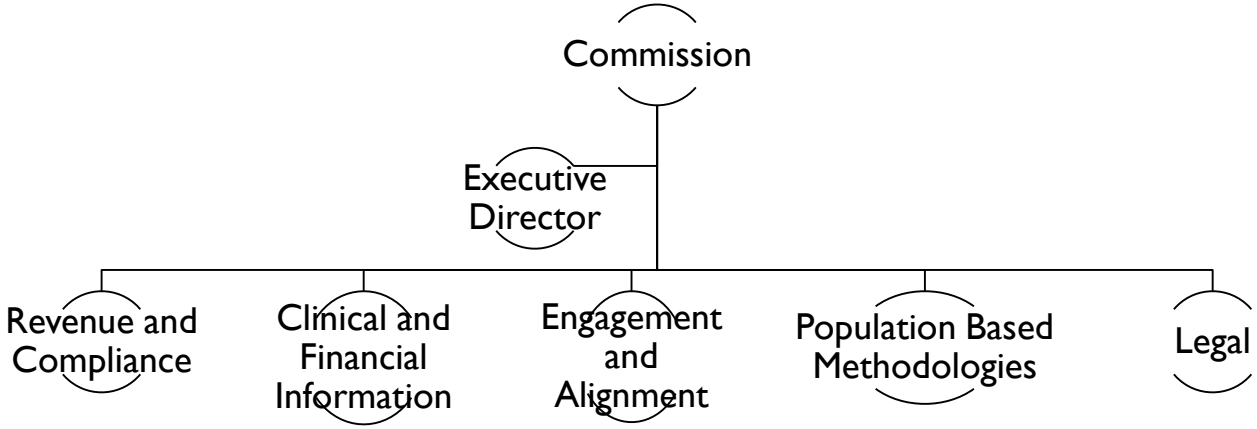
The Total Cost of Care Model and Opportunities for Alignment

