The Maryland All-Payer Model Progression Plan

Update to the December 2016 Proposal to the Centers for Medicare & Medicaid Services

Maryland Department of Health

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Executive Summary

Maryland, under agreement with the Centers for Medicare & Medicaid Services (CMS), launched the All-Payer Model (Model) in 2014 to transform the health care delivery system and improve care, while moderating cost growth. The Model changed the way Maryland hospitals provide care, shifting away from a financing system based on volume of services to a system based on hospital-specific global revenues with overlying value-based incentives. Maryland is already demonstrating that an all-payer system that is accountable for the total cost of hospital care on a per capita basis is an effective foundation for advancing the goals of delivering better care, better health, and lower cost. In the first four years of implementation, Maryland met or exceeded the key measures of the All-Payer Model Agreement (Agreement) for limiting hospital cost growth on an all-payer basis, providing savings to Medicare, and improving quality.

The hospital sector has achieved some success in transforming the delivery system, shifting its efforts to focus on providing care coordination, improving care quality, and providing care management and supports for complex and high-needs patients. Initial efforts of providers and payers to organize beyond hospitals to participate in taking responsibility for the Model's goals are evidenced in mature medical homes of commercial payers, recently initiated chronic condition health homes of Medicaid, and Accountable Care Organizations (ACOs) that encompass approximately one-third of Maryland's Medicare beneficiaries.

The All-Payer Model Agreement (Agreement) between CMS and the State of Maryland called for Maryland to submit its plans to extend the Model to limit the growth in total cost of care for Medicare beneficiaries in a Total Cost of Care All-Payer Model (TCOC Model) that will begin on January 1, 2019. With this document, Maryland is updating the "Progression Plan" (Plan), which outlines its proposal to accomplish the expanded system-wide goals and to address the State's goal of including the Medicaid costs for "dual eligibles" in the next iteration of the Model. The State of Maryland and CMS, with input from diverse Maryland stakeholders negotiated the terms that will be incorporated into the TCOC Model agreement. These terms are reflected in this Plan. Term changes that CMS has proposed can be found throughout this Plan document, but primarily are focused in several key sections:

1. Section I. Introduction – provides a general introduction to the Enhanced Model.
2. Section III. Plan Overview, Sub-Section B. Enhancing the All-Payer Model – describes TCOC Model timeframe, general savings targets, expected achievements, financial goals and model continuation terms.
3. Section V. Proposed Plan, Sub-Section B. Strategy One: Foster Accountability, Key Element 1.b. – introduces the new Medicare Performance Adjustment as a value-based incentive, based on total cost of care.
4. Section V. Sub-Section B. Strategy One: Foster Accountability, Key Element 1.c. – describes a plan to progressively develop and implement Dual-Eligible care and payment alignment initiatives.
5. Section V. Sub-Section D: Strategy Three: Encourage and Develop Payment and Delivery System Transformation, Key Element 3.a. – describes new investments in the Maryland Primary Care Program.
6. Section VI. Model Design Requirements – lays out the TCOC Model tests, savings requirements, calculations and expected results.

7. Section VI. Model Design Requirements, Sub-Section A. All-Payer Total Hospital Cost Growth Ceiling – provides updates on growth calculations and savings commitments.
8. Section VI., Sub-Section A. All-Payer Total Hospital Cost Growth Ceiling – defines the TCOC Model all-payer growth limit test, the Medicare per-beneficiary total cost limit test, expected savings estimates, and exogenous factors.
9. Section VI., Sub- Section A. All-Payer Total Hospital Cost Growth Ceiling, number 4 – addresses medical malpractice reform.
10. Section VI., Sub-Section B. Quality and Value-Based Metrics – provides updates on quality and value-based metrics.
11. Section VI., Sub-Section C. Population Health Goals – provides information on new population health goals.
12. Section VI., Sub-Section D. Calculation Considerations – discusses total cost of care and savings calculations.
13. Section VI., Sub-Section E. Payment and Delivery System Transformation and Supporting Tools – describes new tools that will be used to support system transformation in the TCOC Model, including Care Redesign Programs and their required participation agreements, and fraud and abuse waivers to support physician alignment.
14. Section VII. Severability, Corrective Action and Termination Trigger – provides information on mechanisms for ensuring compliance with federal and state Model Agreement requirements.

Maryland's vision for the next term of the Model is to achieve person-centered care, foster clinical innovation and excellence in care, improve population health, and moderate the growth in costs, on a statewide basis and in the all-payer environment through the transformation of the health care delivery system.

The State—with a robust stakeholder process—designed the Plan to improve care and outcomes for all six million Marylanders. Implementation will first focus on a targeted subset of approximately 800,000 Medicare fee-for-service (FFS) beneficiaries and progress to focus on dual-eligible population and patients with complex and chronic conditions, who would benefit from more robust care management structures. The Plan also seeks to address the broader patient population and improve population health through more robust prevention efforts and care supports aimed at improving the health of individuals and reducing their needs for future health care interventions in higher-cost settings.

With its initial focus on hospitals, the All-Payer Model creates a foundation for health care payment and delivery transformation for all patients and payers. Sustaining and expanding the success of the current Model, which initiated hospital global revenues and value-based incentives, are central goals of the Plan. As Maryland moves to the TCOC Model in January 2019, providers will take on increased responsibility for health of the population, care outcomes, and total cost of care for Medicare beneficiaries. Hospitals cannot accomplish this alone, thus the TCOC Model continues to increase collaboration with physicians, other providers of care, payers, and consumers.

The Plan lays out five strategies to expand beyond the current Model to:

1. **Foster accountability by supporting hospitals, physicians, and other providers as they organize to take responsibility for groups of patients or populations within a geographic area.** Accountability structures enable non-hospital provider groups to share with hospitals the responsibility for care delivery and health outcomes, as well as the Medicare total cost of care over time.

2. **Align measures and incentives for all providers with the goals of the TCOC Model.** The Plan intends to create a system of cooperation and aligned efforts in which physicians, hospitals and all types of providers work together, along with payers and health care consumers, to improve care and offer supports for all Marylanders, with a particular emphasis on those with complex and chronic conditions. Streamlined measures and incentives will be developed to help providers clearly focus on common goals.

3. **Encourage and develop payment and delivery system transformation to drive coordinated efforts and system-wide goals**. The Model must build increased collaboration with physicians and other providers of care. New delivery approaches supported with aligned payment models and incentive structures will help accomplish this.

4. **Ensure availability of tools to support all types of providers in achieving transformation goals.** Maryland will use private resources and public-private resources where implementation is facilitated through cooperation to support transformation.

5. **Devote resources to increasing consumer engagement**. Maryland will support the development of the Model to transform its health care delivery system with consumer-driven and person-centered approaches.

The Plan also lays out continued development and scaling of efforts underway to support complex and high-needs patients, new efforts to support chronic care management and prevention, and further payment and delivery system transformation to help drive coordinated efforts and system-wide goals of better care and health outcomes, all of which are also designed to reduce potentially avoidable utilization in higher-acuity settings. These include:

- Increasing the scale and scope of efforts to coordinate care for complex and high-needs patients who are already using high-acuity resources.
- Increasing efforts to provide high-quality, efficient episodes of care, including care provided in post-acute settings.
- Using resources and flexibility provided in the recently approved Care Redesign Amendment, Medicare Access and CHIP Reauthorization Act (MACRA), along with newly requested flexibility to engage the broader care delivery system in aligned efforts.
- Extending chronic care management and prevention to Medicare beneficiaries through a Maryland Primary Care Program, based on the Comprehensive Primary Care Plus (CPC+) model from CMS and designed to work with Maryland's delivery system to support the needs of Medicare beneficiaries.
- Evaluating and implementing payment models and incentives for post-acute and long-term care that optimize these resources and use them in more flexible ways to improve care for Medicare and dual eligible beneficiaries.

- Planning and implementing dual eligible care and payment alignment programs.

Maryland has a strong base to achieve this, building on the accountability and care transformation initiated under the hospital global revenue system and developing in the broader system. Maryland also has advanced tools through its unique Health Information Exchange (HIE), the Chesapeake Regional Information System for Our Patients (CRISP), which furnishes a foundation for delivering increased information at the point of care, leveraging investments in Electronic Health Records (EHRs), and supporting better care coordination. CRISP is a private not-for-profit organization focused on supporting infrastructure needs that can best be accomplished cooperatively, augmenting resources of payers, health systems, and providers.

The 2014 Agreement requires Maryland to meet certain performance metrics, including limiting all-payer growth to an annual target of 3.58 percent over five years and achieving $330 million in Medicare savings over five years, as well as quality performance requirements. Under the 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. Savings targets relative to Medicare's system-wide costs for the TCOC Model will continue as they were in the Base Model. Maryland and CMS will also address outcomes goals that will be incorporated into value-based payments and utilize federal tools and flexibilities to ensure Model success

This Progression Plan outlines ambitious goals for transforming Maryland's delivery system. The five strategies are designed to complement one another and rely on efforts from different parts of the delivery system. As Maryland moves from planning to implementation, a number of key topics will be more fully developed. The implementation timeline balances the challenges that the delivery system will face during significant transformation and the need to meet the demands of a changing environment, such as the aging of the population and Model performance requirements. The ability to fully implement and scale the proposed strategies will take time. At all stages, implementation of the Plan will be guided by the desire to better serve Marylanders.

Maryland's All-Payer Model Progression Plan outlines the State's overall framework for extending the current Model approach to limit growth in Medicare total cost of care and provides an overview of strategies and components that will be developed and implemented to accomplish these goals. Each component of the Plan will contribute to the management of total cost of care growth and transforming care delivery.

Redesigning primary care to achieve better overall population health outcomes, in concert with targeting the State's current high needs and rising-needs patients with community providers will prepare Maryland for success in the TCOC Model. Redesigning ambulatory practices prepares primary care physicians and other providers for success in the era of new physician payment systems, which was spurred by MACRA. Most importantly, it builds needed supports for patients.

The transformation of primary care in Maryland, coupled with hospital global revenues and care redesign programs, will create a unique laboratory of alignment in an all-payer environment across physicians, hospitals, post-acute and skilled nursing facilities, care managers, and other providers. The Plan also introduces geographic approaches beyond hospital global revenues, such as leveraging local services and supports that enable Maryland to continue to support health care transformation, particularly in rural areas.

For example, the State will encourage and support physicians, long-term care providers, post-acute providers, hospitals, and insurers in developing care redesign programs that advance the goals of better patient outcomes, greater care coordination, increased access to care, improved patient health, and

reduced costs. Ultimately, the Model aims to help physicians and other providers leverage complementary initiatives and federal programs to align participation in efforts focused on improving care and care coordination, and participation in incentive programs that reward those results. These programs will be voluntary, and the State will not undertake setting Medicare and private fee schedules for physicians and clinicians.

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 focused initially on the per capita total cost of hospital care. 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 All-Payer Model (Model) effectively changed the way Maryland hospitals care for patients and the way that hospital care is financed. 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 the Progression Plan is the goal of improving prevention, care and support for Marylanders with complex and chronic conditions by building a system of cooperation and aligned efforts in which physicians, hospitals, other providers and patients work together.*

Even in 2014, Maryland and CMS understood that more changes in health care payment and delivery would be needed to align hospitals, physicians, and other providers to further improve care for Marylanders. Accordingly, and as a required part of the Agreement, Maryland stakeholders have developed this document, the "Progression Plan" (Plan), which updates and advances Maryland's strategies to improve care and health outcomes, while limiting spending growth over time. The Plan describes the State's system-wide transformation with implementation beginning in 2017, continuing through 2018 and leading to the TCOC Model and additional progression in 2019 and beyond.

This Plan, which was submitted to CMS in December of 2016, has been updated to reflect discussions with CMS and stakeholders regarding Maryland's Progression Plan and the terms of a new agreement to replace the current All-Payer Model Agreement with CMS that ends on December 31, 2018. In 2017, the State submitted the TCOC Model and agreement terms for federal approval, to enable planning and implementation of the TCOC Model and its components in 2018. This Progression Plan has also been updated to reflect progress and changes that have been made since December 2016, when the Plan was initially published. For instance, the Plan includes additional details regarding the Maryland Primary Care Program, and the evolution of a Dual Eligible strategy are included.

For purposes of this Progression Plan, the term "Base Model" is used to refer to the current All-Payer Model Agreement with CMS in effect from 2014 through 2018, including its 2017 Amendment. The succeeding All-Payer Model, which has been enhanced to incorporate Medicare Total Cost of Care and other elements, is referred to as the "Total Cost of Care All-Payer Model" (TCOC Model).

The TCOC Model will run from January 1, 2019, through December 31, 2028, so long as the requirements of the TCOC Model are met. The TCOC Model includes both short-term savings and care and payment redesign, as well as long-term population health improvement goals and expectations that

aim to help the State achieve continued health care improvements and savings for Medicare and all payers over the span of more than a decade.

At the heart of this Plan is the desire to better serve Marylanders—those who bear the weight of navigating a complex health care delivery system. It also aims to improve care in the community to prevent and manage chronic conditions. 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. Therefore, the TCOC Model 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 Plan leverages and builds on the hospital per capita model by expanding efforts to support hospitals, physicians and other providers as they organize to engage patients and take on increasing responsibility for system-wide goals.

> *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 providers.*

The Plan aims to engage Maryland hospitals, physicians, other providers, patients, communities, payers, public health professionals and State policymakers in its innovation efforts and payment and delivery system transformation. While the State will set up the framework of the Plan, success of the TCOC Model, and ultimately the health care delivery system's transformation, success depends on innovation and leadership from the provider and payer community. For example, the State will encourage and support physicians, long-term care providers, post-acute providers, hospitals, and insurers, who have appropriate expertise, in developing care redesign programs that advance the goals of better patient outcomes, greater care coordination, increased access to care, improved patient health, and reduced costs. Ultimately, the Model aims to help physicians and other providers leverage other voluntary initiatives and federal programs to align participation in efforts focused on improving care and care coordination, and participation in incentive programs that reward those results. These programs will be voluntary, and the State will not undertake setting Medicare and private fee schedules for physicians and clinicians.

While the Plan will start with a stronger focus on Medicare beneficiaries, including dual eligibles who could benefit from additional supports, the progression is designed for applicability on an all-payer basis.

The five key strategies of the State's Progression Plan are to: (1) foster accountability for system-wide and patient-level goals; (2) align measures and incentives for providers across the continuum of care; (3) encourage and develop payment and delivery system transformation; (4) ensure availability of tools to support all types of providers in achieving transformation goals; and (5) devote resources to increasing consumer engagement. The Plan strategies and key elements will build on the strong foundation of the hospital global revenues, and be designed to work in concert with one another and with other critical innovations under way in the State.

Implementation of many of these strategies outlined in the Plan will require additional federal flexibility. Maryland will work with CMS to identify the federal waivers that will be needed to implement the full range of strategies proposed in this Plan. Maryland expects to maintain federal waivers that are currently authorized under the All-Payer Model Agreement and Care Redesign Amendments and will also need expanded flexibility in certain areas. Potential areas of expanded federal flexibility and waivers could include payment policies for post-acute, long term care facilities, and psychiatric hospitals; coverage policy for telehealth, patient incentives and post-discharge home visits; flexibilities provided to Next Generation Accountable Care Organizations (ACOs); or other federal policies.

By proposing an overall strategy for organizing, incentivizing, and supporting all types of providers in health care transformation, CMS has a unique opportunity to use Maryland as a statewide testing ground for implementing synergistic, value-based strategies that encompass hospitals, physicians and other providers in an all-payer environment. Maryland is establishing mechanisms as part of the Plan that 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, cost and population health in Maryland could serve as a national model.

Additionally, the federal Medicare Access and CHIP Reauthorization Act (MACRA) went into effect in 2017 and created further methods of physician engagement. CMS and the State have incorporated these opportunities into the Progression Plan and have amended the Base Model to conform Care Redesign Programs for MACRA eligibility.

In summary, this document provides background on the existing Model and challenges faced by the Maryland health care system, and describes the strategies that Maryland will employ to move forward in a public-private partnership aimed at bettering the lives of all Marylanders. The State will enter into new Agreements with CMS to implement the TCOC Model, including the Maryland Primary Care Program as a component, which will begin on January 1, 2019. Efforts to prepare for implementation are in progress.

II. Background

A. 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 started a new five-year All-Payer Model 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 Model, the hospital financing system in Maryland has moved away from one based on volume of services to a system based on hospital-specific global revenues with overlying value-based incentives. With this approach, hospitals are responsible for costs within a global revenue cap, and can make investments in care transformations that improve care and prevent potentially avoidable utilization without concerns about revenue decline, which is a significant barrier in a traditional fee-for-service (FFS) model. Major achievements of the All-Payer Model include transformation of payment and delivery systems, the creation of demonstrable value, sustaining rural health care, and the adoption and continuous improvement of support tools, as described below.

