



**All Payer Hospital System Modernization
Payment Models Workgroup**

Meeting Agenda

September 5, 2018

9:00 am to 11:00 am

Health Services Cost Review Commission

Conference Room 100

4160 Patterson Avenue

Baltimore, MD 21215

- I Introductions and Meeting Overview
- II Total Cost of Care Contract Overview
- III Strategy Policy Plan & Implementation
- IV Discussion of the Differential
- V MPA Addendum
- VI Adjourn



Total Cost of Care Model Implementation 2018-2019

Payment Models Workgroup

Health Services and Cost Review Commission
September 2018



Maryland's Total Cost of Care (TCOC) Model

- **CMS approved a new 10-year model for Maryland**
 - Starts January 1, 2019
 - Builds on the All-Payer Model
 - Moves beyond hospitals to further improve health outcomes of individuals and the population, and to slow the growth of per capita healthcare spending
 - Uses State flexibility to promote private-sector efforts
- **CMS and Maryland Legislature require Medicaid Alignment**
 - Medicaid TCOC Savings Targets (Legislature)
 - Programmatic Alignment (CMS)

Annual Medicare TCOC Savings Targets

(Targets are relative to 2013 base)

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 end of 2023, reach **\$300 million** in annual savings to Medicare Parts A and B, including non-claims based payments, through slower TCOC spending growth per beneficiary
- In 2017, annual TCOC savings to Medicare were **\$138 million**
- Projected **\$1 billion** of total savings during the first 5 years (2019-2023) of new TCOC Model
- If there are excess savings during PYs 1-2, half of the total excess savings will be credited to the following year's TCOC savings calculation; the other half would accrue to Medicare

Annual Medicare TCOC Savings Targets (cont'd)

- ▶ **If Maryland fails to meet the Annual Medicare TCOC Savings Target by**
 - ▶ \$100 million or more, it is a Triggering Event:
 - ▶ Maryland must submit a corrective action plan
 - ▶ CMS may also take other corrective actions (including termination of the Model)
 - ▶ \$30 million to \$100 million, it is an Other Event:
 - ▶ CMS may require additional information, monitoring, or a corrective action plan
 - ▶ By itself, an Other Event will not lead to termination of the Model
 - ▶ >\$0, then Maryland will describe in Annual Report to CMS its actions to meet next year's target
- ▶ **State has levers to meet Annual Savings Targets. For example:**
 - ▶ All-Payer hospital rate-setting
 - ▶ Medicare Performance Adjustment (MPA)

MDPCP and Outcomes-Based Credits

- ▶ Care Management Fees (CMF) to physicians for participation in the Maryland Primary Care Program (MDPCP) – as well as other non-claims based Medicare payments, such as ACO Shared Savings Payments – will count as costs when calculating Annual Medicare TCOC Savings
- ▶ Outcomes-Based Credits may be applied against the CMF costs to help the State meet Annual Medicare TCOC Savings Target
 - ▶ State staff currently working with CMS on credits for reduced diabetes
 - ▶ Future credits could be based on reductions in opioid deaths, Hep C prevalence, etc.
 - ▶ Because credits are based on performance beginning in CY2019, likely will not see meaningful credit amounts for some time
 - ▶ Credits cannot exceed CMF (or other future similar federal “investments”)

Other Model Financial Targets

▶ All-Payer Revenue Limit

- ▶ Continue to limit all-payer hospital spending growth per capita to 3.58% annually (compounded from 2013)
- ▶ Failure is an Other Event