HSCRC

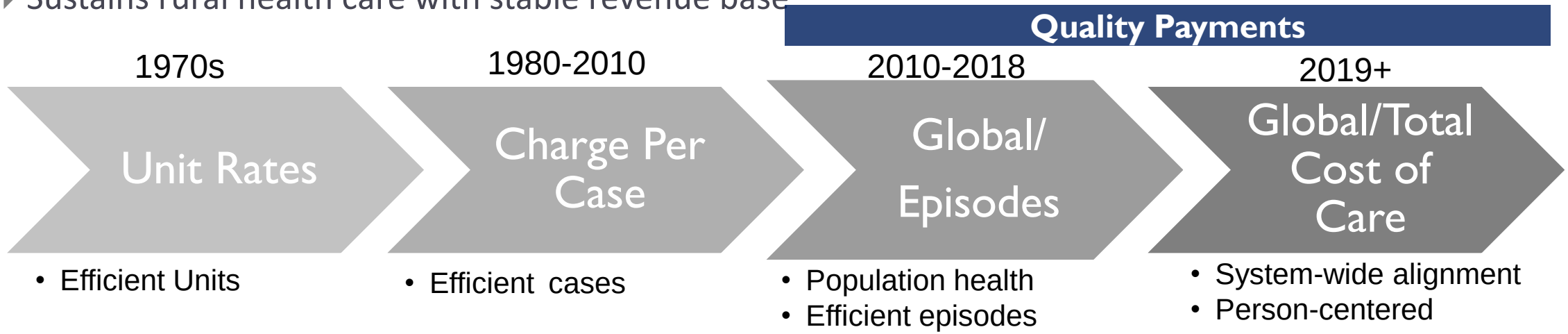
Background: HSCRC

- 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



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

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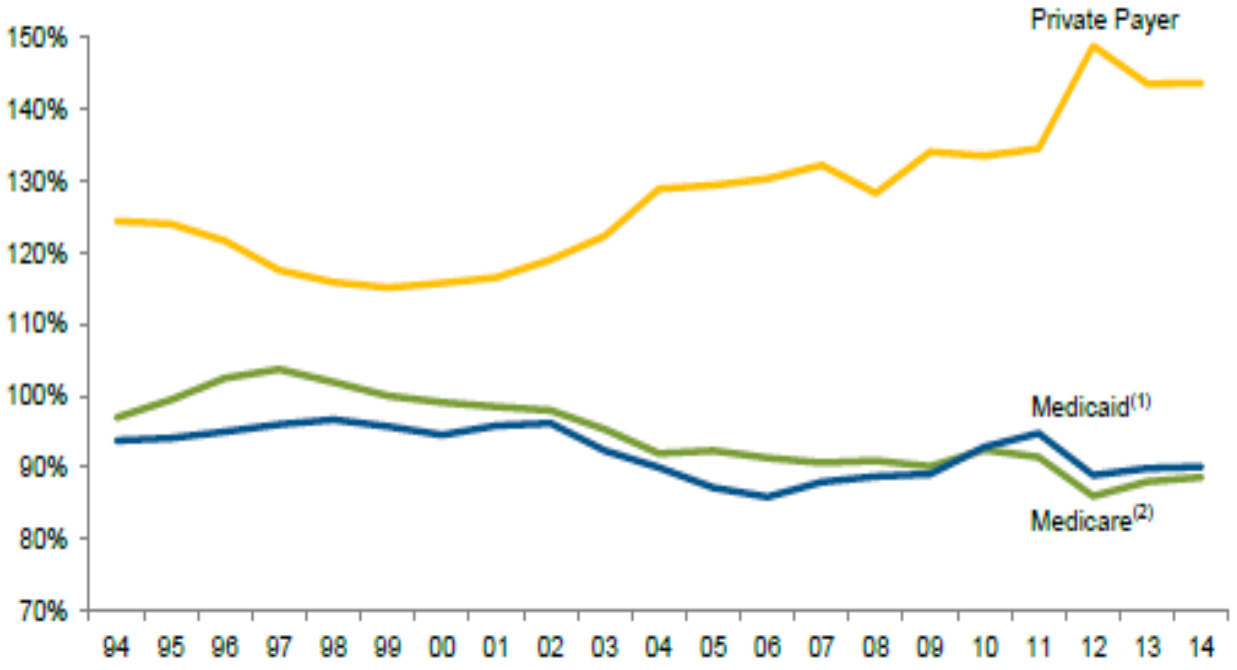
