



# May Advisory Council Meeting: Maryland's All-Payer Model Progression

May 16, 2016

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# National Healthcare Landscape



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

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<u>Focus Areas</u>	<u>Description</u>
<b>Pay Providers</b>	<ul style="list-style-type: none"><li>• Increase linkage of payments to value</li><li>• Alternative payment models, moving away from payment for volume</li><li>• Bring proven payment models to scale</li></ul>
<b>Deliver Care</b>	<ul style="list-style-type: none"><li>• Encourage integration and coordination of care</li><li>• Improve population health</li><li>• Promote patient engagement</li></ul>
<b>Distribute Information</b>	<ul style="list-style-type: none"><li>• Create transparency on cost and quality information</li><li>• Bring electronic health information to the point of care</li></ul>

## Focus Areas

## CMS Innovation Center Portfolio\*

<b>Pay Providers</b>	<p><b><u>Test and expand alternative payment models</u></b></p> <ul style="list-style-type: none"><li>▪ <b>Accountable Care</b><ul style="list-style-type: none"><li>- Pioneer ACO Model</li><li>- Medicare Shared Savings Program (housed in Center for Medicare)</li><li>- Advance Payment ACO Model</li><li>- Comprehensive ERSD Care Initiative</li><li>- Next Generation ACO</li></ul></li><li>▪ <b>Primary Care Transformation</b><ul style="list-style-type: none"><li>- Comprehensive Primary Care Initiative (CPC)</li><li>- Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration</li><li>- Independence at Home Demonstration</li><li>- Graduate Nurse Education Demonstration</li><li>- Home Health Value Based Purchasing</li><li>- Medicare Care Choices</li></ul></li><li>▪ <b>Bundled payment models</b><ul style="list-style-type: none"><li>- Bundled Payment for Care Improvement Models 1-4</li><li>- Oncology Care Model</li></ul></li></ul> <ul style="list-style-type: none"><li>- Comprehensive Care for Joint Replacement</li><li>▪ <b>Initiatives Focused on the Medicaid</b><ul style="list-style-type: none"><li>- Medicaid Incentives for Prevention of Chronic Diseases</li><li>- Strong Start Initiative</li><li>- Medicaid Innovation Accelerator Program</li></ul></li><li>▪ <b>Dual Eligible (Medicare-Medicaid Enrollees)</b><ul style="list-style-type: none"><li>- Financial Alignment Initiative</li><li>- Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents</li></ul></li><li>▪ <b>Medicare Advantage (Part C) and Part D</b><ul style="list-style-type: none"><li>- Medicare Advantage Value-Based Insurance Design model</li><li>- Part D Enhanced Medication Therapy Management</li></ul></li></ul>
<b>Deliver Care</b>	<p><b><u>Support providers and states to improve the delivery of care</u></b></p> <ul style="list-style-type: none"><li>▪ <b>Learning and Diffusion</b><ul style="list-style-type: none"><li>- Partnership for Patients</li><li>- Transforming Clinical Practice</li><li>- Community-Based Care Transitions</li></ul></li><li>▪ <b>Health Care Innovation Awards</b></li><li>▪ <b>Accountable Health Communities</b></li></ul> <ul style="list-style-type: none"><li>▪ <b>State Innovation Models Initiative</b><ul style="list-style-type: none"><li>- SIM Round 1</li><li>- SIM Round 2</li><li>- Maryland All-Payer Model</li></ul></li><li>▪ <b>Million Hearts Cardiovascular Risk Reduction Model</b></li></ul>
<b>Distribute Information</b>	<p><b><u>Increase information available for effective informed decision-making by consumers and providers</u></b></p> <ul style="list-style-type: none"><li>▪ <b>Health Care Payment Learning and Action Network</b></li><li>▪ <b>Information to providers in CMMI models</b></li><li>▪ <b>Shared decision-making required by many models</b></li></ul>