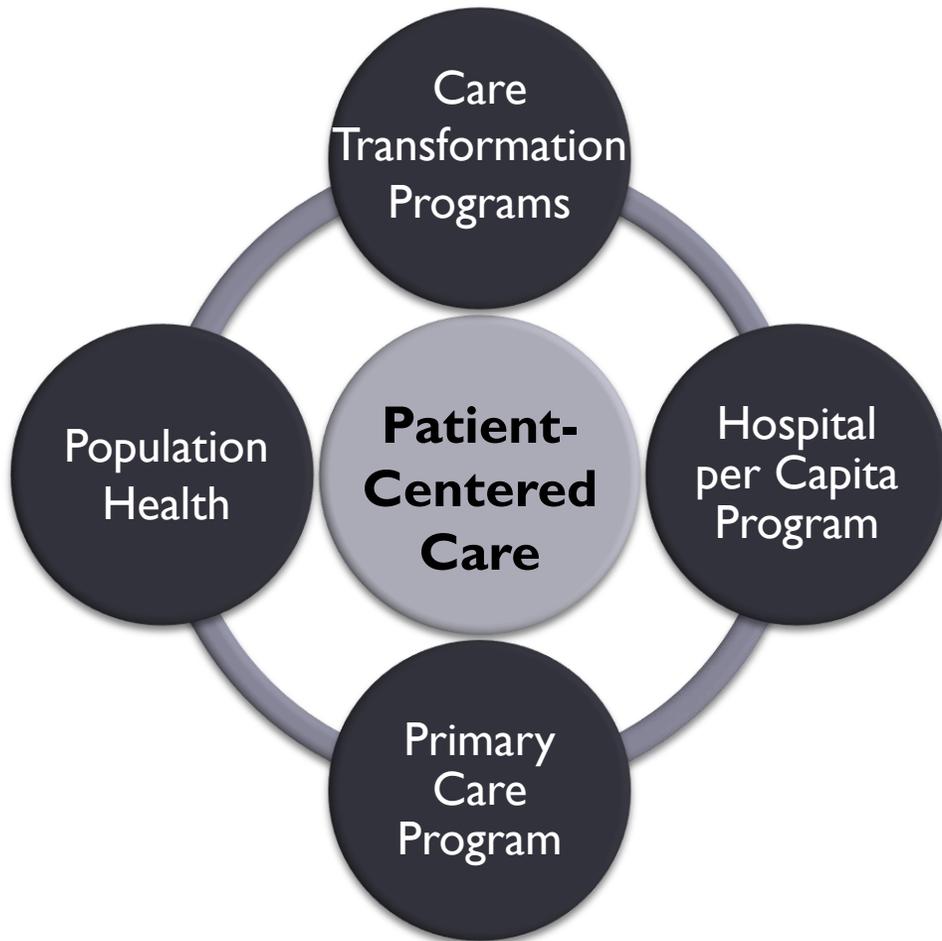
▶ TCOC Guardrails for Medicare TCOC per beneficiary growth

- ▶ No more than 1% above the nation in any one year, and no more than the nation in two consecutive years
- ▶ Failure is an Other Event

▶ Compounded Savings Target (2024+)

