Value Based Models: Spotlight on Specialists

October 11, 2018

INTRODUCTION

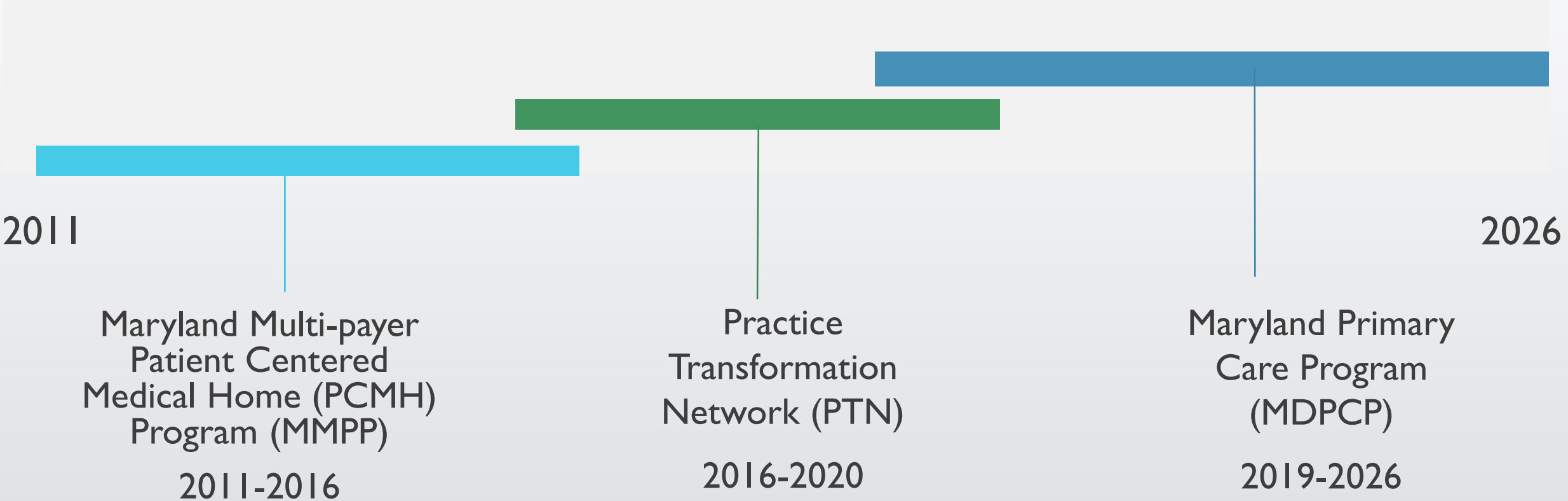
Maryland Health Care Commission

- MHCC's mission:

  To plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public.

MHCC Programs

The MHCC has a key role in developing and administering several innovative care delivery models in Maryland.

