Guiding Principles for Effective Implementation and the Future Direction of Maryland's All-Payer Model

An Interim Report from the Advisory Council to the Maryland Health Services Cost Review Commission and the Department of Health and Mental Hygiene

DRAFT

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Table of Contents

Introduction and Statement of Purpose

The Advisory Council was formed in November 2013. The purpose of the Council is to develop key principles to guide the Department of Health and Mental Hygiene (DHMH) and the Maryland Health Services Cost Review Commission (HSCRC) in the implementation of the All-Payer Model Agreement, undertaken by the State of Maryland and the federal government in January 2014.

The Advisory Council membership represents a variety of diverse stakeholders in the Maryland health care system, including hospitals, physicians, post-acute care providers, mental health experts, health plans, consumer organizations, and health care policy experts. Senior executives from these organizations met five times in the period from November 2013 through January 2014. The Council issued its first report on January 31, 2014.[1] The Council also held a follow-up meeting in November 2014.

The Advisory Council was reconvened in 2016 by HSCRC and DHMH to review the progress of the All-Payer Model after two years of experience and make recommendations to guide the effective implementation and progression of the Model. By December 31, 2016, Maryland is required to submit a proposal to the Centers for Medicare & Medicaid Services (CMS), which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate, to take effect no later than January 2019. A list of the current Advisory Council members appears in Appendix A.

This document is an interim report of the Council to HSCRC and DHMH, based on key points of consensus emerging from five meetings held from February through May 2016. The report also acknowledges different viewpoints on some key points. Some of these differing views may be resolved through the additional work of the Council during planned meetings this year, or differing perspectives may be shared with the DHMH the HSCRC in the Council's final report.

The Council observes that the All-Payer Model has shown early accomplishments and considerable promise in achieving the targets in the 2014 Model Agreement. All hospitals were placed under global revenue caps early in 2014, covering about 95 percent of revenue. The first-year metrics were met: all-payer revenue growth was held to 1.47 percent per capita, compared to the 3.58 percent per capita ceiling; Medicare realized savings in hospital spending of $116 million, a substantial contribution to the five-year requirement of $330 million; quality measures for hospital acquired conditions were achieved and hospital readmissions declined. Results for the full year 2015 are not yet available.

Recommendations

The Council's recommendations are organized around six major domains:

- Vision
- Roadmap, Focus, and Progression
- Person-centered care
- Data

[1] Guiding Principles for Implementation of Population-Based and Patient Centered Payment Systems: A Report from the Advisory Council to the Maryland Health Services Cost Review Commission. January 31, 2014.

- Accountability
- Alignment

Vision

The Council has achieved a great deal of consensus on the high level vision for Maryland's reforms. It believes in a fundamental transformation of our health care system away from rewarding ever more volume toward rewarding value and continuous performance improvement. Improving the health of the population should be a key goal, and we can make progress toward this goal by both redesigning the health care system and moving upstream to address the forces outside that system that drive people into it. Patients should be engaged and empowered to participate in the decisions about their treatment.

The Council recognizes that a considerable amount of health care provided lacks an evidence base, and is frequently inefficiently delivered. A strong effort is needed to reduce avoidable care in high-cost settings. Encouraging the integration and coordination of care and linking payments to value will lead to better health outcomes and lower total spending.

This effort should be led by leaders in the Maryland health care delivery system. The State should play the important role of a facilitator, with innovations emerging from private sector initiatives. The Advisory Council favors the pursuit of a culture of health for all residents of Maryland that reduces the cost of health care while improving health outcomes, and increasing the quality of, and consumer satisfaction with care, and driving a more efficient and effective health care system.

The Council believes that sharing best practices, particularly at the regional level, can help fulfill this vision.

Roadmap, Focus, and Progression

The Advisory Council believes that we need a clear roadmap going forward, with key milestones and a timeline. Maryland has stated goals related to the Triple Aim.

There is considerable consternation with the pace of change required to meet the objectives and goals of Maryland's model. The Council had some debate about the speed with which Maryland should pursue additional reforms. Some recognize the urgency of planning further reforms to keep pace with national changes and meet the contractual requirements of Maryland's agreement with the federal government. Others express frustration with the speed of change and suggest more time for hospital reforms to take hold. The Council will continue its deliberations about this issue.

We need to demonstrate that the current All-Payer Model is both successful and sustainable. To ensure that we are making real progress toward this goal, it is important to define what constitutes success at particular points along the timeline, and the Advisory Council can play a useful role in this endeavor. We should evaluate the current model annually to determine progress toward success and sustainability.

Maryland quickly made excellent progress in placing hospitals under global budgets. Now we face two key challenges: (1) to align incentives of physicians and other providers with these new hospital incentives; and (2) to "move upstream" along the continuum of care to address the forces

driving people into hospitals and improve the health of the State's population. A good place to start is with investments in both primary care and a cluster of social services and policies that improve health and access to health care, including nutrition, transportation, and safe housing, among others.

This should involve setting concrete quantitative goals for managing the cost and quality of care for particular populations. The All-Payer Model agreement places a strong emphasis on controlling the growth of Medicare spending, and there are specific targets in the Model agreement related to Medicare, such as saving Medicare a cumulative $330 million over five years and reducing hospital readmissions. This implies an overriding focus on identifying and better managing high-need, high-cost Medicare patients during the early phase of implementation. The Commission can set the goals, keep score, and provide the ground rules under which providers operate. At the same time, providers will want the flexibility to manage their business most effectively.

There is a need to set out a progression from the initial focus on the Medicare fee-for-service population with complex care situations, to all populations. A sequential approach would spend more time defining accountability, responsibility, program design, outreach and coordination of care for all populations, across the full continuum of care from the well, to those with moderate support and service needs, to the chronically ill, and those in need of greatest care and services; utilizing health education, promotion and use of care pathways such as care and case management, nursing care, and hospice care that would offer a benefit across an entire population. This will help ensure the program's longer-term success.