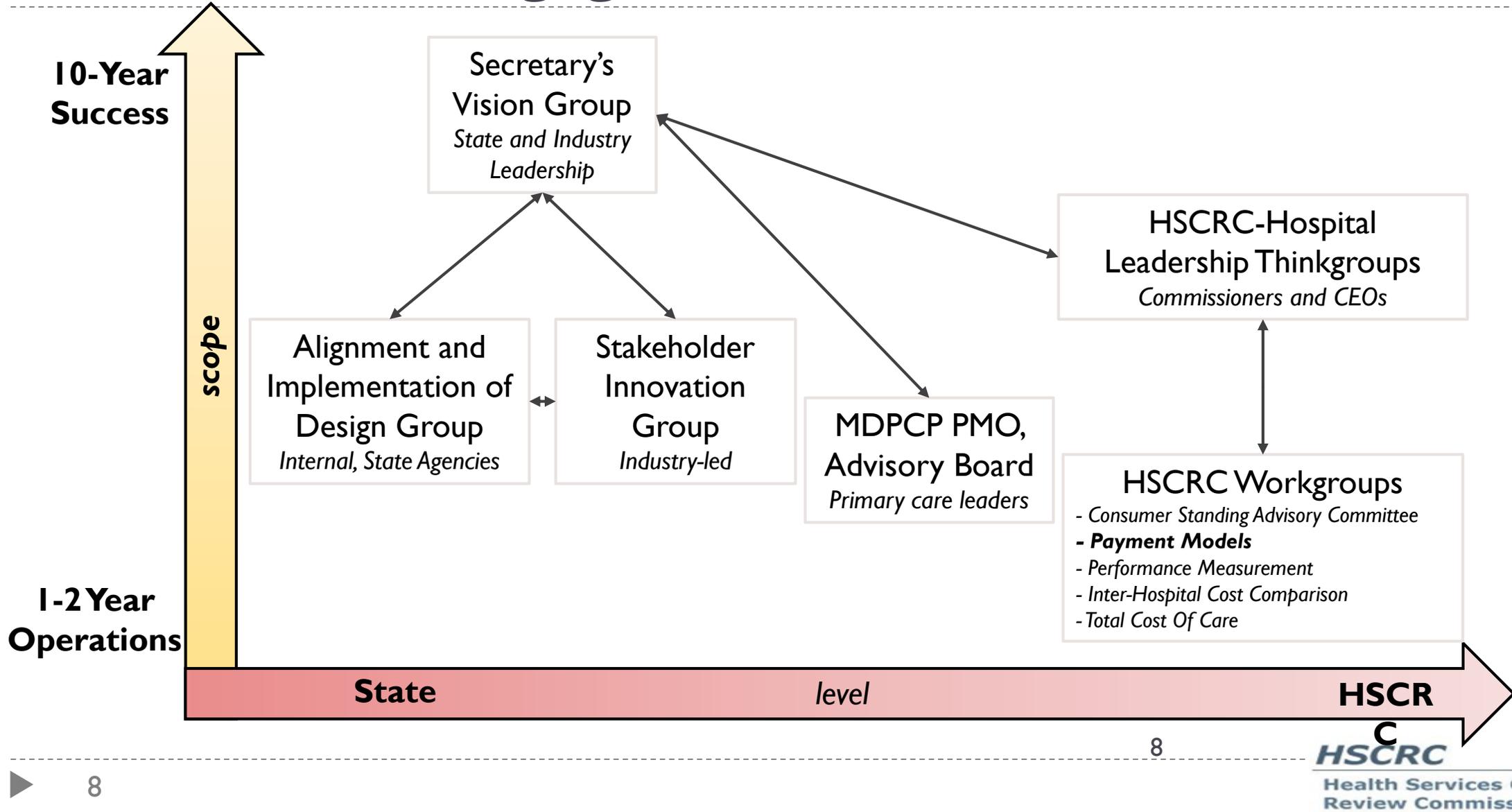
- ▶ The \$300M test for 2023 will be replaced by a new test (details to be negotiated in the future) to ensure Maryland's TCOC growth does not exceed the nation

