Physician Alignment & Engagement Workgroup

April 10, 2014

Maryland Health Services Cost Review Commission

Recommendation to Commission

- Report due for June 11 Commission meeting (due date: May 30)

- Proposed report outline
  - Address Advisory Council recommendations
  - Background on models
  - Recommended Principles
  - Criteria for recommending options
  - Recommended role(s) for HSCRC
  - Most promising areas of opportunity and strategies
  - Implementation issues

- Workplan / Next Steps
  - Next meeting May 6th, so send draft report week in advance
  - Feedback / discussion welcome between today and May 6th
  - Report due May 30th, so will circulate draft final report based on May 6th discussion, and provide opportunity for comments before doing final report

Advisory Council
Guiding Principle Recommendations

1. Focus on meeting early Model requirements

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

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

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.

5. Physician and Other Provider Alignment is Essential

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

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

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

Key Questions for Workgroup

- What are the goals/principles for alignment and engagement efforts?
- What is allowable today, vs what changes in federal / state authority are needed
  - Based on payer (e.g., Medicare vs other) and model (e.g., gain sharing / bundling / shared savings vs P4P)?
- **What specific alignment strategies should we pursue, and how?**
- What are strategies HSCRC should pursue as a "catalyst" vs. "advocate" ?
- What strategies should be pursued collectively?
- Where is it appropriate to pursue common versus expect different approaches?

Principles for Discussion

- Use Alignment Models to facilitate ability to advance Triple Aim
- With all models, target areas where improved quality, reduced cost, and reduced health care disparity are aligned
- Focus on clinical areas with most opportunity (low hanging fruit)
- Focus on cross cutting approaches, such as patient centered, discharge planning, medication management, care transitions and coordination, patient / family engagement, and patient safety
- Prioritize efforts, while maintaining vision for population health approach:
  - Continuum of models possible, with goal to move towards population-based health
  - Collaborate to identify focused strategies that are able to be adopted quickly (models and payers)
  - Impactful (most likely to meet goals of all-payer and Medicare test), Scalable, and Sustainable
  - Scalable
  - Sustainable
- Tailored to meet specific role of physician, recognizing differences
- Leveraging current assets in health care system
- Encourage collaboration and shared infrastructure
- Transparency in model design and operations
- Non-financial (e.g., non-revenue) strategies can also encourage alignment (reporting, ease of practice, quality)

Continuum of Payment Models & Features

Continuum of Accountability →

	Case-Based	Episode-Based	Population-Based
Payment Models	Gain Sharing	Bundling	Shared Savings / P4P
Examples	AMS / Gain Sharing ARMs	BPCI (outside MD) ARMs	ACOs, WMHS / P4P, Health Plans
Example Clinical Opportunities	Cardiology Cardiac Surgery Orthopedic Surgery Vascular Surgery All	Cardiology Cardiac Surgery Orthopedic Surgery Vascular Surgery Other Medicals Conditions Other Surgical procedures	CHF COPD Diabetes ESRD MH / SA Frail, Isolated, 5+ Chronic Conditions All
Example tactics	Supply costs Weekend productivity HACs	Care transitions / Post Acute / SNF Post discharge medication reconciliation Patient / Family Education Readmissions	Predictive modeling Health risk assessments Beneficiary / Caregiver education Prevention Community-based services High Risk DM / Care Management (Diabetes, CHF, COPD, ESRD) Medication management Reduce ER Admissions Palliative Care / Medicare Care Choices

Preliminary thoughts re Recommendations

- Non-Medicare has less barriers, so could start sooner; Medicare has more need / opportunity
- Facilitate consistency across payers where possible to have consistent incentives
- Medicare will need multiple models
  - Case-based / gain sharing, episode-based / bundled payments, and population-based / shared savings, Medicare Advantage, Medicare Choices
- With Medicare, case-based / gain sharing (AMS model) may be fastest, since authority exists
  - Should consider a state-wide approach, to reduce costs, create consistency, improve speed, facilitate best practices (e.g., one convener / program manager)
  - Allow for hospital flexibility (e.g. different clinical priorities)
- Recommend moving quickly to gain any necessary CMS approval(s), initiate simultaneously, but attempt staggered approvals based on what will take the least time to get
  - Should consider if can use Medicare Shared Savings Waiver rules (such as via reference to CMMI Demos) to most flexibly allow multiple and varied approaches, including gain sharing, bundled payments, shared savings, and P4P
  - Initiate discussions with CMMI using this approach, as we are essentially a state-wide ACO (or Medicare Advantage Plan), and the program goals of the Maryland Global Budget system are entirely consistent with the ACO goals and Shared Savings Waiver logic
- HSCRC to serve as Catalyst for considering Care Management components, and extent to which pieces may be done state-wide, regionally, or locally
- Relationship to other workgroups (initial thoughts / continue to monitor)
  - Payments: Consistency with Global payment models - Level of savings needed in order to share savings
  - Data and Infrastructure: Infrastructure needed to manage alignment models, Care Management infrastructure (Predictive modeling, Health Risk Assessments, Call Centers, Community Services, etc.)
  - Performance Measurement: Alignment with performance measures