An Overview of Maryland's Unique All Payor Contract and Rate Setting

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The Maryland State Medical Society

MedChi Facts

- **MedChi is the seventh oldest medical society, formed in 1799 in Annapolis, MD**
- **The Mission of MedChi, The Maryland State Medical Society, is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health of Maryland**
- **Largest physician organization in Maryland**
  - **Physicians – primary care and specialists**
  - **Medical residents and students**
  - **Practice managers and medical staff**

MedChi is Dedicated to Work Hard Enhancing Healthcare for All Marylanders

- Offer CME and work with specialty societies to enhance medical knowledge
- Fight to prevent decreases in Medicaid and Medicare payments to physicians which significantly affects their patients
- Meet the needs of both independent and employed physicians
- Provide free Rx cards to help uninsured and underinsured with prescriptions
- Work with CRISP to support physicians use of free Prescription Drug Monitoring and Population Health tools through the Health Information Exchange.

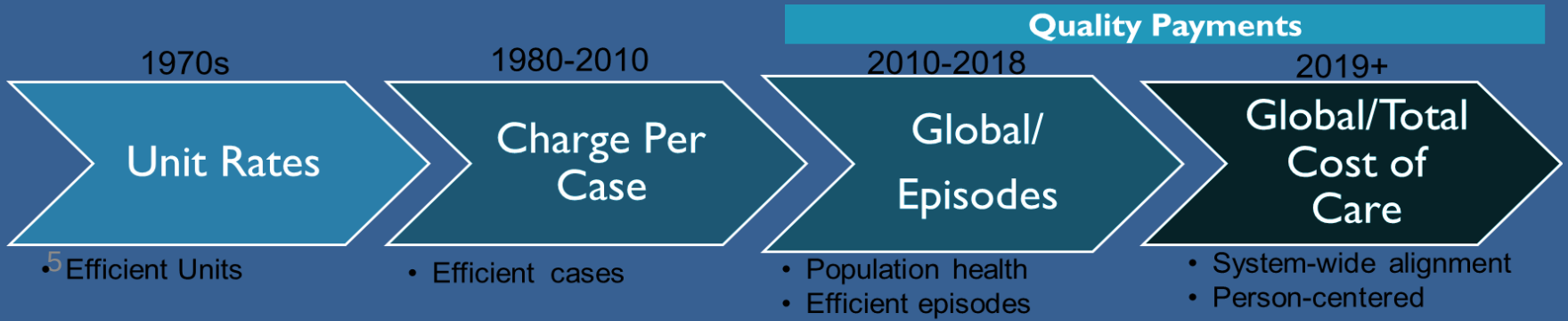
Direction of Health Care

- Integrated care delivery models are causing the industry to shift away from a fee-for-service model
- Payors are looking to make fixed payments to care providers for treating
  a specific patient population
- Savings from care coordination and preventive services are available to incentivize providers
- Technology should allow for better case management and population health reporting

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
  - Per capita, value-based payment framework for hospitals
  - Provider-led efforts to reduce avoidable use and improve quality and coordination
  - Savings to Medicare without cost shifting
  - Sustains rural health care with stable revenue base



Health Services Cost Review Commission

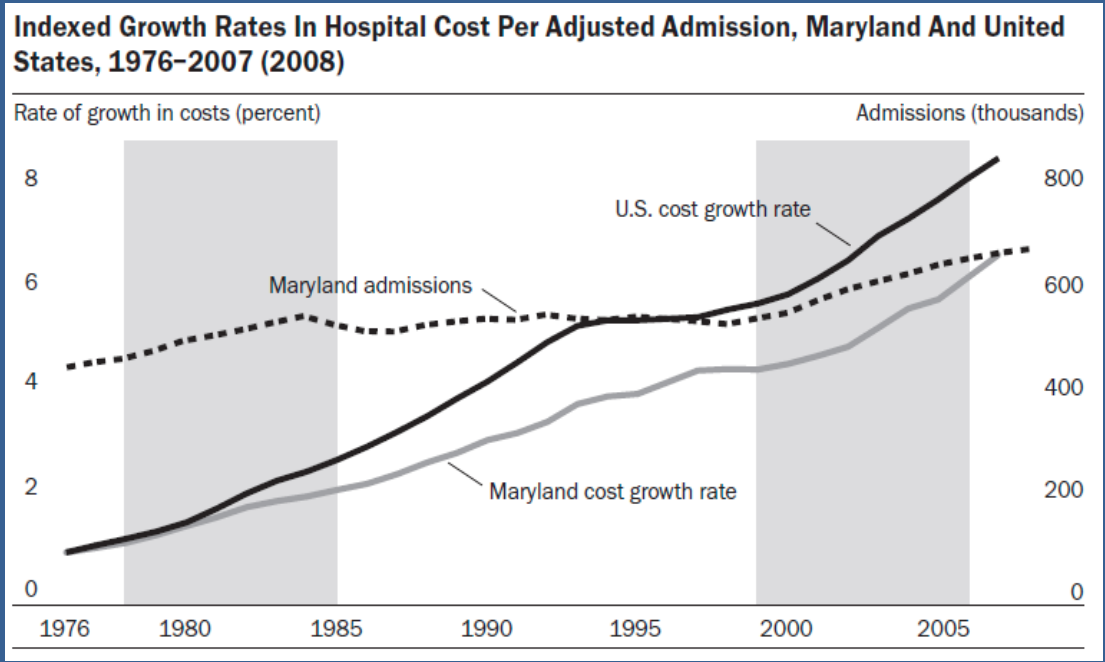
- Oversees hospital rate regulation in Maryland
- Independent 7-member Commission
  - Decisions appealable to the courts
  - Balanced membership
  - Experienced staff
- Broad statutory authority
  - Has allowed Commission methods to evolve
- Broad support

