

Study of Cost Containment Models and Recommendations for Connecticut

Review of Oregon and Maryland

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April 12, 2016

bailit
health

The Healthcare Cabinet Cost Containment Study is a Partnership



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Funded by The Patrick and Catherine Weldon Donaghue
Medical Research Foundation

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Prevention, Access, Collaboration

Agenda

- 1. Review of Oregon's Cost Containment Strategies and Discussion**
2. Review of Maryland's Cost Containment Strategies and Discussion
3. Next Steps

Please Keep in Mind

- As we discuss each of the different strategies, please stay open to new possibilities

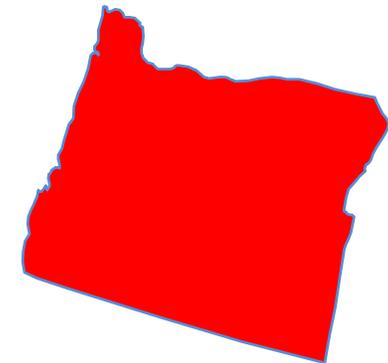


- Ask yourself, if Connecticut were to adopt some or all of the strategies discussed, what are –
 - Some of the facilitators?
 - Some of the barriers?

State Cost Containment Models



Six States of Inquiry



Oregon

Key Statistics



Oregon

Population	4,028,977
Sources of health coverage, 2014	Employer: 46%
	Medicaid: 21%
	Medicare: 16%
	Uninsured: 8%



Connecticut

Population	3,596,677
Employer:	58%
Medicaid:	20%*
Medicare:	12%
Uninsured:	3.8%**

*Source: *The CT Mirror*, 2/13/15.

Available at:

<http://ctmirror.org/2015/02/12/5-things-to-know-about-medicaid-spending-in-ct/>

**Access Health CT (4/5/16).

All other information from the Kaiser Family Foundation, 2014 data.

Health Care Market Profile: Hospitals



Oregon: 58 hospitals

- 4 large hospital systems with 30% of discharges, located in the two largest cities
- 32 small, rural hospitals with less than 50 beds; 25 are critical access hospitals; no public hospitals

Connecticut: 28 hospitals

- Most are domestic, but some are operated by larger health systems
- Two health systems control the majority of the statewide market (in terms of discharges)
- Market characterized by increasing consolidation

Health Care Market Profile: Primary Care



Oregon: ~3000 individual PCPs

- 1333:1 ratio of population to PCPs
- Approximately 50% of physicians are employed; physicians in rural areas are small, independent practices
- 29 FQHCs

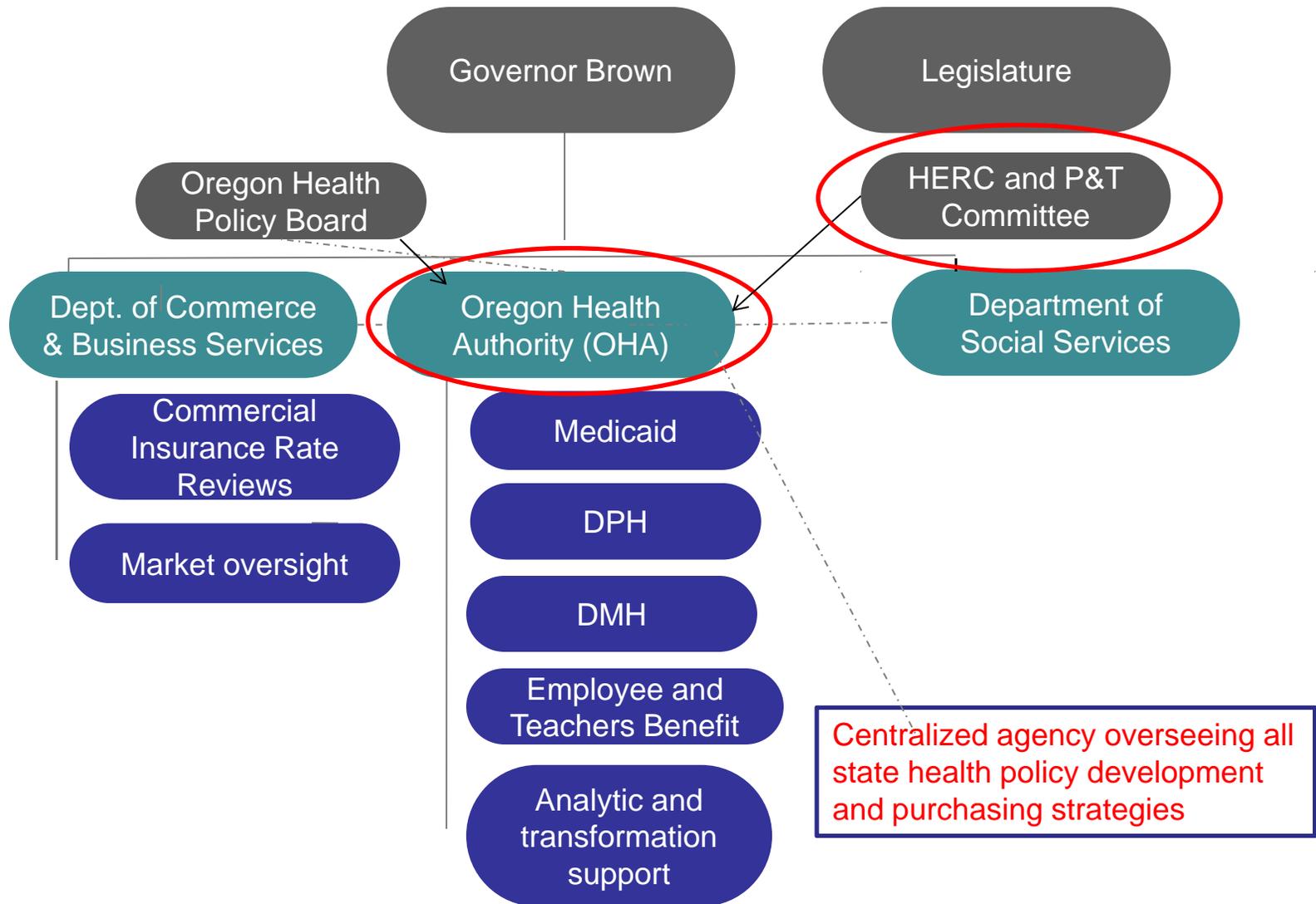
Connecticut: ~ 3000 individual PCPs

- 1385:1 ratio of population to PCPs
- ~20% of family medicine and internal medicine physicians are not accepting new patients*
- 16 FQHCs

OR State Government's Role in Health Reform

- In 2009, Oregon legislature created the Oregon Health Authority (OHA), which consolidated all:
 - health purchasing;
 - health policy development;
 - HIT infrastructure, and
 - analytic support capabilities.
- In 2012, the Medicaid program was granted an 1115c waiver to create local entities responsible for:
 - Providing all medical, dental and BH services to Medicaid beneficiaries
 - CMS capped cost increases at 3.4% annually
- 2015-17: Legislature capped employee/teacher plan rate increases at 3.4% and based OHA budget on cap

OR Government Oversight of Health Reform



Importance of Consolidated Agency

- Foundational to implementing cost containment strategies
 - State accountable for almost 30% of Oregon health care spend
 - Single director, accountable to Governor
 - Creating opportunities for inter-departmental collaboration: Public Health and Medicaid directors talk weekly at cabinet meeting
 - Leaders looking across functions, as well as within each program
 - Creates synergies through aligned strategies
 - Medicaid, employees' and teachers' plans use same quality metrics and performance goals; both emphasize PCMH transformation
 - Shared Pharmacy and Therapeutics committee making Rx coverage decisions for single formulary

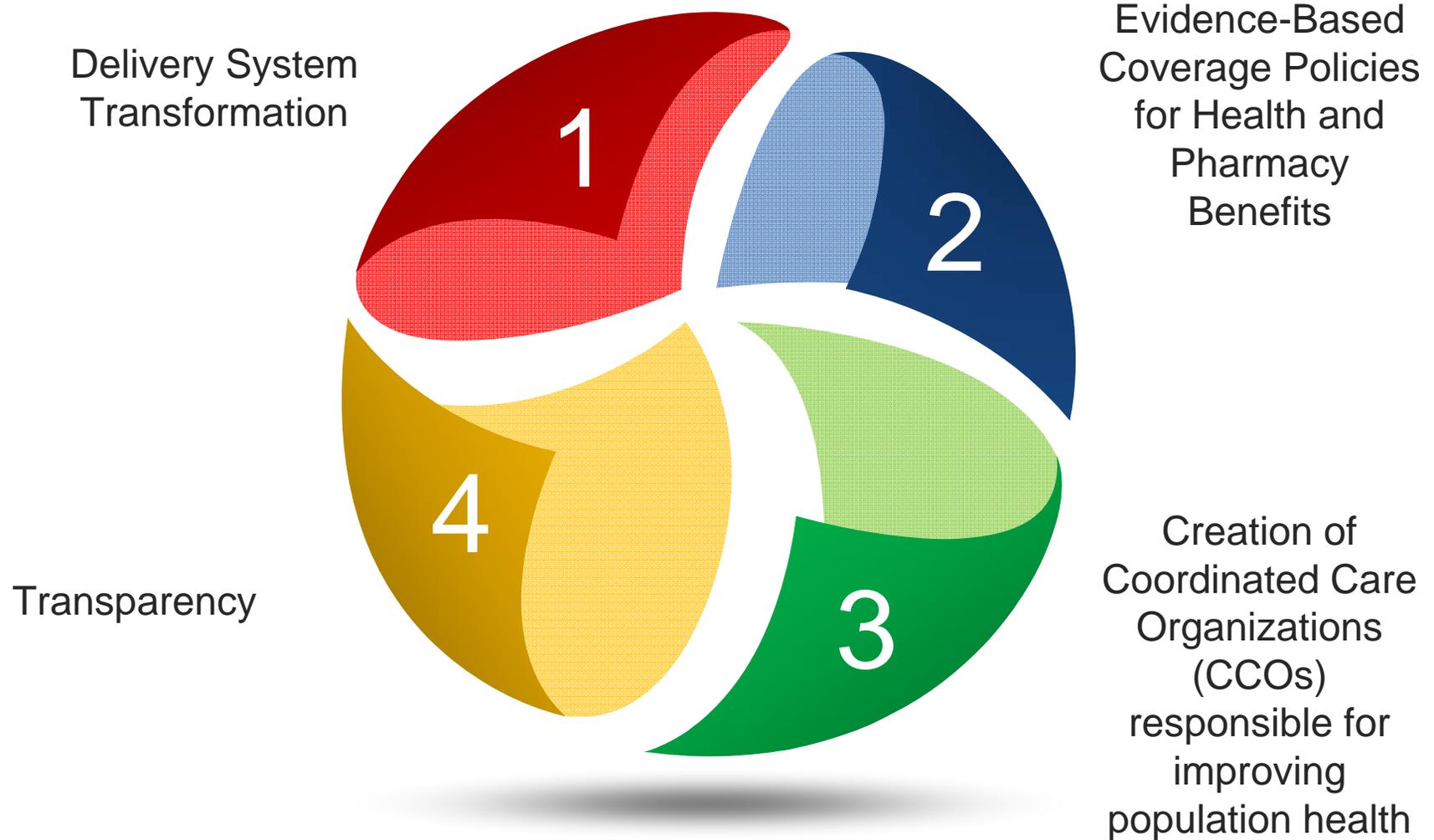
Importance of Consolidated Agency (cont'd)

- Strong analytical and policy development functions are within one agency
 - Have developed analytical capabilities to enable agencies to make informed, thoughtful policy decisions
 - Internal data capabilities, and
 - Partnerships with academic medical centers (centers get easier access to data and OHA get early research results)
 - Enables OHA to obtain data quickly and make timely data-based decisions

Importance of Consolidated Agency (cont'd)

- Health Policy Board provides informed constituent input to OHA
 - Board members are nominated by the Governor; approved by the Senate
 - Include employee union, academic medical center, business, and individual clinician representatives
 - Board assists with health policy development
 - OHA vets policies and seeks constituent consensus
 - Board members participate in public & legislative hearings