Nationally, Cost-Shifting Occurs Between Private and Public Payers

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1994 – 2014



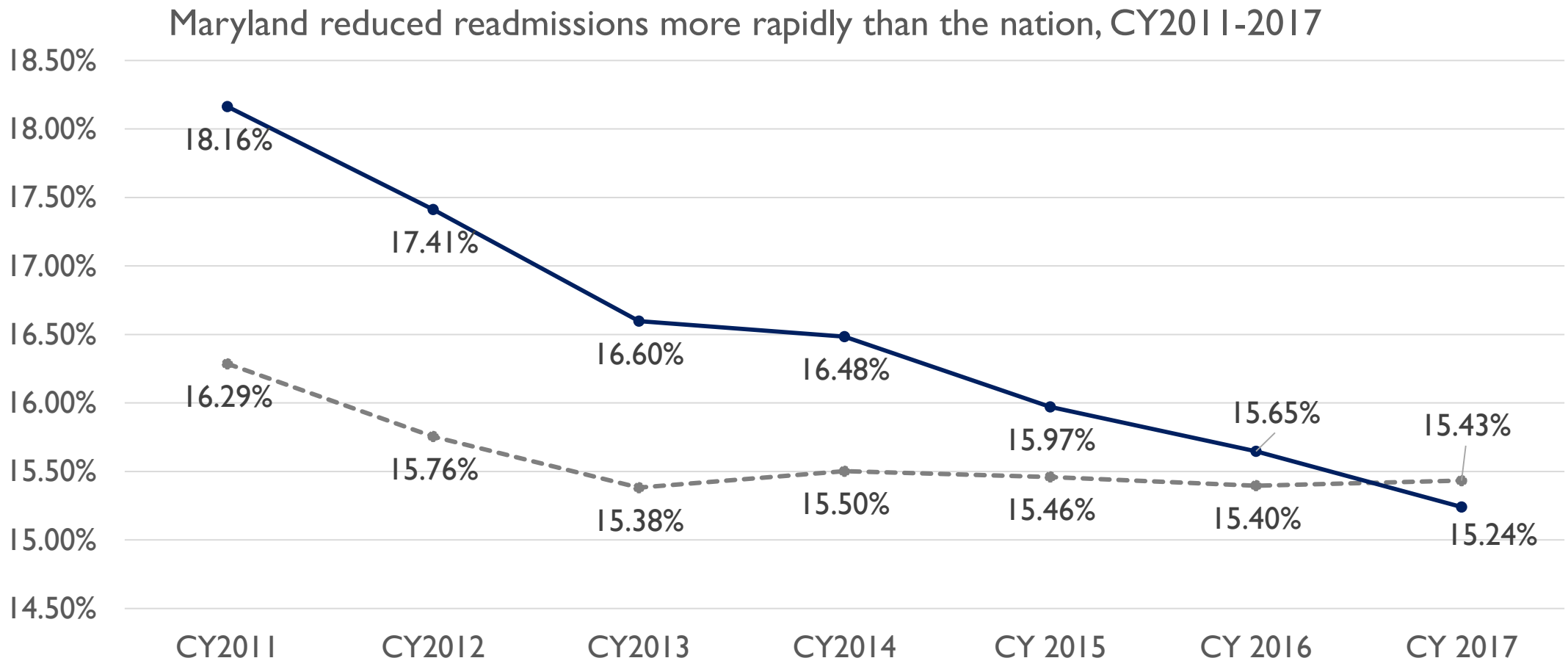
Source: American Hospital Association
(1) and (2). Includes Disproportionate Share Hospital (DSH) payments.

