



Improving Person-Centered Care in Maryland Under the Maryland All- Payer Model

May 2016

Overview

- ▶ The Nation's Evolving Healthcare Landscape: Major Pressures Leading Shift to Value
- ▶ Unique Changes in Maryland's Healthcare Delivery System
- ▶ Potential Alignment Strategies that Could Grow Out of the Models in Maryland
- ▶ Opportunities for Physicians
- ▶ Next Steps



The Nation's Evolving Healthcare Landscape: Shifting to Value

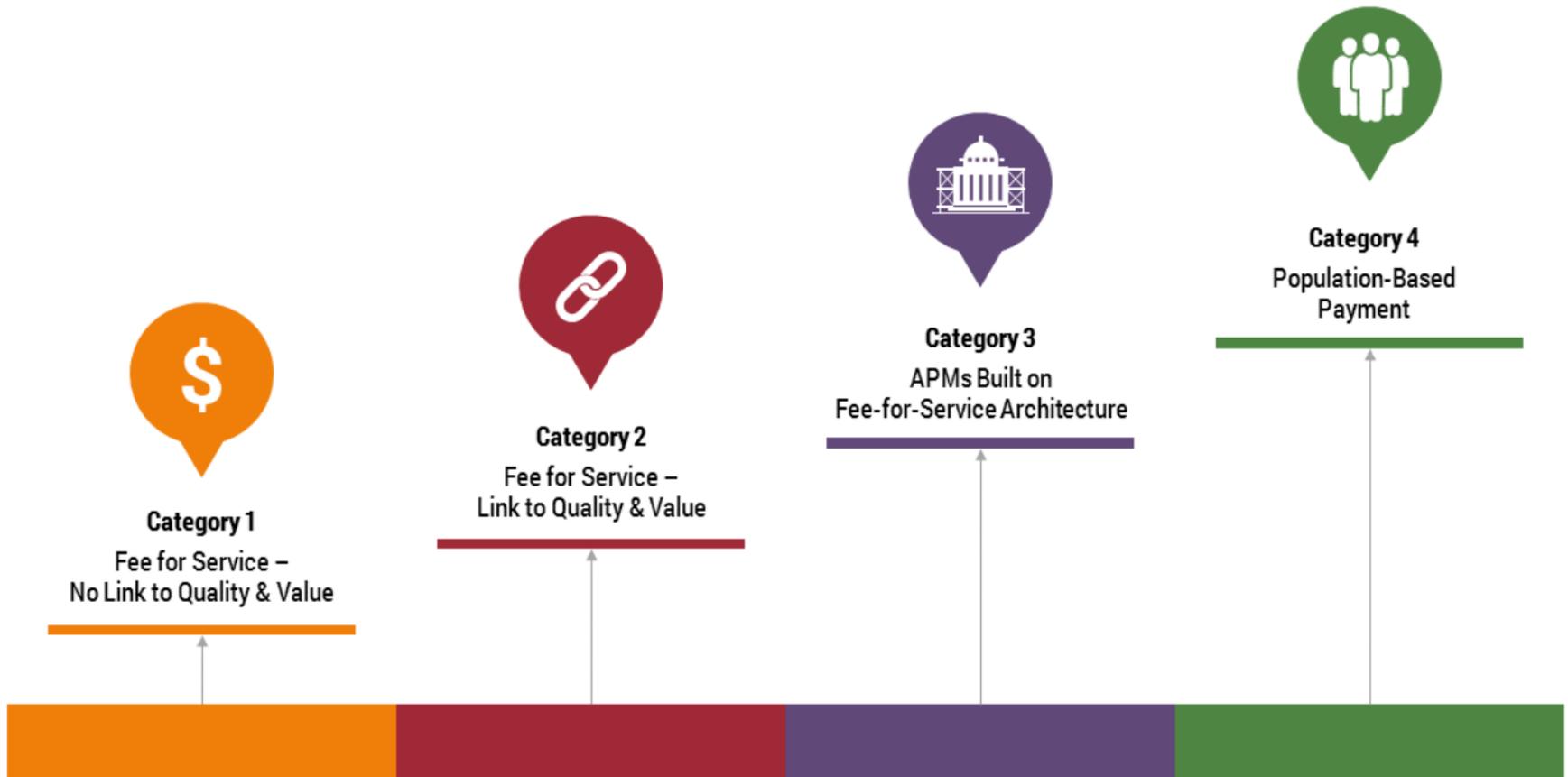


CMS and National Strategy--Change Provider Payment Structures, Delivery of Care and Distribution of Information

