



# Maryland All-Payer Model Background, Progression and Vision Elements

February 2016 Advisory Council Meeting

# Overview

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- ▶ This presentation provides background materials regarding Maryland's All-Payer Model implementation, performance, and plans.
- ▶ Preliminary thinking from diverse stakeholders about model progression and principles to guide evolution have been provided. Each Advisory Council member is asked to review this presentation and the accompanying word document, which contains an amalgamation of stakeholder advice to prepare for a discussion of key principles.
- ▶ Thank you for your input as we undertake the important process of planning the progression of Maryland's All-Payer Model.

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# The Evolving Healthcare Landscape: Shifting to Value



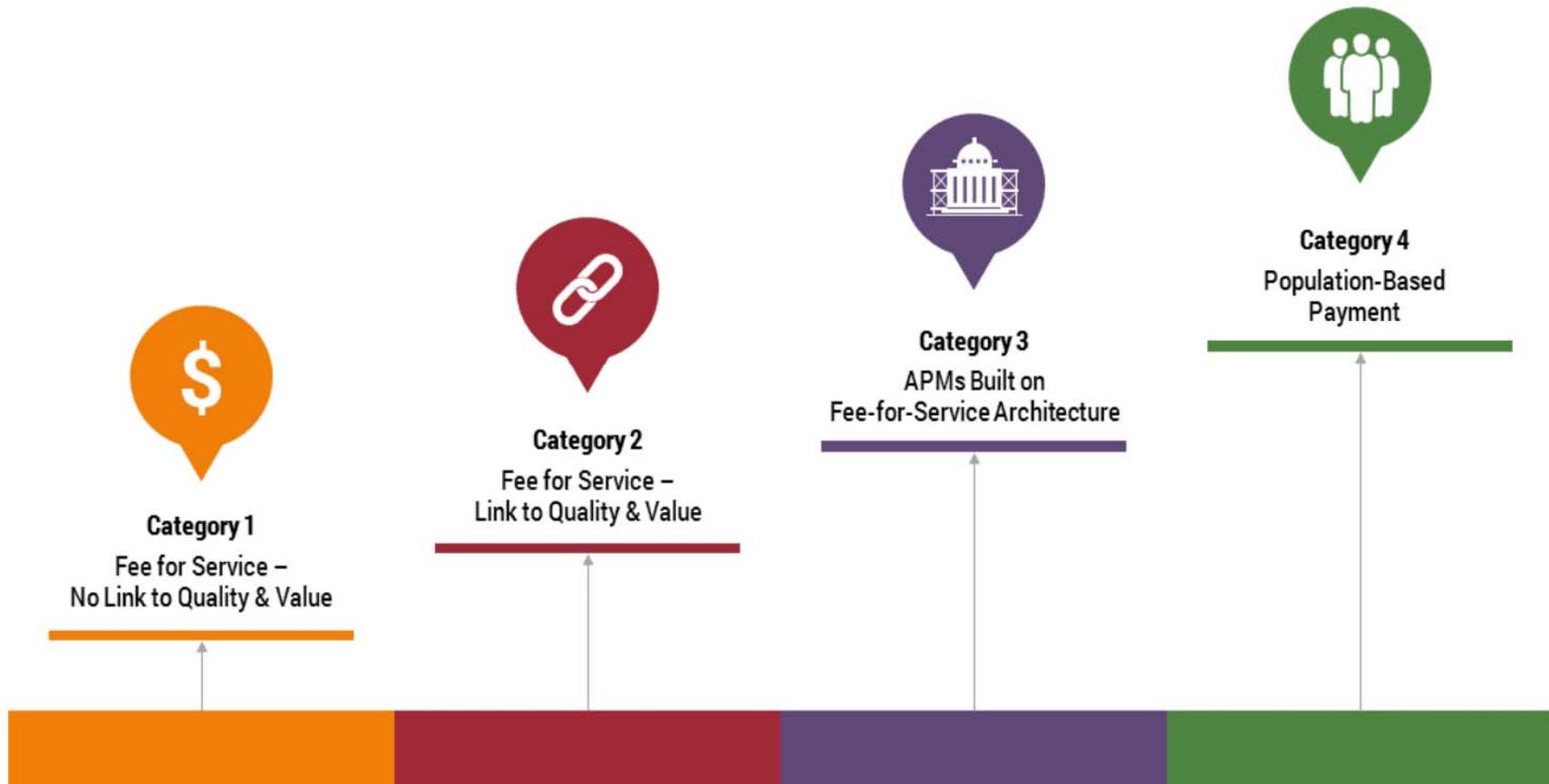
# CMS and National Strategy-Change Provider Payment Structures, Delivery of Care and Distribution of Information

