



Maryland's All-Payer Model Progression

April 18, 2016

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

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

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**

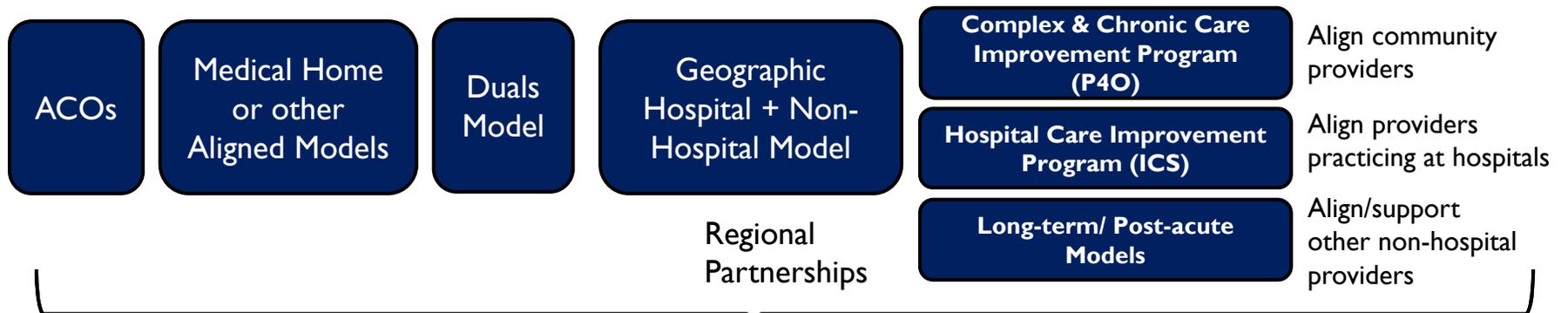
Current All-Payer Model Agreement Term

- ▶ “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

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

- **Who?** For providers practicing at hospitals
- **What?** Designed to reward improvements in hospital care that result in care improvements and efficiency

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

- **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

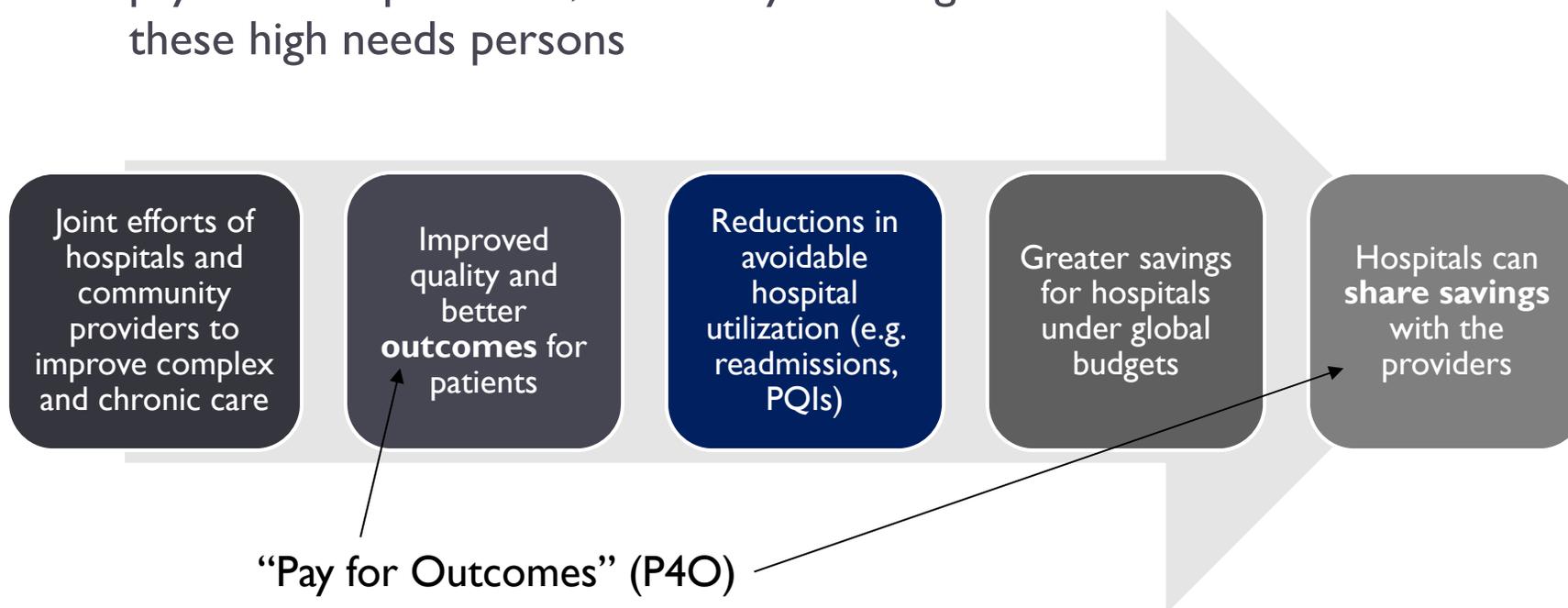


1. Hospital Care Improvement (“Gainsharing” or “Internal Cost Savings”) Program

- ▶ **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

Allocated Costs for Medicare Beneficiaries in Maryland