Success will depend on setting goals that are achievable, getting clarity on these goals, and drawing a roadmap that focuses laser-like on achieving them. This roadmap should include the sequence and scale of actions and reforms that are needed.

We also need a good sense of the *progression* of the work, with one set of accomplishments leading to another set of activities—a map in which we build successively on early accomplishments. This development of a roadmap and a plan for progression are important to the transformation of the delivery system and how that will take place. These milestones should relate to periodic assessments or evaluations of progress in meeting the goals and targets related to the All-Payer Model Agreement.

Preparing the Phase 2 Plan

An important part of the roadmap is the process of creating the Phase 2 plan for the federal government. CMMI has indicated that this plan must broaden the focus of cost control from mainly controlling total hospital costs per capita and improving quality, to a broader context that encompasses controlling the cost and improving the quality of a broad range of health services. This broader context is consistent with reforms coming out of CMS that have tight timelines for providers to adapt to value-based purchasing and alternative payment systems. Some Advisory Council members expressed concern about these timetables and sought assurances that taking on new responsibilities would not jeopardize continued progress on achieving the original All-Payer Model initiatives begun in 2014.

The Council believes that Maryland should meet the December 31, 2016 deadline for submitting the Phase 2 plan to CMS. There is some debate within the Council about the extent to which the plan should include substantial reforms beyond the current model.

The first step in the progression is to better understand where we are today with almost thirty months of operation under the All-Payer Model Agreement. We should strive to understand both what is working well—so that we can expand our tools that have enabled the positive results—and where we believe there are gaps in our performance—so that we can design appropriate interventions to fill those gaps. We will need to resist the urge to embrace potential solutions that appear to be "shiny and new," and instead focus on what will enable us to meet our targets expeditiously. As we do this, we should remind ourselves that more focused efforts are likely to yield the best results. We should also recognize that one approach is unlikely to be the appropriate solution for all situations.

The Council recommends that the movement to a total cost of care model should be phased in during the second five years of the All-Payer Model, beginning in 2019. The prevailing view among Council members was that the first phase would apply the total cost of care approach under the All-Payer Model to Medicare only.

We wish to see a realistic timetable for progression that will best serve the state of Maryland, allowing sufficient time for policy and model development and stakeholder engagement and support.

The Need for Focus

The Advisory Council strongly emphasizes the need to focus efforts to achieve this vision on a few realistic and achievable goals. The Council warns against a "scattershot" approach in which a lot of small initiatives are simultaneously pursued with insufficient coordination and scale to bring breakthrough changes. A better approach is to identify some clear objectives, draw a careful roadmap of how to achieve them, and establish workable strategies for moving down the path to success as rapidly as possible.

The Council stresses the need to build on models that Maryland health care leaders are already doing such as Global Budget Revenue (GBR); Accountable Care Organizations (ACOs); and patient-centered medical homes (PCMHs). The best strategy is to test these models, identify those that prove successful, build on proven models, and bring them to scale.

The Council also supports concentrating care management efforts first and foremost on the more than 800,000 fee-for-service Medicare patients in Maryland; particular emphasis should be placed on the members of this population with complex medical needs. Another important target where more care management is needed is the population that is dually eligible for Medicare and Medicaid. Within this population, the individuals who are disproportionately using inpatient services should be the immediate focus. The next priority is to identify patients who may not be high-need and high users of health services now, but are on the cusp of becoming so, and need good care management to avert deterioration in their health conditions.

Finally, while it is important to target initial efforts on the Medicare and dual eligible populations, the Council believes that all residents of Maryland should receive the best quality and most timely care available. The approaches used to improve care for the Medicare and dual eligible populations should have applicability to all payers. This includes getting regular check-ups and access to an array of important screening tests as well as professional advice on how to remain healthy over time.

Person-Centered Care

Person-centered care involves setting goals that are prioritized by the patient, educating patients on self-care and management, joint decisions between patients and their care teams, and engaging the family and caregiver in care and decisions about care, including functional focus and planning. Connecting patients to a variety of social services is also important.

In a person-centered system, the individual is:

> **Engaged**: involved in prevention and self-management of health.
>
> **Working with a primary care provider:** patients should have a medical home, and an active and trust-based relationship with their primary care physician, physician assistant, or nurse practitioner. There should also be coordination between primary care physicians (PCPs) and specialist physicians to ensure that patients are receiving the best care possible.
>
> **Receiving meaningful care coordination:** consistent and coordinated support based on individual needs.
>
> **Patient as the hub:** the care-givers that patients see are frequently in multiple health systems. This is one of the reasons why health systems, providers, and community resources need to collaborate to serve patients in a holistic and organized manner, using the investments made in electronic health records, health information exchange, and care coordination to put the person at the center of care delivery.

Maryland leaders should strengthen their efforts to educate consumers about the All-Payer model and strive to communicate model goals, implementation steps, and accomplishments in plain, understandable terms that demonstrate the impacts on consumers. This will enhance consumer engagement and promote positive results. Much has been done since that time, but more work is needed.

We need meaningful measures that include consumers' access to quality care. As we strive to create incentives to reduce avoidable use of high-cost services, we should also be vigilant to avoid under-use of appropriate care. This is particularly important for vulnerable populations. What additional measures may be needed to protect consumers and ensure equity? We need a gap analysis of information now available and a plan to develop further measures to address areas where we do not have enough information.

Obtaining Needed Data and Using Data in Hand

The Council members reiterated and stressed the critical importance of obtaining Medicare data for the success of the model. This Medicare data, in conjunction with the hospital data already available, is critical to planning, management and implementation of reforms. There is unanimous frustration among Council members with the administrative barriers to accessing meaningful Medicare data.

There are two different high-level Medicare data needs, each supporting different uses.