Four Key Cost Containment Strategies



Delivery System Transformation

Delivery System
Transformation



Focus: Patient Centered Medical Home

- OHA's Patient-centered Primary Care Home (PCPCH) program certifies practices as PCMHs
 - OR Health Policy Board in 2010 set goal of 75% of Oregonians to have PMCH access by 2015
 - Over 610 practices are PMCH recognized, across state
- OHA and health care leaders led multi-payer effort to support PMCH by developing
 - Shared goals
 - Common definition of PCMH; common outcome metrics, reporting formats and administrative processes
 - Financial support using variable payment models
- OHA initiating new efforts to more closely align public/private payment models, starting in April

Delivery System Transformation: Technical Assistance

- Patient-Centered Primary Care Institute created in 2012
 - Public-private partnership between OHA, Oregon Health Care Quality Corporation and the Northwest Health Foundation
 - Funded by OHA through SIM grant; partner in-kind contributions
 - Offers programs to build practice transformation capacity
 - Behavioral health integration training
 - Learning collaboratives focused on PCPCH program standards
 - Technical Assistance Expert Learning Network: practice coaches, program managers, data/QI professions, peer learning
 - Online learning modules
 - Offers CME and CE Credits
- Well-received by providers seeking enhanced PCMH payments from CCO and commercial payers

Evidence-Based Coverage Policies



Evidence-Based
Coverage Policies
for Health and
Pharmacy
Benefits

Oregon Health Evidence Review Commission (HERC)

- Created by the legislature in 2012 as an independent body
- Reviews medical evidence to:
 - prioritize Medicaid spending (creates a prioritized list of covered services which legislature uses to set funding levels)
 - promote evidence-based practice (creates coverage recommendations)
- Reviews research of well-established medical evidence review organizations to assess comparative effectiveness of services and pharmaceuticals, including
 - Agency for Healthcare Research and Quality
 - Oregon Health and Science University's Center for Evidence-based Policy (CEBP)

Example of Coverage Policy: Advanced Imaging for Low Back Pain

- If patient has non-specific low back pain and no “red flag” conditions, strong recommendation that:
 - imaging not be covered, unless pain persists for > 1 month and patient is candidate for surgery or epidural steroid injection, OR
 - clinicians suspect a serious underlying condition.



Guidance Documentation

- For this recommendation, HERC provided:
 - Principles for forming recommendations (e.g., significant disease burden, important uncertainty regarding efficacy, etc.)
 - Evidence sources and summary of evidence
 - List of potentially serious conditions and recommendations for initial diagnostic work-up
 - List of ICD-9 codes relating to low back pain
 - Information on strength of recommendation and quality of evidence

How Evidence-based Coverage is Applied

- Beyond Medicaid, HERC's research findings and recommendations (available online) are used voluntarily to make coverage decisions by
 - Oregon Public Employees' Benefit Board
 - Oregon Educators Benefit Board
 - Commercial carriers
- HERC uses research from Center for Evidence Based Policy (CEBP), which is a multi-state initiative to reduce overuse and misuse of services
 - Medicaid Evidence-based Decisions (MED) Project reviews medical care/procedures
 - Drug Effective Review Project (DERP) reviews pharmaceuticals
 - 18 states participate in MED and 13 in DERP

Significant Potential Impact of Evidence-based Medicine: Addressing under-use

- Many guidelines that are broadly accepted are not often followed, potentially resulting in unnecessary complications and services*:
 - Approximately 50% of pts do not receive beta blockers after an MI
 - In one study, only 27% of anti-epileptic drug levels were at appropriate therapeutic levels

*DW Bates, et al. "Ten Commandments for Effective Clinical Decision Support: Making the Practice of Evidence-based Medicine a Reality. J of Am Medical Informatics Assn. Available at: <https://jamia.oxfordjournals.org/content/10/6/523.full>

Significant Potential Impact of Evidence-based Medicine: Addressing over-use

- Other services that are provided have minimal effectiveness, resulting in unnecessary costs*
 - Angioplasty is inappropriate in about 1 in 10 patients and questionable in another third
 - Overuse of antibiotics for respiratory infection may cost \$1.1 billion

*Improving Care Provided to Medi-Cal Members: Recommendations for Using Evidence to Reduce Overused and Misused Services. Report by Bailit Health Purchasing, LLC to the California Division of Health Care Services. December 13, 2013

Coordinated Care Organizations



Creation of
Coordinated Care
Organizations
(CCOs)
responsible for
improving
population health

Creating Coordinated Care Organizations (CCOs)

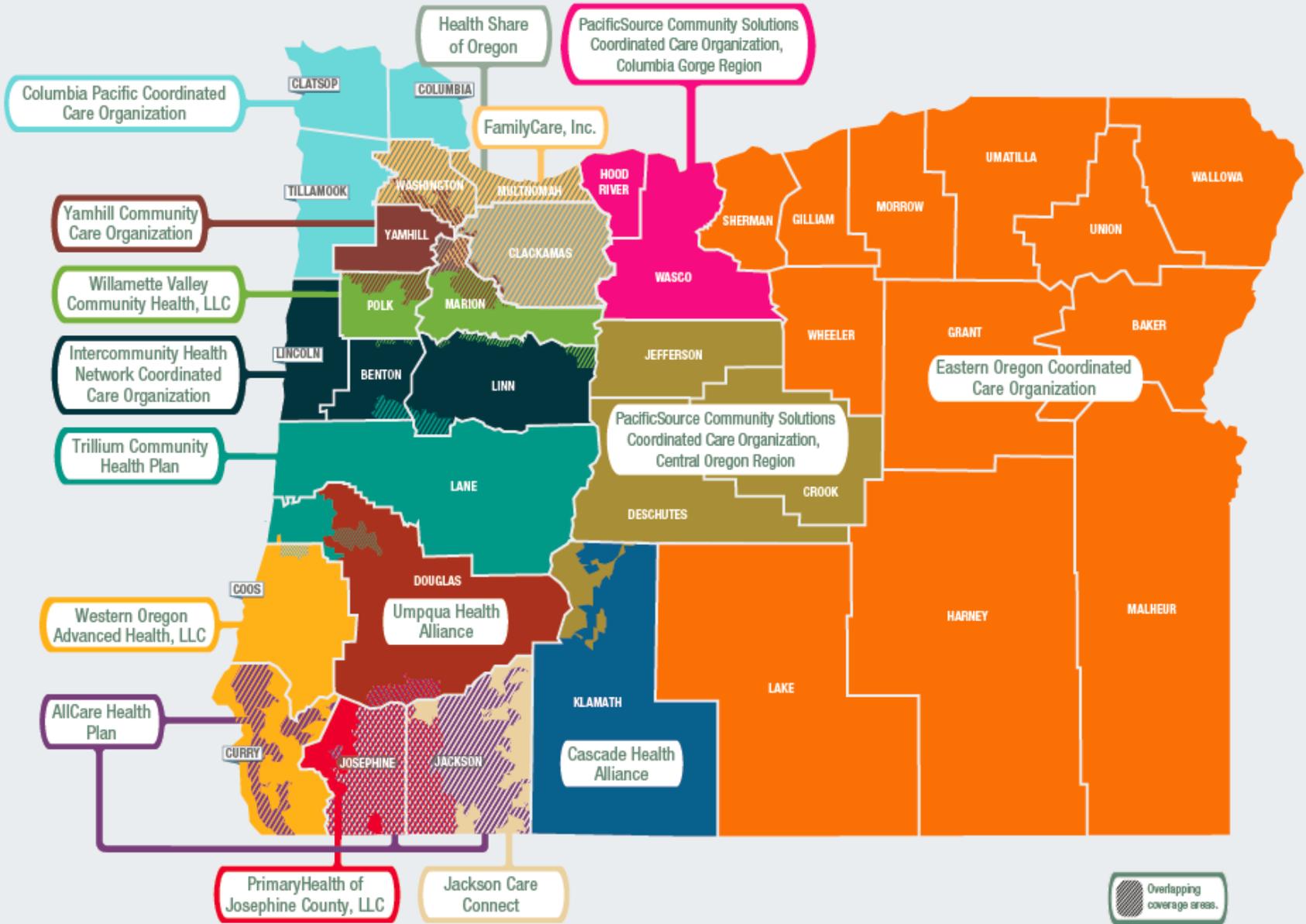


- Network of health care providers and a payer who agreed to work together within their local community to serve Medicaid beneficiaries.
- All are implementing OR's Coordinated Care Model

3. Creating Coordinated Care Organizations (CCOs)

- There are 16 CCOs responsible for all Medicaid-funded care in designated regions
 - OHA consolidated multiple streams of payment to one entity
 - 100% at risk
 - 4% withhold that is earned by meeting quality performance goals
 - Responsible for medical, behavioral health and dental services
 - Generally, responsible for care in unique, non-overlapping regions
- Each is governed by a board composed of community, delivery system and risk-holder representatives
 - Changing nature of health care conversations at local level
 - Focus on community needs
 - As board members, hospitals now have fiduciary responsibilities towards the CCOs.

Coordinated Care Organization Service Areas



Support for the CCOs: Transformation Center

- State used SIM funds to create the **Transformation Center** to provide technical assistance for CCOs:
 - Transformation objectives set for CCOs include areas such as:
 - physical and behavioral health integration;
 - PCMH implementation;
 - Alternative payment methodologies that are aligned with desired health outcomes;
 - reducing discrepancies in care delivery; and
 - community health improvements.
 - Transformation team of experts assigned to each CCO to guide and support changes needed to achieve cost and quality goals

Effectiveness of Transformation Center

- Sped up transformation processes
 - \$30million in seed money for transformation initiatives
 - Funded 120 initiatives
 - On-going technical assistance
 - Peer learning opportunities
- Viewed as neutral, so has credibility with providers
- CCOs highly motivated by 4% withhold to engage with CCO staff and peers
- Legislature expressed interest in continue funding after SIM support has ended

Impact of CCOs on Performance Metrics

Performance Measurement of CCOs

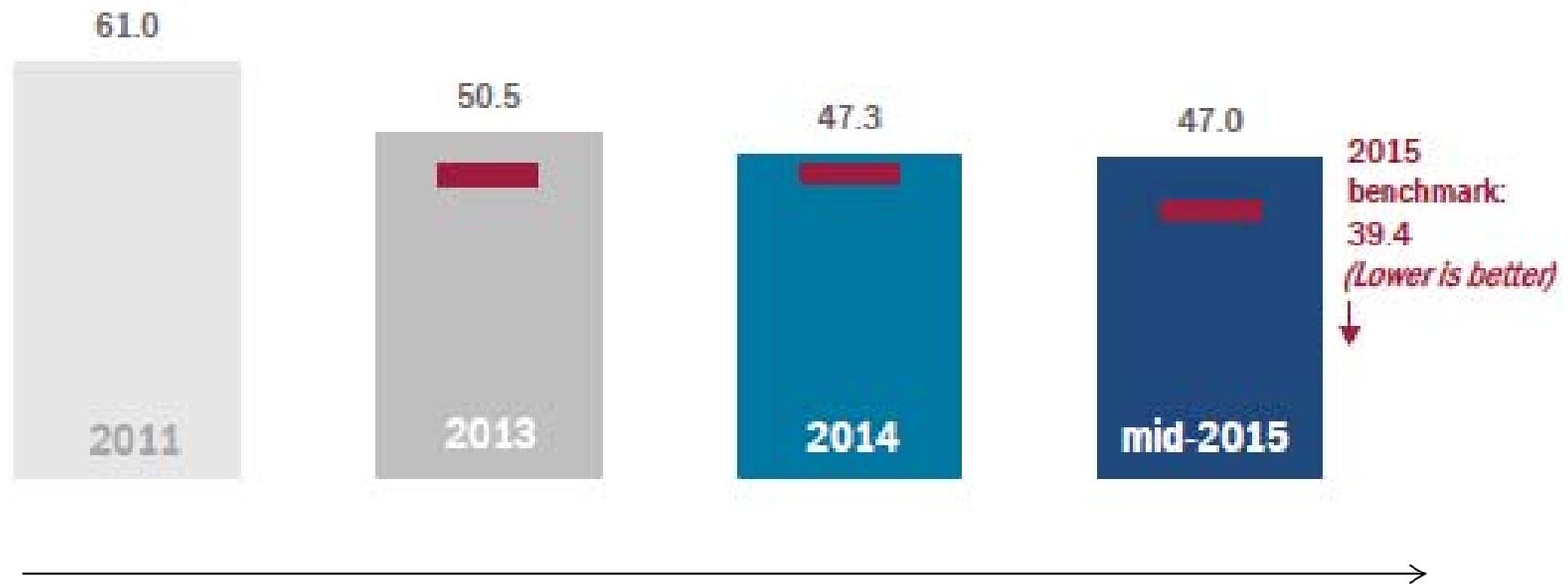
- CCOs are measured on
 - 17 metrics that are tied to financial incentives. For example:
 - Adolescent well-care visits
 - SBIRT screening
 - PCMH enrollment
 - Dental sealants (6-14 yrs)

