ABBREVIATED FOR DISCUSSION PURPOSES

Maryland All-Payer Model Background, Progression and Vision Elements

February 2016 Advisory Council Meeting

HSCRC
Health Services Cost Review Commission

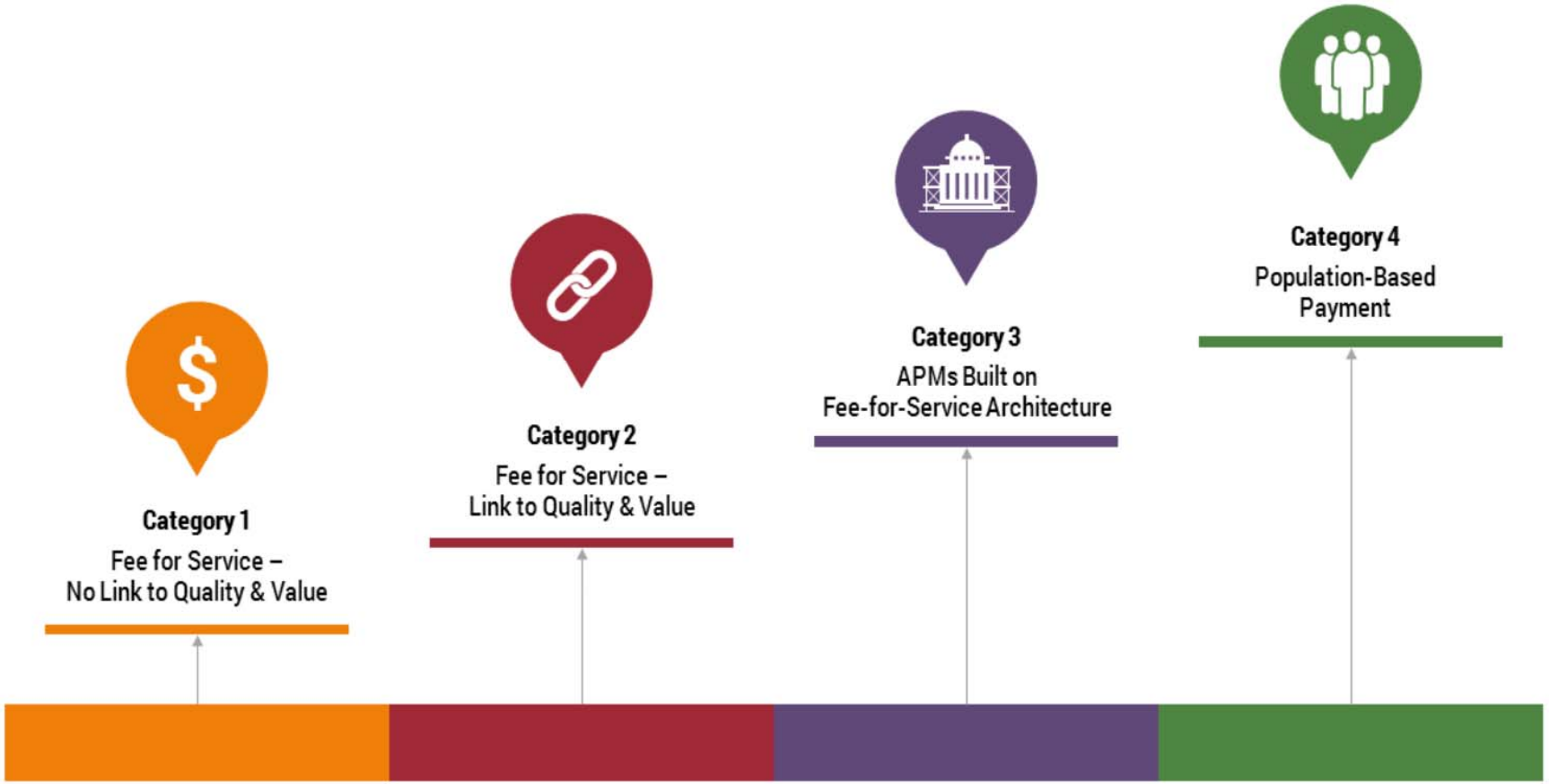
The Evolving Healthcare Landscape: Shifting to Value

