The Implementation and Future Direction of Maryland's All-Payer Model

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

July 2016

Table of Contents

Executive Summary

Statement of Purpose

This report provides advice from the Advisory Council to HSCRC and DHMH as they work on an approach for the strategic plan that is scheduled to be submitted to CMS by December 31, 2016 in accordance with All-Payer Model Agreement. The Council views their role as one of offering ongoing advice to these Maryland agencies throughout 2016. As new information becomes available, and the Council continues its deliberations, updates may be added. Thus, the Council will continue to search for as many areas of consensus as possible, and where alternative perspectives remain, these will be shared with HSCRC and DHMH.

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 highlights the achievements to date after two and a half years of experience with this model, and presents 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. The following recommendations flow from our meetings to date:

Recommendation 1: Maintain focus

The Council stresses the need for selecting a few key objectives and focusing attention on making substantial progress toward these objectives. It is important to avoid being stretched too thinly and tackling a bevy of comparatively small projects in a scattered and uncoordinated way (see section on page 8).

Recommendation 2: Retain the All-Payer System that is benefiting all parties in Maryland

The Council stresses that all parties in Maryland, public and private, are benefitting from the All-Payer Model and therefore, this model should not be placed in jeopardy. Maryland has committed to achieving very substantial goals over a five-year period (e.g. holding the growth of total hospital costs per capita to no more than the growth of the State's economy and ensuring Medicare at least $330 million in cumulative savings), and is performing well on meeting those goals. The addition of new tests of compliance or new cost control elements not included in the current agreement, even as Maryland continues to meet its cumulative savings targets, could jeopardize the success of the All-Payer Model. Such new elements should be considered on their merits without committing the State to adopt them as-is.

A top priority should be to retain and extend the All-Payer Model while Maryland develops and experiments with additions to the Model. All stakeholders benefit from the continuation and success of this model, and all should therefore share in the obligations needed to achieve the strong cost control built into the Model (see section on page 8).

Recommendation 3: Set targets, allow considerable flexibility in meeting them

The State should play the important roles of a facilitator and a convener, with innovations emerging from private sector initiatives. The State should set clear targets, leaving ample flexibility for the key stakeholders in the health system to design their own initiatives that best meet those targets.

This is a long tradition in Maryland's hospital regulation, and should be continued as the All-Payer Model moves into new phases. Any favorable performance versus these targets should be viewed as an indicator of success, leaving no uncertainty in what is being asked of providers (see section on page 9).

Recommendation 4: Ensure person-centered care and consumer engagement

Engaging consumers in health care delivery design and personal decision-making can produce substantial and enduring benefits for the individual, community, and overall health system. These benefits include improved understanding of health conditions, treatment options, and how to access services; improved relationships with providers; improved experience and satisfaction with care; personal sense of value and ownership; high-quality care; and an informed, responsive, and more efficient health care system.

Consumers should have an active voice in decision-making and have access to medical and social services on a timely basis. Meaningful consumer engagement requires provider engagement (see section on page 13).

Recommendation 5: Acquire data

The Council believes that timely access to 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. Now that Maryland has reached 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 that the federal government provide timely updates of data required to identify such patients, their utilization patterns, diagnoses, and other vital information. This is a top priority recommendation (see section on page 15).

Recommendation 6: Coordinate accountability

The Council recommends that Maryland continue to develop a plan for system-wide accountability for quality improvement and long-term cost control. 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 coordinate these initiatives, and synchronize or link these programs. Thus, the Council is calling for the "harmonization" of these programs, to develop system-wide accountability.

It is also important to link the providers inside the health care system to community-based organizations to address the factors frequently driving people into the health care system (see section on page 16).

Recommendation 7: Foster alignment

The Council believes that alignment of incentives across providers is vital. If some provider organizations have incentives to reduce avoidable 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 antiquated incentive programs, the 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 (see section on page 20).

Recommendation 8: Modernize governance and regulatory oversight

As we work to redesign and improve the care delivery system in Maryland, we need to modernize the regulatory and oversight system so that it is synchronized. Changes in the oversight and governance of health care should keep pace and be aligned with changes in care delivery (see section on page 27).

Background

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 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. A list of the current Advisory Council members appears in Appendix A.

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.

Final results for the full year 2015 are not yet available, although preliminary final results show that all-payer revenue growth was 2.31 percent per capita, and Medicare savings in hospital expenditures totaled $135 million, bringing the two-year Medicare savings to about $251 million.

Recommendations from the Council's first report

The Council issued its first report on January 31, 2014.[1] Below are the recommendations from that report:

1. Focus on meeting the early Model requirements

1.1 The Advisory Council recommends that the HSCRC prioritize implementation initiatives that contribute to meeting the All Payer Target hospital per capita spending growth rate and the Medicare savings target in the first two years of the proposed model.

1.2 To ensure that the state is on track in meeting the tight goals, it will be necessary to develop a clear timetable, interim milestones, key benchmarks, and periodic assessments of progress.

[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.