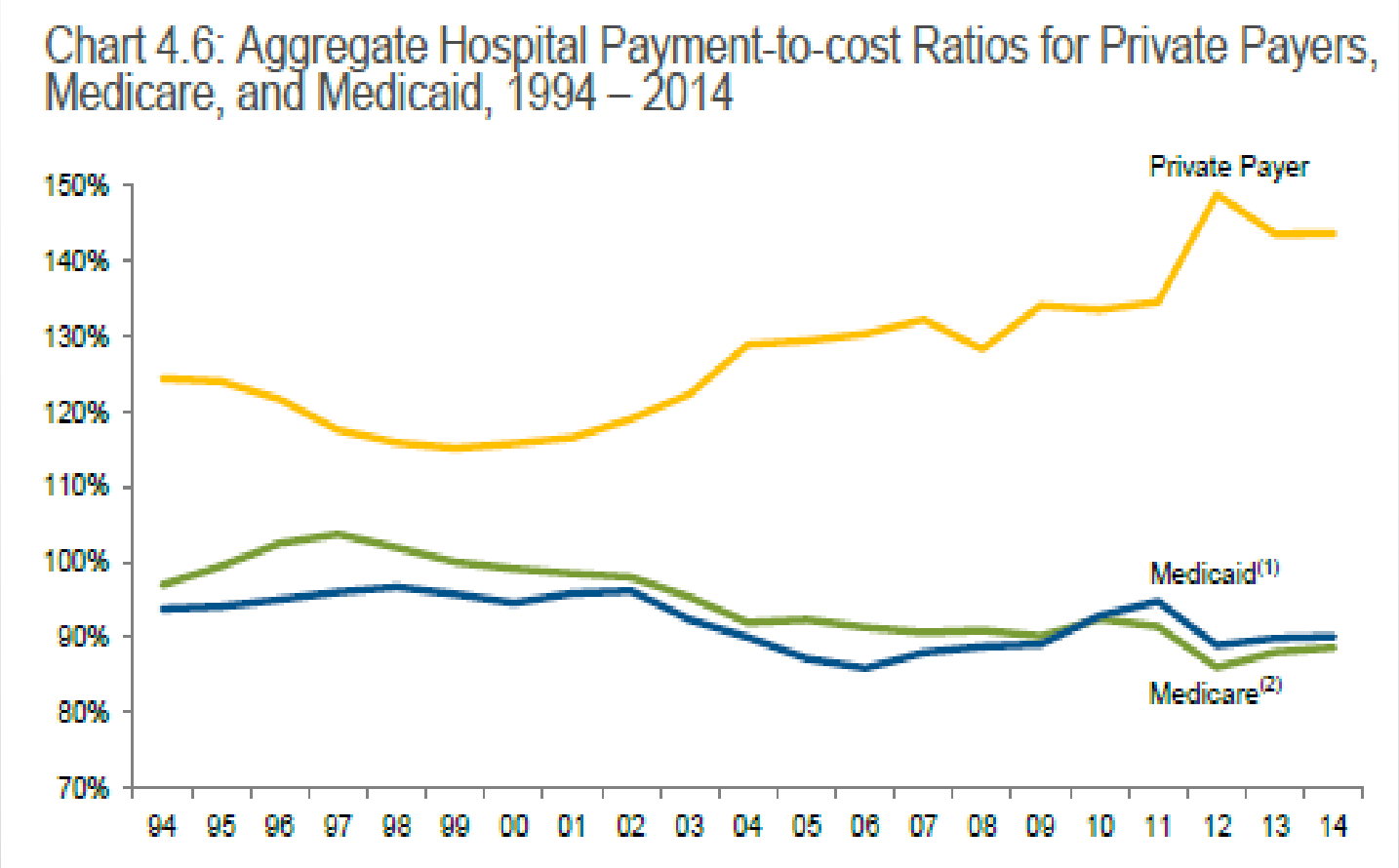


MARYLAND HOSPITAL ALL-PAYER MODEL

- Since 1977, Maryland has operated an all-payer hospital rate-setting system
  - A hospital's charge is the same regardless of payer
  - Charges do differ across hospitals

NATIONALLY, COST-SHIFTING OCCURS BETWEEN PRIVATE AND PUBLIC PAYERS

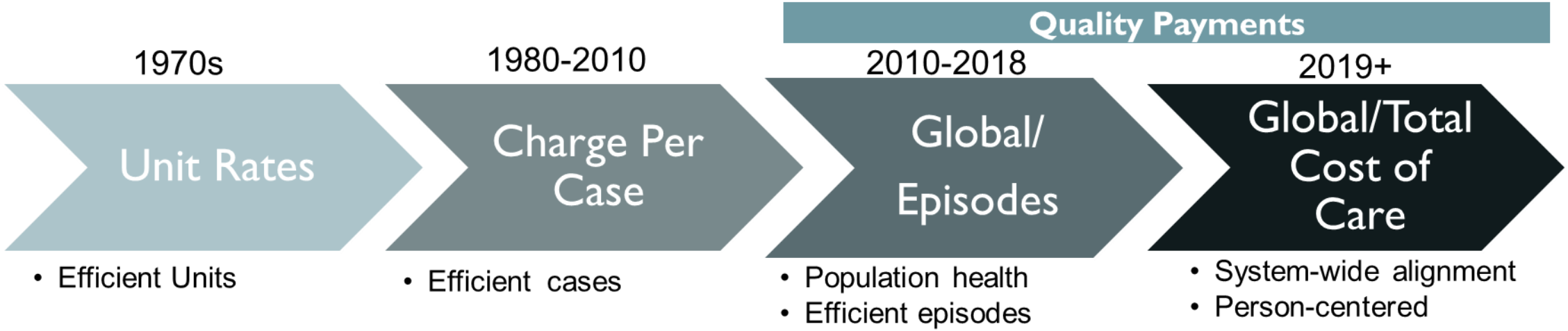
- In Maryland, hospitals are paid using a common rate structure for all payers



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

ALL-PAYER MODEL BACKGROUND AND PERFORMANCE (2014-2018)

Overview: Maryland's All-Payer Model



- 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
  - Payment framework for hospitals to move from volume to value
  - Provider-led efforts to reduce avoidable use and improve quality and coordination
  - Savings to Medicare without cost shifting
  - Sustains rural hospitals with a stable revenue base

2014: ALL-PAYER MODEL EXPANDS HOSPITAL GLOBAL BUDGETS TO ALL MARYLAND HOSPITALS

- In 2010, State experimented with fixed budgets in 10 rural hospitals
- In 2014, under All-Payer Model, all general acute care hospitals went under Global Budget Revenue (GBR)
  - Fixed revenue base for 12-month period, with annual adjustments
  - Reimbursement still administered on fee-for-service basis but only for attaining GBR
  - Hospitals have flexibility to dial charges (within constraints) to dial charges up or down so that, by year end, they have attained their GBR
    - Penalties for being too high or too low
  - HSCRC sets each hospital's GBR
    - Adjustments include for population growth, readmissions, hospital-acquired conditions, etc.
    - Moving to new term: Population-Based Revenue (PBR) instead of GBR

