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

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January 31, 2014

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Introduction and Statement of Purpose

The State of Maryland is leading a potentially transformative effort to lower health care spending in the State while at the same time improving access to care and quality of care. Stated in terms of the "Three Part Aim," the goal is a health care system that enhances patient care, improves health outcomes, 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 innovation 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 is anticipated to approve Maryland's new Model Design application and implementation begins in January 2014.

The Maryland 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 solutions 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, the Council has held four public meetings and taken suggestions from members of the public attending these meetings, including consumer advocacy groups.

Building on the Commission's existing authority to regulate and set hospital rates across all payers including Medicare, the State is preparing to tie system-wide hospital inpatient and outpatient payment to economic growth. Effectively, the State is instituting a plan to shift from payment based on inpatient hospital cost per admission to total hospital cost per capita. The ultimate goal is to tie total health care

spending per capita to the per capita growth of the state's economy. New health care delivery and payment models will be aligned with numerous existing initiatives to help meet the goals.

Maryland has committed to hitting the following targets:

- Medicare per capita 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. According to the Model Design Proposal, cumulative savings will accrue over the life of the model at the following amounts: $49.5M by the end of 2015, $132M by the end of 2016, $247.5M by the end of 2017 and $330M by the end of 2018.
- Annual all-payer per capita total hospital cost 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. In other words, total hospital spending per person should grow at no greater pace than the state's economy.
- Hospital revenues will shift into global payment models over the five-year life of the model, with 50% of revenue in global models by the end of year two, 60% by the end of year three, 70% by the end of year four, and 80% by the end of year five (2018).
- Phase 1 will cover five years (2014-2018) and focus on controlling hospital inpatient and outpatient spending. A proposal for Phase 2 is scheduled to be submitted to the federal government at the end of 2016 and focus on controlling the growth in total health spending. If approved, Phase 2 would begin in 2019.
- The aggregate Medicare 30-day unadjusted all-cause, all-site readmissions 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.

Hitting the targets in the early years of the Model will be very important. This will be necessary to ensure the federal government's continued participation in the new all-payer model. The key challenge is that many of the reforms called for in the new all-payer model represent major shifts in the delivery and payment systems in health care. These shifts are difficult to accomplish in a short time frame, as they require both considerable infrastructure and frequently also new mindsets and new practice

patterns. This will require significant cooperation among various state agencies, the state legislature, hospitals, physicians, business and labor, and organizations representing consumers and patients.

Success in meeting targets will require major improvements in both health care delivery and payment systems. The former will involve a focus on high-needs patients, care coordination and integration, evidence-based medical practices, an emphasis on primary care and prevention, and the effective sharing of electronic information across providers and with patients. The latter will require moving away from fee-for-service payments toward payment models that reward better patient outcomes, quality of care improvements, and overall cost containment.

The Advisory Council recognizes that the HSCRC cannot ensure success of the model on its own. The role of HSCRC should be that of both a regulator and a catalyst for needed reforms. In its regulatory role, within the boundaries of its mandate, the HSCRC plays a key role in payment reforms. To foster needed delivery system innovations, and increased data exchange, the HSCRC should act as a catalyst for change by advocating with CMS and collaborating with other State stakeholders to promote integrated care models, facilitate data sharing, and provide full transparency.

This report provides the Advisory Council's recommendations to the HSCRC for the implementation of the new model. The recommendations include suggestions on the phasing of implementation priorities and issues that should be further considered by ongoing workgroups under the direction the HSCRC.

Advisory Council Recommendations

Focus on meeting the early Model requirements

1. **The Advisory Council recommends that the HSCRC prioritize implementation activities that contribute to meeting the Medicare savings and All Payer targets for the first two years of the proposed model.** This means emphasizing effectively enforced revenue targets, new payment models, and most importantly, reducing avoidable hospital use. Longer-term savings will emerge from addressing the public health, social, and economic forces that drive people into the health

care system in the first place. This involves addressing the "social determinants of health," including achieving reductions in tobacco use and the incidence of obesity; smarter urban and transportation planning; reducing poverty and homelessness; and reducing air and water pollution.[1] Longer-term health improvement can also result from achieving a health care work force that meets the needs of an aging population and vulnerable populations. The leaders of five new Health Enterprise Zones in underserved areas are working on these problems as well as other initiatives underway in Maryland.