- 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

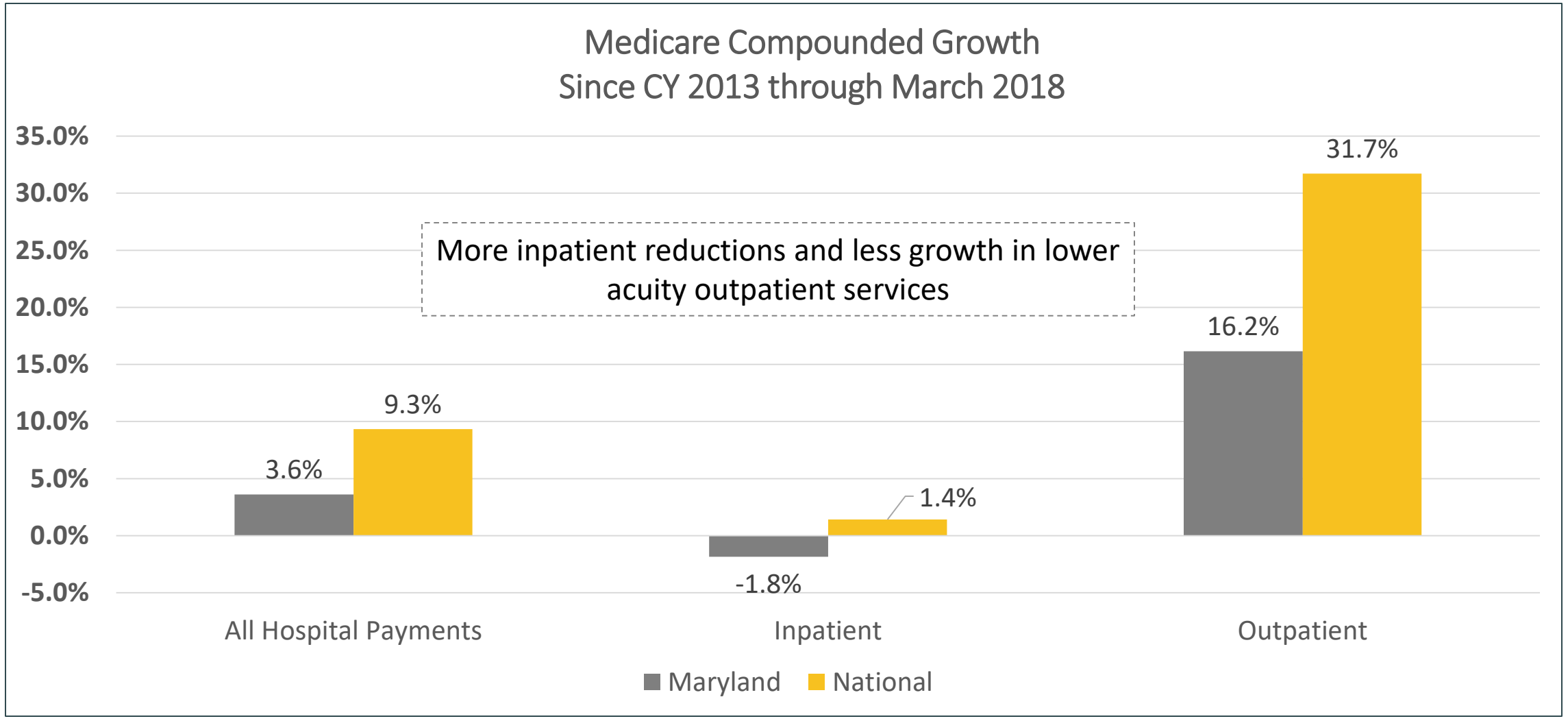
All-Payer Model: Performance to Date

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

Medicare Test: At or below National Medicare Readmission Rate by end of CY 2018



Maryland Experience Moving to Value-Based Payments



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

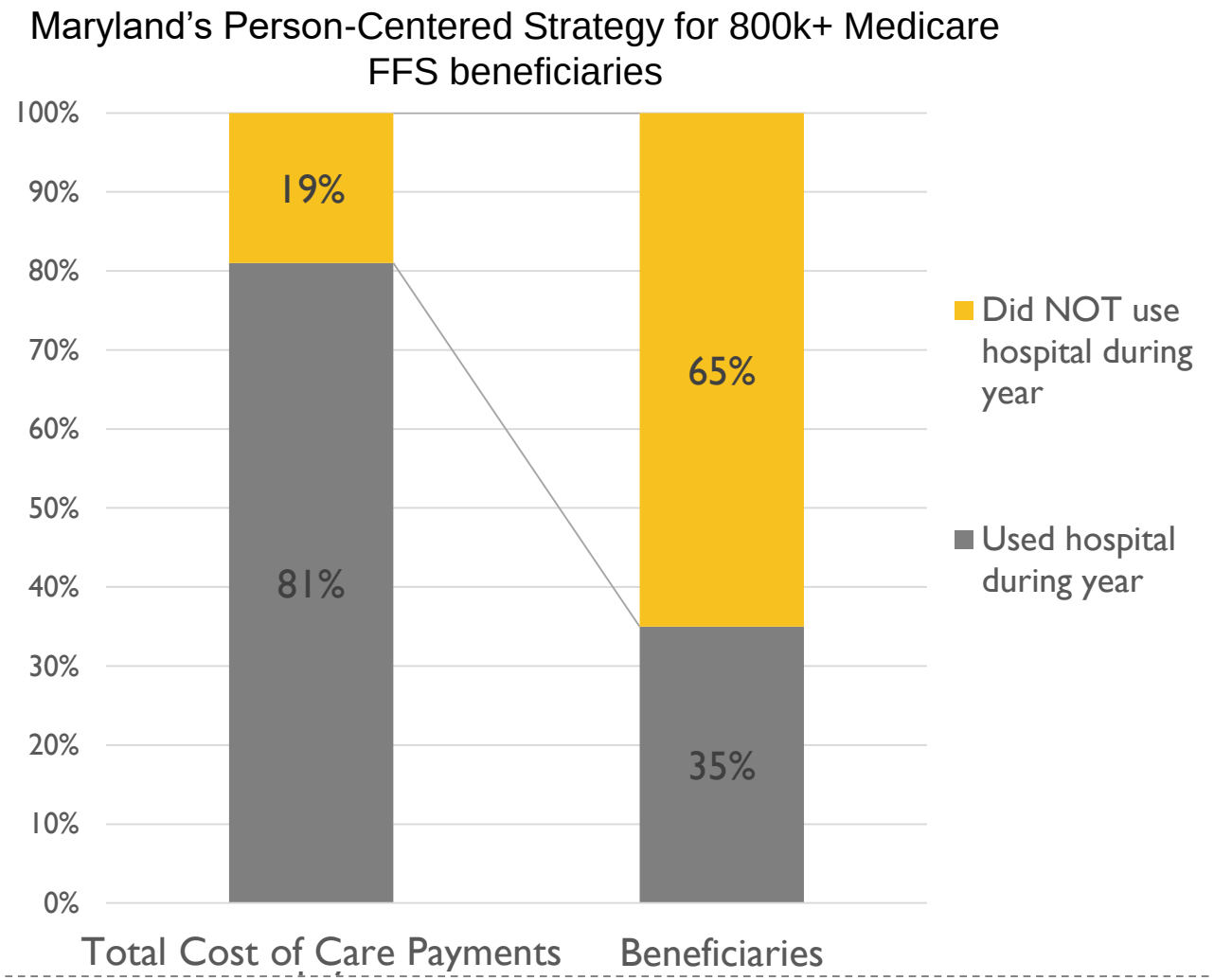
Medicare Hospital Savings
$916M cumulative
(5.63% below national average growth)

Medicare Total Expenditure Savings
$599M cumulative
(1.36% below national average growth)

