

All-Payer Model Progression Plan

DRAFT Strategic Blueprint

The current All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS) requires that prior to the beginning of performance year 4 (2017), Maryland will submit a proposal for a new model, which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate to take effect no later than January 2019. The purpose of this document is to **develop the outline for the contents of a strategic plan, the All-Payer Model Progression Plan**, which will be provided to CMS by December 31, 2016.

A Dual Eligible Model, which encompasses beneficiaries covered by both Medicare and Medicaid, is also currently being designed through a CMMI State Innovation Model (SIM) award. The Dual Eligible Model is expected to be aligned and interoperable with the All-Payer Model, and its implementation will coincide with the next phase of the All-Payer Model in January 2019. The Dual Eligible Model intends to limit the per-beneficiary total cost of care growth rate for the Medicaid expenditures in addition to the Medicare expenditures. This complementary strategy to reduce total cost of care will be referred to throughout this document.

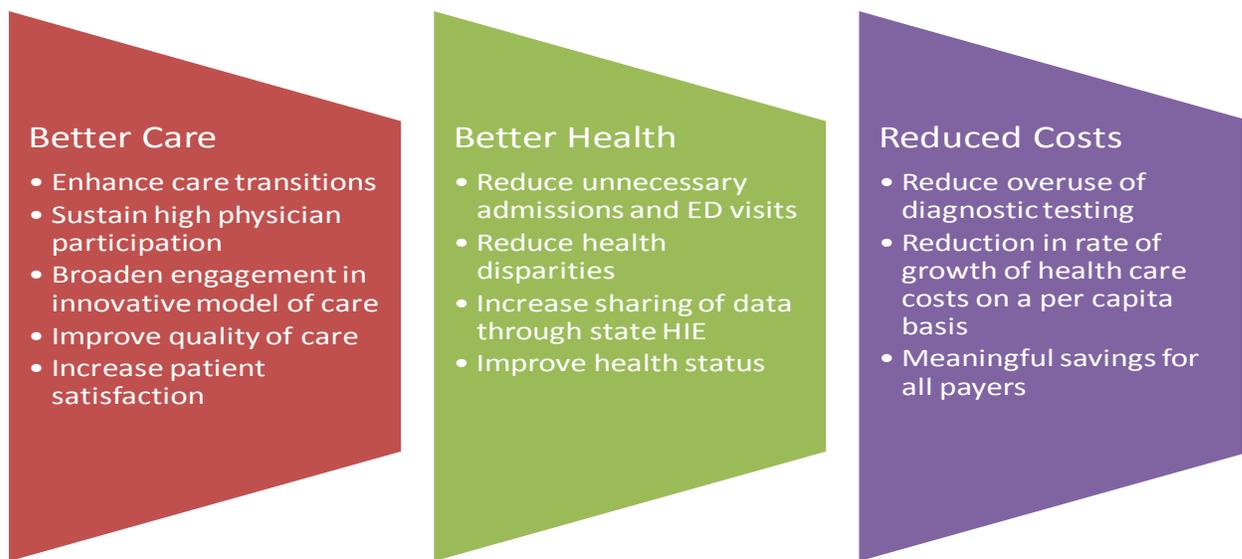
This is a **working document** with draft content provided to aid discussion and development of the final All-Payer Model Progression Plan to be submitted to CMS. It is intended to reflect: 1) the vision that was set forth in the initial application of the All-Payer Model, which was implemented January 1, 2014, and 2) continuous stakeholder input (e.g. Advisory Council, Physician Alignment workgroup, Care Coordination workgroup, Consumer Engagement workgroup, and others) since implementation of the All-Payer Model. This blueprint will outline the proposed components of the strategy for progression of the All-Payer Model and additional developments.