\*Many CMMI programs test innovations across multiple focus areas

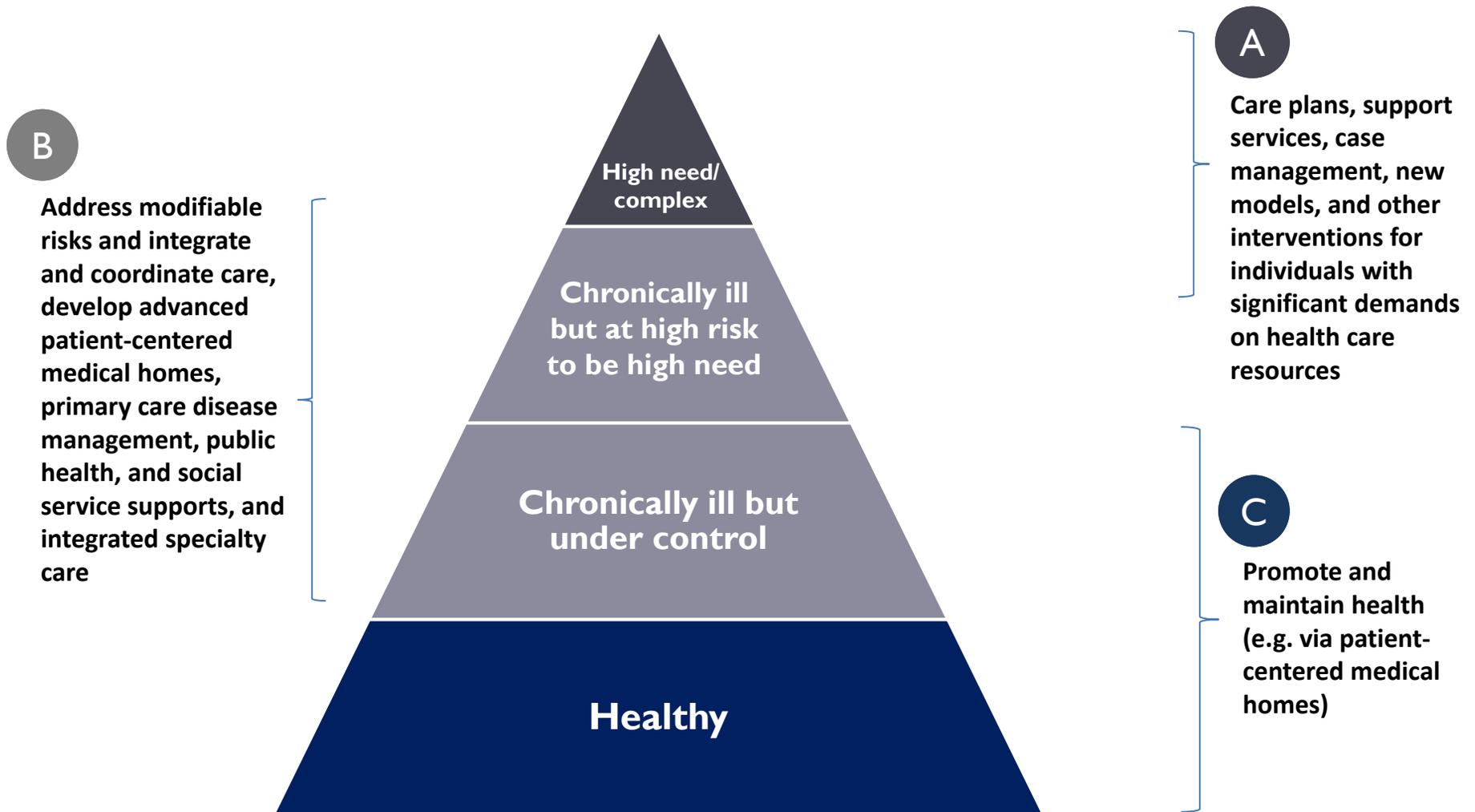
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# Maryland Direction & Strategy



# Recap: Core Approach— Person-Centered Care Tailored Based on Needs

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# Recap: Stakeholder-Driven Strategy for Maryland