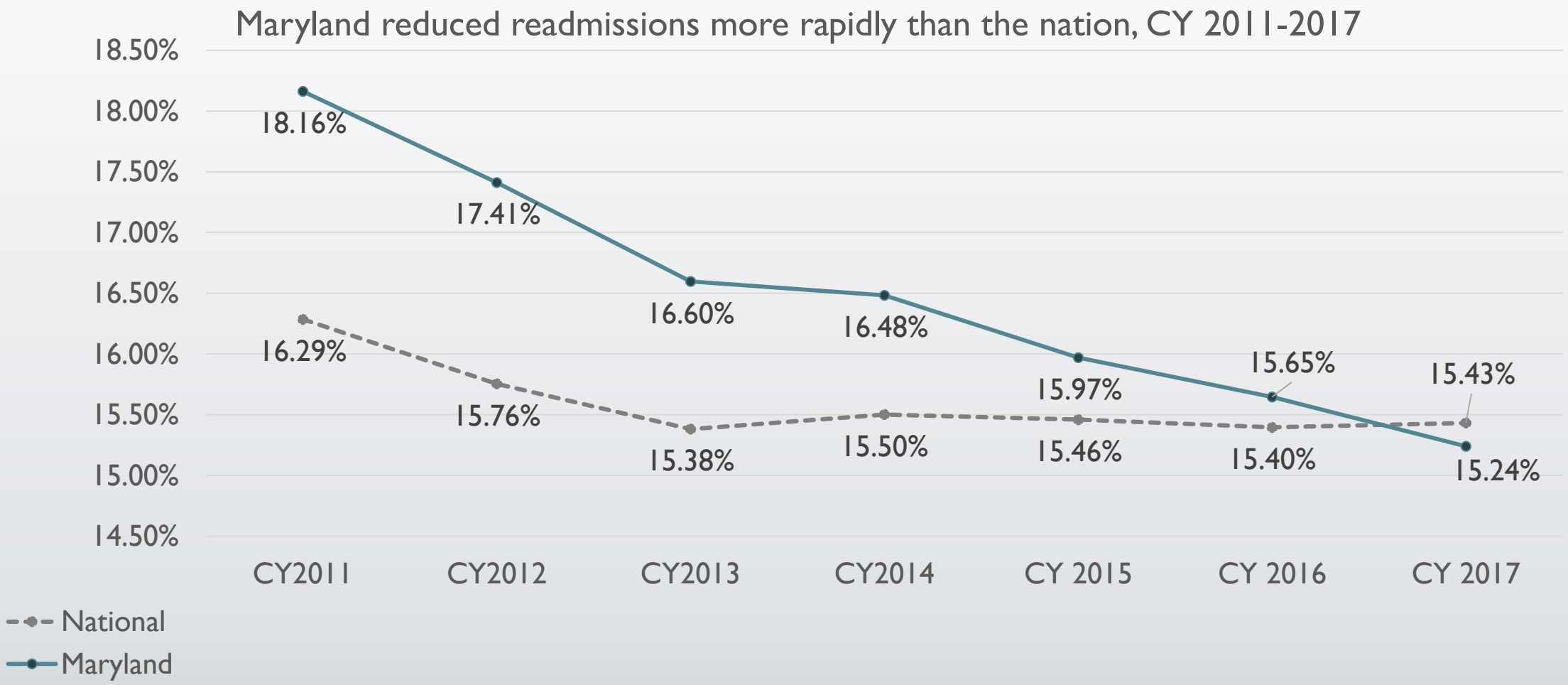
MOVE TO FIXED ANNUAL BUDGETS FOR HOSPITALS TRANSFORMED THEIR INCENTIVES

- No longer chasing volumes on pressured prices
- Incentivizing:
  - Reduced readmissions
  - Reduced hospital-acquired conditions
  - Reduced ambulatory-sensitive conditions (aka Prevention Quality Indicators (PQIs))
  - Better managed internal costs
- Results
  - Improved health care quality, lower costs, better consumer experience

ALL-PAYER MODEL PERFORMANCE (APM) 2014-2017

Performance Measures	APM Requirements from CMS	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 to 2018)	$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 Reductions in Hospital Acquired Conditions	30% reduction over 5 years	53% reduction since 2013	✓
Readmissions Reductions for Medicare	≤ National average after 5 years	< National average after 4 years	✓
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



TOTAL COST OF CARE MODEL (2019-2028)