 - 33 quality and access metrics that OHA is responsible to CMS for performance. For example:
 - Well child visits
 - Diabetes short term admission rates
 - Readmissions

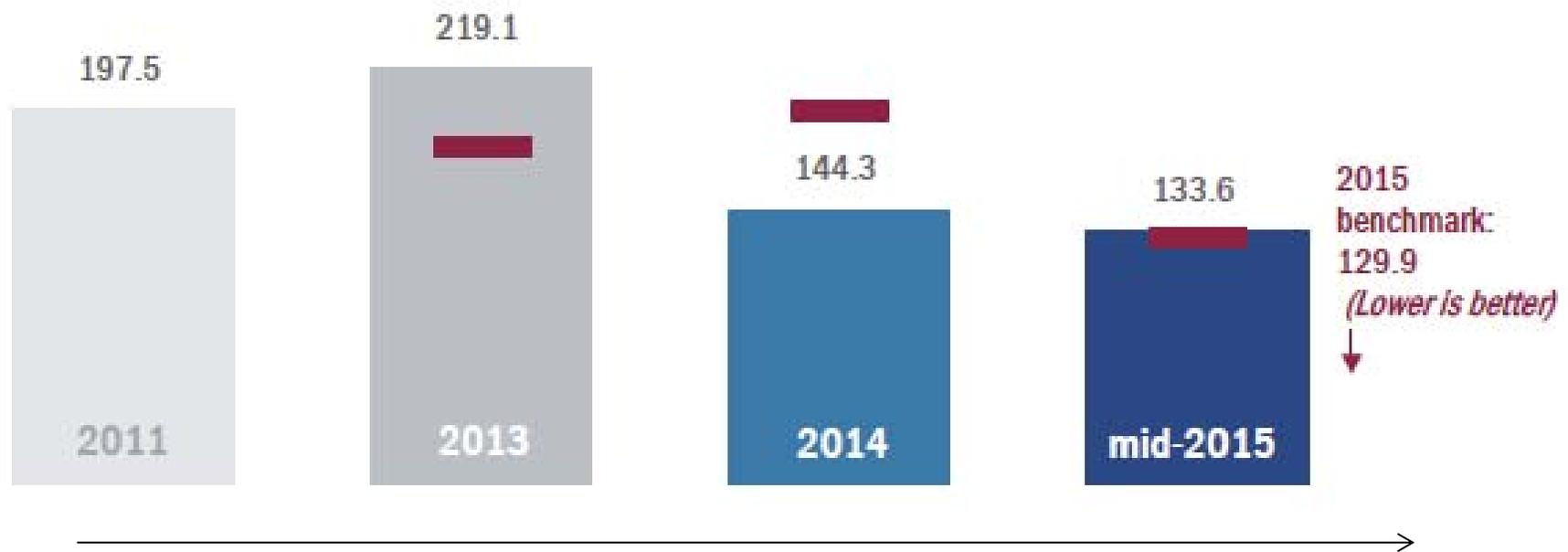
CCO Performance as of Mid-2015

	Improvement in Statewide Averages over Base Year	No Improvement in Statewide Averages over Base Year	Declining Statewide Averages over Base Year
2015 CCO Incentive Metrics (10 metrics)	90% (9/10)	10% (1/10)	0% (0/10)
State Performance Metrics (24 metrics)	75% (18/24)	4% (1/24)	21% (5/24)
Core Metrics (13 metrics)	77% (10/13)	15% (2/13)	8% (1/13)

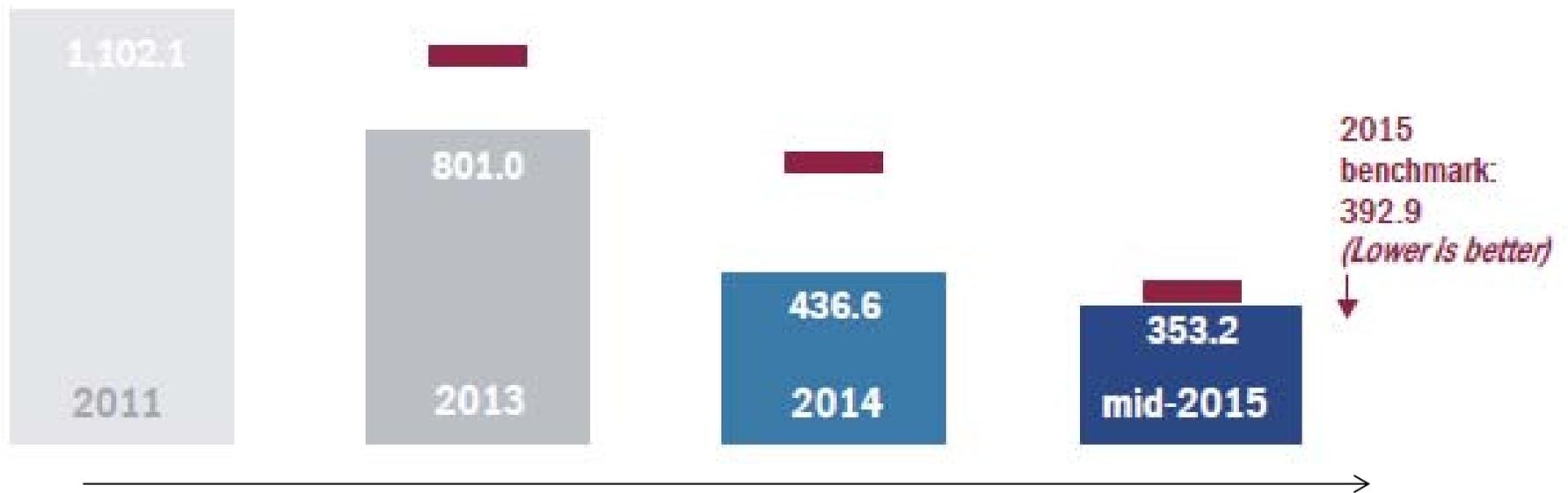
Example: 23% Reduction in ED Visits Compared to Baseline Year



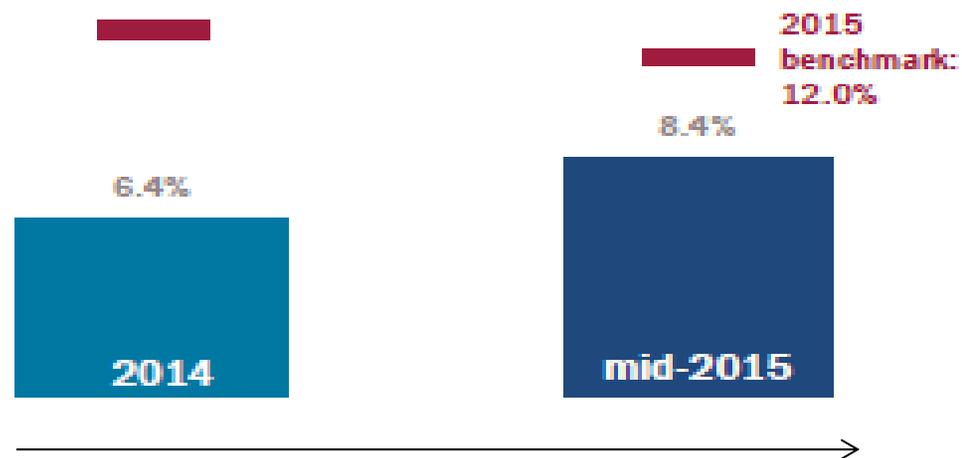
Example: 32% Reduction in IP Admissions for Diabetes ST Complications Compared to Baseline Year



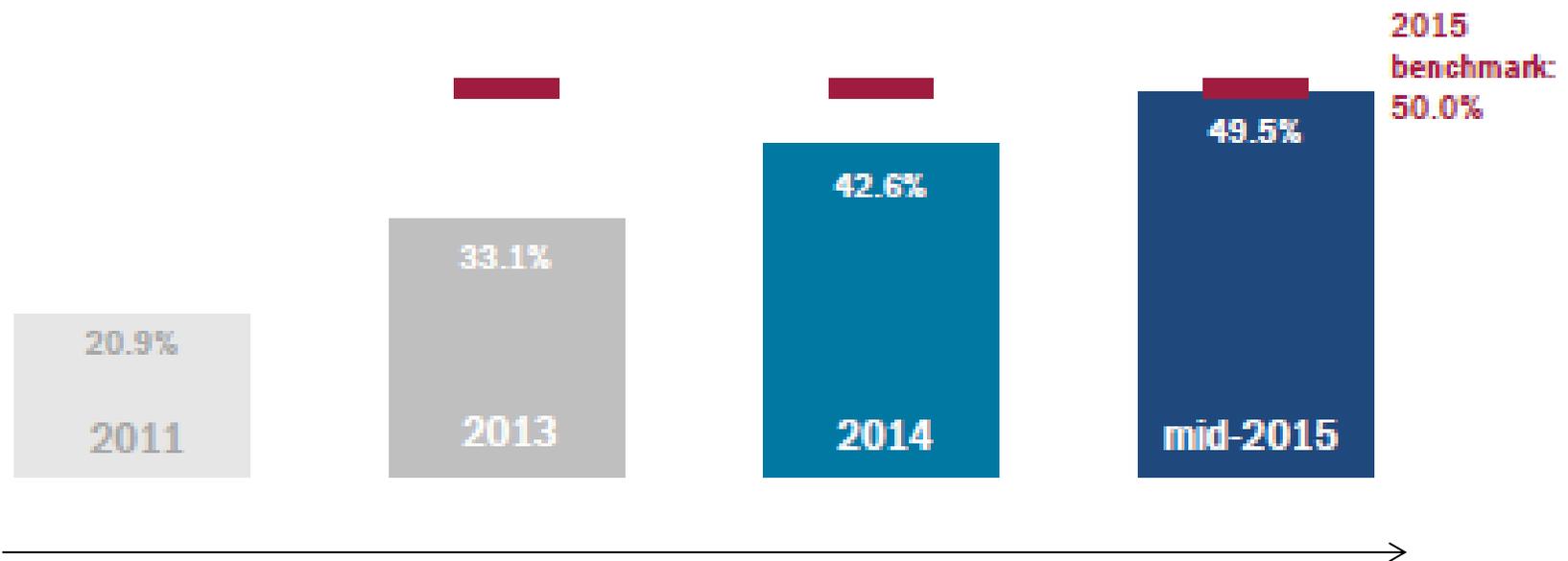
Example: 68% Reduction in COPD/Asthma Admission Rates Compared To Baseline Year



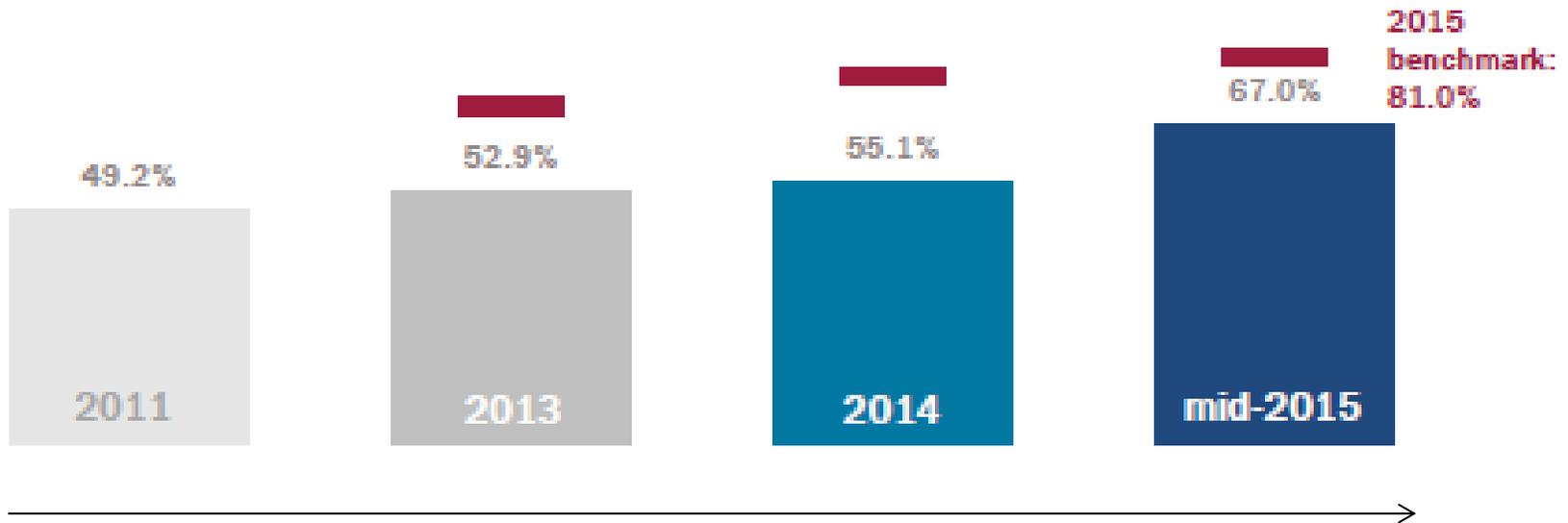
Example: 31% Increase in SBIRT Screening (all ages) Compared to Base Year