Overview of TCOC Model Components

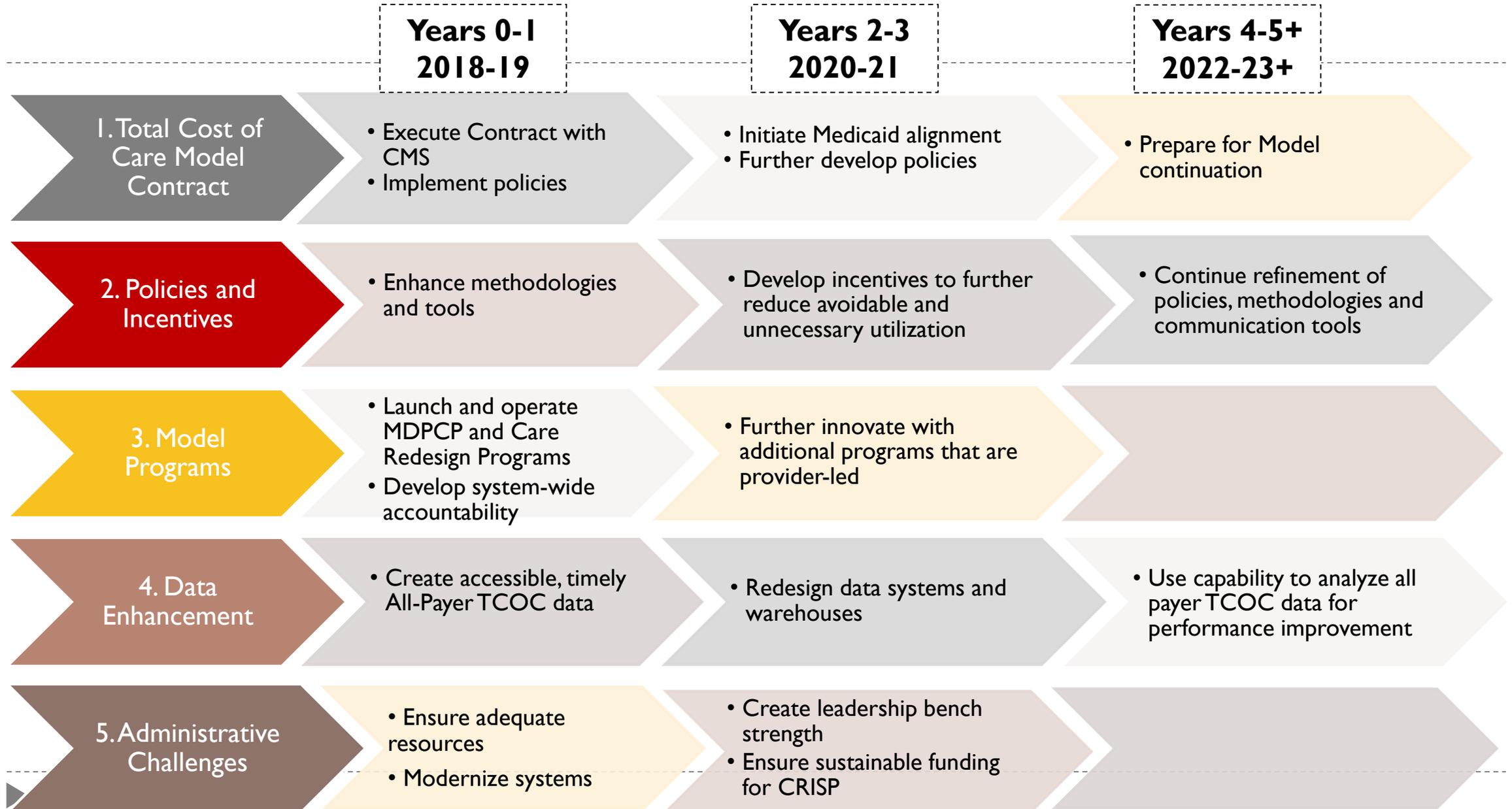


- Continues and enhances hospital program that limits growth per capita for all payers.
- Expands care transformation programs to enable private sector-led programs supported by State flexibility.
- Initiates the Maryland Primary Care Program (MDPCP) to enhance patient centeredness, chronic care and health improvement.
- Harnesses public and private sector efforts to address population health issues, including opioid use, diabetes, and other chronic conditions.