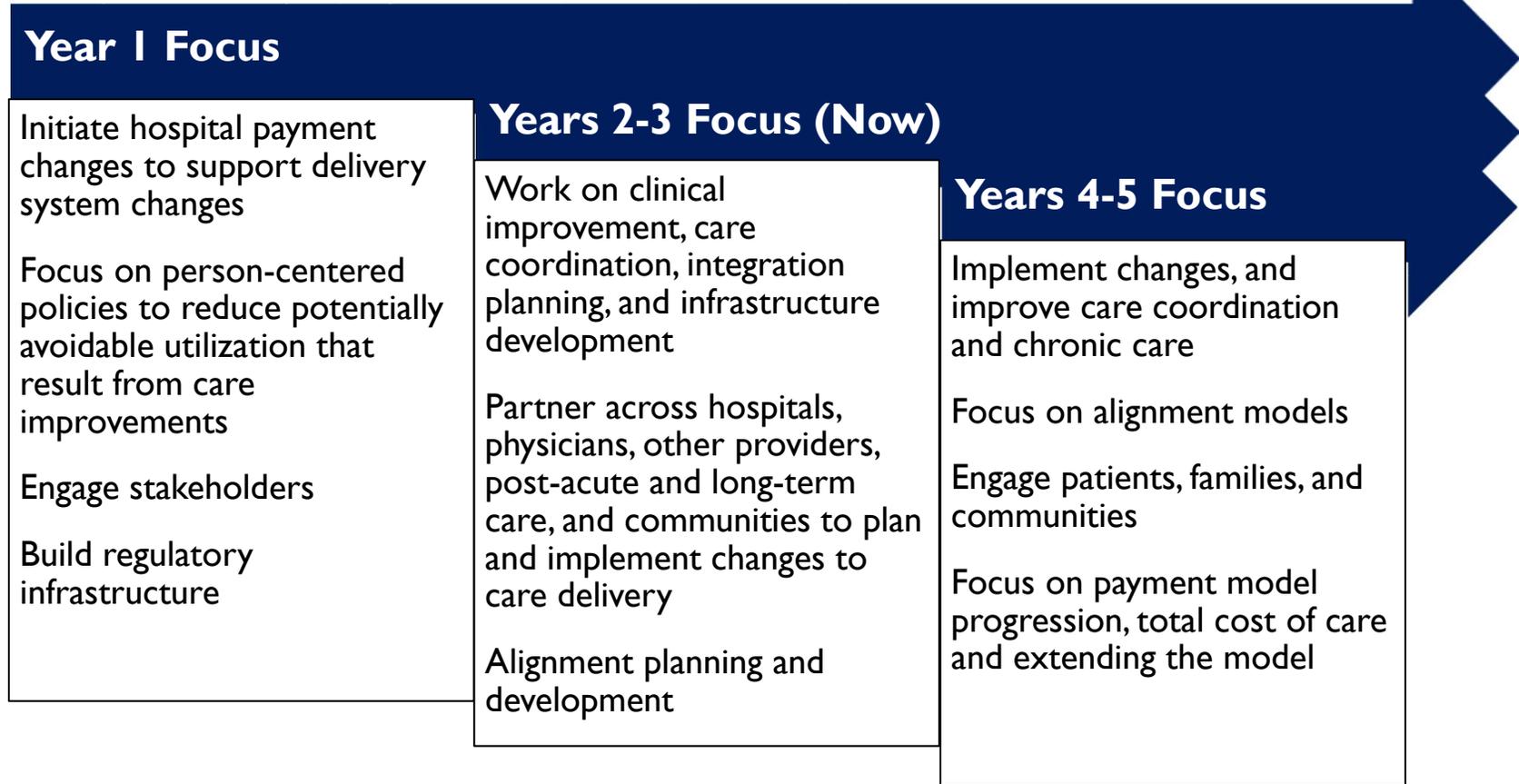
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**Aligning common interests and transforming the delivery system are key to sustainability and to meeting Maryland's goals**