1. Payment and Delivery System Transformation Efforts Underway

Fragmentation within the United States' health care delivery system is a widely-recognized problem. In Maryland, the Base Model 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 taken responsibility for managing patient care beyond the hospital stay through the development of post-discharge programs. Many of these programs include social services that are needed for patients' well-being, such as transportation assistance, access to food, and other home supports.

Maryland hospitals, physicians and other 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 on initiatives that support complex and high-needs patients who use extensive healthcare resources. Most of these efforts are in early stages of implementation and must continue to mature. The pool of high-needs patients will increase with the aging population unless the State focuses on preventing the escalation of chronic conditions and provide better community-based access and supports for individuals with 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 achieve better health outcomes and cost performance for Maryland. Clearly this effort must move beyond hospitals and into the community to create sustainable success.

2. Creation of Value

The All-Payer Model has created value for CMS, other payers, Maryland's hospitals, and health care consumers. With the end of the fourth performance year, Maryland met or exceeded the key Agreement measures for limiting hospital cost growth, while also improving quality.

Despite unusually slow growth in 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). Through December 2017, Maryland achieved total hospital savings of approximately $916 million, exceeding the five-year savings requirement. Medicare hospital costs per beneficiary grew at a rate 5.63 percent lower in Maryland than the national growth rate from 2013 through December 2017. At the same time, Maryland also kept the growth in hospital spending on an all-payer basis well below the ceilings established in the Agreement, which were tied to the long-term growth of the economy.

Maryland achieved cost savings, while also improving several key quality indicators. For example, in calendar year (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. Figure 1 summarizes Maryland's performance on the Agreement's key metrics.

> *The hospital sector has achieved success in shifting from volume to value. Progression toward the same shift to value is now needed across the health care system.*

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 is expected when transitioning care to lower-cost settings. Even though Maryland is ahead of its savings requirements, the non-hospital trend reinforces the need to focus on total cost of care in the remaining years of the current term, and the TCOC Model part of the Agreement. The Plan lays out an approach that builds on the Model's early achievements by expanding transformation to include the continuum of providers, implementing new and better data and tools to support efforts, and adding financial incentives, programs, and accountabilities. Maintaining the pace of improvement under the Model will be challenging, since improvements will increasingly rely on complex delivery system transformation and coordinated efforts beyond hospitals.

Figure 1. Maryland All-Payer Model Performance To Date

Performance Measures	Targets	2014 Results	2015 Results	2016 Results[1]	2017 Results
All-Payer Hospital Revenue Growth	**≤ 3.58%** **per capita annually**	**1.47%** **growth per capita**	**2.31%** **growth per capita**	**0.80%** **growth per capita**	**3.54%** **growth per capita**
Medicare Savings in Hospital Expenditures	**≥ $330m cumulative over 5 years** (Lower than national average growth rate from 2013 base year)	**$120m** (2.15% below national average growth)	**$135m** **$251 cumulative** (2.63% below national average growth since 2013)	**$311m** **$586m cumulative** (5.50% below national average growth since 2013)	**$330m** **$916m cumulative** (5.63% below national average growth since 2013)
Medicare Savings in Total Cost of Care	**Lower than the national average growth rate for total cost of care from 2013 base year**	**$142m** (1.62% below national average growth)	**$121m** **$263m cumulative** (1.31% below national average growth since 2013)	**$198m** **$461m cumulative** (2.08% below national average growth since 2013)	**$118m** **$599m cumulative** (2.08% below national average growth since 2013)
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	**30%** **reduction over 5 years**	**25%** reduction	**34%** reduction since 2013	**44%** reduction since 2013	**53%** reduction since 2013
Readmissions Reductions for Medicare	**≤ National average over 5 years**	**19%** reduction in gap above nation	**58%** reduction in gap above nation since 2013	**79%** reduction in gap above nation since 2013	**116%** reduction in gap above nation since 2013 (Currently 0.19% lower than National RR)
Hospital Revenue to Global or Population-Based	**≥ 80%** **by year 5**	**95%**	**96%**	**100%**	**100%**

3. Sustaining Rural Health Care

Nationally, rural hospitals are facing severe financial challenges. Declining revenue, driven in part by shrinking inpatient demand, has been a major factor in deteriorating financial stability. Many Americans living in rural communities rely on their hospital as one of their few sources of health care. Rural hospitals also serve as anchors for population health initiatives, and are economic engines in what may otherwise be weak local economies. The need to improve preventative care and supports for individuals

[1] During the last six months of CY 2016 (July-December of 2016), hospitals undercharged their Global Budget Revenue mid-year targets by approximately $25M dollars. The measures reported have been adjusted to 'add back' the undercharge to the period of July-December 2016 to offset the decline in savings for January-June 2017.

in rural areas is intensified by population decline that results in an older remaining population with higher levels of need.

However, reimbursement systems dominated by traditional fee-for-service arrangements do not provide the opportunity for hospitals to further develop functions to improve prevention, care and support. Fee-for-service reimbursement places too much reliance on payment for inpatient services and does not encourage a population focus. In this environment, rural hospitals are forced to prioritize inpatient care, instead of playing a broader role in managing total cost of care and population health.

The need for transformation in rural health care delivery is a bellwether for the larger health care delivery system. Rural hospitals in Maryland experienced the challenges faced by rural hospitals nationally. In 2011, Maryland initiated a global revenue system for 10 of its hospitals serving rural communities.

Under the 2011 global revenue system, Maryland's 10 rural hospitals formed a transformation collaborative to develop care strategies to support patients beyond hospitals, reduce readmissions, increase resources for population health, and share successful approaches. Rural hospitals accelerated investments in care management strategies (e.g., placing social workers in emergency departments to address medication needs, connecting patients to primary care providers, and addressing social determinants such as transportation). They also created multi-disciplinary clinics to provide intensive supports to complex and high-needs patients in the initial two-to-seven days post-discharge by educating and stabilizing complex patients before they returned to their primary care providers for ongoing care. These and other initiatives accelerated the reduction of admissions and readmissions in these hospitals, and with global revenue supports, these hospitals were able to maintain financial viability and reinvest the resources in needed community supports and care. After achieving some success, Maryland extended the global revenue model for rural hospitals to all acute hospitals statewide in 2014.

In developing the Progression Plan, Maryland continued to focus on local initiatives and sustainability of rural health care. For instance, Section V. B. Key Element 1b describes plans for development of accountability in local communities. Likewise, Section V. D. Key Element 3a describes the Maryland Primary Care Program, which is especially well suited to support primary care practices in rural settings through care management resources and transformation support.

4. Next Steps: Aligning Providers Across the Continuum of Care

Since the start of the Model in 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 redesign care delivery. However, the rest of the health care system in Maryland (e.g., physicians, post-acute providers, etc.) continues to operate mostly on a FFS basis with financial incentives tied to volume, as opposed to value. Health care services are still often characterized by fragmented care delivery, insufficient integration, and a lack of team-based care. While Accountable Care Organizations (ACOs) and Patient-Centered Medical Home (PCMH) programs are making some progress in ameliorating these problems, they currently include less than 30 percent of the Maryland Medicare FFS population. Additionally, new Medicare Advantage plans have formed and entered the Maryland market, bringing the potential for more care management to the Medicare system.

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 State has taken significant steps to lay the

foundation for delivery system transformation. In response to Maryland stakeholders' requests for greater provider alignment and transformation tools, the State proposed a Care Redesign Amendment to the All-Payer Model that CMS approved. Care redesign encourages hospitals, physicians, and other providers to work together to support the health of Medicare patients who have significant needs. Importantly, providers and payers will have the opportunity to lead the development of care redesign programs, along with collaboration from other care partners.

The Plan's efforts to incorporate providers across the continuum of care and all residents in Maryland will start with Medicare beneficiaries, but are designed to facilitate inclusion of other patients and payers over time. A commitment to all-payer principles will be maintained through a focus on implementing initiatives and performance measures that can be applied across payers and accountable entities, at an appropriate time, with the right conditions. This is important to help drive system transformation, increase administrative efficiency, and reduce hassle for providers.

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 Plan is designed to build on the current hospital model and work together with the other strategies to meet Maryland's objectives. The State's overall goal is to ensure that all Marylanders benefit from delivery system transformation through improved quality of care, better population health, and greater cost efficiency.

5. State of Maryland's Health Care Administration and Agencies Supporting the Progression Plan

The Plan development was supported by the State's agencies including the Maryland Department of Health (MDH)[2], the Health Services Cost Review Commission (HSCRC), and the Maryland Health Care Commission (MHCC). These agencies lead the oversight of ongoing implementation and monitoring as health systems, payers, providers, and other supporting entities transform the delivery system.

- The Maryland Department of Health (MDH) is the State's public health agency, with the mission to promote and improve the health and safety of all Marylanders through disease prevention, access to care, quality management, and community engagement. MDH is divided into four major divisions: Public Health Services, Behavioral Health, Developmental Disabilities, and Health Care Financing, which includes the State's Medicaid program.
- The Health Services Cost Review Commission (HSCRC) is an independent State entity of the Department with statutory authority for maintaining the hospital all-payer rate-setting system and overseeing hospital global budget revenues. The HSCRC is governed by a group of seven volunteer Commissioners appointed by the Governor and has a 37-member staff.
- The Maryland Health Care Commission (MHCC) is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access to cost-effective services. MHCC pursues its mission through information gathering and dissemination, health policy analyses, regulatory authority, and health planning. Its 15 Commissioners are appointed by the Governor with legislative input.

6. Maryland's Health Information Exchange: Foundation for Supporting Transformation

Maryland's Health Information Exchange (HIE), the Chesapeake Regional Information System for Our Patients (CRISP), is uniquely positioned as a tool to support health system transformation in Maryland.

[2] In July 2017, the Maryland Department of Health and Mental Hygiene changed its name to the Maryland Department of Health.

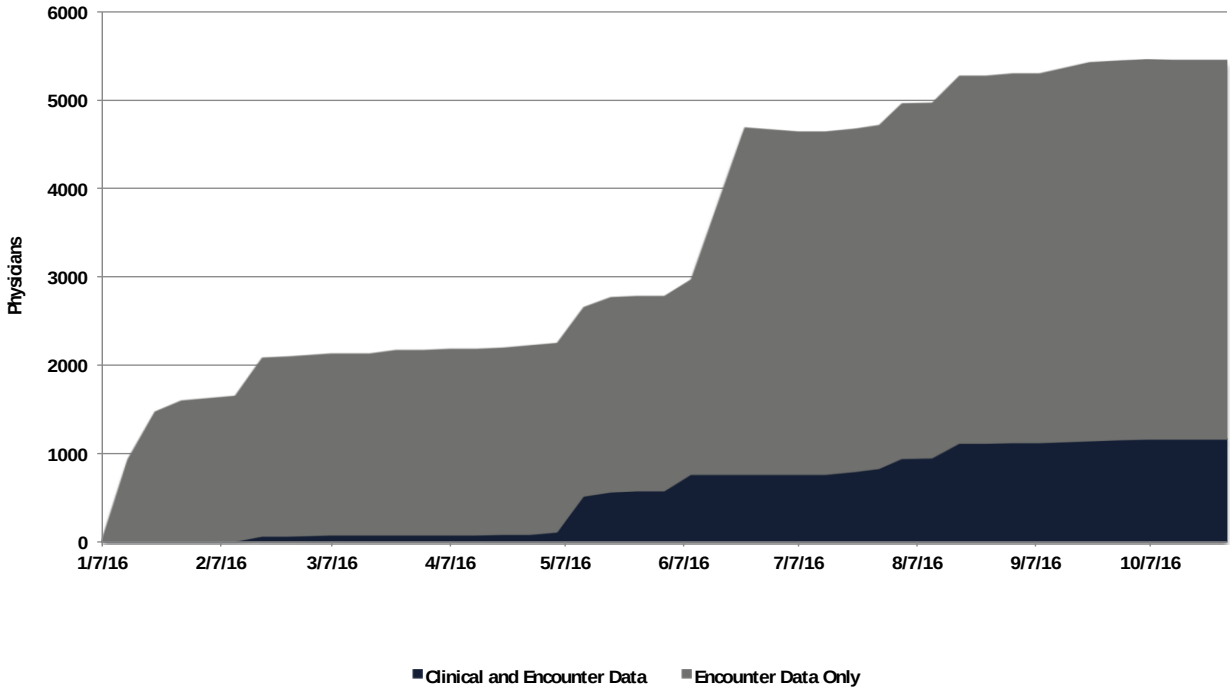
CRISP is a private, not-for-profit enterprise governed by a volunteer board. CRISP focuses on supporting data infrastructure needs that can best be accomplished cooperatively, augmenting resources of payers, health systems, and providers.

Hospitals in Maryland and Washington, DC, submit near real-time admission, discharge, and encounter information to CRISP. CRISP receives and exchanges information with several other facilities in states that border Maryland. CRISP's functions extend beyond those of a traditional HIE.

CRISP's Encounter Notification Service, which notifies physicians, other providers and care managers when patients are hospitalized, has become a critical coordination service in the State. A new web-based capability to proactively manage patient transitions allows a care manager to quickly and efficiently detect recent inpatient and emergency department admissions and discharges. High-needs individuals and their care team members can also be identified through the new capabilities. More than one million Encounter Notifications are being sent and received annually, a number that is steadily growing over 2017.

A key CRISP initiative is increased connectivity with ambulatory practices. New ambulatory integration capabilities allow physicians to view clinical data and receive hospitalization alerts. This helps to coordinate follow-up with patients who have had an acute episode and to reach out to attending physicians; monitor the prescribing and dispensing of drugs that contain controlled dangerous substances; and view more comprehensive patient information, including treatments with other physicians and providers, to make more informed treatment plans. In addition, new automated reports allow physicians and other providers to monitor and improve quality performance, reduce redundant testing and treatment, and easily communicate treatments delivered. New capabilities automate physician and other providers' workflow, reducing unnecessary manual work. Figure 2 shows increases in ambulatory connectivity. As of the end of October 2016, more than 1,100 physicians are sharing clinical and encounter data with CRISP and 4,200 more physicians are sharing encounter data only. This represents a rapid increase in ambulatory connectivity over the past year, incorporating approximately one-third of Maryland's 15,000 physicians.

Figure 2. Ambulatory Connectivity: Number of Physicians Sharing Data with CRISP to Date in 2016



CRISP is currently piloting two key strategies: (1) offering basic care management software as a shared platform; and (2) supporting hospital-selected care management software with data feeds. Both programs will help to create an environment where risk assessments, care plans, care plan updates and other important information and tools can be shared among hospitals, care managers, physicians and other providers involved in the coordinated care of an enrolled patient.

CRISP also provides reporting and analytics resources to inform decision-making. These efforts fulfill several different functions, including guiding care coordination, identifying populations, and providing metrics for care monitoring. Analytics data draw from multiple sources including Medicare data, HSCRC case-mix data, U.S. Census and population data, and CRISP-reported data and provider panels. These data are enriched with analytics and methodologies such as geocoding.

These investments continually improve the richness of clinical information available at the point-of-care and the tools that are used for care coordination, both of which are critical to the success of Maryland's progression efforts.

B. First Step Toward Provider Alignment: Care Redesign Amendment

Maryland stakeholders recognized that greater alignment with physicians and other providers 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 May 2017. The Amendment modifies the Model by:

- Encouraging more effective care management and chronic care management
- Incentivizing hospitals' efforts to provide high-quality, efficient, and well-coordinated episodes of care

- Supporting hospitals' ability, in collaboration with their non-hospital care partners, to monitor and control Medicare beneficiaries' total cost of care growth

The Amendment gives Maryland hospitals the opportunity to implement Care Redesign Programs intended to improve health outcomes. Care Redesign Programs allow hospitals to access comprehensive Medicare data, share resources with each other, and offer incentives to community physicians and practitioners, physicians that practice at hospitals and other providers, collectively known as care partners. Maryland hospitals are 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 Medicare data for implementing, monitoring, and improving their Care Redesign Programs.

> *The Care Redesign Amendment supports hospitals and their partners to achieve care improvements through sharing data, resources, and incentives.*

A portfolio of such programs will be developed over time. In July 2017, 16 hospitals chose to participate in one or both of the first two Care Redesign Programs: The Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP):

- The Hospital Care Improvement Program (HCIP) is being implemented by hospitals and physicians with privileges to practice at a hospital. This Care Redesign Program 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. These efforts are expected to improve quality and patient satisfaction and reduce costs per acute care admission.
- The Complex and Chronic Care Program (CCIP) is being implemented by hospitals in collaboration with community physicians and practitioners. It strives to link hospitals' resources for managing the care of individuals with severe and chronic health issues with primary care providers' efforts to care for the same populations, as well as patients with rising needs. The approach is designed to reduce potentially avoidable utilization and to facilitate overall practice transformation towards more person-centered care.