health services
cost review commission

HSCRC Cost Accomplishments

Cost containment (all payer)

From 26% above the national average cost per case in1976 to 2% below in 2007



Prior to 2014, HSCRC Set Prices Per Unit of Service

Functional Center	Approved Rate	Unit		Units of Service	Charge
Medical/Surgical Unit	$500	Per day	X	5	$ 2,500
Intensive Care Unit	$1,000	Per day	X	2	2,000
Admission	$100	Per case	X	1	100
Operating Room	$15	Per minute	X	150	2,250
Radiology	$20	RVU	X	25	500
Pulmonary	$3.00	RVU	X	10	30
Blood	$15	RVU	X	5	75
Lab	$2.00	RVU	X	25	50
Physical Therapy	$16	RVU	X	5	80
Cost of Drugs Sold	$1,200	Invoice cost	X	patient	1,200
Medical Supplies	$2,100	Invoice cost	X	patient	2,100
Total Charge Per Case					$10,885

Maryland Hospital Payment: All Payer Model

- Maryland is implementing a new All-Payer Model for hospital payment
  - The Center for Medicare and Medicaid Innovation approved the application to go to global budgets in 2014
- Focus on new approaches to rate regulation
- Moved Maryland
  - **From** Medicare, inpatient, per admission test
  - **To** an all-payer, total hospital payment per capita test
  - Shifts focus to population health and delivery system redesign

All Payer 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** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings
- **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