<u>Focus Areas</u>	<u>Description</u>
<b>Care Delivery</b>	<ul style="list-style-type: none"><li>• Improve care delivery and care coordination across episodes of care</li><li>• Tailor care delivery to persons' needs with care management interventions, especially for patients with high needs and chronic conditions</li><li>• Support enhancement of primary and chronic care models</li><li>• Promote consumer engagement and outreach</li></ul>
<b>Health Information Exchange and Tools</b>	<ul style="list-style-type: none"><li>• Connect providers (physicians, long-term care, etc.) in addition to hospitals</li><li>• Develop shared tools (e.g. common care overviews)</li><li>• Bring additional electronic health information to the point of care</li></ul>
<b>Provider Alignment</b>	<ul style="list-style-type: none"><li>• Build on existing models (e.g. hospital GBR model, ACOs, medical homes, etc.)</li><li>• Leverage opportunities for payment reform, common outcomes measures and value-based approaches across models and across payers to help drive system transformation</li></ul>

# Recap: Strategy for Implementing the All-Payer Model

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# Potential Progression in Maryland



## Current All-Payer Model Agreement Term

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- ▶ “Prior to the beginning of PY4 (2017), Maryland will submit a proposal for a new model, which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate to take effect no later than 11:59PM EST on December 31, 2018”.

# Recap: Potential Approach for the Strategic Plan on the All-Payer Model Progression

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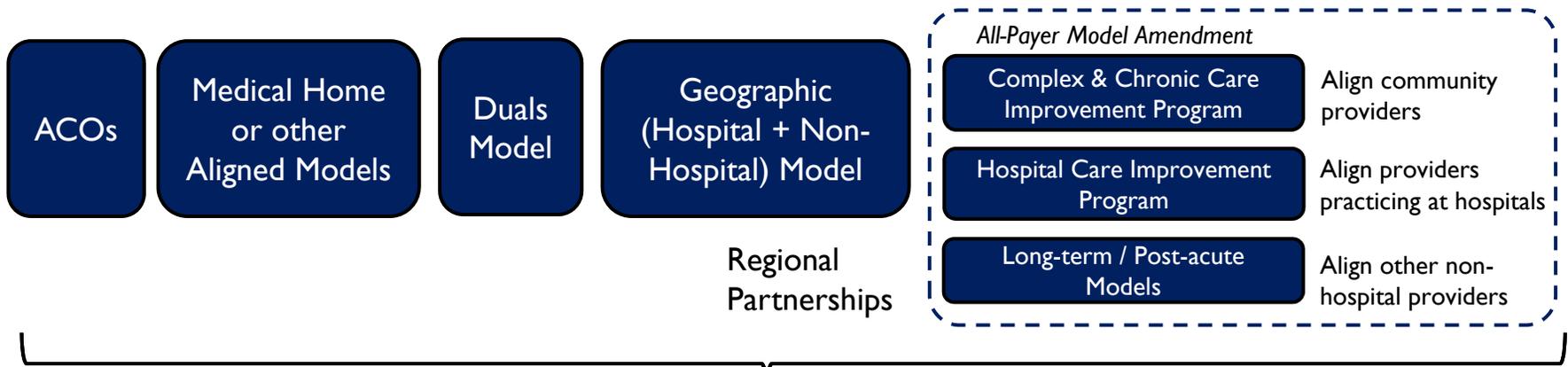
- ▶ Submit a strategic plan to CMS on the All-Payer Model progression that lays out a timeline for Maryland innovations that take on increased accountability over time
  - ▶ For what is Maryland is taking responsibility?
    - ▶ Services, financial accountability, quality
  - ▶ When?
    - ▶ Sequence of innovations in a 2017-2024 strategic plan
  - ▶ How?
    - ▶ High-level concepts in a strategic plan
      - Maintain the All-Payer Hospital Model
      - Develop models for Medicare beneficiaries that will help us progress on taking responsibility for the Medicare TCOC and improving health and outcomes
      - Starting with Medicare, but maintain commitment to all payer principles of developing things in concert with one another for system transformation (e.g. performance measures used across the system, medical home approach)

# Potential Concepts for Strategic Plan

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- ▶ **Current All-Payer Model: Maryland has significant responsibility already**
  - ▶ 56% of Medicare payments are for hospital services—Maryland has full responsibility for these costs under the All-Payer Model
  - ▶ For the remaining costs, Maryland has a guardrail to protect against cost shifting. Cost growth above national growth by more than 1%, or two years in a row above the national growth rate requires a corrective action plan from the State
  
