consumers. This will enhance consumer engagement and promote positive results. Much has been done since that time, but more work is needed.

Accountability requires meaningful measures that include consumers' access to quality care. As we strive to create incentives to reduce avoidable use of high-cost services, we should also be vigilant to avoid under-use of appropriate care. This is particularly important for vulnerable populations. What additional measures may be needed to protect consumers and ensure equity?

For example, ensuring adequate care for diabetes and blood pressure control are quality indicators that can be measured and utilized. The federal government has begun working with private payers and providers to identify common measures that could be used. Maryland should study these efforts and bring forward measures that will promote quality outcomes and improved health equity.

Maryland may want to consider establishing an Ombudsman program led by a consumer/community organization. There are successful models in other states. This could provide an avenue for consumer feedback on the All-Payer Model, and also as a vehicle for evaluation of the implementation efforts. There are a number of consumer protections organized in the State, in various agencies. We should take stock of the existing avenues and how they can be organized to support consumers.

Financing

In our earlier report published on January 31, 2014, the Council called for identifying other sources of funding for care management and infrastructure, in addition to hospital rates. Since that time, Medicare introduced a chronic care management fee for community-based providers and other fees to support care transitions. Also, home health services are growing and these billable services are being used to support care management. It should be noted that as these sources of funding outside of hospitals are accessed, that the growth in non-hospital costs will need to be offset by reductions in hospital costs. DHMH has worked with the federal Medicaid Implementation and Advanced Planning Document program (IAPD) to secure funds to support expansion of CRISP infrastructure. The Council should determine the degree of progress that has been achieved toward this goal, and consider whether this earlier recommendation needs to be brought back and emphasized.

An organizational structure/framework for accountability and alignment

One approach to organizing the policy framework for accountability and alignment is built on the following core principles:

Tie financial accountability to the provider with decision-making authority

Tie financial accountability to measurable outcomes related to cost and quality

Allow some freedom to adapt within a common framework

Only allow shared savings when quality indicators are at acceptable levels and when savings have been demonstrated on a patient population of a certain minimum size

Key elements of a framework for accountability and alignment

- *Patient centric* with a strong role for PCPs: who is accountable for the patient? PCPs? Shared accountability, and if so, how is this sharing worked out?
    - Population health: risk stratification can help focus on those most in need of supports and intensive care interventions;
    - *Global accountability* for achieving targeted cost and quality results over time: for what services and costs? Who goes at risk, how much risk, and how enforced?
- *Care coordination* as an enabling strategy toward success: who is going to do the care coordination? Care managers hired by providers and payers, or staff to the providers and payers? How are they trained, monitored, managed, and overseen? How will patients who need care coordination be selected? How does this relate to the population health/risk stratification strategies for Phase 2?
- *Incentive alignment* to encourage desired results: How are incentives provided so they reward people who are accountable for the results if they succeed? How are risk-sharing and shared savings measured and tied together, and are they symmetrical?

Alignment of hospital care with physician care and post-acute care

We have a tremendous opportunity to align hospital care, physician care, and post-acute care. In its earlier report, the Council called for the alignment of incentives built into the global budgets for hospitals with incentives in post-acute care and physician care. Some progress has been made, but more needs to be done.

New opportunities for alignment of physician/practitioner's care

The federal government's CCM payments permit Medicare to pay for non-face-to-face care management services such as medication reconciliation, coordination among providers, arrangements for social services, and remote patient monitoring. Arranging for such services requires physicians' time as well as the time of office staff, administrative costs, and technology outlays. Prior to this CMS billing code and payment system for care management, medical practices have had to absorb these costs without any reimbursement. Providers are frustrated with some of the CCM requirements. Is there an opportunity to improve on this program as part of the model progression?

Clinicians can also be encouraged to bill for Transitional Care Management (TCM) services. Such services compensate providers for working with patients as they transition from inpatient to community settings.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) establishes a Merit-Based Incentive Payment System (MIPS) that consolidates existing Medicare fee-for-service physician incentive

programs. MACRA also establishes a pathway for physicians to participate in alternative payment models.

Council members noted that Maryland should be aligning MACRA, MIPS, and alternative payment models (APM). This will help physicians participate in new approaches to care delivery and payment.