The Enhanced Model Approved to start in 2019

CENTERS FOR MEDICARE & MEDICAID SERVICES

Date: 7/5/18

By: _____

Adam Boehler, Director, Center for Medicare and Medicaid Innovation

GOVERNOR OF MARYLAND

Date: 7/9/18

By: _____

Lawrence Joseph Hogan, Jr., Governor

MARYLAND DEPARTMENT OF HEALTH

Date: 7/9/2018

By: _____

Robert R. Neall, Secretary of Health

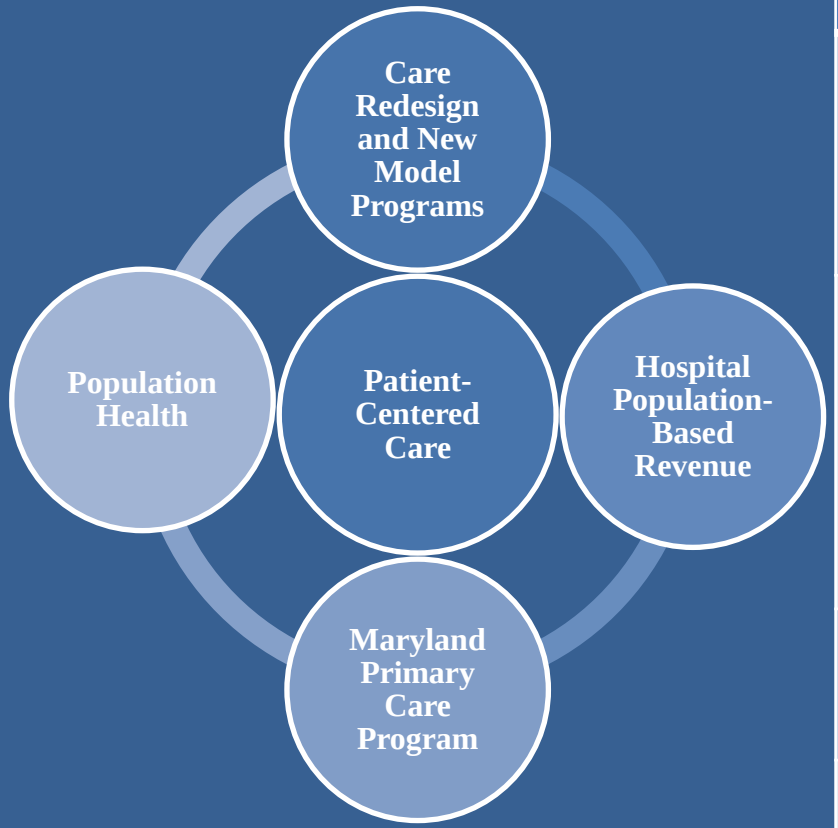
HEALTH SERVICES COST REVIEW COMMISSION

Date: 7/9/2018

By: _____

Nelson Sabatini, Chairman

Total Cost of Care Model Components



Component	Purpose	Status
Hospital Population-Based Revenue	Expand incentive and responsibility to control total costs through limited revenue-at-risk under the Medicare Performance Adjustment.	Expands
Care Redesign and "New Model" Programs	Enable private-sector led programs supported by State flexibility, "MACRA-tize" the model and expand incentives for hospitals to work with others, and opportunity for development of "New Model Programs."	Expands
Population Health	Improvement programs for chronic conditions, opioid deaths, and senior health and quality of life.	New
Maryland Primary Care Program	Enhance chronic care and health management.	New

What does change to global budgets mean?

- New Model represented most significant change in nearly 40 years
- Focus shifts to gain control of the revenue budget and focus on gaining the right volumes and reducing avoidable utilization resulting from care improvement
- Potential for excess capacity will demand focus on cost control and opportunities to optimize capacity
- Opened new avenues for innovation
- Increased efficiency creates opportunities for improved care and better population health

Hospital Payments Have Changed: Focus Shifts from Rates to Revenues

Old Model
Volume Driven

Units/Cases

× **Rate Per Unit or Case**

Hospital Revenue

Unknown at the beginning of year. More units/more revenue

New Model
Population & Value Driven

Revenue Base Year

× **Updates for Trend, Population, Value**

Allowed Revenue Target Year

Known at the beginning of year. More units does not create more revenue

What is the Maryland Primary Care Program?

The State of Maryland has entered a Total Cost of Care All-Payer Model contract with the Federal Government that is designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes, and constrain the growth of health care costs in Maryland.

A key element of the model is the development of the Maryland Primary Care Program (MDPCP). MDPCP is a voluntary program open to all qualifying Maryland primary care providers that provides funding and support for the delivery of advanced primary care throughout the state.

The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.

MDPCP
MARYLAND PRIMARY CARE PROGRAM

Payment Incentives in the MDPCP

Practices – Track 1/Track 2

Care Management Fee

- $6-$100 Per Beneficiary, Per Month (PBPM)
  - Tiered payments based on acuity/risk tier of patients in practice including $50/$100 to support patients with complex needs, dementia, and behavioral health diagnoses
- Timing: Paid prospectively on a quarterly basis, not subject to repayment

Performance-Based Incentive Payment

- Up to a $2.50/$4.00 PBPM payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis, subject to repayment if benchmarks are not met

Underlying Payment Structure

- Track 1: Standard FFS
- Track 2: Partial pre-payment of historical E&M volume with 10% bonus
- Timing:
  - Track 1: FFS; Track 2: prospective

MSSP ACO practices do not receive the Performance-Based Incentive Payment

Potential for additional bonuses via AAPM Status under MACRA Law

Total Payments Program Year 1

- Total investment for Practices & CTOs in Program Year 1 = $67M
- Average amount to practices = ~$176,000*

- *Includes payments to Track 1 2 Practices and CTOs

Eligible Specialties

- General Practice (01)
- Family Medicine (08)
- Internal Medicine (11)
- Obstetrics and Gynecology (16)
- Pediatric Medicine (37)
- Geriatric Medicine (38)
- Nurse Practitioner (50)
- Clinical Nurse Specialist (89)
- Co-located Psychiatry (26)*
- Physician Assistant (97)
- Preventive Medicine (84)
- Certified Nurse Midwife (42)

- Ensure providers are listed as one of the eligible specialties:
- Specialists with these primary specialty codes are not eligible to participate
- * Practitioners identified with a primary specialty code of Psychiatry (26) must be co-located with an eligible practitioner with a primary specialty code other than Psychiatry in order to participate

The Episode Quality Improvement Program – EQIP

- The HSCRC plans to start a voluntary, episodic incentive payment program for specialist physicians in Medicare, EQIP, in 2022.

