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** that will be provided to CMS by December 31, 2016.

This is a **working document** with some draft content provided to aid discussion and development. This document is an attempt to reflect the vision that was set forth in the initial application of the All-Payer Model that was implemented January 1, 2014, as well as the recommendations by the Advisory Council, multiple work groups (e.g. Physician Alignment, Care Coordination and Patient Engagement workgroups), and other stakeholder feedback that has been collected since January 2014. The continued progression under the existing Model and additional developments will need to be laid out in the strategic plan.

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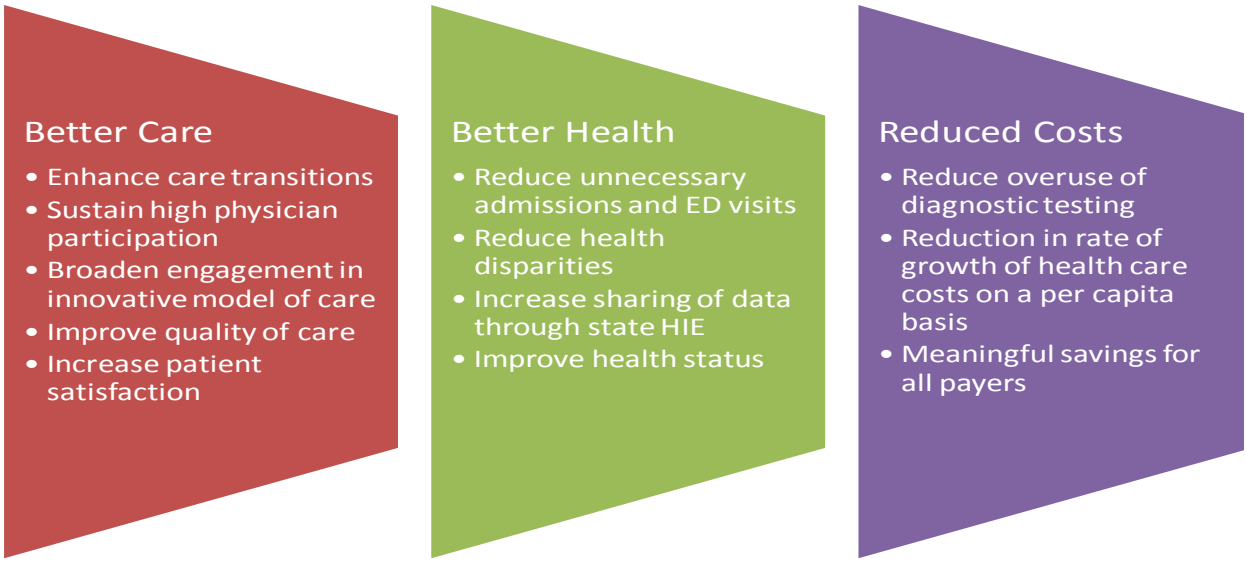
I. Background