Data for Policy and Planning Purposes: There is some debate among the Council about the sufficiency of data for policy and planning purposes. There are multiple data sources available now for policy and planning purposes with varying degrees of availability and accessibility. Many of these data sources include patient-level but non-identifiable data. Different data sources support different types of policy and planning activities. Some on the Council expressed the view that we do not know enough to move forward on further planning of reforms. Others suggest that the publically available data or data such as the Limited Data Set purchased by many vendors are sufficient to support Maryland's current policy and planning efforts. In addition, HSCRC has Medicare data, including professional data, which is helpful in monitoring progress and planning under the All-Payer Model. To date, HSCRC has faced significant federal administrative delays to accessing the data which have limited its use. The HSCRC has recently shared multi-year trend data on total cost of care, and has been working to begin to share monthly reports and drill down analysis of Medicare costs with providers. Working through these barriers and more broadly sharing analysis will be important.

As discussed below, ACOs now include about a quarter of Maryland beneficiaries. Providers involved in these ACOs have ready access to the wealth of data that is provided for these enrollees, to help them understand the needs of the population. Hospitals in Maryland have invested extensively in Electronic Health Records. There is a wealth of information in those systems that can be used to help understand the needs of the population and to identify gaps in health and care for individual patients.

In summary, much data is already in hand that can be useful for policy planning and program design.

Identifiable Data to Support to Implementation of Care Coordination: There is broad consensus on the urgency of accessing identifiable data to support the implementation of care coordination initiatives critical to the success of the model. The HSCRC and CRISP have been actively working with CMS to identify potential federal pathways to accessing the data. The Council recommends strong advocacy for this data. We should also ensure that these steps are HIPAA-compliant and fully respect patient privacy. A commitment to obtaining the best data possible and arranging to share the data across providers leads to the concomitant need to allow consumers to give their permission to use that data and to participate in care management arrangements. This includes a need to provide prior notice to consumers, opportunities for consumers to prevent data sharing, and rights for consumers to access and correct medical records.

The receipt of frequently updated, patient-identifiable Medicare data, including hospital, non-hospital, enrollment, Hierarchical Condition Categories (HCCs), and prescription drug claims will enable providers and regional partnerships to make considerable progress toward meeting the goals of the All-Payer Model. Access to comprehensive data will facilitate care coordination and point-of-service care based on a complete picture of patients' interaction with the health care system. This data would be a critically important complement to the hospital-only data to which Chesapeake Regional Information System for our Patients (CRISP), the State-designated health information exchange, already has access and uses to support care coordination.

The data from CMS will support an important effort to identify patients with complex medical and social needs and develop customized care plans to reduce the likelihood and severity of deterioration and complications of these conditions. The HSCRC Work Group on Care Coordination proposed the development of shared tools requiring Medicare data, such as reports identifying gaps in care, patient care overviews, health risk assessments, and risk stratification. The focus should be on developing plans of care that reduce modifiable risks, integrating care across the spectrum of providers, responding rapidly to changes in patients' conditions, and improving patient self-management and adherence to treatment plans. A shared set of patient care overviews and information facilitates the secure sharing of data across providers in order to foster team-based care, reduce costs, and improve health outcomes.[2]

In summary, the data sought from CMS is essential to the actual achievement of the widely supported goal of identifying the patients most in need of care coordination and management and getting them the care they need in community settings so that their care team can help them manage chronic illnesses, stay healthy, and avoid the repeated use of the ED and inpatient stays.

The Dynamic Nature of the All-Payer Model

Council members expressed the importance of encouraging continuous innovation and adaptation in a dynamic health care system, and the data requirements will need to keep pace with this evolution. What will be the process of going from the current set of statewide innovations to more regional initiatives (already underway) while at the same time encouraging local innovation and promising private sector initiatives? One example involves ACOs. The first generation of ACOs in Maryland involves mostly "upside-only" incentives. But over time a second generation of ACOs is likely to involve "two-sided risk." A related dynamic is the CMS targets released in January 2015 specifying the proportions of Medicare providers that must achieve various targets for tying payments to quality and value (e.g. 30% of Medicare payments are to be tied to quality or value through alternative payment models by the end of 2016, and 50% by the end of 2018). These targets involve both pressure on providers that remain in fee-for-service (FFS) to add quality targets, and the further pressure on providers to move from FFS arrangements to alternative

[2] Maryland Health Services Cost Review Commission. Investing in Care Coordination Infrastructure to Achieve Integrated Care in Support of Maryland's All-Payer Model. April 2015.

payment models. MACRA[3] is consistent with these trends: risks and rewards replacing an old, dysfunctional system of across-the-board physician payment cuts.

Accountability

The Advisory Council places a high value on system-wide accountability. All parties in the health care system should work together to establish accountability for improved patient health, delivering care that is efficient and effective, and empowering consumers to get the care they need and deserve.

In the near-term future we are likely to have multiple sources of stakeholder involvement, engagement, and activity in health care transformation and reform. In this pluralistic landscape in which a number of hospitals, other providers, and health plans are experimenting with different approaches to reforms in the health care delivery and payment systems, there is a need to define accountability for each of the participants, and for all Medicare fee-for-service cohorts. Further, there will be a need to delineate how stakeholders will attribute, coordinate, and divide responsibility and accountability; and align, coordinate and manage care and transitions of care between stakeholders. There is also a need to provide outreach and coordination of care for all cohorts across the full continuum of care, from the well, to those with moderate support and service needs, to the chronically ill, and those in need of greatest care and services.

Some important progress can be made this way. In the silos in which various organizations frequently operate, however, there will be overlap and perhaps disconnects across these disparate initiatives. Over time it will be helpful to better coordinate these scattered initiatives, and design innovations at the regional and local levels in which partners that have been developing reform initiatives independently begin to coordinate, synchronize, or link up their programs. The Council recognizes the pluralistic set of reforms now unfolding, and sees value in accountability being built into each of them, albeit in different ways. But the Council is also calling for the "harmonization" of these programs, with the ultimate goal of reconciling them and developing system-wide accountability.

