



# Total Cost of Care Workgroup

December 2016

# Key Attributes of Maryland's All-Payer Model

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- ▶ Applies to: 6 million Marylanders, ~800k Medicare beneficiaries
- ▶ 5 year agreement with CMS (CY 2014-CY 2018)
- ▶ All-payer annual growth limits in hospital revenue to < 3.58% per capita
- ▶ Medicare hospital savings >\$330 million, TCOC guardrail
- ▶ Quality improvement requirements
- ▶ Hospital global revenue with overlying value-based incentive and rates approved by independent State agency
  - ▶ Maryland Health Services Cost Review Commission (HSCRC)

# Key Accomplishments of the All-Payer Model

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- ▶ **Payment and delivery system transforming**
  - ▶ Hospitals—95% of revenues under global limits
  - ▶ Delivery systems, payers, and regional partnerships organizing and transforming
  - ▶ IT and care coordination infrastructure expanding
  - ▶ Broad stakeholder participation contributing to success
  
- ▶ **Creating value**
  - ▶ All-payer hospital growth contained (well below limits)
  - ▶ Medicare savings on track, less than national growth rate without cost shifting
  - ▶ Quality improving and readmissions going down, benefiting patients
  - ▶ Care coordination resources strengthening, providing better support for patients

# Maryland's Transformation Strategy

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- ▶ Delivery system moves towards higher levels of patient-centered prevention and care management
- ▶ Care redesign programs and population health approaches are implemented to create cooperation and alignment across the continuum of providers
  - ❑ Improve quality
  - ❑ Reduce potentially avoidable utilization
    - ❑ 1% reduction = \$18m
- ▶ Build on Investments and Successes
  - ❑ GBR
  - ❑ Amendment
    - ❑ Complex and Chronic Improvement Program
    - ❑ Hospital Care Improvement Program

# Stakeholder-Driven Strategy for Maryland

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**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

# Timeline for Implementing the All-Payer Model

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## Year 1 Focus

Initiate hospital payment changes to support delivery system changes

Focus on person-centered policies to reduce potentially avoidable utilization that result from care improvements

Engage stakeholders

Build regulatory infrastructure

## Years 2-3 Focus

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

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

Alignment development

## Years 4-5 Focus

Implement changes to improve care coordination and chronic care (**Care Redesign Programs**)

Focus on alignment models

Engage patients, families, and communities

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

# Overview of Progression Components

*Support Groups of Providers Taking Responsibility for Cost and Outcomes of Medicare Fee-for-Service Beneficiaries*

ACOs

Medical Home

Duals ACO

Geographic

Existing

New

Builds on Hospital Global Budget, Regional Partnerships and MACRA

*Supporting Payment/Delivery Approaches with All Payer Applicability*

Global Hospital Budgets and Regional Partnerships  
Amendment--Complex/Chronic Care, Hospital Care/Episodes  
Primary Care Home--Chronic care, Visit budget flexibility  
Incentive Harmonization  
Post-acute and Long-term Care Initiatives  
Other MACRA-eligible programs

# Workgroup Charge

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The initial charge of the TCOC workgroup is to provide feedback to HSCRC on the development of specific methodologies and calculations while considering implications to avoid cost-shifting for:

1. Hospital-level Medicare TCOC guardrails for the Amendment Care Redesign Programs
2. The Hospital-level Incentive Pool for the Complex and Chronic Care Improvement Program (CCIP)
3. Value-based payment modifiers based on Medicare TCOC
4. The development of a Geographic Population Model (Medicare and potentially others)



# Care Redesign Amendment Implications

December 14, 2016

# Care Redesign Amendment

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- ▶ In response to stakeholder input (Advisory Council, HSCRC Care Coordination Workgroup), the State proposed a **Care Redesign Amendment** to the All-Payer Model
  - ▶ Allow hospitals to gain needed approvals (Safe harbors, Stark, etc.) and data for care redesign interventions
  - ▶ 18 month process to work through CMS and stakeholder work group
- ▶ Provides framework for Maryland to create Care Redesign Programs with supporting payment mechanisms, that align all types of providers across the delivery system through hospital based programs
- ▶ Approach: Amendment as an intermediate step to support complex and chronic care, care improvements, efficiency, and patient engagement
  - ▶ Have a “**living**” program that allows for annual adjustments as we learn how to deploy interventions, test new models and focus on TCOC

