HSCRC Update

*Overview of Maryland’s All-Payer Model Progression*

*Donna Kinzer*
Executive Director
Health Services Cost Review Commission

October 7, 2015
Overview

• The Nation’s and Maryland’s Evolving Healthcare Landscape: Shifting to Value

• Maryland’s Delivery System Transformation Strategy

• Opportunities for HFMA Leaders
THE EVOLVING HEALTHCARE LANDSCAPE: SHIFTING TO VALUE
# Emerging National Strategy for Delivery System Change

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Deliver Care** | • Encourage integration and coordination of clinical care  
                   • Improve population health  
                   • Promote patient engagement through shared decision-making                                                                           |
| **Distribute Information** | • Create transparency on cost and quality information  
                                  • Bring electronic health information to the point of care for meaningful use                                                        |
| **Pay Providers** | • Increase linkage of payments to value  
                                 • Alternative payment models, moving away from payment for volume  
                                 • Bring proven payment models to scale                                                                                           |

Source: Summarized from Sylvia Burwell (US Secretary of Health) presentation
Healthcare Landscape in Maryland

• Medical home models have been implemented for a substantial number of persons, particularly for individuals with employer-based coverage

• Accountable Care Organizations (ACOs) have been formed and have nearly one-third of the Medicare population attributed

• Managed care organizations are beginning to expand efforts beyond Medicaid to address Medicare patients

• Nearly all hospital revenues are under global budgets through Maryland’s new All-Payer Model
Maryland’s Current Situation & Future Focus

- Year 1 Model results were good: Financial targets were exceeded and quality was improved
- Hospitals are engaging with partners to plan and implement changes to the delivery system

### Year 1 Focus—Implement All-Payer Model
- Shift to person-centric model
- Initiate payment reform (Hospital Global budgets)
- Focus policies on potentially avoidable utilization that result from care improvements
- Engage stakeholders
- Build regulatory infrastructure

### Year 2 Focus (Now)—Partnerships
- Work on clinical improvement, care coordination, integration planning, and infrastructure development
- Partner across hospitals, physicians and other providers, post-acute and long-term care, and communities to plan and implement changes to care delivery
- Alignment planning and development

### Years 3-5 Focus
- Implement changes, and improve care coordination and chronic care
- Implement alignment models
- Develop new models focusing on costs beyond hospitals
- Engage patients, families, and communities
- Prepare for “Phase 2”, and focus on total cost of care and extending the model
MARYLAND DIRECTION & STRATEGY
Emerging Vision—Target Resources Based on Person Centered 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)
# Stakeholder-Driven Strategy for Maryland

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

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Care Delivery**                        | • Encourage integration and coordination of clinical care  
• Support provider-driven plans for improving care for complex patients and improving chronic care  
• Support enhancement of primary care practices and models  
• Promote consumer engagement                                                                 |
| **Health Information Exchange and Tools**| • Enhance capabilities of CRISP (Maryland’s Health Information Exchange) to support providers, ACOs, and payers  
• Connect providers in addition to hospitals (physicians, long-term care, etc.)  
• Develop shared tools (e.g. common care profiles, data, reports)  
• Bring additional electronic health information to the point of care |
| **Alignment**                            | • Promote value-based payment systems, focused on improved outcomes  
• Develop alternative payment models and gain sharing and pay-for-performance opportunities  
• Build on private payer medical home models, Accountable Care Organizations formed by providers, and emerging Medicare Advantage plans |
Maryland’s Alignment Progression

- **Goal**: Build clinical integration and supporting financial arrangements over time with the ultimate goal of accountability for Total Cost and Outcomes of Care

**2015 Focus**: Hospital avoidable utilization and quality programs centered with hospitals

**2016 Focus**: Expand hospital focus to include partnerships with physicians, nursing homes, behavioral health, and others

**PHASE 1.5 2017-2018 Focus**: Expand focus to include outpatient, professional and skilled nursing opportunities

**PHASE 2 2019-2024 Focus**: Total Cost and Outcomes of Care
Maryland’s Current Activities

• Working on the large-scale implementation of the Maryland All-Payer Model—initially focused on hospital costs and care delivery transformation
  – Improving health information exchange at the point of care—connecting physicians, long term care facilities, and other providers and creating tools
  – Providers engaged in regional and local planning and implementation of care coordination
  – Negotiating additional tools/waivers with CMMI/others needed to facilitate financial and clinical relationships between hospitals and other providers
  – Consumer task forces recommending approaches for consumer engagement