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/5/18

By: _____

Adam Boehler, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF MARYLAND

Date: 7/9/18

By: _____

Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: _____

Robert R. Neall, Secretary of Health

HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

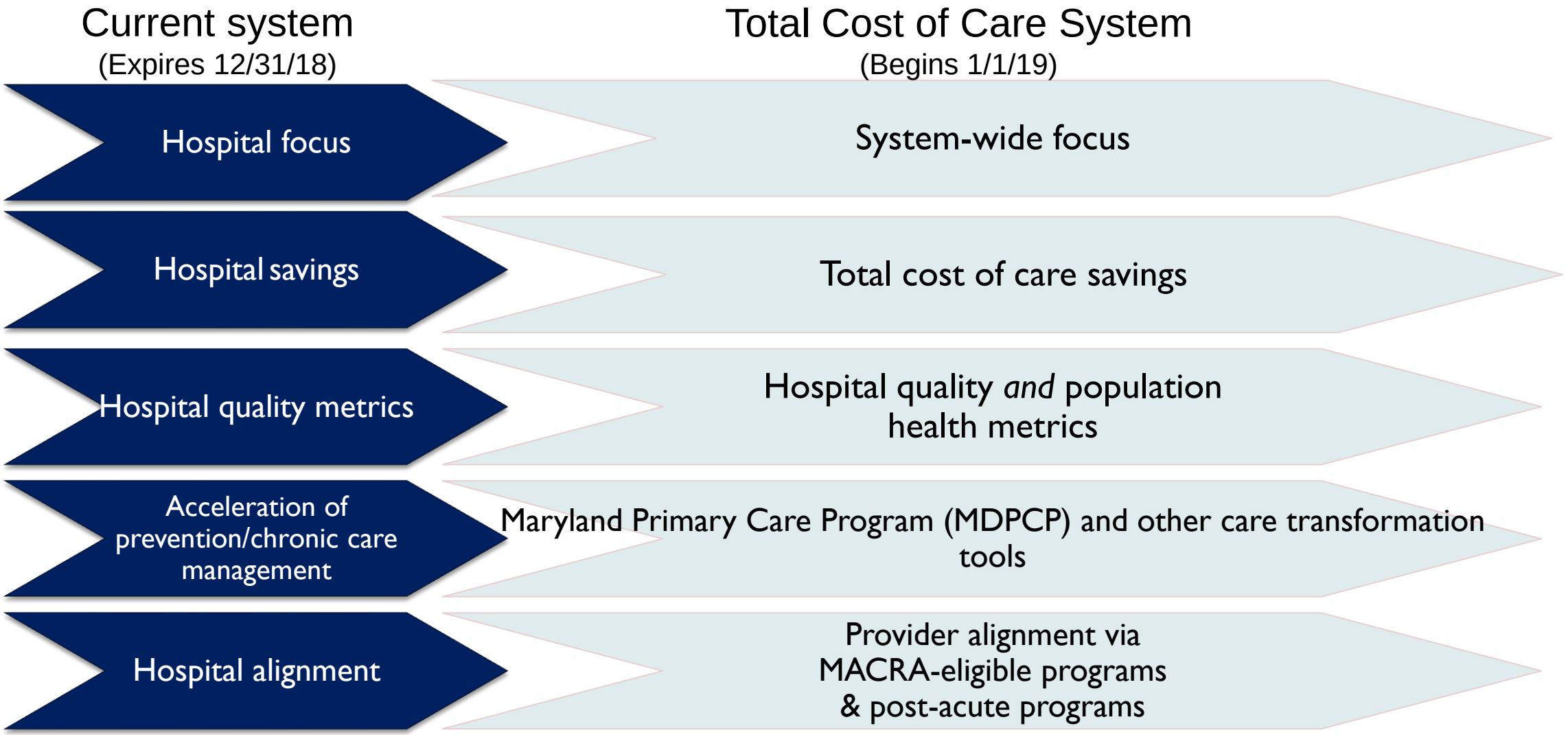
By: _____

Nelson Sabatini, Chairman

TCOC Contract Status

Signed July 9, 2018!

The Change



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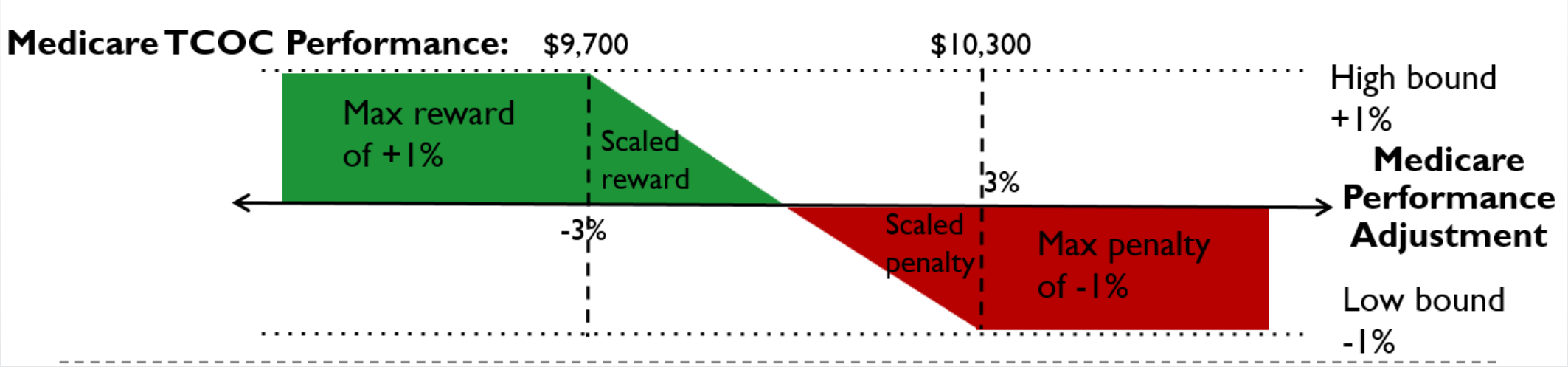
TOTAL COST OF CARE (TCOC) MODEL OVERVIEW