<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 (MACRA)• 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

CMS is Focused on Progression to Alternative Payment Models (APMs)

MACRA is expected to have extensive fee schedule effects on physicians in 2019 based on participation in APMs



How National Changes Might Impact Physicians

- ▶ **CMS Chronic Care Management Fee:**

- ▶ Significant revenue for practices that effectively deliver the appropriate care coordination services for their chronically ill patients

- ▶ **Medicare Access & CHIP Reauthorization Act (MACRA):**

- ▶ 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

- ▶ **CMS Focused on Value-based Payments:**

- ▶ Models referenced above

Unique Changes in Maryland's Healthcare Delivery System

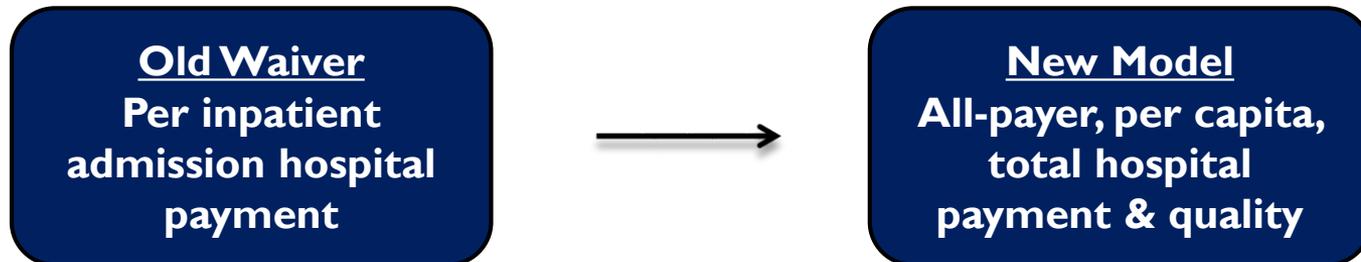


HSCRC Sets Hospital Rates for All Payers

- ▶ **All Payer Rate Setting**
 - ▶ Medicare waiver granted in 1977 and renewed under a different approach in 2014 allows HSCRC to set hospital rates for Medicare—the elderly population.
 - ▶ State Medicaid plan (for financially and medically needy) requires payment of HSCRC rates
 - ▶ State law requires health insurers, managed care organizations, others to pay HSCRC rates
- ▶ **All payers pay their fair share of full financial requirements**
 - ▶ Uncompensated care
 - ▶ Physician/other education costs
 - ▶ Capital costs
- ▶ **Considerable value to patients, State and hospitals**

Unique New Model: Maryland's All-Payer Model

- ▶ Maryland is implementing an All-Payer Model for hospital payment
 - ▶ Approved by Centers for Medicare & Medicaid Services (CMS) effective January 1, 2014 for 5 years
 - ▶ Modernizes Maryland's Medicare waiver and unique all-payer hospital rate system
 - ▶ Health Services Cost Review Commission (HSCRC) is leading the effort



Maryland Performance in Year 1 (CY 2014)

Performance Measures	Targets	CY 2014 Results
Hospital Revenue to Global or Population-based	$\geq 80\%$ by Year 5	$> 95\%$ in Year 1
All-Payer Revenue Growth	$\leq 3.58\%$ per capita	1.47% per capita
Medicare Savings in Hospital Expenditures	$\geq \$330\text{m}$ over 5 years	\$116 in Year 1
Medicare Savings in Total Cost of Care	Lower than the national average	1.5% lower than national average
All-Payer Quality Improvement Reductions in Hospital Acquired Conditions	30% reduction over 5 years	26% reduction in Year 1
Readmissions Reductions for Medicare	\leq National average over 5 years	.2% gap decrease vs national



Maryland's Current Situation & Future Focus

Complex implementation ahead. Uneven implementation of care coordination.