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<u>Focus Areas</u>	<u>Description</u>
<b>Pay Providers</b>	<ul style="list-style-type: none"><li>• Increase linkage of payments to value</li><li>• Alternative payment models, moving away from payment for volume</li><li>• Bring proven payment models to scale</li></ul>
<b>Deliver Care</b>	<ul style="list-style-type: none"><li>• Encourage integration and coordination of care</li><li>• Improve population health</li><li>• Promote patient engagement</li></ul>
<b>Distribute Information</b>	<ul style="list-style-type: none"><li>• Create transparency on cost and quality information</li><li>• Bring electronic health information to the point of care</li></ul>

# CMS is Focused on Progression to Alternative Payment Models

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# Maryland's Unique Approach



# Healthcare Landscape in Maryland

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- ▶ **Hospitals: Maryland starts new All-Payer Model January 2014**

- ▶ Moves from volume-based payment for hospitals to per capita measures, including quality requirements
- ▶ Stakeholder groups provide advice on implementation

- ▶ **Delivery System Organizing:**

- ▶ Mature medical home models in place for many privately covered persons
- ▶ Accountable Care Organizations (ACOs) in Maryland include more than one-third of Medicare beneficiaries
- ▶ Managed care organizations expanding efforts to address Medicare patients
- ▶ Hospitals and regional partnerships organizing around communities and geographic areas

# CY 2014 All-Payer Model Results

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## ***Good initial results but complex transformation ahead***

- ▶ All hospitals on global budgets, ~95% of revenues
- ▶ All Payer hospital revenue growth was contained to 1.47%, compared to the 3.58% per capita ceiling; Medicare hospital savings of \$116 million were achieved toward the \$330 million five year requirement
- ▶ Quality measures for hospital acquired conditions were achieved and readmissions were reduced
- ▶ Expansion of Medicaid and other ACA enrollees within limits

# CY 2015 All-Payer Model Results

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## CY 2015:

- ▶ Overall hospital volume growth limited (thru November)
- ▶ Per capita revenue growth within All Payer limit (thru November)
- ▶ Continued improvement in quality and readmissions measures—but more focus needed on broader outcomes

## Concerns—Pace of Reductions in Avoidable Utilization

- ▶ Pace of implementation rapid and timelines challenging
- ▶ Medicare utilization declining per capita, but we need to accelerate
- ▶ Some excess growth in Medicare costs outside of hospitals (thru July)
- ▶ Our stakeholders do not have non-hospital data

# Further Progress Dependent on Advancing Care Redesign

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- ▶ **System organization for Medicare beneficiaries is immature**
  - ▶ Commercial and Medicaid managed care enrollees have some supports through medical home/managed care models of payers
  - ▶ Historically there have been significant gaps in supports for complex and chronically ill fee-for-service (FFS) Medicare beneficiaries because these functions did not exist in the Medicare FFS program
- ▶ **Further progress for Medicare is dependent on advancing care redesign, alignment, and supporting infrastructure**
  - ▶ Planning efforts are underway for additional system transformation and infrastructure to support it

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# Stakeholder Inputs



# Stakeholder Input

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- ▶ In 2014, engaged broad set of stakeholders in HSCRC policy making and implementation of new model
  - ▶ Advisory Council, 4 workgroups and 6 subgroups
  - ▶ 100+ appointees
  - ▶ Consumers, Employers, Providers, Payers, Hospitals
- ▶ In 2015, the focus turned to work on clinical improvement, care coordination, integration planning, and infrastructure development
  - ▶ ICN-Care Coordination workgroup, Consumer task forces, and Alignment model planning

# Advisory Council Recommendations (January 2014)

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- ▶ Focus on meeting the early model requirements
- ▶ Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation
- ▶ HSCRC should play the roles of regulator, catalyst, and advocate
- ▶ Consumers should be involved in planning and implementation
- ▶ Physician and other provider alignment is essential
- ▶ An ongoing, transparent public engagement process is needed

