Advisory Council Meeting Agenda

October 28, 2016
10:00 am to 1:00 pm
Health Services Cost Review Commission
4160 Patterson Ave, Baltimore, MD 21215

10:00 – 10:30 **Dual Eligible Model Update**
Tricia Roddy, Director, Office of Planning, DHMH

10:30 – 11:30 **Primary Care Home Model and Population Health Update**
Howard Haft, Deputy Secretary of Public Health, DHMH

11:30 – 12:45 **Progression Plan: Draft Update and Discussion**
Donna Kinzer, Executive Director, HSCRC

12:45 – 1:00 **Public Comments**

All meeting materials available at
http://www.hscrc.maryland.gov/hscrc-advisory-council.cfm

CHANGING
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Update: Maryland's Accountable Care Model for Dual Eligibles

Advisory Council Meeting

October 28, 2016

Overview

- Guiding Principles and Integration with the All-Payer Progression
- Recap of Proposed Model
- Next Steps

Guiding Principles

- The resulting model will promote:
  - Care coordination for dual eligibles;
  - Utilization of CRISP and other health IT tools; and
  - Linkage of payment to the total cost of care for Medicare and Medicaid.
- *For beneficiaries*: Whole-person, person-centered care
- *For providers*: Value-based payment, less administrative burden and more beneficiary contact, potential Advanced Alternative Payment Model qualification
- *For the State*: Interoperability with the All-Payer Model

Duals Initiative is Integrated with Maryland's Wider Health Care Transformation Efforts

The Duals Accountable Care Organization (D-ACO) Model aligns with principles of the **primary care model** and refinements to the **all-payer model**. It tests a different payment mechanism and introduces entities that may take broad accountability for these high-risk beneficiaries.

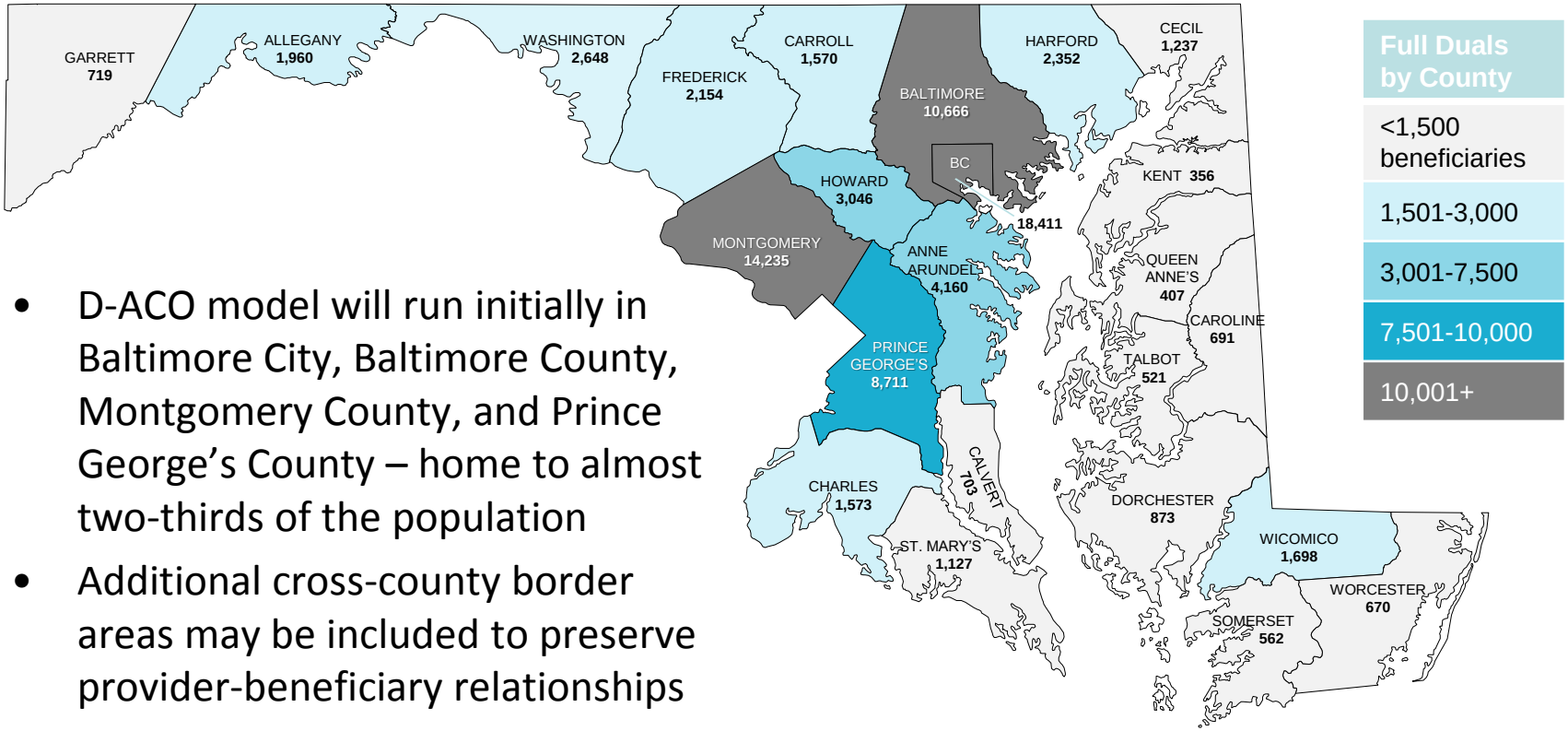
Duals Accountable Care Organizations

- Primary Care Model
- Regional Partnerships
- Complex and Chronic Care Program and Hospital Care Improvement Program
- Geographic Model
- Medicare (MSSP) ACOs

Features in Common

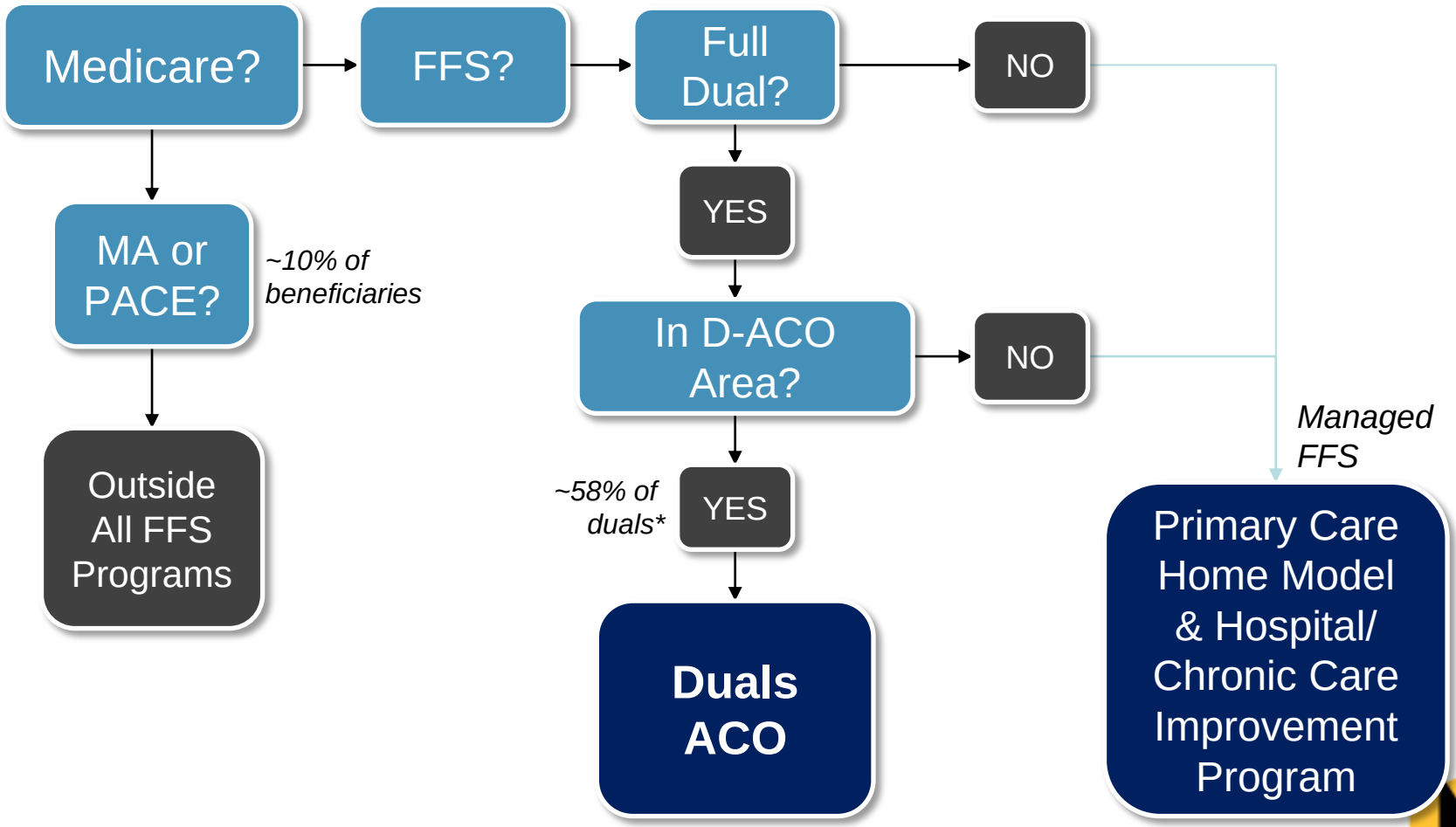
- Person-Centered Health Home
- Data Exchange and Analytics
- Care Coordination
- Population Health
- MACRA: Advanced APMs

D-ACOs Will Operate in the Most-Populous Areas, Covering Approximately 52,000 Fully-Dual Eligibles



- D-ACO model will run initially in Baltimore City, Baltimore County, Montgomery County, and Prince George's County – home to almost two-thirds of the population
- Additional cross-county border areas may be included to preserve provider-beneficiary relationships
- Potential expansion to wider area once concept proven viable

Most Full Duals Will Go into a D-ACO



* 90% of full duals are in FFS Medicare; 64% reside in D-ACO area

Understanding Maryland's Fully-Dual Eligibles*

- Total cost of care: $2.264 billion (51% Medicaid/49% Medicare)
- Average age: 66 years
- Majority demographic: Aged, blind and disabled
- Major cohorts:
  - Individuals residing in nursing facilities
  - Individuals receiving home- and community-based long-term services and supports (LTSS)
  - Individuals residing in the community without LTSS

**CY 2012 data for all full duals, not just those in D-ACO territories; excludes the I/DD population and Medicare Advantage enrollees*

Theory of Change: D-ACOs Drive Accountability for Quality and Efficiency

Current FFS System		Duals ACO Model
Beneficiaries lack a go-to provider	-------	Beneficiary-designated provider who is care coordination quarterback
Discontinuity in care, especially across physical, behavioral, LTSS and social domains	-------	Seamless coordination across health care settings and spanning to social supports
Provider incentives reward volume and intensity of services	-------	D-ACO materially accountable for total cost of care plus quality
Repetition of assessments, testing, procedures	-------	Care coordination tools enable access to data -- assessments, tests, medical encounters Promote standardized processes and assessments
Lack of provider capacity to coordinate care	-------	Incentivize providers and offer resources to coordinate care

D-ACO's Person-Centered Health Home (PCHH) Leverages Planned Primary Care Transformation

- PCHH blends elements of Primary Care Medical Home, Chronic Health Home
  - Serves as person's designated source of care and care coordination quarterback
  - Specialty (including BH) providers and NF-based providers allowed as PCHHs
  - Will follow standards set by PCM; may be enhanced to serve distinct needs of duals
  - Structural and performance expectations will align with MACRA standards for Advanced Alternative Payment Model

Duals Accountable Care Organizations

Long-term care providers, behavioral health clinics or MCOs may qualify as D-ACO sponsors, along with hospitals and physician groups, so long as they:

- Furnish a strong provider network of acute care, behavioral health, LTSS, specialty and social supports providers;
- Embrace and incorporate the PCHH model of care;
- Use a distinct governance body, when the D-ACO is made up of multiple entities;
- Maintain provider leadership over clinical policy;
- Perform care coordination, care management and quality improvement activities and measure their efforts;
- Accept a minimum enrollment of at least 2,000 full dual beneficiaries; and
- Take on staged risk for the population.

MSSP ACOs may qualify as D-ACOs, provided they adhere to anticipated waivers of certain MSSP provisions to better serve the duals.

