Progression Strategy Discussion

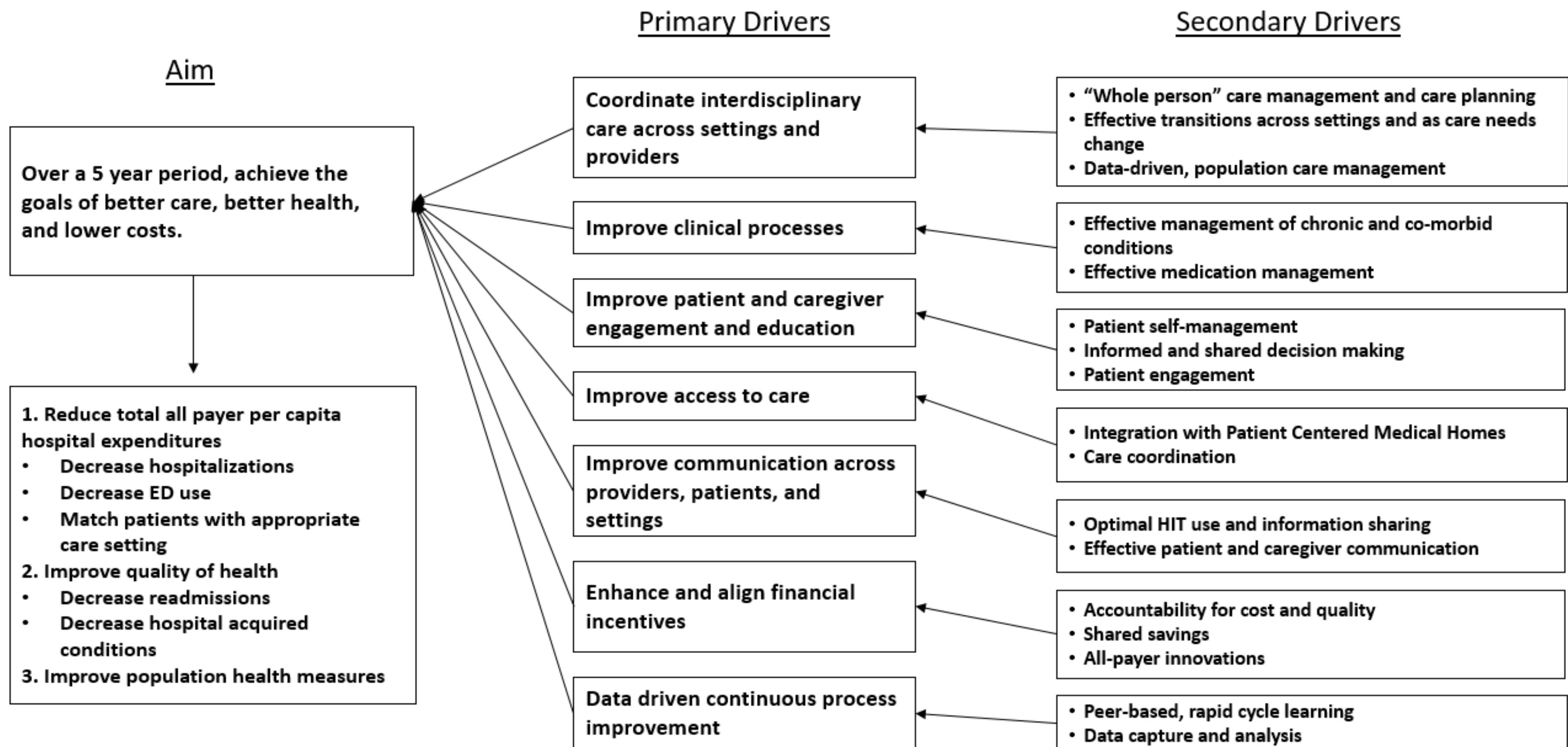
August 5, 2016

HSCRC
Health Services Cost Review Commission

Current All-Payer Model

Original All-Payer Model Application: Maryland's Strategy

Aim: Over a 5 year period, achieve the goals of better care, better health and lower costs.