# Purposes of the Care Redesign Program

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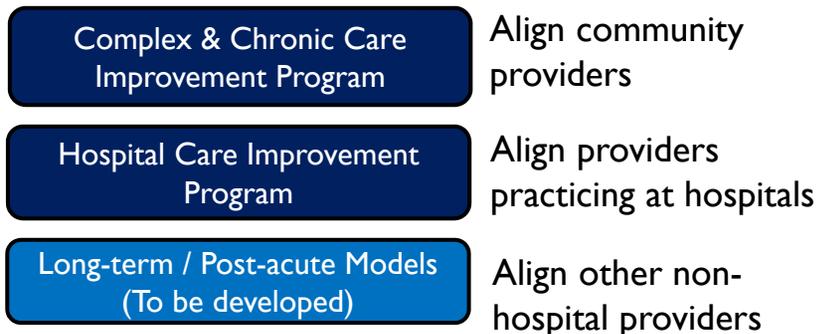
Care Redesign Programs serve three purposes:

- ▶ The Care Redesign Programs give the State flexibility to align incentives between hospitals and other providers.
- ▶ The Care Redesign Programs are intended to give the hospitals the tools that they need to succeed under the All-Payer Model by aligning financial incentives between providers.
- ▶ The Care Redesign Programs create a platform on which to build towards the next version of the Maryland All-Payer Model.

# Care Redesign Amendment: Tools and Programs

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- ▶ The Care Redesign Amendment to the All-Payer Model will provide access to the following **tools**:
  - ▶ Detailed, person-centered Medicare data (beyond hospital data across care continuum) for care coordination and care redesign
  - ▶ Medicare Total Cost of Care data for planning and monitoring
  - ▶ Approvals for sharing resources for care coordination and care improvement
  - ▶ Approvals for hospitals to share savings with non-hospital providers



# First Two Care Redesign Programs (2017)

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## Hospital Care Improvement Program (HCIP)

### Who?

- ❑ Hospitals and physicians practicing at hospitals

### What?

- ❑ Improve quality and efficiency of inpatient medical and surgical services
- ❑ Facilitate effective transitions of care
- ❑ Enhance effective delivery of care during acute care events even beyond hospital walls
- ❑ Manage inpatient resources efficiently
- ❑ Reduce avoidable utilization with a byproduct of reduced cost per acute care event

### Tools/Resources

- ❑ Comprehensive Medicare data for hospitals
- ❑ Financial incentives for hospital-based physicians

## Complex and Chronic Care Improvement Program (CCIP)

### Who?

- ❑ Hospitals and community providers and practitioners
- ❑ High and Rising Risk Patients

### What?

- ❑ Strengthen ongoing care supports for complex and chronic patient
- ❑ Reduce avoidable hospital utilization
- ❑ Enhance care management through tools such as effective risk stratification, health risk assessments, and patient-driven care plans

### Tools/Resources

- ❑ Comprehensive Medicare data
- ❑ Provider access to hospital-funded care management resources and technology
- ❑ Provider access to Medicare Chronic Care Management (CCM) fee
- ❑ Financial incentives to community providers and practitioners if hospital elects to provide