- 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

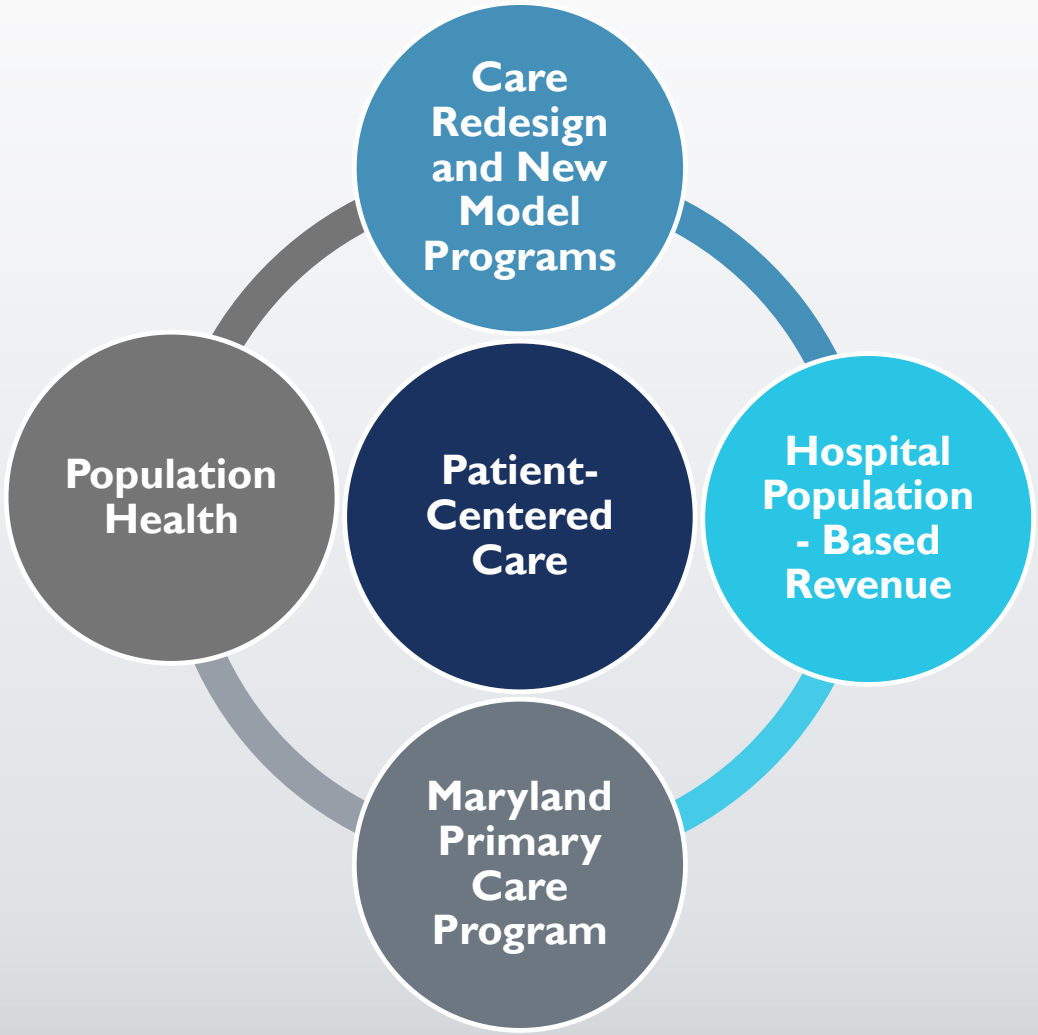
MEDICARE PERFORMANCE ADJUSTMENT (MPA): BRINGING DIRECT ACCOUNTABILITY TO INDIVIDUAL HOSPITALS ON MEDICARE TCOC

- 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.



- All Medicare beneficiaries are attributed to hospitals, primarily through physician relationships
- Medicare Revenue at Risk begins at 0.5% for 2018 and increases to 1% for 2019
- Additional flexibility to use as Efficiency Adjustment and as a Care Redesign tool

Total Cost of Care Model Components



- Continues **Hospital Population-Based Revenue**, while expanding incentives to control total costs
  - Expand responsibility for total costs through gradual revenue at risk under **Medicare Performance Adjustment**
- Expands **Care Redesign Programs** to enable private sector led programs supported by State flexibility; opportunity for **New Model Program** development in the future.
  - Expand MACRA and other incentives for hospitals to work with others
- Develops **Population Health** improvement programs for chronic conditions, opioid deaths and senior health quality of life
- Initiates the **Maryland Primary Care Program** to enhance chronic care and health management

THE MARYLAND PRIMARY CARE PROGRAM (MDPCP)

- Beginning January 1, 2019 Maryland will begin to move Medicare FFS beneficiaries into advanced primary care
- 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
- Care management fees will provide resources for chronic care improvement
- Aligns primary care physicians with TCOC Model goals

MDPCP'S PAYMENT REDESIGN (MEDICARE)

	Care Management Fee (CMF) [per beneficiary per month (PBPM)]	**Performance-Based Incentive Payment (PBIP)**	**Underlying payment structure**
Track 1	$15 on average. $6-50 range	$2.50 PBPM	Regular FFS
Track 2	$28 on average. $9-100 range	$4.00 PBPM	Comprehensive Primary Care Payment (CPCP) + reduced FFS payment