1.3 Global payment methods for Maryland hospitals should be the tool of preference to assure revenue controls.

1.4 Success under global payment methods will feature the ability to reduce avoidable utilization through better care.

1.5 It will also be important to monitor access and quality challenges regarding health services that will likely shift from hospitals to other settings, such as skilled nursing facilities, ambulatory surgery centers, and others that are not under the HSCRC authority to regulate.

2. Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation

2.1 The Advisory Council urges the HSCRC to strike a balance between near-term cost control, which is paramount, and making the required investments in physical and human infrastructure necessary for success. If we do not meet the near-term targets, there will be no long-term program. But if we fail to make the needed infrastructure investments, we will not have the toolkit of reforms necessary to achieve lasting success.

2.2 Given the challenging targets in this initiative, goals should be set in the aggregate as close to the targets as practicable based on the degree of comfort that individual institutional targets will be met.

2.3 There should be incentives for hospitals to meet and exceed the challenging targets of the new model; hospitals should be able to retain and reinvest a high percentage of their savings.

2.4 A portion of the savings that hospitals achieve could be reinvested into "common good" investments. But given the tightness of the revenue caps under the new model, a new and secure funding source for this type of infrastructure is also essential.

2.5 HSCRC, other State agencies, and private sector leaders should build the data infrastructure needed to ensure waiver success. Specific tasks include:

- Lead data collection efforts
- Ensure open access to data by all stakeholders
- Lead data analytics to monitor waiver metrics;
- Assess policy impacts;
- Guide clinical decision making

2.6 Within the context of per capita growth ceilings on hospital spending, HSCRC should allow considerable flexibility for the health care sector to implement its own strategies for achieving the desired results while recognizing the importance of following evidence-based best practices and the potential value of some standardization.

2.7 The consensus of the hospital industry should have a significant weight in policy development

3. HSCRC should play the roles of regulator, catalyst, and advocate

3.1 HSCRC should play three key roles as it strives to make the new model work: *effective regulator, a catalyst for needed reforms, and an advocate* within the state and to the federal government for the support needed to ensure success.

4. Consumers should be involved in planning and implementation

4.1 The HSCRC should actively engage consumers and their representatives to participate in implementation activities.

4.2 Guard against under-use of health services.

4.3 Incorporate quality improvement and patient safety goals into the overall plan

5. Physician and other provider alignment is essential

5.1 Physician engagement and alignment must be strong enough and occur early to support the goals of population-based and patient centered models.

5.2 The HSCRC should charge a workgroup to develop specific recommendations on strategies that align incentives among hospitals, physicians and other providers.

5.3 HSCRC should advocate for arrangements in which physicians can share in the savings achieved by hospitals under the new Model. This could involve pay-for-performance arrangements as well as formal shared-savings arrangements. The State should apply to OIG at HHS to permit gain-sharing arrangements between hospitals and physicians.

6. An ongoing, transparent public engagement process is needed

6.1 The Advisory Council supports the establishment of Work Groups to address technical and operational issues.

Framework for this Report

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

- Vision
- Roadmap, Progression, and Focus
- Person-centered care
- Data
- Accountability
- Alignment
- Governance

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 volume toward rewarding value and continuous performance improvement. Improving the health of the population should be a key goal; progress toward this goal can be made 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.

The Council believes that the All-Payer Model is of huge value to the entire State of Maryland and that it must be retained as long as it is consistent with the HSCRC's statutory mandate to provide adequate resources to allow well-managed hospitals to generate adequate operating margins. The benefits accrue to both the public and private sectors; all stakeholders stand to benefit from the continuation and success of this Model, and all should therefore share in the risks that are inherent in the strong cost control built into the Model.

We also need a more dynamic system that accounts for both population aging and patients' use of more than one facility. This mobility may call for moving toward a geographic model of care as well as "right-sizing" health care capacity—buildings, equipment, work force, and other resources—to meet the new realities. In other words, if we are successful in reducing avoidable hospital care, we need to adequately reward those who contribute to that success. We also need to bring reforms in other sectors that correspond to those we are already making in hospital care and payment.

This effort should be led by leaders in the Maryland health care system. The State should play the important role of a facilitator, with innovations emerging from private sector initiatives. The State should set clear targets, leaving ample flexibility for the key stakeholders in the health system to design their own initiatives that best meet those targets and giving them adequate time to realize the results of the investments they make.

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, increases the quality of, and consumer satisfaction with, care, and drives a more efficient and effective health care system. Improving health equity is also an important goal in Maryland.

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

Roadmap, Progression, and Focus

The Advisory Council believes that Maryland needs a clear roadmap going forward, with key milestones and a timeline.

Maryland needs to demonstrate that the current All-Payer Model is both successful and sustainable. To ensure that the State is making substantial progress toward this goal, it is important to define what constitutes success at particular points along the timeline. The State should evaluate the current All-Payer Model annually to determine progress toward success and sustainability.