Example: 137% Increase in Developmental Screening, First 36 Months of Life Compared to Baseline Year



Example: 36% increase in immunization for adolescents, compared to base year

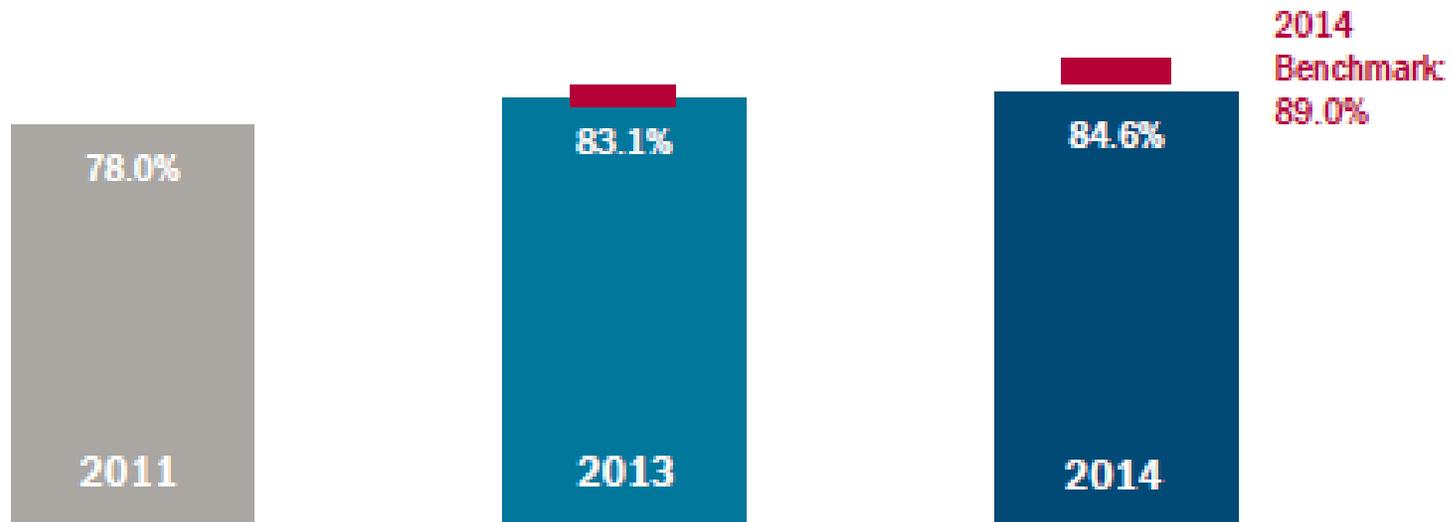


Example: 8% Increase in Patient Satisfaction, Compared to Baseline Year

Statewide, members reported improved satisfaction with care.

Data source: Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Benchmark source: average of the 2013 national Medicaid 75th percentiles for adults and children



Impact of CCOs on costs

- Expected to save \$4.9 billion over 10 years, including both state and federal funds
- Between 2013 and 2015, savings exceeded target of 11.7% reduction in actual costs compared to expected costs
- Savings are “baked” into the CCOs budgets
 - Requires them to be more creative in providing care
 - Quality metrics monitor appropriateness of care

CCO Model is Spreading

- Oklahoma is piloting a CCO model in a Medicaid FFS environment
 - Local community and community-led delivery system entities will be responsible for managing total cost of care for a particular geographic region and meeting quality targets
 - Entities responsible for creating a network of providers and community resources that will deliver care to attributed members
 - Governance structure must incorporate the community they serve
- Will include Medicaid beneficiaries and state employees

Transparency



Transparency

4. Transparency Strategies Employed by State Agencies

- Medicaid
 - OHA publishes annual reports on CCO metrics*
 - Peer comparisons lead to sharing of best practices
 - Unfavorable comparison is a strong motivator (*public shaming*)
 - HERC publishes all coverage recommendations on line and seeks public comment before finalizing recommendations

- Insurance Department
 - Working with employers to address requests for more transparency regarding rate approval process

* Oregon's Health System Transformation: CCO Metrics 2015 Mid-Year Update, January 2016.
Available at: <http://www.oregon.gov/oha/Metrics/Documents/2015%20Mid-Year%20Report%20-%20Jan%202016.pdf>

CCO Performance Reporting by Time, by Ethnic Groups



CHILDHOOD IMMUNIZATION STATUS

Childhood immunization status

Measure description: Percentage of children who received recommended vaccines (series 4:3:1:3:3:1:4) before their second birthday.

Purpose: Vaccines are one of the safest, easiest and most effective ways to protect children from potentially serious diseases. Vaccines are also cost-effective tools which help to prevent the spread of serious diseases which can sometimes lead to widespread public health threats.

mid-2015 data

Statewide change since 2014: **+3%**

Number of CCOs that improved: **14**

Racial and ethnic groups experiencing improvement:

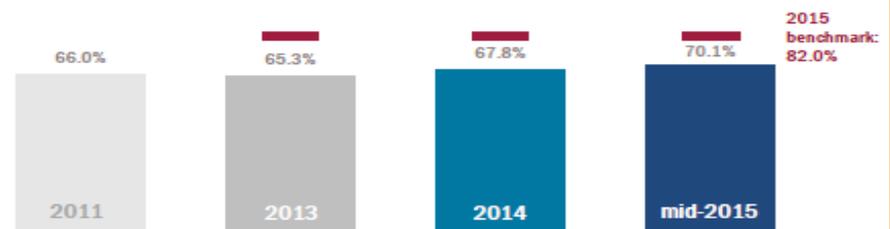
- ✓ American Indian / Alaska Native
- ✓ Asian American
- ✓ White
- ✓ African American / Black

Childhood immunization status will be a CCO incentive measure beginning in 2016.

About these data:

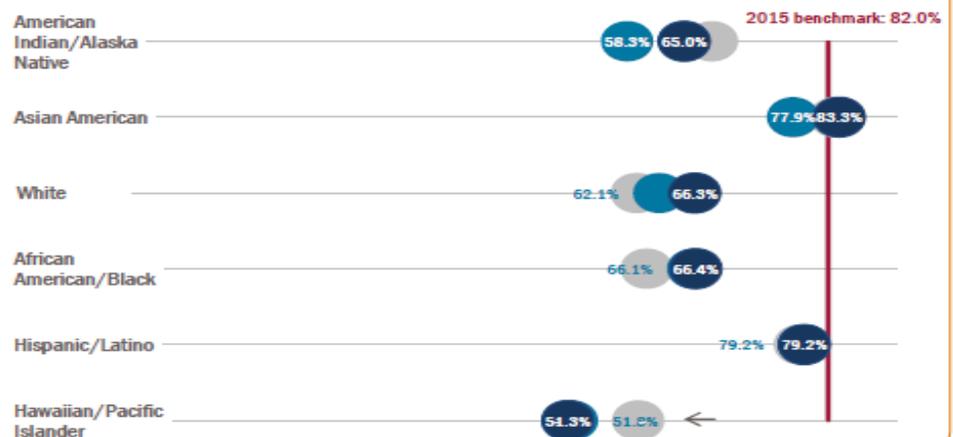
- N=16,253
- Data source: Administrative (billing) claims and ALERT immunization information system
- Benchmark source: 2014 national Medicaid 75th percentile
- Race and ethnicity data missing for 11.6% of respondents
- Each race category excludes Hispanic/Latino
- 2014 benchmark: 82.0%

Statewide, the percentage of children who received recommended vaccines before their second birthday continues to improve.



Hawaiian / Pacific Islander children received recommended immunizations less often than other races and ethnicities in both 2014 & mid-2015.

Gray dots represent 2013.

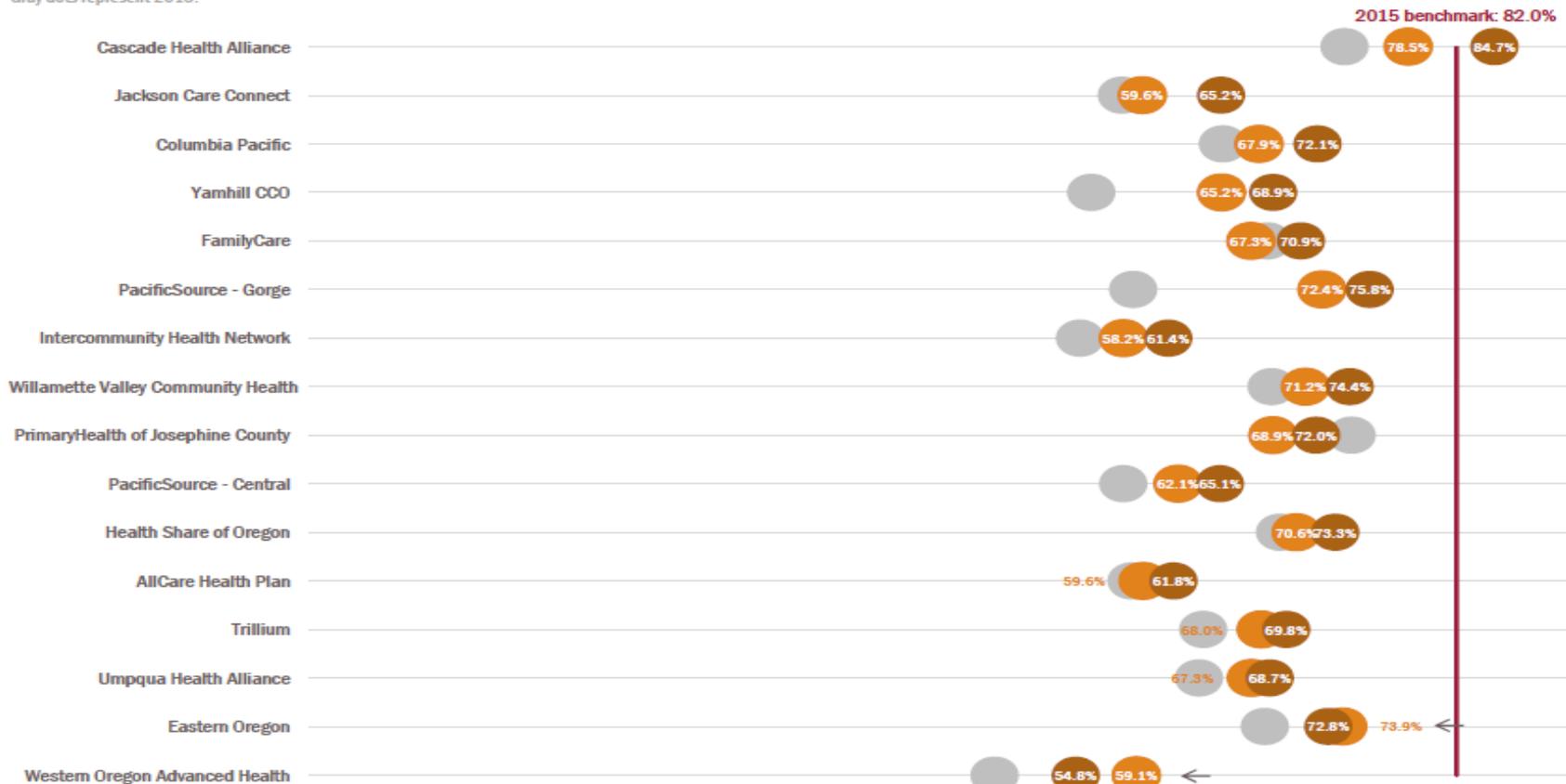


CCO Reporting by Identified CCO

CHILDHOOD IMMUNIZATION STATUS

Childhood immunizations increased in 14 of 16 CCOs between 2014 & mid-2015.