Regional Collaboration can lead to Broader Accountability

In order to accelerate effective implementation, Maryland is developing Regional Partnerships that can collaborate on analytics, target services based on patient and population needs, and plan and develop care coordination and population health improvement approaches. The Regional Partnerships for Health System Transformation are a critical part of the state's approach to foster this collaboration. These partnerships include the hospitals in the area, federally qualified health

[3] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) makes four important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes create a Quality Payment Program (QPP); end the Sustainable Growth Rate (SGR) formula for determining Medicare payments for health care providers' services; make a new framework for rewarding health care providers for giving better care not more just more care; and, combine the existing quality reporting programs into one new system.

centers and other community health centers, medical groups, post-acute and long term care providers, and units of local government, and community-based organizations.

A key element of the Regional Partnerships involves working with CRISP. This organization has the capability to generate patient-specific reports. These can be used by primary care physicians and other providers. The reports can indicate that a physician's patient was hospitalized, the length of the stay, the primary and secondary diagnoses, and the setting into which the patient was discharged. The reports may uncover the fact that a certain patient was hospitalized two or three times in the past year, but that each stay was at a different hospital, underscoring the need for regional partnerships in which hospitals in the area can coordinate their approach to such patients.

Regional collaboration can help identify where to place the central responsibility and accountability for long-term cost control and quality improvement.

Evaluation of the many and disparate initiatives can help determine where to locate this primary responsibility. For example, if we build evaluations with reliable research methods into the many care coordination initiatives in a given region, the results can point the way to the best locus of accountability. If a region has five interesting care management initiatives, some sponsored by hospitals, some by health plans, and some by the State, evaluation results might show that two of the five are successful.

Perhaps one is led by one of a hospital in the region and one is led by a health plan. In this case, the hospital initiative with successful results could be adopted by other hospitals in the region, bringing it more to scale. The sponsoring hospital would be the primary source of accountability for this coordinated effort, and would be designated as the major responsible party. In the case of the initiative led by a health plan that was found through careful evaluation to be very successful, this could be brought to larger scale, and the plan could have overall responsibility, while the providers in the plan who are given the lead in care management would be the accountable entities.

Of course, what works in one region may differ somewhat from what works in another region. So the main locus of accountability might vary somewhat across regions. Further, this variation should not rule out other cases where a *statewide* approach might be justified. The main point is to identify a blend of experimentation, careful evaluation, regional and sometimes statewide planning, which would be followed by bringing successful approaches to scale. This would lead to a balance of capturing the economies of scaling successful strategies up, with a considerable uniformity across sites, and allowing some degree of flexibility for varying the implementation to recognize local and site-specific differences (e.g. urban versus rural settings, the adequacy of the supply of providers of different types, etc.).

An Organizational Structure/Framework for Accountability

Key questions:

- Who has oversight responsibility, will monitor patient outcomes, and is directly responsible?

- Who will involve, engage, and coordinate between all stakeholders to ensure care is provided to all beneficiaries, at all levels of health care needs? How will this be done?
- Who is ensuring that the program is functioning, care is organized, outreach is occurring, coordination of care is being provided to patients, and identifying those not seeking care, gaps in care, and the need for prevention, across the care continuum? How will this be done?

Core principles:

While the locus of leadership and primary accountability for health care transformation may vary from one innovation to another, the following core principles apply to reform initiatives in general:

- Tie financial accountability to the provider with decision-making authority
- Tie financial accountability to measurable outcomes related to cost and quality
- Allow some freedom to adapt within a common framework
- Only allow shared savings when quality indicators are at acceptable levels and when savings have been demonstrated on a patient population of a certain minimum size
- Ensure accountability to the patient

Important elements of a framework for accountability and alignment

- *Patient centric system* with a strong role for primary care providers (PCPs): There is a need to determine who is accountable for the patient. Will it be one party alone, such as PCPs? Alternatively, will there be shared accountability, and if so, how is this sharing worked out across a spectrum of providers including PCPs, specialist physicians, hospitals, and post-acute care facilities? An important element of this shared accountability is that patients have smooth hand-offs from one part of the spectrum to another, and effective advocates as they make these transitions.
- *Population health:* A key element of health care transformation is the steady movement toward population health. This requires transcending the silos that divide the types of care and also the heavy wall that frequently blocks out and separates activities occurring outside the health care system but that are vital to patients' health, such as good nutrition, adequate and safe housing, and a built environment that promotes good health.
- *Risk stratification* can help focus resources on those most in need of supports and intensive care interventions;
- *Global accountability* for achieving targeted cost and quality results over time: for what services and costs? Who goes at risk, how much risk, and how enforced?
- *Care coordination* as an enabling strategy toward success: who is going to do the care coordination? Care managers hired by providers and payers, or staff to the providers and payers? How are they trained, monitored, managed, and overseen? How will patients who need care coordination be selected? How does this relate to the population health/risk stratification strategies for Phase 2?
- *Incentive alignment* to encourage desired results: How are incentives provided so they reward people who are accountable for the results if they succeed? How are risk-sharing and shared savings measured and tied together, and are they symmetrical?

Maryland has made an excellent start by developing strong accountability mechanisms for hospitals through global revenue budgets that reward hospitals for cost control accompanied by meeting quality and outcome metrics. Global budgets are adjusted when care shifts from one hospital to another to maintain responsiveness to consumers and other stakeholders. The Council believes that we can build on this hospital-level accountability to bring physicians, other clinicians, consumers, and social service providers into accountability partnerships.