Maintain Focus

The Advisory Council strongly emphasizes the need to focus efforts to achieve the vision presented above on a few realistic and achievable goals. The Council warns against a "scattershot" approach in which many 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 supports concentrating care management efforts first and foremost on the estimated 800,000 fee-for-service Medicare patients in Maryland; particular emphasis should be placed on the members of this population with complex medical needs. Additional care management supports are needed for the population 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.

While it is important to target resources to people with high health care needs, such patients are certainly not all in Medicare and Medicaid. Patients with complex medical needs can be found in the Veterans Administration's health care system, the Maryland Children's Health Program, people with private health coverage, and the uninsured. In fact, widely prevalent problems such as obesity, diabetes, asthma, depression, substance use, and the misuse of medications cut across various age, coverage status, and other characteristics. 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. Some of 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 and professional advice on how to remain healthy over time.

Retain the All-Payer System that is benefiting all parties in Maryland

Maryland quickly made excellent progress in placing hospitals under global budgets. Some members of the Council believe that Maryland now faces two key challenges: (1) aligning incentives among hospitals, physicians, and other providers; (2) "moving upstream" along the continuum of care to address the forces driving people into hospitals; and (3) improving the health of the State's population. In their view, 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.

Other members of the Council believe that the early progress made by hospitals under the global budget system, combined with expected progress from the care transformation investments made

by hospitals and health systems, will allow Maryland to continue to make progress on meeting or exceeding the targets set by CMS. Therefore, it may be premature to put in place additional system-wide changes and requirements. As the gains from the hospital investments are realized and protected, new innovations could be considered, each on its own merits, provided that they support, rather than jeopardize, the success that Maryland is achieving under the All-Payer Model agreement.

Set targets and allow flexibility in meeting them

The most important target is to improve health and make health care affordable for all residents of Maryland. To do that, Maryland has set targets under the All-Payer Model that tie hospital spending increases per capita to the per capita growth in the State's economy along with targets for reducing potentially avoidable care. This requires both screening and prevention and the delivery of high-quality health care across the whole population.

The Council also believes that Maryland should set 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. HSCRC can set the goals, keep score, and provide the ground rules under which hospitals operate. At the same time, providers and payers will want the flexibility to manage their business most effectively. It should be noted that the Council supports setting quantitative goals for cost and quality but does not support setting goals for the automatic adoption of particular models in the exact form in which they are presented. While we stress the needed flexibility for providers and payers to forge their own initiatives to meet state-determined targets, HSCRC's role consists not only of setting targets, but also carefully monitoring the impact of implementation on consumers under the All-Payer Model. It is important to be alert to the dangers of under-use of services, which balances the important thrust of the All-Payer Model in averting avoidable and unnecessary use of services. This goal can be fostered by changing incentives to reward the avoidance of under-use as well as avoiding unnecessary and inappropriate care. Where inadvertent harmful reductions in use may be detected, swift and effective follow-up is important.

Develop a progression plan

There is a need for 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 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 on achieving them. This roadmap should include the sequence and scale of actions and reforms that are needed.

Maryland needs a good sense of the *progression* of the work, with one set of accomplishments leading to another set of activities. The State needs a map in which it builds 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 it 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.

Prepare 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 primarily 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.

The following discussion highlights the Council's viewpoint that calls for balancing the need to meet the deadline for submitting the Phase 2 plan to the federal government with the need to preserve and build on the progress that has been made to date in implementing the current agreement between Maryland and CMS. The ensuing discussion also highlights several important points on which there remain some differing viewpoints among the members of the Council. The Council will continue to discuss and debate these alternative approaches as it advises HSCRC and DHMH going forward.

Balance the need to meet the year-end deadline for submitting a plan with the need for flexibility in implementing the plan

Maryland has a 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. Some members suggest holding off on incorporating new cost control measures and programs in the Phase 2 plan, and instead concentrating on consolidating and protecting the gains to date and then later committing to additional cost control measures outside of the hospital sector when there is more assurance that the targets in the current All-Payer Model are being met.

Another viewpoint is to agree to build some reforms outside the hospital sector into the Phase 2 plan, but only in a way that does not hold the hospitals accountable for any shortfalls in meeting goals outside that sector. For example, if certain reforms in physician payment are built into the plan with specific savings targets, and the results fall short of what is expected or promised, the gap in expected savings should not be financed, in part or in total, by reductions in the growth in annual updates to hospital revenue caps.

There is considerable concern among some Council members with the pace of change required to meet the objectives and goals of Maryland's All-Payer Model. The Council had some debate about the speed with which Maryland should pursue additional reforms. Some members of the Council recognize the urgency of planning and implementing 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, which they believe could jeopardize the overall goals of the All-Payer Model by losing the need for tight focus, as mentioned earlier. This suggests that more time is needed for hospital reforms to take hold. Some Council members have also raised concerns about the bandwidth and resources required to move more quickly, as well as the risks associated with changing a $50 billion industry so dramatically. The Council will continue its deliberations about this issue.

There is also considerable debate about whether the submission at the end of 2016 should present a *specific model* for moving beyond the accomplishments achieved during the first five-year period, or a *plan for developing a model through testing and experimentation with alternative approaches.*

In summary, the challenge is to make the deadline for plan submission while preserving flexibility based on feasibility, proven results, work in progress, and stakeholder consensus.