Years 2-3 Focus

Work on clinical improvement, care coordination, integration planning, and infrastructure development

Partner across hospitals, physicians and other providers, post-acute and long-term care, and communities to plan and implement changes to care delivery

Alignment planning and development

Years 4-5 Focus

Implement changes, and improve care coordination and chronic care

Focus on alignment models

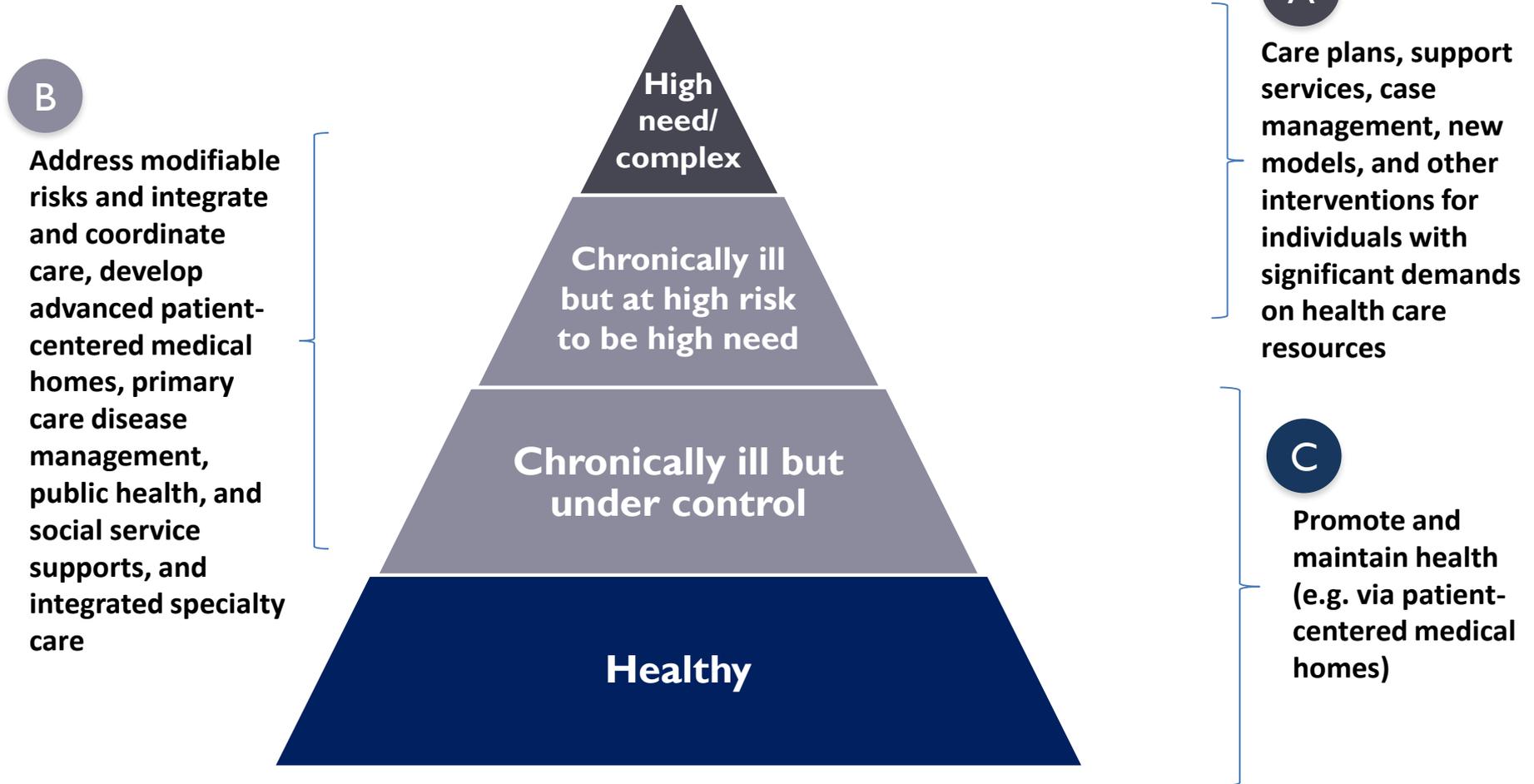
Engage patients, families, and communities

Focus on payment model progression, total cost of care and extending the model



Opportunities for Patients—Tailoring Care Delivery to Persons' Needs = Better Outcomes & Quality of Life, Fewer Hospitalizations

Utilizing EHRs, analytics, health information exchange, and care coordination resources to improve care and health.