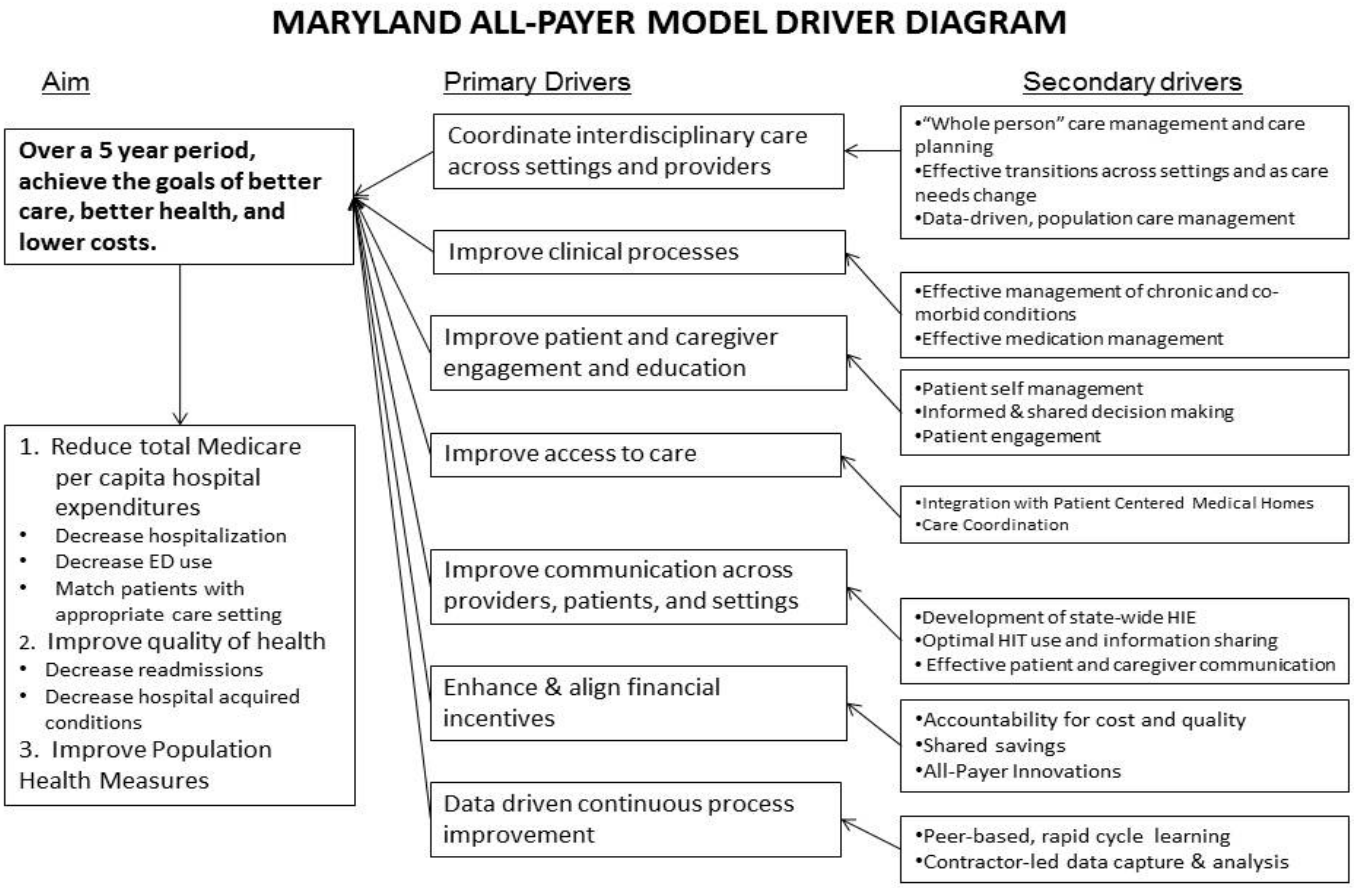
A. **All-Payer Model goals**: In September 2013, Maryland submitted a plan for a new All-Payer Model. The goals of the All-Payer Model were to:

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 health care systems.
3. Improve the health and health care 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, developed as part of Maryland's original application for a new All-Payer Model, depicts the system components (i.e. drivers) required to accomplish the specific aims of the All-Payer Model, implemented in January 2014. This framework describes 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.