Build on success achieved to date

The current All-Payer Model focuses on hospital cost control in a more comprehensive way than in prior years (controlling the growth of total hospital costs per capita versus controlling cost per admission). Under the Model, Maryland already has control over 56 percent of Medicare payments. Moreover, for the remaining 44 percent of Medicare spending, Maryland has a guardrail to protect against cost shifting.

Thus, a key challenge is how to develop and implement initiatives that address the remaining 44 percent of care that is not in the hospital orbit, and how to do so in a way that is synchronized with the global budgets for hospitals. An approach for meeting this goal is developed in sections below on physician alignment and post-acute care. As we do this, we need to recognize that reducing the cost of care in the hospital setting will be partially offset by higher spending in the non-hospital sector. Further, we need to be aware that investment in non-hospital spending may take time to show results and therefore should not, by itself, put the waiver at risk.

A variety of models are either underway or in development in Maryland. These include ACOs; patient-centered medical homes (PCMH); the federally sponsored CPC+ approach to incentives for physicians to manage the care of patients with complex care needs, or a more "Maryland customized" variant of this approach; value-based purchasing arrangements, and other approaches.

Moving forward, we will need to develop a timetable and consider how models and initiatives in the second five years of the All-Payer Model will progress. The most promising, evidence-based approaches to design and execute each model should be identified and used to inform model development. Models should complement existing hospital-led reform efforts and guide the development of future models. The feasibility of moving towards a "geographic model" should be assessed.

The first step in the progression is to better understand where we are today with thirty months of operation under the All-Payer Model Agreement (recognizing the data lag that exists to confirm that progress). 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 providers can design appropriate interventions to fill those gaps. Maryland 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. There is a common sense of urgency among Council members regarding the need to meet the contractual obligation with the federal government. The concern is more around the time that is needed to develop a workable plan and to create stakeholder buy-in to that plan.

More focused efforts are likely to yield the best results. Further, one approach is unlikely to be the appropriate solution for all situations.

Carefully assess the move toward a total cost of care model

The Council members have divergent views about moving to a total cost of care (TCOC) model. Under this approach, total cost of care encompasses the payment for the comprehensive basket of health services used by the patient, including inpatient services; outpatient services including various procedures, therapies, and imaging; professional fees for office visits, other evaluations, procedures, and labs; prescription drugs; skilled nursing facility care; home health; durable medical equipment, and hospice care.[2]

Some members believe that if Maryland proposes a TCOC model, it should be structured in the same way as the hospital test was constructed, e.g. on a cumulative savings basis rather than a year-by-year test. A requirement that the state should meet a total cost of care standard *every year* could result in a situation where Maryland is deemed out of compliance for failing to meet such a standard in one particular year even if, on a cumulative basis, the state is on track to meet a total cost of care target. In this scenario, Maryland would not be able to draw on success in the preceding years that should have been "put in the bank," so to speak, if in one particular year the State barely misses meeting that year's total cost of care target on Medicare spending.

A number of Council members believe that the strategic plan should recommend implementing the TCOC approach but only for Maryland Medicare fee-for-service enrollees; and further, starting that process with the highest-need Medicare patients. There may also be the need to clarify what health services are included in a measure of the total cost of care. What are the boundaries?

The need for a realistic timetable

The Council wants 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. Maryland will submit a plan to CMS by the end of 2016 as required under the All-Payer Model agreement; the Council encourages the State to continue to refine a timeline for implementing the plan. That said, the Council encourages the State as well as CMS to be flexible

[2] CMS. Health Care Innovation Challenge: Achieving Lower Costs through Improvement. https://innovation.cms.gov/Files/slides/Health-Care-Innovation-Challenge-Webinar-3-Slides.pdf

about the schedule as well as the individual components of the plan. Some initiatives may move faster than others while other initiatives may take longer to develop and refine. Some may work well and others may fall short and need to be recast or dropped. All components of the plan need to be carefully evaluated, and the results will help determine what moves forward. Maryland leaders want to be assured that the objectives of demonstration and experimentation are paramount, rather than focusing solely on achieving each particular feature of the Phase 2 plan exactly as it was initially proposed. The Council would like the flexibility to change and modify as Maryland progresses, based on new knowledge and evaluation results.

The key point is the need to test several models, not just one. There is a need to design and test non-hospital initiatives and align them with Maryland's goals.

Finally, the Council would like to stress the importance of having stakeholder input in discussions that Maryland is having with CMS. This should be beneficial to both parties—the stakeholders would learn what CMS considers as the essential ingredients of a plan for moving forward, and CMS would learn more about the feasibility of actually implementing the reforms and realistic timetables.