2. **Hospital Global Payment Models are the best strategy for the first phase of implementation.** The HSCRC anticipates that most hospitals will be operating under global payment models by early 2014. 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. In the long-run, these models will need to evolve to ensure that the revenue in the system follows the patients.

3. **The pace of change should be sufficient to meet model performance targets, but also recognize the readiness of industry infrastructure to support the success of the Model.** The HSCRC should consider the variability in readiness among hospital systems and provider communities as it plans for the phased implementation of model components.

Consumer involvement in planning and implementation

4. **The HSCRC should actively engage consumers and their representatives to participate in implementation activities**. Achieving the goals of the Three Part Aim will require the active

[1] Richard Wilkinson and Michael Marmot. "Social Determinants of Health: the Solid Facts." 2nd Edition. International Center for Health and Society.
http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf

engagement and support from consumers. Consumers or consumer 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. The Council believes that better quality, more efficiency, and enhanced affordability can be achieved simultaneously.

Focused attention on high-need and high-resource patients and care improvements that can reduce avoidable utilization

5. **HSCRC should work with stakeholders on developing a comprehensive set of measures for volume of services that could be avoided with benefit to patients and health care costs.** The HSCRC should work with the stakeholders to identify categories of patients with the most complex medical needs who are often frequent users of the health care system and can benefit from care coordination (identification and planning of care). Additional measures might include hospital acquired conditions (safety issues), readmissions and re-hospitalizations (care planning and coordination), and ambulatory-care sensitive conditions (effective community care). The HSCRC should work with the stakeholders to identify and secure data that can be helpful in targeting the efforts needed. 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 management interventions to be cost-effective, they need to be targeted carefully to patients who could really benefit.
6. **The HSCRC and other State agencies could help facilitate discussions around use and standardization of care management initiatives with proven success.** Both public and private payers as well as providers would benefit from obtaining objective and evidence-based

information on promising care management initiatives. Multi-disciplinary teams including physicians, nurses, nurse practitioners, and people 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 management can help avoid ambulatory-sensitive use of emergency departments, inpatient admissions, and hospital outpatient care. These initiatives should be undertaken in collaboration with other state initiatives including the State Innovation Model process, and recognize private sector innovations that address avoidable utilization. Promising models include 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 can play a very useful role here in helping to gather leaders and data to facilitate discussions about promising strategies and practices. A special and 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 with one and frequently multiple chronic illnesses whose care is not well managed; coordinating the work of the various physicians that treat them; managing their medications; improving discharge planning following hospital stays; and conducting home visits and other interventions to assure that people who leave a hospital are alerted to danger signals and stay in touch with their medical team.

Delivery system redesign should feature "moving care upstream" to emphasize community-based and clinical prevention and primary care that is comprehensive and patient-centered. Maryland is focusing on improving community health through strengthening primary care under its State Innovation Model grant. Should this model move forward, it could serve as an important care coordination resource, particularly for Medicare?

HSCRC could play a helpful role by assembling 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.

Physician and Other Provider Alignment

7. **Physician engagement and alignment must be strong enough and occur early to support the goals of population-based and patient centered models**. 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 and availability determine a large proportion of the utilization across these settings. 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 keep more people from needing hospital care.

   Further, physicians must be made fully aware of the basis for their rewards. 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, including diagnostic centers, outpatient surgery centers, pharmacies, and labs.

8. **The HSCRC should charge a workgroup to develop specific recommendations on strategies that align incentives among hospitals, physicians and other providers**. The workgroup should identify alignment approaches that are allowable within current federal requirements and develop the structure and parameters for applications to CMS to allow gain sharing, changes in the 3-day rule or other payment modifications. The 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.

A Supportive and Balanced Regulatory Approach

9. **HSCRC should set broad targets and goals, allowing considerable flexibility for the health care sector to devise its own strategies for achieving the desired results.** 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, and encourage the industry to develop innovative approaches for meeting those goals.

   Regulatory policies should 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.

Building the Infrastructure to Support the Model

9. **The State will need the infrastructure and the data to support the Model.** 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. HSCRC, in cooperation with the Maryland Health Care Commission, should collect, analyze, and summarize data for both hospitals and non-hospital spending, and also collect and analyze data on out-of-state spending by Maryland residents, and in-state spending by non-Maryland residents.

While data on individual hospital performance is necessary, an important goal is to move toward population-based performance metrics wherever feasible. This can involve 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.

This will require collaboration between state government and private sector leaders to organize and synthesize data from several sources into a coherent repository of timely information that is readily understandable and accessible.