Through the Amendment, Maryland hospitals can promote greater linkages with their 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 Care Redesign Programs complement existing provider and payer-led efforts and jumpstart the State's commitment to delivery system transformation by reaching more providers and patients than existing accountability approaches. As new payment and delivery approaches are introduced (e.g., Maryland Primary Care Program) and as high-performing models attract new providers and consumers, the Care Redesign Programs also will continue to evolve to meet the changing needs of Maryland. Stakeholders and the State may choose to modify or eliminate Care Redesign Programs over time as they are replaced with more comprehensive delivery and payment approaches.

As new approaches are deployed, Maryland will be attentive to how patients progress through the continuum of programs and the need for coordination and continuity. Significant emphasis will be placed on the need for new processes and harmonization of approaches as they are designed and implemented, staying cognizant of and responsive to the experiences of both providers and patients.

Physicians must be collaborators in developing care redesign programs and other delivery models consistent with the All-Payer Model to ensure voluntary participation.[3]

The Amendment gives Maryland the flexibility to expand and refine Care Redesign Programs, based on outcomes, learnings, and the changing levels of sophistication of Maryland's health care system players, as well as the needs of health care consumers. The State is deploying a process by which providers and stakeholders make recommendations on enhancements to current programs or for the introduction of new programs to meet the unique needs of Maryland's patients, payers, and health care providers. This flexibility also 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 ongoing progression towards addressing system-wide health care outcomes and costs. Medicare physician cost data should not be the basis of physician reimbursement or allocation of shared savings to physicians in the Maryland Primary Care Program, in the event that the program evolves to include non-Medicare or non-Medicaid beneficiaries.

C. Accelerated Pace of Change

Demographic trends and environmental factors increase the need to undertake the strategies proposed by this Progression Plan. Over the next 10 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.

Maryland submitted a previous version of this Progression Plan to CMS in December 2016, as called for under the current Agreement with CMS. This Plan emphasizes progressively addressing the growth in total cost of care for Medicare beneficiaries through delivery system transformation. Several State initiatives are targeting different aspects of health care delivery in ways that are consistent with the goals of the Agreement, including Dual Eligible Alignment and the Maryland Primary Care Program, as summarized in this document.

> *The Progression Plan provides a clear path to address the pressures of an aging population, and works in concert with Maryland and federal policy priorities.*

The federal policy environment encourages the types of strategies proposed under the 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 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 has created a new framework by which physicians can be encouraged and incentivized to embrace value-based care

[3] Physicians includes: hospital employed physicians, university hospital employed physicians, independent and private physicians.

delivery. Maryland's objective is to provide a pathway for all physicians and other providers subject to this legislation to participate in the Agreement and receive MACRA incentives through the creation of care improvement programs. Recognizing that CMS only recently issued final regulations to implement MACRA, the Plan includes preliminary concepts on how to accomplish this transition. The State will encourage and support physicians in all specialties, who have appropriate expertise, in developing Care Redesign or other programs with the goal of increasing access to care and team-based support, in providing coordinated treatment and medication management, as well as in providing other services which tend to further the goals of access to care and patient health. Maryland will continue to work with CMS and stakeholders to develop and finalize its strategies.

III. Plan Overview

A. Vision

Maryland's vision is to: *Achieve person-centered care, foster clinical innovation and excellence in care, improve population health, and moderate the growth in costs, on a statewide basis and in the all-payer environment through the transformation of the health care delivery system.*

Maryland plans to achieve its vision by working toward three key goals: (1) improve population health; (2) improve outcomes for individuals; and (3) control growth of total cost of care. These goals guided the development of the All Payer Model Agreement between CMS, and they are reaffirmed in this Plan.

Goal 1: Improve population health

- Ensure adequate access to appropriate community-based care to promote prevention and early detection of disease.
- Identify and provide additional resources (e.g., increased access to care 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 influences on health status, including personal health behaviors, behavioral health issues and environmental factors, particularly for vulnerable populations.
- Address social determinants of health status and access to care through case management, resources from community organizations, and public focus and 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.

- Encourage appropriate use of community-based services so that individuals with complex and chronic health issues, including behavioral health, can continue living and receiving care in the community.
- Improve coordination of care across settings, reducing re-visits and medication errors, and improving outcomes.
- Reduce health care-acquired conditions and complications of care.

Goal 3: Control growth of total cost of care

1. 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.
2. Provide an early and intense focus on fee-for-service (FFS) Medicare and dual eligible beneficiaries, since these populations are rapidly growing, have higher needs and underdeveloped supports.
3. 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.
4. Support all types of providers in organizing to take increasing accountability for cost and care outcomes.
5. Align public health and community organizations to provide chronic illness management supports that enable vulnerable individuals and their families to function safely in their homes and in the community.

B. All-Payer Model Progression

The TCOC Model will begin on January 1, 2019 and continues for 10 years, so long as the State continues to meet the Agreement requirements. Maryland will have the opportunity to transition the TCOC All-Payer Model to an ongoing Model during this timeframe. If it is transitioned to an ongoing Model, it will no longer be a demonstration but will become a payment and delivery Model with certain attributes and ongoing performance requirements.

As Maryland progresses to the TCOC Model in 2019, the State estimates cumulative total cost of care savings for the first five years (2019-2023) to reach more than $1 billion. This will be achieved by:

1. Continuing and expanding efforts focused on improving care management for complex and high-need patients.
2. Accelerating prevention and chronic care management and payment reform through the Maryland Primary Care program.
3. Aligning payment reform beyond hospitals to include Medicare Access and CHIP Reauthorization Act (MACRA) bonus-eligible programs and developing payment and delivery changes applicable to long-term and post-acute care settings.
4. Aligning public health efforts with the population health improvement goals of the TCOC Model.
5. Increasing responsibility for system-wide goals through provider incentives, Accountable Care Organizations (ACOs) and improved management of dual-eligible beneficiaries.

Each of these efforts will continue the progress begun in 2014 and expand upon Maryland's vision for progression of the Model to build broad participation of all providers, patients, the State's public health infrastructure, and payers in the TCOC Model. This, in turn, is expected to result in more rapid and systemic improvements. For example, this work will directly support progress on person-centered care management and health outcomes. This will limit per capita cost growth, yet allows the State to still meet the needs of an aging population, align hospitals with community physicians and other providers, and improve chronic care management.

Financial and outcomes goals and requirements will measure the success of the TCOC Model. The Model will be expected to limit the growth in hospital costs for all payers on a per capita basis. The growth in Part A and B Medicare total cost of care must be limited to a growth rate below the national growth rate to produce targeted saving to Medicare by 2023, and thereafter to maintain those savings. The Maryland Primary Care Program must reach a net savings level over a period of time, and quality and value-based metrics and payment programs that are comparable to national CMS programs must be applied on an all-payer basis for hospitals in Maryland. In addition to these requirements, the TCOC Model will include new population health goals. Success in meeting population health goals may be used to offset investments in care delivery enhancements. Each of these requirements is described in more detail in Section VI of this Progression Plan.

The overall progression and timeline that will apply to the 10-year term of the TCOC All-Payer Model, 2019 – 2028, is as follows:

1. The State commits to reach an annual savings target in total spending for Part A and Part B services of $300 million by Year 5 (2023). Savings will be calculated using Maryland's Medicare growth trend relative to the national total cost of care trend over a 2013 base year.
2. By the end of Year 4 (2022), CMS and Maryland will assess Model progress and determine if savings are on track to meet the savings target. Adjustments will be made to assure that the Model will reach its target by the end of Year 5 (2023), unless otherwise agreed by CMS.
3. Prior to Year 6 (January 2024), the State and CMS will agree on a formula to determine the maximum allowable Medicare total cost of care growth rate for the second five years of the TCOC Model Agreement and potential permanent model. This growth rate will be set to ensure that the compounded annual payment growth in Maryland is no greater than the national average growth. CMS and the State will develop a formula to smooth the requirement (e.g. two-year cycle with corrections from estimates to actual, three-year rolling average period). A rolling average would assure CMS of ongoing limits in the growth per beneficiary, while addressing normal variation that can occur on a year-to-year basis.
4. If the State has not met its Year 5 (2023) savings target, or if additional savings are required to incorporate investments, then the additional savings requirement, net of any portion already adjusted for through the application of the Medicare Performance Adjustment, will be considered in the development of the allowed growth rate. If CMS and Maryland cannot agree to a growth calculation, CMS will require an additional $36 million in annual savings per year, equal to the relative incremental savings in the first five years for the remainder of the contract.

5. Beginning with Year 6 (2024), the State may offset primary care or other approved investment costs with CMS-approved population health savings or credits, which will be determined annually for Year 6 through Year 10 (2028) of the Model.
6. During the initial five years of the TCOC Model, the State will progressively plan and implement aligned payment and delivery transformations for dually-eligible beneficiaries. By Year 6, the State will incorporate an alignment model for Medicaid that limits the growth in both Medicare and Medicaid expenditures for dually-eligible beneficiaries, while also improving the coordination and delivery of care.
7. By Year 6 (2024), CMS will consider whether to make the Model an ongoing Model and test whether Maryland can maintain the $300 million savings level on an ongoing basis through Year 10 of the TCOC Model.
8. By Year 9 (January 2027), if the Model will be expanded, the State and CMS will work to draft regulations to make other changes and agreements needed to accomplish this outcome for implementation no later than January 2029.
9. If the Model is not expanded, CMS will consider Maryland's proposal for a new Model, which will be submitted to CMS no later than the beginning of Year 8 (January 1, 2026). If CMS does not approve Maryland's proposal by the end of Year 8 (December 31, 2026), hospital payment for Medicare will begin the transition to a CMS system over a two-year timeframe, subject to the provisions described in Section VII.

C. Scope of Progression Plan

The Progression Plan engages Maryland hospitals, physicians, and other providers in transforming the way care is provided. The 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 FFS beneficiaries, 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 Plan will seek to target the broader Maryland population, including more robust prevention and support that will help those with moderate risk to prevent future high utilization.

The Plan will affect six million Marylanders and more than $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 3).

Figure 3. 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**

D. Plan Accountability Structures

As the Progression Plan is implemented, the State and CMS will carefully consider how the various initiatives and accountability structures interact for all payers. Methods, to determine how the finances of multiple structures/programs with shared savings from payers operating in the same markets, will be implemented, ensuring that shared savings from payers are uniquely attributed to one accountability structure. Measures and monitoring systems will be created to understand the impact of initiatives on Medicare, Medicaid and commercial patients, payers and provider, facilitated by Maryland's strong data infrastructure and access to patient-level data.

For ACOs, shared savings payments will be added to the total cost of care in both Maryland and national expenditures in determining the Medicare savings. CMS and Maryland will monitor the interaction of ACOs with the TCOC Model components. The State anticipates that ACOs will contribute to the performance requirements of the TCOC Model through their primary care assignments and care management efforts. If CMS and Maryland determine that shared savings payments adversely affect the ability to meet the savings requirements of the TCOC All-Payer Model, CMS may make adjustments to trend factors or benchmarks used for ACOs to ensure consistency with the Medicare savings requirements of the TCOC Model. The Medicare Performance Adjustment (Section VI, Sub-Section A, number 5), a new value-based incentive applicable to hospitals relative to Medicare total cost of care performance, can also act in concert with ACOs as a reinforcing mechanism. As a cost reflected in FFS claims payment, the Medicare Performance Adjustment will not be double counted.

Incentives paid to providers within payment systems will reinforce Model goals and support the goals of accountability structures. The financing of FFS provider incentives are captured in the cost of care within their respective accountability structures. As new payment structures are introduced, it will be important to ensure that these payments also are captured in the accountability structures. Maryland will work with CMS to determine how to attribute costs from non-claims based payments to beneficiaries in order to support cost finding for ACOs, hospital savings, the Medicare Performance Adjustment, and other payment and delivery programs. Non-fee schedule payments made by CMS will be counted as expenditures in both Maryland and non-Maryland settings when calculating the Medicare Total Cost of Care savings requirement until 2024. (Section A, Sub-Section A).

E. Plan Development Process

Maryland's All-Payer Model Agreement was supported by a robust stakeholder process, which started prior to implementation in 2014 and has continued through the development of this Progression Plan.

The MDH and 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 counseled the HSCRC on initial implementation and progress of the Model and has been considering the key elements of this Plan for approximately one year. Guiding Principles developed by the Advisory Council and published in two Advisory Council reports (January 2014 report and July 2016 report) were used for the development of the Plan:

1. Focus on meeting the Model requirements.
2. Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation.
3. HSCRC should play the roles of regulator, catalyst and advocate.
4. Consumers should be involved in planning and implementation.
5. Physician and other provider alignment is essential.
6. An ongoing, transparent public engagement process is needed.

The MDH, HSCRC, and MHCC, convened several workgroups and sub-workgroups to formulate specific details of the Plan. The State also received input directly from many stakeholders. More than 200 people were actively involved in the development and review of this Plan. The Plan was posted for public comment on the MDH and HSCRC websites and sent through stakeholder distribution lists to hundreds of consumers, providers, and other stakeholders throughout the State. MDH and HSCRC also presented the plans to the Maryland State Legislature. The State received input from a significant number of people representing consumers and all types of health care stakeholders. The State also received letters of support, which were submitted to Maryland's Governor.

IV. Theory of Action

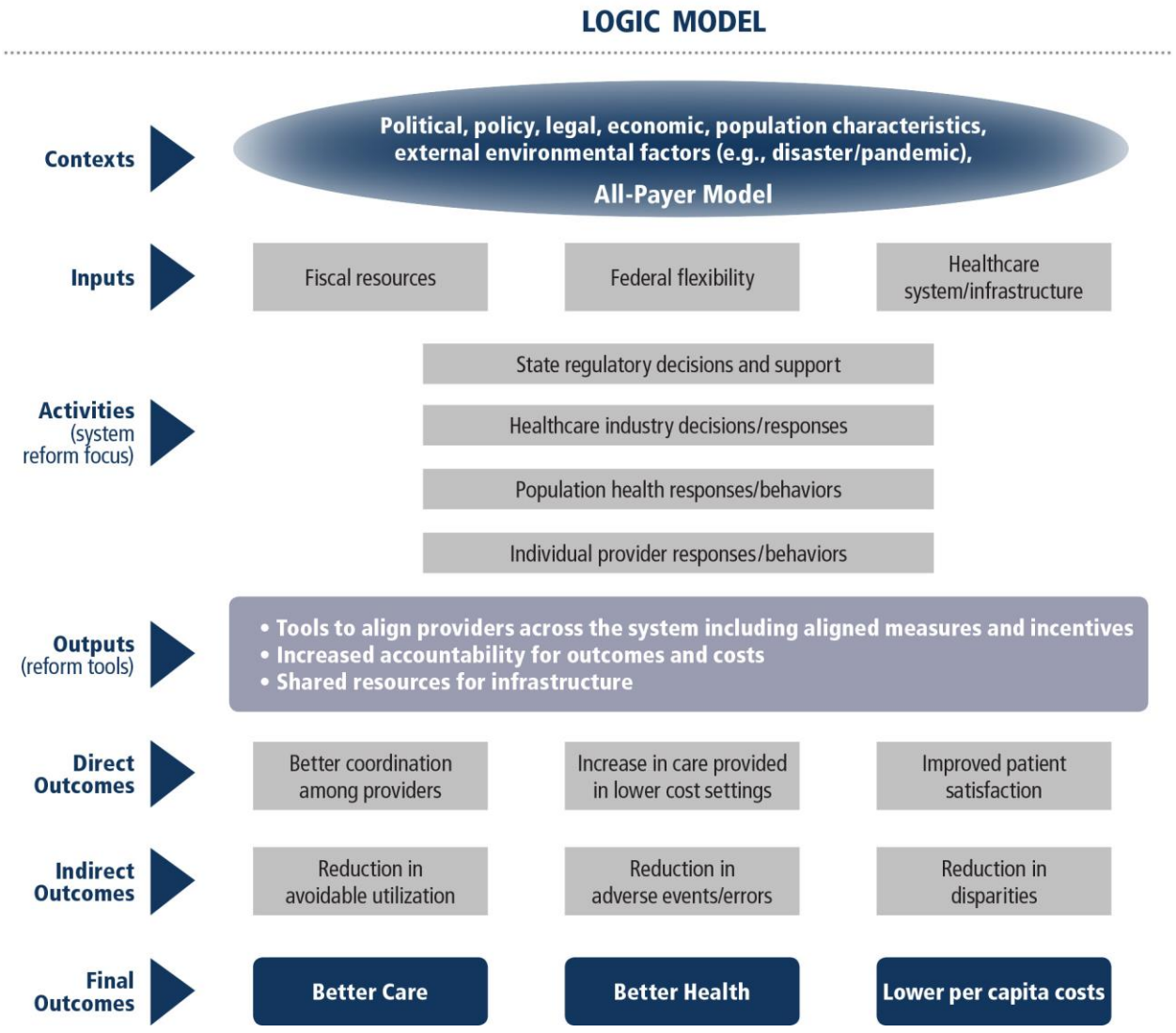
Maryland's All-Payer Model, while successful in limiting hospital cost growth and improving key quality indicators, does not have the tools needed to fully address total cost of care. To sustain the success of the Model and leverage its success for the good of all Marylanders, particularly the aging population, more must be done to thoroughly address total cost of care and the factors that drive costs and quality across all providers. Maryland's plan of action is to improve the overall health of Maryland residents and to create coordinated, person-centered care that results in reductions in potentially avoidable utilization, moderated growth in total cost of care, and higher quality care across the continuum of providers in the health care system.