# Workgroup Recommendations (2014)

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Workgroup	Charge	Recommendations
<b>Physician Alignment</b>	Recommend strategies for supporting and incentivizing physicians to coordinate and cooperate among themselves and other providers to deliver better health, better care and reduced cost to Maryland residents.	<i>Non-compensatory strategies:</i> <ul style="list-style-type: none"><li>• Shared infrastructure, analytics, and other resources</li><li>• Better health care quality and reporting</li><li>• Investment to improve ease of practice, such as care management support</li></ul> <i>Compensatory strategies:</i> <ul style="list-style-type: none"><li>• Pay-for-Performance</li><li>• Gain sharing</li><li>• Shared savings</li><li>• A continuum of case-based, episode-based, and population based models</li></ul>

# Workgroup Recommendations (2015)

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<b>Workgroup</b>	<b>Charge</b>	<b>Recommendations</b>
<b>Consumer Engagement</b>	Recommend principles and strategies that address key audiences and messages that will maximize Maryland's success in engaging consumers to achieve the goals of the All-Payer Model.	<ol style="list-style-type: none"><li>1. Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation.</li><li>2. Continue to give consumers a voice in the transformation of Maryland's health system.</li><li>3. Encourage local leaders to develop and join a dynamic Faith Community Health Network.</li><li>4. Collaborate to educate primary care providers on—and engage them in—health system transformation.</li><li>5. Maximize communications with consumers via traditional and new media.</li></ol>

# Multi-Agency and Stakeholder Group Completed Report and Recommendations on Care Coordination (2015)

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- ▶ Numerous care coordination initiatives underway in Maryland
- ▶ Smart public investments can support promising initiatives and bring them to scale
- ▶ Shared tools are needed to accomplish a three-step sequence to care coordination:
  - ▶ Effective risk stratification to identify people with complex medical and social needs
  - ▶ Health risk assessments to ascertain patients' needs
  - ▶ Patient-driven care profiles and plans addressing the medical and social needs of patients
- ▶ Care coordination will focus on accelerating initiatives for high-needs patients in the Medicare fee-for-service system – the highest cost / highest utilizers in Maryland
  - ▶ 2/3 of high utilizers and dollars are Medicare or Dual eligible beneficiaries
    - ▶ 40k high needs patients
    - ▶ 280k chronically ill Medicare patients with 4+ chronic conditions
- ▶ Partnerships are critical to effective care coordination. The challenge is to create opportunities to cooperate even while healthcare organizations compete in other ways
- ▶ Ultimately, goal is all-payer, all population care coordination with flexible approaches to operate within different payer and provider organizations while leveraging common IT to share structured care profiles and other information

# Workgroup Recommendations (2015)

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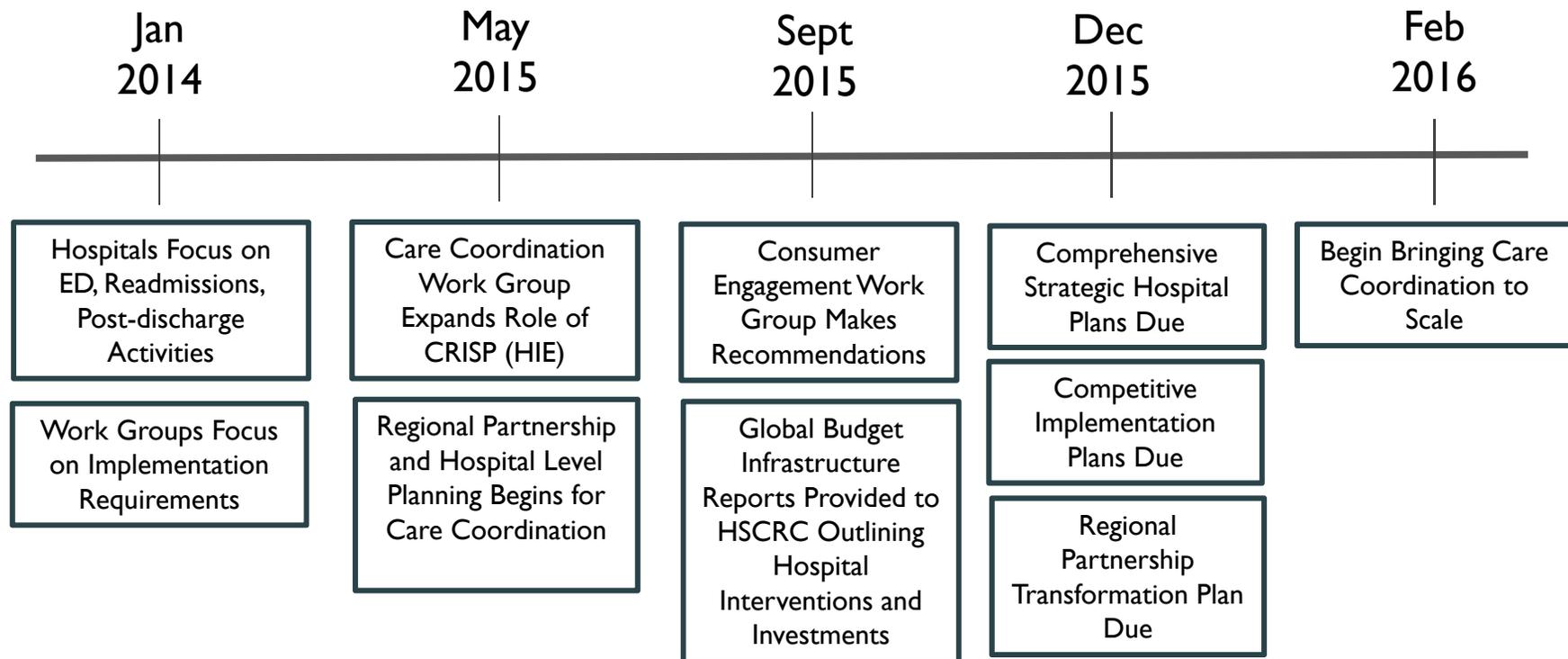
<b>Workgroup</b>	<b>Charge</b>	<b>Recommendations</b>
<b>Care Coordination</b>	Recommend care coordination strategies and priorities that are timely, scalable, reflect best practices, and ultimately applicable to all payers.	<ol style="list-style-type: none"><li>1. Build/secure a data infrastructure to facilitate identification of individuals who would benefit from care coordination.</li><li>2. Encourage patient-centered care.</li><li>3. Encourage patient engagement.</li><li>4. Encourage collaboration.</li><li>5. Connect providers.</li></ol> <p>The Work Group consensus was to begin with high-needs patients and those with multiple chronic conditions in the Medicare fee-for-service system and developing care interventions to reduce avoidable hospitalizations. Engaging and supporting community providers in accessing Medicare's Chronic Care Management Fee was supported as a needed step to accelerate chronic care improvement and to engage community providers.</p>