Currently, a considerable number of primary care physicians are participating in PCMH models, and hospitals and physicians are participating in ACOs in Maryland. Both of these programs include accountability at the program level for a combination of total spending trends and quality/health measures. Accountability should also be part of the business model in post-acute and long-term care, where it is frequently more difficult to measure outcomes. Over time, all participants in the delivery system should be brought into partnerships in which all parties have responsibility for cost and quality.

Fragmented Delivery of Care and Outdated Payment Systems Work against Accountability

The Council observes that the combination of a highly fragmented health care delivery system and traditional fee-for-service payment models work against accountability. Under these approaches, various types of providers frequently work in silos. They are not incentivized or supported to readily share results or work in team-based care in ways that provide holistic and comprehensive care to patients.

Under such systems, accountability is within the narrow confines of each provider's silo and therefore not person-centered or holistic. First, this creates problems for the person who has to try to navigate such a fragmented system, frequently bewildered and overwhelmed. Second, it generates wasteful spending in the form of care provided that lacks an evidence base, duplicative tests, flare ups and complications arising from poorly coordinated care, and gaps in care arising as patients get lost in this labyrinthine system.

That system is heavily comprised of the medical community. However, public health, community organizations, volunteers, and the faith-based community can also complement the medical system and be a natural partner in this work. Maryland should encourage partnerships with community organizations. One example of this is Maryland's Faith Community Health Network, which attempts to align efforts to provide timely support for congregants who have been hospitalized.

The key point is that there is a need for payment systems that hold specific parties across the delivery system at financial risk if key goals are not met, and reward them if these goals are met. Cost-cutting alone should not be rewarded without attention to quality and safety. Neither should inappropriate cost-shifting from one sector of health care to another. What is needed instead is a system of rewards and penalties creating strong incentives for improving quality and patient outcomes *while at the same time* lowering total spending.

Alignment

A system that creates strong incentives for value and outcomes for one important sector of the health care system, but excludes other important segments from the reforms, will find system-wide success elusive. A successful crew team features everyone in the boat pulling the oars in a synchronized rhythm, a strategy that will lead to successful transformation of the health care system.

The Need for Physician and Provider Alignment

It is vital that Maryland physicians and other providers have incentives and reward structures that are aligned with the All-Payer Model. They also need the tools and support to identify patients with the most complex needs, providing knowledge about their patients' use of services outside of the care that they provide directly, including behavioral health, home, and social conditions that may affect their patients' health.

Alignment requires resources to achieve value-based goals rather than just producing volume. It also requires changing the payment model to reward better health outcomes and more efficient and effective delivery of care. When these changes in both public and private payment structures, and providers respond with improvements in the way care is delivered, the savings should be shared across the parties that help bring about this result.

Payment models should provide direct rewards to physicians and providers who participate in innovative care delivery and show positive results from their efforts. Thus, physicians treating patients with diabetes, for example, should benefit when the proportion of their patients with this disease who keep their glucose levels under control rises, and when the proportion of patients who get regular eye and foot exams increases. This may involve close coordination between the patients' primary care provider and an endocrinologist to whom the patient was referred by the PCP.

Patients' family practice providers, internists, pediatricians, obstetricians, and urgent care providers are typically the first point of contact that a patient has with the medical system. It is vital that these primary care providers have incentives to gather all relevant information about their patients in a user-friendly way, and have such information available "in real time" as they are seeing patients. As noted above, physicians need the data in a form that is usable and up-to-date that will enable them to flag and pay special attention to patients whose conditions are resulting in hospitalizations or other advanced care. Primary care providers can use this data to work with other providers serving that patient and develop a care plan that can be followed over a substantial time span. This will help patients recover from illnesses and manage chronic conditions that in many cases are lifetime in nature.

Specialist physicians and surgeons must also have incentives that are aligned with the All-Payer Model.

The importance of working with CRISP

Working with CRISP, providers can use secure texting, receive care alerts, and learn what the patient's care manager accomplished in a recent visit. There may also be information about services the patient received that were outside of the standard medical model, such as indications that the

patient lacks transportation to keep medical appointments, or has a language barrier that is impeding the fulfillment of a care plan.

Physicians and other providers should be directly involved with CRISP, which has the ability to help them improve their care delivery. Many will need help in tapping into CRISP information, which will facilitate data sharing across providers. Physicians should be able to determine which of their patients are designated as having complex medical and social needs, beginning with patient-identified, HIPAA-protected information on the full range of health services used by such patients.

Important Opportunities for Physicians

There are several important physician incentive programs in which Maryland physicians can participate:

Medicare Payments for Chronic Care Management

Effective January 1, 2015, Medicare made a very significant change to primary care payment when it introduced a non-visit-based payment for chronic care management (CCM). This change has the potential to align efforts by physicians and hospitals around the opportunity to improve chronic care and reduce hospitalizations.

CCM payments permit Medicare to pay for non-face-to-face care management services such as medication reconciliation, coordination among providers, arrangements for social services, and remote patient monitoring. Arranging for such services requires physicians' time as well as the time of office staff, administrative costs, and technology outlays. Prior to this CMS billing code and payment system for care management, medical practices have had to absorb these costs without any reimbursement.

The new CCM payments create helpful incentives for physicians to coordinate with other medical providers and organizations providing complementary social services, potentially fostering a more holistic and comprehensive approach to meeting patients' needs. To the extent CCM is done well, more continuity of care will be provided for patients with complex needs and ongoing chronic conditions who might otherwise go from one episode of ED use and/or hospital admission to another, with little care management in between a series of complications.[4]

One concern about the CCM payments involves the affordability of the patient co-payments. Many lower-income patients will be obligated to pay co-payments (likely to be $8) that for some, could pose a barrier to their willingness to participate in this chronic care management initiative. Consideration should be given to finding a way to waive the patient cost-sharing for such patients. The rigidity of the program and the billing costs have also been cited as a difficulty by Maryland stakeholders.