Based on input from stakeholders, including the Advisory Council, the Physician Alignment Work Group, the ICN-Care Coordination Work Group, and other stakeholder input, Maryland is moving ahead to develop approvals that allow for shared resources and for shared savings to be provided from hospitals to non-hospital providers when care improves, and as a result there are savings associated with efficiency and reductions in avoidable utilization. The State is focused on gaining approvals that will allow evolution and changes in programs over time within the parameters of the federal approvals, rather than one or two fixed programs that cannot be changed. One initial program, aimed at providers with hospital privileges, focuses on improving the efficiency and quality of care and care transitions while the second program focuses on improving complex and chronic care with the with the aim of reducing potentially avoidable hospitalizations such as admissions for ambulatory-sensitive conditions and readmissions, among others. It is important that these innovations count toward the requirements of the federal government under MACRA, recognizing that the requirements are evolving.

Medical malpractice reform

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.

New opportunities for alignment of post-acute care

The All-Payer Model presents an opportunity to reduce utilization in higher-cost settings and navigate to lower-cost settings, guided by clinical needs. This goal can be fostered by moving toward coordinated step down care. We can build on patient navigation and advocacy capacity. The phase 2 application should feature partnerships to build strong bridges between acute and post-acute settings. We should help people on Medicare with high-acuity chronic conditions become healthier and better move along the continuum from hospital to post-acute care settings, and from those settings to home.

The focus on post-acute care spotlights the importance of behavioral health needs. A number of the long-term post-acute care (LTPAC) population has moderate to severe cognitive impairment. Nearly 20 percent of SNF residents take anti-psychotic medications. Alignment may be fostered by expanding the shared savings concepts to include LTPAC providers and share resources and provide financial incentives to pursue quality and cost targets. Any new design should incentivize LTPAC providers to take the right action rather than the least expensive action. We should avoid going for a quick “savings” and ensure

that providers are not penalized for placing the patient in the most proper setting. The latter will be cost-effective over time by avoiding readmissions.

A fee-for-service system for LTPAC providers, like any FFS approach, maintains the incentive to keep beds (slot) filled. The new system needs to reduce this dependence, similar to the global payment system operating for acute care hospitals, and reward LTPAC partners for high-quality care. For this new approach to be successful we need accurate and timely data on resident conditions and treatment, and that data needs to be available and communicated in real time.

Governance

We need to pay more attention to governance. The governance of the system should be modernized from one that focuses almost exclusively on hospitals to one that will allow for other practitioners and for patients to have a voice and be represented. The governance needs to be clear and transparent. Governance needs to protect patients, physicians, and the public health of Maryland.

Governance is an important challenge not only in the public sector, but also in the private sector. As various forms of integrated care networks, including ACOs, emerge, it will be important that they, too, are well governed. Some of these new entities are taking on a considerable amount of risk, and good oversight and management will be important to their success.

In terms of developing and implementing needed changes, consideration should be given to using private-public partnerships, such as CRISP, to assist in administration and transformation.

As the All-Payer Model continues to evolve toward a more system-wide focus, greater direct cooperation among HSCRC, DHMH, and MHCC seems warranted and helpful. Is there a need to formalize a multi-agency governance process, or can this best be done on an informal basis? There is a Coordinating Council, which was previously developed as many reforms were initially introduced in the State.

What are the relative roles for State government agencies and the private sector, including the important parts of the health care delivery and financing systems as well as community-based organizations? How can good governance promote alignment and accountability? The Advisory Council can provide guidance as to how the State can find the proper balance between State regulation and market-based incentives. In doing so, we should explicitly recognize and embrace the leading role of private sector initiatives in moving toward transformation, as opposed to government-mandated approaches. As the State continues to work with the federal government, what is the best balance between mainly implementing federal initiatives, on one hand, and positioning Maryland as a leader, with unique innovations under the All Payer Model, on the other hand?

In this regard, it is important to note that HSCRC has always had a philosophy of setting performance targets, rather than detailed design standards, and then “getting out of the way” so that hospitals can respond to those incentives with some variation in approaches. This goal of allowing considerable

flexibility for achieving desired thresholds is still valued, and can apply to physician services, post-acute care, and other parts of the health care system that are largely outside of the purview of HSCRC.

A key issue is whether to expand the scope of long-standing regulatory authority, which focuses on hospitals, versus retaining that authority more or less as is, and relying on market-based approaches outside of major government regulation, to align incentives between hospitals and other key sectors such as physician care and post-acute care. It should be noted that DHMH and MHCC also have important regulatory authority. A mix of public and private strategies may be needed.

One place to start is by developing risk-based and partial risk-based models to pay hospitals and sub-acute facilities that join together to better manage care such care transitions, optimize post-acute care, and reduce avoidable hospitalizations from long-term care settings. In a publicly based model, this would require some rate management of payments to SNF and other sub-acute providers. In a private solution, the parties would work out various combinations of risks and rewards largely outside of State regulatory authority but under the authority of one or more federal models.