A. Logic Model

The logic model, shown in Figure 4 below, offers a visual representation of the context, inputs, activities, outputs, and outcomes expected from the Progression Plan (Plan). This diagram was first used in the application submitted to CMS in September 2013 to depict how the State initially envisioned the All-Payer Model. The logic model has been updated to reflect the context and outputs associated with the Progression Plan.

An important part of the context for the Progression Plan is the All-Payer Model itself, which is the starting point for the Progression Plan. Federal flexibility is particularly critical for the Progression Plan as MACRA is implemented and system investments in infrastructure are brought to scale with their expected long-term return on investment. The outputs, which have been updated based on the progression of the Model, include alignment of incentives and measures across all providers, gradual increases in responsibility for outcomes and costs, and infrastructure that is shared among providers. The ultimate outcomes continue to be better health, better care, and lower per capita costs.

Figure 4. Progression Plan Logic Model



B. Driver Diagram

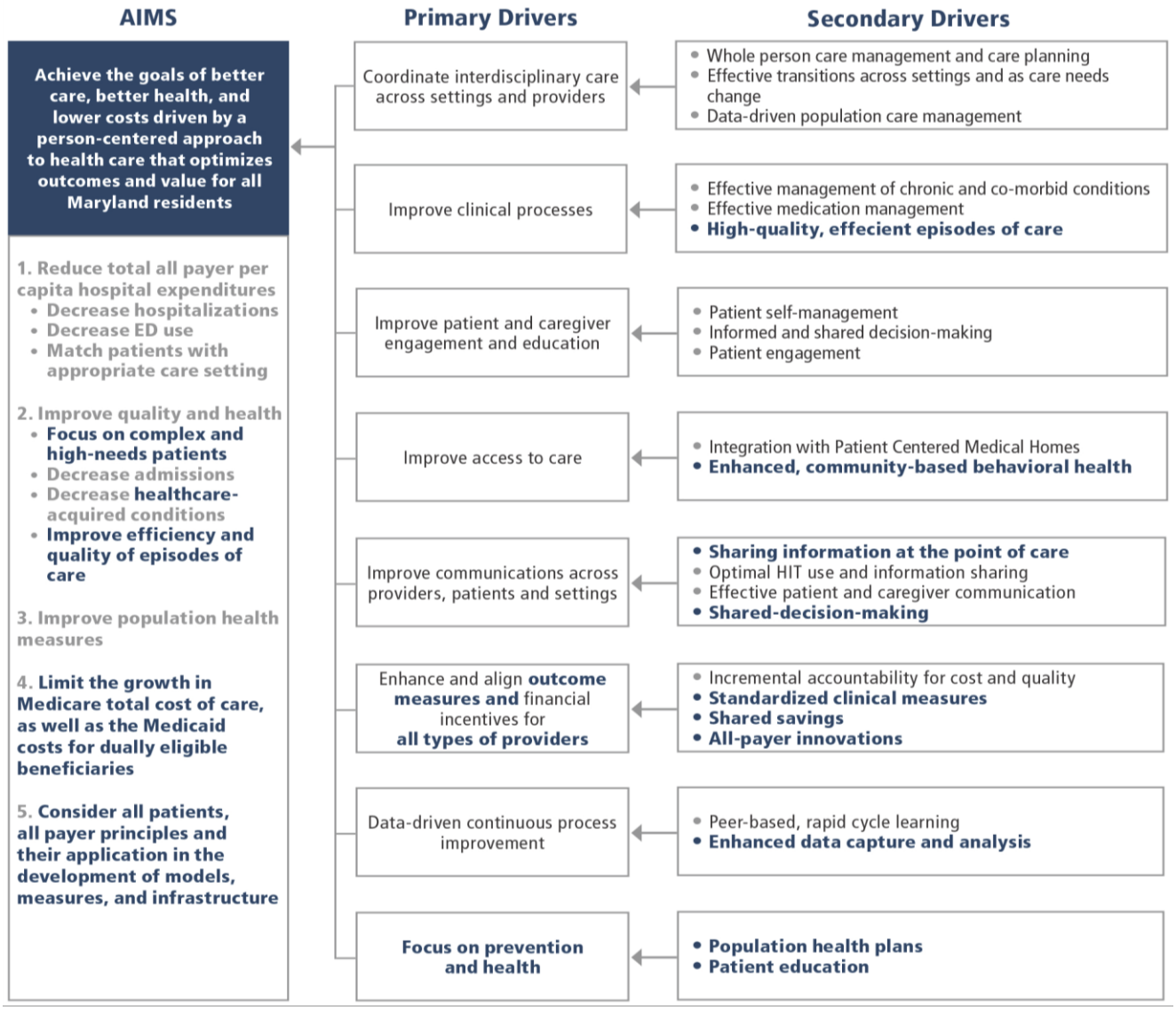
The Driver Diagram in Figure 5, initially developed in 2013 for Maryland's All-Payer Model (Model) application, depicts the system drivers that were identified to accomplish the specific aims of the current Model. The Diagram depicted a statewide health care system that continuously achieves better

health, better care, and lower expenditures based on the achievement of the primary and secondary drivers.

To reflect how the Progression Plan builds on the original framework and intent of the All-Payer Model, the Driver Diagram has been updated with new Aims to create incremental accountability for Medicare total cost of care, as well as Medicaid costs for dual eligible beneficiaries. The overall Aim to achieve the goals of better care, better health, and lower costs driven by a person-centered approach to health care that optimizes outcomes and value for all Maryland residents was extended to 10 years and acknowledges the context of the Model environment.

Additional Primary and Secondary Drivers depict the efforts that will be made to further the success of the Model through programs that harmonize providers through aligned incentives and measures, the provision of more comprehensive data, greater focus on person-centered care, data-driven activities, and care management strategies, as well as a focus on prevention.

Figure 5. Progression Plan Driver Diagram, Updates Depicted in Blue



C. Potentially Avoidable Utilization: Cost Drivers and Progression Strategies

This document outlines the Plan strategies that Maryland will use to create person-centered care and reduce potentially avoidable utilization. The strategies include core delivery system transformation components that address total cost of care, such as: (1) the global revenue system with a new total cost of care value-based incentive and associated Care Redesign Programs; (2) the Maryland Primary Care Program, (3) post-acute and long-term care initiatives; and (4) Dual Eligible Alignment. Core transformation components will be supported by accountability structures and by strategies that will be applied to every component (e.g., leveraging MACRA incentives and aligning measures/incentives across components).

Figure 6 depicts the expected types of reductions in potentially avoidable utilization that will be driven by each of the core transformation components and accountability structures, shown in two major categories: (1) complex and chronic care management, and (2) coordination and high-quality, efficient coordinated episodes.

Figure 6. Reductions in Potentially Avoidable Utilization Driven by Components of Progression

Potentially Avoidable Utilization	Admissions	Readmissions	Hospital Care	Post-Acute Care	Emergency Visits	Other Part B Costs	Need for Long-Term Care
Progression Components							
Complex and Chronic Care Management, Care Coordination							
TCOC Value-Based Incentives	X	X		X	X	X	
Complex/ Chronic Improvement Program	X	X			X		X
MD Primary Care Program	X	X			X	X	X
ACOs/Dual Eligible Alignment	X	X		X	X	X	X
Post-Acute and Long-Term Care Initiatives	X	X			X		
Aligned Measures/Incentives	X	X			X		
High Quality Efficient Coordinated Episodes							
TCOC Value-Based Incentives			X	X		X	
Hospital Care Improvement Program		X	X	X			
Post-Acute and Long-Term Care Intiatives		X		X			
Leverage MACRA Incentives			X	X		X	
Population Health							
Enhancing Community Behavioral Health					X		
Public health resources devoted to prevention and health improvement	X	X			X	X	X

Maryland believes that deploying the components of the Plan and achieving wider adoption of improved clinical practices with supporting payment mechanisms will result in improved outcomes and give Maryland the opportunity to fully manage total cost of care through:

a) Fewer potentially avoidable admissions and readmissions by managing chronic and complex conditions and delivering care in the best setting at the right time.

b) Fewer unnecessary visits to the emergency department by creating alternative access and closely managing conditions to reduce the number of emergencies.

c) Higher quality and more efficient acute episodes of care.

d) Reductions in healthcare-acquired conditions.

e) Less need for long-term care through improved health and functionality that faciliates independent living.

f) Proactive management of the best setting for post-acute care.

g) Better management of Medicare outpatient non-hospital costs, known as "Part B" costs, through total cost of care accountability, a focus on prevention and proactive management of conditions.

h) Overall improvement in the health of Maryland consumers.

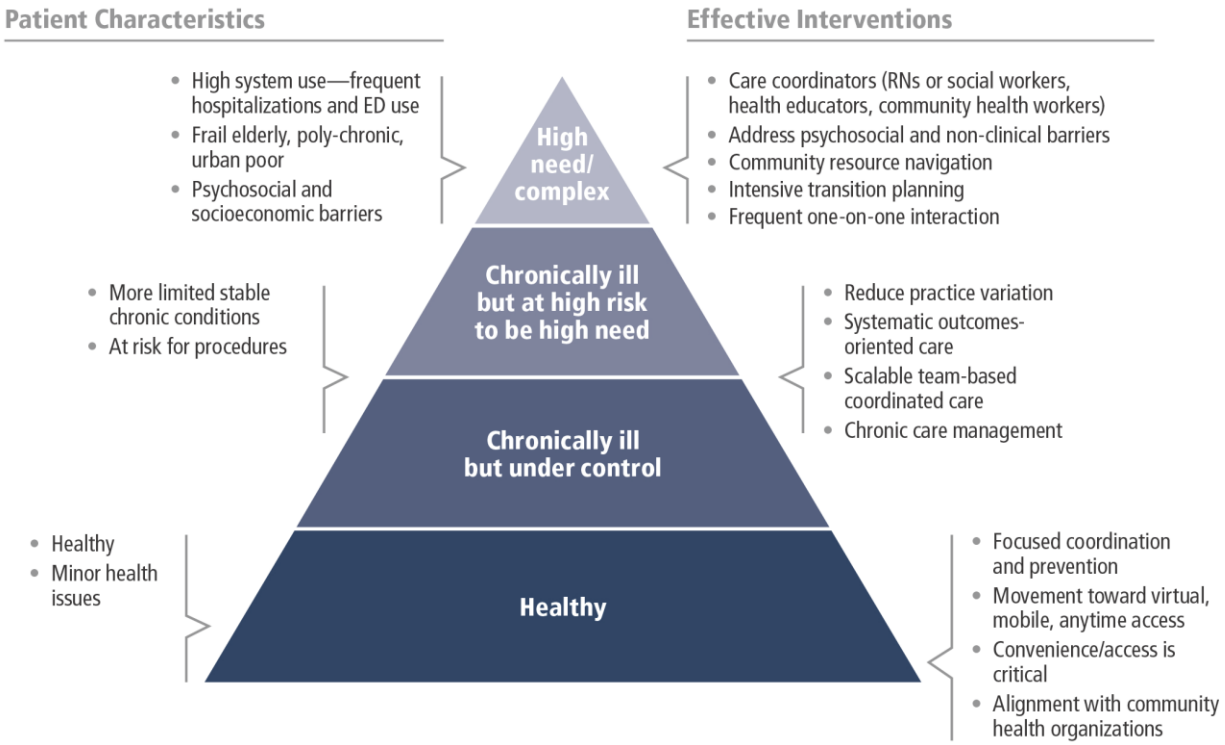
Maryland expects to rely on private resources of health systems, payers, and others, as well as public-private partnerships, where cooperation is beneficial, to provide the infrastructure and transformation resources that will be needed to accomplish the Progression Plan.

V. Proposed Plan

A. Introduction and Strategy Overview

To achieve its person-centered vision and goals, beyond the hospitals, Maryland intends to engage health care providers, patients, communities, payers, and public health professionals in its innovation efforts and payment and delivery system transformation (Figure 7). The pyramid below illustrates the stratification of patients by relative need to help focus on those who can most benefit from care interventions.

Figure 7. Tailoring Interventions to Patients' Needs



Most people do not remain in a static state. They may move up and down in the pyramid shown in Figure 7. 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 physicians and other providers who manage chronically ill patients to prevent disease progression and the need for higher-acuity care settings. The Plan expands the scope of Maryland's current hospital model to make available 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 five main strategies:

- **Strategy One**: **Foster accountability** by organizing hospitals, physicians, and other providers to take accountability for groups of patients or populations. This effort will build on the hospital accountability already in place under the All-Payer Model (Model) and will be accomplished through the following strategies:
    1. Leverage existing provider and payer accountability structures.
    2. Implement local accountability for population health and Medicare total cost of care through a new hospital-specific total cost of care value-based incentive.
    3. Progressively increase Dual Eligible Alignment.
- **Strategy Two**: **Align measures and incentives** for all providers with the goals of the Model. This will be accomplished via the following strategies:
    1. Reorient hospital measures to align with updated Model goals.
    2. Align measures across the continuum of providers and programs.

3. Engage physicians and other professionals by leveraging the incentives and requirements created by the Medicare Access and CHIP Reauthorization Act (MACRA).

- **Strategy Three**: **Encourage and develop payment and delivery system transformation** to drive coordinated efforts and system-wide goals. This will be accomplished via the following strategies:
    1. Develop a Maryland Primary Care Program.
    2. Develop initiatives focused on post-acute and long-term care.
    3. Explore initiatives to include additional physicians and providers and services in care transformation.
    4. Improve the financing and organization of the behavioral health delivery system.
    5. Promote investments in innovation, technology, and education.
- **Strategy Four**: **Ensure availability of transformation tools** to support all types of providers in achieving transformation goals.
    1. Enable and support the healthcare community to appropriately share data in order to improve care.
- **Strategy Five: Devote resources to increasing consumer engagement**
    1. Transform the health care delivery system with consumer-driven and person-centered approaches.
    2. Engage, educate, and activate patients, caregivers, providers, and all stakeholders.

B. Strategy One: Foster Accountability

Accountability structures, such as those represented in Figure 8 below, 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 strategy of Maryland's Plan is strengthening accountability structures to advance system-wide goals.

> *Maryland's Plan proposes new accountability approaches for providers who are caring for consumers not currently served by existing structures.*

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 health care expenditures in Maryland. While the current hospital Model continues to be essential, it is not sufficient. Maryland's Plan proposes new accountability approaches for providers who are caring for Marylanders, particularly the Medicare fee-for-service (FFS) 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. Accountable Care Organizations (ACOs) and one Patient-centered Medical Home (PCMH) demonstration are currently the only system-wide accountability structures serving Medicare FFS beneficiaries.

Figure 8 shows new and existing accountability structures that will be used to support the entire Medicare FFS population. Two important transitions will work together over time: (1) Increasing

numbers of Medicare beneficiaries will be included in accountability structures, and (2) accountability structures will take on increasing responsibility through incentives with both upside and downside potential. Figure 8 depicts both movements (the numbers do not necessarily add up, as many ACOs have no downside accountability).

While Figure 8 focuses on the Medicare population, several of these structures are already incorporated into other payer-led or provider-led strategies for the non-Medicare population (e.g. the CareFirst Patient-Centered Medical Home). Over time, high-performing structures may expand to incorporate additional providers and consumers. Ultimately, more of Maryland's providers will be working collectively toward common goals.