# TCOC Workgroup will Focus on Two Elements of the Care Redesign Programs

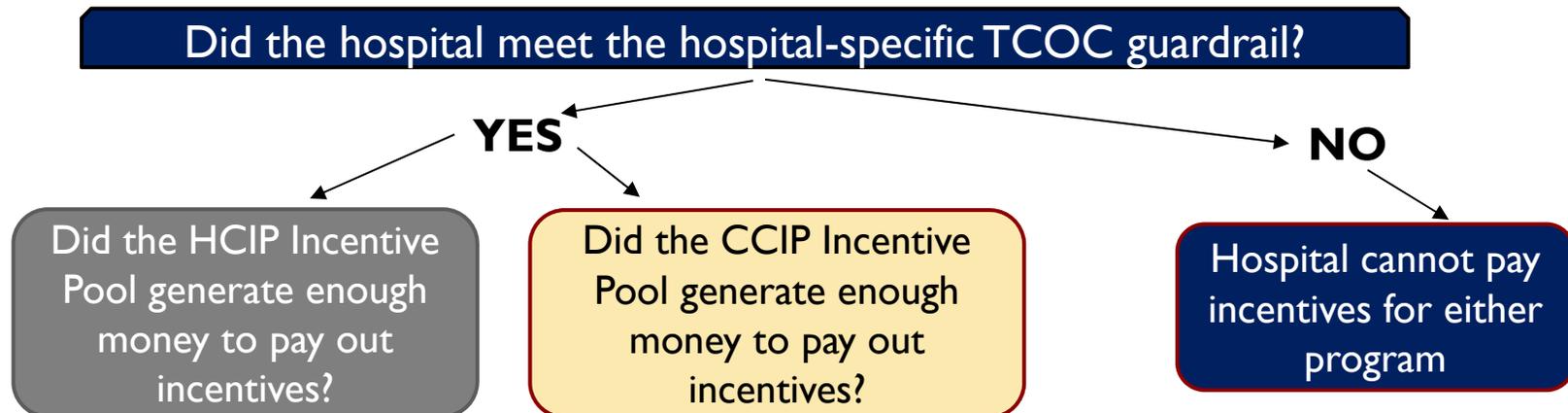
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## TCOC Guardrails

- ▶ Medicare Hospital-specific TCOC guardrails apply to **both** CCIP and HCIP
- ▶ The same Medicare Hospital-specific TCOC calculation will be used for both programs

## Incentive Pools

- ▶ Physician incentives in both programs are funded out of the hospital GBR, through realized savings
- ▶ This workgroup will focus on the **CCIP program only for the incentive pool**



# Funding the Physician Incentives

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Incentive pools in the Care Redesign programs are designed to provide the hospitals care partners (PDPs and Specialists) financial incentives when costs are reduced.

## HCIP

- ▶ The incentive pool dollars are derived from the savings driven by reduced costs for acute care events including the efficiency of admissions, reductions in readmissions and reduced costs by other providers involved in the acute care event covered by the program.

**-----Our Work will focus on the CCIP Incentives Pool-----**

## CCIP

- ▶ Funded by savings generated by a larger cohort of patients similar to those in the program.
- ▶ Incentive Pool Amount =  $[(\text{Standardized Historical Costs of PAU in Base Period} - \text{Standardized Current Period Costs of PAU}) - \text{Intervention Costs}] * 50\% \text{ Variable cost}$
- ▶ Intervention Costs are those borne by the hospital providing the care management resources for the PDPs

# Guiding Principles for Care Redesign Incentive Pools

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- ▶ Incentives paid for the HCIP and CCIP are funded out of the hospital GBR, by actual savings
- ▶ The pools should measure the program's impact in a fair and continuous fashion so that information can be readily transmitted to the providers for regular feedback.
- ▶ The pool's composition should acknowledge that behavior change is contagious and will impact more patients than those in the program.
- ▶ It should reflect the understanding that savings will result over time as the program rolls out
- ▶ It is the program's intent to generate savings large enough to pay incentives.

# Total Cost of Care Context

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- ▶ The over-arching All-Payer Model has a statewide TCOC guardrail
  - ▶ Tied to national average TCOC growth rate
  - ▶ Maryland's performance has performed well when compared to national trend
- ▶ CMS has a priority focus on TCOC
  - ▶ Approval of the Care Redesign Amendment was contingent on meaningful TCOC guardrails
- ▶ TCOC guardrails for the Amendment are hospital specific
- ▶ The purpose of the TCOC guardrail is to create a local focus on TCOC
  - ▶ Ensure that no unintended consequences result from the care redesign programs, such as cost shifting.
  - ▶ Create TCOC awareness and focus by all providers in the Programs, including hospitals and physicians

# Role of the Total Cost of Care Guardrail in the HCIP and CCIP

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- ▶ The TCOC guardrail in the CCIP and HCIP must be met if financial incentives are going to be paid
- ▶ If the TCOC target is not met, then financial incentives will be reduced or not paid at all.
- ▶ The TCOC guardrails in the CCIP and HCIP do not add any financial risk to hospitals.
  - ▶ The main financial implication to hospitals for the CCIP and the HCIP are the investment costs (care management resources) for the programs.
  - ▶ The financial return is expected reductions in PAUs and improved efficiency
- ▶ The hospital's ability to provide care management resources to PDPs in the CCIP program is not impacted by the TCOC calculation.