- Care Management Fees paid by CMS to practices and designed to cover additional cost of better care coordination, managing chronic conditions, etc.
- PBIP is paid prospectively to practices but can be recaptured based on quality
- Track 2 CPCP payment is a partial capitation payment, with FFS payments reduced, but still yielding practice approximately 10% bonus

CARE REDESIGN PROGRAM (CRP)

CARE REDESIGN PROGRAMS – ALIGNING HOSPITALS AND NON-HOSPITAL PROVIDERS

- Introduced as an Amendment to the All-Payer Model Agreement (2017)
- Now part of Total Cost of Care Model Agreement
- Opportunity to innovate new tracks the system needs and achieve savings
- Allows hospitals to align with other care partners (e.g., facilities)
- Voluntary programs allow hospitals to obtain data, share resources with providers, and offer optional incentive payments
- Advanced Alternative Payment Model qualification (MACRA)
- Under CRP, participating hospitals:
  - Are the conveners,
  - Bear the financial risk under the PBR and MPA (which qualifies Care Partners for MACRA bonus)
  - Choose whether or not to participate and, if so, whether or not to share incentives or resources with Care Partners

Current Care Redesign Program Tracks

Hospital Care Improvement Program (HCIP)
40 Hospitals

- Designed for hospitals and Care Partners practicing at hospitals
- Hospitals improve care and save money through more efficient episodes of care
- Physicians may share in those gains
- **Goal**: Facilitate improvements in hospital care that result in care improvements and efficiency

Complex and Chronic Care Improvement Program (CCIP)
9 Hospitals

- Designed for hospitals and community-based Care Partners
- Hospitals and Care Partners collaborate on care of complex and chronic patients
- Hospitals provide resources to practices that should improve quality and reduce costs
- **Goal**: Enhance care management and care coordination

Episode Care Improvement Program (ECIP)

- Designed for hospitals and continuum of Care Partners
- Hospitals and Care Partners collaborate on care for 23 clinical episodes (90 day episodes)
- Clinical episodes assessed on quality and cost of care
- Hospitals may share incentive payments with care partners
- **Goal**: Facilitate care improvements for episodes across all care settings, with a focus on post-acute opportunities

Began in July 2017
43 Hospitals in one or both programs in PP3

Begins January 2019
35 Hospitals submitted LOIs

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SELECTED CARE INTERVENTIONS

- Hospital Care Improvement Program (HCIP)

  Hospital selects Care Interventions for its Care Partners, such as:

  - Medication reconciliation form completed
  - Care plans completed for high-risk patients
  - Patients with high risk of readmission identified and connected with transitional services
  - Follow-up appointments scheduled before discharge
  - Infection/sepsis prevention activities completed
  - Advanced directives obtained
  - Interdisciplinary palliative care consults completed
  - Individualized patient/family education documented

- Complex and Chronic Care Improvement Program (CCIP)

  - Hospital may provide resources to care partners to support care interventions for patients
    - CEHRT and other technology investments
    - Care management staff
  - Core Care Partner Interventions for High Risk and Rising Need Patients
    - Completing care plans
    - Medication reconciliations
    - Provider visits within 7 days of acute discharge
    - One care management conversation per month
    - Patients have access to support 24/7 by phone

CERTIFIED CARE PARTNER ENROLLMENT

Track	Hospital	Certified Care Partners as of Dec 31, 2017	Certified Care Partners as of May 1, 2018	Certified Care Partners for PP3 Q1
HCIP	Anne Arundel Medical Center	N/A	250	271
	Atlantic General	11	12	12
	Doctors Community	65	123	158
	Frederick Memorial	27	27	27
	Holy Cross Hospital	2	2	10
	Holy Cross Germantown	3	3	3
	Carroll	N/A	0	10
	Northwest	N/A	0	9
	Sinai	N/A	0	19
	Mercy	7	11	31
	Meritus	40	43	43
	Peninsula Regional Medical Center	N/A	82	85
	Shady Grove Medical Center	7	7	7
	Washington Adventist	5	5	5
	Western Maryland Health System	40	38	43
	HCIP Subtotal	*207*	*603*	*733*
CCIP	Garrett	1	1	1
	GBMC	311	350	357
	Carroll	0	0	2
	Doctors Community	N/A	N/A	5
	Northwest	0	0	8
	Sinai	0	0	6
	Saint Agnes	0	36	46
	Shady Grove Medical Center	N/A	0	0
	Washington Adventist	N/A	0	0
	CCIP Subtotal	*312*	*387*	*425*
Total		**519**	**990**	**1,158**

EPISODE CARE IMPROVEMENT PROGRAM (ECIP)

- The Episode Care Improvement Program (ECIP) is a new Care Redesign Track under the Maryland Total Cost of Care Model
- Begins January 1, 2019
- Hospital-convened, with option of several care partner types beyond physicians, such as:
  - Skilled nursing facility (SNF)
  - Home health agencies
  - Hospice
- Upside-only, voluntary episode payment model, inspired by and based on the federal Bundled Payments for Care Improvement Advanced Model (BPCI-A)
- ECIP primarily focuses on post-acute care management and care coordination outside the walls of the hospital