In pursuing alignment of incentives, it is important to define the desired change first, and then see what organizational entities emerge to achieve this change, rather than starting first with the organizations (e.g. ACOs).

An important part of good governance is a substantive evaluation process. This is the key for both good governance and effective administration, and could serve as an accountability tool. For the All-Payer program, this evaluation could include an analysis of the models and programs being undertaken through the Transformation Grants to identify the most effective strategies. Such strategies can then be scaled up for broader use, or applied as appropriate in discrete areas.

In sum, there is a need to define and identify global governance for the entire All-Payer Model, starting with the continuum of beneficiaries in the Medicare fee-for-service program

- ✓ Who will govern the program and how will it be accomplished?
- ✓ Who has oversight responsibility, will monitor program outcomes, and is directly responsible?
- ✓ Who will involve, engage, and coordinate all stakeholders to ensure care is provided to all beneficiaries, at all levels of health care needs?
- ✓ Who is ensuring that the program is functioning, care is organized, outreach is occurring, coordination of care is being provided to patients, and identifying those not seeking care, gaps in care, and the need for prevention, across the care continuum and stakeholders?

The Council should discuss and resolve its recommendations for the development of the Phase 2 plan to the federal government and its implementation

An important part of the roadmap is the process of creating the Phase 2 plan for the federal government. This plan will broaden the focus of cost control from mainly controlling total hospital costs per capita and improving quality, to a broader context that encompasses controlling the cost and improving the quality of a broad range of health services. An important choice is whether this much

broader focus for the second five-year period of the All-Payer Model will apply only to Medicare or to other payers as well, and the Council may want to make a recommendation on this. The Council may also like to weigh in on what Medicaid reforms could be included in the Phase 2 plan.

The Advisory Council would like to work through these issues to ascertain what they would like to recommend regarding the Phase 2 plan. We wish to see a realistic timetable for progression. We should advocate for what will best serve the state of Maryland, allowing sufficient time for policy and model development and stakeholder engagement and support.

We should also take into account the reforms that are already underway in Maryland and what models we should consider, including ACOs, PCMH, and geographic models.

Progress along the full continuum of care

Maryland quickly made excellent progress in placing hospitals under global budgets. Now we face two key challenges: (1) to align incentives of physicians and other providers with these new hospital incentives; and (2) to "move upstream" along the continuum of care to address the forces driving people into hospitals and improve the health of the State's population. A good place to start is with investments in both primary care and a cluster of social services and policies that improve health and access to health care, including nutrition, transportation, safe housing, among others.

Mapping capacity to the achievement of goals

The achievement of the goals of the All-Payer Model will take enhanced capacity in non-acute areas of the system. The Council's original report called for development of funding resources in addition to hospital rates, and we would like to reiterate that recommendation. This raises the challenge of figuring out both the desired hospital capacity looking out into the future, as well as the needed capacity in such areas as outpatient surgical centers, rehab centers, home care, and nursing homes. This involves efforts to plan for "right-sizing" the health care delivery system in the face of trends in demographics, technology, new market entrants, virtual visits, telemedicine, and the major policy changes that Maryland is undertaking.

CMS launches largest-ever multi-payer initiative to improve primary care in America

New Affordable Care Act initiative, designed to improve quality and cost, gives doctors and patients more control over health care delivery

The Centers for Medicare & Medicaid Services (CMS) today announced its largest-ever initiative to transform and improve how primary care is delivered and paid for in America. The effort, the Comprehensive Primary Care Plus (CPC+) model, will be implemented in up to 20 regions and can accommodate up to 5,000 practices, which would encompass more than 20,000 doctors and clinicians and the 25 million people they serve. The initiative is designed to provide doctors the freedom to care for their patients the way they think will deliver the best outcomes and to pay them for achieving results and improving care.

“Strengthening primary care is critical to an effective health care system,” said Dr. Patrick Conway, CMS deputy administrator and chief medical officer. “By supporting primary care doctors and clinicians to spend time with patients, serve patients’ needs outside of the office visit, and better coordinate care with specialists we can continue to build a health care system that results in healthier people and smarter spending of our health care dollars. The Comprehensive Primary Care Plus model represents the future of health care that we’re striving towards.”