# MACRA Overview

December 2016

## Accelerating Movement via MACRA

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- ▶ **MACRA is formally known as the H.R.2 Medicare Access and CHIP Reauthorization Act of 2015**
  - ▶ Signed into law in April 2015
  
- ▶ **MACRA Highlights**
  - ▶ Repeals use of the Sustainable Growth Rate (SGR) Formula
    - ▶ Cut Medicare physician fees for all services if total physician spending exceeded a target, penalizing individuals who did control their costs
    - ▶ Was volume-based- did not reward improvements in quality
  - ▶ Replaces SGR with new quality-driven payment systems for providers

# MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

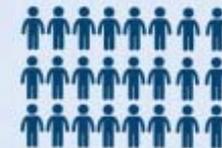
## Medicare Fee-for-Service

**GOAL 1:** **30%** 

Medicare payments are tied to quality or value through **alternative payment models** (categories 3-4) by the end of 2016, and 50% by the end of 2018

**GOAL 2:** **85%** 

Medicare fee-for-service payments are **tied to quality or value** (categories 2-4) by the end of 2016, and 90% by the end of 2018



### STAKEHOLDERS:

Consumers | Businesses  
Payers | Providers  
State Partners



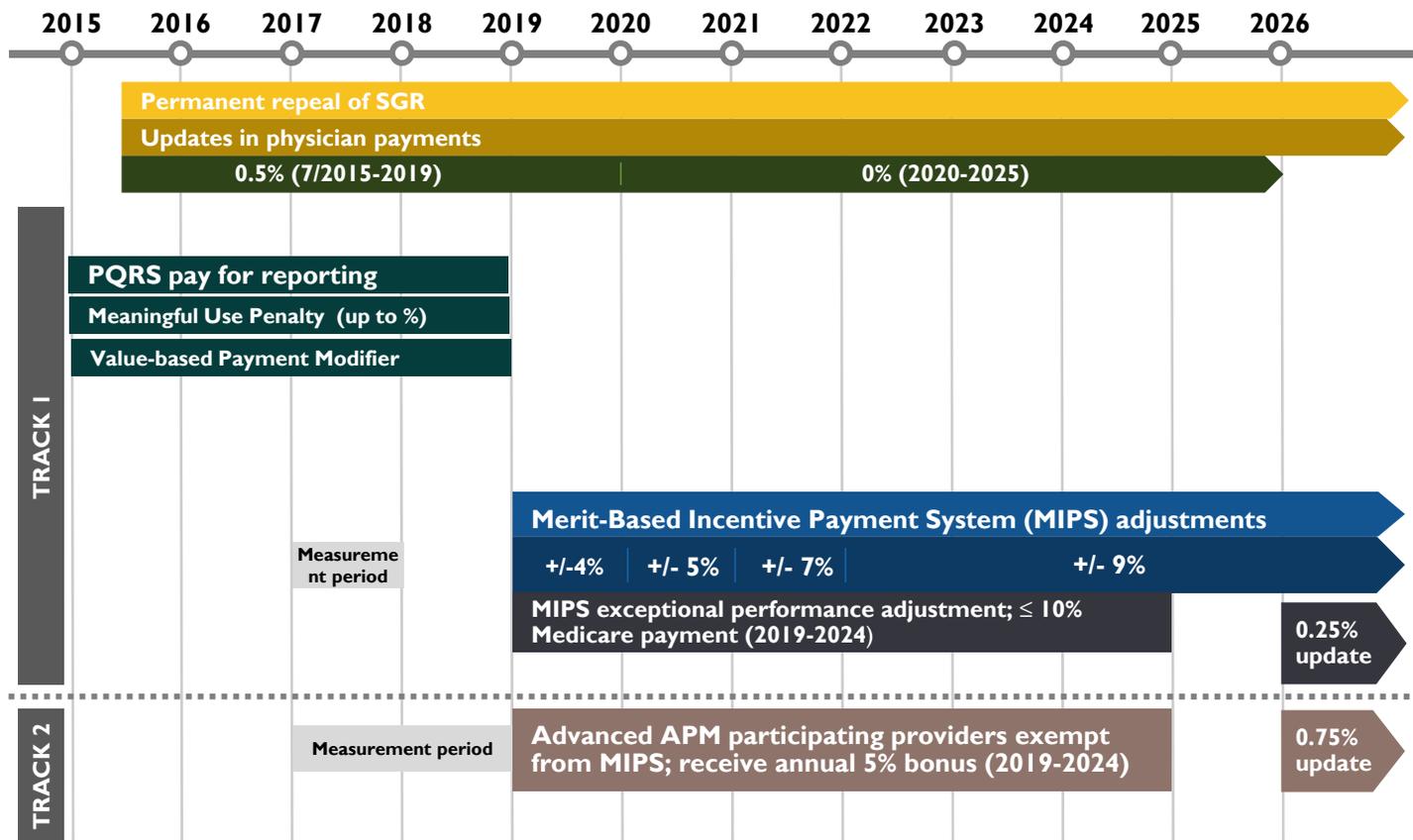
Set **internal goals** for HHS



Invite **private sector payers** to match or exceed HHS goals

# MACRA reform timeline

(Medicare Access and CHIP Reauthorization Act of 2015)



