



**CRISP**

# Future of Care Transformation Models

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maryland  
**health services**  
cost review commission

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# Future of Care Transformation Programs in Maryland

June 2023

# Care Transformation in Maryland

After approval of the TCOC Model, the HSCRC began developing programs that **align with hospital efforts to control costs across the healthcare system.**



Maryland **physicians largely remain on fee-for-service** reimbursement incentives and, as a result of the TCOC Model, are left out of national, **Medicare** value-based payment programs.



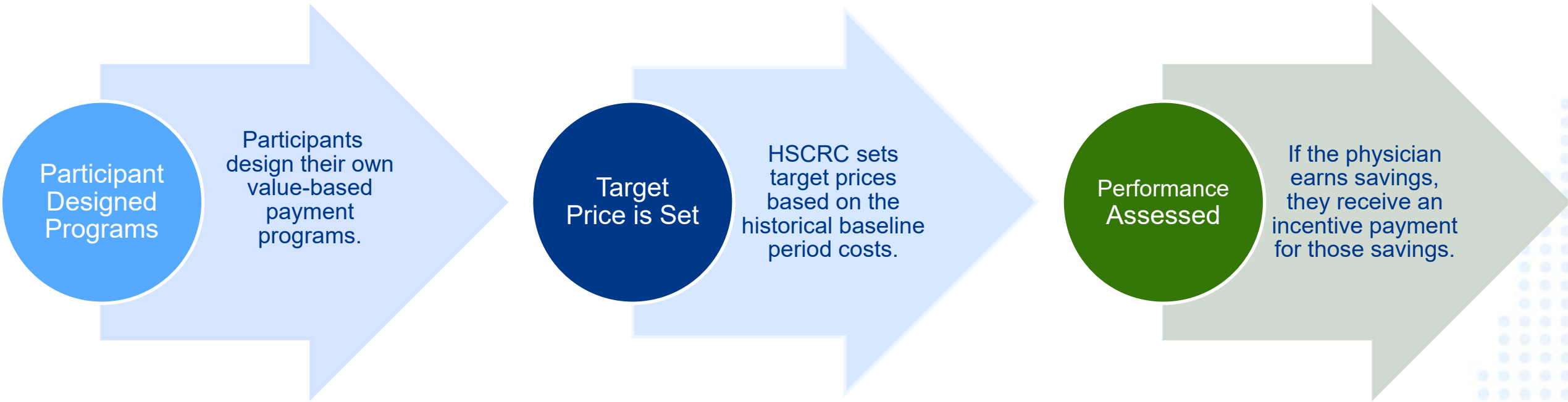
Therefore, it is imperative that the State **creates new value-based reimbursement opportunities to ensure cost containment in non-hospital settings.**



# HSCRC History of Care Transformation Programs

- The HSCRC had created several programs that were designed to expand hospital accountability to the rest of the delivery system.
  - Some of these programs were homebrewed. For example, HCIP focused on reducing unnecessary internal hospital costs.
  - Some were based off federal programs. For example, ECIP replicated post-acute care bundles.
- However, the State realized that payer-designed programs do not map to the way the hospitals deploy clinical interventions.
  - For example, hospitals were focusing on chronic condition management, frequently utilizers, etc., rather than the hospital-based DRGs, as in ECIP.
  - The State needed to reframe how programs were designed into better capture hospitals' efforts in reducing the Total Cost of Care.

# A new philosophy for designing care transformation programs



# New Care Transformation Programs

- The HSCRC built two different programs for managing the Medicare TCOC.
  - Care Transformation Initiations – this program allows hospitals to create their own value-based payment programs, including primary care capitation, bundled payment, and specialty medical homes.
  - Episode Quality Improvement Program – this program allows physicians to create their own bundled payment programs.
- Participants partner with the HSCRC to design their own value-based payment programs around clinical redesign efforts, rather than trying to build clinical care redesign efforts around value-based payment programs.

# Year 1 CTI Results

- In Year 1 of the CTI program, hospitals saved \$127 million across all CTI.
  - On average participants saved, 3% of their attributed Medicare costs.
  - The CTI results tie roughly one third of the annual savings rate (in CY 21) to some sort of care transformation activity.
- CTI adjustments are made in a net neutral manner. That means that hospitals which failed to achieve savings will ‘pay for’ the savings of the successful hospitals.
  - 15 hospitals earned a positive reconciliation.
  - 11 hospitals earned savings but not enough to offset their share of the statewide savings.
  - 17 hospitals did not earn any savings.
- The magnitude of the adjustment ranges from +7% to -3% of Medicare revenue.

