The Total Cost of Care Model and Opportunities for Alignment
Background: HSCRC

- Created in 1970s
- Independent state agency that works closely with Maryland Department of Health (MDH)
- 7 Commissioners, including a Chair and Vice Chair
  - Day jobs of commissioners have included hospital executives, physicians, executives of long-term care facilities, and health policy consultants, experts, and economists
  - Budget of $14.1 million in FY18
    - 100% from assessments
- 40 full-time staff plus analytic support from contractors and Maryland’s HIE, CRISP
Background: Maryland’s All-Payer Model

- Since 1977, Maryland has had an all-payer hospital rate-setting system
- In 2014, Maryland updated its approach through the All-Payer Model
  - 5-year state innovation between Maryland & federal government (2014 through 2018) focused on hospital payment transformation
  - Per capita, value-based payment framework for hospitals
  - Provider-led efforts to reduce avoidable use and improve quality and coordination
  - Savings to Medicare without cost shifting
  - Sustains rural health care with stable revenue base

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Payment Method</th>
<th>Quality Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970s</td>
<td>Unit Rates</td>
<td>• Efficient Units</td>
</tr>
<tr>
<td>1980-2010</td>
<td>Charge Per Case</td>
<td>• Efficient cases</td>
</tr>
<tr>
<td>2010-2018</td>
<td>Global/Episodes</td>
<td>• Population health • Efficient episodes</td>
</tr>
<tr>
<td>2019+</td>
<td>Global/Total Cost of Care</td>
<td>• System-wide alignment • Person-centered</td>
</tr>
</tbody>
</table>
Value of the All-Payer System

- Cost containment for the public
- Equitable funding of uncompensated care
- Stable and predictable payment system for hospitals
- All payers fund Graduate Medical Education
- Transparency
- Leader in linking quality and payment
- Local access to regulators
- Avoids cost shifting across payers
- Leverages increased federal payments
In Maryland, hospitals are paid using a common rate structure for all payers distributing costs equitably, for example:
- Uncompensated Care
- Physician/other education costs

The Model is tackling total costs using value-based approaches and care redesign on an all-payer basis.

With payer mix changes, Maryland hospitals are less susceptible to margin deterioration.

Not dependent on volume growth.

Source: American Hospital Association (1) and (2). Includes Disproportionate Share Hospital (DSH) payments.
### All-Payer Model: Performance to Date

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Targets</th>
<th>2014-2017 Results</th>
<th>On Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Payer Hospital Revenue Growth</td>
<td><strong>≤ 3.58% per capita annually</strong></td>
<td>2.03% average growth per capita</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Savings in Hospital Expenditures</td>
<td><strong>≥ $330M cumulative over 5 years</strong> (Lower than national average growth rate from 2013 base year)</td>
<td>$916M cumulative (5.63% below national average growth)</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare Savings in Total Cost of Care</td>
<td>Lower than the national average growth rate for total cost of care from 2013 base year</td>
<td>$599M cumulative (1.36% below national average growth)</td>
<td>✓</td>
</tr>
<tr>
<td>All-Payer Quality Improvement Reductions in PPCs under MHAC Program</td>
<td><strong>30% reduction over 5 years</strong></td>
<td>53% Reduction since 2013</td>
<td>✓</td>
</tr>
<tr>
<td>Readmissions Reductions for Medicare</td>
<td><strong>≤ National average over 5 years</strong></td>
<td>Below national average at the end of the fourth year</td>
<td>✓</td>
</tr>
<tr>
<td>Hospital Revenue to Global or Population-Based</td>
<td><strong>≥ 80% by year 5</strong></td>
<td>100%</td>
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Medicare Test: At or below National Medicare Readmission Rate by end of CY 2018

Maryland reduced readmissions more rapidly than the nation, CY2011-2017
Maryland Experience Moving to Value-Based Payments

Medicare Compounded Growth
Since CY 2013 through March 2018

- More inpatient reductions and less growth in lower acuity outpatient services

<table>
<thead>
<tr>
<th>All Hospital Payments</th>
<th>Inpatient</th>
<th>Outpatient</th>
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<tr>
<td></td>
<td>-1.8%</td>
<td>16.2%</td>
</tr>
<tr>
<td></td>
<td>3.6%</td>
<td>9.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31.7%</td>
</tr>
<tr>
<td>Maryland</td>
<td>0.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>National</td>
<td>-5.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td></td>
<td>5.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td></td>
<td>10.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td></td>
<td>15.0%</td>
<td>35.0%</td>
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Performance of the Current Model is Indicative of where Maryland’s Care Transformation will Continue