Figure 8. New and Existing Medicare Fee-for-Service (FFS) System-wide Accountability Structures

	ACOs	Payer-Supported Program	Dual Eligible Alignment	Hospital Value-Based Incentives	Medicare Fee for Service Beneficiaries ONLY in Hospital Global Revenue Accountable Structure	Medicare Fee for Service Beneficiaries in Additional Accountable Structure	
						With Upside Potential	With Upside & Downside Potential
2016 (Actual)	210k	40k	0	0	550k	220k	30k
Short-Term Projection	240k	40k	0	770k?	0	0	800k
Long-Term Projection	250k?	150k?	50k?	340k?	0	0	800k

Note: This chart is for illustrative purposes only, and does not account for factors such as population growth and fluid movement of beneficiaries between approaches over time.

Maryland recognizes that success in managing total cost of care will rely on alignment and clarity about responsibility and accountability among all stakeholders, including hospitals, physicians, other providers, nursing homes, and payers, all working with consumers.

Key Element 1a Leverage Existing Provider and Payer Accountability Structures

The Progression Plan builds on provider and payer structures that are already in place, such as ACOs, PCMHs, and Clinically Integrated Networks (CINs), all of which bring providers together to work towards common outcomes. Patients and payers alike will benefit from a transformation that creates a high-performing delivery system. The delivery system has significant influence on quality and costs, regardless of the payer.

Maryland will explore, with CMS, the possibility of ACOs having more flexibility to assume additional financial responsibility.

> *Action: Adopt an approach in which a payer supports an accountability program for practices participating in Maryland's Primary Care Program.*

Maryland's ACO environment is evolving. As of August 2017, 25 ACOs are operating in Maryland, with about 280,000 total beneficiaries. Maryland's ACOs are an important foundation for advancing accountability goals. Currently, most

> *Action: Explore flexibility of Accountable Care Organizations to accept more financial responsibility.*

of them are Medicare Shared Savings ACOs, with no downside financial risk. 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 will explore this flexibility with CMS.

A second action of Key Element 1a is the role of a commercial payer in promoting accountability of Maryland's primary care practices in the proposed Maryland Primary Care Program described in Key Element 3a, below. A PCMH structure with shared savings was tested by the Center for Medicare & Medicaid Innovation (CMMI) in Maryland under a grant to CareFirst. The grant ended and is no longer 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 commercial payer that operates an accountability program for commercial beneficiaries will take on increasing responsibility for outcomes and cost of Medicare FFS patient populations over time. In this manner, Maryland would test whether extending well-developed PCMH tools and shared savings to Medicare beneficiaries is effective in transforming primary care practices and meeting the broader All-Payer Model goals when offered in conjunction with other payers. The State and CMS will invite payers to participate in the Maryland Primary Care Program as Care Transformation Organizations (CTOs), an important component of the program described in Key Element 3a below. Payers will be given the opportunity to align Medicare participants with commercial and other payer delivery and savings approaches, so long as specified CTO requirements are met.

Key Element 1b: Implement Local Accountability for Population Health and Medicare Total Cost of Care through a Value-Based Incentive

The current All-Payer Model Agreement (Agreement) creates full financial accountability for all-payer hospital services at each hospital and includes a statewide guardrail to evaluate cost growth for Medicare total cost of care. 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 spending for hospital and non-hospital services. The emphasis on total cost of care brings providers 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 value-based incentive as a vehicle to incorporate responsibility for Medicare total cost of care in provider payment systems. Through this incentive mechanism, the Progression Plan will begin to incorporate accountability for all Medicare beneficiaries, as mentioned above in Figure 8.

In 2018, a new Medicare Performance Adjustment (MPA) will be implemented, which incorporates attribution, episodes and/or geographic measures of total cost of care for Medicare into hospital value based payments. This will provide a level of direct hospital accountability within the All-Payer Model for total cost of care and support the process of aligning physicians with the All-Payer Model. A geographic approach may be particularly attractive in rural areas where provider service areas are discreet, or to regional partners in more populated areas.

Initially, the MPA will apply only to hospitals' Medicare revenues. The MPA will be administered similarly to other value-based programs for hospitals in Maryland: if Medicare total cost of care growth in the service area is better than the target, a positive incentive will be applied to the global revenue. Conversely, if the total cost of care exceeds the target, a negative adjustment will be applied to the hospital's global revenue.

> *Action: Over time, incorporate incentives for improving population health and moderating growth in Medicare total cost of care.*

For calendar year 2018, the revenue-at-risk under the MPA will be 0.5 percent of Medicare hospital revenues. For calendar year 2019, the revenue-at-risk will be 1 percent of Medicare hospital revenues. The HSCRC will determine the need to increase the revenue-at-risk in the succeeding years based on performance and other factors.

Implementation of the MPA will facilitate Maryland's and CMS' intent to have the All-Payer Model be qualified as an Advanced Alternative Payment Model ("Advanced APM") and hospitals with Global Revenue agreements and MPAs be classified as Advanced APM entities. Physicians will then be linked to hospital global revenues through the Care Redesign Amendment (Amendment) or other avenues, aligning the efforts of physicians with the goals of the All-Payer Model and giving physicians and eligible other providers a pathway for participation in an Advanced APM. CMS and Maryland may make amendments as needed to the Model to ensure that it meets the requirements of an Advanced APM.

In order to conform with MACRA requirements for quality performance payment (QPP), adjustments under the MPA will be increased or reduced by multiplying the adjustment using each hospital's revenue adjustment percentages for selected quality programs, as shown in Section VI. Designing the MPA is technically challenging. Maryland and its Total Cost of Care stakeholder workgroup continue to review and refine potential options and details for the MPA. Careful consideration must be given to how the MPA interacts with the other structures shown in Figure 8 above. Maryland and CMS acknowledge that the MPA and the ACO models can act as reinforcing mechanisms. When there is significant overlap in savings, CMS and Maryland will determine the approach to adjust for the overlap. To the extent that the MPA is recognized in FFS claims payments and therefore recorded as a cost or cost recovery, the issue of overlap is a timing and policy issue, which will be addressed by the HSCRC with stakeholder input.

The State will not set physician or other non-hospital fee schedules for private payer or Medicare payments under the TCOC Model Agreement. Medicare and Medicaid physician payment data shall not be the basis for design of a care redesign program for private payers or allocation of shared savings to physicians in a care redesign program that treats non-Medicare or non-Medicaid beneficiaries. In evaluating voluntary care redesign programs and performance for private patients that may be proposed, the State will access and use independent data bases for services beyond hospital services that contain claims for private payers, avoiding the use of Medicare and Medicaid payments and service utilization to develop benchmarks or design programs for private patients or payers.

Because it includes all Medicare beneficiaries, the MPA has the advantage of more easily relating to regional public health resources. It also facilitates opportunities for additional physicians, such as those practicing in skilled nursing facilities and long-term care facilities and others who may be included in a care redesign program to participate in an Advanced APM.

The MPA concept may be modified and strengthened over time in a number of ways. For example, after 2019, Maryland may submit a request to CMS to introduce an MPA for non-hospital providers, which may also incorporate population health targets. The modifier could be applied to voluntary participants in Care Redesign programs that have a direct relationship with CMS and the State through a

Participation Agreement. The State will work together with CMS and stakeholders to identify voluntary opportunities to optimize alignment of all specialties of physicians and clinicians and to qualify them for participation in Advanced APMs.

Medicaid costs for dual eligible patients could be incorporated into the total cost of care calculations. Multiple regions could be defined across the State according to service patterns and cost variations. As new MACRA regulations are better understood and evolve, Maryland will continue to explore how to accomplish integration that aligns efforts of physicians with the TCOC Model goals, while also qualifying them for participating in Advanced APMs and receiving MACRA bonuses. Strategies to include skilled nursing facilities, long-term care facilities, and others will also be developed incrementally.

Key Element 1c: Progressively Plan and Implement Dual Eligible Care and Payment Alignment

Dual eligible beneficiaries, consumers who are eligible for both Medicare and Medicaid, are widely recognized as a high-need, high-cost population. Many face complex physical, behavioral and social challenges that demand holistic care coordination efforts to generate favorable outcomes. Services, coverage policies, payment provisions and administrative rules are split between Medicare and Medicaid. This results in misalignment in care delivery, as well as costly duplication of effort such as needs assessments and care coordination. Fragmentation frustrates the ability to coordinate care across service domains. Medicaid pays for half of expenditures for dual eligibles, but there is no good way to manage only half of a person's care.

> *Action: New Dual Eligible Care and Payment Alignment will be Progressively Planned and Implemented*

Payment responsibility is split between Medicare and Medicaid, creating separate total cost of care responsibility that could lead to inappropriate cost shifts from Medicare to Medicaid, or vice versa, when rolling out new payment innovations. For instance, as a patient moves from acute care to post-acute care to long-term care, the primary payer shifts from Medicare to Medicaid. Long-term care, especially if it requires permanent placement in a nursing facility rather than home- and community-based alternatives, is very costly for the State. Financial and clinical alignment are important to minimize cost shifts and to support this vulnerable population.

Maryland recognizes the dual eligible population as an important priority and, at the same time, acknowledges that careful consideration by stakeholders representing many aspects of the health care system will be required to create alignment among a complex network of providers and payers. Maryland has begun planning the Dual Eligible Alignment through progressive steps.

The State will systematically align payment and delivery for dual eligible beneficiaries, starting with the integration of behavioral health and Medicaid service providers with the Maryland Primary Care Program, beginning in 2018 and 2019. Alignment will progress to incorporate an accountability approach for dual eligibles. The State may consider the national dual-eligible ACO model or one of the other national Medicare/Medicaid models, with future modifications to the national models to meet State needs, as the State and providers gain experience with service delivery under the models. During 2018 and thereafter, Maryland expects to develop and submit additional plans for this progression, incorporating delivery changes for Medicare and Medicaid post-acute and long-term services and supports (LTSS) services. Maryland anticipates systematic progression with these changes beginning in 2018 through 2023. By 2024, Maryland expects that it will complete the integration of the Medicaid services and payments for dual eligibles into the total cost of care framework.

C. Strategy Two: Align Measures and Incentives

At the heart of the Progression Plan is the goal of creating a system of cooperation and aligned efforts in which physicians, hospitals, and all types of providers work together, along with health care consumers, to better care for and provide supports for patients with serious medical and chronic conditions. Establishing formal communication, processes, and infrastructure will be steps to achieve this goal. To support the alignment of efforts across the care continuum, Maryland will need to address the measures and incentives that are used.

Maryland's Plan develops and uses consistent performance metrics for health, care delivery, and efficiency across providers and programs. The State envisions that this streamlined approach will align efforts and increase synergies, which will lead to improvements. It also will 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 Primary Care Program described below, the Care Redesign Amendment, and hospital quality programs, data collection will be less burdensome, investments to collect data will be reduced, and providers will be focused on and rewarded for common or closely related outcomes. This should increase the likelihood of achieving desired outcomes through aligned efforts and more rapid transformation. Ultimately, the same metrics for health, care delivery, and efficiency will be applied across the continuum of physicians and other providers, as well as across payers. This metric alignment will need to be facilitated by alignment of payment models and value-based incentives over time.

Key Element 2a: Reorient Hospital Measures to Align with New Model Goals

The Health Service Cost Review Commission (HSCRC) will continue to create value-based payment approaches that promote access to care, preventive services, high-quality effective delivery, 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.

> *Action: Increase focus on reducing potentially avoidable utilization by encouraging hospitals to improve care transitions and collaborate with community providers.*

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 avoidable utilization, increasing the alignment of hospitals' incentives with those of ACOs, PCMHs, and other accountability structures. As HSCRC, in concert with stakeholders, updates value-based incentive programs for hospitals for 2020 and beyond, it will focus on measures of prevention, care management and care coordination, care outcomes, and care transitions. This focus will assure better care supports for complex and chronic conditions, improving health, and reducing potentially avoidable utilization. Measures incorporating potentially avoidable utilization encourage hospitals to strengthen investments in improving care transitions and collaborating with community providers. Optimally managed and coordinated outpatient care can potentially prevent the need for hospitalization, or early intervention can prevent complications or more severe disease.

HSCRC is also beginning the process of reorienting hospital measures to focus on episodes of care. This builds on the hospital inpatient measures currently in place, and extends 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 improves the care experience by smoothing the transitions across sites and types of care. 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 physicians and other providers across the system, and across payers and settings.

> *Action: Reorient hospital value-based measures to episodes of care. This approach incorporates both inpatient and outpatient care, and provides a more meaningful assessment of how care is delivered and experienced.*

Key Element 2b: 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.

CMS' Comprehensive Primary Care Plus (CPC+) model uses a set of standardized measures that are closely related to the ACO measures. In Maryland, the Complex and Chronic Care Improvement Program (CCIP), described in Section II B 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.

> *Action: Align measures across State initiatives as well as with federal efforts.*

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. All of the providers together will need to achieve savings for a geographic area and individual physicians and practitioners 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 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. As the Plan begins to incorporate population health measures, it will be important for the State to support these goals with complementary public policy that can help achieve the desired outcome.

Key Element 2c: Engage Physicians and Other Professionals by Leveraging MACRA

To achieve the Model goals, payments for physicians, other health professionals, and institutional providers must evolve from rewarding volume to promoting value. In MACRA, Congress overwhelmingly affirmed the approach by consolidating an array of Medicare pay-for-performance mechanisms into a single Merit-based Incentive Payment System (MIPS) and creating strong incentives for physician participation in alternative payment models (APMs).

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.

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

Several programs discussed in this Progression Plan would benefit physicians by qualifying for Advanced APM status under MACRA. The Maryland Primary Care Program, will extend comprehensive primary care services to Medicare beneficiaries and is designed to encompass up to one-fourth of Maryland's physicians and other providers out of the more than 15,000 practicing in Maryland. The program is described further below in Key Element 3a. CMS has special rules for practices that participate as part of an ACO and Maryland will need to pay special attention to ensure that these practices also have an opportunity to receive Advanced APM status qualification under MACRA.

Other Maryland programs aimed at qualifying for Advanced APM status under MACRA include the initial two programs developed under the Care Redesign Amendment, which focus on physicians who practice at hospitals and primary care community providers. Additional programs will be developed under the Amendment. Maryland will need to work with stakeholders to develop programs that can be deployed for other community physicians and practitioners, such as radiologists and community oncologists, among others. Participation of these physicians 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.

CMS and Maryland intend for the All-Payer Model to be classified as an Advanced APM, and regulated hospitals under Global Revenue agreements with Medicare Performance Adjustment Requirements, described in Section VI, Sub-Section A, to be qualified as Advanced APM Entities. CMS and Maryland may amend the Model to assure MACRA qualification and will work together to ensure that Care Redesign or other programs such as the Maryland Primary Care Program, are available to allow physicians and other clinicians to participate in the All-Payer Model. CMS and Maryland may make amendments as needed to the Model to ensure that it meets the requirements of an Advanced APM.

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

D. Strategy 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 TCOC Model in January 2019, providers will take on increased responsibility for health, care outcomes, and total cost of care for Medicare FFS beneficiaries. Hospitals cannot accomplish this alone. The TCOC All-Payer Model builds on increased collaboration with physicians and other providers of care. New delivery approaches supported with aligned payment models and incentive structures will help accomplish 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.

Key Element 3a: Develop a Maryland Primary Care Program

Hospital-initiated programs are focused on complex and high-need patients who already are using extensive health care resources. While these programs are essential, they do not broadly address the need for transforming primary care. Primary care is essential for patients with chronic diseases that progress over time, to prevent them from having to seek care in 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 multiple chronic conditions. Necessary resources include care management, care coordination, connections to behavioral health, social services**,** and other resources from local public and private health organizations.

Nationally, the CMS' Comprehensive Primary Care Plus (CPC+) model is being promoted in select regions to deploy resources to support primary care and to transform the payment and delivery system. The CMS CPC+ model offers primary care providers extensive support to practice population health management, coordinate care across settings, and focus on improving outcomes for its patient panel.

Maryland, bolstered by experience and expertise in primary care transformation, is implementing a Maryland-specific version of CPC+, the Maryland Primary Care Program (MDPCP). This voluntary, foundational payment and delivery system reform is designed to align and integrate payment and delivery incentives of primary care providers ensuring that they share the same goals of the accountability structures described above in Key Element 1a.

Action: Maryland, equipped with experience and expertise in primary care transformation, now proposes its own version of a Primary Care Program. This foundational payment and delivery system reform is designed to be interoperable with every accountability structure.

The MDPCP will offer practices robust transformation resources and technical assistance, as well as actionable patient-level cost and utilization data, to guide their decision making.

