Update on Maryland's Health Care Transformation

June 2017

HSCRC
Health Services Cost Review Commission

Goals of Today's Discussion

- The Nation's Evolving Healthcare Landscape: Shifting to Value
- Maryland's Unique Healthcare Delivery System and Transformation
- All-Payer Model Progression

The Nation's Evolving Healthcare Landscape: Shifting to Value

Context: Health Care System Challenges

- Rising health care costs with less favorable outcomes
- Fragmented health care system
- Growing aging, sicker population
  - Profound impact on federal and state budgets, and the delivery system

Year	Age 65+	Age 85+
2000	35 million	4.2 million
2010	40 million	4.7 million
2020	55 million	6.7 million
2030	72 million	9.1 million

Source: U.S. Census Bureau

CMS and National Strategy for Health Care Transformation

Focus Areas	Description
Pay Providers	• Increase linkage of payments to value • Alternative payment models, moving away from payment for volume • Bring proven payment models to scale
Deliver Care	• Encourage integration and coordination of care • Improve population health • Promote patient engagement
Distribute Information	• Create transparency on cost and quality information • Bring electronic health information to the point of care

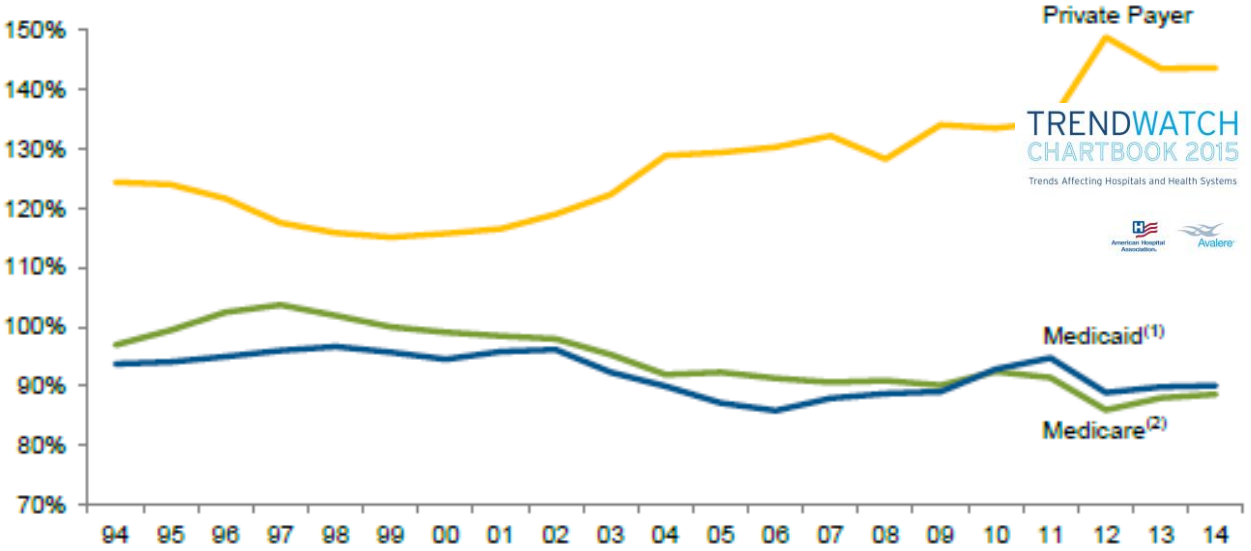
Maryland's Unique Healthcare Delivery System and Transformation

Background: Maryland's All-Payer Model

- Since 1977, Maryland has had an all-payer hospital rate-setting system
- In 2014, Maryland updated its approach through the All-Payer Model
  - 5-year state innovation between Maryland & federal government (2014 through 2018) focused on hospital payment transformation
  - Each hospital receives fixed Global Budget Revenue (GBR)
    - Shifts from volume to value-based payments
    - Greater focus on patients and working with providers across the care continuum

Nationally, Cost-Shifting Occurs Between Private and Public Payers

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1994 – 2014



Source: American Hospital Association

Outside of Maryland, Medicare costs are shifted onto businesses and consumers

- In Maryland, hospitals are paid using a common rate structure by ALL payers, which eliminates cost shifting

What Are We Trying to Do?