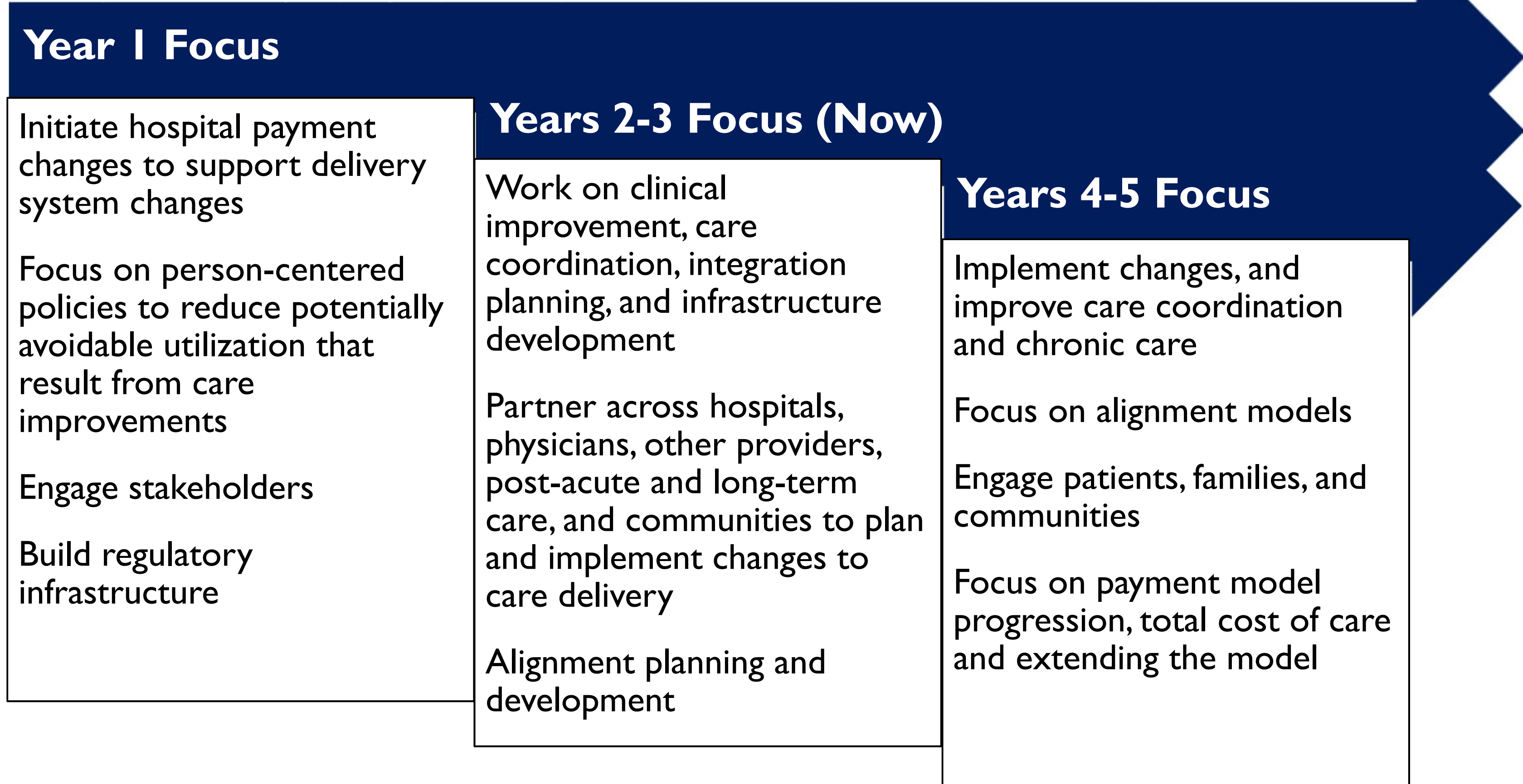


Recap: Stakeholder-Driven Strategy for Maryland

Aligning common interests and transforming the delivery system are key to sustainability and to meeting Maryland's goals

Focus Areas	Description
Care Delivery	• Improve care delivery and care coordination across episodes of care • Tailor care delivery to persons' needs with care management interventions, especially for patients with high needs and chronic conditions • Support enhancement of primary and chronic care models • Promote consumer engagement and outreach
Health Information Exchange and Tools	• Connect providers (physicians, long-term care, etc.) in addition to hospitals • Develop shared tools (e.g. common care overviews) • Bring additional electronic health information to the point of care
Provider Alignment	• Build on existing models (e.g. hospital GBR model, ACOs, medical homes, etc.) • Leverage opportunities for payment reform, common outcomes measures and value-based approaches across models and across payers to help drive system transformation