ECIP DESIGN

- Episode Construction
  - 90-day post-acute episodes
  - Excludes inpatient spending
  - 23 clinical episodes available in 2019 (next slide)
- Reconciliation payment to hospitals
  - Hospital receives payment for TCOC savings beyond 3% below target
    - Medicare gets 3% savings in those cases
  - No downside risk for hospitals (except potential payment is offset by poor performing episodes)
  - 20% program stop-gain
  - Two performance periods per year, with corresponding reconciliation true-ups
  - Two-stage (initial and final) reconciliation to allow for appeals process and retrospective quality adjustments

23 ECIP EPISODES

1. Acute myocardial infarction (AMI)
2. Back and neck except spinal fusion
3. Cardiac arrhythmia
4. Cardiac valve
5. Cellulitis
6. Cervical spinal fusion / Combined anterior posterior spinal fusion / Spinal fusion (non-Cervical)
7. Chronic obstructive pulmonary disease (COPD), bronchitis/asthma
8. Congestive heart failure (CHF)
9. Coronary artery bypass graft surgery (CABG)
10. Major joint replacement of the lower extremity (MJRLE) / Double joint replacement of the lower extremity
11. Fractures, femur and hip/pelvis
12. Gastrointestinal hemorrhage
13. Gastrointestinal obstruction
14. Hip and femur procedures except major joint
15. Lower extremity and humerus procedure except hip, foot, femur / Major joint replacement of upper extremity
16. Major bowel procedure
17. Pacemaker
18. Percutaneous coronary intervention (PCI)
19. Renal failure
20. Sepsis
21. Simple pneumonia and respiratory infections
22. Stroke
23. Urinary tract infection (UTI)

ECIP DESIGN: QUALITY ADJUSTMENT ON HOSPITALS

- Maximum 5% positive earned quality adjustment
- Adopts quality measures and calculation approach from BPCI Advanced
  - All measures weighted evenly within clinical episode categories
  - Single composite quality score (CQS) calculated for each participant, weighted by volume in elected clinical episode categories
  - Scored based on performance scaled relative to highest and lowest performing hospitals in the state of Maryland
- Added to retrospective reconciliation payments allowing for collection, analysis, and benchmarking of administrative (claims-based) quality measures during performance period

ECIP QUALITY MEASURES

- All 23 episodes:
  - All-Cause Hospital Readmission Measure (NQF #1789)
  - Advanced Care Plan (NQF #0326)
  - CMS Patient Safety Indicators (NQF #0531)
- Episode specific
  - Perioperative Care: Selection of Prophylactic Antibiotic: First or Second Generation Cephalosporin (NQF #0268)
  - Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (NQF #1550)
  - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft Surgery (NQF #2558)
  - Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (NQF #2881)

EXAMPLE ECIP INTERVENTIONS: HOSPITALS SPECIFY INTERVENTIONS AND MEASURES FOR CARE PARTNERS IN THEIR ECIP

Intervention Category	Intervention
Clinical Care/ Care Redesign	• Standardized, evidence-based protocols are implemented, for example for discharge planning and follow-up care.
	• Implementation of enhanced coordination with post-acute care providers.
	• Interdisciplinary team meetings address patients' needs and progress.
	• Pharmacists embedded on unit.
Beneficiary/ Caregiver Engagement	• Patient education is provided pre-admission and addresses post-discharge options.
	• Shared decision-making processes and/or tools are implemented to help patients assess treatment options.
	• Methods for fostering "health literacy" in patient/family education are implemented.
	• Patient supports, items, and/or services are furnished to beneficiaries.
Care Coordination and Care Transitions	• Patient risk assessment/stratification is used to target services.
	• Assignment of a care manager/ coordinator/ navigator to follow patient across care settings (e.g., to help coordinate follow-up appointments and to connect patient to needed community resources).
	• Performance of medication reconciliation.
	• Remote patient consultation monitoring.

ECIP CARE PARTNER INCENTIVE PAYMENTS

- Hospitals may elect to distribute incentive payments to care partners
- Hospital selects proportional distribution of payments between care partners (if any)
- Conditions of payment required for incentive earn-out; hospital sets weights for these as well
- Caps imposed on care partner payments where appropriate