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# Transformation Plans and Investments



# Transformation Planning is Underway with a Focus on Complex High-Needs Individuals and Chronic Conditions



# Transformation Planning in 2015

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- ▶ Funding provided in rates for focus on reducing potentially avoidable utilization (PAU)
- ▶ Hospital and Partnerships reports
  - ▶ Hospital FY 2014 and FY 2015 reports for investments to reduce PAU
  - ▶ Eight regional partnership plans filed
  - ▶ System Transformation Plans filed by all hospitals
  - ▶ Twenty-two Implementation proposals filed
- ▶ HSCRC and other reviewers, including consultants, assessing reports and plans

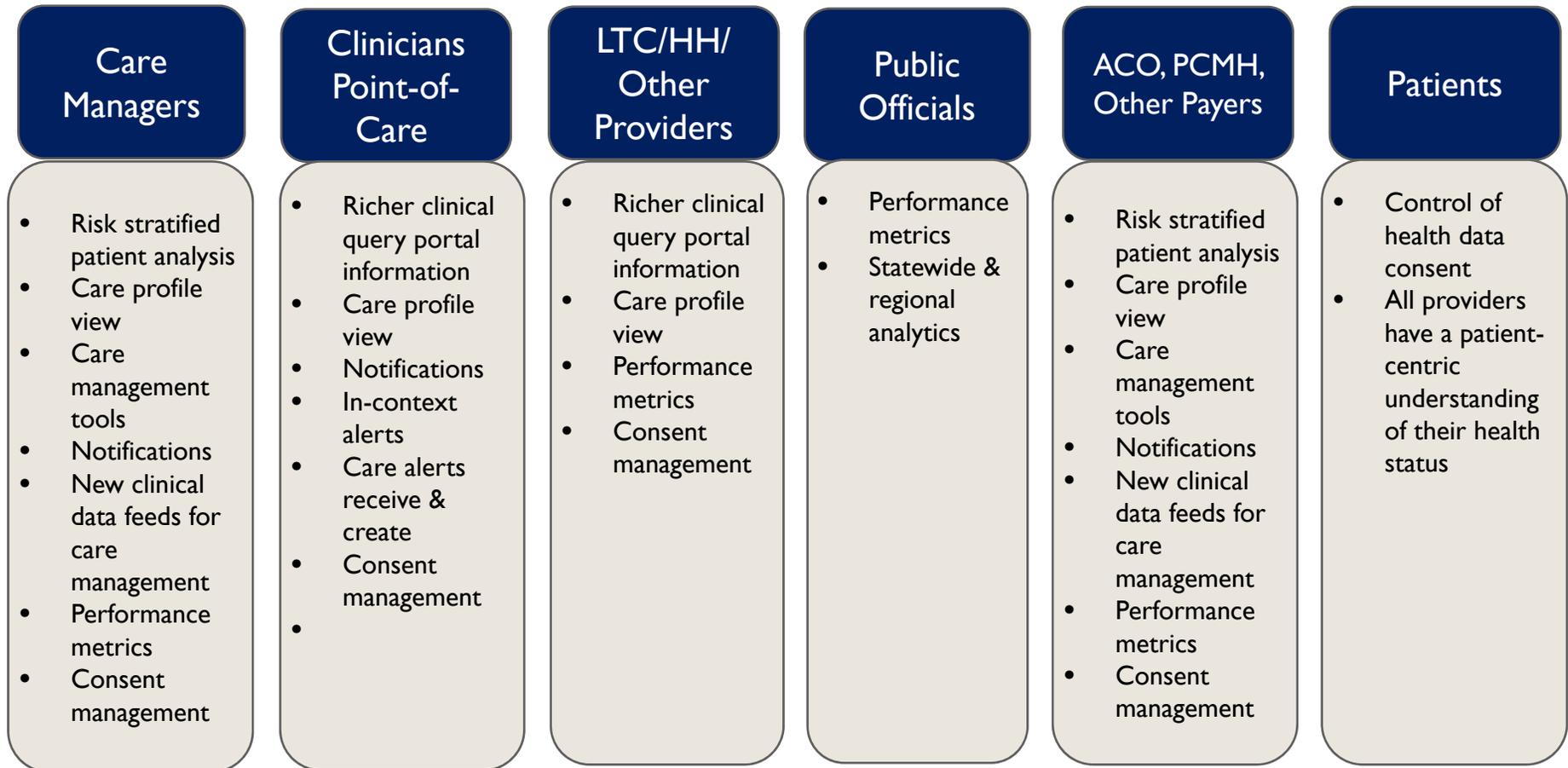
# Transformation Planning Focused on 9 Transformation Domains

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1. Clearly articulated goals, strategies, and outcomes that will be pursued and measured
2. Formal relationships through legal, policy, and governance structures to support delivery and financial objectives
3. Data and analytic resources
4. Risk stratification, health risk assessments, care profiles and care plans
5. Care coordination people, tools, processes, and technology
6. Alignment with physicians and other community-based providers
7. Organizational effectiveness tools
8. New care delivery models
9. A financial sustainability plan

# Statewide HIE Infrastructure (CRISP) to Support Care Redesign in Progress

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# Maryland Direction & Strategy



# Model Progression

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- ▶ The following pages, and the accompanying word document, present a collection of some of the guiding principles and model progression concepts that have been derived from multiple stakeholder interactions and will be used to help facilitate the discussion of the Advisory Council

