PUBLICATION

Maryland All-Payer Model's Progression to Total Cost of Care: Alignment Strategies for Stakeholders in New Cost Paradigm

June 2018

The State of Maryland is unique in its historical experimentation with rate setting and global budgets for hospitals, and that experimentation continues with the Maryland Total Cost of Care Model (TCOC). Beginning January 2019, the Centers for Medicare & Medicaid Services (CMS) plans to hold Maryland fully at risk for the total cost of care for Medicare beneficiaries. Maryland's TCOC is the first statewide model focusing on total cost of care, which was announced in partnership with CMS's Center for Medicare & Medicaid Innovation (CMMI).

With the many changes outlined by the TCOC and the rapid pace of change in health care reimbursement, Maryland providers have several opportunities for pursuing new, or expanding upon existing, alignment strategies. This article introduces the TCOC and discusses the All-Payer Model leading to the TCOC before concluding with alignment options for Maryland providers to consider for thriving under this new reimbursement environment.

Maryland Total Cost of Care Model: Context and Background

Maryland's current All-Payer Model is a five-year agreement with CMMI that began January 1, 2014, and implements a prospective global budget for hospital payment (i.e., a fixed amount of revenue for hospitals in a given year). This approach provides hospitals with an annual revenue expectation for all inpatient and outpatient care in advance, the aim of which is to reduce hospital expenditures and to improve preventative and community services. By shifting away from paying for volume of services to a focus on hospital-specific global revenues with overlying value-based incentives, the All-Payer Model holds hospitals accountable for the total cost of hospital care on a per capita basis.

The TCOC builds upon the successes of the All-Payer Model by expanding beyond hospitals to other settings across the continuum of care for Medicare beneficiaries. The TCOC will run from January 1, 2019 through December 31, 2028, so long as various requirements imposed by CMMI are met. Adding to the All-Payer Model, the TCOC incorporates various participation incentives to encourage physicians and other providers to coordinate and reward improvements in care and care coordination. The progression of the TCOC will begin with a focus on Medicare beneficiaries and transition to an all-payer basis.

Maryland and CMS have documented several strategies for transforming health care in Maryland as part of the TCOC. Dubbed the Progression Plan, the document outlines Maryland's evolution to the TCOC, along with the following key strategies:

1. Foster accountability by supporting hospitals, physicians, and other providers as they organize to take responsibility for groups of patients or populations within a geographic area.
2. Align performance measures and incentives for all providers with the goals of the TCOC Model.
3. Encourage and develop payment and delivery system transformation to drive coordinated efforts and system-wide goals.
4. Ensure availability of tools to support all types of providers in achieving transformation goals.
5. Devote resources to increasing consumer engagement.

It is important to note that TCOC is simply a framework, and the Progression Plan identifies goals, strategies, and areas of improvement. Consequently, many aspects of this model are in flux. The TCOC provides Maryland and CMS flexibility to provide solutions for achieving these over-arching strategies of the Progression Plan. For example, the Progression Plan identifies certain waivers of federal requirements for achieving the goals of the TCOC, such as, among others, telehealth coverage policy, patient incentives prohibitions, and post-acute payment policies.

Interplay with Federal Programs

At the federal level, CMS has promulgated several alternative payment models and various iterations of Accountable Care Organizations, all of which have a role in promoting accountability among the various stakeholders in health care. The Progression Plan contemplates the interplay of the TCOC with those existing federal programs. In particular, the Progression Plan identifies changes to the TCOC so that CMS may determine it as an Advanced Alternative Payment Model (Advanced APM). Advanced APMs are part of the larger Quality Payment Program (QPP), which is an expansive and complex federal system of quality measures that combines previously distinct quality reporting programs under one federal program. For further information about the QPP, refer to Baker Donelson's in-depth white paper on the topic.

To qualify as an Advanced APM, the TCOC must meet several requirements, one of which includes accepting downside risk. Although the TCOC subjects hospitals to global budgets, which, in essence, subjects them to capitated risk, it does not place hospitals at financial risk for reduced payment rates of more than a "nominal amount." In order to subject hospitals to such risk, the Progression Plan implements a new Medicare Performance Adjustment (MPA) in 2018. The MPA will place a Medicare hospital's revenue at risk depending on if that hospital meets a certain target. The target relates to the calculated annual total-cost-of-care growth rate in a service area. If a hospital falls below the target, it can receive a positive adjustment to its MPA. On the other hand, a hospital that exceeds the target can be subject to a negative adjustment to its MPA.

Similar to the federal bundled payment programs, such as the Comprehensive Care for Joint Replacement Model (CJR), the TCOC includes the Care Redesign Program. The Care Redesign Program allows hospitals to make incentive payments to nonhospital health care providers who collaborate and perform care redesign activities that reduce costs and improve quality of care. The Care Redesign Program provides hospitals with access to comprehensive Medicare data and allows them to share resources with each other and to offer incentives to physicians and other providers who help with care redesign. Importantly, under TCOC, hospitals can make incentive payments only from the savings they achieve under their global budgets. In order to participate, a hospital must enter into a "Care Redesign Program Participation Agreement" with CMS and Maryland, and then must have downstream contracts with the various providers the hospital wishes to engage in the Care Redesign Program in order to make incentive payments.

The Progression Plan's Maryland Primary Care Program (MDPCP) is another federal lookalike program, the federal counterpart to which is the Comprehensive Primary Care Plus Model (CPC+). The CPC+ combines Medicare and private payer patients in specific geographic regions in an attempt to change how primary care medicine is delivered and reimbursed. CPC+ will accomplish this by subtly shifting reimbursement away from traditional fee-for-service and towards a monthly per-patient per-month capitation payment with performance-based incentive payments. (Additional background information on CPC+ is available here.) Similar to CPC+, the MDPCP will offer prospective payments, a risk-stratified monthly care management fee, and an at-risk performance bonus to primary care practices electing to participate in the program. The latter two vary depending on one of two tracks available in the MDPCP.

