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 achieving the Three Part Aim and permit the federal government to continue to participate in the four-decade long all-payer 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 has held four public meetings from December 2013 through January 2014, and taken 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 tie payments to quality and to tie system-wide hospital inpatient and outpatient payment to economic growth. Effectively, the State is instituting a plan to shift from controlling inpatient hospital cost per admission to controlling 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. This represents a savings level of about one-half 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.

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 for the first two years of the proposed model.

1.2 Global Budgets for Maryland hospitals will be needed to assure revenue controls under these tight targets.

1.3 An early key to success under global hospital budgets is to reduce avoidable utilization that can be realized through better care.

1.3.1 This will require data collection to identify and pinpoint the most significant opportunities. The essential elements needed to meet the targets are the identification of high-need patients with complex medical conditions and the development and implementation of effective care coordination programs to meet their needs.

Discussion

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

The HSCRC should develop strategies to determine 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 will yield significant savings and also likely improve patient care and health outcomes. It is also 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-needs patients. The HSCRC should work with the 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

The next important step is to develop 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.

HSCRC and other State agencies 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 as quickly as possible, toward payment models that reward better patient outcomes, quality of care improvements, and overall cost containment.

The HSCRC anticipates that 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.

Increasing efficiency

Reducing avoidable utilization is critical, but meeting total spending targets will also require greater efficiency. This begins with full price transparency, and also features creating incentives for providers, health plans, and patients to impose price discipline on the system. Prices and utilization comprise the twin building blocks of controlling total spending.

2. Strike a balance between meeting the budget targets and making important investments in infrastructure and modernization

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 infrastructure necessary for long-term 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.

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, and some combination of public and private resources will need to be devoted to making the up-front investments needed to produce that infrastructure.

The HSCRC should consider the variability in readiness among hospital systems as it plans for the phased implementation of model components. There is a need for a plan to develop the infrastructure through private and public organizations, and ensure that it is financed, to help hospitals and physicians in care coordination.

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.

Access to Care Infrastructure

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.

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 the conversion of all 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 foster 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.

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, and well as improvements in the health status of people who have these diseases.

4. Consumer involvement in planning and implementation

4.1 The HSCRC should actively engage patients 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 patients 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.

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.

Discussion

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, poor quality, or poorly coordinated 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.

5. Physician and Other Provider Alignment

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 play a supportive role in encouraging 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. If necessary, the State should apply to OIG at HHS to permit gain-sharing 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 gain-sharing 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 may 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.

6. A Supportive and Balanced Regulatory Approach

6.1 HSCRC should set broad targets and goals, allowing 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. The Council urges the HSCRC to set broad targets and goals that support meeting Model performance objectives. HSCRC should *encourage, facilitate, and promote promising private sector initiatives to help meet the goals.*

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.

Another important challenge in the new model design is that regulatory standards continue to incorporate quality into its 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 and thus should also be a featured component of HSCRC regulatory policies.

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 permit and encourage market share shifts that involve patient volume moving toward high-value providers.

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

Discussion

When hospitals adopt global or population-based budgets, they will be taking on significant responsibility for the total cost of care under the new Model design and 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.

7. An ongoing, transparent public engagement process

7.1 The Advisory Council supports the establishment of Work Groups to address technical 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 all 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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