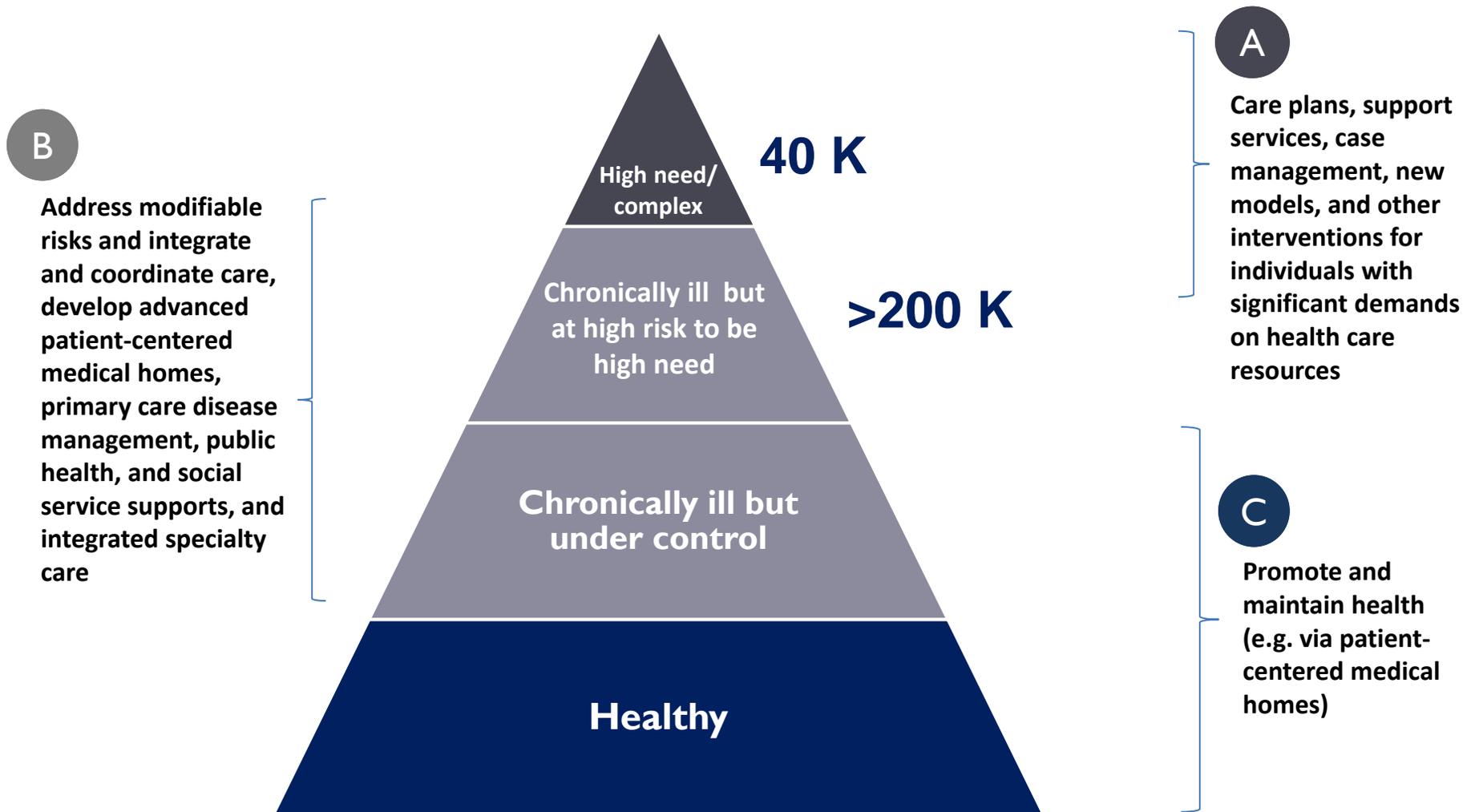
# Potential Principles to Guide Discussion on All-Payer Model Progression

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- ▶ The accompanying word document includes guiding principles

# Core Approach--Tailoring Care Delivery to Persons' Needs

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# Maryland's Potential Transformation Progression

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## 2014-2015 Model

Global Budgets--  
Hospital avoidable  
utilization and quality  
programs centered  
with hospitals

## 2015 Planning

Develop plans to  
include partnerships  
with other providers  
and community  
resources



## New 2016-2017 Model

Bring care coordination to  
scale for high needs  
complex and chronic  
patients, together with  
partners.

## 2016-2017 Planning

Develop plans for dual  
eligible, additional progress  
on medical homes, ACOs,  
and long term/ post-acute  
models.



## 2018-2019 Implementation

Implement plans  
for dual eligible,  
additional  
progress on  
medical home  
and long-term/  
post-acute  
models

Engage Consumers

# Progression of Focus

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- ▶ The most significant opportunities for progression towards the focus on system-wide costs and outcomes are:
  - ▶ Reduce avoidable hospitalizations and promote hospital operational efficiencies through care transformation
  - ▶ Reduce variations in post-acute care
  - ▶ Focus on dually eligible beneficiaries (Medicare & Medicaid eligible)—not under managed care in Maryland for Medicaid
- ▶ In the progression of Maryland's model, we should be sure to focus on these opportunities first

## Next Steps Needed for Maryland—Care Improvements that Reduce Avoidable Hospitalizations

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- ▶ **Fully implement care coordination to scale, first for complex and high needs patients**
  - ▶ Intense focus on Medicare and dual eligible, where supports are immature
- ▶ **Organize and engage consumers, primary care, long-term care, and other providers in care coordination and chronic care management**
  - ▶ Intense focus on Medicare, where models do not exist or are immature, in Maryland
  - ▶ Build on growing PCMH and ACO models, global budgets and geographic areas, and Medicare Chronic Care Management fees