Physician ownership of performance	Upside-only risk with dissavings accountability	Alignment with CareFirst's episode payment program	AAPM/value-based payment participation opportunities for MD physicians

- EQIP will utilize the Prometheus Episode Grouper approach. The first performance year will include episodes in the following specialty areas:
  - Gastroenterology
  - Orthopedics
  - Cardiology

EQIP Roles – Definitions and Responsibilities

"CRP Entity" (a Maryland hospital)

- Signs a **Care Partner Arrangement** with all Care Partners
- **Pays incentive payments** or savings to EQIP entities

"EQIP Entity"

- Consists of an **individual Care Partner** or **multiple Care Partners**
- **Performance evaluation** occurs at the EQIP entity level
- Receives **Incentive Payments**

"Care Partner" (a specialty physician)

- **Triggers episodes** and **performs EQIP care interventions**
- Signs a **Care Partner Arrangement** with the CRP Entity
- Receives normal fee-schedule payments from Medicare and a **potential "Incentive Payment" with the EQIP Entity**
- Eligible to achieve **Quality Payment Program Status** and bonuses

HSCRC and CRISP

- Will calculate episodes, monitor performance and **determine Incentive Payments**
- Maintains reporting and monitoring requirements per the Participation Agreement and to **support CRP Entity**
- Will facilitate **EQIP Entity and Care Partner Enrollment**, Reporting and Learning Systems

Participation Requirements

Qualify as a Care Partner with CMS

- Must be licensed and enrolled in the **Medicare** Provider Enrollment, Chain, and Ownership System (**PECOS**)
- Must use **CEHRT and CRISP**, Maryland's health information exchange

Enroll in EQIP

- Establish **EQIP Entity** with **multiple Care Partners**
- **Select Episodes and Interventions** and agree to quality metrics*
- Each Care Partner Signs a **Care Partner Arrangement**
- Determine **Payment Remission Recipient***

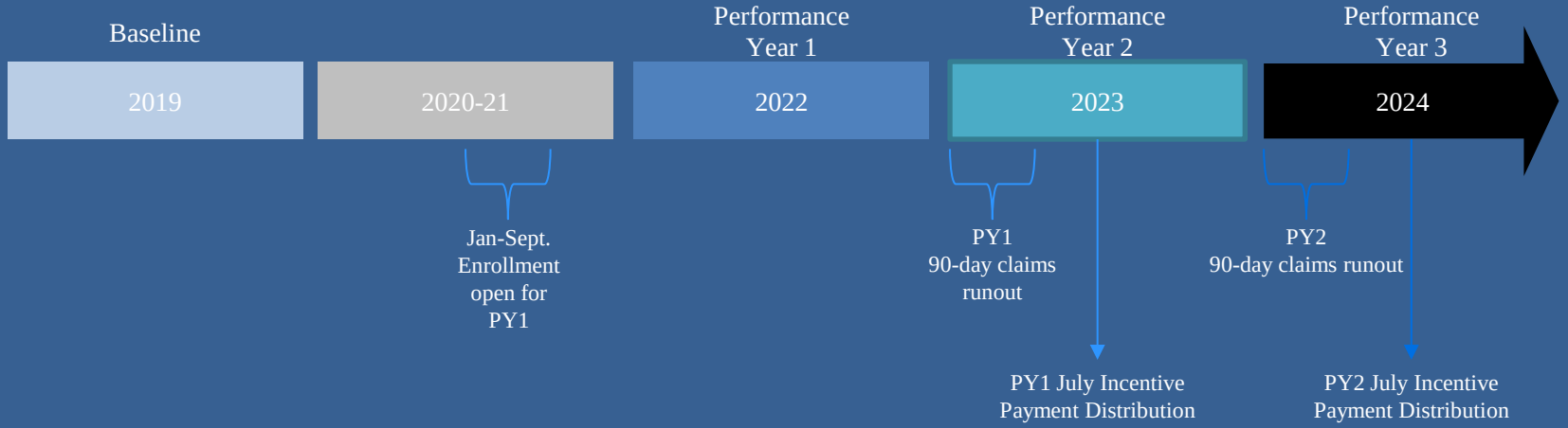
Meet Episode Thresholds

- Provide care in **Maryland**
- For a **single episode, threshold = 11** episodes in the baseline
- Across **all episodes of participation, threshold = 50** episodes in the baseline

**All Care Partners in an EQIP Entity will share the same episodes, quality metrics and payment recipient.*

Participation Timeline

- EQIP will have an annual opportunity to enroll in EQIP. The enrollment period will open **July through September** of each year prior to the performance year.
- The policy may be updated, and participation opportunities increased year to year through HSCRC's stakeholder engagement process



Questions?

Thank You

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