Ensure Person-Centered Care and Consumer Engagement

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 September 2015 report, the Consumer Engagement Task Force (CETF) established by HSCRC concluded that to fulfill the Triple Aim, "consumers must have access to a health care delivery system that is reflective of their needs and preferences and equips them to be fully engaged in and take ownership of their health and health care. Extensive effort is needed to ensure that consumers understand this reorientation [to the new All-Payer Model] so they can make informed decisions and engage in the personal lifestyle changes, self-care, and system design that are essential to health care transformation.[3]"

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.

[3] Health Services Cost Review Commission. Consumer Engagement Task Force Final Report. September 9, 2015 p.i.

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.

Engaging consumers in health care delivery design and personal decision-making can produce substantial and enduring benefits for the individual, community, and overall health system. These benefits include improved understanding of health conditions, treatment options, and how to access services; improved relationships with providers; improved experience and satisfaction with care; personal sense of value and ownership; high-quality care; and an informed, responsive, and more efficient health care system.[4] A three-step path to consumer engagement can help achieve these goals:

1. Health insurance literacy: individuals have the ability to understand the complex terms, concepts, and financial implications when purchasing health insurance in order to pick the right plan.
2. Health care literacy: People understand their benefits and are comfortable navigating the health care system to get timely, effective care in the most appropriate setting.
3. Full patient/consumer engagement: individuals have the knowledge to make informed decisions about their own health and to actively engage in the health of the community.[5]

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.

Another key element of person-centered care is the active involvement of providers. Physicians, hospitals, and other providers should work with patients to help them understand their medical conditions and treatment options, and work with patients and their families to develop a plan of care that addresses their health problems. In short, meaningful consumer engagement also requires provider engagement.

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.

[4] HSCRC Consumer Engagement Task Force. Supra. pp. i-ii.
[5] HSCRC Consumer Engagement Task Force. Supra. p. 6.

Obtain Needed Data and Use 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 members of 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 access to the wealth of data that is provided for these enrollees, to help them understand the needs of the population. Complicating the access to data, however, is the reality that time lags in the receipt of data make it difficult to use for "real-time" management purposes. 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 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 Chesapeake Regional Information System for our Patients (CRISP), the State-designated health information exchange, 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. Education of consumers about care management and about the use of data to support such activities is important. Once patients who could benefit from care management are identified, consumers must be asked to opt in to care management relationships, consenting to the ongoing use of their data for this purpose. Providers should seek to

educate and engage consumers in these efforts to coordinate their care. CRISP can play an important role in managing access to identifiable data, ensuring both that it is only used for its intended purpose and that only providers with a bona fide care management relationship continue to receive patient identifiable data.

The receipt of frequently updated, 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 more 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 CRISP 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.[6]

In addition to CMS data on Medicare enrollees, it will also be helpful to have population health data. State agencies are already collecting some useful information on population health, an effort that should continue to build with data being widely shared.

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 in order to manage chronic illnesses, stay healthy, and avoid the repeated use of the ED and inpatient stays.

Coordinate 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, deliver care that is efficient and effective, and empower consumers to get the care they need and deserve.

In the near-term Maryland is likely to have a wide variety 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

[6] 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.

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 healthy, to those with moderate support and service needs, to the chronically ill, and those in need of the highest level of 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. 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.

An important element of accountability involves a proactive approach to informing and engaging all stakeholders—including consumers—about the progress of the All-Payer Model and getting strong consumer input as the model develops. To that end, HRSRC established the Consumer Standing Advisory Committee (CSAC) with representation that reflects the gender, racial, ethnic, and geographic diversity of the state and a diverse cross-section of consumers, consumer advocates, relevant subject matter experts, and other stakeholders. The primary purpose of the CSAC is to provide the HSCRC, staff and Commissioners, with expertise and the consumer perspective on the design and implementation of the All-Payer Model.[7]

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

Community-based organizations (CBOs) can make an important contribution to collaboration across partners. These CBOs include both primary and preventive care organizations within the health care system, such as federally qualified health centers, and a wide range of organizations operating largely outside of the health care system. An important part of accountability is to ensure that these organizations are included in collaborative initiatives to improve health care access and quality and lower total spending. The role of CBOs will be further discussed in the section of this report on the importance of including social services in programs and interventions to improve health and lower costs.

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

[7] Maryland Health Services Cost Review Commission (HSCRC) Consumer Standing Advisory Committee (CSAC)—Scope and Charge. Updated 6/24/2016. http://www.hscrc.state.md.us/documents/md-maphs/csac/CSAC-Inaugural-Projects-Overview-Updated-2016-06-24.pdf

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.

An organizational structure/framework for accountability

Hospitals, physicians, post-acute providers, and health plans pursuing innovations under the All-Payer Model would benefit from a clear organizational structure to improve 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 freedom to adapt within a common framework
- 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 frequently block and separate activities occurring outside the health care system that are vital to patients' health, such as good nutrition, adequate and safe housing, and a built environment that promotes good health. How will investments to address the "social determinants of health" be financed? Which population health outcome metrics will be used, and over what time period?

- *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 is at risk, how much risk, and how is it 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 do we measure risk-sharing and shared savings, and tie them together, and are they symmetrical?

Oversight

There is a need to define and identify proper oversight for the entire All-Payer Model, and any additional pilots or contract amendments added.

