Health Services Cost Review Commission (HSCRC) and the All-Payer Model – HEZ Summit

November 3, 2016
Background: HSCRC and the All-Payer Model
Unique New Model: Maryland’s All-Payer Model

- Maryland is implementing an All-Payer Model for hospital payment
  - Approved by Centers for Medicare & Medicaid Services (CMS) effective January 1, 2014 for 5 years
  - Modernizes Maryland’s Medicare waiver and unique all-payer hospital rate system
  - Health Services Cost Review Commission (HSCRC) is leading the effort

**Old Waiver**
Per inpatient admission hospital payment

**New Model**
All-payer, per capita, total hospital payment & quality

- HSCRC back drop:
  - Oversees hospital rate regulation for all payers
  - Rate setting authority extends to all payers, Medicare waiver
    - Granted in 1977 and renewed under a different approach in 2014
  - Provides considerable value
    - Limits cost shifting- all payers share in medical education, uncompensated care, etc.
Approved Model at a Glance

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate for first 3 years

- **Medicare payment savings:**
  - Minimum of $330 million in savings for Maryland beneficiaries compared to dynamic national trend
  - Total Cost of Care guardrail on all health care services

- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland’s Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets
All-Payer Model Status

- All Payer hospital revenue growth contained
- Medicare hospital savings on track/non-hospital costs rising—need to accelerate reductions in unnecessary and preventable hospitalizations to offset “investments” in non-hospital costs
- Quality measures on track
- Delivery systems, payers, and regional partnerships organizing and transforming
- Stakeholder participation contributing to success
- Generally positive feedback from CMS
### 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

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**Stakeholder-Driven Strategy for Maryland**

Aligning common interests and transforming the delivery system are key to sustainability and to meeting Maryland’s goals.
Global Budget Incentives
**Year 1 Accomplishments: Global Model**
Shifts Focus from Volumes

**Former Hospital Payment Model:**
Volume Driven

- **Units/Cases**
  - **Rate Per Unit or Case**
  - **Hospital Revenue**
    - Unknown at the beginning of year
    - More units creates more revenue

**New Hospital Payment Model:**
Population and Value Driven

- **Revenue Base Year**
  - **Updates for Trend, Population, Value**
  - **Allowed Revenue for Target Year**
    - Known at the beginning of year
    - More units does not create more revenue
What do Global Budgets mean

- **Hospitals:**
  - Incentive to reduce potentially avoidable utilization
    - Readmissions
    - Complications
    - Ambulatory sensitive conditions
  - Prevent new admissions:
    - Spearhead prevention
    - Collaborate with community providers
    - Help to address social determinants

- **Payers**
  - Reduced utilization
  - Predictability in overall hospital costs
  - Control on growth in hospital charges
  - Consistent with PCMH type programs
Regional Partnerships, and Implementation Awards
Hospital Rate Support to Implement Care Coordination Infrastructure

- FY 14 and FY 15 – Included $160 million in hospital rates to support care coordination for high needs patients
  - High Utilizing Patients with Chronically Needs
  - Medicare
- Support Care Transitions
  - 30-60 days after hospital stay
  - Discharge Planning and Follow-up
  - Coordination with Pharmacy, Physicians and Long-term Care and Post-acute Care
- Next Phase is to establish Partnerships around patients for both Transitions and Community-based Care Coordination
  - Regional Hospital Partnerships
  - Partnerships with Community Providers
  - Work Force Support
Overview of Regional Planning Grants