Performance Measures	Targets	2014-2017 Results	On Target
All-Payer Hospital Revenue	≤ 3.58% per capita annually	2.03% average growth per capita	✓
Medicare Savings in Hospital	(Lower than national average growth rate from 2013 base year)		✓
Medicare Savings in Total Cost of Care	Lower than the national average growth	from 2013 base year	✓
All-Payer Quality Improvement: Reductions in PPCs under	30% reduction over 5 years	53% Reduction since 2013	✓
Readmissions Reductions for	≤ National average over 5 years	Below national average at the end of the fourth year	✓
Hospital Revenue in Global or Population-Based	80% by year 5	100%	✓

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



Source: Draft HSCRC analysis based on CY 2016 Medicare (CCW) data

Core Approach— Person-Centered Care Tailored Based on Needs

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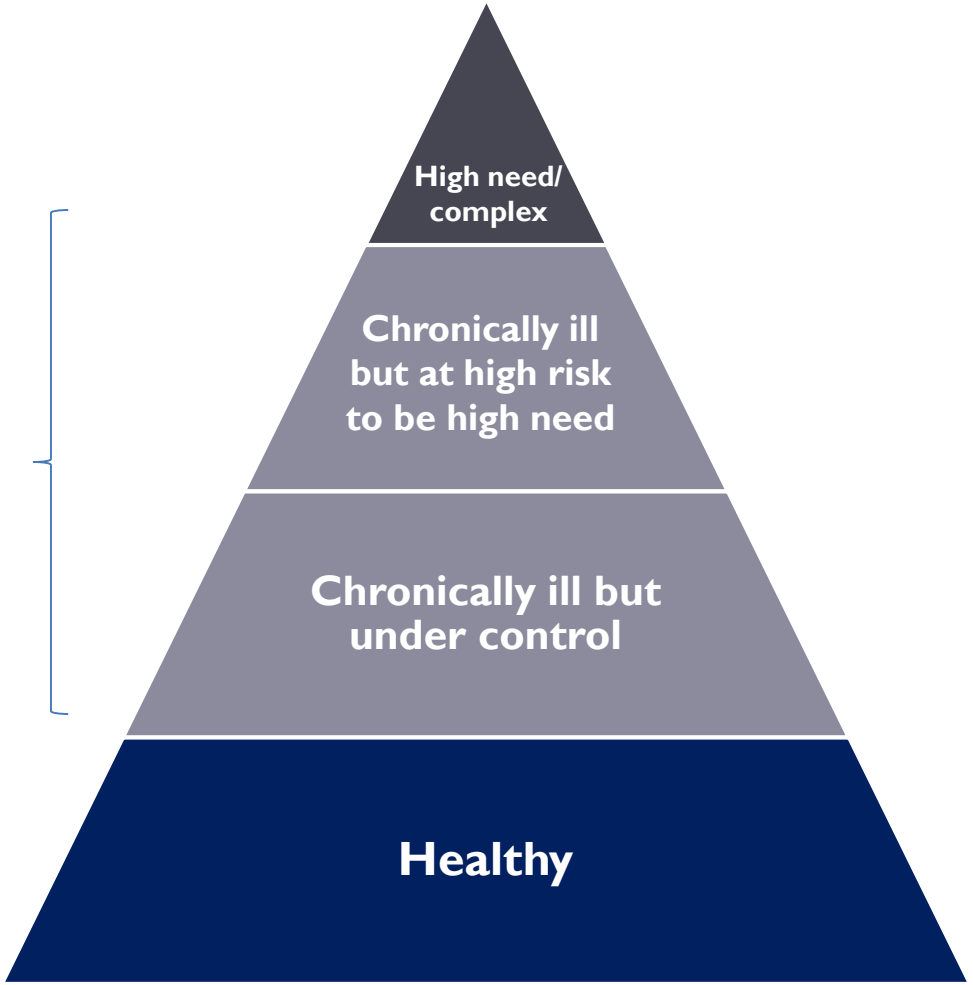
Address modifiable risks and integrate and coordinate care, develop primary care disease management