# Next Steps Needed for Maryland's Transformation

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- ▶ Develop financial alignment programs between hospital and non-hospital providers, and get data and waivers needed for implementation
  - ▶ Ensure focus on qualified Alternative Payment Models for physicians and other providers to optimize payment levels under MACRA legislation
- ▶ Optimize acute/post-acute
- ▶ Engage other providers in the care continuum
- ▶ Develop plan for dually eligible beneficiaries in alignment with All-Payer Model evolution
- ▶ Support primary care and other providers in transformation

# Duals Care Delivery Strategy

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- ▶ Developing an improved care delivery system for dual eligibles is a top priority in Maryland
  - ▶ Alignment: Promote value-based payment
  - ▶ Care delivery: Increase integration and coordination
  - ▶ Health information technology: Support providers
- ▶ A diverse, representative workgroup has been formed, which will meet from February to June 2016
- ▶ The duals strategy will be aligned with broader statewide transformation efforts

# Foster Competing Approaches

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- ▶ Foster competing delivery system approaches for developing integrated care and implementing alternative payment models with increasing responsibility, including;
  - ▶ Hospitals on global budgets engaging in geographic efforts (with partners) for their communities and patients
  - ▶ ACOs, focused on attributed patients
  - ▶ Medical homes, focused on attributed patients
  - ▶ Utilizing Medicare's Chronic Care Management and non-visit fees to support expanding community based care to Medicare FFS patients
- ▶ Payers/purchasers/MCOs, focused on enrolled individuals, should be held accountable for enrolled individuals
- ▶ Approaches should rely on common goals, outcomes measures, and benchmarks to support transformation and ensure benefits for consumers

# To Keep the Momentum, Maryland Needs:

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- ▶ **A revision of the All-Payer Model to incorporate Care Redesign and extend timeline**
  - ▶ Capitalize on global budgets for hospitals to support care changes
  - ▶ Launch Care Redesign components in 2016
  - ▶ Extend timeline to keep critical commitment of “all in” and progression of redesign and alignment outside of hospitals
  - ▶ Incorporate dual eligible approach being developed by DHMH in alignment with the model
  - ▶ Provide MACRA support for physicians
  - ▶ Increase responsibility for system-wide costs and outcomes over an extended period of time, consistent with stakeholders’ ability to implement care redesign
  
- ▶ **Gain early approvals and data needed to support activities for:**
  - ▶ Physician and practitioner engagement
  - ▶ Care coordination
  - ▶ Post-acute/acute optimization
  - ▶ Understanding and evaluating system-wide costs of care

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# CMS Agreement

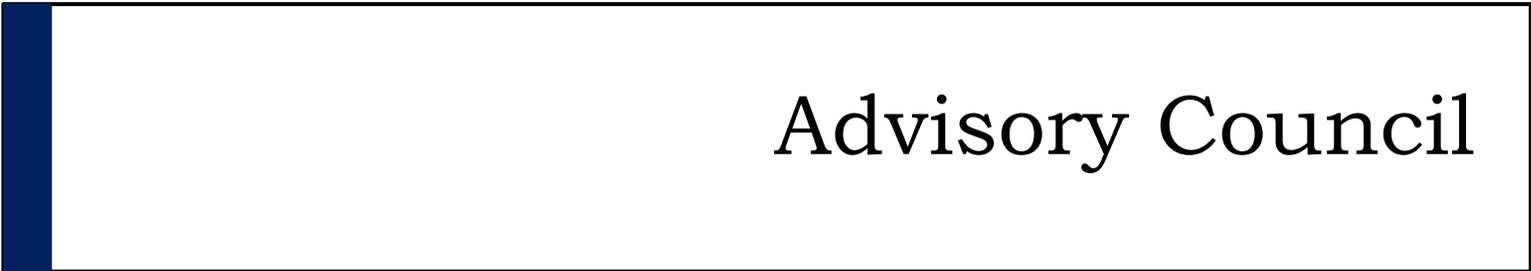


## Contract Term

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- ▶ “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”.