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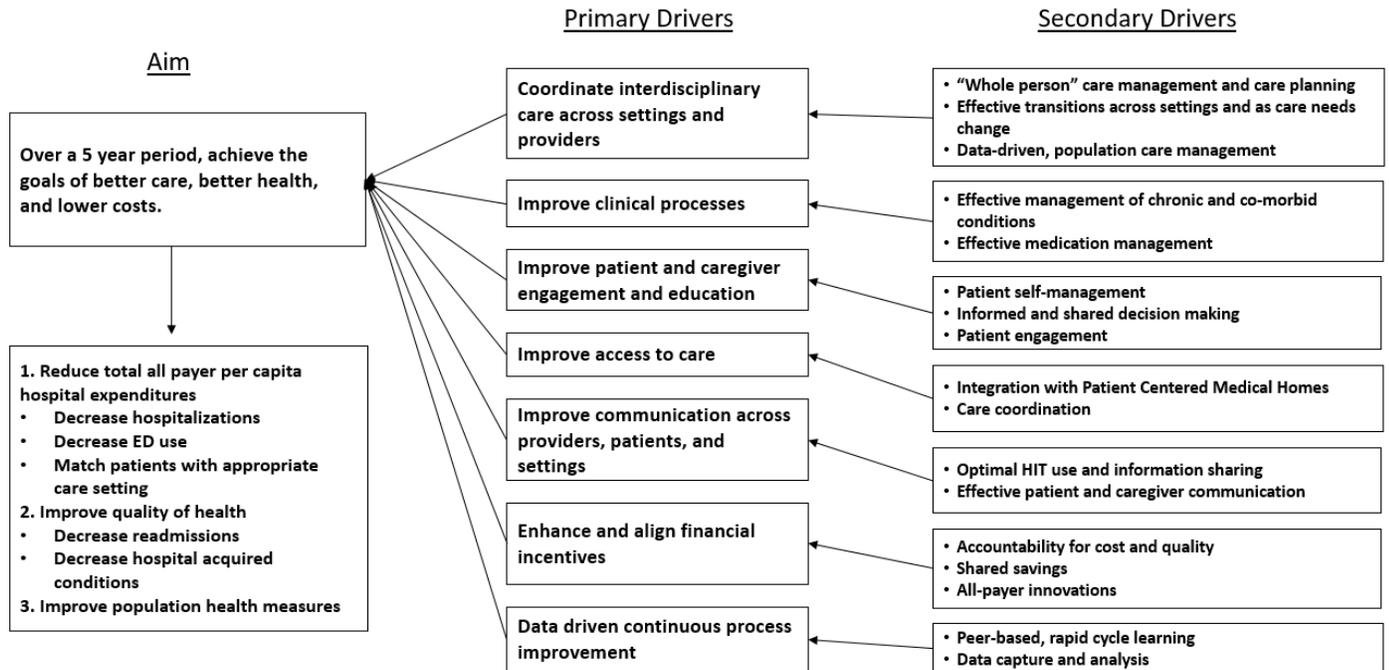
I. Background

- A. **All-Payer Model goals:** In January 2014, Maryland began implementation of a new All-Payer Model. The goals of the Model were to:
1. Reduce growth in spending for All-Payers, including CMS.
 2. Partner with CMS to deploy innovative delivery system and payment models in order to transform and improve Maryland health care systems.
 3. Improve the health of Maryland residents.
 4. Evaluate Maryland’s efforts and initiatives.



Source: All-Payer Model Final Application

B. **All-Payer Model driver diagram:** The Diagram below was developed as part of Maryland’s original application for a new All-Payer Model in September 2013 to depict the system components (i.e. drivers) required to accomplish the specific aims of the All-Payer Model. This framework described how a state-wide health care system that continuously achieves better health, better care, and lower expenditures is possible when the primary and secondary drivers are achieved.



Source: Final All-Payer Model Application, with “all payer” added into the “Aim” as originally intended

C. **All-Payer Model results to date:** In the first two years of the Model implementation, calendar years (CYs) 2014 and 2015, Maryland performed well (Figure 1). Maryland was able to keep hospital per Medicare beneficiary cost growth below the national Medicare growth rate without shifting costs to the private sector. In CY 2014, non-hospital Medicare spending growth per beneficiary was also below national levels. However, in CY 2015, non-hospital spending in Maryland rose faster than the nation, leading to a reduction in annual total cost of care (TCOC) savings for Medicare.