[4] Maryland Health Services Cost Review Commission. Investing in Care Coordination Infrastructure to Achieve Integrated Care in Support of Maryland's All-Payer Model. April 2015.

Clinicians can also be encouraged to provide Transitional Care Management (TCM) services. The TCM fee compensates providers for working with patients as they transition from inpatient to community settings. CRISP can notify physicians when their patients are discharged from hospitals.

MACRA and MIPS

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) establishes a Merit-Based Incentive Payment System (MIPS) that consolidates existing Medicare fee-for-service physician incentive programs. MACRA also establishes a pathway for physicians to participate in alternative payment models (APMs) such as PCMH, ACOs, and other APMs.

Council members noted that Maryland should be aligning its plans with MACRA, MIPS, and APMs. This will help physicians participate in new approaches to care delivery and payment.

Comprehensive Primary Care Plus (CPC+)

The CPC+ initiative builds on the foundation of the Comprehensive Primary Care (CPC) initiative, a model being tested by CMMI from October 2012 through December 31, 2016. CPC+ builds in lessons learned from the first three years of the CPC program, including insights on practice readiness, the progression of care delivery redesign, actionable performance-based incentives, necessary health information technology, and claims data sharing with practices. The key features of CPC + are:

- Support patients with serious or chronic diseases to achieve their health goals
- Give patients 24-hour access to care and health information
- Deliver preventive care
- Engage patients and their families in their own care
- Work together with hospitals and other clinicians, including specialists, to provide better coordinated care.[5]

Primary care practices will be offered a choice of two models under CPC+. Under Track 1, CMS will pay practices a monthly care management fee in addition to the fee-for-service payments under the Medicare Physician Fee Schedule for activities. Under Track 2, practices will also receive a monthly care management fee and, instead of full Medicare fee-for-service payments for Evaluation and Management services, will receive a hybrid of reduced Medicare fee-for-service payments and up-front comprehensive primary care payments for the type of care management services noted above. The up-front payments may be retained if performance targets are met. The hybrid payment allows more flexibility in how practices deliver care outside of the traditional face-to-face encounter (e.g. 24/7 telephone or electronic access, coordinating care across the health system).[6]

Medical Malpractice Reform

The Council recognizes that medical malpractice is not within the purview of HSCRC. We recommend that the Commission be aware of the dissonance between its cost containment goals and the current medical malpractice system, and lend its voice to the need for reforming it. While

[5] Centers for Medicare & Medicaid Services. CMS launches largest-ever multi-payer initiative to improve primary care in America.

[6] CMS. CMS launches largest-ever multi-payer initiative to improve primary care in America.

the Council did not reach unanimous agreement on the specific types of reforms that are needed, or the likely impact of those reforms, most of the Council believes that addressing issues around medical malpractice is important in supporting the goal of reducing avoidable utilization and should be pursued in concert with the three-part aim.

Important Opportunities for Post-Acute Care and Long-Term Care Providers

The All-Payer Model presents an opportunity to reduce utilization in higher-cost settings and navigate to lower-cost settings, guided by clinical needs. This goal can be fostered by moving toward coordinated step down care. We can build on patient navigation and advocacy capacity. The phase 2 plan should feature partnerships to build strong bridges between acute and post-acute settings. We should help people on Medicare with high-acuity chronic conditions become healthier and better move along the continuum from hospital to post-acute care settings, and from those settings to home.

The focus on post-acute care spotlights the importance of behavioral health needs. A number of the long-term post-acute care (LTPAC) population has moderate to severe cognitive impairment. Nearly 20 percent of SNF residents take anti-psychotic medications. Alignment may be fostered by expanding the shared savings concepts to include LTPAC providers and share resources and provide financial incentives to pursue quality and cost targets. Any new design should incentivize LTPAC providers to take the right action rather than the least expensive action. We should avoid going for a quick "savings" and ensure that providers are not penalized for placing the patient in the most proper setting. The latter will be cost-effective over time by avoiding readmissions, and it represents a good example of patient-centered care.

A fee-for-service system for LTPAC providers, like any FFS approach, maintains the incentive to keep beds (slots) filled. The new system needs to reduce this dependence, similar to the global payment system operating for acute care hospitals, and reward LTPAC partners for high-quality care. We also need to address the considerable variation in costs across providers. The Medicare Payment Advisory Commission reports a high degree of variation in costs across skilled nursing facilities.[7]

For this new approach to be successful we need accurate and timely data on resident conditions and treatment, and that data needs to be available and communicated in real time.

Better alignment of long term and post-acute care

Aligning providers of post-acute care and long-term care with the goals of the All-Payer Model is also very important. This includes skilled nursing facilities, home care, rehab hospitals, hospice, and nursing home care, as well as durable medical equipment. This sector is fragmented and frequently disconnected from acute care medicine.

Hospital discharge presents one of the biggest challenges to patient care management if not properly handled. About one of six Medicare patients discharged from a hospital is readmitted in

[7] http://www.medpac.gov/documents/reports/mar13_ch08.pdf?sfvrsn=0

the 30 days following discharge. Under the All-Payer Model, Maryland is required to sharply reduce hospital readmissions rates to a level that is in line with the national average.

Patients in long-term care facilities are frequently sent by ambulance to the emergency room for escalation of conditions that might be prevented or addressed through adjustments in medication dosages or other elements of treatment that can be safely done in their facilities with some additional support. Many such trips to the ER result in an admission to the hospital that could have been avoided with the proper guidance and clinical support. Evidence-based care transition approaches can reduce such hospital readmissions from long-term care facilities. Examples of successful programs that reduce such poor outcomes include the Interventions to Reduce Acute Care Transfers (INTERACT) program and Project Re-engineered Discharge (RED).

Information technology is also important to improving post-acute care and establishing stronger bridges between acute and post-acute and long-term care. CRISP can be helpful in this process.