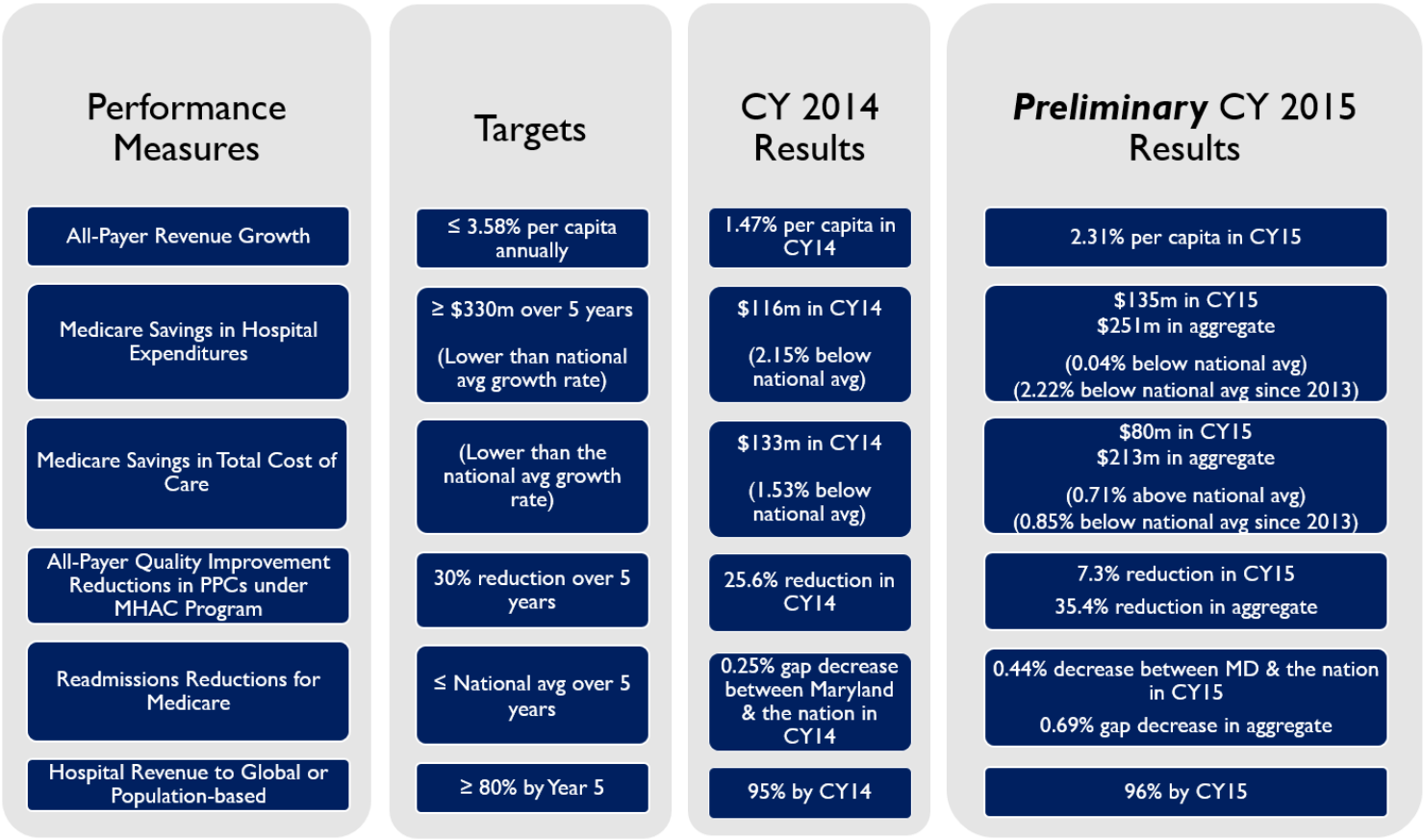


Source: Final All-Payer Model Application

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 (see Chart 1 below). Federal updates to Medicare rates for CY 2014 and CY 2015 were very low. 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. While Maryland is still ahead of its savings requirements, this trend indicates the need for increased implementation of care redesign in alignment with non-hospital providers that will enhance care while reducing potentially avoidable hospitalizations. It also indicates the need for increased focus on TCOC. Hospitals

and other providers need access to TCOC data to design effective interventions and monitor results. They also need identifiable claims detail to operationalize implementation.

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



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 expected in the near and long-term future.

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 changes the basic payment methodology for Medicare providers to a value-based, instead of volume-based, method.
3. Comprehensive Primary Care Plus (CPC+), an advanced primary care model aimed at creating a multi-payer approach to using medical homes, 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 for the provider community to take accountability for patient care with some level of down-side financial risk.
5. CMS' Chronic Care Management fee, aimed at creating a medical home for Medicare patients with chronic and complex conditions.

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 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 work on ways to make the All-Payer Model successful and sustainable, and to define Maryland's vision for progression.

B. The following vision for Maryland's future was discussed:

> 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 patients to participate in decisions about their treatment, 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 mid-summer 2016 and implementation beginning in 2017 with a staged approach.