# MACRA: Provider Reimbursement Changes

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- ▶ 2019-2025: Move to value-based payments via involvement in either of two tracks:

## 1) MIPS: Merit-Based Incentive Payment System

- Continues traditional FFS track
- BUT a portion of Medicare provider payment at risk will gradually increase up to **-9% to +9%** based on their performance on quality and outcomes measures

## 2) AAPMs: Advanced Alternative Payment Models

- Medicare providers can opt out of MIPS and **receive +5% bonus** in rates if a substantial portion of their revenue is through AAPMs

- ▶ 2026+: All Medicare providers receive 0.25% update
  - ▶ AAPM providers will receive an additional 0.5% update, thereby receiving a 0.75% update overall for Medicare services

# Track 1: Merit-Based Incentive Payment System (MIPS)

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- ▶ **MIPS is based on traditional Medicare FFS payments**
- ▶ **Performance Areas**
  - ▶ Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  - ▶ Adds a fourth component to promote ongoing improvement and innovation to clinical activities.

Performance Area	Description	Previous Program
Quality	Preventive care, safety, etc	PQRS and Quality Portion of the VBM
Cost	Medicare spending per beneficiary, etc	Physician VBM
Advancing Care information	certified EHR technology	Meaningful Use
Improvement Activities	Shared decision making, APM participation, patient safety, coordinating care, increasing access, etc	None