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

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

Source: Summarized from Sylvia Burwell (US Secretary of Health) presentation

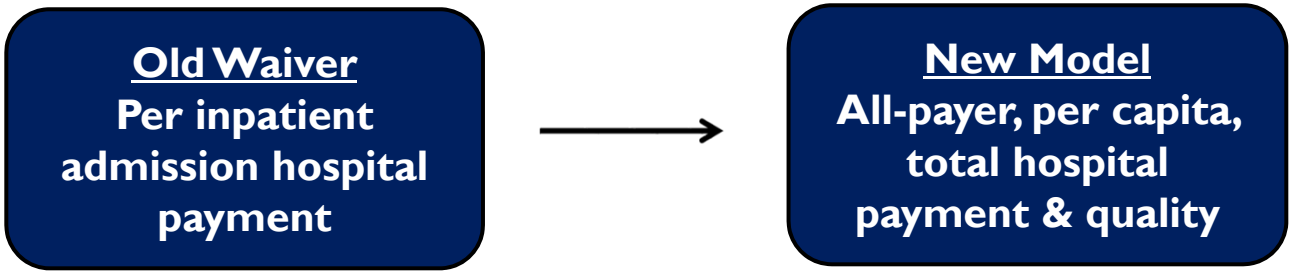
CMS is Focused on Progression to Alternative Payment Models



Maryland's Unique Approach

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



- Key provisions of the new Model:
  - Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least $330 million to Medicare over 5 years
  - Patient and population centered-measures to promote care improvement
  - Payment transformation to global and population based for hospital services
  - Proposal covering all health spending, to include at least Medicare patients, due at the end of Year 3 for 2019 and beyond

CY 2014 All-Payer Model Results

Good initial results but complex transformation ahead

- All hospitals on global budgets, ~95% of revenues
- All Payer hospital revenue growth was contained to 1.47%, compared to the 3.58% per capita ceiling; Medicare hospital savings of $116 million were achieved toward the $330 million five year requirement
- Quality measures for hospital acquired conditions were achieved and readmissions were reduced
- Expansion of Medicaid and other ACA enrollees within limits

CY 2015 All-Payer Model Results

CY 2015:

- Overall hospital volume growth limited (thru November)
- Per capita revenue growth within All Payer limit (thru November)
- Continued improvement in quality and readmissions measures—but more focus needed on broader outcomes

Concerns—Pace of Reductions in Avoidable Utilization

- Pace of implementation rapid and timelines challenging
- Medicare utilization declining per capita, but we need to accelerate
- Some excess growth in Medicare costs outside of hospitals (thru July)
- Our stakeholders do not have non-hospital data

Further Progress Dependent on Advancing Care Redesign

- System organization for Medicare beneficiaries is immature
  - Commercial and Medicaid managed care enrollees have some supports through medical home/managed care models of payers
  - Historically there have been significant gaps in supports for complex and chronically ill fee-for-service (FFS) Medicare beneficiaries because these functions did not exist in the Medicare FFS program
- Further progress for Medicare is dependent on advancing care redesign, alignment, and supporting infrastructure
  - Planning efforts are underway for additional system transformation and infrastructure to support it

Stakeholder Inputs

Advisory Council Recommendations (January 2014)

- Focus on meeting the early model requirements
- Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation
- HSCRC should play the roles of regulator, catalyst, and advocate
- Consumers should be involved in planning and implementation
- Physician and other provider alignment is essential
- An ongoing, transparent public engagement process is needed

Multi-Agency and Stakeholder Group Completed Report and Recommendations on Care Coordination (2015)