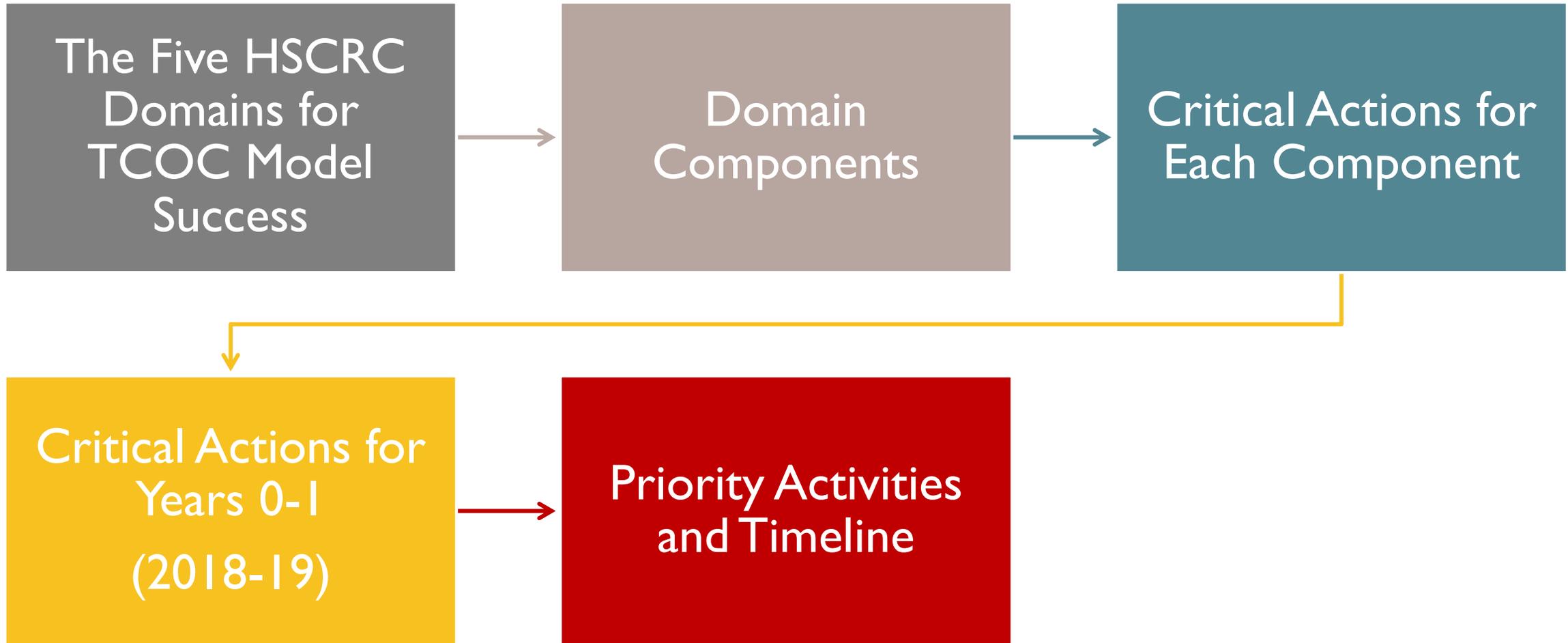
TCOC Model Engagement



Roadmap for TCOC Model Success



Process Map for 2018 Priority Activity Development



Aim High



- Population health improvement
- Improved outcomes
- Lower disease burden
- Lower costs of care



2018/2019 HSCRC Priority Activities

1. Total Cost of Care Model Contract

- Complete the TCOC contract
- Communications rollout and signing ceremony
- Small meetings with stakeholders and commissioners/staff to discuss success factors, priorities
- Develop 3-5 **B**old **I**mprovement **G**oals for the five-year horizon

2. Clear Policies and Incentives for the Total Cost of Care Model

- Enhance building blocks for policy advancement
- Implement policy tools
- Update policies for TCOC Model

3. Launch and Operate Model Programs

- Support MDPCP Rollout
- Implement and enhance care redesign programs
- Develop approach and infrastructure for new model programs beyond hospitals

Domains 4 and 5: Ongoing staff expansion, succession, and enhanced data infrastructure

2a. Clear Policies and Incentives: Enhance Building Blocks

| HSCRC Tasks | Importance and Rationale |
|--|--|
| <p>Improve Volume Measures</p> <ul style="list-style-type: none">- Cycle-billed services- Clinic RVUs- High-cost Drugs | <p>Needed for efficiency measurement and volume policy development (PAU, Demographic Adjustment, Market Shift)</p> |
| <p>ICC Refinements</p> <ul style="list-style-type: none">- Incorporate cycle billed services- Site neutrality- Indirect Medical Education Differentiation- Targeted Reductions to Profit Strips- Per capita measures | <p>Better efficiency measures in an enhanced per capita context</p> |
| <p>Cost and Rate Realignment and Differential Impact</p> <ul style="list-style-type: none">- Inpatient Room & Board, ER & clinic charges, and drug overhead- Private payer uncompensated care- Site neutrality | <p>Improved cost accounting to support decision management and to better relate rates to cost. An adjustment to the payer differential may be needed to accompany these two changes.</p> |
| <p>Develop TCOC and Utilization Benchmarks</p> <ul style="list-style-type: none">- Expand PAU definitions- Refine application of methodology | <p>Needed at hospital specific levels for MPA attainment and policy development.</p> |

2b. Clear Policies and Incentives: Update Policies for TCOC Model

| HSCRC Tasks | Importance and Rationale |
|---|--|
| Align Quality, Outcomes, and Value Policies with Bold Improvement Goals and Contract Requirements | Initiating and refining the policies and incentives to drive success under the new TCOC Model. |
| Redesign global budget policies including MPA modification | |
| Develop New Hospital Contracts | Incorporating new policies and Model requirements. |
| Address system capacity <ul style="list-style-type: none">- Address excess capacity and alternative uses- Address deregulation | Developing new policies regarding capacity and deregulation/growth in non-hospital services. Payment adjustments for non-hospital services. |