The MDPCP will create aligned incentives for enrolled providers to transform the delivery of care to individuals in the community, improving health and reducing avoidable utilization in higher-acuity settings. The MDPCP will be enhanced by new Care Transformation Organizations (CTOs), which will offer practices robust comprehensive care management resources, care coordination, practice transformation resources, risk stratification, and other services to address various levels of health risk and prevention for their beneficiaries. Upon request, CTOs will deploy these resources (e.g. care managers) to practices based on their needs, supporting both flexibility for practices with more robust infrastructure and additional services for practices with fewer in-house resources. The MDPCP is

especially well suited to support primary care practices in rural settings via care management resources and transformation support.

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

- Align community primary care physicians to collaborate in the care of shared patients to improve care and reduce potentially avoidable and unnecessary utilization
- Develop behavioral health resources for every practice
- Provide 24/7 access to care and care management support
- Create more timely access to appointments with physicians and care teams
- 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 all patients, through care coordination commensurate with each patient's level of need - medium-risk, rising-risk and high-risk
- Reduce gaps in prevention and treatment, contributing to a reduction in the need for higher-cost settings, including both hospital and long-term care settings
- Improve patient outcomes through effective medication reconciliation and optimize costs through attention to the use of lower-cost, highly effective medications
- Align providers and public health resources to address priorities
- Screen and address social determinants of health by connecting patients to resources and programs
- Identify and reduce disparities in care delivery and health outcomes
- Encourage innovation in health care delivery, including increased use of visits in the community.

CMS will support the MDPCP by making several investments to incentivize care management and practice transformation. Beginning in 2019, practices participating in the Maryland Primary Care Program will receive prospective payments including a risk-stratified monthly care management fee ranging from $6-50 PBPM (Track 1) or $9 to $100 PBPM (Track 2) and an at-risk performance bonus ranging from $2.50 (Track 1) to $4.00 (Track 2) PBPM, for every Medicare FFS patient on their panel. The performance bonus may be partially or entirely clawed back based on performance against established quality, patient satisfaction and utilization benchmarks.

Additionally, the State intends for primary care providers participating in the Maryland Primary Care Program to be eligible as Qualifying Advanced APM participants, as long as they meet all other Advanced APM criteria. Providers who do not receive an at-risk performance bonus because they are participating in a different CMS model will need to qualify for the APM under a different program.

CTOs, beginning in 2019, will receive an at-risk performance bonus of $4.00 PBPM, based on population health measures, quality, patient experience and utilization measures that may be adjusted annually.

Beginning in Year 1 (2019) the care management fees will be incorporated as costs into the required calculations for Medicare total cost of care savings. In Year 6 (2024) and thereafter, the State may offset primary care or other approved investment costs with CMS-approved population health savings and

improvement credits, which will be determined annually through Year 10 of the Model. The State intends to develop a mechanism to remove the care management fees from the calculation of the annual hospital rate update and to identify potential strategies to offset the care management fees during the first five Model years to ensure the primary care system has time to scale and build capabilities that will eventually reduce utilization and hospital spending.

Redesigning primary care to achieve better overall population health outcomes, in concert with implementing the Care Redesign Amendment programs that target the State's current high and rising-risk patients, prepares hospitals for success in the TCOC Model; it prepares primary care physicians and other practitioners for success in the era of value based payments associated with MACRA; and, most importantly, it builds needed supports to Medicare patients. The Maryland Primary Care Program, along with the All-Payer Model and the Care Redesign Amendment programs, will create a unique and exemplary setting of alignment across physicians and other practitioners, hospitals, and care managers.

Key Element 3b: 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 from hospitals to skilled nursing facilities (SNFs) are frequently complex or high-needs patients. Currently, there is little comprehensive care coordination between settings that address the needs of these patients who experience higher rates of potentially avoidable utilization.

Maryland's goals are to coordinate and optimize the use of post-acute services and SNF services, ensuring that patients are receiving the best care in the most appropriate setting. Specific goals are to increase services in-home settings and reduce potentially avoidable hospital admissions and emergency department visits from long-term and custodial care. Maryland will also strive to reduce the need for long-term care by keeping people healthy enough to stay at home. Capacity resulting from these changes would still be needed to meet future needs of a rapidly aging population.

As noted above in the description of the Dual Eligible Alignment, the cost of long-term services and supports (LTSS) 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 LTSS, such as custodial care, that are the responsibility of states. The rules also govern eligibility for Medicaid that in turn 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 the opportunity for improvements and incentives. The Dual Eligible Alignment will optimize services for long-term and community-based care of dual eligible beneficiaries, but additional initiatives need to focus on the larger Medicare population.

As part of the Progression Plan, Maryland will use the expertise of its long-term care and post-acute providers to develop new ways of addressing the increasing needs of an aging population and individuals with complex needs. 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. A measured approach will be used, considering the fragile nature of this population.

> *Action: Seek the expertise of long-term care and post-acute providers to develop new ways of addressing the increasing needs of an aging population and individuals with complex needs.*

The Care Redesign Amendment creates a vehicle to establish initiatives to align the financial incentives of post-acute providers and hospitals. The subgroup's work will need to integrate with the Dual Eligible Alignment plans, and explore

interconnections to geographic value-based incentives for hospitals and the Maryland Primary Care Program. 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 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 types of patients could benefit from the relaxation of the three-day rule. During 2018 and beyond, Maryland expects to develop and submit plans for incorporating delivery changes for Medicare and Medicaid post-acute and LTSS. Maryland anticipates systematic progression with these changes beginning in 2019 and thereafter.

Key Element 3c: Explore Initiatives to Include Additional Physicians and Providers and Services in Care Transformation

> *Action: Engage diverse specialty practices and other community providers in developing additional Care Redesign approaches to meet All-Payer Model goals.*

The Care Redesign Amendment and Maryland's Primary Care Program addresses physicians practicing at the hospital and some community providers, including most primary care physicians. However, not all physician specialists and health professionals who work primarily in community settings are addressed by these approaches, yet their care influences outcomes and costs. For example, oncology patients frequently need complex and chronic management supports to reduce development of preventable conditions and avoid preventable hospitalizations and emergency department visits. Additionally, other services that are provided in the community, such as radiology, laboratory, dialysis, home health and durable medical equipment, could benefit from shared information and coordination to improve efficiency and quality of care. Under the TCOC Model, Maryland and CMS will make opportunities to develop voluntary care redesign programs with other providers and services over time that allow for participation agreements with providers beyond hospitals (See Section VI). The State will engage diverse specialty practices and other community providers in developing additional programs to meet TCOC Model goals.

All of these voluntary opportunities to optimize alignment of physicians and other providers to the TCOC Model will be designed with the aim to provide opportunities for participation in Advanced APMs under the MACRA rules.

Key Element 3d: Improve the Financing and Organization of the Behavioral Health Delivery System

Maryland recognizes that providing better behavioral health supports is critically important to improving health outcomes and reducing preventable utilization. Behavioral health is frequently treated as if it were disconnected from other health conditions. Yet behavioral health, mental health, and substance use disorders are often inextricably intertwined with other health issues, each exacerbating the other.

Substance-use related emergency department visits and mental health-related emergency department visits are growing significantly in Maryland. Improved access to community-based behavioral health services and care coordination will reduce acute and short-term hospital utilization and readmissions related to mental and behavioral health. As patients with mental and behavioral health conditions continue to drive hospital admissions, readmissions, and emergency department visits, the Maryland delivery system and stakeholders are beginning to take action to address the alignment of behavioral health with other medical care and social services.

For example, in June 2015, the Maryland Hospital Association established a Behavioral Health Task Force to identify opportunities to strengthen Maryland's behavioral health infrastructure. The Task Force recognized that development of a well-coordinated, accessible, affordable and accountable system for delivering behavioral health care must consider the local needs of the population and the available supply of physicians, other behavioral health providers and community supports in that area. Work is underway to ensure care is integrated not only within health care settings, but also with community partners, to identify where more access and supports are needed. However, this work continues to be challenged by care delivery silos, maldistribution of funding, and under-developed community resources.

The ideal care delivery system in Maryland will fully integrate care, with increased funding in the community. This includes smooth handoffs of patients among primary care, specialty, and behavioral health providers, recognizing the critical contribution that each makes to the health outcomes for patients. This also includes investing in more community-based behavioral health services to improve access to providers.

> *Action: Continue to develop and implement plans to improve the financing and organization of the behavioral health delivery system, particularly in the community setting.*

The Progression Plan lays out several strategies aimed at enhancing behavioral health services and integration. While these strategies are aimed in the right direction, they are not sufficient. The State will need to continue to develop and implement plans to improve the financing and the organization of the behavioral health delivery system, particularly in the community setting.

Strategies included in the Plan and existing efforts that address behavioral health include:

The Maryland Primary Care Program referenced in Key Element 3a, will allow community behavioral health providers to serve as the Patient Designated Provider, allowing patients with serious mental illness or substance use disorders to receive the care they need from the provider with whom they feel most comfortable. This also will help to align payment and delivery for selected Medicaid beneficiaries, including those who are dually eligible.

Dual Eligible Alignment, referenced in Key Element 1a, is being designed to respond to the needs of Medicare-Medicaid dual eligible beneficiaries with behavioral health and other conditions that require specialized resources. The Medicare-Medicaid dual eligible population in Maryland includes many individuals with serious mental illnesses and substance use disorders, as well as other neuro-degenerative diseases such as Alzheimer's. The Maryland Primary Care Program will create a locus of care, and require coordination with behavioral health providers. Medicaid has made substantial progress in implementing home and community supports, and these efforts are helping keep more individuals in the community setting.

Medicaid is also testing a chronic condition health home, with an emphasis on patients with behavioral health needs. These efforts will be leveraged through the development of the Dual Eligible Alignment progression and may also provide insights for additional development for other patient populations. Through one regional transformation initiative in 2016, Maryland hospitals and their community partners are beginning to test specific therapeutic interventions through a Behavioral Health Center by mental health professionals to reduce inpatient hospitalizations caused by mental illness. Highly structured individual and group-focused treatment, as well as comprehensive case management services, are available in an outpatient setting for a target of 60 to 90 days after hospital discharge, although there is not a hard limit on the number of days' post-discharge for the interventions. The

Behavioral Health Center also serves as a resource to community physicians and practitioners and their patients.

A significant and immediate challenge to the care delivery system is access to community-based, behavioral health professionals. Even where there may be an adequate number of behavioral health providers in the aggregate, for instance, they are not easily accessed by people living in smaller towns or rural areas. Further, there are an increasing number of providers who do not accept insurance. According to the Mental Health Association of Maryland, in 2014, just 14 percent of the psychiatrists listed on Maryland's health benefit exchange were accepting new patients and were available for an appointment within 45 days. To help tackle this problem, Maryland will need to address barriers to widespread use of telehealth and facilitate additional opportunities to engage, organize, support, and build the workforce.

Through the Progression Plan, the Maryland delivery system, stakeholders, community-based organizations, and government will explore integrated care models proven effective in other states and consider opportunities to test innovative value-based payment arrangements that are aimed at improvement of access and overall health and well-being of each patient, including those with behavioral health needs.

Private inpatient psychiatric facilities play a critical role in providing care for behavioral health. However, the State's rate setting authority for these institutions does not extend to Medicare and there are currently limitations on use of these facilities for adult inpatient care for Medicaid patients. The State would like to continue to explore options for these facilities, as stakeholders continue to focus on efforts to integrate behavioral health and other health care for Marylanders.

Critical issues remain around coverage for outpatient behavioral health services and treatment for behavioral and mental health conditions, including chronic pain management. Further strategies to improve coverage and develop quality metrics to incentivize improved behavioral and mental health outcomes among patients seen at acute care and inpatient hospitals will be developed through a re-convening of the Behavioral Health Task Force in 2017.

Key Element 3e: Promote Investments in Innovation, Technology and Education

Maryland's rich academic and research resources must be leveraged in the Progression Plan as a means to improve population health for both Maryland and the world by setting standards of clinical care, medical education, and research. Academic Health Systems are often the birthplace of innovative diagnostic and therapeutic interventions as well as care delivery, requiring significant investments in infrastructure, staff and technology. They are also uniquely positioned to train the next generation of physicians and health care providers that will embrace and expand upon the future of population health, community engagement, and disease management. Building and maintaining outstanding educational programs is of vital importance to the State.

> *Action: Foster investments in innovation, technology and education.*

In addition to the critical nature of discovery and innovation for patients and the ecosystem in the State at large, core operations of the State's academic medical centers are significantly different than many community-based hospitals with respect to both their patient catchment because of their urban settings and the cooperative relationship with care providers across a broad geography. Planning around reduction in total cost of care should create approaches that account for such fundamental differences.

The Progression Plan should foster investments in innovation, technology, and education that offer the opportunity to reduce long-term health care costs and vastly improve the quality of care and patient outcomes. Academic Health Systems play a critical role in that work. There will always be a need for specialized research-intensive hospital services; the goals and metrics of this demonstration should value and not inhibit this need.

E. Strategy Four: Ensure Availability of Tools to Support All Types of Providers in Achieving Transformation Goals

Maryland policy makers and stakeholders have long believed that timely, accurate, and actionable 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, the Maryland Department of Health (MDH) 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 Chesapeake Regional Information System for our Patients (CRISP) to focus on care coordination and to expand its role beyond that of a traditional health information exchange.

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.

Key Element 4a: Enable and Support the Health Care Community to Appropriately Share Data to Improve Care

As described above in the Background section, CRISP has enabled the healthcare community to securely share data to facilitate care and improve care delivery. Maryland is making significant strides in ambulatory connectivity and is at the cusp of realizing the benefits from its foundational investments in health information technology. These investments focus on providing innovative information at the point-of-care in support of care managers and for population health teams. Creating tools to support care coordination and alignment between hospitals and physicians fits perfectly into CRISP's vision to advance health and wellness by deploying health information technology (HIT) solutions adopted through cooperation and collaboration. CRISP will continue to build out capabilities and engage providers.

> *Action: CRISP will continue to build out capabilities and engage providers.*

Through the Care Redesign Amendment, Medicare data can be accessed by hospitals under HIPPA-compliant processes for care delivery purposes. Maryland will work with CMS to give providers access to timely and appropriate data for effective care coordination and management as well as data for total cost management. CMS also needs to make non-fee schedule payment data available on a timely basis, providing sufficient details to allow

> *Action: CMS provides timely data for effective care management and total cost management*

cost allocations by beneficiary, which are needed to manage cost distributions for accountability under care redesign programs and total cost of care model components. CMS will also provide data on payments made outside of Maryland to enable Maryland to account for the cost and cost growth for fee-for-service beneficiaries on a national basis. CMS will provide breakdowns by provider type and state to support more detailed efforts to benchmark costs and cost growth.

F. Strategy Five: Devote Resources to Increasing Consumer Engagement

Consumers have both an important stake and key role in achieving the goals of better care, better health, and lower spending. In Maryland, this transformation of the health care delivery system calls for a person-centered care model that prioritizes the impact on individuals. A multi-pronged approach is required to address that, and it must be one that actively engages Marylanders in both the design and implementation of this new model. Such an approach requires multi-stakeholder collaboration and commitment. The benefits of success will be seen in long-term savings to the system, but more importantly in the health and well-being of individuals and communities.

Examples of improvements that can be achieved with effective consumer engagement include:

1. Improved levels of health literacy with consumers who understand their options for optimal care and how to navigate the health care system.
2. Enhanced patient-provider relationships with better care coordination.
3. Improved patient experience and satisfaction with care, with a personal sense of value and ownership.
4. Higher-quality care and improved overall health outcomes.
5. A more informed, responsive, and efficient health care system.

In September 2015, the HSCRC Consumer Engagement Task Force submitted a set of specific recommendations to advance consumer engagement to support the success of the All-Payer Model. These are relevant to the Progression Model and include:

1. Establish and fully support a Consumer-Standing Advisory Committee.
2. Develop a statewide public education campaign that is part of a broader campaign to promote health and wellness.
3. Convene an interagency task force which would enhance the integration of all transformation efforts and would include consumer participation.
4. Provide options and opportunities to support regular, longitudinal, and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.

In framing these recommendations, the Consumer Engagement Task Force highlighted two essential areas for consumer engagement: (1) policy; and (2) engagement, education, and activation. The Progression Plan recognizes the value of each of these and seeks to address them in its proposed strategies.

Key Element 5a: Transform the Health Care Delivery System with Consumer-Driven and Person-Centered Approaches

The State will continue to use its workgroup structure to bring the interests and expertise of consumers to its decision-making process. In addition, in 2016, HSCRC and MDH first convened its new Consumer Standing Advisory Committee (C-SAC) representing 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 to inform the establishment and implementation of its person-centered model. The C-SAC, together with other avenues, will be used to leverage the perspective of consumers, providers, and other stakeholders.