- Numerous care coordination initiatives underway in Maryland
- Smart public investments can support promising initiatives and bring them to scale
- Shared tools are needed to accomplish a three-step sequence to care coordination:
  - Effective risk stratification to identify people with complex medical and social needs
  - Health risk assessments to ascertain patients' needs
  - Patient-driven care profiles and plans addressing the medical and social needs of patients
- Care coordination will focus on accelerating initiatives for high-needs patients in the Medicare fee-for-service system – the highest cost / highest utilizers in Maryland
  - 2/3 of high utilizers and dollars are Medicare or Dual eligible beneficiaries
    - 40k high needs patients
    - 280k chronically ill Medicare patients with 4+ chronic conditions
- Partnerships are critical to effective care coordination. The challenge is to create opportunities to cooperate even while healthcare organizations compete in other ways
- Ultimately, goal is all-payer, all population care coordination with flexible approaches to operate within different payer and provider organizations while leveraging common IT to share structured care profiles and other information

Transformation Plans and Investments

Transformation Planning in 2015

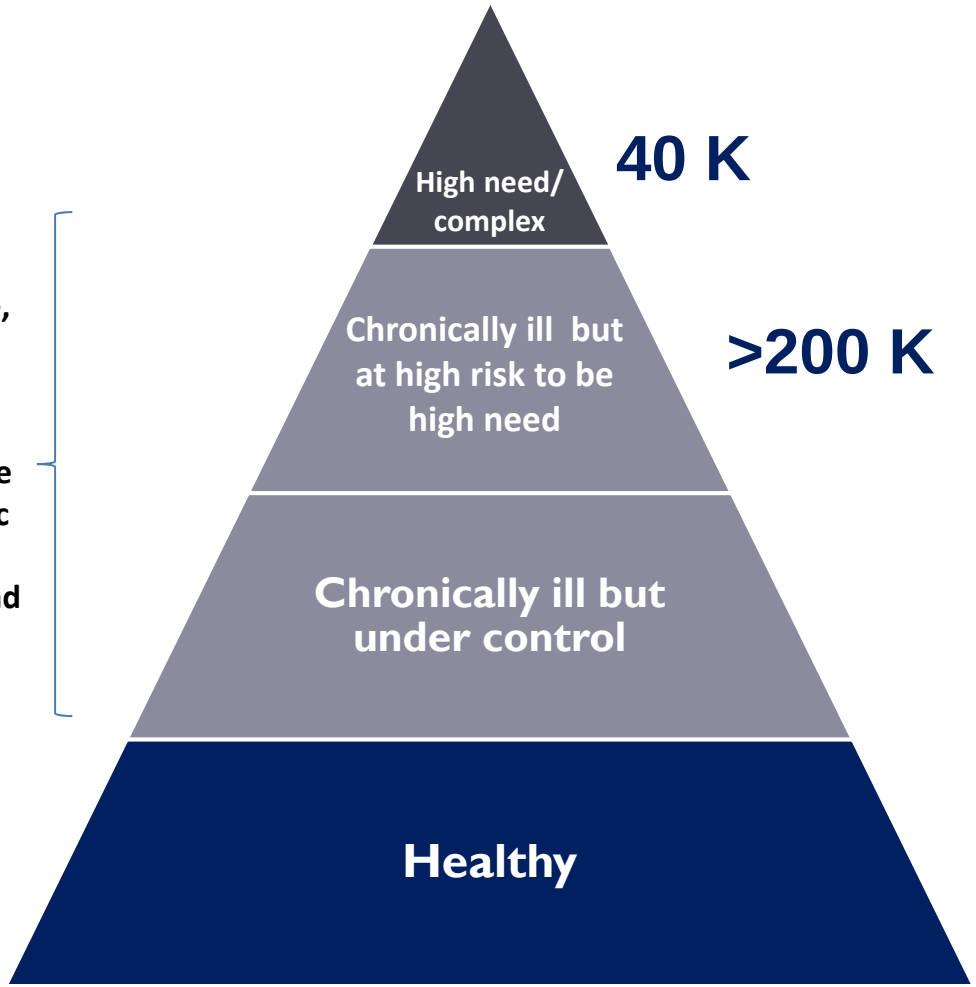
- Funding provided in rates for focus on reducing potentially avoidable utilization (PAU)
- Hospital and Partnerships reports
  - Hospital FY 2014 and FY 2015 reports for investments to reduce PAU
  - Eight regional partnership plans filed
  - System Transformation Plans filed by all hospitals
  - Twenty-two Implementation proposals filed
- HSCRC and other reviewers, including consultants, assessing reports and plans