Beneficiary Designation to D-ACO

- With authority granted by CMS's Center for Medicaid and CHIP Services, Maryland will mandate D-ACO designation as condition of receipt of *Medicaid* benefits for non-I/DD full dual eligibles residing in the D-ACO area
  - No authority is being sought to change any rules pertaining to beneficiaries' freedom of provider choice in *Medicare*—No beneficiary lock-in to a network
- Beneficiary will be informed of requirement to choose a D-ACO
  - Determine if beneficiary already attributed to MSSP ACO
  - Beneficiary counseled on benefits of D-ACO and options available
  - Beneficiary guided to choose from available PCHH providers in D-ACOs
  - Beneficiary not affirmatively selecting PCHH/D-ACO will be assigned

Next Steps

- 2016
  - Duals Care Delivery Workgroup meetings through November
  - Continued focus on linkages and building interoperability with other components under the All-Payer Progression
  - Negotiations with CMMI
- 2017-2018
  - Model refinement and program development
  - Waiver negotiation
- 2019
  - Program Implementation

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Maryland Primary Care Model
Presentation to the HSCRC Advisory Council

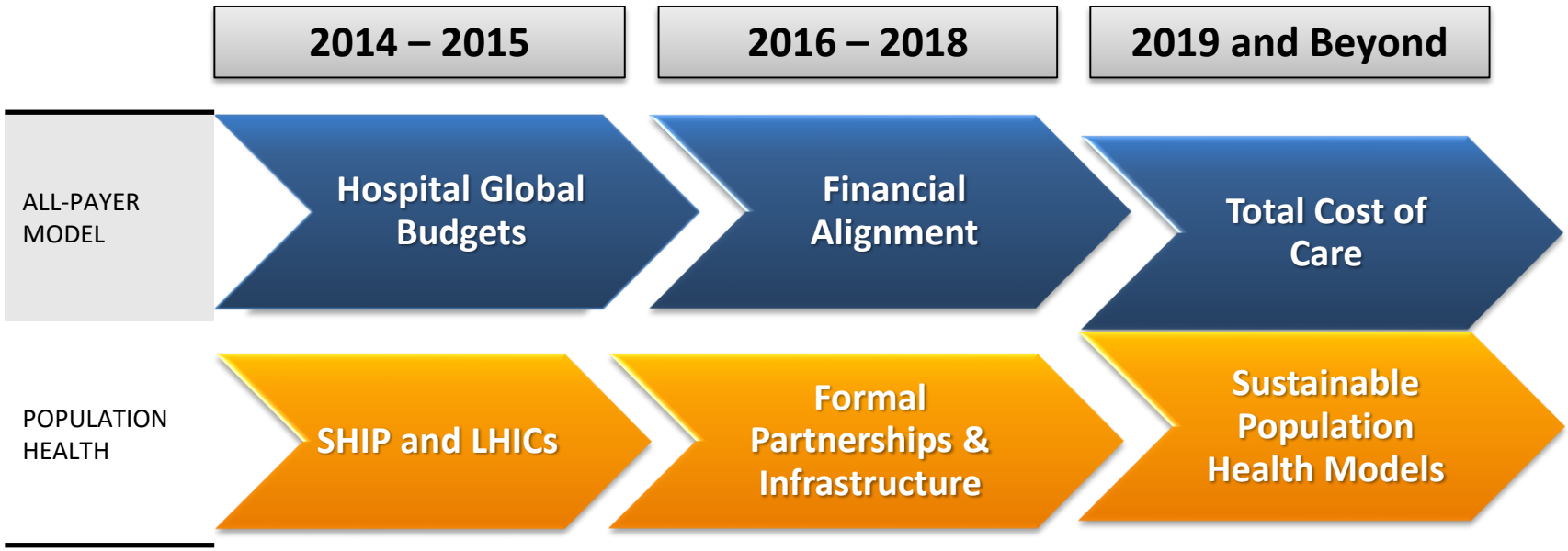
Dr. Howard Haft, MD
Deputy Secretary, Public Health Services
Department of Health and Mental Hygiene
October 28, 2016

Goals of Primary Care Model

- **Improve the health of Maryland through:**
  - Person-centric healthcare
  - Team-based support
  - Evidence-based approach
  - Consistent quality and outcome metrics
  - Volume to Value
  - Reduce potentially avoidable utilization
  - Improve management of chronic illness
  - Alignment with Maryland All-Payer Model and Medicaid Duals ACO
  - Alignment with State Population Health Improvement Plan (due to CMMI: 12/31/2016)

- **Timeline:**
  - 12/31/2016: Submit Primary Care Model concept paper to CMMI
  - 2017: Enhanced Infrastructure development begins:
    - Coordinating Entity development
    - Regional Care Management Entity formation / applications
    - Practice adoption/technical assistance
    - HIE Expansion, more primary care providers achieve connectivity
  - 2019 – 2022: Sustainability achieved through long term Return on Investment

Transformation Progression



Dec 31, 2016

Submit designs of:
- Primary Care Model
- State Population Health Plan
- All Payer Model Progression Plan
- Duals ACO

2017

- All Payer Model Amendment, Population Health Plan – Design
- Primary Care Model – infrastructure development

2018

- Primary Care Model – Year 1 Operation
- Additional Population Health Plan and VBP - Planning

Relationship to All-Payer Model and Progression Plan

- The Primary Care Model will help sustain the early gains of the All-Payer Model as targets becoming increasingly reliant on factors beyond the hospital
  - Aligns incentives
- Complements the Care Redesign Amendment
  - Community-level alignment to CCIP
- Reduces avoidable hospitalizations and ED usage through advanced primary care access and prevention
  - Components include embedded care managers, 24/7 access to advice, medication mgt., open-access scheduling, behavioral health integration, and social services
- Enhanced version of CPC+ will complement and support hospital global budgets

MACRA

Law *intended* to align physician payment with *value*

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**

Quality Payment Program

- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

Source: CMS webinar slides, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

The Quality Payment Program Provides Additional Rewards for Participating in APMs

Potential financial rewards

Not in APM	In APM	In Advanced APM (AAPM)
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
		5% lump sum bonus

If you are a **Qualifying APM Participant (QP)**

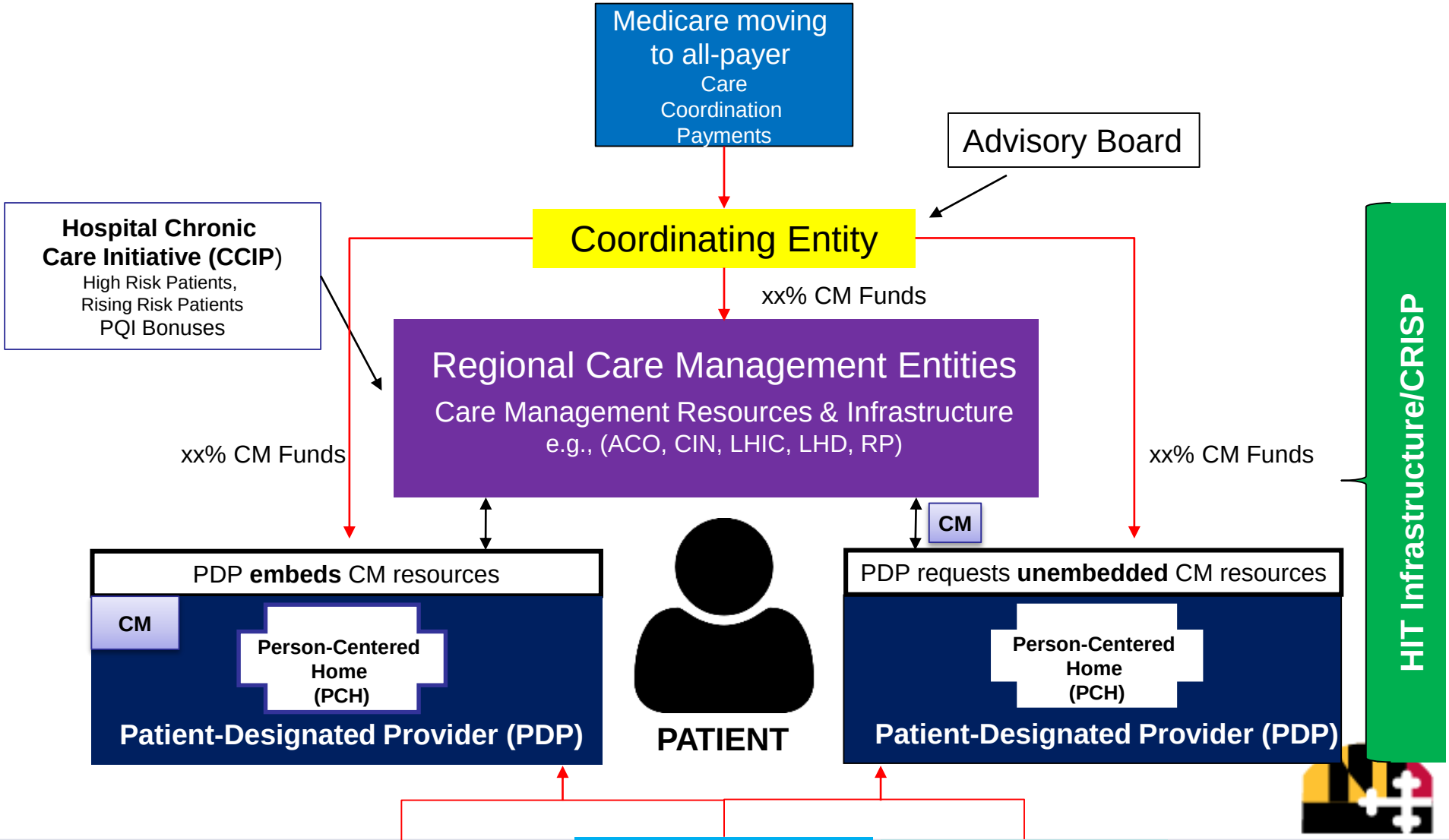
Source: CMS webinar slides, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

Leveraging Window of Opportunity

- Federal government willing to make substantial financial investment to implement Primary Care Model and help the state manage Medicare and Duals populations
- CMMI willing to allow the State to customize CPC+, which is an approved AAPM model
- Maintaining All Payer Model and broader health transformation in State depend on primary care with strong supports

OVERVIEW OF PRIMARY CARE MODEL

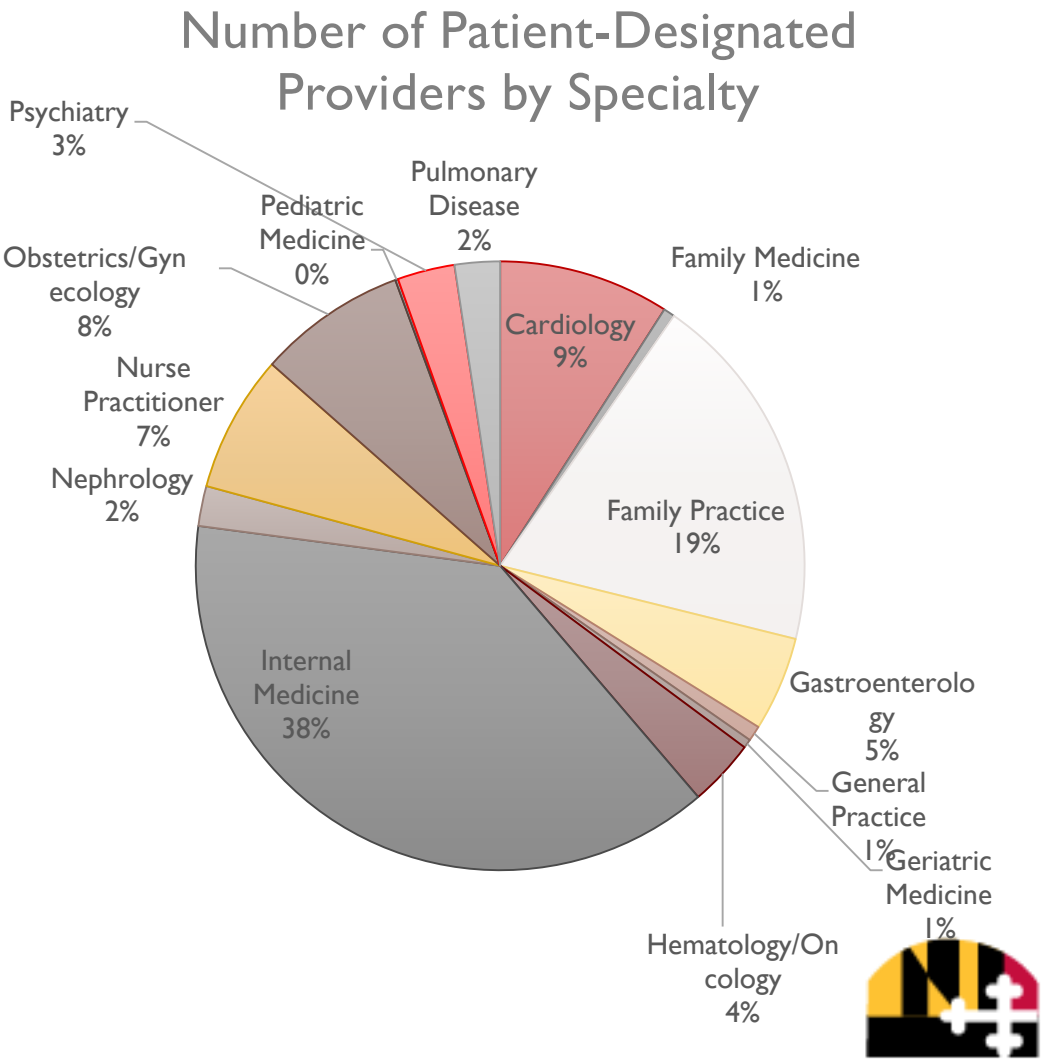
Maryland Primary Care Model



PATIENT DESIGNATED PROVIDERS

PDPs

- Patient Designated Providers (PDPs)
  - The most appropriate provider to manage the care of each patient
  - Provides preventive services
  - Coordinates care across the care continuum
  - Ensures enhanced access
  - Most often this is a PCP but may also be a specialist, behavioral health provider, or other depending on patients health needs



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Person Centered Home

- Person-Centered Home (PCH)
  - An individual provider or group of providers that deliver care as a team to a panel of patients
  - The PCH must have at least one PDP
  - PCH practices must meet the requirements laid out by the Model – CPC+ like
  - Practices may span multiple physical sites in the community

Practice Transformation is Key!