Action: Provide a visible and ongoing role for consumers in the: (1) design and implementation of person-centered policies and procedures at all levels for both providers and health plans; and (2) evaluation of the Model, and its individual strategies, as it is implemented.

Key Element 5b: Engage, Educate, and Activate Patients, Providers, and All Stakeholders

Consumers, both individually and collectively, must be fully engaged in managing their own health care. This will require that they have the information and resources required to make the best decisions for themselves and their families. That will include information on the value of preventive care, how to work most effectively with a primary care provider, and how best to understand, access and protect their rights as consumers. Positive action in these areas will, in turn, help to promote better outcomes for individuals and a more efficient and effective use of the health care system more broadly.

There are several paths for engagement under the Progression Plan- one for the consumer, one for the physician and others who intersect with the patient, and a third path for communication/engagement between the two. As demonstrated in the work of the Consumer Engagement Task Force and the Consumer Outreach Task Force, there are multiple touch points along these paths. To achieve successful engagement, it is critical that it is the *right* message that is being given by the *right* person at the *right* point in time. To address this, the Plan relies upon the implementation of a cohesive, comprehensive and well-coordinated communications plan based upon the Consumer Engagement Task Force's Report. This will be the predicate for the integration of engagement strategies that intersect between the consumer and the provider.

Action: Develop a cohesive, comprehensive, and well-coordinated communication plan to support the implementation of the Progression Plan.

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, improving health literacy to allow patients to make informed decisions, and engaging family and designated or informal caregivers in care and decisions about care - including functional focus, planning, and social services.

In addition to the communications plan, the Progression Plan leverages other opportunities. Team-based care management, including risk stratification, care plan development and longitudinal care for high-risk patients are standards in the Maryland Primary Care Program, referenced in Key Element 3a and in the Complex and Chronic Care Improvement Program (CCIP), referenced in the Care Redesign Amendment and in the care management models for Dual Eligible alignment, referenced in Key Element 1c, Strategy 1 These features are all designed to better engage patients.

The Progression Plan includes several Population Health Goals. Maryland will use a variety of existing sources to identify regional and community-level population health goals and will develop consumer engagement campaigns and population health initiatives around those goals in collaboration with regional/local hospitals, physicians and other providers, community partners, and public health entities. In addition, Maryland will evaluate what has been done and what has worked well under the State Health Improvement Process and the Local Health Improvement Coalitions to advance community health initiatives.

Action: Provide consumers with information that they can use for a personal plan for their health and well-being and to provide them with an understanding of the health care delivery system.

Maryland will continue and expand its strategies to educate consumers about the All-Payer Model with advice of the C-SAC and with an integrated and comprehensive communications plan as discussed above. The will include communicating the Model's goals, implementation steps, and accomplishments in understandable terms that demonstrate the impact on consumers.

There are several projects currently underway that address education and activation. These include:

- In 2015 and 2016, the Maryland Citizens' Health Initiative, in collaboration with several key healthcare stakeholders (e.g., SCRC, MDH, Maryland Hospital Association (MHA), and others), held 15 regional public forums across the State. The forums, which were open to the public, brought together key stakeholders, including hospitals, to discuss the changes in Maryland's health care system and to foster a dialogue on expanding community involvement.
- Multiple organizations (MHA Maryland Faith Health Network, AARP Maryland, NAACP Maryland State Conference, Young Invincibles and Maryland Citizens' Health Initiative Education Fund, Inc.) partnered 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 them to information on hospital wellness and chronic disease management initiatives, as well as other critical resources that can help patients get the care and support they need, when and where they need it. The MHA-maintained website provides resources in three areas: (1) patient bill of rights; compliments and concerns; (2) community health resources; and (3) resources for patients.

Under the Progression Plan, these programs will serve to inform the development of comprehensive and cohesive communications initiatives and strategies that will help consumers to understand, and engage in the State's ongoing transformation efforts.

VI. Model Design and Requirements

A. All-Payer Financial Targets

Hospital accountability will continue as a foundation of Maryland's TCOC All-Payer Model.

The All-Payer Model (Model) limits the growth of total inpatient and outpatient hospital costs for all payers to a trend that was based on the State's long-term Gross Domestic Product. In 2013, this was referred to as Gross State Product; however, the federal government has renamed this measure to Gross Domestic Product by State. Per capita GDP for Maryland was selected as a benchmark for health care spending growth in recognition of the growing share of resources devoted to health care. By committing to limit the growth in hospital expenditures, this model stabilizes expenditures.

The test, which was set in 2014, required Maryland to limit its annual per capita total inpatient and outpatient hospital cost growth to 3.58 percent, which represented Maryland's long-term smoothed growth rate in State GDP.

For the TCOC Model, Maryland will continue to limit the growth in hospital costs to 3.58 percent per capita on an annual basis, measured annually on a cumulative basis from 2013 through the term of the TCOC Model. The all-payer trend limit is a ceiling and not a floor. There will continue to be opportunities for reductions to the trend based on policies related to utilization, efficiency, or other factors adopted by the HSCRC. The HSCRC will have the discretion to review and adjust the overall 3.58 percent cap, based on future economic growth trends or other factors, subject to prior approval by CMS.

1. Medicare Total Cost of Care Savings

In addition to limiting the total all payer inpatient and outpatient hospital cost growth as described above, Maryland also agrees to limit its Medicare per beneficiary spending growth. Maryland intends to achieve at least $1 billion in cumulative Medicare Total Cost of Care (TCOC) per Beneficiary Savings during the period of 2019 through 2023. Maryland will be expected to reach a compounded annual savings level of $300 million in 2023 (Year 5 of the TCOC Model). Maryland has also committed to progressively meet the Annual Medicare TCOC per Beneficiary savings target, leading up to the cumulative target.

Medicare savings will be calculated by establishing a baseline that is the actual Medicare per beneficiary total expenditures in Maryland in 2013 trended forward by the national average growth rate in Medicare per beneficiary total expenditures to each year of the Model, and comparing Maryland's annual Medicare per beneficiary total expenditures to that baseline. Regardless of the changes in the national trend over the course of the Model, Maryland will be expected to reach a compounded annual savings level of $300 million in 2023, Year 5 of the TCOC Model, as shown in Figure 9 below.

The Annual Medicare TCOC per Beneficiary Savings Target for each Model Year are listed in Figure 9 building to $300 million in 2023. Savings are relative to the national growth rate in Medicare Part A and Part B expenditures for Maryland fee-for-service beneficiaries. The starting point for TCOC savings in 2019 will be $120 million in annual savings. During Model years 1 and 2, any excess savings above the targets will be split; half of any excess will accrue to Medicare and the other half may be used to offset MDPCP care management fees calculated in the total cost of care savings targets. If the State fails to meet an Annual Target, the difference between the Annual Target and the State's performance will be added to the savings target for futures years. If the State fails to meet the target progression by $100 million, a corrective action plan may be required.

Figure 9. Medicare Savings Targets and Estimated Annual and Cumulative Savings through 2023.

Performance Year	TCOC Savings Relative to the 2013 Base	Incremental TCOC Savings	Cumulative TCOC Savings*
Performance Year 1 (2019)	**$120 million**	($0 increment)	**$719 million**
Performance Year 2 (2020)	**$156 million**	($36m increment)	**$875 million**
Performance Year 3 (2021)	**$222 million**	($66m increment)	**$1.097 billion**
Performance Year 4 (2022)	**$267 million**	($45m increment)	**$1.364 billion**
Performance Year 5 (2023)	**$300 million**	($33m increment)	**$1.664 billion*** ($1.060 billion less $599 Base Model TCOC savings)

* Assuming Base Model TCOC savings of $599 million. This is the actual TCOC savings CY2013-CY2017, performance year five (CY2018) was ongoing at the time of report publication.

For each Model Year, the Maryland Medicare TCOC Growth per Beneficiary must not exceed the National Medicare TCOC Growth per Beneficiary by more than 1 percent for any given Model Year or grow faster than National Medicare TCOC Growth per Beneficiary by any amount for two consecutive Model Years ("Maryland Medicare TCOC Guardrail"). If the State does not meet the requirements of the Maryland Medicare TCOC Guardrail, the State may need to submit a corrective action plan.

By the end of 2023 (Model Year 5), progress-to-date will be assessed to determine if savings exceed the requirements or if additional savings are required in 2024 (Model Year 6) to meet the Annual Medicare TCOC per Beneficiary Savings Target.

2. Exogenous Factors

Maryland and CMS recognize the potential for exogenous factors to affect cost growth and other performance metrics, both for the all-payer and Medicare trends, in unpredictable ways. For example, Maryland could experience a localized disease outbreak that does not occur in other parts of the nation or changes in insurance coverage under the Patient Protection and Affordable Care Act (Affordable Care Act) could affect savings performance. CMS and the State will take this into account in evaluating performance and in revising savings targets if necessary. Since Medicare Advantage plans' rates are set in reference to FFS performance, changes in Medicare Advantage enrollment may affect the accumulation of savings. To account for this effect, the FFS savings will be extrapolated based on the Medicare Advantage enrollment changes.

Assuring that innovation is not inadvertently stifled will be important. Because Maryland is a center for research and medical education, it may develop and adopt prevention and treatment innovations at an accelerated pace. If this happens, it will be important to evaluate the pace of adoption relative to other similar environments when evaluating success, recognizing that this is a timing issue rather than a system problem. The TCOC Model contract will also be examined should Maryland enact legislation that prevents private insurers from participating in the healthcare market.

As the State monitors the total cost of care relative to targets, at both a statewide and local level, the HSCRC will seek to monitor preventive services costs separately to ensure that the Model does not discourage care that is needed by patients and spending for services that are expected to have a future payoff of improved population health.

3. Medical Malpractice Reform

While medical malpractice is not under the purview of the HSCRC, there is recognition of a dissonance between the cost containment goals of the Model and the current medical malpractice system, and the need for reform. Although there is not unanimous agreement on specific types of reforms needed, or the likely impact of those reforms, there is wide agreement that addressing the issues around medical malpractice is important in supporting the goal of reducing avoidable utilization and should be pursued in concert with the three-part aim of the Model.

The State will support efforts to reform Maryland malpractice laws with the intent of supporting modernized approaches to care delivery, implementation of care redesign and population health improvement under the TCOC All-Payer Model goals, and supporting the provision of evidence-based care delivery.

In recognition of the changing health care delivery landscape, the State will continue to vigilantly monitor and actively support tort reform measures that will reduce the cost of care and allow physicians to practice medicine in line with the goals of the TCOC All-Payer Model.

4. Per Beneficiary Expenditure Calculation and Adjustments to Savings Calculations

Medicare spending per beneficiary will be used in calculating savings, along with data from other sources where necessary. The Medicare spending will be calculated with two fractions – Medicare per FFS beneficiary Part A costs and per FFS beneficiary Part B costs. These two fractions will be added to determine the Medicare per beneficiary total cost.

The growth in Maryland per beneficiary total cost will be compared to the national growth rate in per beneficiary total cost. The per beneficiary total cost calculation for Maryland will include all provider expenditures, regardless of the state of service. The calculation will be based on Medicare's definition of total costs specified in the TCOC Model contract. Non-fee schedule payments made by CMS will be counted as expenditures in both Maryland and non-Maryland settings, including primary care management fees in the MDPCP. Savings will be extrapolated to incorporate the expected impact on Medicare Advantage payments.

Maryland will work with CMS to determine how to attribute costs per beneficiary, as needed to support calculations for Accountable Care Organizations (ACOs), hospital savings, geographic models, and other payment models. Maryland acknowledges that the Medicare Performance Adjustment (MPA) and the ACO models can act as reinforcing mechanisms. When there is significant overlap in savings, such as a geographic performance program, a determination will be made regarding how to adjust for the overlap in savings. MPA will be recognized as a cost reflected in FFS claims payment, and, therefore, not double counted.

Maryland and CMS will continue to calculate hospital savings, recognizing that investments will be made in non-hospital settings to produce hospital savings. This effort will support adding, adjusting, and eliminating components as needed, based on their performance.

5. Medicare Performance Adjustment

The MPA, as described in Key Element 1b, will play a key role in the TCOC Model, tying hospital performance to Medicare total cost of care performance progressively over time as the Model matures. The MPA is a value-based incentive that will be used as a vehicle to incorporate responsibility for hospital-specific Medicare total cost of care, creating local responsibility for care outcomes and population health, and providing a direct link to the Medicare total cost of care. Through the MPA, if a hospital's Medicare total cost of care growth is better than the target, a positive incentive, with a quality modifier, will be applied to the Medicare payments. Conversely, if the total cost of care exceeds the target, a negative adjustment, with a quality modifier, will be applied to the hospital's Medicare payments. The State will work with CMS to operationalize the use of the Medicare Performance Adjustment by July 1, 2019.

B. Quality and Value-Based Metrics

Quality and Value-based incentives are an essential component to the All-Payer Model, providing Maryland with powerful levers to drive quality and improve outcomes.

Under the Base Model, CMS waived the requirements of section 1886(p) of the Social Security Act establishing the Hospital Acquired Conditions program, the requirements of section 1886(q) of the Social Security Act establishing the Hospital Readmissions Reduction Program, and the HHS Secretary granted Maryland an exemption from Value-based Payment provisions.

For the TCOC Model, Maryland will be waived from the CMS Value Based Purchasing, Hospital Acquired Conditions and readmissions programs, and will run comparable quality programs applied on an All-Payer basis. Maryland will report to CMS the same hospital quality measures that are reported by hospitals nationally under the Inpatient Quality Reporting (IQR) program. The performance initiatives linked with payment will be incorporated in the routine evaluation and reporting to CMS.

Maryland and it stakeholders will develop population health measures to include in the portfolio of measures incorporated in value-based hospital payment programs, as part of the TCOC Model. A plan will be submitted to CMS by March 31, 2019.

Aggressive and progressive annual performance targets will be set for quality and value-based metrics. Maryland will report to CMS performance against the targets, savings achieved, and linkage to payments. Maryland will also file an annual report documenting changes in its programs and demonstrating that its programs continue to meet or exceed the scope of the CMS programs. If CMS finds the Maryland value-based programs are not achieving performance improvement, Maryland will have the opportunity to submit a corrective action plan, following the same timelines as those for overall model performance. At the end of this process, CMS may exercise its right to terminate Maryland's exclusion from the CMS national program under section 1886(p) of the Social Security Act, if Maryland has not successfully implemented corrective action.

1. Quality Performance Programs

Maryland will continue its current practice of increasing the percent of all-payer revenue at risk in value-based payment programs consistent with the Medicare percent revenue at risk in national programs. In its annual report to CMS, Maryland will include a description of how the quality and other value-based

payment programs achieve or surpass the patient health outcomes and cost savings of the national programs.

Stakeholders and the State will work to utilize measures recognizing that both tie to the All-Payer Model goals and national quality goals, recognizing that Maryland may use different measures in some instances. Maryland will work with CMS to ensure that Maryland is included in national measures in an accurate and appropriate manner.

If Maryland fails to meet specified targets, CMS will have the right to take appropriate corrective action including subjecting Maryland to the requirements of national programs.

C. Population Health Goals

Maryland and its stakeholders recognize their responsibility to improve the health of the population. The State fully supports the overall mission and vision of the All Payer Model and will direct the resources and activities under its control to the extent possible in partnership with others and in support of population health goals, including:

> Goal 1: Improve Chronic Condition Prevention and management—Reduce incidence and/or prevalence of chronic conditions such as obesity, diabetes, hepatitis C, hypertension, and tobacco use
>
> Goal 2: Improve Behavioral Health—Reduce deaths from opioid use
>
> Goal 3: Improve Senior Health and Quality of Life—Reduce fall related deaths

These three goals will be used in focusing care improvement activities and will be incorporated into value based measures over time. Work will be done with Chesapeake Regional Information System for Our Patients (CRISP) and others to establish ways of collecting outcomes measures. Claims-based measures will be used in value based payment while other measures are brought to maturity.

Additionally, the State will establish a group of major population health measures that broadly reflect the State's overall health goals. Performance against these measures will be based on comparisons to validated predicted trends over the TCOC Model's duration. Initially, performance on these measures will come from survey data but may change over time, with the availability of comprehensive Electronic Health Record (EHR) data. CMS will award the State credit towards health system investments such as the primary care program, equivalent to the overall healthcare savings that can be ascribed to the improvements in the selected measures.