Maryland's All-Payer Model Goals:

- Fundamentally transform the Maryland health care system
  - Provide person-centered care
  - Improve care delivery and outcomes
  - Moderate the growth in costs

Why?

Cost and Outcomes

- Higher costs (affordability)/less favorable outcomes
- Population health/health equity

Aging of Population

- 37% increase in Maryland's population >65-years-old over next 10 years
- Profound impact on federal and state budgets and delivery system needs

The Progression Model

Progression Plan: Key Strategies

I. **Foster accountability** for care and health outcomes by supporting providers as they organize to take responsibility for groups of patients/a population in a geographic area.

II. **Align measures and incentives** for all providers to work together, along with payers and health care consumers, on achieving common goals.

III. **Encourage and develop payment and delivery system transformation** to drive coordinated efforts and system-wide goals.

IV. **Ensure availability of tools** to support all types of providers in achieving transformation goals.

V. **Devote resources to increasing consumer engagement** for consumer-driven and person-centered approaches.

Core Approach— Person-Centered Care Tailored Based on Needs

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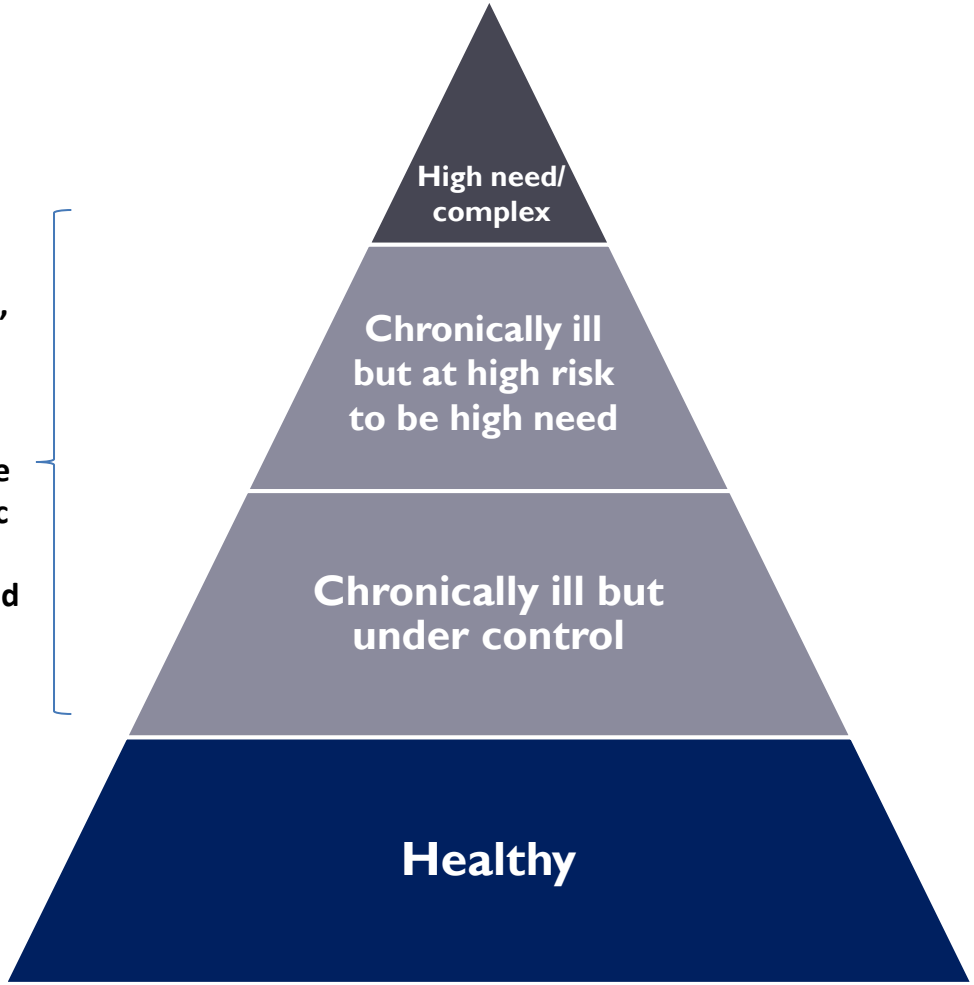
Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care