- Practices will **NOT** be expected to be transformed on day 1 or program start
- The State is committed to designing a system to provide assistance with practice transformation:
  - Care Management Entities (RCMEs) will be approved to assist practices
  - Practices will choose the best RCME for them
  - RCMEs will ensure that practices meet requirements under program by developing high functioning services including:
    - Care management resources and people
    - Technical assistance on practice transformation
    - IT supports (RCME and CRISP)

I am a Patient: What does a transformed practice look like to me?

- I am a Medicare beneficiary
- Provider selection by my historical preference
- I have a team caring for me led by my Doctor
- My practice has expanded office hours
- I can take advantage of open access and flexible scheduling:
  - Telemedicine, group visits, home visits
- My care team knows me and speaks my language
- My records are available to all of my providers
- I get alerts from care team for important issues
- My Care Managers help smooth transitions of care
- I get Medication support and as much information as I need
- I can get community and social support linkages (e.g., transportation, safe housing)

I am a Provider: What does a transformed practice look like to me?

- Voluntary participation
- Able to spend more time with patients
- Patient care management support based on severity index
- Care managers embedded in my practice and part of my care team
- Practice incentives:
  - 5% MACRA participation bonus (lump sum); CPC+ participation
  - Quality and Utilization incentive bonus $2.50 or $4 PBPM (Track 1, Track 2, respectively) – Prepaid
  - Track 2 comprehensive payment – Prepaid
  - Care Management payment PBPM risk adjusted
  - Care management infrastructure
  - Practice transformation support
  - Healthier patient population
  - Reimbursement for non-office based visits

REGIONAL CARE MANAGEMENT ENTITY

How do I become a Regional Care Management Entity?

- Certification by external accrediting body
- Apply through Coordinating Entity (CE)
  - CE holds RCME accountable for requirements and outcomes
- Ability to provide following services includes:
  - Care management infrastructure
    - Nurses, pharmacists, nutritionists, Community Health Workers, LCSWs, Health educators
  - Technical assistance for 24/7 after-hours access
  - Social support connections – Community Health Workers
  - "Hot-spotting" areas with high and/or specific needs
  - Pharmacist support for medication management and consultations
  - Assisting practices in meeting Primary Care Model requirements
  - Physician training resources
  - CRISP connectivity

COORDINATING ENTITY

Functions of Coordinating Entity

Primary Care Model Oversight

- Provide oversight, review applications, and advise on and approve changes to operational and payment mechanisms, and approve reasonable exceptions to agreed- upon payment algorithms and rules through an approved procedure

Budget Administration

- Run algorithms for the defined payment model logic to determine budget amounts, adjustments, and payer proportions

Data Analytics

- Perform ongoing reporting and analysis in support of model-specific goals
- Provide stakeholders with regular reports to inform decision-making

Quality Assurance

- Provide an annual assessment of compliance with transformation plan and global budget targets; recommends corrective action plans where needed
- Contract with an independent credentialing groups to provide documentation of RCME and PCH program status

Expert Oversight

- Engage stakeholders through an Advisory Board for input on program policy and outcomes Dedicated support will be provided to RCME and PCHs to help administer the model and assist with practice transformation.

FURTHER MODEL DEVELOPMENT

Stakeholder Engagement

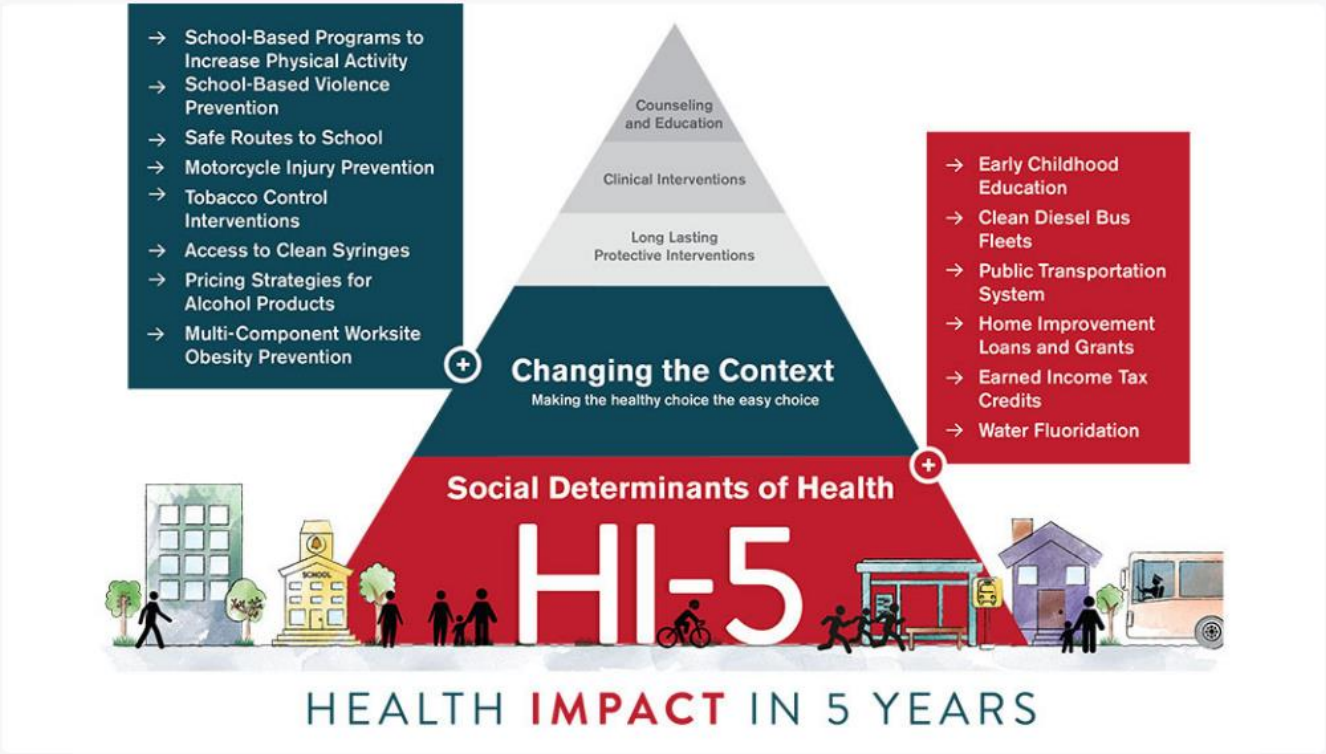
- Ongoing meetings with:
  - Providers
  - Health Systems
  - Payers
  - Consumers
  - Local Health Departments
- CMMI meetings on a biweekly basis
- HSCRC, Medicaid, CRISP, MHCC collaboration
- Incorporating Dual Eligibles FFS outside of ACO regions – working with Duals Workgroup

Concept Paper

- Outlining concept paper now
- Will be developing early draft in coming weeks
- Draft to be shared informally with CMMI in November
- Submit Concept Paper by December 31, 2016
- Formal proposal to be developed in early 2017

The Importance of Population Health to the All-Payer Model

Figure 4 | Health Impact in 5 Years



Source: U.S. Centers for Disease Control and Prevention, Health Impact in Five Years. http://www.cdc.gov/hi5

Questions?

- Primary Care Model Progression can be tracked: http://pophealth.dhmh.maryland.gov/Pages/transformation.aspx

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Executive Summary

[To be added]

I. Introduction

On January 1, 2014, the State of Maryland permanently shifted away from its 35-year-old statutory hospital waiver of Medicare's prospective payment systems in exchange for a five-year agreement with the Centers for Medicare & Medicaid Services (CMS). This new agreement—referred to as the All-Payer Model Agreement ("Agreement")—has been initially focused on the total cost of hospital care on a per capita basis. Its goal was to transform the delivery system to improve care. Maryland made this change because it believed that the volume incentives created by the old waiver test—which had focused on limiting growth in Medicare cost per admission—deterred State efforts to redesign its delivery system to achieve the goals of delivering better care, better health, and lower cost. The new All-Payer Model ("Model") effectively changed the way Maryland hospitals do business. While still in the early stages of transformation, Maryland is already demonstrating that an all-payer system accountable for the total cost of hospital care on a per capita basis is an effective model for advancing its goals.

At the heart of this Progression Plan is the desire to better serve Marylanders with serious medical conditions—those who bear the weight of navigating a complex health care delivery system while battling the cascade of challenges that are part of acute health crises and chronic disease. It also aims to improve care in the community to manage and prevent chronic conditions that can lead to hospitalization.

Even in 2014, Maryland and CMS predicted that more changes in health care payment and delivery would be needed to align all providers in order to further improve care for beneficiaries. Accordingly, and as a required part of the Agreement, Maryland stakeholders have developed this document, the "Progression Plan," which updates and advances Maryland's strategies to improve care and health outcomes while limiting spending growth over time. The Progression Plan describes the State's system-wide transformation to be implemented beginning in 2018, leading up to a second term and additional progression in 2019 and beyond.

This Progression Plan expands Maryland's All-Payer Model beyond hospitals to achieve system-wide transformation of health care delivery with physicians as well as other community-based providers.

At the heart of this Progression Plan is the desire to better serve Marylanders with serious medical conditions—those who bear the weight of navigating a complex health care delivery system while battling the cascade of challenges that are part of acute health crises and chronic disease. It also aims to improve care in the community to manage and prevent chronic conditions that can lead to hospitalization. To support the health and well-being of individuals as they move across care settings, collaboration across the spectrum of health care delivery is necessary. The Progression Plan, therefore, expands beyond hospitals to address other parts of the health care system that must be involved in changes to achieve meaningful system-wide transformation. The Progression Plan leverages and builds on the hospital per capita model by expanding efforts to organize hospitals and non-hospital providers in engaging patients and taking on increasing responsibility for system-wide goals.

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The Progression Plan will involve all Maryland residents as participants in the proposed system changes. It aims to engage all Maryland care providers, patients, communities, payers, and public health professionals in its innovation efforts and payment and delivery system transformation. While the Progression Plan will start with a stronger focus on Medicare beneficiaries, including dual eligibles, the design process will also prepare for applicability on an all-payer basis.

The key themes of the State's Progression Plan are to (1) foster accountability for system-wide and patient-level goals, (2) align measures and incentives for all providers, (3) encourage and develop payment and delivery system transformation approaches, and (4) ensure availability of tools to support providers in achieving transformation goals. The Progression Plan themes and strategies will not only build on the strong foundation of the hospital global revenues, they will also be designed to work in concert with one another and with other critical innovations under way in the State.

By proposing an overall strategy for organizing, incentivizing, and supporting all types of providers in health care transformation, this Progression Plan provides CMS with an opportunity to use Maryland as a unique statewide testing ground for implementing synergistic, value-based strategies that encompass hospital and non-hospital providers. Maryland believes this Progression Plan will permit CMS to evaluate the effectiveness of particular strategies and to assess the potential for replicating them in other states. Further, the process by which public payers work with others to achieve greater progress in long-term care transformation and population health in Maryland could serve as a national model.

In summary, this document provides background on the existing Model and the challenges faced by the Maryland health care system, and describes the strategies Maryland proposes under the Progression Plan. Maryland submits this Progression Plan to CMS to build on the successes of the current Agreement and to broaden the scope of health care delivery transformation in the State beyond hospitals. This Progression Plan proposes to enter into a second term of agreement with CMS effective January 1, 2019. Efforts to prepare for this second term will begin even earlier, owing to the opportunities presented by the Medicare Access and CHIP Reauthorization Act (MACRA), which go into effect in 2017 and provide new and attractive methods of physician engagement.