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# Advisory Council

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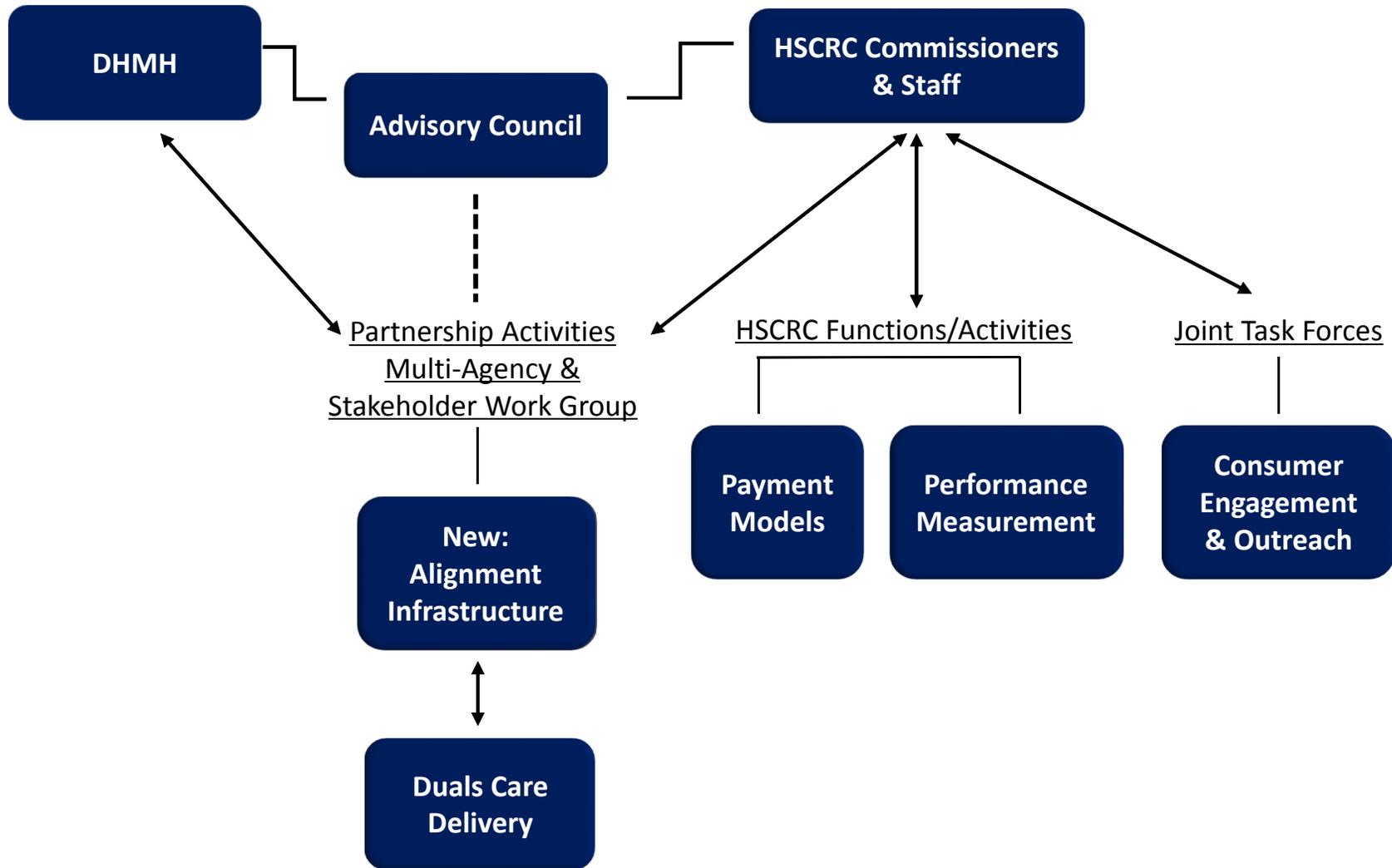
## Advisory Council Charge

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- ▶ **Charge:** The purpose of the Advisory Council is to provide the DHMH and HSCRC with senior-level stakeholder input on the long-term vision for Maryland's transformation efforts. Continuing successful implementation of a new payment model and meeting the terms of the CMS demonstration will require the input and support of hospitals, payers, providers and other stakeholders, including patients and families.
- ▶ **Proposed Framework:** Facilitate a forum for discussion and debate among stakeholders that can generate solutions and, when consensus is not possible, identify issues to be taken to the Staff, Secretary, and Commissioners for consideration and action.

# Stakeholder Input Structure

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# Proposed Timeframe

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- ▶ *Focus of February 2016:* Create guiding principles for discussions with CMMI
- ▶ *By the end of March 2016 :* Provide a preliminary report to the DHMH and the HSCRC. In this preliminary report, the Council will propose recommendations for the continuing success of the existing All-Payer Model and lay out the foundation and guiding principles of a long-term vision for Maryland's payment and delivery system transformation efforts. This draft report should update the DHMH and the HSCRC on the Advisory Council's progress and identify areas of consensus.
- ▶ *Throughout 2016:* The Council will continue to meet, as needed, to continue to evaluate developments regarding progress under the All-Payer Model.