1. The All-Payer Model has been successful largely due to ongoing and collaborative efforts of stakeholders in implementing the model. [Insert content]
2. While Maryland is still ahead of its savings requirements, federal updates to Medicare rates for CY 2014 and CY 2015 were very low. Further, Maryland’s CY 2015 growth in non-hospital spending reinforces the need for accelerated implementation of care redesign in alignment with non-hospital providers. As the All-Payer Model increasingly focuses on TCOC, non-hospital providers will need to participate fully in enhancing care, while reducing potentially avoidable hospitalizations. Hospitals and other providers need access to TCOC data to design effective, actionable interventions, and monitor results. They also need identifiable claims detail to operationalize implementation.

Figure 1: Maryland All-Payer Model Metrics: Performance Year 1 & 2 Performance

Performance Measures	Targets	CY 2014 Results	Preliminary CY 2015 Results
All-Payer Revenue Growth	≤ 3.58% per capita annually	1.47% per capita in CY14	2.31% per capita in CY15
Medicare Savings in Hospital Expenditures	≥ \$330m over 5 years (Lower than national avg growth rate)	\$116m in CY14 (2.15% below national avg)	\$135m in CY15 \$251m in aggregate (0.04% below national avg) (2.22% below national avg since 2013)
Medicare Savings in Total Cost of Care	(Lower than the national avg growth rate)	\$133m in CY14 (1.53% below national avg)	\$80m in CY15 \$213m in aggregate (0.71% above national avg) (0.85% below national avg since 2013)
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	30% reduction over 5 years	25.6% reduction in CY14	7.3% reduction in CY15 35.4% reduction in aggregate
Readmissions Reductions for Medicare	≤ National avg over 5 years	0.25% gap decrease between Maryland & the nation in CY14	0.44% decrease between MD & the nation in CY15 0.69% gap decrease in aggregate
Hospital Revenue to Global or Population-based	≥ 80% by Year 5	95% by CY14	96% by CY15

- D. **National direction:** At the same time, CMS and the Center for Medicare & Medicaid Innovation (CMMI) have implemented numerous national initiatives and innovations, sending a clear message that delivery system transformation is already underway and will continue in the near and long-term future. Specific examples include:
1. Secretary Burwell’s 3-point directive to change provider payment structures, delivery of care, and distribution of information.
 2. Medicare Access & CHIP Reauthorization Act (MACRA), which transitions the basic payment methodology for Medicare providers toward value-based methods, decreasing reliance on volume-based methods.
 3. Comprehensive Primary Care Plus (CPC+), an advanced primary care model aimed at creating a multi-payer approach to using medical homes, aligning providers through standard metrics, and an organized approach for many of the patients on a primary care panel.
 4. Next Generation Accountable Care Organizations (ACOs), aimed at creating a more sophisticated ACO opportunity to increase accountability for patient care by introducing some level of down-side financial risk for the provider community.
 5. CMS’ Chronic Care Management fee, aimed at reforming physician reimbursement to allow physicians to be paid for the necessary activities in creating a medical home for Medicare patients with chronic and complex conditions.

6. Medicare-Medicaid Alignment Initiatives, aimed at aligning the care and funding of Dual Eligible beneficiaries.

In addition to the All-Payer Model, Maryland was awarded a SIM grant to redesign payment models and service delivery for its dually eligible population (i.e. the Dual Eligible Model), and develop a population health improvement plan. Both of these are examples of programs being driven by federal and state initiatives.

II. Maryland's Vision

- A. During the implementation of the new All-Payer Model, many stakeholder workgroups and councils were convened to discuss ways to make the All-Payer Model successful and sustainable and define Maryland's vision for progression. The following vision has emerged from these discussions:

Fundamentally transform the Maryland health care system with the goal of providing more person-centered care, increasing excellence in care, and improving the health of the population while moderating the growth in costs. Engage and empower consumers to participate in decisions about their health, leading to better health outcomes and lower spending. Contribute to the health of the population in Maryland and in the world by setting standards of excellence in clinical care as well as medical education and research.