2c. Clear Policies and Incentives: Implement Policy Tools

| HSCRC Tasks | Importance and Rationale |
|--|--|
| <ul style="list-style-type: none">- Hospital revenue reductions for outlier high-cost hospitals (top 5)- Address the low outlier hospitals through full rate reviews and other mechanisms | Implement efficiency tools and realize efficiencies. |
| Adjust hospital revenues for shifts to unregulated settings | Ensuring payers are not overpaying for services through the hospital global revenues and additional setting. |
| <p>Develop MPA infrastructure</p> <ul style="list-style-type: none">-Process with CMS intermediary-Calculation processes | Prepare to execute payment adjustment on July 1, 2019. |

| | | January | July | December |
|---|---|----------------------------|-------------------|----------|
| | 2019 Target Completion: | | | |
| 1. Total Cost of Care Model Contract | <ul style="list-style-type: none"> - Complete the TCOC contract communications rollout and signing ceremony - Small meetings with stakeholders and commissioners/staff to discuss success factors, priorities - Develop Bold Improvement Goals (BIG) for the five-year horizon | <p>✓</p> <p>✓</p> <p>✓</p> | | |
| 2a. Clear Policies and Incentives: Enhance Building Blocks | <ul style="list-style-type: none"> - Improve volume measures - ICC Refinements - Cost and Rate Realignment and Differential Impact - Develop TCOC and utilization benchmarks | <p>✓</p> <p>→</p> | <p>✓</p> <p>→</p> | |
| 2b. Clear Policies and Incentives: Update Policies for TCOC Model | <ul style="list-style-type: none"> - Align Quality, Outcomes, and Value Policies with Key Objectives and Contract Requirements - Redesign global budget policies including MPA modification - Develop New Hospital Contracts - Address system capacity | <p>✓</p> <p>→</p> | <p>→</p> <p>→</p> | |
| 2c. Clear Policies and Incentives: Implement Policy Tools | <ul style="list-style-type: none"> - Hospital revenue reductions for outlier high-cost hospitals (top 5) - Adjust hospital revenues for shifts to unregulated settings - Develop MPA infrastructure | <p>✓</p> | <p>✓</p> <p>✓</p> | |
| 3. Launch and Operate Model Programs | <ul style="list-style-type: none"> - Support MDPCP Rollout - Implement and enhance care redesign programs - Develop approach and infrastructure for new model programs beyond hospitals | <p>✓</p> <p>→</p> | | <p>✓</p> |

Briefing Document – HSCRC Staff Proposed Recommendation for Adjustment to the Payer Differential