II. Background

A. Current Status and Challenges of Maryland All-Payer Model Agreement

Prior to January 1, 2014, Maryland's waiver of Medicare's hospital prospective payment systems was based on limiting growth in Medicare's cost *per admission*. On January 1, 2014, Maryland entered into a new five-year Agreement with CMS that broadened the range of accountability to include the total cost of hospital care for all payers on a *per capita* basis. Under the new Model, the hospital financing system in Maryland has moved almost entirely away from one based on volume to one based on hospital-specific global revenues with overlying value-based incentives. Under this new approach, hospitals are responsible for costs within a global revenue cap, and can make investments in care transformations that improve care and prevent avoidable utilization without concerns about revenue decline. Major achievements of the Model include transformation of payment and delivery systems, and the creation of demonstrable value, as described below.

1. Payment and Delivery System Transformation Efforts Underway and the Tools That Support Them

Fragmentation within the United States health care delivery system is a widely recognized problem. The Agreement has addressed this challenge by beginning to fund hospital initiatives to strengthen care coordination and care transitions with the goal of providing better support for patients before and after hospitalizations. For example, Maryland hospitals have begun to take responsibility for managing patient care beyond the hospital stay through the development of 90-day post-discharge programs. Many of these programs include social services that are interwoven with patients' well-being, such as transportation assistance, access to food, and other home supports.

Maryland hospitals and non-hospital providers are coming together to transform delivery systems. These partnerships are designed to meet the needs of their shared patients, particularly those who are vulnerable, and reduce potentially avoidable utilization. Partnerships have focused their current initiatives and collaboration on strategies to support complex and high needs patients who already use extensive healthcare resources. Most of these current efforts are in early stages of implementation and must be brought to scale. The pool of high needs patients will increase with the aging population unless the State also focuses on preventing the escalation of chronic conditions and providing better access and supports in the community for individuals with advanced chronic conditions. As described in this document, system-wide care redesign that incentivizes the right care to be given at the right time and place is necessary to accomplish this effort, and subsequently ensure better health outcomes and cost performance for Maryland. Clearly this effort must move beyond the hospitals and into the greater community of care in order to create sustainable success.

Maryland's designated Health Information Exchange (HIE), the Chesapeake Regional Information System for Our Patients (CRISP), also continues to transform and support the delivery system. Hospitals in Maryland and Washington, DC submit near real time admission, discharge, and encounter information to CRISP, and CRISP also receives and exchanges information with several other facilities in states that border Maryland. In addition to traditional roles of information exchange, CRISP supports physicians in emergency rooms with access to rich clinical information to enhance emergent care and supports hospital care managers with information to aid readmission reduction efforts. Recently, CRISP expanded its capabilities to make tools available at the point of care to provide a full picture of a given patient's clinical history and care team, and provides critical information (e.g. shared care alerts and care plans) to improve patient care within a provider's workflow. CRISP also provides data and analytic tools to help providers plan and evaluate their efforts, as well as identify patients who could benefit from care coordination. CRISP increasingly supports care coordination activities by expanding notifications and exchanging information to support individuals who are actively enrolled in care coordination efforts. A key CRISP initiative is to increase the number of ambulatory practices that submit Electronic Medical Record (EMR) information through the HIE, further enriching the clinical information available to providers to support care delivery across the care continuum.

2. Creation of Value

The Model has created value for CMS and other payers along with Maryland's hospitals, patients and its population from its beginning. In the first two and one-half years of implementation (CY 2014, CY 2015, and through mid-year CY 2016), Maryland met or exceeded the key Agreement measures for limiting hospital cost growth on an all-payer basis while improving quality. Despite unusually slow growth in national Medicare expenditures per beneficiary, Maryland has kept Medicare hospital and total cost per

beneficiary growth below national levels since the Agreement's base year (CY 2013). In its first two years, relative to national growth, the Agreement saved Medicare $251 million of the $330 million in hospital costs that is required over the five-year demonstration. Maryland achieved cost savings while also improving several key quality indicators. For example, in CY 2014 and CY 2015, hospital-acquired conditions for all payers as well as the gap between Maryland and national Medicare readmission rates both decreased.

[GRAPHICS PLACEHOLDER]

Despite these improvements in cost control and quality, more work needs to be done in Maryland. In CY 2015, non-hospital spending for Medicare rose faster in Maryland than in the nation, relative to the prior year. Some of the increases in non-hospital spending might be expected in transitioning care to lower-cost settings. While Maryland is ahead of its hospital savings requirements and its cumulative total Medicare spending per beneficiary growth rate is below the national trend since 2013, the non-hospital spending trend reinforces the need to increasingly focus on the total cost of care in the remaining years of the current term, as well as the second term of the Agreement. The Progression Plan lays out an approach that is designed to build on the Model's early achievements by expanding transformation to include other providers, providing data and tools to support efforts, and adding incentives, programs, and accountabilities that will be structured to meet these challenges.

The hospital sector has achieved some success in shifting from volume to value. Maryland must also look to change the ways care is provided and value is rewarded throughout the health care delivery system.

3. Next Steps

Since the start of the Model in CY 2014, Maryland hospitals have been paid under a global revenue system that is designed to limit total hospital spending per capita. Maryland has achieved hospital sector gains by putting strong incentives in place to reorganize care delivery. However, the rest of the health care system in Maryland (e.g. most physicians, post-acute providers, ambulatory surgical centers) continues to operate mostly on a fee-for-service basis with financial incentives tied to volume. Health care services are still often characterized by fragmented care delivery, insufficient integration, and a lack of team-based care. Accountable Care Organizations (ACOs) and Patient-Centered Medical Home (PCMH) programs are making some progress in ameliorating these problems, but ACOs and PCMHs currently include less than 30 percent of the Maryland Medicare fee-for-service population. Additionally, new Medicare Advantage plans have formed and entered the Maryland market. Next, Maryland needs to transform the delivery of primary, specialty, post-acute, and long-term care. Further refinement of hospital global revenues, along with strategic alignment of the rest of the system, should yield better outcomes and lower total spending.

The Progression Plan's efforts to incorporate providers beyond hospitals will start with Medicare and dual eligibles, but are designed to facilitate inclusion of other payers over time. Maintaining the integrity of the current hospital model is critical to the ongoing success of Maryland's health care system. Each of the strategies proposed in the Progression Plan is designed to build on the current hospital model and work together to meet Maryland's objectives. Maryland's overall goal is to ensure that all payers and residents benefit from delivery system transformation through improved quality of care, better population health, and greater cost efficiency.

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B. Care Redesign Amendment: Authority to Design and Test Mechanisms for Non-Hospital Provider Alignment

Maryland stakeholders recognized that greater provider alignment and transformation tools are needed under the All-Payer Model to better serve patients. The State proposed, and CMS approved, a Care Redesign Amendment ("Amendment") to the Agreement in September 2016. The Amendment aims to modify the All-Payer Model by:

- Implementing effective care management and chronic care management;
- Incentivizing efforts to provide high quality, efficient, and well-coordinated episodes of care; and
- Supporting hospitals' ability, in collaboration with their non-hospital care partners, to monitor and control Medicare beneficiaries' total cost of care growth.

The Care Redesign Amendment enables hospitals and their partners to focus on care improvements and total cost of care by sharing data, resources, and incentives.

The Amendment gives Maryland hospitals the opportunity to implement State-developed Care Redesign Programs. Care Redesign Programs will allow hospitals to access comprehensive Medicare data, share resources, and offer incentives to non-hospital care partners. Maryland hospitals will be able to share incentives for these programs as long as care is improved, hospital-level total cost of care growth benchmarks are not exceeded, and other requirements are met. Hospitals and their care partners can leverage comprehensive and patient-level Medicare data for implementing, monitoring, and improving their Care Redesign Programs.

A portfolio of such programs will be developed over time. Starting in CY 2017, hospitals can choose to participate in the first two Care Redesign Programs: the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP):

- The HCIP will be implemented by hospitals and physicians with privileges to practice at a hospital. The HCIP strives to improve the efficiency and quality of inpatient episodes of care by encouraging effective care transitions; encouraging the effective management of inpatient resources; and promoting decreases in potentially avoidable utilization. All of these efforts should improve quality and patient satisfaction and reduce costs per acute care admission.
- The CCIP will be implemented by hospitals in collaboration with community physicians and practitioners. The CCIP strives to link the hospitals' efforts in managing the care of current high-utilizing patients with the primary care providers' efforts to care for the same populations, as well as patients with rising needs. The approach also aims to facilitate overall practice transformation towards more person-centered care.

Through the Amendment, Maryland hospitals can promote greater linkages with their non-hospital care partners on key Model goals, including improving care management of complex and chronically ill patients, improving episodes of care, enhancing population health, and addressing the total cost of care.

The Amendment gives Maryland the flexibility to expand and/or refine the set of Care Redesign Programs that it employs as it moves forward with the implementation of the Progression Plan. For example, the initial Care Redesign Programs for CY 2017 implementation focus on improving episodes of care through the HCIP, as well as addressing the complex and chronic care needs of patients through the CCIP. However, over time Maryland providers can propose modifications to the Care Redesign

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Programs, and the State will have the ability to approve these changes, and to introduce other adjustments to meet the unique needs of Maryland's patients, payers, and health care providers. This flexibility improves the State's responsiveness to external changes brought on by MACRA and other new federal regulations and initiatives. Through this flexible framework, the Amendment will facilitate the State's next steps toward addressing system-wide costs and outcomes under the Progression Plan.

C. Environmental Factors

Demographic trends and a number of environmental factors increase the need to undertake the strategies proposed by this Progression Plan. Over the next ten years, Maryland will see a 37 percent increase in its population over age 65. The aging of the population will: drive up costs, because older persons use more health care services; change the nature of needed services to address chronic diseases; and create a greater need to have services accessible in convenient ways to persons with less mobility. These challenges will have profound impacts on the State's care delivery system, community and public health, and Medicare and Medicaid budgets. Moreover, these challenges are not unique to Maryland—they are on the horizon across the country. For example, primary care providers will need to increasingly focus on chronic care, including addressing medication management and social supports.

The Progression Plan addresses the pressures of an aging population, and works in concert with Maryland and federal policy priorities.

The current Agreement calls for Maryland to provide CMS with its plans for limiting growth in system-wide costs for Medicare beneficiaries by the end of CY 2016. Several State initiatives are targeting different aspects of health care delivery in ways that are consistent with the goals of the Agreement, including the proposed dual eligible ACO and the Maryland CPC+ Primary Care Home, as summarized in this document.

The federal policy environment encourages the types of strategies proposed under the Progression Plan. Congress authorized CMS to test a large portfolio of payment and service delivery models that aim to achieve better care for patients, smarter spending, and healthier communities. Many CMS innovation models are consistent with Progression Plan strategies to accelerate the development and testing of new payment and service delivery models, including: accountable care; episode-based payment initiatives; primary care transformation; initiatives focused on dual eligible individuals; and partnerships with local and regional stakeholders.

Following the inception of the Agreement, MACRA was enacted at the federal level and it has created a new framework within which physicians and other providers can be encouraged and incentivized to embrace value-based care delivery. Maryland's objective is to provide a pathway for all providers subject to this legislation to participate in the Agreement, through the creation of care improvement programs. Recognizing that CMS only recently issued final regulations to implement MACRA, the Progression Plan includes preliminary concepts on how to accomplish this transition. Maryland will continue to work with CMS and stakeholders to develop and finalize its strategies.

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III. Plan Overview

A. Plan Development: Stakeholder Engagement and Advisory Council

Maryland's All-Payer Model Agreement has been supported by a robust stakeholder process, which started prior to implementation in 2014 and has continued through the development of this Progression Plan. The Department of Health and Mental Hygiene (DHMH) and the Health Services Cost Review Commission (HSCRC) convened an Advisory Council of the highest levels of leadership representing health care providers, payers, consumers, national experts, and State agencies. The Advisory Council has advised the HSCRC on initial implementation and progress of the Model, and has been considering the key elements of this Progression Plan for approximately one year. The HSCRC, the Maryland Health Care Commission (MHCC), and DHMH also convened several workgroups and sub-workgroups to formulate specific details of the Progression Plan. In addition, the State received input directly from a number of stakeholders. Furthermore, acting on a recommendation from its consumer advisors, DHMH and HSCRC are convening a new multi-agency Consumer Standing Advisory Committee to provide advice on the implementation and ongoing developments of the All-Payer Model.

B. Vision

Maryland's vision is to fundamentally transform its health care system by aligning all providers with the goal of delivering person-centered care, increasing excellence in care, and improving the overall health of the population while moderating the growth in costs. The Progression Plan will provide the opportunity and impetus for providers to redesign care. Achieving this transformation will require engaging and empowering consumers so that they can make informed decisions about their health, with the hope that such involvement will contribute to better health outcomes and lower spending. Given Maryland's rich academic and research resources, the State hopes to leverage this Progression Plan to improve population health in both Maryland and the world by setting standards of excellence in clinical care, medical education, and research.