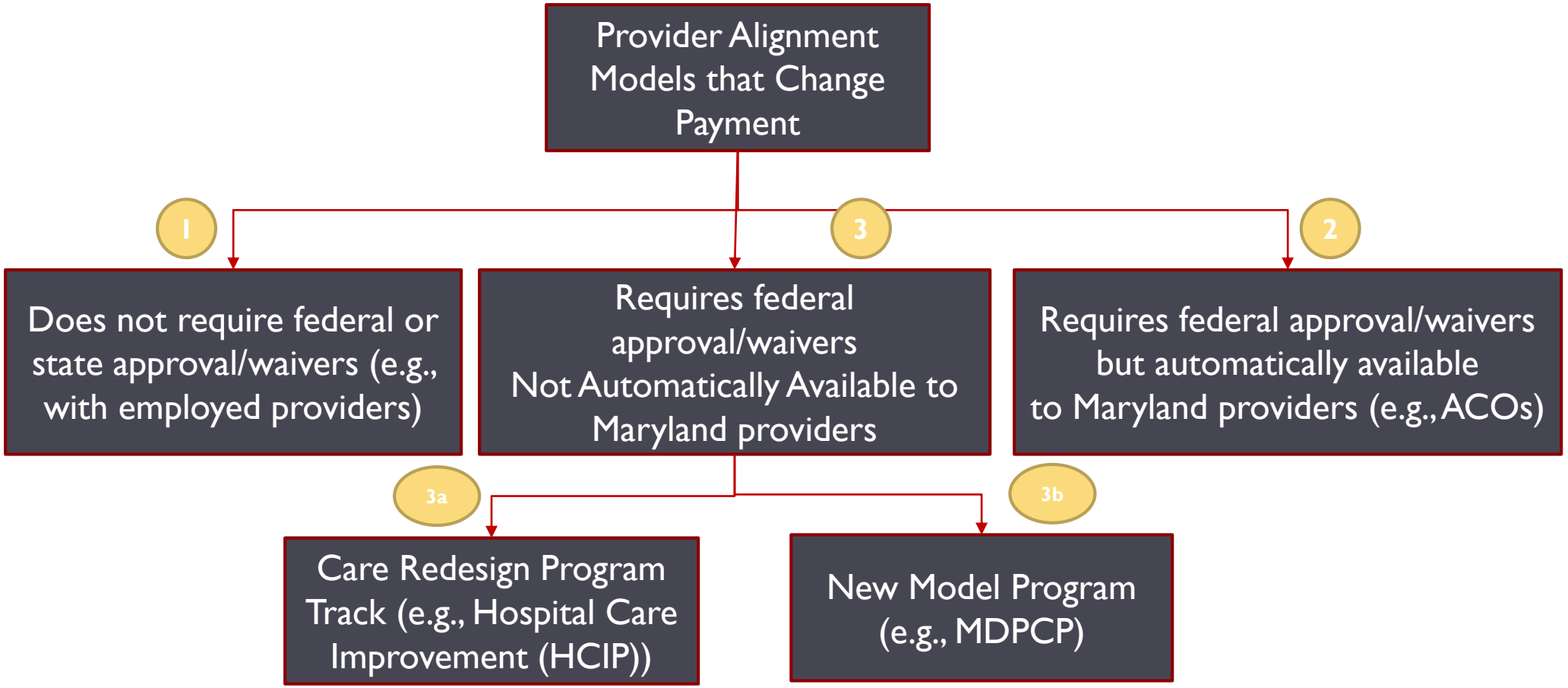
- 9 Care Partner Types
  - General or specialist physician
  - Clinical nurse specialist / nurse practitioner
  - Physician assistant
  - Physical therapist
  - Skilled nursing facility (SNF)
  - Home health agencies (HHA)
  - Long term care hospitals
  - Hospice
  - Inpatient rehabilitation facilities (IRF)

ECIP TIMELINE

- 10/31/18: Hospital submits ECIP Implementation Protocol (that is, filled out the Track Template) and Supplemental Workbook to HSCRC for State and Federal approval
  - IP and Workbook specify whether or not the hospital will make incentive payments and, if so, how incentive payments will be calculated
  - Conditions of incentive payments must be related to care interventions – not only just financial performance
- 12/14/18: Hospital submits first of quarterly ECIP Certified Care Partner list
  - Only those on a Certified Care Partner list are eligible for incentive payments (if the hospital chooses to make incentive payments)
  - Those on a Certified Care Partner list will be determined for MACRA eligibility (aka Qualifying APM Provider (QP) based on their QP Threshold Score)
  - Other submissions are 3/15/19, 6/14/19, and 9/16/19. If on any of the first three (12/14/18, 3/15/19, 6/14/19), a clinician will be assessed for QP eligibility for CY 2019. If being determined a QP for any of those three "windows," clinician is considered a QP for all of CY 2019.

LOOKING FORWARD

Conceptual Framework for Advancing Payment Models



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POSSIBILITY FOR NEW MODEL PROGRAMS

- Maryland's TCOC Model contract allows payment programs that are not directly associated with a hospital -- "New Model Programs"
- Program details must be negotiated with CMS and the state
- Require alternative or additional payments from CMS or other funding sources
- Use of waivers and MACRA eligibility will be program specific
- Opportunity to create broad authority for non-hospital conveners with tracks underneath, similar to structure of Care Redesign Amendment but may require mechanism to enable participants to take risk

STAKEHOLDER INNOVATION GROUP (SIG) TO REVIEW POTENTIAL NEW MODEL PROGRAMS

- At request of MDH Secretary, SIG was formed to:
  - Capture existing transformation and population health models, create baseline
  - Recommend approach for voluntary stakeholder-developed models and programs to be considered for adoption/approval
  - Identify statutory and regulatory barriers to adoption or spread of transformation efforts
  - Track progress toward model goals
- SIG has members from across the care continuum
- Next meeting October 15 to discuss several potential New Model Programs
- Best-case/aggressive scenario: Obtain federal approval for a Participation Agreement and 1 or 2 New Model Programs to begin January 2020
- Likely scenario: First New Model Program begins January 2021

THANK YOU

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