September 2018 – Payment Model Workgroup

Maryland's Public-Private Payer Differential

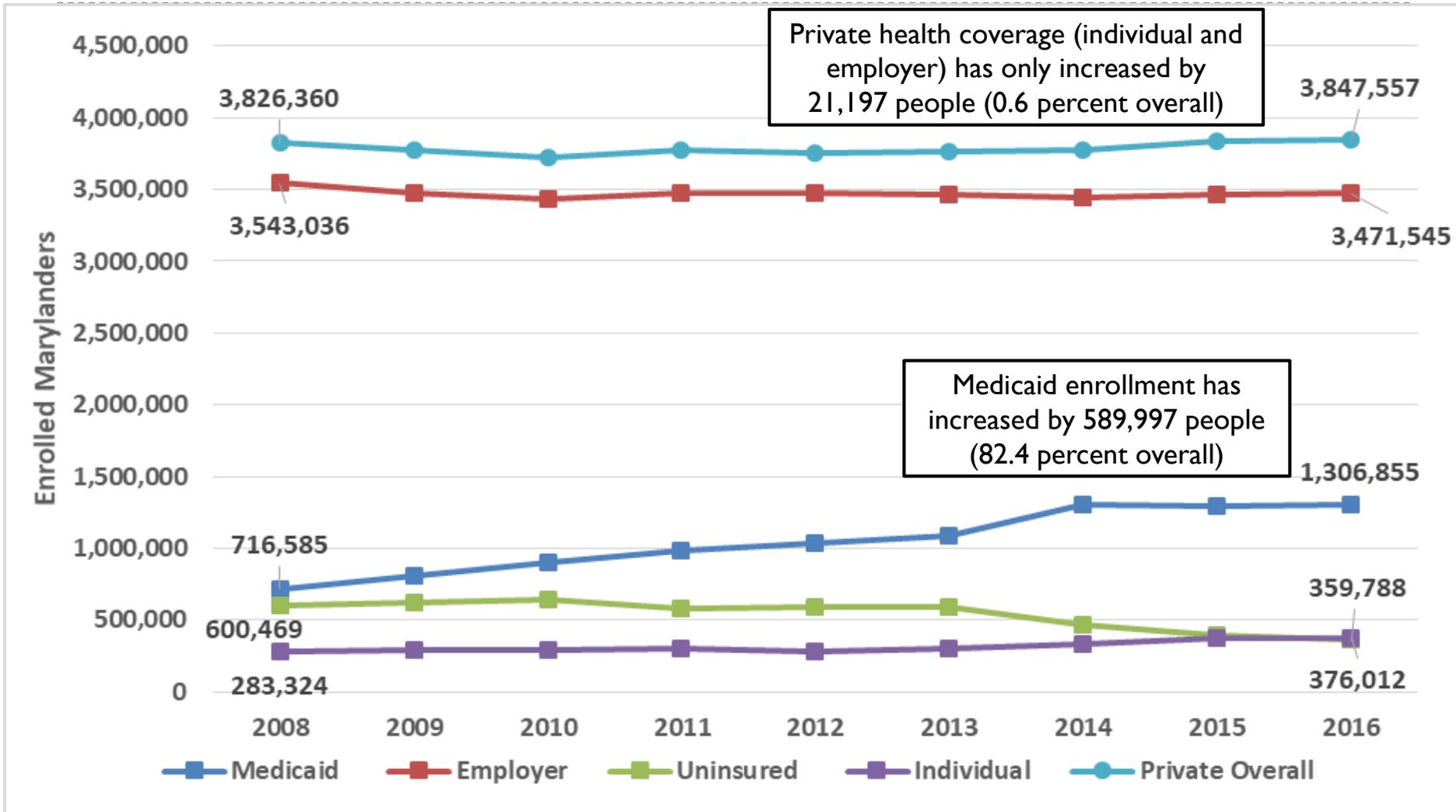
- ▶ Negotiated at the beginning of the All-Payer system in 1977
- ▶ Public payers (Medicare and Medicaid) pay 6 percent less than other payers (primarily commercial payers).
 - ▶ The All-Payer Model contract requires that the differential, “be at a minimum 6.0 percent,” to account for Medicare’s, “business practices and prompt payment practices.”
- ▶ Hospital charges are adjusted to ensure that the differential’s reduction in charges to public payers does not result in a decline in hospitals’ total revenue.
- ▶ Maryland’s payer differential is significantly less than the rest of the nation where public payers typically pay 12 percent less than other payers

Increasing the Public-Private Payer Differential

- ▶ Staff will be asking the Commission to approve a final recommendation to increase the public-payer differential from the current 6.0 percent to 7.7 percent, effective July 1, 2019.
 - ▶ This increase is recommended to respond to increasing bad debt write-offs in commercial coverage and prevent cost shifting to Medicare and Medicaid.
- ▶ Uncompensated care in Maryland has declined as a result of increased insurance coverage from the Affordable Care Act
- ▶ Private insurance plan design changes increasingly expose hospitals to bad debt as consumers are responsible for more cost sharing

| | Medicare and Medicaid | Commercial | Difference |
|----------------|------------------------------|-------------------|-------------------|
| FY 2015 | 2.2% | 3.6% | 1.4% |
| FY 2016 | 2.1% | 3.8% | 1.7% |
| FY 2017 | 1.8% | 3.6% | 1.9% |
| Change | -0.5% | 0.0% | |