Gray dots represent 2013.



Transparency Strategies Employed by Private Sources

- **OR Health Quality Council** publishes public reports on provider-specific HEDIS quality measures
 - Women’s and children’s health
 - Diabetes, asthma, heart disease and low back pain care
 - Using antibiotics and generic drugs
- **OR Association of Hospitals and Health Systems** reports hospital quality scores, where available
 - Utilization and financial trends by hospital
 - Quality data (e.g., readmissions w/in 30 days after heart attack)
 - Cholesterol-lowering drugs given at discharge
 - Aspirin given at discharge
 - Death within 30 days of a heart attack

Keys to Success in Oregon

Leadership

**Consolidated
Agency**



Innovation

Keys to Success in Oregon



Leadership

- Legislature has been proactive in creating integrated administrative structure, setting trend caps for state and teacher plans
- OHA leadership has pushed to integrate disparate agencies
- CCOs are run by Board including consumers, providers and risk-bearing entity.

Keys to Success in Oregon



Consolidated Agency

- Agency controls nearly 30% of Oregon health care spend, so can drive strategic change in the state
- Agency has data and analytic capabilities to make data-based, thoughtful decisions relatively quickly

Keys to Success in Oregon



Innovation

- Creating OHA to drive strategic change
- Creating single flow of funding to local entity responsible for integrated care
- Creating partnerships with academic medical centers to bolster research capabilities
- Evidence-based coverage
- VBID designs for state and teacher plans (not discussed)
- Supporting local transformation through
 - Transformation Center (CCOs)
 - Patient-Centered Primary Care Institute

Challenges

- CCOs
 - Most sub-capitate services to existing providers, preserving old silos; some CCOs are now working to implement integrated models of care
 - CCOs are not using the flexibility they have to deliver non-traditional services
 - Managing 16 CCOs is challenging, particularly around actuarial soundness and sustainable rate of growth
 - CCOs have incentive to overspend to get more money
 - CCOs have been slow to adopt APMs; primary care capitation arrangements are not often linked to quality outcomes
 - Challenging to get patient-level data to CCOs and providers

Slide 53

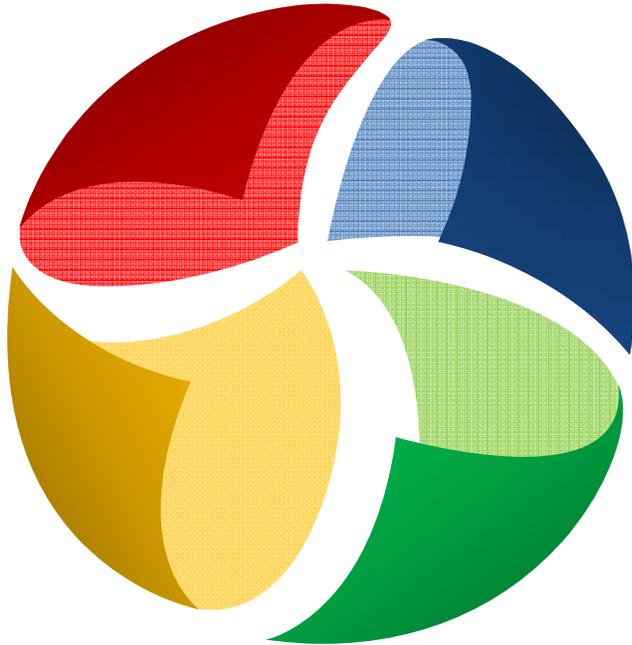
Megan32 Could this be organized by strategy (1-4)?

Megan Burns, 3/22/2016

Challenges (cont'd)

- **State employee and teacher plans**
 - Have had low inflation rates in past 3 years
 - 2017 premium increases will likely increase between 5% and 10% (depending on plan), exceeding 3.4% cap
 - Cost increases due primarily to skyrocketing Rx costs
- **Commercial insurers**
 - Alignment with state strategies is less robust than hoped
 - OHA is restarting alignment talks in April
- **Transformation support funding after SIM ends**
 - Transformation Center hoping for legislative support
 - Patient-centered Primary Care Transformation Institute trying to develop sustainability model

Summary of Strategies and Key Facilitators

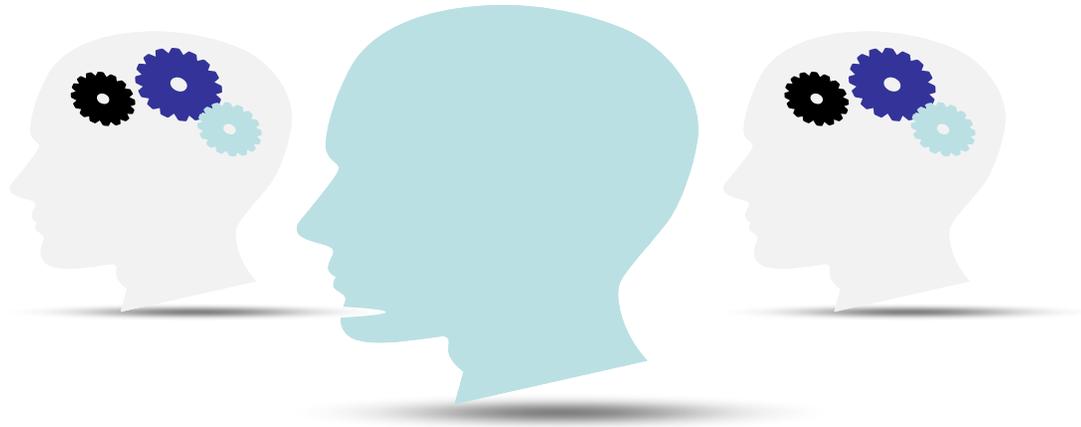


- 1. Delivery System Transformation**
 - Patient Centered Medical Homes
 - Robust provider transformation assistance
- 2. Evidence-Based Coverage**
 - Medical and pharmacy benefits
- 3. Coordinated Care Organizations**
 - Single-stream funding to local entities
- 4. Transparency**
 - Selected cost and quality data for COOs, hospitals, primary care providers
 - For rate setting process

Facilitators:

1. Consolidated state agency with aligned strategies
2. Strong data analytics to support policy development

Questions and Discussion



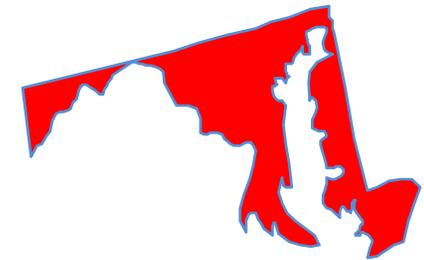
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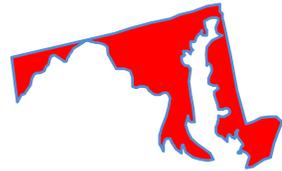
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State Cost Containment Models



Key Statistics



Maryland

Population 6,006,401

Sources of health coverage

Employer:	60%
Medicaid:	14%*
Medicare:	12%
Uninsured:	6%

Since 2014 experienced an additional 21% growth with Medicaid expansion



Connecticut

3,596,677

Employer: 58%
Medicaid: 20%*
Medicare: 12%
Uninsured: 3.8%**

**Source: The CT Mirror, 2/13/15.*

Available at:

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Maryland: 50 hospitals

- 3 large hospital systems
- Top 10 hospitals account for 44% of discharges
- Group of independent hospitals have formed collaborative to share best practices to improve population health

Connecticut: 28 hospitals

- Most are domestic, but some are operated by larger health systems
- Two health systems control the majority of the statewide market (in terms of discharges)
- Market characterized by increasing consolidation

Health Care Market Profile: Primary Care



Maryland: ~4,481 individual PCPs

- 1339:1 ratio of population to PCPs
- Half of providers are employed, with the percentage increasing
- 16 FQHCs

Connecticut: ~3,000 individual PCPs

- 1385:1 ratio of population to PCPs
- ~20% of family medicine and internal medicine physicians are not accepting new patients*
- 16 FQHCs

Health Care Market Profile: Health Plans



Maryland:

- Commercial market is dominated by CareFirst BCBS with 68% of market
- Other commercial plans include Aetna, Cigna and UnitedHealthcare

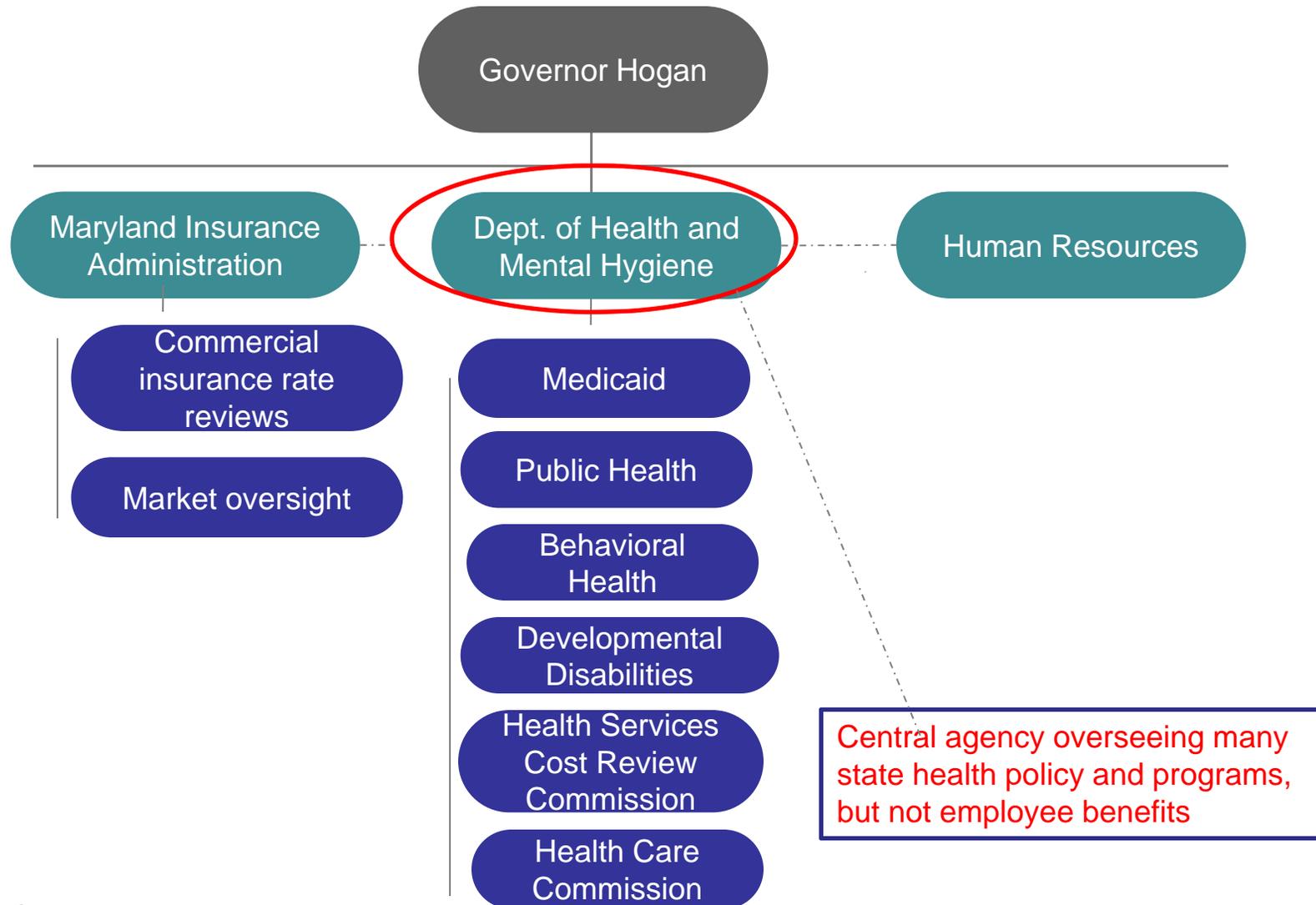
Connecticut: Dominated by national plans:

- Anthem: 44%
- Cigna: 20%
- Aetna: 18%

Maryland State Government's Role in Health Reform

- The state is proactive in managing costs
- It has been setting hospital rates for 40 years under the direction of the Maryland Health Services Cost Review Commission (HSCRC)
- 2010: the legislature initiated a 3-year PCMH pilot, mandating support by all large payers
- 2014: the state negotiated a 5-year All-Payer Agreement with CMS and implemented Global Hospital Budgets
- The Medicaid program actively manages its 8 MCO contractors relative to quality and cost.