# Overview of CTI Results

Thematic Area	Number of CTI	Number Exceeding Target Price	Percent Exceeding Target Price	Number Exceeding MSR	Percent Exceeding MSR	Average Savings
Care Transitions	55	36	65%	28	51%	1.6%
Palliative Care	5	3	60%	3	60%	2.9%
Primary Care	23	14	61%	11	48%	2.2%
Geographic	10	5	50%	5	50%	3.2%
ED	14	8	57%	7	50%	1.0%
Total	107	66	62%	54	50%	1.9%



# Enrollment Summary

EQIP entities enrolled:	62
Total Care Partners:	2,787
Specialties represented:	43
Participation in all 45 available EQIP Episodes	
Smallest Entity:	1 CP
Largest Entity:	994 CPs
Entities participating in more than 2 episodes:	36

Clinical Episode Categories	Number of EQIP Entities	Number of Care Partners
Allergy	14	1461
Cardiology	24	1570
Dermatology	5	1201
Emergency Care	11	1703
Gastroenterology	21	1545
Ophthalmology	7	1171
Orthopedics	33	2097
Urology	6	238

# Transformation on this scale is only possible due to CRISP

- Designing new value-based payment programs is challenging, from both a provider and information technology standpoint.
  - Designing one value-based program is challenging enough from a data programming standpoint. Designing a hundred is daunting.
  - In order to be successful, the State must make analytic data available to providers so they can tailor their care transformation efforts to their clinical programs.
- CRISP has built an incredible IT system to support the hospital's care transformation efforts.
  - Participants to analyze claims data on their patients, identify the targeted population of their clinical redesign efforts, and track progress in real time.
  - No other state has the same level of access to healthcare data readily available to providers; nor the

# What's next?

## Short Term

- The HSCRC has partnered with providers to develop a muscular skeletal bundle-payment program to incentivize greater use of PT as an alternative to surgery.

## Medium Term

- We look forward to partnering with hospitals, physicians, or any other providers in the State of Maryland to develop additional value-based payment programs.
- If you have an idea, we will build it!

## Long Term

- Our current efforts are limited to claims-based analysis, which will always have limited clinical value. CRISP collects other information that could be used to target our value-based care models more closely to real clinical programs.



# Center for Medicare and Medicaid Innovation Update

## CRISP Annual Summit

PRESENTED BY:

Amy Bassano,

Managing Director, Medicare

June 6, 2023

# CMS INNOVATION CENTER AND ALTERNATIVE PAYMENT MODELS

**The Affordable Care Act created the Center for Medicare and Medicaid Innovation (CMMI) to test alternative payment models.**

- Broad authority to test Medicare and Medicaid models. Can waive certain provisions of law to implement models.
  - If models are determined to be successful, the Secretary has authority to expand the model.
- Model can be voluntary or mandatory. Must be evaluated.
- More than 50 models tested. Most are Medicare payment focused. Fewer Medicaid models due to flexibility authorities.
- CMMI portfolio has focused on certain model approaches
  - Accountable Care Organizations/population health (Pioneer, Next Gen ACO, ACO REACH)
  - Bundled or episodic payments (BPCI, BPCIA, CJR)
  - Primary Care improvement (CPC, CPC+, PCF)
  - State Based initiatives (Maryland Total Cost of Care, Vermont All Payer, Pennsylvania Rural Health Model)
  - Health Conditions – ESRD (CEC, KCC, ETC), oncology (OCM)
- The Quality Payment Program incentivizes physicians to participate in certain CMMI models.

# CMMI RESULTS AND LESSONS LEARNED

- As of May 2023, 4 models have met the expansion criteria
  - Pioneer ACO
  - Diabetes Prevention Program
  - Home Health Value Based Purchasing
  - Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)
- Others such as the Maryland All-Payer Model achieved savings but CMMI developed a successor model (Maryland Total Cost of Care) to test concept more broadly in Maryland
- It is difficult to achieve savings in models especially when CMS need to take in to account additional costs of infrastructure, incentive or other new payments provided in the course of the model.
- Stakeholder concerns about the number of models, overlap between models, types of models (voluntary vs mandatory) and opportunities for certain types of providers to participate in models.

# CMMI STRATEGY REFRESH

Building on lessons learned to date, CMMI looks to set the stage for future model tests and engagement with other payers and partners to support a system wide movement to value based payment



- + Drive accountable care that results in all Medicare enrollees and “the vast majority of Medicaid beneficiaries [will be] in a care relationship with accountability for quality and total cost of care by 2030.”
- + Embed health equity in all models through mandatory reporting of demographic and, as appropriate, social determinants of health data, and including underserved populations and safety net providers in new models.
- + Support innovation by strengthening patient engagement and person-centered measures across all models.
- + Facilitate approaches and specific targets that address price and affordability for high-value care, including new approaches to cost-sharing and drug prices.
- + Pursue more collaborative and ongoing partnerships with a broader group of stakeholders to improve quality, achieve equitable outcomes and reduce health care costs, and allow for multi-payer alignment in new models by 2030.

# POTENTIAL UPCOMING CMMI MODELS

- Prescription Drug Models
  - Medicare High-Value Drug List
  - Cell and Gene Therapy (CGT) Access
  - Accelerating Clinical Evidence - mandatory model
- Advanced Primary Care
- State-Based Models
- Safety Net Providers
- Dementia Care Model
  
- Scheduled to implement Enhancing Oncology Model on July 1, 2023
- Bundled Payments for Care Improvement Advanced extended through 2025
- Value-Based Insurance Design Model extended through 2030





QUESTIONS/DISCUSSION

# THANK YOU!

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