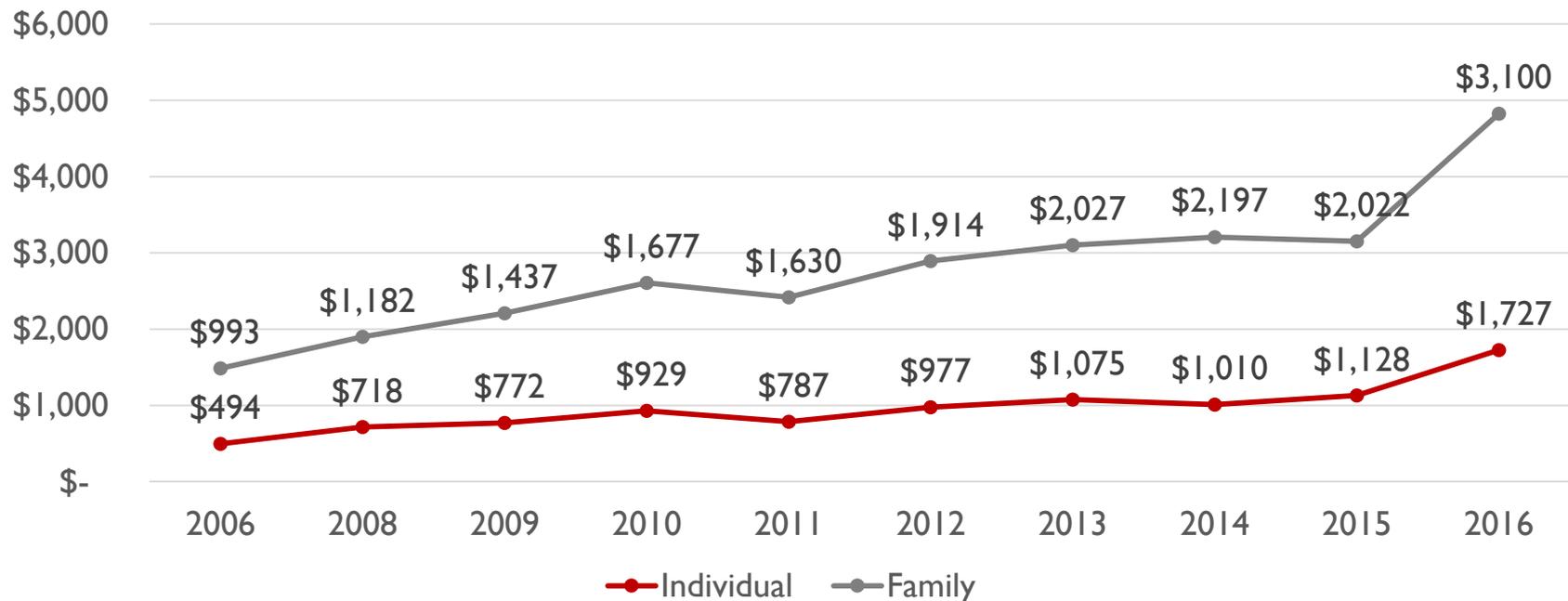
Increases in Medicaid Coverage have Reductions in the Uninsured Population



Private Insurance Deductibles Costs are Increasing Rapidly

- ▶ The share of privately insured Marylanders with a deductible has increased from 49.9 percent in 2006 to 88.7 percent as of 2016.
- ▶ Increases in deductibles outpace consumer and medical cost inflation

Percent of Maryland private-sector employees enrolled in a health insurance plan with deductible (CY2002-CY2016)



Staff Proposed Recommendation

- ▶ Based on the assessment above, staff recommends the following, effective July 1, 2019:
 1. Increase the differential by 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to more equitably allocate higher uncompensated care costs incurred by commercially insured patients. This adjustment will be made through the hospital mark-up adjustment, which will provide a net revenue neutral approach for hospitals. This increase would result in:
 - ▶ A lower cost to Medicare of approximately \$40 million;
 - ▶ A lower cost to Medicaid of approximately \$27 million; and
 - ▶ An increase in overall commercial payer costs of \$67 million, or 0.4 percent, assuming commercial costs reflect approximately one-third of total hospital costs.

Staff Proposed Recommendation, Continued

2. The cost reduction to Medicare as a result of the change in the differential be removed from the Total Cost of Care performance evaluation when establishing future annual updates, including any reconsideration of the rate year 2019 update.
3. Similarly, the savings to Medicare resulting from the differential adjustment should not be included in the trend factor used to calculate a hospital's performance under the Medicare Total Cost of Care algorithm.
4. The Commission should develop and adopt policies regarding the appropriate use of various rate-setting tools to meet Medicare total cost of care performance requirements.