- Hospital savings have outpaced total cost of care savings
  - Partially due to hospital global budgets incentivizing shifts to outpatient settings
  - Another part due to the Model incentivizing more preventive care and appropriate settings
  - Overall, Maryland has more improvement opportunities and needs to align incentives system-wide, to continue cost growth containment and quality improvement

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<tr>
<td>All-Payer Emergency Room Reductions in Payer Hospitals</td>
<td>10% reduction over 5 years</td>
<td>53% Reduction since 2013</td>
<td>✓</td>
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<td>100%</td>
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Medicare Hospital Savings
$916M cumulative
(5.63% below national average growth)

Medicare Total Expenditure Savings
$599M cumulative
(1.36% below national average growth)
The Maryland Model Progression: Increasing Accountability and System-wide Transformation

- **Goals of the TCOC Model**
  - Modernize to person-centered care
  - Drive total cost of care savings through improved care delivery
  - Improve the health of the population

![Bar Chart]

Maryland’s Person-Centered Strategy for 800k+ Medicare FFS beneficiaries

- Did NOT use hospital during year: 19%
- Used hospital during year: 81%
- Did NOT use hospital during year: 35%
- Used hospital during year: 65%

Source: Draft HSCRC analysis based on CY 2016 Medicare (CCW) data
Core Approach—Person-Centered Care Tailored Based on Needs

A
Interventions for individuals with significant demands on health care resources

B
Address modifiable risks and integrate and coordinate care, develop primary care disease management

C
Promote and maintain health

Healthy

Chronically ill but under control

Chronically ill but at high risk to be high need

High need/complex
The Change

Current system (Expires 12/31/18)

- Hospital focus
- Hospital savings
- Hospital quality metrics
- Acceleration of prevention/chronic care management
- Hospital alignment

Total Cost of Care System (Begins 1/1/19)

- System-wide focus
- Total cost of care savings
- Hospital quality and population health metrics
- Maryland Primary Care Program (MDPCP) and other care transformation tools
- Provider alignment via MACRA-eligible programs & post-acute programs
Total Cost of Care (TCOC) Model Overview

- New Contract will be a 10-year agreement (2019-2028) between MD and CMS
  - Five years (2019-2023) to build up to required Medicare savings and five years (2024-2028) to maintain Medicare savings and quality improvements

- Total Cost of Care (TCOC) Medicare Savings building to $300 million annually by 2023

- Continue to limit growth in all-payer hospital revenue per capita at 3.58% annually

- Designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes and constrain the growth of costs
  - Aligns hospitals, physicians, long term care, skilled nursing facilities and other health care providers
  - Focuses on managing and preventing chronic and complex conditions
  - Enhances primary care delivery

- Expand value based payment programs to include population health outcomes via outcomes based credits
By the end of 2023, achieve $300 million in annual savings to Medicare Parts A and B (~4%), through slower TCOC spending growth per beneficiary

- In 2017, annual TCOC savings to Medicare were $138 million
- Beyond 2017, the improvement necessary is $162 million, or approximately 1% of total hospital revenues

- No cumulative liability or credit
- Missed performance does not need to be paid back
- The State has to catch up to the next savings target

### Annual Medicare TCOC Savings Targets (relative to 2013 base)

<table>
<thead>
<tr>
<th>Year</th>
<th>PY</th>
<th>Annual Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>1</td>
<td>$120 million</td>
</tr>
<tr>
<td>2020</td>
<td>2</td>
<td>$156 million</td>
</tr>
<tr>
<td>2021</td>
<td>3</td>
<td>$222 million</td>
</tr>
<tr>
<td>2022</td>
<td>4</td>
<td>$267 million</td>
</tr>
<tr>
<td>2023</td>
<td>5</td>
<td>$300 million</td>
</tr>
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</table>
Total Cost of Care Model Components

- Expands **Care Redesign Programs** to enable private sector led programs supported by State flexibility; opportunity for **New Model Program** development in the future.
  - ‘MACRA-tize’ the model and expand incentives for hospitals to work with others

- Continues **Hospital per Capita Budgets**, while expanding incentives to control total costs
  - Expand responsibility for total costs through gradual revenue at risk under **Medicare Performance Adjustment**

- Initiates the **Maryland Primary Care Program** to enhance chronic care and health management

- Develops **Population Health** improvement programs for chronic conditions, opioid deaths and senior health quality of life
Succeeding Under the TCOC Model – Aim High