- Track 1 – Participants receive a monthly care management fee ranging from $6 to $50 per beneficiary per month (PBPM) and an at-risk performance bonus of $2.50 PBPM.

- Track 2 – Participants receive a monthly care management fee ranging from $9 to $100 PBPM and an at-risk performance bonus of $4 PBPM.

The MDPCP determines the at-risk performance bonus based on the participant's performance against established benchmarks consisting of quality, patient satisfaction, and utilization. Therefore, this amount is subject to claw back in whole or in part depending on benchmark performance.

Alignment Options in Light of the Changing Reimbursement Environment

With hospital spending remaining a major cost driver across payers, the TCOC will continue to focus on hospital spending. However, structuring accountability across the various stakeholders in Maryland is necessary in order to help providers take more responsibility for advancing system-wide goals, such as reducing health care costs and improving health outcomes. This need reflects the reality that physicians control the vast majority of health care spending and that they are often seen as "gatekeepers," evaluating the needs of their patients, monitoring the quality of care, and shaping discussion regarding care redesign. In addition, however, opportunities to reduce waste and improve efficiency and quality of care extend beyond physicians' offices to the post-acute care space. To thrive under this new reimbursement environment, hospitals must explore opportunities to execute alignment strategies with physician and various health care providers.

- *Medical Directorships:* As arguably the least integrated option, Medical Directorships can help begin the transition for physicians or practice groups to assume additional hospital-related responsibilities. Medical Directorships also provide opportunities for hospitals to bring in experts to assist in redesigning care pathways in a variety of ways, many of which can contribute in achieving quality measures under new reimbursement models.

- *Clinical Co-Management Agreements:* Clinical co-management agreements allow physicians to provide administrative services and leadership over a service line in addition to providing incentives for meeting established metrics. Metrics may include, among other things, patient care, patient experience, quality measure, and cost reductions.

- *Gainsharing Agreement:* Hospitals share the cost savings resulting from efficient management of high-cost supplies by streamlining those supplies and other direct costs under gainsharing agreements. Bundled payment models, such as the CJR, include parallel concepts to gainsharing agreements, except in CJR the cost savings shared with physicians are protected by fraud and abuse waivers. Gainsharing agreements can be successful but pose several regulatory hurdles when entered into outside of applicable bundled payment models. With that said, traditional gainsharing arrangements are a viable alignment strategy.

- *Bundled Payment Models:* Bundled payment models generally allow hospitals to make incentive payments to nonhospital health care providers who collaborate and perform care redesign activities that reduce costs and improve quality of care. Physicians who participate in care redesign may have employment status with the hospital or health system or remain as independent contractors. Bundled payment arrangements assign risk to the hospital for a patient's entire episode of care, including post-acute care. The hospital, in turn, contracts with physicians to assume certain responsibility for receiving incentive payments and/or downside risk.

  Two relatively new Maryland programs provide a platform for such alignment. Both are part of the Care Redesign Program. Through downstream arrangements with providers, hospitals participating in the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP) can encourage alignment with providers through common goals and incentives. The HCIP is aimed at improvement of care management and delivery as well as reduced utilization

between hospitals and hospital-based physicians. The CCIP is focused on arrangements between hospitals and community providers to improvement care management and primary care delivery. Both programs benefit from CMS fraud and abuse waivers, which allow for more flexibility in the compensation models and other elements of the arrangement.

- *Employment:* Hospitals employing physicians is a more integrated approach than the options mentioned above. Increasingly, physician compensation includes more value-based components as opposed to a traditional salary. Additionally, value-based compensation models can include incentives for achieving various metrics, such as quality, cost reduction, and, overall, improvement in care redesign. Employment provides an opportunity for hospitals to evaluate current compensation models, or introduce new models, to incorporate value-based components that align with alternative payment models.

- *Accountable Care Organization (ACO):* ACOs are designed to integrate providers, requiring a level of cooperation and joint decision making for improving patient care and achieving savings. CMS provides several different types of ACOs, referred to as tracks, that require varying levels of collaboration and sharing of financial risks. CMS opens applications for certain ACO tracks on an annual basis. Advanced APMs under the QPP, as discussed above, include certain tracks of ACOs, demonstrating CMS's ongoing commitment to this care delivery and alternative payment model.

Baker Donelson Comments

In many ways, the alignment options discussed here are not new, but rather are evolving with the transition to value-based care. The TCOC is yet another payment model encouraging providers to compete under a reimbursement framework of value-based care. This is an optimal opportunity for Maryland stakeholders to identify and fine-tune their alignment strategies.

CMS, and the state of Maryland with the TCOC, are encouraging, and in some instances mandating, hospitals and other providers to take on more financial risk for their patients. At the same time, value-based care, including the TCOC, is promulgating an era in which billing, collecting, and understanding the payments for their services is increasingly more complex. With the advent of the TCOC and the rapid pace of change in health care reimbursement, Maryland providers have several opportunities for pursuing new, or expanding upon existing, alignment strategies.

The alignment options available through the TCOC can be the key to Maryland providers thriving under this new reimbursement environment. Maryland providers should consult their strategic plan to identify how integration looks for them, and then identify alignment options appropriate for their goals. Baker Ober Health Law is adept at helping clients execute their strategies. Contact our health law team to see how we can help you with the transition to value-based care, including evaluation of options under Maryland's TCOC Model.