III. Care Redesign Amendment to Current All-Payer Model

(Note: Add detailed Appendix explaining the Amendment when available)

- A. As a first step toward the vision and sustainability of Maryland's current All-Payer Model, a Care Redesign Amendment has been proposed to CMMI. The scope of the Amendment is based on stakeholder feedback through the Care Coordination and Physician Alignment workgroups, as well as other stakeholder input.
- B. The Amendment is in progress, with expected approval by summer 2016 and staged implementation beginning in 2017.
- C. The Amendment is a flexible tool that will allow Maryland hospitals to create programs on an ongoing basis within the framework of the Amendment. The programs will be developed through Implementation Protocols that can change over time, which will provide flexibility by region or hospital. The Amendment will:
 1. Allow hospitals and their care partners to access comprehensive Medicare data and beneficiary-identified Medicare data to accelerate a broader, more intense focus on care coordination and total cost of care.
 2. Provide needed regulatory flexibility to implement hospital care redesign under the program framework outlined in the Amendment. This will allow for supporting payment mechanisms to align hospitals and physicians, as well as other community providers. The initial focus is on improved episodes of care, especially for patients in need of complex and chronic care. Over time, additional care redesign and alignment

- programs will be implemented based on patient, delivery system, and payer needs and input.
3. Create increased awareness of total cost of care, promote delivery system transformation, enable supportive payment mechanisms, and give Maryland a path to ease into the next phase of the All-Payer Model.
 4. Provide a potential opportunity for the All-Payer Model to qualify for MIPS and MACRA Advanced APM status through Maryland-specific programs. The programs will offer a pathway for physicians and other providers in different settings to qualify for the additional funding under MACRA. The programs will be designed to align incentives, promote accountability and success, and drive clinical redesign initiatives that improve outcomes while controlling cost.
- D. In order to achieve this flexibility and gain approval of these programs, the State will be required to take on significant administrative functions, while CMS will retain significant monitoring and oversight. The Progression Plan will need to address the development of these resources.

IV. Dual Eligible Model in the Context of the All-Payer Model

(Note: Add detailed Appendix explaining the Dual Eligible Model when available)

- A. A Dual Eligible Model is currently being designed through a CMMI SIM award. Its implementation will coincide with the next phase of the All-Payer Model in January 2019.
- B. The Dual Eligible Model is expected to limit the per-beneficiary total cost of care growth rate for both Medicaid and Medicare costs for beneficiaries in the model.
- C. The Dual Eligible Model and the All-Payer Model Progression will need to be aligned and interoperable. Therefore, the design of both models will have significant implications for every other model in the Progression Plan and potentially for current models in the state, such as ACOs.
 1. Dual Eligible beneficiaries across all care delivery models will need to be actively identified and managed.
 - a. Dual Eligible beneficiaries are included in ACOs, PCMHs, and other models, but are currently not recognized, and coordination with the state is virtually non-existent.
 2. Healthcare delivery and payment models proposed in the progression plan will need to be aligned with the Dual Eligible Model, including addressing:
 - a. Total cost of care guardrails for both Medicare and Medicaid; and
 - b. Data exchanges, reporting requirements and overall benefit management.
 3. Infrastructure that is built to support the All-Payer Model must include Medicaid functional connections and data for both Medicare and Medicaid for Dual Eligible beneficiaries.
 - a. CRISP functionality and transformation support will need to include Medicaid for Dual Eligible beneficiaries.
 4. Decisions will be made regarding Dual Eligible beneficiaries in current healthcare delivery models in Maryland, such as ACOs. Some options being considered include:

- a. Option 1: ACOs take some financial responsibility for Medicare and Medicaid total cost of care.
- b. Option 2: ACOs may be required to undergo certain rules changes or be required to relinquish Dual Eligible members over time.

V. Model Progression Plan: Purpose

(Note: Open for discussion—additions, deletions, edits)