Behavioral Health

The Advisory Council believes that better management of behavioral health conditions is critically important to improving health outcomes and controlling spending. In our fragmented health care system, behavioral health is frequently "carved out" of the health benefits package and treated as if it were unconnected to acute care medical conditions. Yet, we know that physical health and challenges around mental health and substance use disorders are frequently inextricably intertwined.

Behavioral health needs adequate funding and linkages to the somatic health care system across the full continuum of care. This includes smooth handoffs from primary care physicians to behavioral health providers. Primary care physicians should be trained to recognize patients who frequently present only somatic health conditions but also have mental and emotional issues, and to make timely and appropriate referrals to behavioral health providers. Behavioral health providers treating people with serious mental illness should also recognize the numerous physical health problems that frequently emerge from mental health treatment, as when medications generate side effects such as substantial weight gain, diabetes, and other illnesses, and make appropriate referrals to primary care and specialist physicians so that those conditions are controlled and managed. In addition, people leaving the hospital after a stay related to a severe episode involving mental health and/or substance abuse problems should be linked to ongoing care and affordable medications to help avoid repeated hospitalizations.

Barriers to care frequently emerge from an insufficient number of behavioral health providers in communities. Even where there may seem to be an adequate number of such providers in the aggregate, many do not accept Medicaid and do not see uninsured patients. Further, they may be clustered around urban centers, but quite remote from people living in smaller towns or rural areas.

Governance

We need to pay more attention to governance. The governance of the system should be modernized from one that focuses almost exclusively on hospitals to one that will allow for other practitioners

and for patients to have a voice and be represented. The governance needs to be clear and transparent. Governance needs to protect patients, physicians, and the public health of Maryland.

Governance is an important challenge not only in the public sector, but also in the private sector. As various forms of integrated care networks, including ACOs, emerge, it will be important that they, too, are well governed. Some of these new entities are taking on a considerable amount of risk, and good oversight and management will be important to their success.

In terms of developing and implementing needed changes, consideration should be given to using private-public partnerships, such as CRISP, to assist in administration and transformation.

As the All-Payer Model continues to evolve toward a more system-wide focus, greater direct cooperation among HSCRC, DHMH, and the Maryland Health Care Commission (MHCC) seems warranted and helpful. The Advisory Council was reconstituted with the joint efforts of DHMH and HSCRC, with other workgroups also being coordinated and constituted as multi-agency work groups. To address the "social determinants" of health, cooperation with the Department of Aging, Department of Housing and Community Development, and the Community Health Resources Commission could be helpful.

What are the relative roles for State government agencies and the private sector, including the important parts of the health care delivery and financing systems as well as community-based organizations? How can good governance promote alignment and accountability? The Advisory Council explicitly recognizes and embraces the leading role of private sector initiatives in moving toward transformation, while recognizing that government, as a growing purchaser of care, is actively funding and driving the direction of transformation in changing the way providers are paid, services are delivered, and information is shared. As the State continues to work with the federal government, we should determine the best balance between mainly implementing federal initiatives, on one hand, and positioning Maryland as a leader, with unique innovations under the All Payer Model, on the other hand.

In this regard, it is important to note that HSCRC has always had a philosophy of setting performance targets, rather than detailed design standards, and then "getting out of the way" so that hospitals can respond to those incentives with some variation in approaches. This goal of allowing considerable flexibility for achieving desired thresholds is still valued, and can apply to physician services, post-acute care, and other parts of the health care system that are largely outside of the purview of HSCRC.

A key issue is whether to expand the scope of long-standing regulatory authority, which focuses on hospitals, versus retaining that authority more or less as is, and relying on market-based approaches outside of major government regulation, to align incentives between hospitals and other key sectors such as physician care and post-acute care. It is important to note that the state has no interest or intent in taking on the authority of setting physician fee schedules for Medicare or the private sector, particularly when the system is focused on reducing volume-based approaches to payment. It should be noted that DHMH and MHCC also have important regulatory

authority. Some form of integrated governance could avoid duplication of effort and help target resources to unmet needs. A mix of public and private strategies is needed.

One place to start is by developing risk-based and partial risk-based models to pay hospitals and sub-acute facilities that join together to better manage care such care transitions, optimize post-acute care, and reduce avoidable hospitalizations from long-term care settings. In a publicly based model, this would require some rate management of payments to SNF and other sub-acute providers. In a private solution, the parties would work out various combinations of risks and rewards largely outside of State regulatory authority but under the authority of one or more federal models.

In pursuing alignment of incentives, it is important to define the desired change first, and then see what organizational entities emerge to achieve this change, rather than starting first with the organizations (e.g. ACOs).

An important part of good governance is a substantive evaluation process. This is the key for both good governance and effective administration, and could serve as an accountability tool. For the All-Payer program, this evaluation could include an analysis of the models and programs being undertaken through the Transformation Grants to identify the most effective strategies, and to respond to the questions of what, how, and why? Such strategies can then be scaled up for broader use, or applied as appropriate in discrete areas.

In sum, there is a need to define and identify global governance for the entire All-Payer Model, starting with the continuum of beneficiaries in the Medicare fee-for-service program.

- ✓ Who will govern the program and how will it be accomplished?
- ✓ Who has oversight responsibility, will monitor program outcomes, and is directly responsible?
- ✓ Who will involve, engage, and coordinate all stakeholders to ensure care is provided to all beneficiaries, at all levels of health care needs?
- ✓ Who is ensuring that the program is functioning, care is organized, outreach is occurring, coordination of care is being provided to patients, and identifying those not seeking care, gaps in care, and the need for prevention, across the care continuum and stakeholders?

Mapping capacity to the achievement of goals

The achievement of the goals of the All-Payer Model will take enhanced capacity in non-acute areas of the system. The Council's original report called for development of funding resources in addition to hospital rates, and we would like to reiterate that recommendation.