1. Establish Meaningful Partnerships

2. Deliver High-Value Care

3. Improve Health
   - Population health initiatives to improve diabetes, reduce opioid overdoses and improved chronic disease management

4. Center the System
   - Patient-centered focus, community-based primary care, access to mental health services

5. Get Connected
   - Enhance data sharing and analytics to optimize care and improve coordination
Care Redesign Programs – Aligning hospitals and non-hospital providers

- Opportunity to innovate new tracks the system needs and achieve savings
- Allows hospitals to further align with care partners
- Voluntary programs allow hospitals to obtain data, share resources with providers, and offer optional incentive payments
- Advanced Alternative Payment Model qualification (MACRA)
- Maryland can add/delete/modify programs on an annual basis, without requesting the approval of a new model or model amendments

<table>
<thead>
<tr>
<th>Hospital Care Improvement Program (HCIP)</th>
<th>Complex and Chronic Care Improvement Program (CCIP)</th>
<th>Episode Care Improvement Program (ECIP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 Participants</td>
<td>9 Participants</td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong>: Facilitate improvements in hospital care that result in care improvements and efficiency</td>
<td><strong>Goal</strong>: Enhance care management and care coordination</td>
<td><strong>Goal</strong>: Facilitate care improvements for episodes across all care settings, with a focus on post-acute opportunities</td>
</tr>
</tbody>
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Medicare Performance Adjustment (MPA)

- A scaled adjustment (positive or negative) to each hospital’s federal Medicare payments based on its performance relative to a Medicare per capita Total Cost of Care (TCOC) benchmark.
- Further increases accountability for care, outcomes, total costs and population health
- All Medicare beneficiaries are attributed to hospitals, primarily through physician relationships
- Flexibility to use as a Care Redesign tool
- Medicare Revenue at Risk begins at 0.5% for 2018 and increases to 1% for 2019
Quality Programs

- Quality targets that are aggressive and progressive, but developed jointly between the State and stakeholders
  - Requirement to maintain more aggregate revenue at risk than national Value-based Purchasing (VBP) program
  - Potential switch from MHAC to national HAC programs to allow for alignment
  - Incorporate population health measures into reporting and savings calculations

- The State will develop Bold Improvement Goals jointly between the State and stakeholders

- Population health programs will be added

- Current quality programs that will be continued, refined and built upon include:

  - **Quality Based Reimbursement (QBR)**
    - Similar to National value-based purchasing

  - **Potentially Avoidable Utilization (PAU) Savings**
    - Prevention quality indicators and 30 readmissions
    - Removes utilization from hospital budgets
    - Similar to National value-based purchasing program

  - **Readmission Reduction Incentive Program (RRIP)**
    - Penalizes readmissions across all payers
    - Reduce and maintain Medicare readmission rate below national rate

  - **Maryland Hospital Acquired Conditions (MHAC)**
    - Incentivizes reducing potentially preventable complications
The Maryland Primary Care Program

- Beginning January 1, 2019 Maryland will move Medicare FFS beneficiaries into care management over 6 years
- Strengthens and transforms primary care delivery by introducing care management and coordination supports such as:
  - Telemedicine, mental health and substance abuse counseling, care management, and other patient supports
  - Development of Care Transformation Organizations to support small and independent practices, unique to Maryland
- Financial alignment with national programs and TCOC APM Incentives
  - Care management fees will provide resources for chronic care improvement
  - Performance based incentive payments reward quality care
  - Aligns Maryland providers with national MACRA incentives
- Aligns primary care physicians with TCOC APM goals
  - Move primary care from volume to value
  - Increase health equity and reduced disparities
  - Improve health status and lower costs
Outcomes-Based Credits for Population Health Improvement

- The State of Maryland and providers will jointly focus on health improvement initiatives.
- Improved population health may offset the cost of primary care investments.

- Improve Behavioral Health
  - Reduce deaths from opioid use

- Improve Chronic Condition Prevention
  - Diabetes initiatives
  - Obesity, hypertension, hepatitis C and smoking

- Senior Health and Quality of Life
  - Fall related death prevention
The TCOC Model will further leverage the statewide health information exchange (HIE) infrastructure, to optimize processes, achieve the goals of the TCOC Model and improve care.

HIE reporting services to better inform patient care and population management at the point of care.

Data sharing available to providers engaged in Model Programs.

Available Analytic and Care Coordination Tools:
- Medicare data analytics
- Clinical query portal
- Emergency notification services (ENS) for providers
- Prescription Drug Monitoring Program (PDMP)
- Ambulatory integration
- Meaningful Use resources
- CQM Aligned Population Health Reporting (CAliPHR)