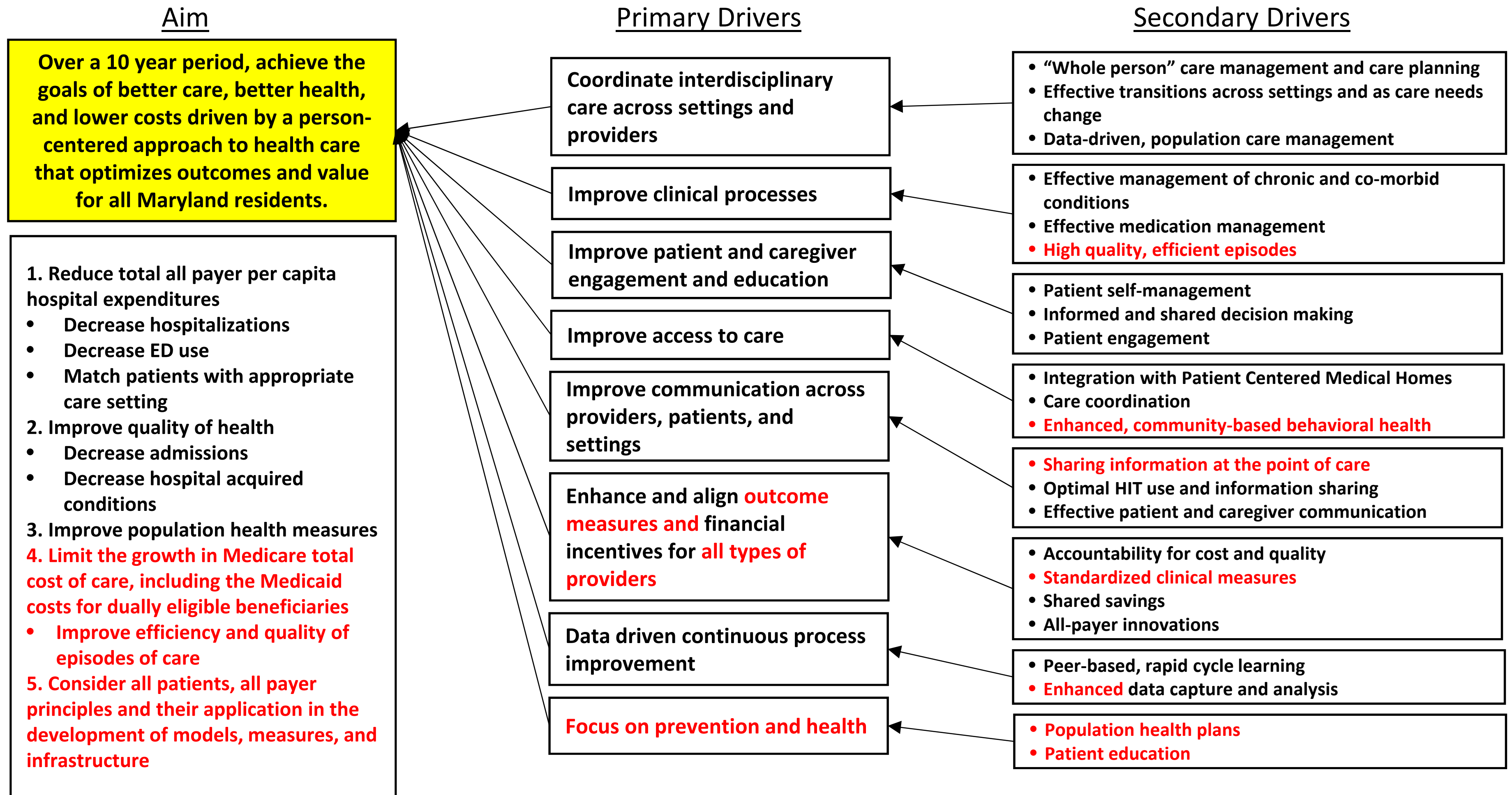
Recap: Strategy for Implementing the All-Payer Model



Progression of the All-Payer Model

Maryland All-Payer Model Driver Diagram

With Updates for the Model Progression



Maryland’s Updated Strategy

Updated Aim: Over a 10 year period, achieve the goals of better care, better health, and lower costs driven by a person-centered approach to health care that optimizes outcomes and value for all Maryland residents.