This raises the challenge of figuring out both the desired hospital capacity looking out into the future, as well as the needed capacity in such areas as outpatient surgical centers, rehab centers, home care, and nursing homes. This involves efforts to plan for "right-sizing" the health care delivery system in the face of trends in demographics, technology, new market entrants, virtual visits, telemedicine, and the major policy changes that Maryland is undertaking.

Ensuring that we have a health care workforce that matches emerging needs

This report has highlighted the key elements of the fundamental health care transformation that is underway in Maryland. As part of that transformation, the locus of care delivered, and sometimes the type of care delivered, will be shifting. For example, as care moves "upstream" with the goal of reducing avoidable ED use and inpatient admissions, there is likely to be a greater demand for a trained and skilled work force in primary care and services in the community. Some types of activities will require more workers, others may require less. For example, over time, Maryland may need more nurses, nurse practitioners, and medical technologists in primary care and specialty care, and less in hospital inpatient settings. Other skilled workers can support tele-health. Another need may involve bolstering the supply of nutritionists and community health workers.

As a result, planning for the future should include consideration of what it will take in terms of recruitment, training, and adequate pay and benefits to attract and retain a modern health work force that meets the needs of the changing delivery system.

Summary and Recommendations

The Advisory Council recognizes the significant progress made by the State of Maryland during the first two years of the All-Payer Model. In this report, the Council has highlighted the major challenges that lie ahead as the State strives to achieve a fundamental transformation of the health care system over the next several years.

Recommendation 1: Focus

The Council stresses the need for selecting a few key objectives and focusing attention on making substantial progress toward those objectives. It is important to avoid being stretched too thinly and tackling a bevy of comparatively small projects in a scattered and uncoordinated way.

Recommendation 2: Data

The Council believes that the timely acquisition of Medicare data that covers all major areas of health services in a patient-identifiable format is critical to making further progress toward meeting the goals of the All-Payer Model. Maryland has agreed to very tight targets in the All-Payer Model. As we approach the halfway point in the five-year agreement between the federal government and the State, it is crucial that the federal government give Maryland a chance to perform as expected by quickly providing the data necessary to do so. Effective care management for Medicare patients with complex medical needs is absolutely vital to reducing avoidable care in high-cost settings. Yet, such an outcome requires the acquisition and timely updates of data required to identify such patients, their utilization patterns, diagnoses, and other vital information. This is a top-priority recommendation.

Recommendation 3: Accountability

The Council recommends that Maryland develop a plan for system-wide accountability for quality improvement and long-term cost control. The Council encourages the further development of the multiple sources of stakeholder involvement, engagement, and activity in health care transformation and reform. In this pluralistic landscape, the various leaders of innovation will be challenged to establish accountability for each of the participants, and assign primary responsibility

to one party. Further, there will be a need to delineate how stakeholders will attribute, coordinate, and divide responsibility and accountability; and align, coordinate and manage care and transitions of care between stakeholders.

Over time it will be helpful to better coordinate these scattered initiatives, and design innovations at the regional and local levels in which partners that have been developing reform initiatives independently begin to coordinate, synchronize, or link up their programs. Thus, the Council is also calling for the "harmonization" of these programs, with the ultimate goal of reconciling them and developing system-wide accountability.

Accountability will be fostered by linking the providers inside the health care system to community-based organizations that address the factors frequently driving people into that system.

These elements of accountability should be woven together to meet the goal of person-centered care. Through provider collaboration, the initiatives of health plans, and government activities, the silos can be transcended in a way that focuses on the patient's needs. Regional partnerships can help bring the players in the health care and social service systems together to meet these needs.

Recommendation 4: Alignment

The Council believes that alignment of incentives across providers is vital. If some provider organizations have incentives to reduce avoidable use of care and improve quality while others do not, the potential for slippage and cost-shifting is significant. Moreover, if those who are needed to make the All-Payer Model work are stuck with the incentives in the old-fashioned system, many of the good efforts of those who have converted to more modern approaches could be frustrated.

Physicians, physician assistants, nurses and other providers, including behavioral health providers, should be rewarded for spending time on care management, rather than required to donate time to this effort. These providers need a pathway and a reward structure to encourage participation in alternative payment models.

Alignment of incentives in the long-term and post-acute care system is also vital to reducing hospital readmissions and an avoidable deterioration in health conditions in these settings. The Council recommends that greater attention be paid to improving care and aligning incentives across the acute and post-acute care and long-term care settings.

Recommendation 5: Demonstrations

As we move ahead and continue the negotiations with CMS, we should be sure to protect the key features of our four-decade long tradition of an all-payer hospital model, as well as what we have accomplished through global budgets for hospitals. While we are responsible for meeting the targets under the All-Payer Model agreement, we need to have the flexibility to develop demonstrations with CMS and others beyond hospital providers. Some of these demonstrations may be unsuccessful. We should take care to develop the models in such a way that they do not threaten the core model, and that unsuccessful demonstrations can be ended, while successful demonstrations are expanded.

Recommendation 6: Consistent requirements and reform initiatives across payers

A long-standing concern among hospitals, physicians, and other providers is the multiplicity of requests and reporting requirements from public and private payers. Frequently, these requests and requirements are quite diverse, and sometimes may even be contradictory. Providers are generally willing to take the initiative to gather the data and information requested. But they find it burdensome and expensive to compile multiple and divergent submissions. A set of common measures across payers would reduce the "hassle factor" for providers; this approach has the additional advantage of facilitating larger, consistent bases of data and information, which can facilitate the determination of community-wide patterns. This is consistent with moving in the direction of a population-based system.

Another way to foster such goals is to invest in common initiatives, in areas such as PCMH models and CPC+. System-wide transformation could be facilitated by conducting some of these interventions on an all-payer basis, even as the various payers maintain their own fee schedules. This combination of consistency with flexibility is one of the strengths of the Maryland approach to health reform.

Appendix A

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