MD Government Oversight of Health Reform



Two Principal Cost Containment Strategies

1. Delivery system transformation/payment reform

- PCMH initiatives in both the commercial and Medicaid markets
- Considering ACO-like arrangements for Medicaid non-hospital providers

2. All-payer limit on rate of per capita health care cost increases

- Global hospital budgets beginning 2014
- Total cost of care and incentivizing population-based care by 2019

Strategy #1: Multi-Payer Patient-Centered Medical Home Program (MMPP)*

- Legislatively mandated, all-payer 3-year PCMH pilot initiated in 2011
 - included 52 primary and multi-specialty practices
 - covered enrollees of the 4 largest plans
 - Medicaid MCOs, state employee health benefit plan, federal employees, TRICARE and Medicare Advantage all participated voluntarily
- Payment model supported by plans consisted of:
 - a PMPM payment for the achievement of NCQA recognition and care coordination
 - a shared savings initiative based on total cost of care and quality

Multi-Payer Patient-Centered Medical Home Program (cont'd)

- Primary care practice delivery system expectation included:
 - team-based care
 - chronic disease management
 - increased primary care access
 - NCQA recognition
- Technical assistance provided through collaborative learning sessions

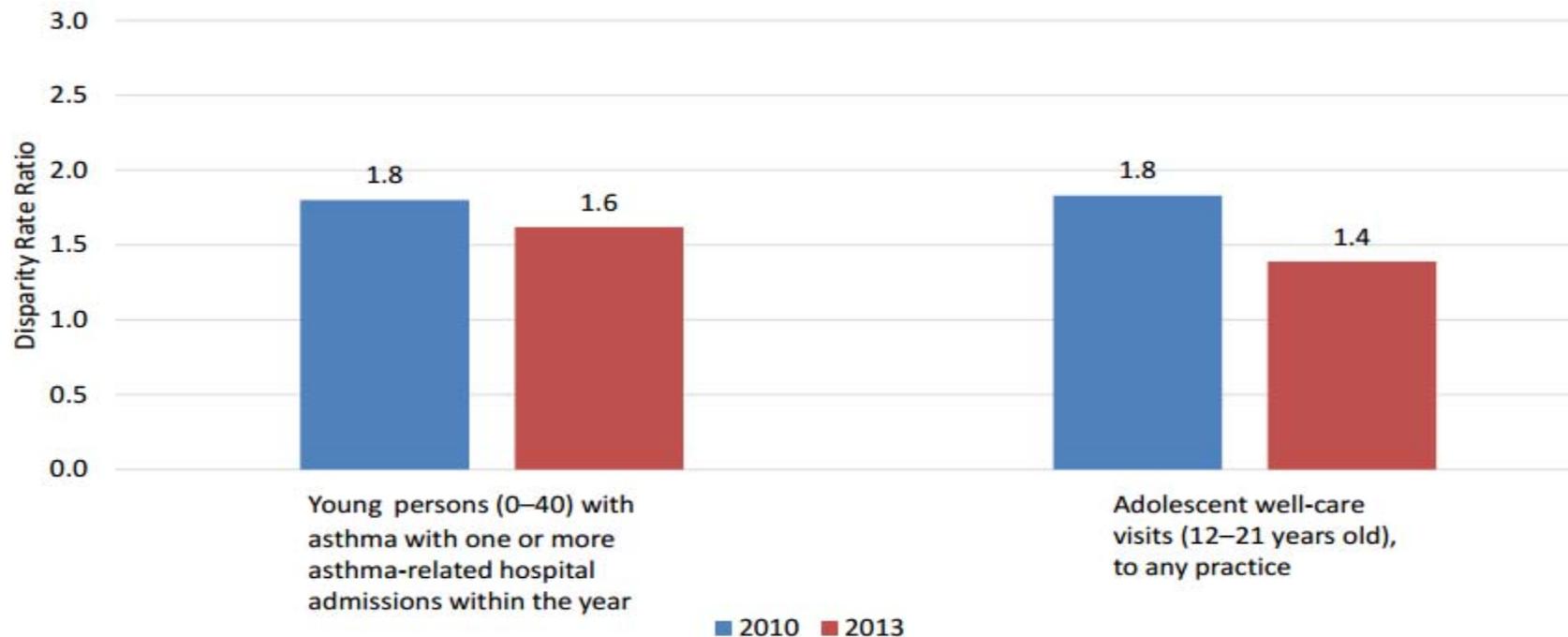
MMPP Results: Impact on Costs

- For Medicaid, inpatient payments declined for MMPP practices, while these costs remained stable in the comparison practices
- For Medicaid outpatient payments evidenced a smaller increase than comparison practices
- Costs for commercially insured patients did show the same results

Source: Maryland Health Care Commission. "Evaluation of the Maryland Multi-Payor Patient Centered Medical Home Program: Final Report." July 31, 2015. Available at: http://mhcc.maryland.gov/pcmh/documents/MMPP_Evaluation_Final_Report_073115.pdf

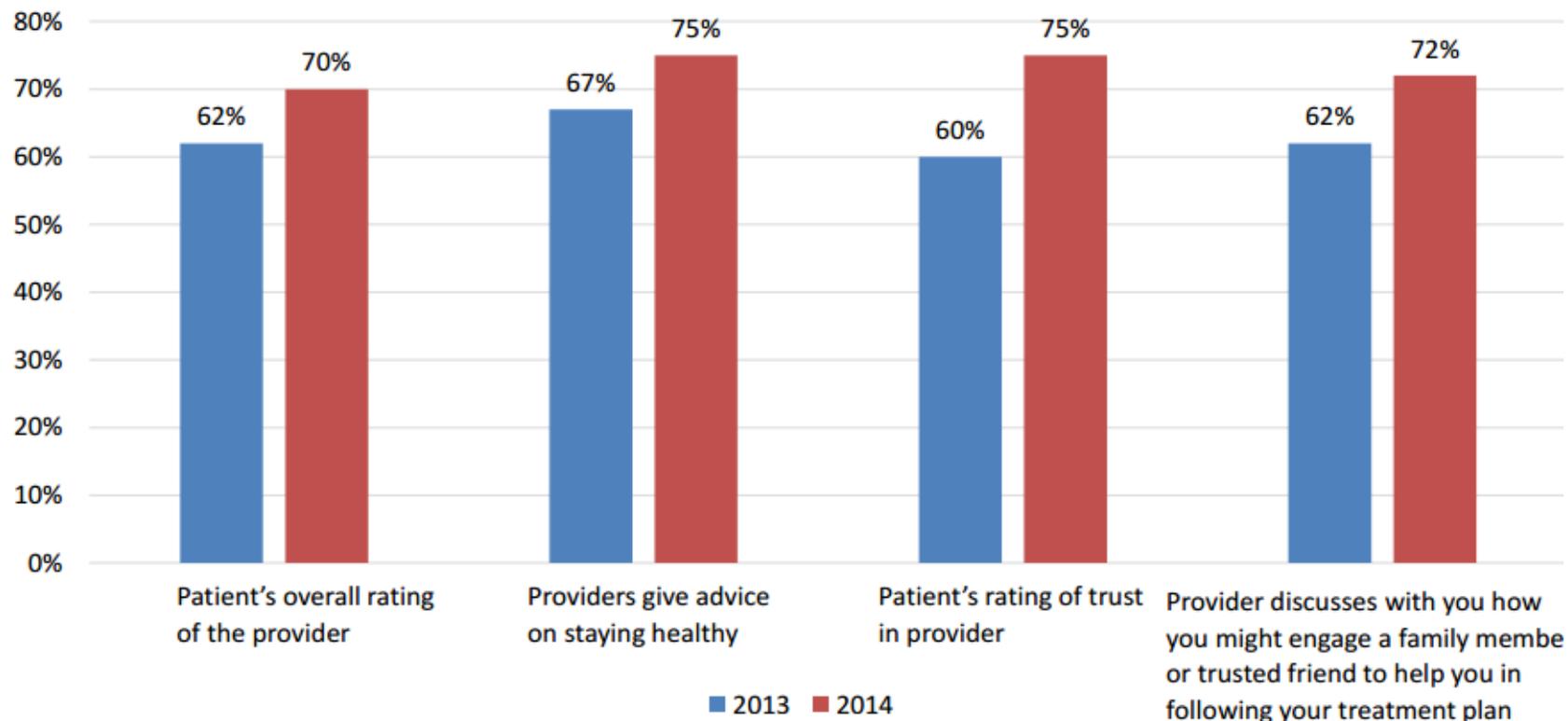
MMPP Results: Reduction in Racial Disparities

- Example: Asthma admissions and adolescent well care
 - The smaller the disparity ratio, the less disparity
 - A ratio 1.4 or below indicates little or no disparity



Source: PowerPoint presentation by the Maryland Health Care Commission, dated 11/19/15. Available at: http://mhcc.maryland.gov/pcmh/documents/pcmh_medicaid_brief_prst_111915.pdf

MMPP Results: Improved Patient Satisfaction



Source: PowerPoint presentation by the Maryland Health Care Commission, dated 11/19/15. Available at: http://mhcc.maryland.gov/pcmh/documents/pcmh_medicaid_brief_prst_11915.pdf

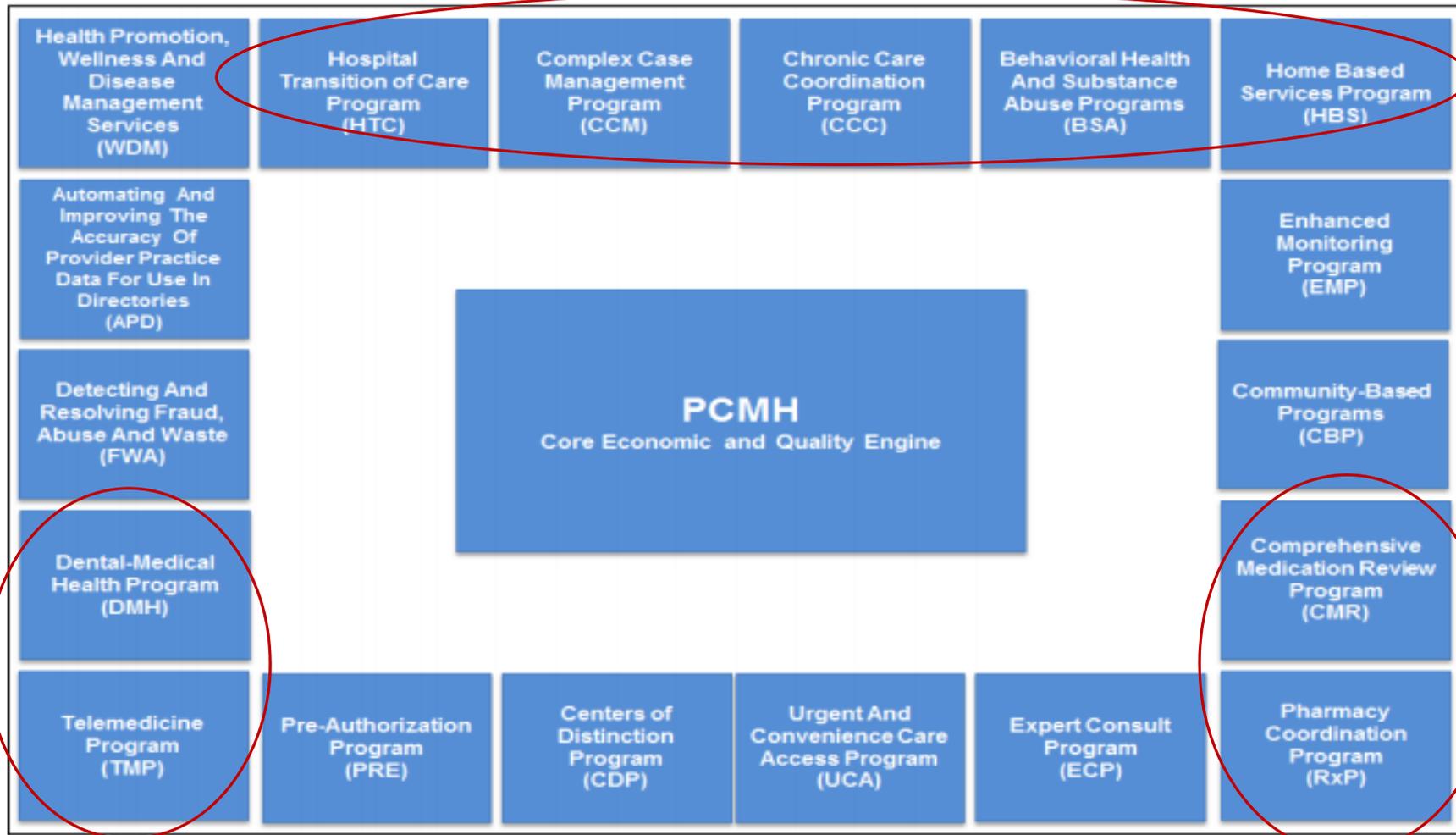
CareFirst PCMH Model

- Aggressively pursuing the PCMH model since 2011 participation in MMPP
- 80% of eligible PCPs are in a PCMH
 - 4,052 primary care physicians and nurse practitioners
- CareFirst views PCMH as an important cost management strategy. It's specific PCMH approach involves:
 - Directing referrals to cost-effective specialists and hospitals
 - Engaging high-cost, high-need patients in care management
 - Effectively managing medications
 - Reducing gaps in care and quality deficits
 - Engaging PCPs in transformation