C. Progression Plan Goals

Maryland hopes to achieve its vision by working toward three key goals, which are widely recognized throughout the health care sector as the "Triple Aim": (1) improve population health, (2) improve care outcomes for individuals, and (3) control growth of total cost of care. These goals guided the development of the Agreement between Maryland and CMS, and they are reaffirmed in this Progression Plan.

Goal 1: Improve population health

- Ensure adequate access to appropriate community-based care and medications in order to promote prevention and early detection of disease.
- Identify and provide additional resources (e.g. increased access and team-based supports, effective coordinated treatment, medication management, behavioral health services, and other services) for individuals with complex and chronic conditions to slow disease progression;
- Address upstream influencers of health status, including behavioral health issues, smoking, obesity, nutrition, and exercise, particularly for vulnerable populations; and

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- Recognize the impact of social determinants on health status and access to care, and address these through case management, resources from community organizations, and public supports.

Goal 2: Improve care outcomes for individuals

- Enhance the delivery system's person-centered care approach. This approach tailors care based on individual needs and goals, engages patients and families in decision-making, and educates patients and caregivers on appropriate care and recovery;
- Improve episodes of care, reaching beyond individual events. Person-centered care uses state-of-the art health information tools to make better information available at the point-of-care and to coordinate care across the system;
- Increase supports for complex and chronically ill patients to enable them to manage their conditions effectively in order to prevent avoidable utilization and complications of disease;
- Improve coordination of care across settings, reducing re-visits, medication errors, and negative health outcomes; and
- Reduce health care-acquired conditions and complications of care.

Goal 3: Control growth of total cost of care

- Strive to achieve the first two goals (i.e. improving population health and improving care outcomes) because the most effective strategy for reducing the need for high cost settings and interventions is to keep people healthy and well supported in the community;
- Provide an early and intense focus on fee-for-service Medicare and dual eligible beneficiaries, since these populations are rapidly growing, and, while their needs are higher, existing supports are underdeveloped;
- Transform and align payment and delivery systems around the core goals of improving outcomes and health, and thereby supporting high value care in appropriate settings;
- Organize providers to take increasing accountability for cost and care outcomes; and
- Align public health and community organizations to help increase prevention and supports for vulnerable individuals in their homes and in the community.

D. Scope of Progression Plan

The Progression Plan will engage all Maryland hospitals and other providers in changing the way care is provided. The Progression Plan is designed to improve care and outcomes for all Marylanders. The immediate implementation focus will be a targeted subset of approximately 800,000 Medicare fee-for-service beneficiaries (including dual eligibles), many of whom would benefit from more robust care management structures. Among these, the dual eligible population and patients with chronic and complex conditions will be prioritized. While a subset of the population will be targeted for care management interventions, other efforts in the Progression Plan will seek to target the broader Medicare population, including those with rising risk to prevent future high utilization.

The Progression Plan will affect six million Marylanders and over $20 billion in annual health spending. It includes strategies that address all-payer hospital revenues, Medicare spending outside of hospitals, and Medicaid costs for dual eligibles (Figure 1).

Figure 1: Costs Addressed by Progression Plan

Approximate CY 2015 Figures (for 6 million Marylanders, including ~800k Medicare FFS beneficiaries)	
All Payer Hospital Revenues (including Medicare) For Maryland Residents	$14.8 billion
Medicare FFS Non-Hospital Spend and Other	$4.4 billion
Medicaid Costs for Dual Eligible Patients	$1.7 billion
Total Costs to be Addressed in the Progression Plan	**$20.9 billion**

IV. Theory of Action/Rationale

(To be added- Section currently in development)

V. Proposed Plan

A. Introduction and Strategy Overview

To achieve its person-centered vision and goals, Maryland intends to engage all health care providers, patients, communities, payers, and public health professionals in its innovation efforts and payment and delivery system transformation (see Figure 2 below).

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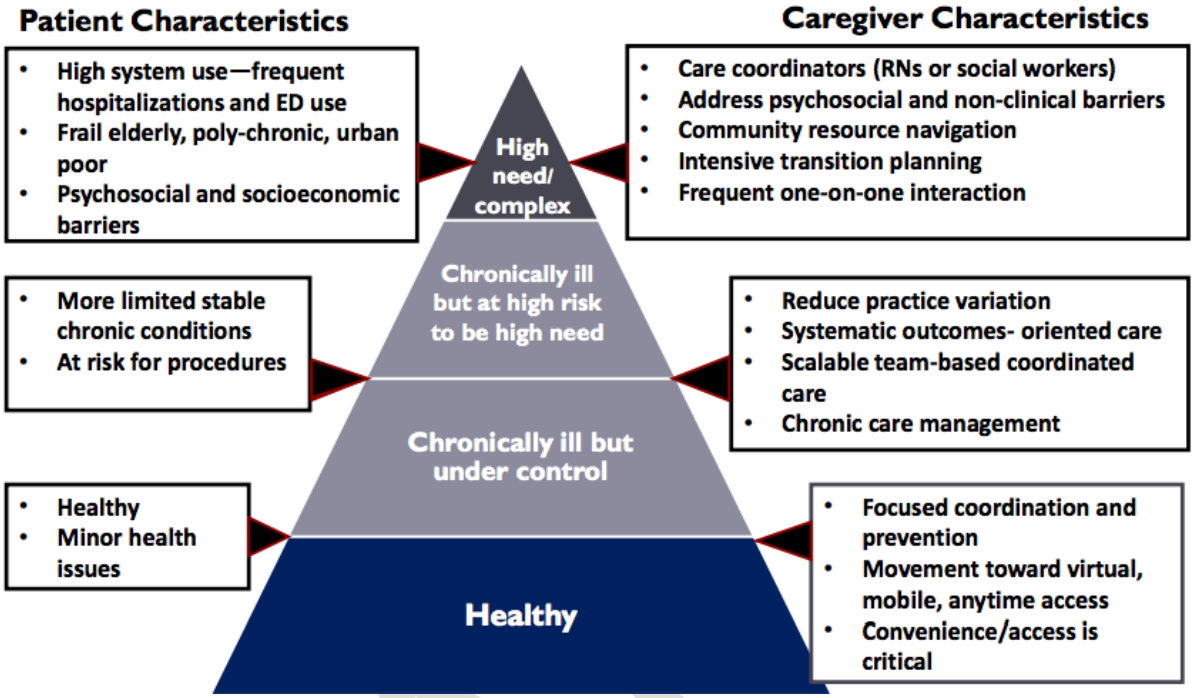
Figure 2. Patient and Caregiver Characteristics



Most patients do not remain in a static state. They may move up and down in the pyramid shown in Figure 2. System-wide alignment and collaboration of providers is key to achieve a person-centered focus across potential changes in health status over time. Hospitals and physicians practicing at hospitals are working to meet the needs of complex and high needs patients, and are also increasing coordination with community-based providers who manage chronically ill patients to prevent disease progression and the need for higher acuity care settings. The Progression Plan expands the scope of Maryland's current hospital model to provide the tools and incentives for all providers to align efforts in helping patients stay within the lower levels of the pyramid.

The Progression Plan organizes strategies under four main themes:

(1) **Theme One**: **Foster accountability** by organizing hospitals and other providers to take accountability for groups of patients or populations within a geographic area. This effort will build on the hospital accountability already in place under the All-Payer Model and will be accomplished through the following strategies:
   a. Leverage existing provider and payer accountability structures;
   b. Implement local accountability for population health and Medicare total cost of care through a geographic value-based incentive; and
   c. Establish a Dual Eligible ACO.

(2) **Theme Two**: **Align measures and incentives** for all providers with the goals of the All-Payer Model. This will be accomplished via the following strategies:
   a. Reorient hospital measures to align with new Model goals;
   b. Align measures across providers and programs; and
   c. Engage physicians and other professionals by leveraging the incentives and requirements created by MACRA.

(3) **Theme Three**: **Encourage and develop payment and delivery system transformation** which drive coordinated efforts and system-wide goals. This will be accomplished via the following strategies:
   a. Develop a Maryland CPC+ Primary Care Home;
   b. Develop initiatives focused on post-acute and long-term care;
   c. Explore initiatives inclusive of other providers and services; and
   d. Devote resources to increasing consumer engagement in care.

(4) **Theme Four**: **Ensure availability of tools** to support providers in achieving transformation goals.

As the Progression Plan is implemented, the State and CMS will need to carefully consider how the different initiatives and accountability structures will interact for all payers. Incentives within the fee-for-service delivery system reinforce Model goals, and are already captured in the cost of care within their respective accountability structures. However, it will be important to ensure that shared savings from payers are uniquely attributed to one accountability structure. This will be facilitated by Maryland's strong data infrastructure and access to patient level data.

B. Theme One: Foster Accountability

Maryland's plan proposes new accountability approaches for providers who are caring for consumers not currently served by existing structures

Accountability structures organize providers to take responsibility for quality, health, and cost. They introduce benefits for consumers and the larger health delivery system through a number of avenues. Accountability structures help providers to: (1) identify patients with high levels of need; (2) track health status, share information, and coordinate care across a patient's care team; and (3) better manage chronic conditions. A major theme of Maryland's Progression Plan is strengthening accountability structures to advance system-wide goals.

Hospital accountability will continue to serve as the cornerstone of Maryland's All-Payer Model, given that hospital spending is a significant cost driver across payers. For Medicare in particular, hospitalizations, related physician fees, and post-acute costs comprise approximately three-fourths of Medicare service expenditures in Maryland. While the current hospital Model continues to be essential, it is not sufficient. Maryland's Progression Plan proposes new accountability approaches for providers who are caring for Marylanders, particularly the Medicare fee-for-service population, who are not currently served by the existing structures. Medicare Advantage is providing an accountability structure for approximately 80,000 Medicare beneficiaries. Hospitals are providing an accountability structure for all beneficiaries, but only for hospital services. ACOs and one PCMH demonstration are currently the only system-wide accountability structures serving Medicare fee-for-service beneficiaries. Figure 3 shows how new accountability structures are needed to reach the entire Medicare fee-for-service population, with increasing accountability over time. While initially focused on the Medicare population, these structures could be incorporated into other payer-led or provider-led strategies for the non-Medicare population. Ultimately, more of Marylanders' providers will be working collectively towards common goals.

Figure 3. New and Existing Medicare FFS System-wide Accountability Structures

		ACOs	Payer-Supported Program	Dual Eligible ACO	Hospital Geographic Incentives
#Medicare benes in models with upside/downside incentives	2016 (Actual)	210k	40k	0	0
	Short-Term Projection	30k?	0k	0	770k?
	Long-Term Projection	250k?	150k?	50k?	340k?

Note: This chart is for illustrative purposes only, and does not account for factors such as population growth.

Strategy One: Leverage Existing Provider and Payer Accountability Structures

The Progression Plan builds on provider and payer structures that are already in place (ACOs, PCMHs, Clinically Integrated Networks (CINs), and Medicaid Managed Care Organizations) to bring providers together to work towards common outcomes. ACOs, CINs, and PCMHs are vehicles to organize providers to take responsibility for cost, quality, and health outcomes for an attributed panel of patients.

Action: Explore flexibility regarding the ability of ACOs to accept more financial responsibility.

Maryland's ACO environment is still evolving. As of January 2016, there were 21 ACOs with more than 1,000 attributed Maryland beneficiaries, and just over 210,000 total attributed beneficiaries across all ACOs. The number of attributed beneficiaries is expected to grow in 2017 to more than 250,000 with the launch of one additional large ACO. Maryland's ACOs are an important foundation for advancing accountability goals. However, most of the existing ACOs in Maryland do not currently have downside risk for Medicare costs. Over time, CMS is likely to require them to accept some downside risk or exit the program. Some ACOs have expressed an interest in accepting downside risk prior to the completion of their current timeframe as shared savings only entities. The State would like to explore this flexibility with CMS.

Action: Adopt an approach in which a payer supports an accountability program for practices participating in Maryland's CPC+ Primary Care Home.

A PCMH structure with shared savings was tested by CMMI in Maryland under a grant to CareFirst. The grant ended and it is not currently available to Medicare beneficiaries in Maryland, although CareFirst has continued to provide the infrastructure to practices. The State is interested in adopting an approach in which a payer supports an accountability program for practices participating in Maryland's CPC+ Primary Care Home, a payment and delivery model discussed in Theme Three, Strategy One below. Participants will be expected to take on increasing responsibility for outcomes and cost over time. Maryland would test whether extending well-developed PCMH tools and shared savings to Medicare beneficiaries are effective in transforming primary care practices and meeting the broader All-Payer Model goals when offered in conjunction with other payers.

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Strategy Two: Implement Local Accountability for Population Health and Medicare Total Cost of Care through the Geographic Value-Based Incentive

The current All-Payer Model Agreement creates full accountability for hospital spending by including requirements for all-payer and Medicare hospital spending. The Progression Plan proposes to provide additional tools and structures for hospitals and their care partners to control the growth in the total cost of care, inclusive of both hospital and non-hospital spending. The emphasis on total cost of care brings providers that are external to hospitals into accountability structures.