Maryland's Strategy—Care Coordination for High Needs Patients

- ▶ **Fully implement care coordination to scale, first for complex and high needs chronically ill patients**
 - ▶ Organize and engage consumers, primary care, long-term care, and other providers in care coordination and chronic care management
 - ▶ Intense focus on Medicare, where models do not exist or are immature in Maryland
 - ▶ Build on growing PCMH and ACO models, global budgets and geographic areas, and Medicare Chronic Care Management (CCM) fee
- ▶ **Develop financial alignment programs across hospitals and other providers, and get data and approvals needed for implementation**

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
- ▶ 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

- ▶ 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

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 (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



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

Next Steps: Model Extension

- ▶ Focus on developing Model extension concepts with stakeholder input
- ▶ Begin to prepare a plan with stakeholders, especially with physicians, that expands focus on total cost of care (due at the end of 2016 for implementation in 2019 and beyond)
 - ▶ Best approach is to focus on care redesign to reduce avoidable hospitalization costs
 - ▶ Alignment of incentives across multiple settings
 - ▶ Maryland will not propose rate-setting of physician fees

How Might All-Payer Model Developments Impact Physicians?

- ▶ Improved data infrastructure/exchange/tools for care management, care coordination, and community health
- ▶ Increased focus on interoperability and connection with CRISP
- ▶ Increased collaboration and coordination among providers
- ▶ Increased programmatic efforts by hospitals and other providers to reduce potentially avoidable utilizations (PAUs)
- ▶ Increased focus on factors affecting patients in their homes (e.g. medication reconciliation, nutrition, transportation)
- ▶ Increased opportunities for shared savings arrangements, outcomes-based payment, and other incentives when care is improved and avoidable utilization is decreased

Opportunities for Physicians in Maryland

Get Connected

- Utilize CRISP encounter alerts, common care histories, and other care management tools
 - Address gaps in patients' health

Get Coordinated

- Coordinate your patients' care with other providers across clinical and community settings
- Work with case managers to address the medical and social needs of complex patients

Participate

- Help improve outcomes and lower costs
- Join Accountable Care Organizations, medical homes, geographic initiatives, etc.
- Get involved in outcomes-based payment programs, etc.

Be Proactive

- Be a watchdog for the patient
- Contribute to the redesign of the state's healthcare delivery system



Thank you for the opportunity to work together to improve care for Marylanders

Questions?



Appendix

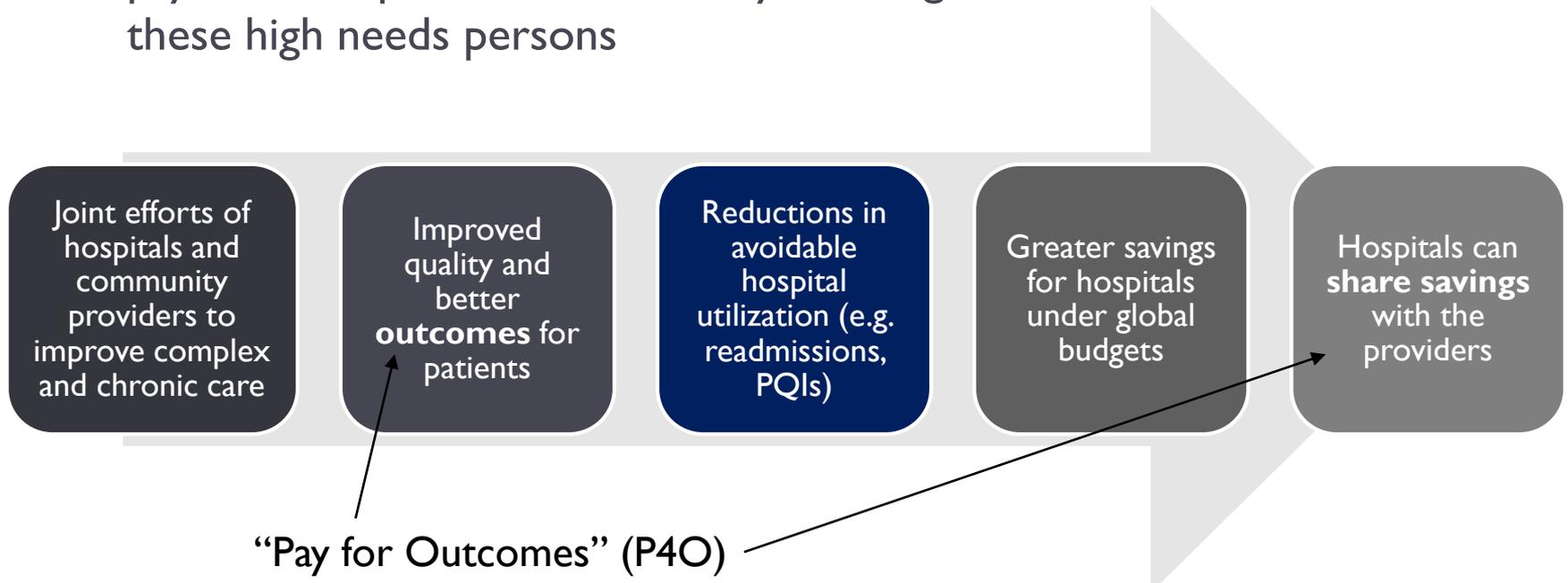


Potentially Avoidable Utilization (PAU)