- ▶ **Potential Plan for Progression: Concepts in 2019 and beyond**
  - ▶ Maintain All-Payer Hospital Model, non-hospital models can be tested and expanded or discontinued apart from hospital model
  - ▶ Have hospitals and non-hospital providers in shared savings models for Medicare
  - ▶ Use common outcomes measures across the system (e.g. population health, outcomes, avoidable utilization, cost) for Medicare
  - ▶ Add two sided models (upside savings and down side risk) and/or soft cap (such as savings targets like the current All Payer Model) with value based modifier – date TBD
  - ▶ Pay particular attention to MACRA requirements
  - ▶ Add specific provider responsibility under agreed approach, starting in 2017 (e.g. post acute and long term care, dual-eligibles, medical home, etc.)
  - ▶ Develop common outcomes measures, value approaches across models and across payers, to the extent possible, to help drive system transformation

# Potential Long-Term Developments



Shared savings

Additional financial and outcomes responsibility across the system over time

Support alignment infrastructure and activities

Engage and support consumers

## Models Supported By Delivery Systems and Payers:

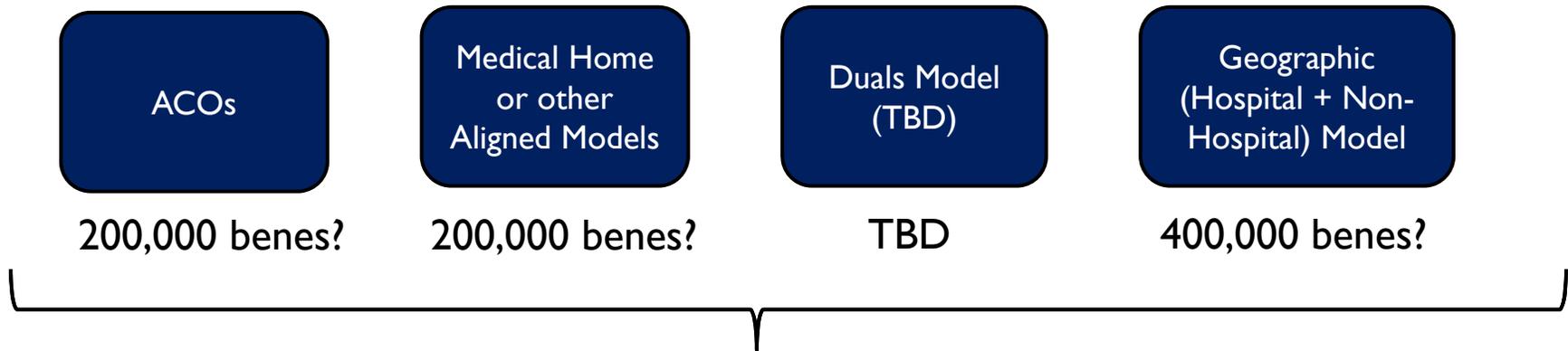
- Data & Financial Incentives for Providers (Alignment tools and data for P4O, ICS, etc.)
- Common Technology Tools (Via CRISP: risk scores, care histories, etc.)
- Care Coordination Resources

## Common Goals:

- Person-Centered Care
- Improve Quality, Outcomes, Health
- Reduce Potentially Avoidable Utilization
- Reduce Spending Growth
- Aligned Providers

# Example: How We Can Get Focused on Medicare TCOC

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- ▶ **Not taking on full responsibility for outcomes yet**
  - ▶ Start receiving TCOC data and data to support care coordination and chronic care improvement
  - ▶ Learn how to utilize data and make delivery system changes that act on the most significant opportunities for care improvement
- ▶ **Can improve care and control costs by focusing on:**
  - ▶ 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)

# Potential Items in Strategic Plan

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## High-level timelines for discussion:

- ▶ 2014: Global budgets ✓
- ▶ 2015: Model refinements ✓
- ▶ 2016: Care redesign Amendment; Prepare a strategic plan for CMS; Initial CPC+ model?
- ▶ 2017: Implement Care Redesign Amendment; Implement initial CPC+ model? and develop custom primary care model; Conceptualize Geographic model, MACRA approaches and post-acute model
- ▶ 2018: Implement custom primary care model and Phase I of duals model (care coordination); Prep for MACRA; Post-acute model approval and prep; Develop geographic model and CMS clearance
- ▶ 2019: Test drive (State specific?) shared savings models for Geographic model, ACOs, medical home; Implement post-acute model
  
- ▶ Timeline and approach TBD:
  - ▶ Expanded TCOC progression, Other payment reforms and alignments

# Care Redesign Amendment: An Intermediate Step in How We Can Get Focused on Medicare TCOC

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- ▶ In response to stakeholder input, the State is proposing a **Care Redesign Amendment** to the All-Payer Model, which will allow hospitals to gain needed approvals (Safe harbors, Stark, etc.) and data for care redesign interventions
- ▶ 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

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

# Amendment: Overview of Operationalization from the Hospital Perspective

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## 2016

- **Summer/Fall:** Submit letter of intent; receive limited data sets (non-identifiable) to design programs and prep for implementation
- **Fall/Winter:** Sign Participation Agreement with CMS; receive waivers and comprehensive data (patient-identifiable)



## 2017

- **Jan 1:** Launch PY1 of Amendment programs
- Care redesign activities and shared resources



## POST INITIATION

- **Jan 1:** Launch PY2 of Amendment Programs - Pick **one of two tracks**
- Track 1: Care redesign activities & shared resources
- Track 2: Care redesign activities & shared resources + incentive payment programs

# Medical Home Progression

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- ▶ Will payers and primary care providers leverage the standard CMS CPC+ Model?
  - ▶ This is driven by multi-payer and provider participation
- ▶ Should Maryland seek customized medical home approach similar to CPC+ that could serve as a foundation across models and payers?
  - ▶ Incorporate in other models?

# Next Steps

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- ▶ Finalize Interim Report
- ▶ At June Advisory Council Meeting: Review and discuss draft outline for a strategic plan on the All-Payer Model progression

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*Appendix:  
CMS CPC+ Model*



# Background: CMS Comprehensive Primary Care Plus (CPC+) Model

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- ▶ Regionally-based, multi-payer care delivery and alternative payment model that aims to support comprehensive primary care
  - ▶ Focus on 5 pillars:
    - ▶ Access and continuity, care management, comprehensiveness & coordination, patient & caregiver engagement, and planned care & population health
  - ▶ Payment structure includes:
    - ▶ Chronic care management fee
    - ▶ Performance-based incentive payment
    - ▶ Comprehensive primary care payments (Track 2 only)
  - ▶ Funds mostly aimed at supporting infrastructure and actionable data needed to support primary care
- ▶ 20 regions, 5000 practices; Up to 3.5m Medicare FFS beneficiaries
- ▶ 5 year demonstration; January 1, 2017 Model launch
- ▶ Potential increases in practice revenue/Medicare cost:
  - ▶ Track 1 ~\$17 pmpm = for each 100,000 benes this is \$20 million
  - ▶ Track 2 ~\$32 pmpm = for each 100,000 benes this is \$38 million

# Background: CMS Comprehensive Primary Care Plus (CPC+) Model (cont.)

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- ▶ **2 Tracks- dependent upon practice readiness**
  - ▶ Both tracks:
    - ▶ Monthly, risk-adjusted care management fee (CMF)
    - ▶ Performance-based incentive payments:
      - Paid upfront; providers will either have to keep or repay based on their performance on quality and utilization measures
    - ▶ Actionable data on cost and utilization
  - ▶ Additions in Track 2:
    - ▶ More comprehensive services for patients with complex medical and behavioral health needs
    - ▶ Comprehensive primary care payments (CPCP):
      - Hybrid payment: Reduced in Medicare FFS payments and up-front comprehensive primary care payments for those services

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*Appendix:  
Geographic Model- Concepts*



# Geographic Model: Concept

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- ▶ **Leverage Global Budget Revenue (GBR) because it provides a payment model for hospitals that moves away from volume-based to value-based payment**
  - ▶ For the All-Payer Model Progression, Maryland must determine how to limit growth in Medicare total cost of care (TCOC)
  - ▶ Maryland will need a glide path to get to TCOC for Medicare over time
  - ▶ A Geographic Model is one of several potential approaches