- A. Lay out a plan for the State to make health care more affordable, continuing to improve the health of the population and improve consumers' engagement in and experience of their care. Support Maryland's efforts to create a more efficient and effective healthcare system through coordination of care centered around the patient, leading to better health outcomes and lower spending.
- B. Meet CMS requirement for development of an All-Payer Model Progression Plan by December 31, 2016 that will expand the focus of the Model, at a minimum, to limit the growth in Medicare total cost of care.
- C. Create alignment and interoperability with the Dual Eligible Model, which will improve care and limit the growth in both Medicare and Medicaid total cost of care for Dual Eligible beneficiaries.
- D. Lay out a strategic plan for the progression of Maryland's healthcare system transformation with supporting mechanisms for the remaining two years of the current All-Payer Model Agreement and the anticipated five or more years of a subsequent model.
- E. Submit a high-level blueprint of potential strategies for care redesign, payment mechanisms, and other supporting tools that extend beyond hospitals, allowing for continued success under the All-Payer Model while accelerating the focus on more comprehensive goals and models.
- F. Propose a phased approach that will allow more responsibility for care, health outcomes, and system wide cost containment.
- G. Commit to timeframes by which specific types of models and implementation plans will be considered beginning in 2017, as each phase of the strategy is developed.
- H. Fully leverage MACRA opportunities for all Medicare providers through the building and staging of models and negotiations with CMS.
- I. Outline the commitments that will be needed from CMS to support the plan, including data, approvals, waivers, MACRA alignment, and implementation support.
- J. Lay out how existing and developing payment and delivery models (e.g. hospitals with global budgets, ACOs, medical and health homes, and alignment programs that include community and other non-hospital providers) can work together to build infrastructure and support transformation.
- K. Use stakeholder input from a broad set of representatives to develop the plan, the timeframes, the strategies, and implementation plans for each model.
- L. (Open for additions)
- M. (Open for additions)

VI. Model Progression Plan: Current Landscape Analysis

(Note: Open for discussion—additions, deletions, edits)

A. Current strengths:

1. Under the current All-Payer Model, Maryland has responsibility for hospital payments, which account for 56 percent of Medicare payments in Maryland. For the remaining 44 percent of Medicare spending, Maryland has a guardrail to protect against cost shifting.
2. A variety of healthcare delivery and payment initiatives are either underway or in development in Maryland. These include: global budgets and geographic based initiatives; ACOs; Patient Centered Medical Homes (PCMHs); the federally-sponsored CPC+ or a broader Maryland variant of a similar multi-payer approach to support primary care practice transformation to tailor care and care management based on patients' needs; and other approaches.
3. The hospital regulatory infrastructure and Maryland's designated Health Information Exchange (HIE), Chesapeake Regional Information System for Patients (CRISP), are well developed.
4. Current stakeholder engagement and participation has significantly contributed to the initiatives that have driven the success of the All-Payer Model. Stakeholder engagement continues with the development of the Care Redesign Amendment, the Progression strategy, and many other initiatives that are driving the transformation of the delivery system in Maryland.
5. (Open for additions)
6. (Open for additions)

B. Current challenges:

1. Though the current All-Payer Model has direct financial risk for hospital services, there is a need to address the remaining 44 percent of Medicare cost (non-hospital), which is not included in the global hospital budgets. This is particularly important as non-hospital costs are increasing. Total cost of care is important to the State and CMS to assure the goals of controlling the growth in spending.
2. The State does not yet have strong alignment tools and programs to overcome the fragmentation between the global budget revenue payment model and the largely fee-for-service payment model for physicians, post-acute and long-term care facilities, and other community providers.
3. The infrastructure and governance for non-hospital costs has not been developed.
4. Maryland providers lack the necessary Medicare data and alignment tools to promote care coordination, monitor key metrics, and effectively move towards total cost of care goals.
5. Consumer education and engagement need more defined plans.
6. (Open for additions)
7. (Open for additions)
8. (Open for additions)

VII. Model Progression Plan: Design Principles

(Note: Still under discussion by Advisory Council)