• Working on additional plans that require stakeholder input and approvals from CMS
  – Developing plans for additional financial alignment and care delivery integration models focused on high needs patients/episodes together with stakeholders around the state
  – Developing plans for a dual eligible (people enrolled in both Medicare and Medicaid) Accountable Care Organization (ACO) for implementation in 2017
  – Beginning preparation of a plan, together with stakeholders, for extension of the current Maryland model, incorporating plans to assume responsibility (due at end of 2016 for implementation in 2019)
Other Current HSCRC Initiatives

• Focus on development and enhancement of efficiency and performance measures
  – Potentially Avoidable Utilization, Total Cost of Care, Per Capita, Episodes

• Refine current model
  – Capital, Shift, Other

• Development of data for phase 1.5 (model extension to other providers) and phase 2 needs (model extension to focus on cost and outcomes for the entire delivery system)
  – Total cost and outcomes
  – APCD, Medicaid, Medicare
  – EHR, registry, other
IMPLICATIONS FOR HFMA LEADERS
Success Depends on Supporting Care Delivery Changes—Are You On Strategy?

• SEE WHAT MATTERS
  – Population and person centered opportunities
  – What will drive success for your organization—how will you measure it?

• MEASURE WHAT MATTERS
  – Opportunities and outcomes of care delivery
  – Information needed for value based payments
  – Total cost and outcomes of care (across the system)

• CHANGE WHAT MATTERS
  – Transformation to person centered care based on needs
  – Care coordination and integration
  – Reducing avoidable use
  – Managing risk and improving outcomes
Success Dependent on Leadership in Maryland’s Movement to Population-based Health

- Develop and leverage data competencies
- Track changes in service utilization and outcomes in new ways
  - Equivalent Case-mix Adjusted Discharges (ECMADs): a new way to measure volumes
  - CRISP reports- PATH
  - Potentially Avoidable Utilization
  - Interventions for Nursing Home, High Needs Patients
  - HCAPS/ Stars
- Understand shifts in Maryland’s delivery system and determine how to measure its success
  - Care coordination
  - Working with providers across the care continuum
  - New outcomes measures
Example--CMS Shifts Focus to Increasing Value-Based Payment Approaches

<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service – No Link to Value</th>
<th>Category 2: Fee for Service – Link to Value</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality and/or efficiency of health care delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
</tr>
<tr>
<td>Medicare examples</td>
<td>Limited in Medicare fee-for-service</td>
<td>Hospital value-based purchasing</td>
<td>Accountable care organization</td>
<td>Eligible Pioneer accountable care organizations in years 3-5</td>
</tr>
<tr>
<td></td>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value-Based Modifier</td>
<td>Medical homes</td>
<td>Next Generation Accountable Care Organizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Readmissions / Hospital Acquired Conditions Reduction Program</td>
<td>Bundled payments</td>
<td>Maryland All-Payer Hospital Model fits into this category</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comprehensive primary Care initiative</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comprehensive ESRD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model</td>
<td></td>
</tr>
</tbody>
</table>

Example--Utilization Analytics

• Utilization as measured by Equivalent Case-mix Adjusted Discharges (ECMAD)
  • 1 ECMAD Inpatient discharge=1 ECMAD Outpatient Visit
• Observation stays with more than 23 hour are included in the inpatient counts
  • IP=IP + Observation cases >23 hrs.
  • OP=OP - Observation cases >23 hrs.
• Preliminary data, not yet reconciled with financial data
• Careful review of outpatient service line trends is needed
• Tableau Visualization Tools
All-Payer Inpatient (IP) and Outpatient (OP) ECMAD Trend

![Bar chart showing the trend of IP and OP ECMAD from FY2013 to FY2015.]

- IP ECMAD:
  - FY2013: 740,581
  - FY2014: 724,508
  - FY2015: 721,431

- OP ECMAD:
  - FY2013: 418,278
  - FY2014: 422,910
  - FY2015: 431,227
All-Payer MD Resident Largest 10 Service Line Trends

- ED
- Readmission_IP
- Orthopedic Surgery_IP
- Oncology_OP
- Major Surgery_OP
- General Surgery_IP
- PQI_IP
- Obstetrics/Delivery_IP
- Clinic_OP
- Infectious Disease_IP

FY2013 - FY2014 - FY2015
All-Payer MD Resident Service Lines with Largest Net Changes FY15 vs FY13