- The Commission authorized up to $2.5 million from hospital rates to be used for planning of regional partnerships
- Funds are to be used for partnership planning activities
  - Funds may be used for data analysis, operational/strategic planning, health IT/analytics planning, consultants, meetings, and related expenses.
- A Review Committee and the Commission approved 8 of 11 proposals for funding ranging from $200,000 to $400,000
<table>
<thead>
<tr>
<th>Regional Group Name</th>
<th>Award Amount</th>
<th>Lead Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional Planning Community Health Partnership</td>
<td>$ 400,000</td>
<td>Johns Hopkins Hospital(s)</td>
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<tr>
<td>Baltimore Health System Transformation Partnership</td>
<td>$ 400,000</td>
<td>University of Maryland Medical Center</td>
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<tr>
<td>Trivergent Health Alliance</td>
<td>$ 133,334</td>
<td>Western Maryland Health System</td>
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<tr>
<td>Trivergent Health Alliance</td>
<td>$ 133,333</td>
<td>Frederick Regional Health System</td>
</tr>
<tr>
<td>Trivergent Health Alliance</td>
<td>$ 133,333</td>
<td>Meritus Medical Center</td>
</tr>
<tr>
<td>Bay Area Transformation Partnership</td>
<td>$ 400,000</td>
<td>Anne Arundel Medical Center</td>
</tr>
<tr>
<td>NexusMontgomery</td>
<td>$ 300,000</td>
<td>Holy Cross Hospital</td>
</tr>
<tr>
<td>Howard County Regional Partnership for Health System Transformation</td>
<td>$ 200,000</td>
<td>Howard County General Hospital</td>
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<tr>
<td>U of M Upper Chesapeake Health and Hospital of Cecil County Partnership</td>
<td>$ 200,000</td>
<td>University of Maryland Upper Chesapeake</td>
</tr>
<tr>
<td>Southern Maryland Regional Coalition for Health System Transformation</td>
<td>$ 200,000</td>
<td>Doctors Community Hospital</td>
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<tr>
<td>Total</td>
<td>$ 2,500,000</td>
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Implementation Grantees

In June 2015, the Commission authorized up to 0.25% of total hospital rates to be allocated to deserving applicants under a competitive Healthcare Transformation Implementation Grant Program.

- “Shovel-ready” projects that generate short-term ROI and reduced Medicare PAU
- Involve community-based care coordination and provider alignment and not duplicate care transitions and prior infrastructure funding

In June, 9 of 22 proposals were awarded in Round 1
# Recommendations

<table>
<thead>
<tr>
<th>Partnership Group Name</th>
<th>Award Request</th>
<th>Award Recommendation</th>
<th>Hospital(s) in Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bay Area Transformation Partnership</strong></td>
<td>$4,246,698.00</td>
<td>$3,831,143.00</td>
<td>Anne Arundel Medical Center; UM Baltimore Washington Medical Center</td>
</tr>
<tr>
<td><strong>Community Health Partnership</strong></td>
<td>$15,500,000.00</td>
<td>$6,674,286.00</td>
<td>Johns Hopkins Hospital; Johns Hopkins – Bayview; MedStar Franklin Square; MedStar Harbor Hospital; Mercy Medical Center; Sinai Hospital</td>
</tr>
<tr>
<td><strong>GBMC</strong></td>
<td>$2,942,000.00</td>
<td>$2,115,131.00</td>
<td>Greater Baltimore Medical Center</td>
</tr>
<tr>
<td><strong>Howard County Regional Partnership</strong></td>
<td>$1,533,945.00</td>
<td>$1,468,258.00</td>
<td>Howard County General Hospital</td>
</tr>
<tr>
<td><strong>Nexus Montgomery</strong></td>
<td>$7,950,216.00</td>
<td>$7,663,683.00</td>
<td>Holy Cross Hospital; Holy Cross – Germantown; MedStar Montgomery General; Shady Grove Medical Center; Suburban Hospital; Washington Adventist Hospital</td>
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<tr>
<td><strong>Total Eldercare Collaborative</strong></td>
<td>$1,882,870.00</td>
<td>$1,882,870.00</td>
<td>MedStar Good Samaritan; MedStar Union Memorial</td>
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<tr>
<td><strong>Trivergent Health Alliance</strong></td>
<td>$4,900,000.00</td>
<td>$3,100,000.00</td>
<td>Frederick Memorial Hospital; Meritus Medical Center; Western Maryland Hospital Center</td>
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<tr>
<td><strong>UM-St. Joseph</strong></td>
<td>$1,147,000.00</td>
<td>$1,147,000.00</td>
<td>UM St. Joseph Medical Center</td>
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<td><strong>Upper Chesapeake Health</strong></td>
<td>$2,717,963.00</td>
<td>$2,693,475.00</td>
<td>UM Harford Memorial Hospital; UM Upper Chesapeake Medical Center; Union Hospital of Cecil County</td>
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<tr>
<td><strong>Total</strong></td>
<td>$42,820,692.00</td>
<td>$30,574,846.00</td>
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Next Steps

- HSCRC will monitor the implementation of the awarded grants through additional reporting requirements.
- HSCRC is also recommending that a schedule of savings be remitted to payers through the global budget on the following schedule.
  