- 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, and coordination of care is being provided to patients? Who is identifying those not seeking care, gaps in care, and the need for prevention across the care continuum?

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 Maryland 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. For Medicare patients in fee-for-service arrangements, outcomes can be identified and measured, particularly for shorter-term rehab patients as care goals must be clearly indicated in the patient's care plan. Outcome measures could include: discharge to the community without hospital readmission; discharge to home without creating a need for family members or friends to devote significant time providing care; weaning a patient off antipsychotic or other psychotropic medications, and successfully treating wounds.

Over time, all participants in the delivery system should be brought into partnerships in which all parties have responsibility for cost and quality.

Foster Alignment

Creating strong incentives for value and outcomes for only one sector of the health care system is not likely to succeed. 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 volume. It also requires changing the payment model to reward better health outcomes and more efficient and effective delivery of care. With these changes in both public and private payment structures and providers responding 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. 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.

Specialist physicians and surgeons must also have incentives that are aligned with the All-Payer Model. One promising model envisions a future where the high-risk, high-spend patient is referred for anesthesiology consultation as soon as an elective surgical procedure is contemplated, with close communication between anesthesiology and primary care, and assignment of a navigator to coordinate the activation of nurses, pharmacists, educators, and other non-physician personnel. For patients who have had little motivation to improve their health, or insufficient access to care, an

acute episode of care may be an entry point into the health system, and an opportunity for better long-term health management.[8]

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 accessing 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.

New 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.[9]

---

[8] Boudreaux AM, Vetter TR: A Primer on Population Health Management and its Perioperative Application. Anesthesia & Anesthesia 123(1), July 2016 [Published ahead of print May 2016].
[9] 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.

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.

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) ended the long-standing and endangered Sustainable Growth Rate (SGR) physician payment system and 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. The overall theme is to replace an inflexible across-the-board physician payment update system with a payment system based on incentives, rewards, and penalties that promotes quality improvement, cost control, and data sharing in real time.

There are four components of physician payment under MIPS: Quality; Resource Use; Clinical Practice Improvement; and Use of Certified EHR technology.

1. Under the Quality area, physicians may select from six measures and face no requirement to cover multiple domains; measures should include at least one cross-cutting quality indicator and one outcome measure, or a specific set of measures (e.g. a cluster of diabetes quality metrics); this Quality component accounts for 50 percent of the composite score.
2. For the Resource Use, CMS calculates a score based on claims—comparative resources used to treat similar care episodes and clinical condition groups across practices (risk-adjusted). The indicator is 10 percent of the composite score.
3. Physicians who select at least one clinical practice improvement activity, out of 90 or more, are assured of not getting a zero score (the more selected, the higher the score); full credit is given to those physicians in a PCMH and a minimum of half credit for being in an APM. Year One weight is 15 percent.
4. Advancing Care Information Performance (use of certified EHR): comprised of a base score, a performance score and a bonus point. The scores will be based on key measures of health information interoperability and information exchange; more flexible than the all-or-nothing meaningful use standard which this new approach replaces. The weight is 25 percent.[10]

[10] Barbara J. Connors. The Medicare Access and CHIP Reauthorization Act of 2015. Webinar on May 31, 2016. http://www.hscrc.maryland.gov/documents/wr/Maryland-Connors-Hamilton.pdf

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.[11]

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).[12]

Medical Malpractice Reform

The Council recognizes that medical malpractice is not within the purview of HSCRC. The Council recommends 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 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 and building on patient navigation and advocacy capacity. The

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

phase 2 plan should feature partnerships to build strong bridges between acute and post-acute settings and helping people on Medicare with high-acuity chronic conditions become healthier and move more smoothly along the continuum from hospital to post-acute care settings, and from those settings to home. This will take an array of integrated medical and social services.

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. This situation is improving, however, as the proportion of skilled nursing facility (SNF) residents who take anti-psychotic medications has fallen to 14 percent, from 20 percent in 2011. Alignment may be fostered by expanding the shared savings concepts to include LTPAC providers, and sharing resources and providing financial incentives to pursue quality and cost targets. Any new design should incentivize LTPAC providers to select the appropriate and most efficient level of care rather than the least expensive action. Maryland 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 represents a good example of patient-centered care.

Regarding SNF care, the goal should not be to set a blanket approach to reducing SNF admissions or length of stay, as in many cases care in these facilities may be the most cost-effective setting for patients, and discharging patients to the community before they are well enough could increase readmissions, which would be counter-productive. That said, there are likely to be cases where length of stay could be reduced.

Payment reforms for LTPAC providers should 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.[13]

For this new approach to be successful Maryland needs accurate and timely data on resident conditions and treatment, 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 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. Frequently,

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

patients or their family members push for going to the ER when they observe symptoms or conditions that they believe require emergency care. In many of these cases, the post-acute care facility has the advanced clinical capacity to address the situation in-house in lieu of going to the hospital. This points to the need for better education of patients and their family members, and sometimes physicians as well.