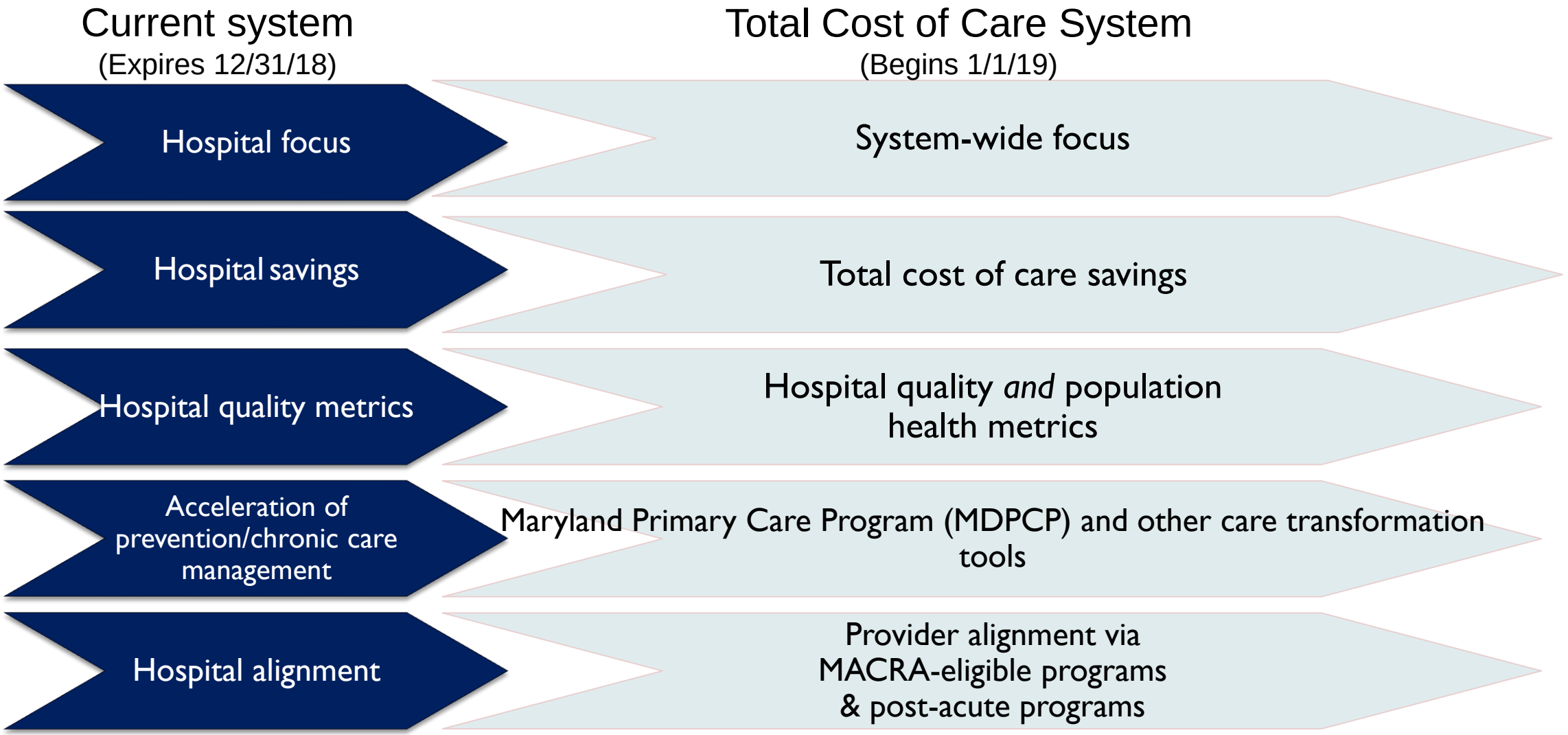
A

Interventions for individuals with significant demands on health care resources

C

Promote and maintain health

The Change



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Total Cost of Care (TCOC) Model Overview