- 1. Reduce total all payer per capita hospital expenditures
  - Decrease hospitalizations
  - Decrease ED use
  - Match patients with appropriate care setting
- 2. Improve quality and efficiency of health care
  - Decrease admissions
  - Decrease health care acquired conditions
  - Improve efficiency and quality of episodes of care

- 3. Improve population health measures
- 4. Limit the growth in Medicare total cost of care, including the Medicaid costs for dually eligible beneficiaries

- 5. Consider all patients, all payer principles and their application in the development of models, measures, and infrastructure

Progression Plan: Scope

Approximate CY 2015 Figures (for 6 million Marylanders)	
All Payer Hospital Revenues (Maryland Residents in Maryland hospitals)	$14.8 billion
Medicare Non-Hospital Spend (Maryland Beneficiaries anywhere)	$3.9 billion
Medicare Hospital Spend Non-Regulated	$0.5 billion
Medicaid Costs for Dual Eligible Patients	$2.0 billion
Total Costs to be Addressed in the Strategic Plan	**$21.2 billion**

Notes:

1) Regulated hospital revenues incorporate ~$4.8 billion of Medicare spend.
2) Medicare spend includes only payments by Medicare.
3) Medicare non-regulated hospital spend is primarily out-of-state hospital spend. Also includes in-state specialty hospital spend.
4) Medicaid figures are estimated and may be updates.

Test Several Concepts Along with Hospital Model to Take on Responsibility for TCOC and Outcomes

Need to address all Medicare beneficiaries

ACOs	Medical Home or other Aligned Models	Duals Model (TBD)	Geographic (Hospital + Non-Hospital) Model
200,000 beneficiaries?	200,000 beneficiaries?	91,000 beneficiaries?	400,000 beneficiaries?

Tackling TCOC

- How to start addressing TCOC
  - Start receiving TCOC data and data to support care coordination and chronic care improvement and more efficient high quality episodes (the Amendment)
  - Learn how to utilize data and make delivery system changes that act on the most significant opportunities for care improvement and controlling costs, including:
    - A medical home approach that cuts across payers and models
    - Patients with high needs and chronic conditions
    - Population health
    - Episode costs and outcomes (including post-acute)

All-Payer Model: Progression Strategy Blueprint

Strategic Considerations:

- Allow all system components and consumers, including physicians, long-term care, behavioral health, and others, to participate in care delivery and payment transformation initiatives
- Align hospital and provider performance measures and incentives
- Support providers/practitioners in practice transformation (e.g. streamlining administrative requirements)
- Assist providers with qualifying for additional funding under MACRA (financial incentives under MIPS and Advanced APM bonuses)
- Leverage current strengths, works in-progress, and available funding from the federal government
- Build in the flexibility to:
  - Improve models over time
  - Allow for adaptation in a dynamic health care system

Please refer to Progression Strategy Blueprint document for Design Principles

Starting to Address the Strategic Considerations: Care Redesign Amendment

- In response to stakeholder input, the State is proposing a **Care Redesign Amendment** to the All-Payer Model, which will allow needed approvals (Safe harbors, Stark, etc.) and data for care redesign and alignment
- Opportunity to incorporate physicians and other providers in focus on All Payer hospital costs and Medicare TCOC
  - Have a "**living**" program that allows for annual adjustments as we learn how to deploy interventions, test new models (e.g. considering episodes) and focus on TCOC
  - Focus on addressing MACRA coverage for the All Payer Model

Program	Purpose
Complex & Chronic Care Improvement Program	Align community providers
Hospital Care Improvement Program	Align providers practicing at hospitals
Long-term / Post-acute Models	Align other non-hospital providers

- **Tools:**
  - Shared care coordination resources
  - Detailed Medicare data for care coordination
  - Medicare TCOC data
  - Shared savings from hospitals
  - Possible MACRA Advanced APM status

Progression Strategy Blueprint: Areas for Consideration

- Consider transformation in the following strategy areas:
  1. Payment and Delivery Approaches
     1. Primary/Complex Care
        1. Amendment--Complex and Chronic Care
        2. Comprehesive Primary Care
        3. Behavioral health
        4. Long term care
     2. Episodes
        1. Amendment—Hospital Care Improvement
        2. Post acute
  2. TCOC Focus
     1. Geographic Population Model (including leveraging Amendment) transitioning to upside/downside incentive payments and or risk
     2. Dual Eligibles ACO/PCMH transitioning to upside/downside risk
     3. Continuing/Increasing ACO/PCMH approaches transitioning to upside/downside risk

- Questions for consideration:
  - Are these elements the right ones?
  - What is the timeline? How should the strategies and models be prioritized? What is the best phased approach?
  - How should we go about developing the plan and the models?