Building on the Comprehensive Primary Care initiative launched in late 2012, the five-year CPC+ model will benefit patients by helping primary care practices:

- Support patients with serious or chronic diseases to achieve their health goals
- Give patients 24-hour access to care and health information
- Deliver preventive care
- Engage patients and their families in their own care
- Work together with hospitals and other clinicians, including specialists, to provide better coordinated care

Primary care practices will participate in one of two tracks. Both tracks will require practices to perform the functions and meet the criteria listed above, but practices in Track 2 will also provide more comprehensive services for patients with complex medical and behavioral health needs, including, as appropriate, a systematic assessment of their psychosocial needs and an inventory of resources and supports to meet those needs.

CPC+ will help practices move away from one-size-fits-all, fee-for-service health care to a new system that will give doctors the freedom to deliver the care that best meets the needs of their patients.

In Track 1, CMS will pay practices a monthly care management fee in addition to the fee-for-service payments under the Medicare Physician Fee Schedule for activities.

In Track 2, practices will also receive a monthly care management fee and, instead of full Medicare fee-for-service payments for Evaluation and Management services, will receive a hybrid of reduced Medicare fee-for-service payments and up-front comprehensive primary care payments for those services. This hybrid payment design will allow greater flexibility in how practices deliver care outside of the traditional face-to-face encounter.

To promote high-quality and high-value care, practices in both tracks will receive up-front incentive payments that they will either keep or repay based on their performance on quality and utilization metrics. The payments under this model encourage doctors to focus on health outcomes rather than the volume of visits or tests.

Practices in both tracks also will receive data on cost and utilization. Optimal use of Health IT and a robust learning system will support them in making the necessary care delivery changes and using the data to improve their care of patients. Track 2 practices' vendors will sign a Memorandum of Understanding (MOU) with CMS that outlines their commitment to supporting practices' enhancement of health IT capabilities. These partnerships will be vital to practices' success in the care delivery work and align with the Office of the National Coordinator for Health IT priority to ensure electronic health information is available when and where it matters to consumers and clinicians.

Under the CPC+ model, Medicare will partner with commercial and state health insurance plans to support primary care practices in delivering advanced primary care. Advanced primary care is a model of care with five key components:

- Services are accessible, responsive to an individual's preference, and patients can take advantage of enhanced in-person hours and 24/7 telephone or electronic access.
- Patients at highest risk receive proactive, relationship-based care management services to improve outcomes.
- Care is comprehensive and practices can meet the majority of each individual's physical and mental health care needs, including prevention. Care is also coordinated across the health care system, including specialty care and community services, and patients receive timely follow-up after emergency room or hospital visits.
- It is patient-centered, recognizing that patients and family members are core members of the care team, and actively engages patients to design care that best meets their needs.
- Quality and utilization of services are measured, and data is analyzed to identify opportunities for improvements in care and to develop new capabilities.

CMS will select regions for CPC+ where there is sufficient interest from multiple payers to support practices' participation in the initiative. CMS will enter into a Memorandum of Understanding (MOU) with selected payer partners to document a shared commitment to align on payment, data sharing, and quality metrics in CPC+.

CMS will accept payer proposals to partner in CPC+ from April 15 through June 1, 2016. CMS will accept practice applications in the determined regions from July 15 through September 1, 2016.

The Affordable Care Act, through the creation of the Center for Medicare and Medicaid Innovation, allows for the testing of innovative payment and service delivery models, such as the CPC+ model, to move our health care system toward one that rewards clinicians based on the quality, not quantity, of care they give patients. Today's announcement is part of the Administration's broader strategy to improve the health care system by paying providers for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality.

In March 2016, the Administration estimated that it met the ambitious goal – eleven months ahead of schedule – of tying 30 percent of Medicare payments to quality and value through alternative payment models by 2016. The Administration's next goal is tying 50 percent of Medicare payments to alternative payment models by 2018. The Health Care Payment Learning and Action Network established in 2015 continues to align efforts between government, private sector payers, employers, providers, and consumers to broadly scale these gains in better care, smarter spending, and healthier people

Comprehensive Primary Care Plus

Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through a regionally-based multi-payer payment reform and care delivery transformation. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.). The care delivery redesign ensures practices in each track have the infrastructure to deliver better care to result in a healthier patient population. The multi-payer payment redesign will give practices greater financial resources and flexibility to make appropriate investments to improve the quality and efficiency of care, and reduce unnecessary health care utilization. CPC+ will provide practices with a robust learning system, as well as actionable patient-level cost and utilization data feedback, to guide their decision making.

CPC+ is a five-year model that will begin in January 2017.