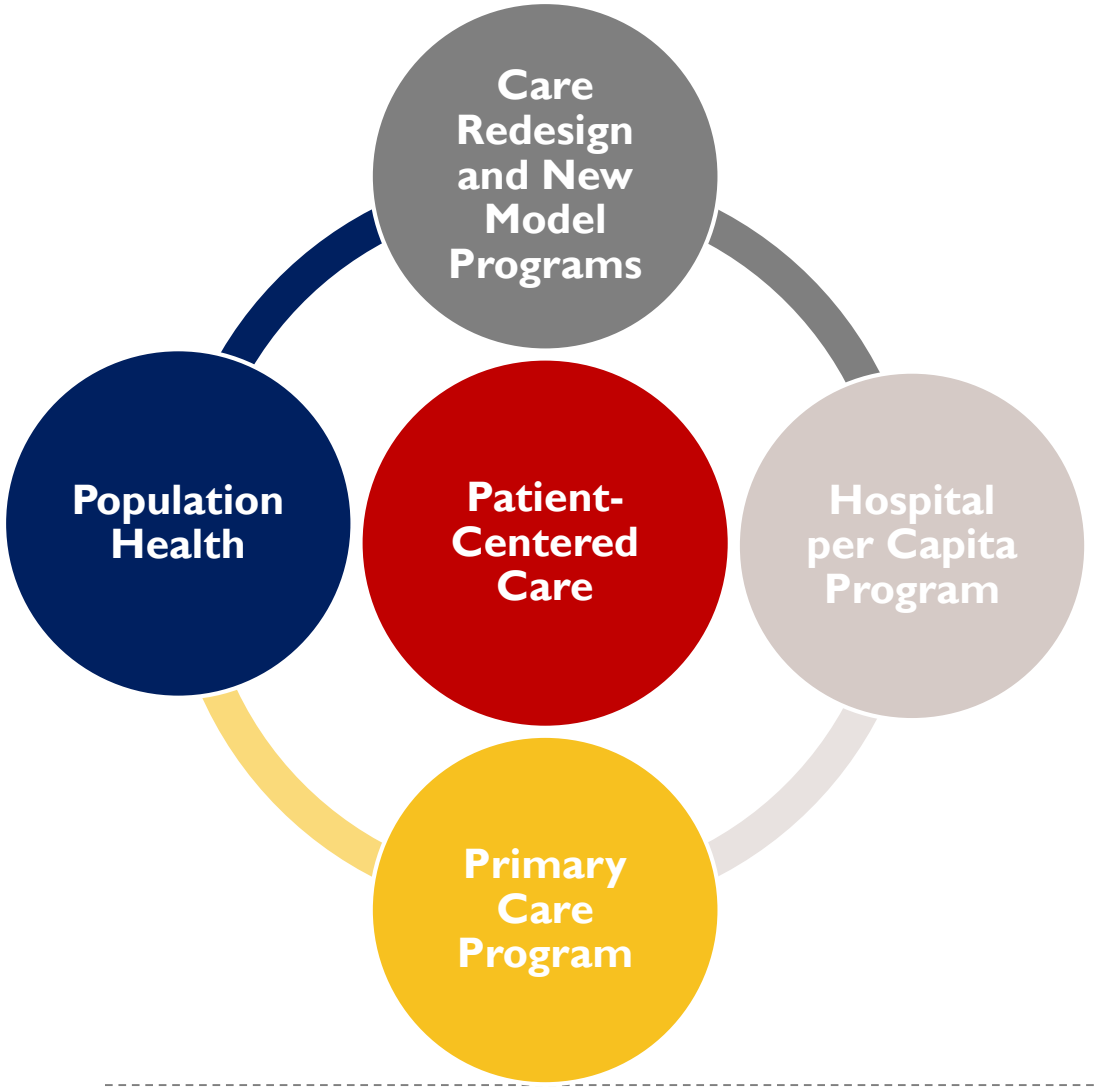
- New Contract will be a 10-year agreement (2019-2028) between MD and CMS
  - Five years (2019-2023) to build up to required Medicare savings and five years (2024-2028) to maintain Medicare savings and quality improvements
- Total Cost of Care (TCOC) Medicare Savings building to $300 million annually 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

Annual Medicare TCOC Savings Targets

Annual Medicare TCOC Savings Targets (relative to 2013 base)		
2019	PY 1:	$120 million
2020	PY 2:	$156 million
2021	PY 3:	$222 million
2022	PY 4:	$267 million
2023	PY 5:	$300 million

- 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

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

MARYLAND Department of Health

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

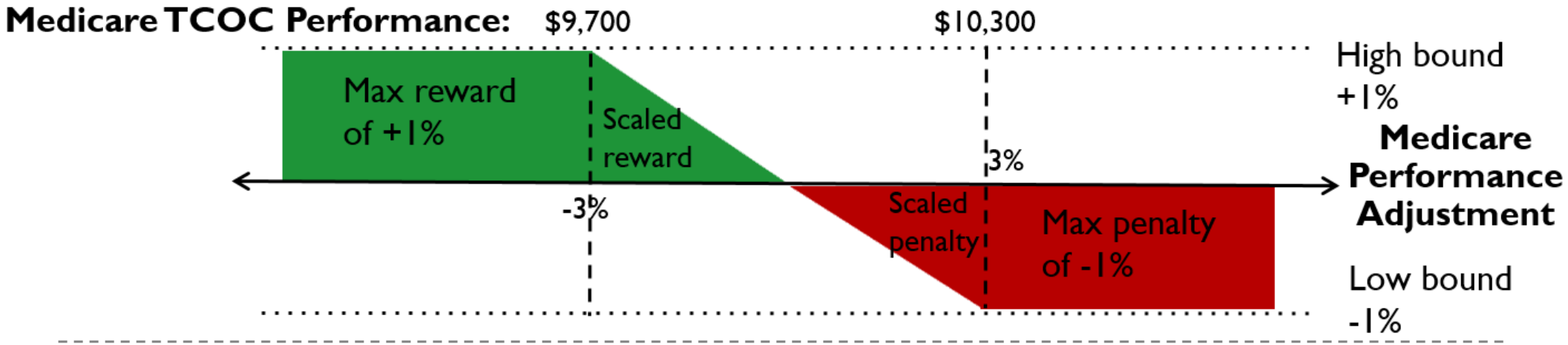
Hospital Care Improvement Program (HCIP) 40 Participants
• **Goal**: Facilitate improvements in hospital care that result in care improvements and efficiency