Statewide HIE Infrastructure (CRISP) to Support Care Redesign in Progress

Care Managers	Clinicians Point-of-Care	LTC/HH/ Other Providers	Public Officials	ACO, PCMH, Other Payers	Patients
• Risk stratified patient analysis • Care profile view • Care management tools • Notifications • New clinical data feeds for care management • Performance metrics • Consent management	• Richer clinical query portal information • Care profile view • Notifications • In-context alerts • Care alerts receive & create • Consent management •	• Richer clinical query portal information • Care profile view • Performance metrics • Consent management	• Performance metrics • Statewide & regional analytics	• Risk stratified patient analysis • Care profile view • Care management tools • Notifications • New clinical data feeds for care management • Performance metrics • Consent management	• Control of health data consent • All providers have a patient-centric understanding of their health status

Maryland Direction & Strategy

Core Approach--Tailoring Care Delivery to Persons' Needs



A

Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources

B

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

C

Promote and maintain health (e.g. via patient-centered medical homes)

Progression of Focus

- The most significant opportunities for progression towards the focus on system-wide costs and outcomes are:
  - Reduce avoidable hospitalizations and promote hospital operational efficiencies through care transformation
  - Reduce variations in post-acute care
  - Focus on dually eligible beneficiaries (Medicare & Medicaid eligible)—not under managed care in Maryland for Medicaid
- In the progression of Maryland's model, we should be sure to focus on these opportunities first

Next Steps Needed for Maryland—Care Improvements that Reduce Avoidable Hospitalizations

- Fully implement care coordination to scale, first for complex and high needs patients
  - Intense focus on Medicare and dual eligible, where supports are immature
- Organize and engage consumers, primary care, long-term care, and other providers in care coordination and chronic care management
  - Intense focus on Medicare, where models do not exist or are immature, in Maryland
  - Build on growing PCMH and ACO models, global budgets and geographic areas, and Medicare Chronic Care Management fees

Next Steps Needed for Maryland's Transformation

- Develop financial alignment programs between hospital and non-hospital providers, and get data and waivers needed for implementation
  - Ensure focus on qualified Alternative Payment Models for physicians and other providers to optimize payment levels under MACRA legislation
- Optimize acute/post-acute
- Engage other providers in the care continuum
- Develop plan for dually eligible beneficiaries in alignment with All-Payer Model evolution
- Support primary care and other providers in transformation

Duals Care Delivery Strategy

- Developing an improved care delivery system for dual eligibles is a top priority in Maryland
  - Alignment: Promote value-based payment
  - Care delivery: Increase integration and coordination
  - Health information technology: Support providers
- A diverse, representative workgroup has been formed, which will meet from February to June 2016
- The duals strategy will be aligned with broader statewide transformation efforts

To Keep the Momentum, Maryland Needs:

- A revision of the All-Payer Model to incorporate Care Redesign and extend timeline
  - Capitalize on global budgets for hospitals to support care changes
  - Launch Care Redesign components in 2016
  - Extend timeline to keep critical commitment of "all in" and progression of redesign and alignment outside of hospitals
  - Incorporate dual eligible approach being developed by DHMH in alignment with the model
  - Provide MACRA support for physicians
  - Increase responsibility for system-wide costs and outcomes over an extended period of time, consistent with stakeholders' ability to implement care redesign
- Gain early approvals and data needed to support activities for:
  - Physician and practitioner engagement
  - Care coordination
  - Post-acute/acute optimization
  - Understanding and evaluating system-wide costs of care

CMS Agreement

Contract Term

- "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".

Facilitated Discussion