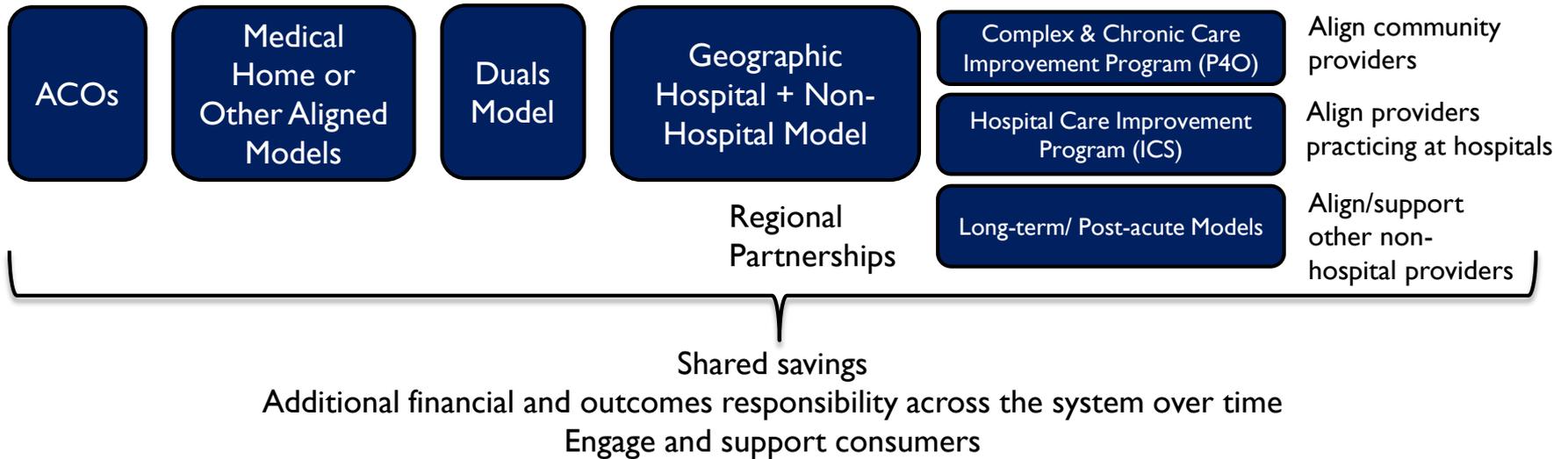
- ▶ “Hospital care that is unplanned and can be prevented through improved care, coordination, effective primary care and improved population health.”
 - ▶ Readmissions/Rehospitalizations that can be reduced with care coordination and quality improvements
 - ▶ Preventable Admissions and ER Visits that can be reduced with improved community based care
 - ▶ Avoidable admissions from skilled nursing facilities and assisted living residents that can be reduced with care integration, remote services, and prevention
 - ▶ Health care acquired conditions that can be reduced with quality improvements
 - ▶ Admissions and ER visits for high needs patients that can be moderated with better chronic care and care coordination

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



Potential Long-Term Developments



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

MACRA: Provider Reimbursement Changes

- ▶ **2019-2025: Move to value-based payments via involvement in either of two tracks:**
 - ▶ 1) Merit-Based Incentive Payment System (MIPS)
 - ▶ Continues traditional FFS system
 - ▶ BUT a portion of their Medicare FFS payment at risk will gradually increase up to **-9% to +9%** based on their performance on quality and outcomes measures
 - ▶ 2) Alternative Payment Models (APMs)
 - ▶ Medicare providers can opt out of MIPS and **receive +5% bonus** in rates if a substantial portion of their revenue is through APMs
 - ▶ APM definition TBD based on rulemaking, but will be value-based payment systems
- ▶ **2026+: All Medicare providers receive 0.25% update**
 - ▶ APM providers will receive an additional 0.5% update, thereby receiving a 0.75% update overall for Medicare services