In other cases, trips to the ER and subsequent admissions to the hospital could be 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).

While seeking to avoid unnecessary trips to the ER, however, it is also important to avoid inhibiting access to ER care from post-acute settings. The goal is to balance the need to reduce unnecessary use of the ER from the post-acute setting while protecting the needs of patients who need this care. Frequently, it is difficult to know ahead of time whether ER care is actually the right path to take. In the same spirit, reforms in the post-acute care delivery system could be phased in gradually and carefully, rather than rushed in. This is a highly vulnerable population.

Incorporation of social services into the delivery model

As documented in the report of the HSCRC Care Coordination Work Group, successful care coordination must transcend the boundaries that separate medical care from social supports and services. We have a sophisticated medical system capable of diagnosing and treating illness, improving quality of life, and prolonging life expectancy. Yet, with an aging population, and socio-economic disparities, many of the needs of our high-risk populations cannot be adequately addressed by the medical model alone.

For the elderly, particularly the "old-old" (e.g. people 85 years of age and older), these needs include risks of falling and other aspects of an unsafe home environment, a lack of transportation, social isolation, and inadequate nutrition. Many seniors face serious financial barriers to accessing health services. Low and moderate-income seniors with multiple chronic illnesses may need adult day care, meals-on-wheels, and other supportive services that help them stay in their homes and avoid going into long-term care facilities. Others need physical, occupational, or speech therapy following acute care episodes such as strokes or surgery.

It is also important to recognize that nationwide, more than 5 million people are living with Alzheimer's disease. In 2016, total payments for health care, long-term care, and hospice are estimated to be $236 billion for people with Alzheimer's and other dementias, with just under half of the costs borne by Medicare. In 2015, more than 15 million caregivers in the US provided an estimated 18.1 million hours of unpaid care for Alzheimer's disease.[14] People with these diseases plus those with Parkinson's disease, stroke and other vascular events, Multiple Sclerosis, and other conditions will require not only many medical services, but also an array of social services.

[14] Alzheimer's Association. 2016 Alzheimer's Disease Facts and Figures. http://www.alz.org/facts/

Regional and local planning initiatives should factor in these social and financial needs of the elderly with chronic illnesses.

Among the non-elderly adult population, homelessness and unsafe housing, obesity, long-term unemployment, and chemical dependency are very serious problems that drive people into the health care system. The homeless population is at-risk for serious health problems, including worse outcomes for chronic diseases. Others live in "food deserts," and have poor nutrition. About one in three Americans is obese, constituting one of the nation's most serious health problems. Substance use and violence contribute to potentially avoidable visits to hospital emergency departments. Smoking, though decreasing, is highly dangerous to health.[15]

Community-based organizations and local government initiatives form very important components of the incorporation of social services into service delivery systems. Examples include organizations that use mobile vans to bring health care screening, immunizations, and other important services directly to a family's home. This can be very valuable for households with serious transportation barriers. Another example is Healthy Howard, an experienced organization designed to increase health coverage, promote healthy work places, and improve care coordination for people who have been frequently hospitalized. One program is the Healthy Eating and Active Living (HEAL) Zone serving the towns of North Laurel, Savage, and Jessup in Howard County. Healthy Howard also manages the area's Local Health Improvement Coalition (LHIC), a group of more than 40 community-based organizations designed to reduce health disparities and improve health and wellness.[16]

Addressing these and other social problems, along with improving access to primary and preventive health care, can make a big difference in improving health equity in Maryland.

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 is Maryland's Faith Community Health Network, which attempts to align efforts to provide timely support for congregants who have been hospitalized.

Adequate funding for services addressing these needs is required. The resources needed to finance these initiatives cannot all come from acute or long-term care funding. Maryland needs to synthesize the information on best practices and most cost-effective strategies to address these social determinants of health.

Behavioral health

The Advisory Council believes that better management of behavioral health conditions is critically important to improving health outcomes and controlling spending. It is also important to recognize that there is no integrated infrastructure and that behavioral health care is chronically under-

[15] 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.
[16] http://www.healthyhowardmd.org/program/?program-category=community-partnerships-for-health

funded and fragmented. 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 these 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 behavioral health providers in the aggregate, many do not accept Medicaid and do not see uninsured patients. Further, they may be clustered around urban centers and not easily accessed by people living in smaller towns or rural areas.

Modernize governance and regulatory oversight

As we work to redesign and improve the care delivery system, Maryland needs to modernize and synchronize the regulatory and oversight system. Changes in the oversight of health care should keep pace and be aligned with changes in care delivery.

Maryland should continue the long-established HSCRC practice of not micro-managing and over-prescribing exactly what hospitals and their collaborating non-hospitals providers and insurers must do to achieve systems change. Clear rules and effective monitoring should allow leeway for hospitals and their collaborating partners to develop the innovations as they see fit. The State should identify state-level infrastructure problems and gaps that could inhibit hospitals in their efforts to lead system-wide innovations, and develop a plan to alleviate those problems.