Action: Develop value-based incentives based on total cost of care growth for Medicare patients in a hospital's service area.

Currently Medicare total cost of care spending is only evaluated on a statewide basis. The Progression Plan introduces a geographic value-based incentive as a vehicle to incorporate responsibility for Medicare total cost of care in provider payment systems. By shifting to geographic areas, the Progression Plan will begin to incorporate accountability for all Medicare beneficiaries, as mentioned above in Figure 3.

The geographic value-based incentive creates local responsibility for care outcomes and population health, and provides a direct linkage to the Medicare total cost of care. The geographic areas could be a hospital's service area, a region, a county, or other area. Initially, the geographic value-based incentive would apply to hospitals. If Medicare TCOC growth in the service area exceeds a target level, there would be a negative incentive adjustment to hospital global revenue. Conversely, there would be a positive incentive amount, potentially available for sharing with care partners, if Medicare total cost of care growth were lower than the target level.

The application of this incentive incorporates Medicare costs for all service providers, including physician services, into the existing All-Payer Model. Maryland hopes to utilize this vehicle to connect physicians to the All-Payer Model. This will create a pathway for participation in an Advanced Alternative Payment Model (AAPM), aligning efforts of physicians with the goals of the All-Payer Model. Maryland will continue to discuss this approach with CMS as the final regulations for MACRA are implemented.

In the longer term, as the geographic value-based incentive matures, it will be important to carefully consider how that accountability structure interacts with the others shown in Figure 3, to ensure that savings are not double counted. Because it includes all Medicare beneficiaries, the geographic incentive has the advantage of more easily relating to public health, and facilitates opportunities for alternative payment approaches for non-hospital providers in an area. A geographic approach may be attractive to rural providers where there are discrete provider service areas, or to regional partners in more populated areas. The geographic value-based incentive concept may be modified and strengthened over time in a number of ways. Medicaid dual eligible costs could be incorporated into the total cost of care incentives. The geographic value-based approach could incorporate incentives for improving population health and care delivery outcomes in addition to addressing the Medicare total cost of care. Multiple regions could be defined across the State according to service patterns and cost variations. Providers could be accountable for services they provide locally, excluding quaternary and tertiary services that are already covered by hospital global revenues. In the future, a similar incentive

Action: Over time, incorporate more incentives for improving population health in addition to Medicare total cost of care.

needs to be folded into payment mechanisms for other providers beyond hospitals. As new MACRA regulations are better understood, Maryland will continue to explore how to accomplish this for physicians.

Geographic targets are also utilized in the Care Redesign Programs. Incentives will only be paid when the Care Redesign Programs in those geographic areas have achieved their goals of controlling both total (hospital and non-hospital) Medicare spending growth. This is an important step towards connecting specific hospital investments and strategies to their success in controlling total Medicare spending.

Strategy Three: Establish a Dual Eligible ACO

Medicaid is developing a Duals Accountable Care Organization (D-ACO) for individuals eligible for both Medicaid and Medicare (dual eligibles). The D-ACO is specifically for dual eligibles who are eligible for full Medicaid benefits (partial QMBs, SLMBs, QI/QDWI are not included) and are not developmentally disabled. The D-ACO program would initially run in Baltimore City, Baltimore County, Montgomery County, and Prince George's County in 2019 and may be expanded in future years. The population initially covered is estimated to be approximately 52,000.

Dual eligibles are widely recognized as a high-need, high-cost population. Many face complex medical, social, and/or behavioral challenges that demand extraordinary care coordination efforts to generate favorable outcomes. Services are split between Medicare and Medicaid, which creates misalignment in care delivery, increasing duplication of services such as assessments and care coordination, and decreasing the opportunity for organizations to develop a holistic care coordination plan for services offered across programs. Furthermore, the division of Medicare and Medicaid into separate total cost of care buckets may result in cost shifts from Medicare to Medicaid as new payment innovations targeting the Medicare-only total cost of care are implemented. Alternatively, cost shifts from Medicaid to Medicare could occur as increased medical interventions are funded in home or skilled nursing facility (SNF) settings with controlled waivers of the 3-day hospitalization requirement prior to a Medicare-covered SNF admission, or with other coverage extensions.

> *Action: Look to a Duals ACO to better serve a complex population with high levels of need, while minimizing incentives to cost shift between Medicare and Medicaid.*

The D-ACO has been designed to resolve this misalignment and promote integration between Medicare and Medicaid. At the center of the model is the Person-Centered Health Home (PCHH), which blends elements of a chronic health home and a patient-centered medical home, and is intended to serve as a person's first source of care and as a constant care coordination resource. An array of providers—including primary care, behavioral health, and long-term care providers, among others—will be able to serve as PCHHs, so the beneficiary will be attributed to the provider with the best expertise to oversee their care.

PCHHs will be nested in D-ACOs, which will be responsible for supplying care management support, maintaining a network and linkages in that network between Medicare and Medicaid providers, providing data exchange infrastructure and data analytics, and generally ensuring that beneficiary needs are met across the health care continuum, including social supports and long-term services and supports. In order to drive this integration, D-ACOs will receive a care coordination fee and will be

incentivized with upside and downside risk based on a Medicare and Medicaid total cost of care benchmark. D-ACO savings will be shared meaningfully with the providers in the D-ACO network. Thus, all providers in the D-ACO can be incentivized to achieve better health outcomes for the beneficiaries across their total spectrum of services.

The D-ACO concept is essential to the All-Payer Model progression because it provides a scalable and manageable way to link Medicaid services to Medicare for dual eligibles. A number of long-term services and supports are available to dual eligibles under traditional Medicaid benefits and Medicaid home and community based services waivers. It would not be feasible for a decentralized model to be linked to the existing technological and programmatic infrastructure used by the State's long-term care providers. The system is not designed to conform around a multitude of a la carte care redesign solutions. It is necessary to design a uniform process that defines what roles will be handled by the different entities. These processes will be included in the D-ACO's design.

Furthermore, the D-ACO concept fully embraces the need to integrate Medicaid and Medicare services by operationally and financially joining the programs — a major step forward in aligning the social determinants of health with the provision of health care. Where other programs may aim to address social determinants by pushing payment for care coordination, the D-ACO program folds in Medicaid spending on long-term services and supports (LTSS), creating accountability and responsibility for those benefits and linking LTSS delivery to the delivery of traditional health care services in a coordinated manner.

C. Theme Two: Align Measures and Incentives

Under the theme of aligning measures and incentives, Maryland's Progression Plan aims to develop and use consistent performance metrics for health, care delivery, and efficiency across all providers and programs. The State envisions that this approach will align efforts and increase synergies, which will lead to improvements. It will also optimize infrastructure investments and lessen administrative burden, which may improve provider satisfaction and engagement. For example, if Maryland uses the same measure sets for ACOs, the Maryland CPC+ Primary Care Home described below, the Care Redesign Amendment, and hospital quality programs, data collection will be less burdensome, investments to collect data will be lowered, and providers will be focused on and rewarded for common or closely related outcomes, increasing the likelihood of achieving those outcomes through aligned efforts and more rapid transformation. Ultimately, the same metrics for health, care delivery, and efficiency will be applied across providers. This will need to be facilitated by aligning payment models, quality metrics, and total cost of care requirements across payers.

Strategy One: Reorient Hospital Measures to Align with New Model Goals

As part of the Progression Plan, HSCRC will continue to create incentives for hospitals and other providers to promote access to care, preventive services, and effective transitions. With the inception of the All-Payer Model in 2014, HSCRC began the process of adjusting its value-based programs to align efforts and incentives for better care and for lower costs resulting from reduced avoidable utilization at the hospital level.

HSCRC has increasingly focused on potentially avoidable utilization, which is influenced by outpatient and community care. HSCRC's FY 2017 changes to value-based programs emphasize potentially

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avoidable utilization, increasing the alignment of hospitals' incentives with those of ACOs, PCMHs, and other accountability structures. Measures incorporating emphasize potentially avoidable utilization encourage hospitals to strengthen investments in improving care transitions and further collaborate with community physicians. Optimally managed and coordinated outpatient care can potentially prevent the need for hospitalization, or early intervention can prevent complications or more severe disease.

Action: HSCRC is increasingly focused on reducing potentially avoidable utilization by encouraging hospitals to improve care transitions and collaborate with community providers.

HSCRC is also reorienting hospital incentives to episodes of care. This builds on the hospital inpatient episode measures currently in place, and reaches further to incorporate outpatient activity. For example, a percutaneous coronary intervention (PCI) episode would align measures along multiple aspects of care, including readmission rates, infection rates, complications, and costs, including post-acute care costs. Focusing at the episode level has several important advantages. From a patient perspective, it is more meaningful in terms of how care is delivered and experienced. In addition, measures of care episodes can engage a range of providers, including specialty physicians and post-acute care providers. These are important aspects of the Progression Plan. HSCRC working in partnership with stakeholders will update its value-based payment approaches to be more meaningful to consumers and more useful in engaging providers across the system, across payers and settings.

The geographic value-based incentive for hospitals, described above in Theme One Strategy Two, is a major step towards incorporating Medicare total cost of care performance into hospital global revenue incentives at the population level for defined geographic service areas. This will create a direct financial link the hospital model to the expanded aims of the All-Payer Model. As HSCRC updates its value-based incentive programs for hospitals for FY 2018 and beyond, it will focus on measures of prevention, care management and care coordination, and care transitions, with the objective of assuring better care supports for complex and chronic conditions, improving health, and reducing potentially avoidable utilization.

Action: HSCRC is reorienting hospital incentives to episodes of care. This measurement and incentive strategy includes both inpatient and outpatient care, and provides a more meaningful assessment of how care is delivered and experienced.

Strategy Two: Align Measures Across Providers and Programs

A key effort of the Progression Plan consists of aligning measures and their related incentives across the delivery system. To align efforts and reduce reporting burdens for providers, the State will streamline assessment of care improvement by building on existing patient-level data collection and measurement capabilities. Maryland is aligning its measures across State initiatives as well as with federal efforts. CMS has begun to initiate standard measures for outcomes and value, and that effort is anticipated to expand under MACRA. For example, CMS has standardized patient level reporting for ACOs.

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Action: Maryland is aligning its measures across State initiatives as well as with federal efforts.

CMS' comprehensive primary care model (referred to as CPC+) allows primary care clinicians to depart from the current model of balancing the demands of meeting practice overhead (e.g. by maintaining high patient visit volume) with the demands of providing needed preventive care, reporting on quality metrics, and performing other services, which in combination are a significant source of frustration and a cause of the high drop-out rate among the primary care workforce. CPC+ uses a set of standardized measures that are closely related to the ACO measures. In Maryland, the CCIP, described above, uses a subset of CPC+/ACO measures. ACOs, CPC+, and CCIP all promote prevention, care coordination, and chronic care management to reduce potentially avoidable utilization. As described above, Maryland's value-based incentive programs for hospitals utilize measures of potentially avoidable utilization in multiple incentive components.

At the population level, the geographic value-based incentive for hospitals (described above) will make inroads to aligning hospitals and their care partners. Hospital-level Medicare total cost of care goals will help the hospitals and their partners understand cost of care drivers within an entire service area. This will help them prioritize care redesign interventions, evaluate interventions, and take on increasing levels of accountability over time. Individual providers will need to achieve savings for a geographic area and will receive incentives for improving care. These population level incentives will constitute a part of each provider's incentive payments, linking all providers to a consistent set of performance goals at a system level. Population level health and care outcome goals will be established as the Progression Plan unfolds, and will be incorporated into value-based payment programs. In 2019, the HSCRC will incorporate incentives for population health based on priorities established in Maryland's health improvement plan.

Strategy Three: Engage Physicians and Other Professionals by Leveraging MACRA

To achieve the triple aim, payments for physicians, other health professionals, and institutional providers must evolve from rewarding volume to promoting value. In MACRA, Congress affirmed the U.S. Department of Health and Human Services' approach in Medicare by consolidating an array of pay-for-performance mechanisms into a single merit-based incentive payment system (MIPS) and creating strong incentives for provider participation in alternative payment models (APMs).

Action: Leverage MACRA, ensuring that programs that advance the All-Payer Model also qualify for Advanced Alternative Payment Model status.

Maryland initiated that evolution for hospitals by moving hospital payment away from a volume-based system to global revenues tied to a population, and by incorporating value-based incentives aimed at improving care delivery and reducing potentially avoidable utilization for all patients. Several preliminary concepts, which are meant to link physicians and other professionals to the All-Payer Model, are being initiated in Maryland in recognition of the fact that CMS has recently issued final MACRA regulations. Maryland will need to continue to work with CMS and stakeholders to refine and finalize its strategies. Leveraging MACRA is essential to the ongoing success of the All-Payer Model. Maryland will need to work closely with CMS to create attractive pathways for physicians and other providers to join forces in the All-Payer Model as participants in a MACRA eligible Advanced

Alternative Payment Model (AAPM).