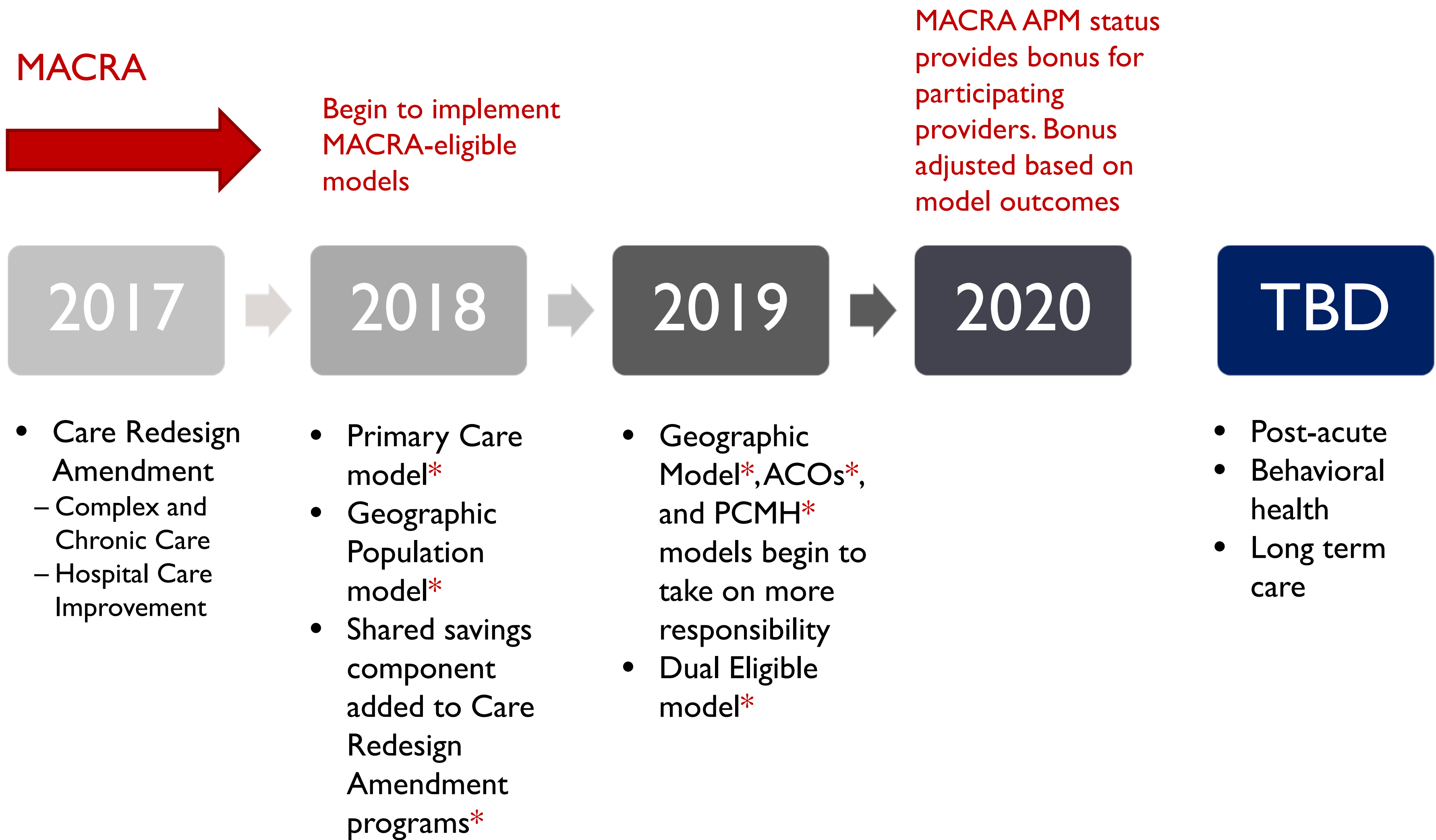
Envisioning Core Strategic Elements

- Primary Care/Complex and Chronic Care
  - Create a person-centered locus of care with supporting interdisciplinary care teams across all care settings, data-driven care coordination, and financial incentives that move towards greater accountability.
  - Behavioral Health
    - Improve access to community-based, behavioral health services, promote clinical integration between primary care and behavioral health, and develop value-based payment mechanisms
  - Long-term Care
    - Create value-based payment and care delivery mechanisms that improve care coordination and delivery of long-term care and home and community-based services

Envisioning Core Strategic Elements (cont.)