# Track 2: Advanced Alternative Payment Models (AAPMs)

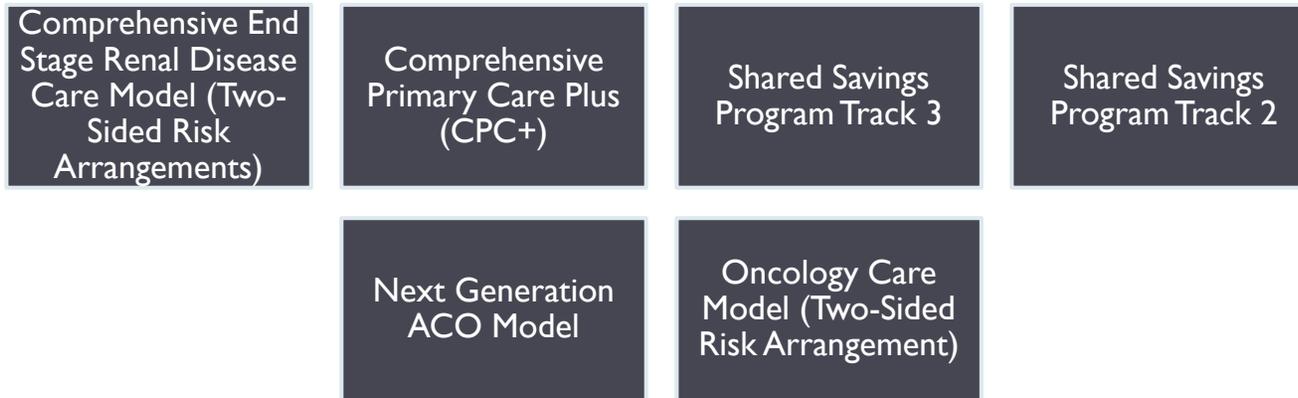
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- ▶ **Advanced Alternative Payment Models (Advanced APMs)** enable clinicians and practices to earn greater rewards for taking on some risk related to their patients' outcomes
  - ▶ Advanced APMs are a Subset of Alternative Payment Models.
  - ▶ Alternative Payment Models on their own do not take on “nominal risk,” as defined by CMS, but can qualify providers for additional credit in MIPS
- ▶ **Advanced Alternative Payment Models (AAPM) Entities Must:**
  - ▶ Use certified EHR technology,
  - ▶ Pay based on MIPS comparable quality measures, *and*
  - ▶ Bear more than “nominal” financial risk for losses
    - ▶ 8% of the average estimated total Medicare Parts A and B revenues of participating APM Entities; OR 3% of the expected expenditures for which an APM Entity is responsible under the APM.
- ▶ **Providers will receive +5% bonus incentive payment in 2019** for **Advanced APM Participation in 2017** if
  - ▶ They receive 25% of their Medicare Part B payments through an Advanced APM;
  - ▶ OR See 20% of their Medicare patients through an Advanced APM

# Track 2: Advanced Alternative Payment Models (AAPMs)

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▶ Eligible for 2017 Performance Year



▶ CMMI anticipates the following models will be Advanced APMs in the future:



# Language Referencing Maryland in the MACRA final rule

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- ▶ Final Rule on MACRA was released in October 2016
- ▶ There was a specific clause in the final rule referencing the Maryland All-Payer Model and eligibility for MACRA in 2018:
  - ▶ *“With new Advanced APMs expected to become available for participation in 2017 and 2018, including the Medicare ACO Track 1 Plus (1+), and anticipated amendments to reopen applications to modify current APMs, such as the Maryland All-Payer Model and Comprehensive Care for Joint Replacement (CJR) model, we anticipate higher numbers of QPs—approximately 70,000 to 120,000 in 2017 and 125,000 to 250,000 in 2018.”*

# MACRA-tizing the Maryland Model

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- ▶ **Progression**
  - ▶ Engaged physicians and other providers in aligned efforts
- ▶ **Key Strategies to have the All-Payer Model qualify as Advanced APM:**
  - ▶ CMS approved Care Redesign Programs to link physicians to the All-Payer Model
  - ▶ Hospital global revenues incorporate non-hospital Part B costs through incentives
- ▶ **Other Key approaches to have Advanced APMS in Maryland:**
  - ▶ Statewide Comprehensive Primary Care Model (CPC+ design)
  - ▶ ACOs with downside risk, new Dual Eligible ACOs

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# Appendix



# MIPS Timeline and “Pick Your Pace”

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- ▶ **Test Pace:**
  - ▶ Submit a minimum amount of data after January 1, 2017.
  - ▶ Neutral or small payment adjustment
- ▶ **Partial Year**
  - ▶ Report for 90-day period after January 1, 2017
  - ▶ Small positive payment adjustment
- ▶ **Full Year**
  - ▶ Fully participate starting January 1, 2017
  - ▶ Modest positive payment adjustment
- ▶ **OR Participate in an Advanced Alternative Payment Model in 2017**
- ▶ **Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.**

# QP performance period

The QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs to determine if they will be QPs for the payment year.

- The QP Performance Period for each payment year will be from January 1—August 31 of the calendar year that is two years prior to the payment year.

During the QP Performance Period (January—August), CMS will take three “snapshots” (March 31, June 30, August 31) to determine which eligible clinicians are participating in an Advanced APM and whether they meet the thresholds to become Qualifying APM Participants.

Reaching the QP threshold at any one of the three QP determinations will result in QP status for the eligible clinicians in the Advanced APM Entity

- Eligible clinicians will be notified of their QP status after each QP determination is complete (point D)