- A. Based on stakeholder input, the following principles will guide the development of the Progression Plan and the models set forth in the Plan:
1. **Ensure Initiatives Are Person-Centered:** Care delivery should be person-centered, tailoring and integrating care across the system and into the community. Social determinants should be addressed and health equity should be achieved for all Maryland residents.
 2. **Promote Shared Responsibility:** Maryland providers, payers, consumers, and accountable entities should take increasing responsibility for outcomes and costs of the population's health and health care over time.
 3. **Ensure Quality of Care and Stakeholder Satisfaction:** Mechanisms will be used to promote understanding of, and contribution to, the management of quality and patient, family, and provider satisfaction. Appropriate metrics will be used to monitor quality and satisfaction in meaningful ways as each step of the progression plan is implemented.
 4. **Focus on Medicare Total Cost of Care:** Total cost of care for Medicare is a main focus for Maryland's health care system in the near term. This is not only because Maryland's All-Payer Model Agreement calls for a plan relative to Medicare, but also because Medicare patients have a greater need for care management supports with coordination across the system. Currently, care management supports are inadequate under the dominant Medicare fee-for-service system in Maryland. Mechanisms will be used to promote understanding of, and contribution to, the management of each patient's total cost of care with a focus on enhanced coordination and improved quality. Appropriate metrics will be used to monitor total cost of care as each step of the progression plan is implemented.
 5. **Focus on Medicare and Medicaid Total Cost of Care for Dual Eligible Beneficiaries:** Total cost of care for Medicare and for Medicaid will be a focus for Dual Eligible beneficiaries. Dual Eligible beneficiaries in every model will need to be actively identified and managed. Each model will need to include a formal coordination relationship with DHMH. Infrastructure that is built to support the All-Payer Model must include Medicaid functional connections and data for both Medicare and Medicaid for those programs that include Dual Eligible beneficiaries.
 6. **Consider Cost Shifting:** As new models are designed and current models are refined, a primary focus will be on creating care redesign processes and supporting payment structures that do not result in pure cost shifting, but rather adjust payments as services are moved to more appropriate, lower cost care settings.
 7. **Targeted Care for High Needs and Rising Risk Patients:** Models will first focus on high needs and rising risk patients with multiple chronic conditions, with a particular focus on Medicare. Patients with high needs can more quickly benefit from these supports. Improvements for these patients will result in reductions in avoidable hospitalizations. It will also focus resources on populations with health disparities.
 8. **Continued Commitment to All-Payer Principles:** The hospital model will continue to operate on an all payer basis, continuing to recognize the possible need for adjusting

the Medicare payment differential if Medicare performance levels cannot be synchronized with all payer performance levels. For Total Cost of Care, though Medicare will be a priority, a commitment to all payer principles will be maintained through a focus on implementing models and performance measures that can be applied across payers and accountable entities, at an appropriate time, with the right conditions. This is important to help drive system transformation, increase administrative efficiency, and reduce hassle for providers.

9. **Encourage Multiple Initiatives with Aligned Goals:** Multiple initiatives and accountability approaches will be tested to allow for flexible adoption of models and to understand what the best models are for Maryland consumers in the context of its unique healthcare system. These efforts will be designed to leverage each other, and align with each other.
10. **Develop Concrete Initiatives within Appropriate Timeframes:** Maryland will build on its existing efforts and focus on concrete initiatives that can be accomplished within the timeframes of the All-Payer Model (e.g. to meet the needs for cost containment to achieve Medicare savings both prior to 2019 and shortly thereafter). A focused approach will be used to ensure that models can be executed within timelines set by stakeholders. In implementing new approaches, it may take time to achieve savings or other outcomes. Maryland should work with CMS to ensure that this is recognized when assessing responsibility for total cost of care and outcomes under the All-Payer Model.
11. **Enhance Supportive Infrastructure:** Infrastructure and information should be built or bought to support transformation initiatives. Input will be sought to determine the best approaches to investments and implementation using a utility approach only where it improves outcomes or lowers costs. Serious consideration will be given to the expanded use of common infrastructure, including the State's HIE and care management tools, by hospitals and other providers to achieve cost effective outcomes.
12. **Share Financial Responsibility Among Payers:** CMS and other payers should continue to bear financial and outcomes responsibilities. As CMS implements new payment models and demonstrations, CMS should initially take an agreed amount of responsibility for those investments, with ongoing evaluations to ensure that programs are meeting predefined goals. CMS should retain some level of responsibility for total cost of care. Inside of CMS risk corridors and responsibility, Maryland should explore other mechanisms to reduce high or unmanageable risk through risk corridors and other mechanisms that limit the risk for Maryland and its providers.
13. **Foster Strong Partnership with CMS:** It is important that CMS work closely in partnership with the State to support effective model development, implementation, and transformation. This includes approving model enhancements and new complementary models in a timely manner, providing data to the providers with financial risk for savings and performance outcomes in advance of the start of any new model, and working with the State to align the All-Payer Model with MACRA eligibility or other value-based-purchasing needs. This will ensure that providers have tools needed to: 1) support planning, implementation, and transformation; and 2)