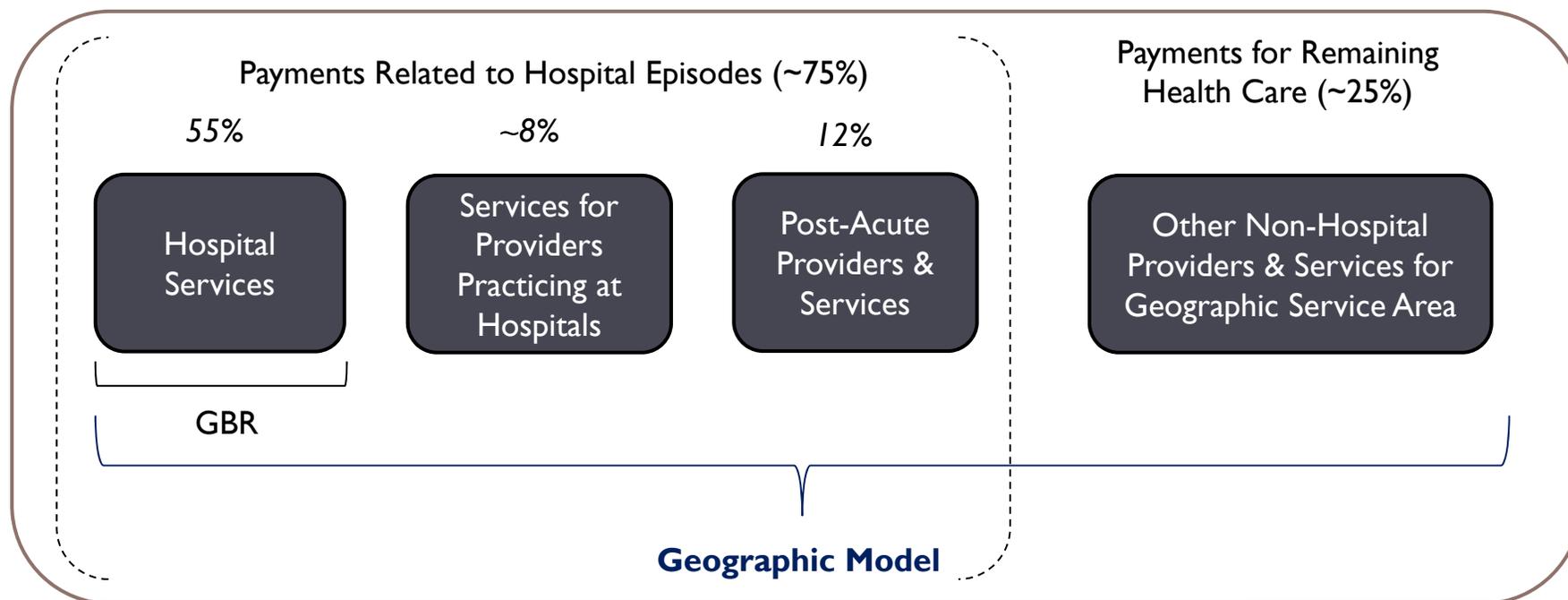
# What is a Geographic Model?

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- ▶ **Global budget(s) + non-hospital costs**
  - ▶ 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 (e.g. excludes tertiary and quaternary care provided in other hospitals)
  - ▶ Allows for local control, instead of taking responsibility for a set of patients across providers in various geographies
  - ▶ Creates a large pool that mitigates high-cost patients, allowing providers to learn how to effectively share responsibility gradually

# Geographic Model: Expands the Population-based GBR Model to Incorporate Non-Hospital Partners

## Allocated Costs for Medicare Beneficiaries in Maryland



- ▶ **Geographic Model: Shared resources, responsibility, and savings between care providers**
  - ▶ Care partners in care coordination, but there are no bundles / no shared risk
  - ▶ In the future, can develop shared financial responsibility over time based on cost and quality priorities