Complex and Chronic Care Improvement Program (CCIP) 9 Participants
• **Goal**: Enhance care management and care coordination

Episode Care Improvement Program (ECIP)
• **Goal**: Facilitate care improvements for episodes across all care settings, with a focus on post-acute opportunities

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)

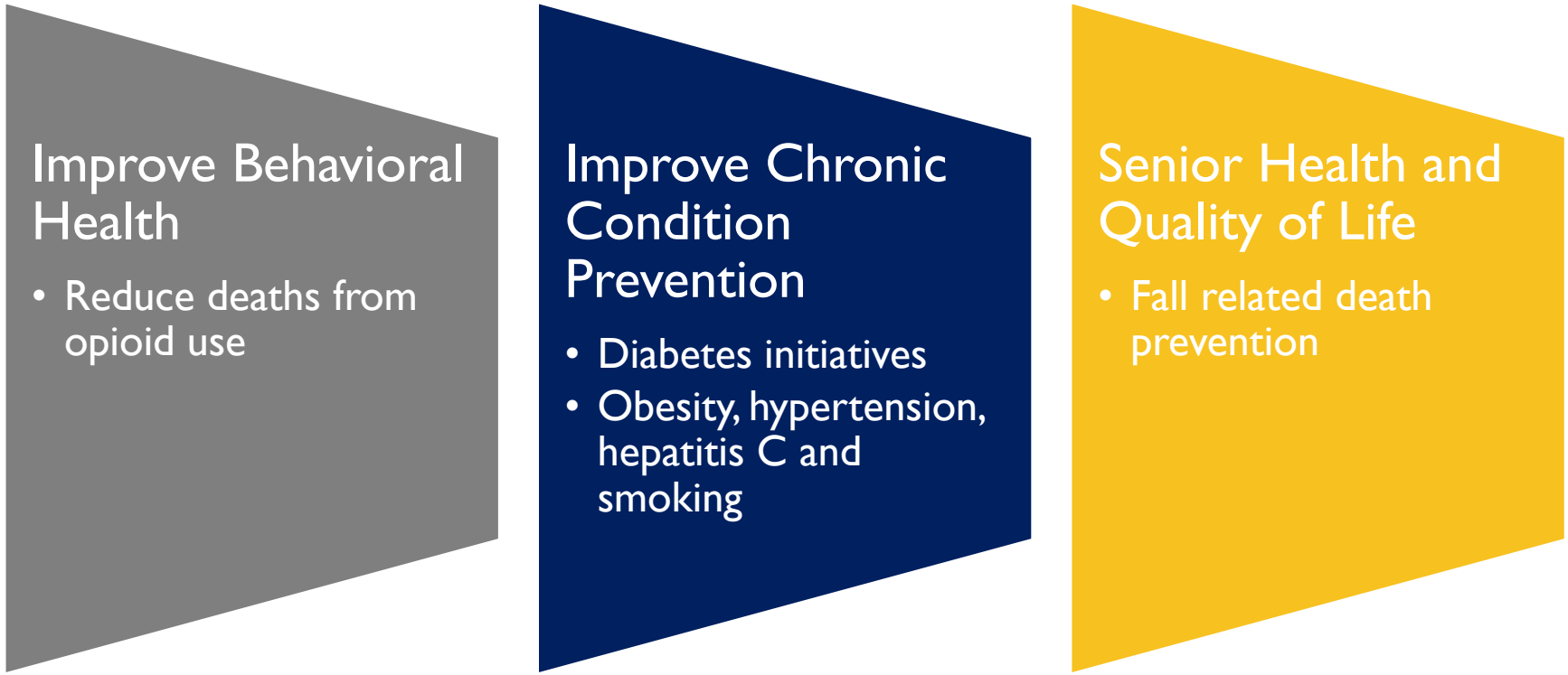
- Incentivizes reducing potentially preventable complications

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.



Public-Private Health Information Infrastructure Supports Model

- 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)