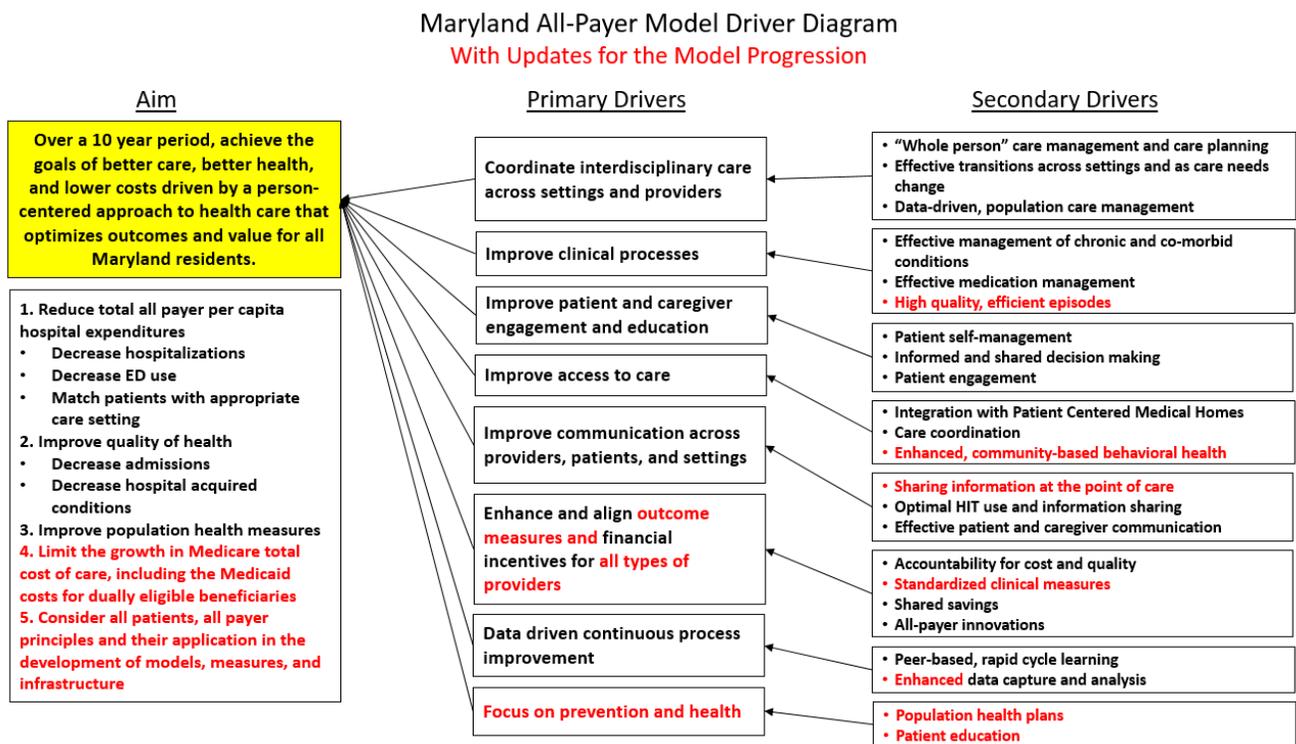
plan for and use meaningful and actionable data for multiple purposes, including analysis, planning, care management, point-of-care decision-making and care delivery.

14. **Expand Stakeholder Input in Governance:** Mechanisms to support inclusion of additional provider groups should be considered, including an advisory board for the purposes of developing policies among hospitals, physicians, and community-based providers. A Consumer-Standing Advisory Committee will be used for these purposes as well.
15. (Open for additions)
16. (Open for additions)
17. (Open for additions)

VIII. Model Progression Plan: Elements

A. This section will be completed based on the information in the Progression Strategy Presentation that will be discussed at the August 1st Advisory Council meeting.

IX. Updated Driver Diagram



X. Timeline

Note: Still needs to be worked through