Maryland envisions that several programs discussed in this Progression Plan can qualify for AAPM status under MACRA. The most significant of these, the proposed Maryland CPC+ Primary Care Home, would extend comprehensive primary care services to Medicare beneficiaries. It would be designed to qualify as an AAPM and would encompass up to one-fourth of Maryland's physicians and other providers out of the more than 15,000 practicing in Maryland. This is discussed further below in Theme Three, Strategy One.

Other Maryland programs aimed at qualifying for AAPM status under MACRA include the initial two programs developed under the Care Redesign Amendment, which focus on hospital-based physicians and primary care providers. Additional programs can be developed under the Care Redesign Amendment. Maryland will need to work with stakeholders to develop programs that can be deployed for other community providers, such as radiologists and community oncologists, among others. Participation of these providers could be accomplished through an accountability approach (e.g. ACO, PCMH, or geographic program). Further discussion will need to take place to determine the State's role in development.

Action: With stakeholders, develop programs that engage community-based specialty physicians.

One of the considerations for Maryland's Progression Plan is how to tie financial results for physicians and other professional providers to the population level goals of the All-Payer Model. The Care Redesign Programs initiated under the Amendment are structured to accommodate incentives based on patient level quality indicators and hospital level savings. The proposed Maryland CPC+ Primary Care Home incorporates both utilization and quality measures. However, these programs do not explicitly tie incentives to total cost of care performance. By participating in one of these Maryland programs, physicians are expected to be eligible for a five percent MACRA bonus two years after qualifying as participating in an AAPM. Maryland will continue to work with CMS on how to structure incentives and align efforts under the All-Payer Model that also meet requirements as a qualified participant in an AAPM under MACRA.

D. Theme Three: Encourage and Develop Payment and Delivery System Transformation

With its focus on hospitals, the All-Payer Model creates a foundation for payment and delivery transformation for all patients and payers. As Maryland moves to the second phase of the All-Payer Model in January 2019, providers will take on increased responsibility for health, care outcomes, and total cost of care for Medicare fee-for-service beneficiaries. Hospitals cannot accomplish this alone. The All-Payer Model must build in increased collaboration with non-hospital providers of care, and work is under way now to do this. The rapid aging of the population and related increase in the number of patients with chronic conditions spur transformation to begin as soon as possible.

Strategy One: Develop Maryland CPC+ Primary Care Home

Hospital-initiated programs are focused on complex and high need individuals who already are using extensive resources in the health care delivery system. These programs do little to address the need for

transforming primary care for an aging population. Primary care is essential to meet the needs of chronically ill patients, slow disease progression, and prevent the need for higher acuity care settings. However, primary care settings lack the resources to meet the full range of needs of the growing number of patients with chronic conditions. Needed resources include care management, care coordination, and connection to social services.

Nationwide, CMS' CPC+ program is being promoted in selected regions to deploy resources needed in primary care and to transform the payment and delivery system. The CMS CPC+ program offers primary care clinicians the opportunity to focus more on patient panel management and improved outcomes.

Maryland, equipped with experience and expertise in primary care transformation, now proposes its own version of CPC+: the Maryland CPC+ Primary Care Home. This foundational payment and delivery system reform is designed to be interoperable with every fee-for-service accountability system. These will ensure that providers share the same incentives of the accountability structures described above in Theme One, Strategy One. Over time, Maryland's objective is to have nearly all Medicare beneficiaries served through these new primary care homes.

Action: Maryland, equipped with experience and expertise in primary care transformation, now proposes its own version of CPC+ Primary Care Home. This foundational payment and delivery system reform is designed to be interoperable with every fee-for-service accountability structure. These will ensure that providers share the same incentives as accountability structure.

The goals of the Maryland CPC+ Primary Care Home are consistent with the vision for All-Payer Model progression:

- Align community providers with hospitals and specialists to collaborate in the care of shared patients in order to improve care and reduce potentially avoidable utilization;
- Provide improved care access to primary care on a 24/7 basis;
- Tailor care to patients' needs and goals;
- Engage patients and their caregivers in managing chronic conditions and improving health;
- Reduce preventable complications of chronic conditions through better management of the rising-risk population;
- Reduce gaps in prevention and treatment, contributing to a reduction in needs for higher cost settings, including both hospital and long-term care settings;
- Reduce pharmacy costs through effective medication reconciliation and attention to the use of lower-cost, highly effective medications;
- Align providers and public health resources to address priorities;
- Identify and reduce disparities in care delivery and health outcomes; and
- Encourage innovation in health care delivery, including increased use of non face-to-face visits.

A key feature of the new approach to primary care is the establishment of a set of regional care management entities (RCMEs). These new organizations would make care managers available to those primary practices that want to "embed" them in their practices. Those who do not elect this option would have access to technical assistance and advice to their patients provided by nurses, pharmacists, nutritionists, asthma educators, social workers, and community health workers.

Redesigning primary care to achieve better overall population health outcomes, in concert with implementing the Care Redesign Amendment programs targeting the State's current high need patients,

prepares hospitals for success in the second term of the All-Payer Model. This prepares primary care clinicians for success in the era of MACRA, and most importantly provides needed supports to Medicare patients. The Maryland CPC+ Primary Care Home, in concert with the current All-Payer Model and the programs of the Care Redesign Amendment, will provide a unique laboratory of fully aligned providers of care.

Maryland CPC+ Primary Care Home Background

Effective care coordination is a core objective of the All-Payer Model. Care coordination is central to improve care for complex patients and introduce community-based interventions to reduce potentially avoidable hospitalizations. On January 1, 2015, Medicare initiated a professional fee for Chronic Care Management (CCM) that does not require a face-to-face visit, and focuses on provision of care coordination for approximately 60 percent of the Medicare population who have two or more chronic conditions. Obtaining access to these funds and implementing the CCM program requires electronic sharing of information about patients that is available 24/7.

HSCRC convened a multi-agency work group, the ICN-Care Coordination Work Group, also in January 2015, to address implementation of care coordination in Maryland. This work group provided a series of recommendations regarding: the aggregation, use, and sharing of data; infrastructure; and organization of care coordination. The Work Group also recommended the development of a hospital-funded care redesign program to support physicians and other professional providers in providing care management services for complex and high needs patients who are more resource intensive. The program is meant to facilitate the access of these providers to funding for care management services.

In September 2016, Maryland secured approval for the Care Redesign Amendment, described above. It provides authority in the current term of the All-Payer Model for hospitals to share resources and incentive programs for non-hospital providers of care. While the Care Redesign Amendment seeks to combine the efforts and resources of hospitals with resources provided by the CCM fee, the CCM fee is a fee-for-service mechanism that does not allow for tailoring of care to patients' needs. It also poses significant administrative burdens and costs. When Maryland sought approval for the Care Redesign Amendment, it discussed its desire to replace the CCM fee with a risk adjusted payment per beneficiary for chronic care management. When CMMI initiated the CPC+ demonstration in 2016, Maryland applied to participate. However, the program did not directly address the Maryland situation with the All-Payer Model and CMMI did not award a program to Maryland. Instead, CMMI suggested an alternative approach focused on the need for accelerated preparation for the second phase of the Model.

Maryland has significant experience in improving primary care models. CareFirst, the largest insurer in Maryland, has implemented a PCMH which engages most primary care physicians in the State and covers a substantial portion of its commercial business. It holds panels of primary care providers accountable for the quality and total cost of care for attributed beneficiaries, and provides fee schedule increases based on shared savings. It has a well-developed analytic infrastructure and deploys nurse care managers throughout the region. Other payers in Maryland have also begun to develop value-based contracts with providers. Many Medicare Shared Savings Program (MSSP) ACOs are functioning throughout the state, with more scheduled to begin in January 2017, and Maryland intends to establish D-ACOs (described above). Taken together, the experience of these initiatives, and the important lessons learned with each, demonstrate Maryland's continued focus on supporting primary care providers and increasing accountability to improve quality and reduce cost.

Primary care focused initiatives are strengthened by the incentives provided to hospitals by the All-

Payer Model to support preventive care and the provision of care in lower cost settings and by state infrastructure capabilities that will enhance ability to redesign care. CRISP, Maryland's HIE, is expanding its capabilities to provide reliable and consumable data for clinicians quickly, at the point of care. Recently, CRISP has undertaken efforts to organize patient level data to enhance care coordination and population health management activities. Innovative clinician-to-clinician communication tools as well as shared care plans are now being piloted through CRISP, with practicing clinicians involved in the design and testing of these tools. This is a strategy which promotes greater adoption of these new features and resources that save clinicians' and patients' time and improves patient safety and quality.

Strategy Two: Develop Initiatives Focused on Post-Acute and Long-Term Care

Persons in long-term custodial and assisted living facilities suffer from multiple chronic conditions, dementia, and frailty, among others. Patients discharged to SNFs rather than home are frequently complex or high needs patients that are a key focus of the All-Payer Model. Currently there is little comprehensive care coordination that addresses these patients' needs and they have higher rates potentially avoidable utilization.

Maryland's goals are to encourage optimal use of post-acute services and skilled nursing facility services, reduced need for long-term care, increased services in home settings, reductions in hospital admissions and ER visits from long-term and custodial care, and reductions in admissions. Capacity resulting from these changes would be needed to meet future needs of a rapidly aging population and to serve some additional patients in skilled nursing facilities.

As described above in the description of the D-ACO, long-term services and supports are split between Medicare and Medicaid, with the potential for misalignment in care delivery. A complex set of Medicare and Medicaid rules govern post-acute and long-term care. The rules exist to prevent Medicare from taking on the long-term services and supports that are the responsibility states. The rules also govern eligibility for Medicaid that is tied to need for long-term care and financial resources. As patients transition across settings, the delivery of hospital, post-acute, and long-term care must be considered together to fully assess incentives. The D-ACO, referenced earlier, will optimize services for long-term and community-based care, but additional initiatives need to focus on the larger Medicare population.

> *Action: Maryland will seek the expertise of its long-term care and post-acute providers to address in new ways the increasing needs of individuals with high levels of an aging population and individuals with high levels of complex need.*

As part of the Progression Plan, Maryland will seek to utilize the expertise of its long-term care and post-acute providers to address in new ways the increasing needs of these persons and an aging population. The State will convene a Long-Term and Post-Acute Payment subgroup to make recommendations and develop approaches for Maryland's long-term and post-acute settings. The Care Redesign Amendment creates a vehicle to establish potential initiatives to align the financial incentives of post-acute providers with those of the hospital. The subgroup's work will need to integrate with the Duals-ACO plans, and consider interconnections to geographic value-based incentives for hospitals and the Maryland CPC+ Primary Care Home. One possible strategy for the subgroup to develop is the concept of bundled payments that have been implemented across the country, but have it more broadly applied and focused on acute and post-acute services, rather than all services. Another possible strategy is potentially a controlled relaxation of the three-day rule within the context of a total cost of care

accountability structure. Most surgical patients are discharged in three days or less, but some need rehabilitation in a skilled nursing or rehabilitation facility. Furthermore, some patients are admitted to hospitals from long-term care when they could have been served well with a higher level of service in the SNF. These patients could benefit from the relaxation of a 3-day rule.

Strategy Three: Explore Initiatives Inclusive of Other Providers and Services

Some physicians and other health professionals who work primarily in community settings will not be addressed by the Care Redesign Amendment's current programs. The State will need to explore opportunities for including them. Other services which are provided in the community, such as laboratory and durable medical equipment (DME), could benefit from shared information and coordination in order to improve efficiency.

Community-based physicians

> *Action: Engage community oncology and radiology practices, as well as other community providers, in developing approaches for meeting All-Payer Model goals.*

The Care Redesign Amendment provides a vehicle for hospitals to work with physicians practicing at the hospital and some community providers. Maryland is developing an approach for primary care, which covers the majority of physicians who work primarily in the community. However, not all community providers are addressed by this approach. The State needs to work with stakeholders to develop MACRA-eligible payment and delivery approaches for physicians who work primarily in the community. For example, oncology and radiology services are frequently provided in community settings, and care can be improved and costs can be reduced.

To further illustrate this concept, oncology patients frequently need complex and chronic management supports to reduce development of preventable conditions and avoid preventable hospitalizations and ER visits. Maryland could evaluate the CMMI Oncology Model or other available approaches for adoption. High quality, cost effective radiology services are provided in free standing centers in Maryland. However, avoidable utilization for duplication and unnecessary testing often occurs. Maryland should engage oncology and radiology practices, as well as other providers working primarily in community settings in developing approaches for their participation in meeting the All-Payer Model goals and in qualifying for participation in AAPMs under MACRA.