- Readmission_IP
- General Surgery_IP
- Cardiology_IP
- Gynecological Surg_IP
- Oncology_IP
- Invasive Cardiology_IP
- Spinal Surgery_IP
- Radiology_OP
- Pulmonary_IP
- Rehab & Therapy_OP
- ED
- Categorical Exclusions_IP
- Clinic.OP
- Cardiovascular_OP
- Infectious Disease_IP
- Major Surgery_OP
- Orthopedic Surgery_IP
- Oncology_OP

-6,000 -4,000 -2,000 0 2,000 4,000 6,000

FY2014 FY2015
Example—Needs in Analytics and Decision Support

Need for Data Competencies & Decision Support Tools

Revenue/Cost

- Market Shift Adjustment
- Quality Programs
- Productivity
- Potentially avoidable utilization
- Trends

Management

- Risk adjustment
- Chronic conditions
- High needs patients
- Patient profiles and patient centered care
- Potentially avoidable utilization
- Gain sharing
Example—Key Care Coordination Strategies

Stratify patients to customize and focus targeted approaches to care

• Focus initially on identifying populations with the greatest opportunity to improve care and achieve a return on investments in strategies- those with high need (~40K)
  • Patients at high risk for poor outcomes and avoidable utilization (e.g. Medicare patients, dual eligible population)

• For selected higher risk patients:
  • Perform assessments and develop additional stratification techniques
  • Develop individualized care plans
  • Provide individualized community-based case management and integrated long-term and post-acute care
  • Respond rapidly to changes in patient conditions to reduce avoidable utilization

Implement approaches and interventions to reduce and modify risks and integrate care across providers and settings

• Focus on chronically ill/at-risk (e.g. ≈240K) patients that are the target of the Medicare Chronic Care Management Fee
  • Monitor outcomes
# Example - Potential Core Outcome & Process Measures

## Outcome Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total hospital cost per capita</td>
<td>Hospital charges per person</td>
</tr>
<tr>
<td>Total hospital admits per capita</td>
<td>Admits per thousand person</td>
</tr>
<tr>
<td>Total health care cost per person</td>
<td>Aggregate payments/person</td>
</tr>
<tr>
<td>ED visits per capita</td>
<td>Encounters per thousand</td>
</tr>
<tr>
<td>Readmissions</td>
<td>All Cause 30-day Inpatient Readmits (see HSCRC specs)</td>
</tr>
<tr>
<td>Potentially avoidable utilization</td>
<td>Total PAU/ECMADs</td>
</tr>
<tr>
<td>Patient experience</td>
<td>TBD</td>
</tr>
<tr>
<td>Composite quality measure</td>
<td>TBD</td>
</tr>
</tbody>
</table>

## Process Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Encounter Notification Alerts</td>
<td>% of inpatient discharges that result in an Encounter Notification System going to a physician</td>
</tr>
<tr>
<td>Completion of health risk assessments</td>
<td>% High utilizers with completed Health Risk Assessments</td>
</tr>
<tr>
<td>Established longitudinal care plan</td>
<td>% of High Utilizers Patients with completed care</td>
</tr>
<tr>
<td>Shared Care Profile</td>
<td>% of patients with care plans with data shared through HIE in Care Profile</td>
</tr>
<tr>
<td>Portion of target pop. with contact from assigned care manager</td>
<td>% of High Utilizers Patients with contact with an assigned care manager</td>
</tr>
</tbody>
</table>
HOW WILL YOU LEAD?
Invest in Your Competencies

• Data competencies
• Decision support
• Risk management competencies
• Total cost and outcomes of care
• Care coordination
• Strategic support
Thank you for the opportunity to work together to improve care in Maryland

Questions?

Donna Kinzer
HSCRC Executive Director
donna.kinzer@maryland.gov
Speaker Biography

Donna Kinzer serves as the Executive Director of the Maryland Health Services Cost Review Commission (HSCRC). Ms. Kinzer took a leave from her 40 year consulting career to help lead the HSCRC staff through development and implementation of hospital payment modernizations. In that role, she assisted leadership in developing the new All-Payer Model for Maryland and in obtaining the new Medicare Waiver. She is also leading the staff in implementation of the new Model.

Ms. Kinzer has focused her career on helping payers, providers, and other health care entities develop and implement new analytics, delivery approaches, payment models, and supporting infrastructure in response to transformational market shifts, changing customer demands, and health care reform.

During the first year of the new All-Payer Model, Ms. Kinzer led the HSCRC staff and the field through implementing global budgets for all Maryland hospitals, aligned quality payment approaches with the new Model, and implemented monitoring infrastructure. She is now leading the field through developing and implementing strategies for delivery transformation needed to sustain and support the objectives of the new Model.