CareFirst PCMH Model (cont'd)

- Places PCPs into one of four groupings based on PCP organizational characteristics and size
- Within groupings, creates panels, which may be comprised of several practices within region
- Panel as a team is accountable for aggregate quality/cost outcomes of their pooled population
- Savings compared to risk-adjusted, global budget are shared with panel providers
 - Quality scores ratchet gain sharing up or down
 - Low overall quality scores and low engagement = no gain sharing
 - Shared savings distributed through enhanced fee in next year

CareFirst Supports: Total Care and Cost Improvement Program – 18 Programs



Panel Incentives Focus on Engagement

- 35% of a Panel's quality score is based on the degree of their engagement

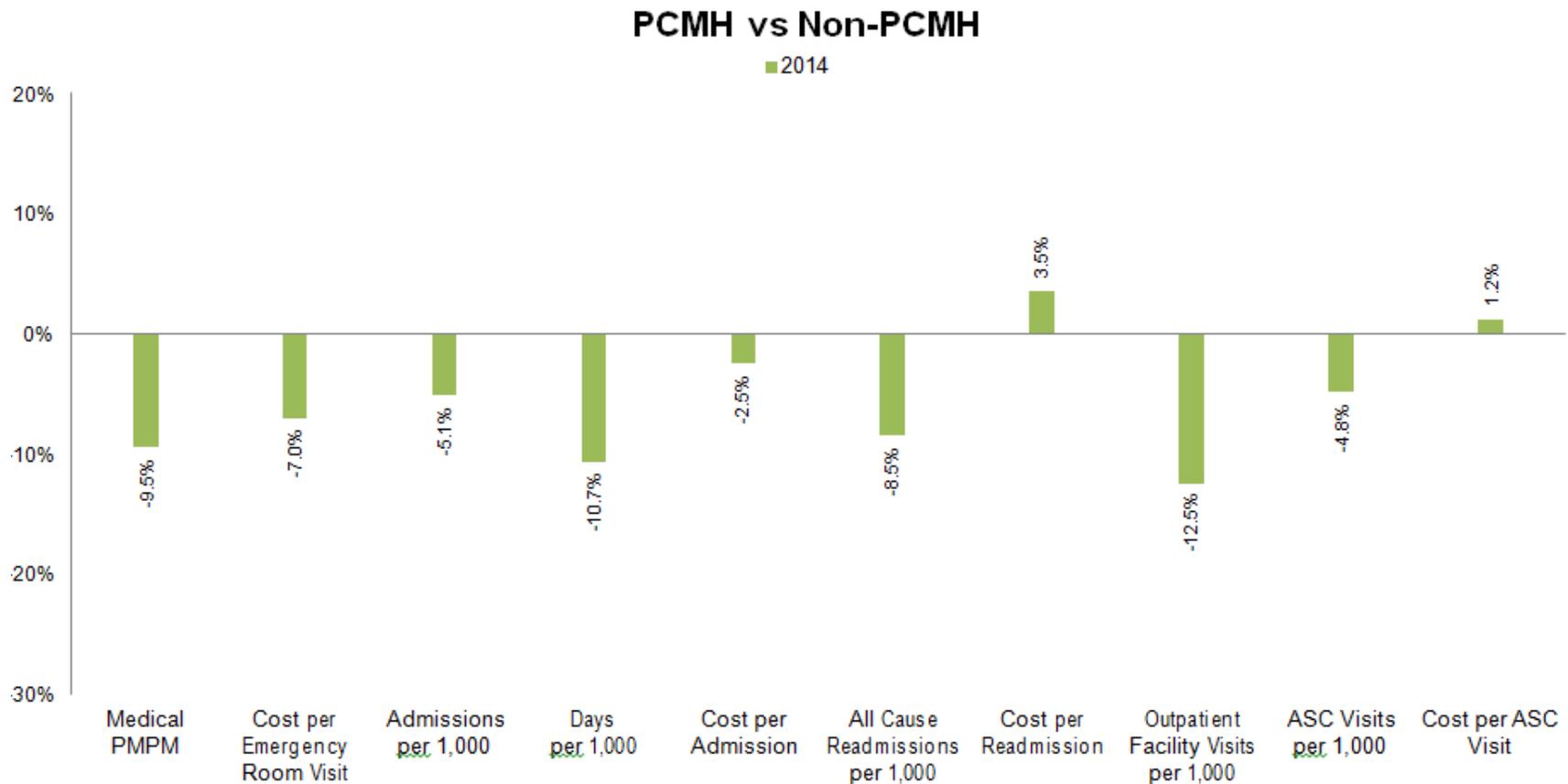
PCP Engagement	35 points
PCP Engagement with the PCMH Program	7.5 points
PCP Engagement with Care Plans	7.5 points
Member Satisfaction Survey	7.5 points
Program Consultant Assessment	10 points
Program Representative Assessment	2.5 points
Appropriate Use of Services	20 points
Admissions	8 points
Potentially Preventable Emergency Room Use	4 points
Ambulatory Services, Diagnostic Imaging and Antibiotics	8 points
Effectiveness of Care	20 points
Chronic Care Maintenance	10 points
Population Health Maintenance	10 points

Patient Access	15 points
Online Appointment Scheduling	3 points
Unified Communication Visits / Telemedicine	3 points
Office Hours Before 9:00am and After 5:00pm on Weeknights	3 points
Office Hours on Weekends	3 points
Overall Patient Experience	3 points
Structural Capabilities	10 points
Use of E-Prescribing	2 points
Use of Electronic Medical Record (EMR)	2 points
Meaningful Use Attestation	2 points
Medical Home Certification	2 points
Effective Use of Electronic Communication	2 points

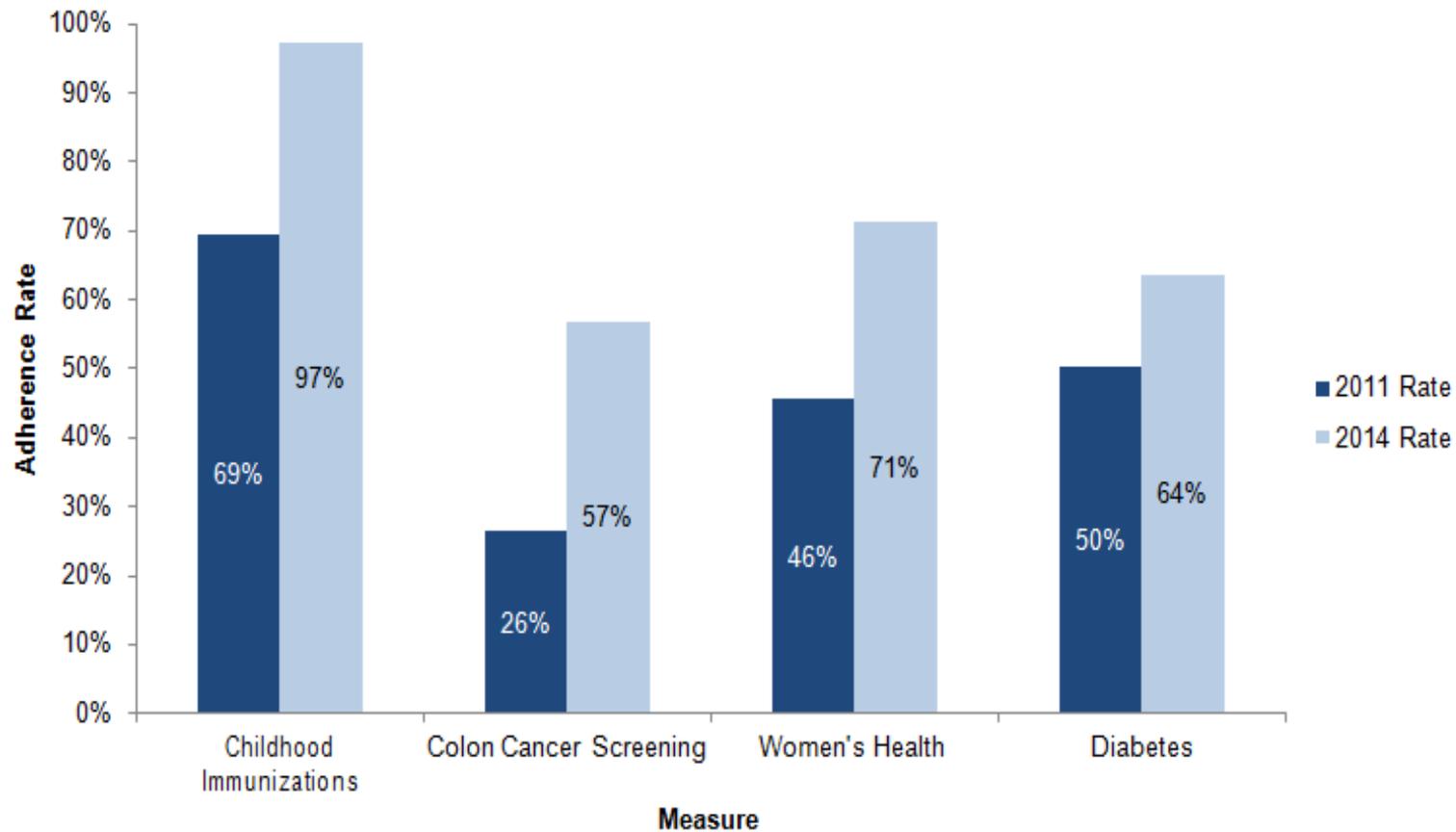
- By 2017, 50% of the Panel's quality score will be based on engagement, with the other 50% based on CMS ACO quality measures – 2016 will be a transition year.

Impact on Costs at End of 2014

- Ten measures are tracked
- All are favorable – even the cost of readmission given the greater acuity.



