Proposed Principles: All Payer System Model Proposal

The following principles, initially proposed by the Maryland Women's Coalition for Health Care Reform (Coalition),[1] are intended to provide a framework for the deliberations of the All Payer Hospital System Modernization Council (Council). The Coalition recognizes the intrinsic value in the realignment and reformation of the health care delivery system that is at the core of the All Payer System Model Proposal (Model). We also recognize that this must be developed within the context of other health care reform initiatives that include, but are not limited to the implementation of the Patient Protection and Affordable Care Act (ACA) with the Maryland Health Benefit Exchange (MHBE); the State Health Improvement Process (SHIP), and the State Innovation Model/Community Integrated Medical Home (SIM/CIMH).

To achieve success on any one of these is a large undertaking, but taken together they represent a unique opportunity but they also pose daunting challenges. As the Health Services and Cost Review Commission (HSCRC) and the Council work with the Department of Health and Mental Hygiene (DHMH) and others to design and implement these initiatives we hope that they will consider the following seven principles[2]. These can be used to not only guide the initial decision-making but also to serve as standards against which to measure success.

1. Core Principle: Ensure Transparency and Meaningful Public Input.

The initial design of the Model and its ultimate success can only be achieved by incorporating the expertise of the broad and diverse constituency that will be impacted by it. This will build confidence in the Model itself and create a two-way channel for communications. To support this principle, the Coalition recommends the creation of a standing committee with a broad-based membership that includes patients and consumers, consumer advocates, and community health care and social service providers. Members should have expertise with diverse and vulnerable populations and should have a particular focus on continuity in the delivery of high-quality care that meets the needs of individual consumers.

2. Core Principle: A Patient and Family Centered Model.

The Institute of Medicine (IOM) defines patient-centered care as, "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." To support this, the goal to lower health care costs must be tied to increasing the quality of care with patient-centered initiatives that promote the Triple Aim. Therefore, the Model should be designed to encourage prevention practices and healthier life

[1] The Principles, submitted on 20 November 2013, will be shared with the Coalition's partners for the purpose of gaining further feedback and signatories.
[2] Similar principles have been proposed for the SIM/CIMH

styles; and embrace shared decision-making among the patient and their families, their provider(s); and the community.

Recommendation:
The principle of shared decision making should be incorporated to ensure that medical care better aligns with patients' preferences and values as new models of care are developed that will fundamentally change how patients access care. This must have a goal of informing and empowering patients.

3. **Core Principle: Data-Driven Design, Implementation and Evaluation.**

The success of the Model's design and implementation will be driven by evidence-based measures with data that is derived from effective performance standards. These must be predicated on well-formulated goals that include not only the reduction in health care costs, but improved and positive outcomes for the health of Maryland's population that include a decline in health disparities.

A robust evaluation process, built upon these performance measures, should be integrated into each phase from development through implementation and on-going operations.

Recommendations:
a. Appoint a work group of consumer advocates, public health experts, and clinicians with appropriate expertise or knowledge to be actively engaged in the evaluation process.
b. Set a reasonable timetable that includes time for community input.

4. **Core Principle: Safeguard Vulnerable Populations.**

All delivery system reforms must reinforce access to culturally competent providers and those with the expertise and experience to effectively provide appropriate care to vulnerable and hard to reach consumers.

5. **Core Principle: Focus on Coordination Of Care.**

To support this goal, health care services can, and should, be coordinated regardless of any financial or contractual arrangements on the part of the provider(s). Several strategies should be considered to achieve this.

***Recommendations*:**
The health care team must be able to clearly identify a well-defined care coordination process for patients with either acute and/or chronic conditions. Care coordination should be the responsibility of a health care practitioner or practitioners depending on the primary provider's capacity for broad care coordination.

a. Coordinated, team-based care must occur across people, specialties, functions, activities, locations and time.
b. Patients must also actively participate in coordination of care through demonstrable interactions with providers and/or care coordinators and, where appropriate, relevant community resources, whether done face-to-face or via information and communications technology.
c. Clinical decisions should ultimately be made by the patient and provider. Care coordination should serve to support those clinical decisions beyond the walls of health care institutions and providers offices.

6. Core Principle: Incentives Designed To Develop A Comprehensive Continuum Of Care.

Delivery system redesign must have incentives that encourage health systems to invest in the needed levels of care that provide patients a comprehensive array of health services spanning all levels of intensity of care.

7. Core Principle: Robust Complaint, Grievance And Appeal Process.

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he Model may result in restricting access without an appeal process. Therefore there needs to be a clear articulation of patient rights and a process for submitting complaints, grievances and appeals. These safeguards must be in place before changes are made to the waiver. Consumers must have clear avenues for the handling of grievances, complaints and appeals for matters concerning access and quality of care.

> ***Recommendation:*** Designation of a single State agency is required to handle these types of complaints. Currently, the existing avenues for consumers to file complaints are relatively inaccessible and sometimes challenging, especially for those with complex medical and social needs.

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