[More on behavioral health will be added]

DME and other services

Medicare patients and others frequently need access to DME and other supplies. Coordinating these services to provide the right DME and other services to patients when they need it is critical to the success of post-acute care and ongoing care management. This requires sophisticated coordination systems that are not available in the fee-for-service Medicare system. Accountable providers and entities will need to take on this responsibility to ensure that patients are getting the right DME when they need it.

Increasingly, services can be provided in home settings. However, these services require coordination and consumer education and engagement for effective high quality delivery. For example, home infusion, oral cancer drugs, and other treatments can often be effectively provided in home settings. As providers accept accountability for costs and outcomes, increased delivery of services in home settings

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supported with appropriate physician supervision, care management, and telemedicine and telephonic supports can be deployed.

Strategy Four: Devote Resources to Consumer Engagement

In order to achieve the key goals of better care, better health, and lower spending, Maryland 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 their health and health care. Multi-stakeholder collaboration and commitment is needed to develop such a system. Engaging consumers in health care delivery system design and personal decision-making can produce substantial and enduring benefits for the individual, community, and overall health care 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. Moreover, consumers must understand this reorientation so they can make informed decisions and engage in the personal lifestyle changes, self-care, and system design that are essential to health system transformation. It is critical that consumers have an active voice in decision-making and access to medical and social services on a timely basis.

> *Action: Maryland will continue to focus on (1) establishing a person-centered health care delivery system with ongoing roles for consumers, and (2) engaging, educating, and activating users of hospital services.*

Leveraging recommendations from the HSCRC's Consumer Engagement Task Force in 2015, Maryland will continue to focus on two critical areas for Consumer Engagement: 1) Establish a person-centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels for both providers and health plans; and 2) Engage, educate, and activate people who use or are potential users of hospital services in their own health care in order to promote efficient and effective use of the health care system.

Policy: Consumer input is critical to developing person-centered policies and procedures. HSCRC and DHMH are convening a Consumer Standing Advisory Committee (C-SAC) in 2016. C-SAC brings together a diverse cross-section of consumers, consumer advocates, relevant subject matter experts, and provider, payer, and other key stakeholders to discuss developing State policies and initiatives. The State will continue to leverage this input structure as Maryland stakeholders continue to work collaboratively in health care transformation.

Engagement: Meaningful consumer engagement also requires provider engagement—both with the patient and between providers.

- 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, planning, and social services. Maryland hospitals, physicians, and other providers will continue to 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.

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- Maryland hospitals also continue to find ways to work more closely with community partners to ensure all of their patient's needs are met. For example, based on a successful pilot in Memphis, the Maryland Citizens' Health Initiative and LifeBridge Health created the Maryland Faith Community Health Network in 2016. This Network aims to organize and align resources in the faith and health care communities to support patients. LifeBridge staff serve as "navigators" to connect patients with community resources and support, and work with "liaisons" from congregations, who can help look out for their congregants' well-being. While this initiative is still in its early implementation stages, there has been positive feedback. Maryland plans to continue to test initiatives such as this pilot, which engages patients beyond the hospital walls.

Education and Activation: Maryland will continue and strengthen their efforts to educate consumers about the All-Payer Model and strive to communicate model goals, implementation steps, and accomplishments in understandable terms that demonstrate the impact on consumers. For example:

- In 2015 and 2016, the Maryland Citizens' Health Initiative, in collaboration with several key healthcare stakeholders (e.g. HSCRC, DHMH, MHA, Maryland hospitals, and others), held 15 regional public forums across the state. The forums focused on talking with consumers about the changes in Maryland's health care system and describing opportunities for deeper community involvement. Maryland will continue to hold similar educational forums to inform and engage the public in the state's ongoing healthcare transformation efforts.
- The MHA, Maryland Faith Health Network, AARP Maryland, NAACP Maryland State Conference, and Young Invincibles partnered together to launch a patient engagement campaign in 2016, entitled "A Breath of Fresh Care". The campaign aims to engage patients in their care by directing patients to information on hospital wellness and chronic disease management initiatives, as well as many other critical resources that can get patients the care and support they need-- when and where they need it. The "Breath of Fresh Care" website directs patients to individual hospitals' community programs, information on patient bill of rights, and processes for filing complaints, as well as education forums, among many other resources. By organizing supporting resources in one place and co-hosting education forums, "Breath of Fresh Care" empowers patients with the information they need to make informed decisions about their health care. These partners will continue to support consumer engagement and promote patient empowerment as Maryland implements the Progression Plan.

E. Theme Four: Ensure Availability of Transformation Tools

Maryland policy makers and stakeholders have long believed that information is a fundamental part of Maryland's success. Hospital payments across several years have explicitly provided funding for these infrastructure developments within hospitals. Additionally, regional partnerships were funded to implement collective care coordination strategies focused on high need populations.

Building upon an understanding that care coordination is an essential component of population health investment, DHMH and HSCRC convened a Care Coordination Work Group to guide further investment in care coordination tools. In April 2015, the Care Coordination Work Group finalized its report, which outlined recommendations to achieve patient-centered care coordination. Many of the recommendations called on CRISP to focus on care coordination and to expand its role beyond that of traditional HIEs.

Action: CRISP's focus on care coordination infrastructure is a foundation for the transformation tools needed to support this Progression Plan.

These recommendations launched significant new investments in CRISP, to pay for and provide shared tools and resources to support care management, and to leverage individual hospital investments, connect ambulatory providers, and provide population-based reporting. CRISP's focus on care coordination infrastructure is a foundation for the transformation tools needed to support this Progression Plan. These investments, described below, focus on providing innovative information at the point-of-care in support of care managers and for population heath teams. These efforts, guided by CRISP's provider and consumer stakeholders, are critical to the success of Maryland's progression efforts.

[More content to come]

VI. Federal Requests

Maryland's current Agreement, which consists of hospital global revenues and value-based incentives, has promoted the achievement of State and federal goals. The 2014 Agreement required Maryland to meet certain performance metrics, including limiting all-payer growth to a target of 3.58% over five years and achieving $330 million in Medicare savings over five years, as well as other quality performance measures. Under the Progression Plan, Maryland will continue to limit the growth in hospital revenues on an all-payer basis, recognizing that the specific targets will need to be revisited periodically based on environmental factors. Maryland will need to agree with CMS on savings targets for the second term of the Agreement.

Maryland will need to update or replace its Agreement with CMS. This will include updating and revisions to some of the terms, reporting requirements, and other aspects of the Agreement. Several considerations are outlined below, but this is not meant to be a comprehensive list.

The Progression Plan presents a strategy whereby Maryland and CMS can jointly test an advanced payment and delivery approach that extends beyond hospitals. Maryland's Progression Plan will require a close partnership with and support from CMS. The State and stakeholders will need flexibility to implement its proposed strategies. The State will need federal data and other resources to administer the All-Payer Model. The delivery system will need data to provide care coordination and care management, as well as planning and monitoring relative to the total cost of care. The State will need to work closely with its partners at CMS to finalize the details of what is needed and carefully craft the federal tools that will be critical to success.

The implementation of Maryland's Progression Plan must:

1. **Maintain the strong foundation of Maryland's hospital all payer system**
    - The core of Maryland's Progression Plan continues hospital per capita growth parameters, which have demonstrated all-payer success in early implementation.
    - The Progression Plan can build upon this foundation to strengthen efforts to meet our system-wide goals without undermining the base model.
2. **Strengthen primary care as a fundamental part of delivery system reform**
    - Maryland's Primary Care Home Model is being designed to leverage federal payment reforms (MACRA and CPC+) and ensure Maryland providers are able to leverage new federal payment tools. This effort needs to be treated by CMS as an investment with a longer-term return on investment with near-term reductions in potentially avoidable

utilization, but also longer-term savings through a focus on population health improvement and changing the model of care for the increasing numbers of individuals with chronic conditions and polypharmacy.

3. **Rely on new federal flexibility to implement strategies**
    - Implementation of many of the strategies outlined in the Progression Plan will require flexibility from CMS. Several areas of needed federal waivers are listed in Figure 4. The State would like to continue discussions of how to gain flexibility while taking into account administrative requirements.
4. **Maximize MACRA statewide in Maryland**
    - Support ability to attach physicians to the All-Payer Model as a MACRA-eligible model and create synergy in approaches and incentives.
    - Align incentives for specialists with the incentives in the all payer system and initiatives in primary care.
5. **Account for investments with long-term return on investment**
    - As the State monitors TCOC at both a statewide and local level relative to targets, HSCRC will seek to monitor costs separately for preventative services to ensure that the Model does not discourage spending money for recommended services that are expected to have a future payoff of improved population health for consumers.
    - As interventions are tested, there will be some that are unsuccessful and do not save money. CMS and the State should terminate these interventions without jeopardizing successful components of the Model.

Figure 4: Needed Federal Waivers

Medicare Payment Waivers

- Inpatient Prospective Payment Systems (IPPS)
- Outpatient Prospective Payment Systems (OPPS)
- Medicare Readmissions Reduction Program
- Medicare Hospital Acquired Conditions Program
- Medicare Hospital Value Based Purchasing
- Electronic Health Record Penalty

Medicare Innovation Waivers, and Fraud and Abuse Waivers

- Three (3) Day Skilled Nursing Facility (SNF) Rule
- Telehealth
- Post-Discharge Home Visits
- Civil Monetary Penalties, Anti-Kickback Provisions, and Physician Self-Referral law, categorized as follows:
    - ACO Pre-Participation Waiver
    - ACO Participation Waiver
    - Shared Saving Waiver
    - Compliance with Physician Self-Referral Waiver
    - Patient Incentives Waiver

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VII. Implementation Timeline

[To be added]

VIII. Conclusion

[To be added]

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Summary Table of Proposed Themes, Strategies, and Actions
October 21, 2016 -- DRAFT for Stakeholder Discussion

Theme One: Foster Accountability	
Strategy One: Leverage Existing Provider and Payer Accountability Structures	Action: Explore flexibility regarding the ability of ACOs to accept more financial responsibility.
	Action: Adopt an approach in which a payer supports an accountability program for practices participating in Maryland's CPC+ Primary Care Home.
Strategy Two: Implement Local Accountability for Population Health and Medicare Total Cost of Care through the Geographic Value-Based Incentive	Action: Develop value-based incentives based on total cost of care growth for Medicare patients in a hospital's service area or geography. Deepen the incentives over time.
	Action: Over time, incorporate more incentives for improving population health in addition to Medicare total cost of care.
Strategy Three: Establish a Dual Eligible ACO	Action: Look to a Duals ACO to better serve a complex population with high levels of need, while minimizing incentives to cost shift between Medicare and Medicaid.
Theme Two: Align Measures and Incentives	
Strategy One: Reorient Hospital Measures to Align With New Model Goals	Action: HSCRC is increasingly focused on reducing potentially avoidable utilization by encouraging hospitals to improve care transitions supports for high needs patients, and to collaborate with community providers.
	Action: HSCRC is reorienting hospital incentives to episodes of care. This measurement and incentive strategy includes both inpatient and outpatient care, and provides a more meaningful assessment of how care is delivered and experienced.
	Action: Introduce measures and incentives for Medicare total cost of care.
Strategy Two: Align Measures Across Providers and Programs	Action: Maryland is aligning its measures across State initiatives as well as with federal efforts.
	Action: Introduce measures and incentives for population health and total cost of care.
Strategy Three: Engage Physicians and Other Professionals by Leveraging MACRA	Action: Leverage MACRA, ensuring that programs that advance the All-Payer Model also qualify for Advanced Alternative Payment Model status.
	Action: With stakeholders, develop programs that engage community-based specialty physicians.
	Action: Explore options for introducing flexibility in the deployment of MACRA's 5% AAPM bonus.
Theme Three: Encourage and Develop Payment and Delivery System Transformation	

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Summary Table of Proposed Themes, Strategies, and Actions
October 21, 2016 -- DRAFT for Stakeholder Discussion

Strategy One: Develop Maryland CPC+ Primary Care Home	Action: Maryland, equipped with experience and expertise in primary care transformation, now proposes its own version of CPC+, the Maryland CPC+ Primary Care Home. This foundational payment and delivery system reform is designed to be interoperable with every fee-for-service payment system. These will ensure that providers share the same incentives as accountability structures.
Strategy Two: Develop Initiatives Focused on Post-Acute and Long-Term Care	Action: Maryland will seek the expertise of its long-term care and post-acute providers to address in new ways the increasing needs of individuals with high levels of an aging population and individuals with high levels of complex need.
Strategy Three: Explore Initiatives Inclusive of Other Providers and Services	Action: Engage community oncology and radiology practices, as well as other community providers, in developing approaches for meeting All-Payer Model goals
Strategy Four: Devote Resources to Consumer Engagement	Action: Maryland will continue to focus on (1) establishing a person-centered health care delivery system with ongoing roles for consumers, and (2) engaging, educating, and activating users of hospital services.
Theme Four: Ensure Availability of Transformation Tools	
[To be added]	Action: CRISP's focus on care coordination infrastructure is a foundation for the transformation tools needed to support this Progression Plan.

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