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Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources (e.g., HCIP, CCIP)

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Promote and maintain health (e.g., Maryland Primary Care Model)

Next Steps in Maryland's Progression

- All-Payer Model Amendment
  - Enable hospitals to partner with physicians and other providers in further care improvement
  - Start with two new programs effective this year
    - Hospital Care Improvement Program (HCIP)
    - Complex & Chronic Care Improvement Program (CCIP)
- Maryland Comprehensive Primary Care Model
  - Increase focus on prevention and primary care
- Second Term of the All-Payer Model
  - Accountability of providers for populations in a geography
  - Align measures and incentives for all providers
  - Encourage and develop further payment & delivery transformation
  - Ensure availability of tools to support providers
  - Devote resources to increasing consumer engagement

Purpose of the Amendment

- Maryland has added an Amendment to the All-Payer Model that 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
  - Increasing the hospitals' reach to be inclusive of primary, hospital – based physicians and post-acute care adds another tool to address the some of the core drivers in PAUs

Flexibility of the Amendment

- To provide flexibility, the Amendment is drafted with a framework that aligns categories of care redesign with partners across the delivery system
  - By using a general approach, Maryland can add/delete/modify programs on an annual basis, without requesting the approval of a new model or model amendments
    - New models or amendments can take 6+ months for approval
  - This allows for a "living" approach that can be used to meet Maryland's unique needs on an ongoing basis
    - Programs can be adjusted in response to external changes, such as those introduced by MACRA, Maryland Primary Care Model or other new models
- While the Amendment provides increased flexibility, CMS will:
  - Delegate some administrative functions to the State
  - Retain significant monitoring and oversight responsibilities

Care Redesign Amendment: Two Initial Programs

- Two initial care redesign programs aim to align hospitals & other providers

Hospital Care Improvement Program (HCIP)

- **Who?** For hospitals and providers practicing at hospitals
- **What?** Facilitates improvements in hospital care that result in care improvements and efficiency

Complex and Chronic Care Improvement Program (CCIP)

- **Who?** For hospitals and community providers and practitioners
- **What?** Facilitates high-value activities focused on high needs patients with complex and rising needs, such as multiple chronic conditions
- Leverages Medicare Chronic Care Management (CCM) fee*

- Hospitals can select which program(s) to participate in
- Through these voluntary programs, hospitals will be able to obtain data, share resources with providers, and offer optional incentive payments

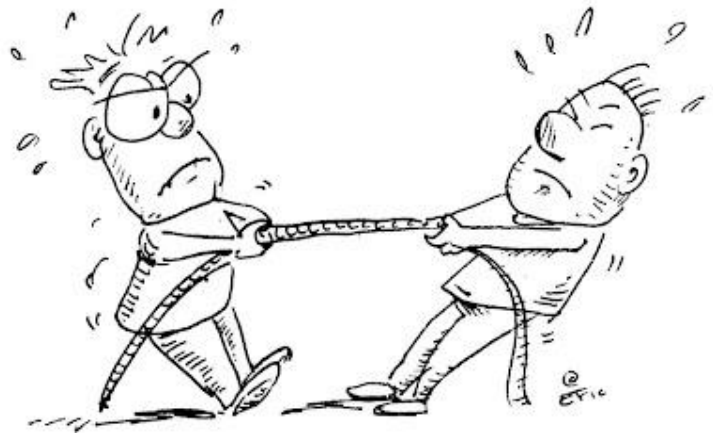
*Maryland will modify program as needed to adapt to Medicare's MACRA program and the Maryland Primary Care Model

Enhanced "Total Cost of Care" All-Payer Model

- Designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes and constrain the growth of costs
- Timeframe
  - Model currently in federal clearance (June - October)
  - Engagement with stakeholders (June – October)
  - Contract signed by end of year
  - New Model to begin January 1, 2019
- Key Objectives:
  - Build on global budget model
  - Use Care Redesign Programs, and other care redesign tools
  - Improve Population Health
  - Coordinate with other State agencies

Payment and Care Delivery Alignment

Current



- Hospitals on Global Budgets with quality targets
- Providers on volume-based care without quality targets
- Little coordination of care

Planned

- Hospitals and Providers with aligned quality targets
- Sharing information
- Driving down costs
- Improving the health of populations

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