Impact on Quality: 2011 to 2014



Future of Maryland's PCMH Initiatives

- The MMPP officially ended in December 2015, although Medicaid MCOs will continue to participate until the end of FY 2016.
- CareFirst will continue its PCMH model.
- MD Health Care Commission is currently establishing a primary care council to:
 - develop aligned metrics, incentives and payment systems across payers
 - work with state agencies/stakeholders to develop recommendations on how to integrate PCMH initiatives into the new All-Payer Global Hospital Budget Model (*forthcoming discussion*)

Strategy #2: All-Payer Limitation on Per Capita Health Care Cost Increases

- Maryland has been setting hospital FFS rates for all payers since 1974
- Enabling legislation is broadly written, allowing Health Services Cost Review Commission (HSCRC) flexibility to evolve rate setting methodology
- Maryland needed to move to a global budget model because:
 - Lack of volume controls was resulting in increased spending
 - As admissions/complications are reduced, cost per admission increases, enhancing the likelihood of exceeding the CMS rate limit
- Maryland negotiated a new CMS all-payer agreement, effective January 1, 2014

Maryland New All-Payer Model: Requirements

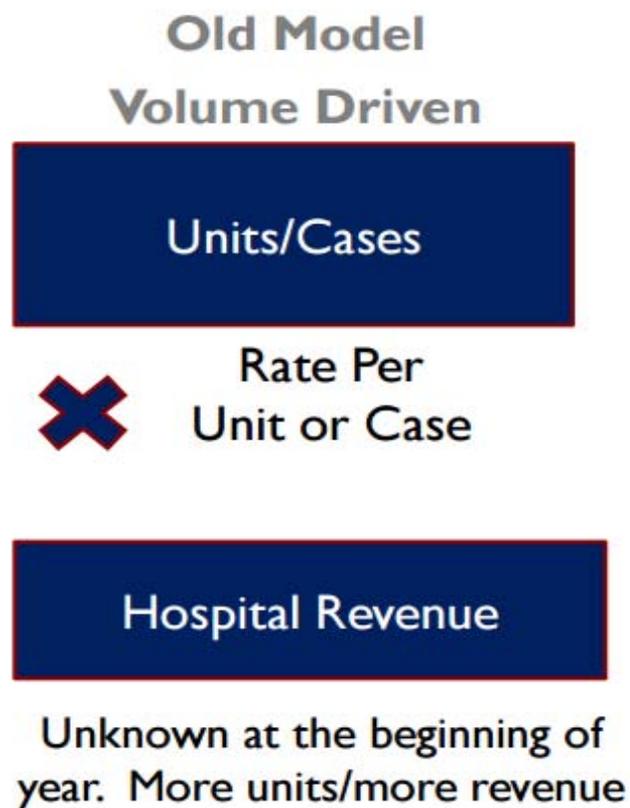
- Establishes all-payer total hospital per capita revenue growth ceiling for Maryland residents tied to long-term projected per capita state economic growth (GSP)
 - 3.58% annual growth rate
- Medicare payment savings for Maryland beneficiaries compared to dynamic national trend
 - Minimum of \$330 million in savings
- Patient/population centered-measures and targets to promote population health improvement
 - Medicare readmission reductions to national average
 - 30% reduction in preventable conditions over a 5-year period
 - Quality-related revenue at risk to equal or exceed Medicare programs

Phase I: All-Payer Global Hospital Budget

- All-payer Hospital Global Budget launched 1/1/14
 - All payers pay same rates for inpatient and outpatient services at individual hospitals
 - Budget for year is set; FFS rates are adjusted up or down to generate targeted revenue, regardless of volume
 - Budgets vary by hospital and are based on base year revenue with adjustments for quality and market volume changes
- Hospitals incentivized to:
 - Short-term: reduce readmissions, complications, LOS
 - Long-term: partner with community-based providers to prevent hospitalizations, inappropriate ED utilization, improve population health, manage highest cost patients

Global Hospital Budget

Focus Shifts from Rates to Revenues



Opportunities for Success under Maryland's Global Hospital Budget

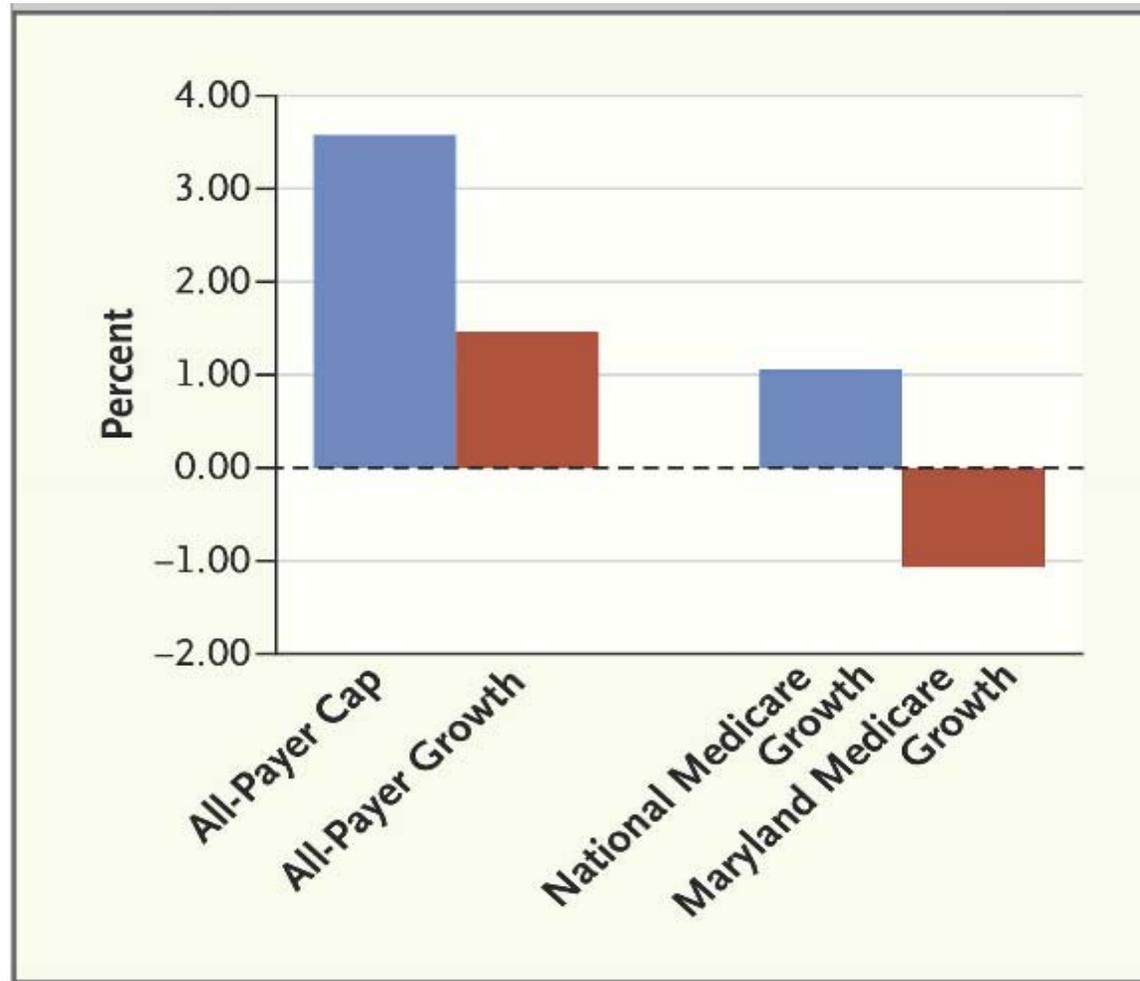
Model Opportunities

- Global revenue budgets providing stable model for transition and reinvestment
- Lower use—reduce avoidable utilization with effective care management and quality improvement
- Focus on reducing Medicare cost
- Integrate population health approaches
- Control total cost of care
- Rethink the business model/capacity and innovate
- Align with physicians and other providers

Delivery System Objectives

- Improved care and value for patients
- Sustainable delivery system for efficient and effective hospitals
- Alignment with physician delivery and payment model changes

First Year Financial Results



First Year Results (cont'd)

- Improved quality
 - Target: reduce 65 potentially preventable conditions by 30% over 5 years
 - Between 2013 and 2014: reduced the rate by 26.3%
 - But, in 2014 rates of infection due to central venous catheters and catheter-related urinary tract infections increased
 - Difference in rate of all-cause readmissions for Maryland compared to Medicare decreased from 1.2% to 1.0%.
- Opportunities for improvement
 - Medicare hospital admission and readmission rates
 - Per capita spending levels for Medicare patients
 - Patient experience scores

Phase II: Move to Total Cost of Care

- Agreement with CMS requires Maryland to expand model to contain per capita cost increases to full spectrum of services and providers by 2019
 - Maryland empowered by CMS to develop its own payment models across full spectrum of care
 - Maryland wants to better integrate public health activities
 - Maryland considering how to develop regional collaboration efforts to build infrastructure to support integration of a full range of providers
- The state's vision is all-payer total cost of care budgets with quality targets

Value of Rate Setting Approach for Maryland*

- Holds down costs
- Fairly funds hospital uncompensated care
- Fairly funds Medicaid services
- Predictable system
- Transparent
- Incorporates quality component to improve care
- Recognizes broad support from all stakeholders

Why Maryland's HSCRC Has Been Effective

- Commission's decisions are directly appealable to the state courts: minimized regulatory capture
- 7 Commissioners work closely together to develop trust and to consider inclusive view
- 3 of 7 Commissioners are from the provider community to provide expertise, but not control
- Enabling statute is broadly written, so model changes do not have to go through the legislature
- Consequences of failure are high, so parties are motivated to make system work

Challenges

- Hospitals lack timely data on costs and utilization outside of the hospital; can't ID/manage highest cost patients
 - Functional HIE partially meets needs by providing real-time information regarding admissions, discharges and transfers; helps with identifying patterns
- Currently hospitals have all the risk; it is unclear how to distribute risk to other providers still on a FFS model and meet the requirements of the CMS all-payer agreement.
 - May need to get more flexibility from CMS to develop alternative payment models with non-hospital providers
 - Looking at pay-for-outcomes, global capitation and bundled payments
 - Uncertain how to build on PCMH model to align with All-Payer Model

Challenges (cont'd)

- Hospitals must develop a new culture and new skills to implement population health-focused care delivery
 - Building relationships with community-based providers
 - Looking beyond a focus on hospital costs
 - Developing infrastructure to manage and share risk, including data systems, care management functionality
 - Changing culture to a population-based perspective
- HSCRC is providing grants to encourage regional collaborations among all providers
- The “market shift” adjustment to the budget is complex and will need adjusting
 - Some hospitals do not find the current formula to be fair

Challenges for PCMH Initiatives

- Challenge for Commission: All-Payer Model is hospital-focused and PCMH is physician-focused.
 - Need to bring providers across the continuum into the transformation process
- Challenges for All-Payer Aligned PCMH Model
 - Unclear if state can achieve aligned models: CareFirst wed to its model
 - Other payers have different models
- Challenges for Medicaid
 - Looking at ACO-like models with others than hospitals as incentivized partners (e.g., assisted living program) to bring in other providers that most impact Medicaid costs

Keys to Success in Maryland

Leadership

**Quasi-
independent
regulatory
authority**



Innovation

Keys to Success in Maryland



Leadership

- Legislature has been supportive of and respectful of rate-setting role of HSCRC
- HSCRC leadership has remained largely free of regulatory capture
- Legislature has supported PCMH initiatives

Keys to Success in Maryland



Quasi-independent Regulatory Agency

- Agency has strong, capable leadership to develop, implement and adjust complex rate setting and now global hospital budget system
- Agency has sufficient staffing and a sophisticated system to oversee and implement its work

Keys to Success in Maryland



Innovation

- Rate setting models have gone through numerous iterations
- Broadly written enabling statute allows for innovation without political complexities
- Moving to Global Hospital Budget Model is unique among states

Summary of Strategies

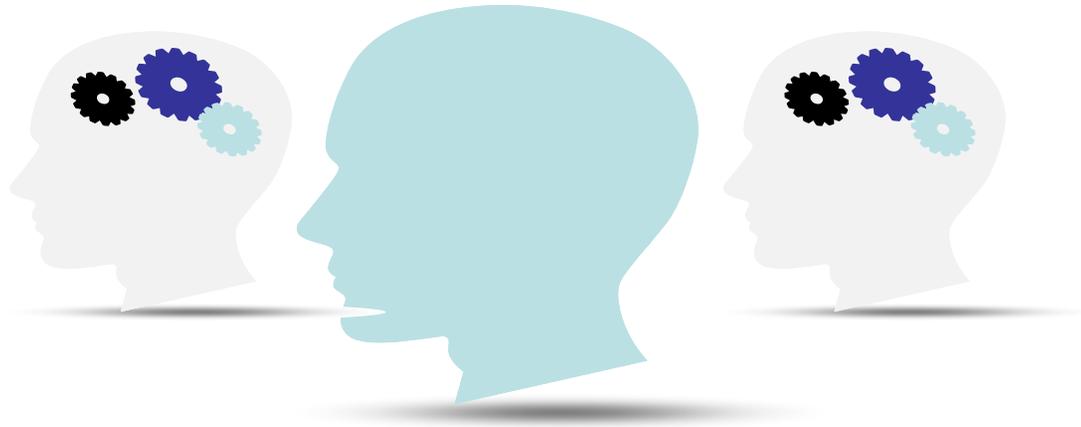
1. Delivery System Transformation

- Patient Centered Medical Homes
 - Strong adoption by dominant commercial payer
 - Public-private efforts to align key elements of PCMH model: payment model, performance measures
- Medicaid is considering ACO-like entities for non-hospital providers

2. All-payer limit on rate of per capita health care cost increases

- Global hospital budgets beginning 2014
- Total cost of care and incentivizing population-based care by 2019

Questions and Discussion



If Connecticut were to adopt some or all of these strategies, what are –

- Some of the facilitators?
- Some of the barriers?