- Post-acute Care
  - Create alignment between hospitals and post-acute providers and facilities that optimizes transitions and resource use across care settings (e.g. acute, post-acute, long-term care, home, etc.)
- Geographic Population Model
  - Promote All-Payer Model progression through an accountability model that creates local responsibility for patient health outcomes and total cost of care in an actionable geographic area, first focusing on Medicare
- Dual Eligibles
  - Create payment and care delivery mechanisms that improve care coordination and access to care for Dual Eligible beneficiaries, and incorporate payer accountability for Dual Eligible total cost of care (e.g. including medical and custodial care)

Potential Timeline



Note: * Indicates anticipated MACRA-eligible models (Advanced Alternative Payment Models).

Appendix- Strategies & Models To be Worked Through

Geographic Population Model

- Concept:
  - Global budget(s) **+ non-hospital costs** → Medicare total costs for a geography
    - Focuses on services provided in a particular geography
  - Creates responsibility for a patient population in an actionable geographic area
    - Includes services provided in local geographic area (excludes tertiary and quaternary care provided in other hospitals)
    - Allows for local focus and increases opportunities for population health partnerships
    - Creates a larger pool that mitigates high-cost patients, allowing providers to learn how to effectively share responsibility gradually

Geographic Population Model (cont.)

- Rationale:
  - While the global budget already distributes responsibility for ~ 56% of Medicare costs, CMS expects Maryland to take on increasing accountability for TCOC over time
    - A geographic model can cover the additional 15%-20% of Medicare spend for non-hospital services related to hospitalizations (e.g. post acute, physician costs, etc.)
  - More partnerships with community providers are needed to continue reducing avoidable utilization and improving outcomes for the sustainability of the All-Payer Model
    - A geographic model can create an approach to engage non-hospital providers, organize resources, and create accountability approaches across providers
  - MACRA is creating significant financial consequences for providers to support value-based payments, rather than volume-based payments
    - A geographic model can help physicians and others qualify for greater funding under MACRA if they work with hospitals that take some responsibility for TCOC and thus become Advanced APM entities

Geographic Population Model (cont.)

- **Geographic Population Model:** Promote All-Payer Model progression through a payment model that creates local responsibility for patient health outcomes and total cost of care in an actionable geographic area, first focusing on Medicare

- Model Considerations:
  - Base the model on geography/episodes or a combination of approaches
  - Consider regional organizations to service local health care community
  - Consider value-based payment in CY 2017/FY 2018 based on TCOC for Medicare to use with global budgets/engage physicians through Amendment
    - Physician idea—value based payment could be applied to physician payment
      - Assists with MACRA eligibility
    - Accelerate TCOC focus for Medicare while limiting risk
    - For 2019, could become a shared savings model or increase value based portion of payment tied to Medicare TCOC and outcomes
    - Works along with ACOs and PCMH models

Primary Care

- Rationale:
  - The population is aging and chronic diseases are becoming more prevalent (e.g. 18% of MD population >65 by 2025)
    - Need for more care coordination and chronic care management
  - Taking on Medicare Total Cost of Care (for the sustainability of the All-Payer Model) relies heavily on primary and complex and chronic care
    - CMS is focused on enhancing chronic care and primary care, and is providing significant funding sources. E.g. Chronic Care Management fees (CCM), Comprehensive Primary Care Plus model (CPC+)
  - Main idea--Focus on the opportunity to replace the CCM fee with a CPC+ type of model that pays care management dollars on a risk-adjusted per person basis rather than a fee schedule, and support primary care transformation

Primary Care (cont.)

- **Primary Care Strategy**: Create a person-centered locus of care with supporting interdisciplinary care teams across all care settings, data-driven care coordination, and financial incentives that move towards greater accountability

- Concept:
  - Tailor care according to persons' needs
  - Engage consumers and families
  - Help people with chronic disease and complex needs live healthier lives, reducing downstream utilization
  - Continue to build care coordination infrastructure and resources
  - Improve care and reduce potentially avoidable utilization