While many of the investments will be initiated by hospitals in cooperation with various partners both inside and outside of the health care system and funded through approved payments under the All-Payer Model, as highlighted above, Maryland cannot finance all of the required investments needed to improve health and control spending growth via the spending streams that flow through hospital rates. As a result, the Advisory Council reiterates the recommendation it made in its original report that: *A portion of the savings that hospitals achieve could be reinvested into "common good" investments. But given the tightness of the revenue caps under the new model, a new and secure funding source for this type of infrastructure is also essential*.

Infrastructure needs include continued improvements in health information technology through CRISP, behavioral health, and social services that address the "social determinants" of good health. Future work will include determining an alternative and stable source of funding for public health and infrastructure improvements that do not directly relate to the delivery of health care services but affect health in important ways.

Additional goals

Map 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; the Council would like to reiterate this 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 "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.

Ensure 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.

Further, as the population continues to age and we strive to reduce avoidable hospital readmissions, there will be a need for an adequate supply of well-trained workers in post-acute care. This may be a particular challenge in areas such as skilled nursing facilities and home health.

There is an important need for a more adequate work force in behavioral health. Maryland, like other states, faces a challenge in having enough providers to meet the serious needs of high-risk and high-needs patients, and an adequate number of providers who will see patients enrolled in Medicaid or remain uninsured. A concomitant need is for those working in behavioral health to form strong linkages with people providing family and social services, law enforcement officials, and staff involved in housing and transportation.

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.

Set up demonstrations and learning capacity

As Maryland moves ahead and continues negotiations with CMS, the Advisory Council believes the State needs the flexibility to develop demonstrations with CMS and others beyond hospital providers. Some of these demonstrations will show favorable results while others may be unsuccessful. Maryland should 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 can be expanded.

A key feature of this approach is a kind of "learning community" in which leaders of various initiatives in quality improvement, patient safety, access improvement, and cost control can exchange ideas, models, and results. This kind of learning collaborative can feature dissemination and transfer of workable solutions. This will help innovators share their work with others, indicating what elements of the intervention worked, and those elements that did not work, or needed to be redesigned.

A strong and solid evaluation of the innovations is an important element of these learning communities. It will be important to collect baseline information to serve as a benchmark against which progress can be measured.

Develop 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. Requests can be diverse, and sometimes contradictory. A set of common measures across payers could reduce the "hassle factor" for providers; this approach has the additional advantage of generating 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.

Acknowledgements

The Advisory Council would like to thank the following people who helped to make this report possible. First, we would like to thank Jack Meyer from Health Management Associates who facilitated the Advisory Council discussions and was the primary author of the Advisory Council's report. We also thank Deborah Gracey and Meghan Kirkpatrick from Health Management Associates who provided valuable advice and support to the Council. We thank the staff of the HSCRC, in particular, Steve Ports, who has played a vital role in the planning and execution of HSCRC's stakeholder engagement efforts. Jessica Lee and Kim Biasucci of HSCRC helped organize the meetings and provided important organizational planning. Lastly, the Council would like to thank the stakeholders and members of the public who attended our meetings and offered comments, which informed our discussion and the content of this report.

Appendix A

2016 Advisory Council Membership

Vincent Ancona
President and Chief Executive Officer
Amerigroup Maryland, Inc.

David Blumenthal
President
The Commonwealth Fund

Chet Burrell
President and Chief Executive Officer
CareFirst

Robert A. Chrencik
President and Chief Executive Officer
University of Maryland Medical System

Carmela Coyle
President and Chief Executive Officer
Maryland Hospital Association

Vincent DeMarco
President
Maryland Citizens' Health Initiative

Joe DeMattos
President and Chief Executive Officer
Health Facilities Association of Maryland

Willarda Edwards
Drs. Edwards & Stephens, LTD
Internal Medicine Practice
Managing Partner

Dean Farley
Senior Vice President
OptumInsight

Isabella Firth
President
LifeSpan

Howard Haft
Deputy Secretary of Public Health
Department of Health and Mental Hygiene

Donna Kinzer
Executive Director
Health Services Cost Review Commission

Peggy Naleppa
President and Chief Executive Officer
Peninsula Regional Medical Center

Ramani Peruvemba
President, Pain Management Specialists
First Colonies Anesthesia Associates

Leni Preston
President
Consumer Health First

Gene Ransom
Chief Executive Officer
MedChi (The Maryland State Medical Society)

Joe Ross
President and Chief Executive Officer
Meritus Medical Center

David Salkever
Professor, Public Policy UMBC
Professor Emeritus, The Bloomberg School at Johns Hopkins

Kevin Sexton
President and Chief Executive Officer
Holy Cross Health

Gary Simmons
Senior Vice President, Networks
Mid Atlantic Health Plans United HealthCare

Ben Steffen
Executive Director
Maryland Health Care Commission

Bruce C. Vladeck
Senior Advisor
Nexera, Inc.

Eric Wagner
Executive Vice President
External Affairs and Diversified Operations
MedStar Health

Thomas M. Walsh
Primary Care Physician
Maryland Primary Care Physicians, LLC