  (Savings represent the below percentage of the award amount)

<table>
<thead>
<tr>
<th></th>
<th>FY2018</th>
<th>FY2019</th>
<th>FY2020</th>
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<tr>
<td></td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
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- A Second Round of partial rate funding was provided to 5 proposals
  - Efficacious individual projects
  - Support promising regional Partnerships
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<thead>
<tr>
<th>Partnership Group Name</th>
<th>Award Request</th>
<th>Award Recommendation</th>
<th>Hospital(s) in Proposal</th>
<th>Purpose of Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calvert Memorial</td>
<td>$ 361,927.00</td>
<td>$ 360,424.00</td>
<td>Calvert Memorial Hospital</td>
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<tr>
<td>Lifebridge Health System</td>
<td>$ 6,751,982.00</td>
<td>$ 1,350,396.00</td>
<td>Carroll Hospital, Northwest Hospital, Sinai Hospital - 24-hour call center/care coordination hub - Efforts to enable seniors to age in place - Tele-psychiatry capability expansion</td>
<td></td>
</tr>
<tr>
<td>Peninsula Regional</td>
<td>$ 3,926,412.00</td>
<td>$ 1,570,565.00</td>
<td>Atlantic General Hospital, McCready Memorial Hospital, Peninsula Regional Medical Center - Inter-Hospital Care Coordination Efforts - Patient Engagement and Activation Efforts - Crisfield Clinic - Wagner Van</td>
<td></td>
</tr>
<tr>
<td>Totally Linking Care – Southern MD</td>
<td>$ 6,211,906.00</td>
<td>$ 1,200,000.00</td>
<td>Calvert Memorial Hospital, Doctor’s Community Hospital, Fort Washington Medical Center, Laurel Regional Hospital, MedStar Southern Maryland Hospital, MedStar St. Mary’s Hospital, Prince George’s Hospital Center - Support the continuation of the regional partnership - Reinforce care coordination with special focus on medication management - Support physician practices providing care to high-needs patients</td>
<td></td>
</tr>
<tr>
<td>West Baltimore Collaborative</td>
<td>$ 9,902,774.00</td>
<td>$ 1,980,555.00</td>
<td>Bon Secours Hospital, St. Agnes Hospital, University of Maryland Medical Center, UMMC – Midtown Campus - Patient-related expenditures - Care Management Teams, particularly focused on primary care - Collaboration and sharing resources with community providers</td>
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$27,154,371.00 $ 6,461,940.00
Maryland Primary Care Model

Coordinating Entity

Regional Care Management Entities
Care Management Resources & Infrastructure
e.g., (ACO, CIN, LHIC, LHD, RP)

Hospital Chronic Care Initiative (CCIP)
High Risk Patients, Rising Risk Patients PQI Bonuses

xx% CM Funds

PDP embeds CM resources

CM

Person-Centered Home (PCH)

Patient-Designated Provider (PDP)

PDP requests unembedded CM resources

CM

Person-Centered Home (PCH)

Patient-Designated Provider (PDP)

Portion of Payments at Risk (MACRA qualifying)

Visit/Non-Visit-based Payments

MACRA bonus
Key Elements of the Model

- **Primary Care Home/ Patient-designated Provider** – The most appropriate provider to manage the care of each patient, provides preventive services, coordinates care across the care continuum, and ensures enhanced access.
  - Practice – means an individual provider or group of providers that deliver care as a team to a panel of patients. Practices may span multiple physical sites in the community.

- **Regional Care Management** – Organization that coordinates and provides resources for care management within a region-leveraging existing resources such as ACOs, CINs, LHICs and other regional healthcare programs.

- **Coordinating Entity** - State sponsored, advisory board managed entity for accounting and program analytics.

- **Incenting Value-based Care**
  - Payers
    - CM Funding
    - Funding for Quality and Utilization Improvement
    - Upfront non-Visit based payments - facilitates alternative care delivery
  - Hospitals - chronic Care bonus pool alignment with community

- **Population Health Management/HIT** – key data exchanged to all care participants through CRISP, using tools and analytics for risk stratification, improved care, and efficient connection to other services.
How Can HEZs participate?

- Contact awardees and participating hospitals
  - Show data on hospital utilization
  - Work with CRISP and the hospital on accessing data for the population
- If patients in HEZs have multiple chronic illnesses and have a high proportion of Medicare patients, there is an incentive for hospitals to work with organizations that can help with:
  - Care Coordination Activities
  - Provider Alignment
  - Addressing Social Determinants