Background

Strengthening primary care is critical to promoting health and reducing overall health care costs in the U.S. CPC+ builds on the foundation of the Comprehensive Primary Care (CPC) initiative, a model tested through the Center for Medicare & Medicaid Innovation that runs from October 2012 through December 31, 2016. CPC+ integrates many lessons learned from CPC, including insights on practice readiness, the progression of care delivery redesign, actionable performance-based incentives, necessary health information technology, and claims data sharing with practices.

CPC+ will bring together CMS, commercial insurance plans, and State Medicaid agencies to provide the financial support necessary for practices to make fundamental changes in their care delivery. CMS will enter into a Memorandum of Understanding (MOU) with selected payer partners to document a shared commitment to align on payment, data sharing, and quality metrics throughout the five year initiative.

Model Details

The goal of CPC+ is to improve the quality of care patients receive, improve patients' health, and spend health care dollars more wisely. Practices in both tracks will make changes in the way they deliver care, centered on key Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health. Additional information about each CPC+ track is listed below:

	Track 1	**Track 2**
Practice Capabilities	Pathway for practices ready to build the capabilities to deliver comprehensive primary care.	Pathway for practices poised to increase the comprehensiveness of care through enhanced Health IT, improve care of patients with complex needs, and inventory of resources and supports to meet patients' psychosocial needs.
Medicare Care Management Fee	Average Medicare care management fee of $15 per beneficiary per month.	Average Medicare care management fee of $28 per beneficiary per month, which includes a $100 care management fee for patients with the most complex needs.

Medicare Payment Structure	Practices will receive regular fee-for-service payments.	Practices will receive "Comprehensive Primary Care Payments (CPCP)" – a hybrid of Medicare fee-for-service and a percentage of their expected Evaluation & Management (E&M) reimbursements upfront in the form of a CPCP. Practices will receive a commensurate reduction in E&M fee-for-service payments for a percentage of claims.
Medicare Performance-Based Incentive Payment	Practices are eligible for a performance-based incentive payment of $2.50 per beneficiary per month. Incentive payments are prepaid at the beginning of a performance year, but practices may only keep these funds if quality and utilization performance thresholds are met.	Practices are eligible for a performance-based incentive payment of $4 per beneficiary per month. Incentive payments are prepaid at the beginning of a performance year, but practices may only keep these funds if quality and utilization performance thresholds are met.
Health IT Vendor Partner	N/A	Practices must submit a letter of support from their health IT vendor(s) that outlines vendors' commitment to supporting practices with advanced health IT capabilities.
Medicare Payment Structure	Practices will receive regular fee-for-service payments.	Practices will receive "Comprehensive Primary Care Payments (CPCP)" – a hybrid of Medicare fee-for-service and a percentage of their expected Evaluation & Management (E&M) reimbursements upfront in the form of a CPCP. Practices will receive a commensurate reduction in E&M fee-for-service payments for a percentage of claims.
Multi-Payer Support	Practices must have support from multiple payers partnering in CPC+.	Payers must have support from multiple payers partnering in CPC+.

How to Apply

Payer solicitation and practice applications will be a staggered process. First, CMS will solicit payer proposals to partner with Medicare in CPC+ (April 15-June 1, 2016). The choice of up to 20 CPC+ regions will be informed by the geographic reach of selected payers.

Next, CMS will publicize the CPC+ regions, and solicit applications from practices within these regions (July 15-September 1, 2016). Practices will apply directly to the track for which they believe they are ready; however, CMS reserves the right to offer practice entrance into Track 1 if they apply to, but do not meet the eligibility requirements for Track 2.

Practices applying to Track 2 will need to submit a letter of support from their Health IT vendor(s) that outlines vendors' commitment to supporting the practice with advanced health IT capabilities. CMS will sign a Memorandum of Understanding with those health IT vendors supporting Track 2 practices selected to participate in CPC+.

Stakeholder Webinars

CMS will host webinars on the following dates for interested stakeholders:

- **CPC+ Model Announcement – open to all members of the public**
  - Thursday, April 14 | 3:00 – 4:00 p.m. EDT | Registration is open
  - Tuesday, April 19 | 3:00 – 4:00 p.m. EDT | Registration is open

- **CPC+ Health IT Vendor Event – open to Health IT vendors only**
  - Thursday, April 21 | 12:00 – 1:00p.m. EDT | Registration is open

- **CPC+ Interested Payer Event – open to payers only**
  - Wednesday, April 27 | 2:00 – 3:00p.m. EDT | Registration is open
  - Tuesday, May 10 | 2:00 – 3:00p.m. EDT | Registration is open

For questions about the model or the solicitation process, please email CPCplus@cms.hhs.gov.

Additional Information