C. The Amendment is a flexible tool that allows Maryland 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 some flexibility by region or hospital. The Amendment:

1. Allows hospitals and their care partners to access unidentified comprehensive Medicare data and beneficiary-identified Medicare data to accelerate a broader, more intense focus on care coordination and total cost of care.
2. Provides approvals to implement care redesign and possible supporting payment mechanisms that create alignment between hospitals and physicians as well as other community providers. The initial focus is on improved episodes of care as well as complex and chronic care. Over time, redesign and alignment programs will be added based on patient, delivery system and payer needs and input.
3. Creates the next steps toward total cost of care, delivery system transformation, and supporting payment mechanisms, giving Maryland a path to ease into the next phase.

4. Leverages the opportunity to qualify for MACRA APM status, anticipating federal MACRA requirements by advocating for and creating Maryland-specific programs that offer a pathway to risk for large numbers of diverse clinician types in different settings. These programs will align incentives, promote clinician 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 strategic plan will need to address the development of these resources.

IV. Model Progression Plan: Purpose

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

A. Lay out a plan for the State to make healthcare affordable, continuing to improve the health of the population and improve patients' experience of care. Support Maryland's efforts to create a more efficient and effective health care system in Maryland 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's total cost of care.
C. Lay out a strategic plan for the progression of Maryland's health care 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.
D. Submit a high-level blueprint of potential models 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.
E. Propose a phased approach that will allow more responsibility for care and health outcomes and controlling system wide cost growth.
F. 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.
G. Outline the commitments that will be needed from CMS to support the plan, including data, approvals, waivers, MACRA alignment, and implementation support.
H. Lay out how payment and delivery models (e.g. hospitals with global budgets, ACOs, medical homes and alignment programs) can work together to build infrastructure and support transformation.
I. Use stakeholder input from a broad set of representatives to develop the plan, the timeframes, the models, and implementation plans for each model.
J. (Open for additions)
K. (Open for additions)
L. (Open for additions)

V. 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 models 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. (Open for additions)
5. (Open for additions)
6. (Open for additions)

B. Current challenges:

1. The current All-Payer Model has direct financial risk for hospital services. A focus on the total cost of care is important to the State and CMS to assure the goals of controlling the growth in spending.
2. There is a need to address the remaining 44 percent of Medicare cost that is not in the global hospital budgets, and do so in a way that is synchronized with the global hospital budgets and all payer values.
3. 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. Non-hospital costs are increasing. Some portion of those cost increases, particularly post-acute costs, could be attributed to the model implementation.
4. Maryland providers lack the necessary Medicare data and alignment tools to promote care coordination and monitor and effectively move towards total cost of care goals.
5. The infrastructure and governance for non-hospital costs has not been developed.
6. (Open for additions)
7. (Open for additions)
8. (Open for additions)

VI. Model Progression Plan: Guiding 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. **Person-centered care**: Care delivery should be person-centered, tailoring and integrating care across the system and into the community. Social determinants should be addressed.
    2. **Shared responsibility**: Maryland providers, payers, and accountable entities should take increasing responsibility for outcomes and costs of the population's health and health care over time.
    3. **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 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 in the system, which are currently 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 across the system. Appropriate metrics will be used to monitor total cost of care as each step of the progression plan is implemented.
    4. **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.
    5. **All-Payer principles**: 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.
    6. **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.
    7. **Concrete initiatives**: Maryland will build on its existing models 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).
    8. **Multiple approaches**: Multiple models and accountability approaches will be tested to allow for flexible adoption of models within the limits of reasonability, and to understand the best models for Maryland patients in the context of its unique health care system. Models will be designed to leverage each other, and in some cases align with each other. 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.

9. **Transformation Support**: 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.
10. **Payer involvement**: CMS and other payers should continue to bear financial and outcomes responsibilities. As CMS implements new payment models and demonstrations, it should initially take an agreed amount of responsibility for those investments, with ongoing evaluations to ensure that programs are meeting their expectations. 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.
11. **CMS commitments**: 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 support planning, implementation, and transformation, and to plan for and use meaningful and actionable data for multiple purposes, including analysis, planning, care management, point-of-care decision-making and care delivery.
12. **Expansion of governance and stakeholder mechanisms**: 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.
13. (Open for additions)
14. (Open for additions)
15. (Open for additions)

VII. Model Progression Plan: Elements

Note: Still needs to be worked through

VIII. Updated Driver Diagram

Note: Still needs to be worked through

IX. Timeline

Note: Still needs to be worked through