Measures will include, at a minimum, the prevalence or incidence of diabetes, and deaths from opioid overdoses. Additional measures may include smoking, asthma and hypertension, among others. The State will hire an independent contractor to develop specifications for the State's submission of the population health methodology. The specification will include, at a minimum, a measure definition such as data sources and any adjustments in the methodology; a predicted incidence rate or prevalence for the population or the actual performance relative to a propensity matched comparison group, and the expected reduction in annual costs due to the reduction in the incidence/prevalence rate, which may include the present annual value of future costs, excluding any additional costs resulting from increased life expectancy. The State will propose credits for improvements that are not readily susceptible to savings analysis, such as opioid deaths. Any new methods will be submitted annually, by December 31 of each year.

The State will submit a report to CMS, detailing the methodology and all data, programs and documentation used in the report. Within six months of submission, CMS will reply to the State

indicating whether it approves the methodology and a dollar amount of the Maryland Primary Care Program care management fees that will be offset by a reduction in the incidence/prevalence rate. The State will submit at least one measure with an associated methodology for trend prediction and savings attribution by the end of 2017. The State will also report its actual trends beginning in 2021 (Year 3 of the TCOC Model). The State may offset primary care or other approved investment costs with population health savings or credits due to lower incidence/prevalence which will be determined annually through Year 10 of the Model.

D. Calculation Considerations

1. Adjustments to Differential

Maryland expects that the targets established under this Model are achievable without any change in the hospital differential. However, if hospital expenditures are lower than the all-payer limit, but Medicare total cost of care savings are not sufficient, a differential may be used to assure the required savings. Additionally, Maryland may request a change in the differential to effectuate changes in overhead allocations or other factors used in the rate setting system that may be necessary to adjust and modernize the rate setting structure while avoiding shifting costs. To ensure that the differential is only used in a manner consistent with the terms of the TCOC Model Agreement, CMS must review and approve any change in the differential prior to its implementation.

2. Medicare Savings Payment Adjustment

Circumstances may emerge where it is desirable to adjust hospitals' Medicare payments. Examples of potential circumstances include all-payer trends that diverge from Medicare trends or adjustments related to Medicare total cost of care performance for the new Medicare Performance Adjustment (MPA), including adjustments for value-based partnerships, such as a geographic partnership.

The HSCRC may request the use of a Medicare Savings Payment Adjustment (MSPA) to the hospital Medicare payments if the cumulative all-payer hospital growth rate is lower than the cumulative all-payer ceiling and the Medicare total cost of care savings targets cannot be met without an adjustment. CMS will evaluate Maryland's request by considering Maryland's reductions in utilization, and may reject, modify or approve the proposed adjustment. If the adjustment is no longer needed to achieve the required savings after a succeeding period of time, HSCRC may remove or modify the adjustment, subject to CMS approval.

The HSCRC will calculate the MPA, subject to CMS's review of the associated calculations, revenue at risk, trend factors, and other components. The MPA will be included as an Amendment to the Base Model Agreement, and will be updated in the TCOC Model.

If CMS has made a non-claims-based payment determination such as a shared savings amount under a new care redesign track for a Maryland healthcare provider under a voluntary Medicare participation agreement, which is based on the provider's care redesign results or Medicare total cost of care performance, the non-claims-based payment may be effectuated through a payment discount or premium, subject to CMS approval and administrative capability.

E. Payment and Delivery System Transformation and Supporting Tools

Maryland will continue to use a population-based model for hospital reimbursement. A population based-model refers to a model of hospital reimbursement that is either "directly population-based" (i.e., tying hospitals' reimbursement to the projected services of a specific population or specific residents) or

one that establishes a fixed global budget for hospitals for services connected through an attributed population of patients.

For care redesign programs beyond hospitals, the State will seek to design programs that would be available on a voluntary basis to multiple payers and providers, should they choose to participate. Although, in some instances, initial implementation may be focused on Medicare, aligned efforts can serve to support transformation goals and to increase effectiveness and reduce administrative burden for providers and payers.

The State will not set physician fee schedules for Medicare or non-governmental payers. The State has not proposed to set any shared savings programs that allocate savings based on physician expenditures. Additionally, the State will not propose commercial or non-governmental programs that utilize Medicare expenditures or payment rates to set commercial payment benchmarks, also acknowledging that State law and purchaser contracts have requirements for payments to non-participating physicians and providers.

1. Care Redesign Programs

As described in Section II B, the Care Redesign Amendment, which went into effect in July 2017, is a tool to create greater alignment between hospitals, physicians and other providers. The Amendment aims to modify the Model by:

- Implementing effective care management and chronic care management.
- Incentivizing efforts to provide high-quality, efficient, and well-coordinated episodes of care.
- Supporting hospitals' ability to monitor Medicare beneficiaries' total cost of care growth.

The Amendment gives Maryland the flexibility to expand and refine Care Redesign Programs, based on outcomes, learnings, and the changing levels of capabilities of Maryland's health care system participants, as well as the needs of health care consumers. Two initial programs have been implemented and plans for further development are in progress. During the term of the TCOC Model, Maryland will design, deploy, measure, refine and discontinue care design components as part of the model progression. Care delivery and payment programs that are not directly related to hospitals and their global revenues, such as the Maryland Primary Care Program, are also anticipated as new model components. Care redesign programs that are not directly related to hospitals will have their own Participation Agreements with CMS and the State.

Each model component with a Participation Agreement, such as the Maryland Primary Care Program, will have performance measures and requirements. Failure of a component to meet its objectives will subject the component to a corrective action. The component may be terminated and other components of the TCOC Model will continue so long as the other components are meeting their performance requirements and the goals of the TCOC Model.

Maryland and CMS have developed a calendar to use for review of Care Redesign Programs and templates. Proposals for Care Redesign Programs or other new model components that require waivers, changes in claims processing, payment, or new participation agreements will require additional time for review, completion, and operationalization. Maryland will need to submit an operational plan with its proposal. A general timeline applicable to review of new programs or model components will be developed. Maryland will work with CMS so that CMS operations may adjust claims processing as needed and to ensure proper cost distributions of non-fee schedule items to support ACO and total cost of care models.

To bind participants in Care Redesign Programs to the TCOC All-Payer Model provisions, participants will sign a Participation Agreement with the State of Maryland and CMS. Participation agreements will include applicable waivers (described below) and access to data (described in section VI, Sub Section E).

In the TCOC Model, total cost of care guardrails applicable to incentive payments under Care Redesign Programs will no longer be applicable. The MPA will function as a tool to ensure that care redesign participants will be attentive to the total cost of care performance when designing and implementing care redesign interventions.

The Base Model's Care Redesign Amendment includes CMS waivers that allow participating hospitals to share resources and incentives with participating care partners. The TCOC Model will include opportunities to deploy Medicare waivers to support care redesign. After 2019, the State may request additional waivers by proposing new Care Redesign Programs or modifications to existing programs, which must be filed with CMS according to the Care Redesign Calendar. If needed, the State and CMS will amend the hospital Participation Agreement. Waivers may include, but are not limited to: three-day skilled nursing facility (SNF) rule waiver, telehealth waiver, home health waiver, and beneficiary inducements waiver. CMS will have final approval of amendments to existing or new Care Redesign Programs. CMS and the State will develop implementation requirements and processes for approved Care Redesign Programs and participating providers.

The State may propose new participation agreements. Each new participation agreement will be assessed for needed waivers and will clearly state the performance responsibilities of the participant(s). Based on the participation agreement, if CMS determines that a non-claims-based payment or receivable is applicable to a Maryland healthcare provider based on total cost of care savings or other value based-payment mechanisms, an adjustment may be made through a discount or premium to future provider payments, subject to approval of CMS and prior delineation of the process to manage such arrangement with carriers and fiscal intermediaries.

2. Fraud and Abuse Waivers

Fraud and abuse waivers are an important tool for the All-Payer Model. Financial arrangements between and among providers must comply with all applicable laws and regulations except as may be explicitly provided in a written waiver issued specifically for this model pursuant to section 1115A(d)(1) of the Social Security Act. The Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Social Security Act, as may be necessary solely for purposes of carrying out this model. Such waivers would be set forth in separately issued documentation specific to this model. Any such waiver would apply solely to this model and could differ in scope or design from waivers granted for other programs or models. The waivers will include those already provided with the Care Redesign Amendment. Additional waivers may be provided by CMS with additional care redesign tracks, new participation agreements, or other new model components.

3. Rate Setting and Other Waivers

All waivers from the Base All-Payer Model, including hospital rate setting authority and those fraud and abuse waivers provided with the Care Redesign Amendment, will continue throughout the course of the TCOC Model. The Outpatient Facility Waiver will continue to allow for development of free-standing medical facilities and 340B programs. Medicare restrictions on reimbursement for licensed alcohol and drug abuse counselors and wrap-around recovery services will be addressed under the TCOC Model. CMS and the State will consider the possibility of future Medicare rate setting authority for freestanding psychiatric facilities, as payment and delivery programs are developed and the need becomes clear.

4. Meaningful Use

In the TCOC Model, provisions in existing laws related to meaningful use incentives and disincentives will continue to apply in Maryland.

VII. Severability, Corrective Action, and Termination Trigger

The Plan provides an overview of strategies and components that will be developed and implemented to accomplish the goals of moving beyond hospitals to encompass an approach to limit growth in Medicare total cost of care and Medicaid costs for dual eligibles. Each component of the Plan will contribute to the management of total cost of care growth and transforming care delivery.

Section 1115A(b)(3)(B) of the Social Security Act requires the Secretary to terminate or modify the design and implementation of a model unless the Secretary determines that the model is expected to improve quality without increasing spending; reduce spending without reducing quality; or improve quality and reduce spending.

During the term of the Agreement, as part of the Progression Plan, Maryland will design, deploy, measure, refine and discontinue Care Redesign Programs and new Model components that are not directly related to hospitals. Each Model component (e.g., Maryland Primary Care Program, Dual Eligible Alignment, Post-Acute Model) will have performance measures and requirements.

Failure of a component to meet its objectives will subject the component to a corrective action. In considering corrective action, CMS may determine that a sub-component of the model is creating a failure to achieve savings or is reducing quality, then CMS may approve the termination of the sub-component of the model without a resulting termination of the entire model. If a component is terminated, other components of the All-Payer Model may continue so long as they are meeting their performance requirements.

CMS and the State will determine any new triggering events that may be required based on the savings methodology agreed to for Years 5 through 10 of the Model.

The State may terminate the Model at any time with 180 days of notice, consistent with the current agreement.

The Base Model specified four events that would lead to further review by CMS and potentially early termination. All four of these events followed the same triggering event scenarios. Under the TCOC Model, early termination has been further limited and there are increased opportunities for corrective action. Events that could lead to review, potential corrective action, or early termination in the TCOC Model include:

1. The Primary Care Investment

To monitor savings performance of the Primary Care Program, beginning in 2021, CMS and Maryland will evaluate actual and projected CMS investments in care management fees relative to actual and projected hospital savings from 2019 through 2023. If projected intervention costs exceed projected savings, the State shall submit a corrective action plan within 90 days, beginning in 2021.

CMS has 90 days to either accept Maryland's response or require other corrective action, which must be completed within one year of the initial notification unless otherwise agreed. CMS may accept the State's corrective action plan or CMS may choose to limit the acceptance of new Person-Centered Homes (PCHs) for one year, require additional transformation efforts with providers not meeting expectations, or undertake corrective action. After the fifth year of the program, CMS may reduce the

care management fees, exclude categories of non-performing providers from future iterations of the program, or terminate the Maryland Primary Care Program.

If the subsequent year investment exceeds savings without improvement in quality and/or population health, it would trigger a further corrective action or a two-year termination sequence of the Maryland Primary Care Program.

2. Statewide Total Cost of Care growth

By the end of the fifth year, Maryland will commit to reaching a compounded annual Medicare savings target relative to the national Medicare total cost of care trend from the Model base year 2013. The State will set hospital rates and budgets prospectively. Maryland may rely on estimates of growth provided by the Office of the Actuary when setting its budgets. Variations in performance caused by deviations in actuarial estimates will not result in a corrective action plan, so long as Maryland adjusts hospital payment levels within the following year and CMS continues to expect the State to meet the Year 5 annual savings target.

If the annual growth in Medicare total cost of care per beneficiary for Maryland residents, regardless of state of service, is more than 1 percent greater than the national Medicare total cost of care growth rate, the State must submit a response to CMS within 90 days. The State must also submit a response within 90 days if the annual growth in Medicare total cost of care per beneficiary for Maryland residents that is more than the comparable national growth rate in each of any two consecutive years. This applies unless annual growth measures were based on federal growth estimates, to be corrected the following year. If CMS rejects the State's response, within 90 days of its submission, Maryland will have 30 days to submit a corrective action plan.

CMS may accept the State's corrective action plan or may require that the State increase the value-at-risk for the Medicare Performance Adjustment (MPA) and /or adjust the MPA trend factor, if the State has not met its annual savings target and an adjustment is necessary to assure that the Year 5 annual savings target is met.

3. Determination of Quality Decrement

CMS will monitor and determine if a significant deterioration in the quality of care provided to Medicare, Medicaid or Children's Health Insurance Program (CHIP) beneficiaries occurs. The determinations will be made based on quality and value-based metrics, including 30-day all cause readmissions, hospital-acquired conditions, quality-based reimbursement and Prevention Quality Indicators (PQIs). For each performance year, Maryland will place the same percentage of hospital revenue at risk as the national Medicare quality programs.

If CMS determines there is a significant deterioration in the quality of care, the State shall begin to implement corrective actions immediately and shall submit a corrective action plan to CMS within 90 days. The corrective action plan must be completed within one year of the initial notification. If, after one year from the initial notice of the triggering event, CMS determines that the corrective action plan has not been implemented successfully, CMS may terminate the Model. If there is successful implementation of the corrective action plan, there will be one additional year of monitoring.

4. Medicare Savings Performance

Upon failure to meet the annual Medicare savings target by the greater of $30 million or 20 percent of the difference between the 2018 actual Medicare savings and the Year 5 annual performance requirement, the State shall submit a response to CMS within 90 days. The same applies if there is a failure to meet the annual Medicare savings target by $100 million or more (price-leveled by the

Medicare Advantage update factor beginning in Year 6 of the Model Agreement). If CMS reject's the State's response, Maryland has 30 days to submit a corrective action plan. This holds true unless the savings target was based on federal growth estimates, and will be corrected during the following year.

CMS may accept the State's corrective action plan or require that the State increase value-at-risk for the MPA and/or adjust the MPA trend factor if the State has not met its annual savings target and an adjustment is necessary to ensure that the Year 5 annual savings target is met.

If federal deliverables delay implementation, CMS will evaluate extending the savings progression to permit sufficient time to achieve the Year 5 savings goal beyond the 2023 timeline. If the savings performance is adversely affected by exogenous factors, including changes in insurance coverage under the Affordable Care Act, CMS and the State will take this into account in devising a corrective action plan and in revising savings targets if necessary.

Waiver Transition Plan

The All-Payer Model will operate under Section 1115A of the Social Security Act. In the event a triggering event leads to termination of the Model, Maryland will transition to national Medicare programs or another alternative model over a two-year period, to be negotiated by the State and CMS.

VIII. Timing Considerations

This Progression Plan (Plan) outlines ambitious goals for transforming Maryland's delivery system. Strategies are designed to complement one another and rely on efforts from different parts of the delivery system. Successfully deploying new initiatives and supporting technologies will be complex. For example, re-engineering workflows to support the use of Electronic Health Records (EHRs) to improve care, support care coordination and engage patients, families and communities will require extensive time and resources.

Transformation takes time, and the progression timeline must reflect a pace of change that balances the ability of the delivery system to affect change, the policy environment, and the need to keep pace with the demands of a changing environment such as the aging of the population and the requirements of the All-Payer Model Agreement (Agreement).

The implementation and transformation are expected to extend beyond five years and will require significant ongoing investments. It may take longer to develop and deploy initiatives. The federal policy environment and Center for Medicare and Medicaid Services (CMS) payment capabilities are evolving. The Plan will need to adapt to these changes. Progress is dependent on the ability of CMS to provide approvals, payment system changes, and data within planned timeframes. Recognizing this complexity, the timeline will need to be further detailed and adjusted as more plans are developed and there is a better understanding of the scope of the work required to deploy new delivery system and payment programs.

The ability to fully implement and scale the proposed strategies and components will take time. Demonstrating savings and improved care outcomes will also take time. Maryland will work with CMS to ensure that this is recognized when assessing responsibility for total cost of care and outcomes under the All-Payer Model (Model). Maryland will also discuss the length of the TCOC Model with CMS, recognizing the need to support extensive long-term investments and reconfigurations that involve a large workforce.

The timeline for negotiation and clearance of an amended or new Agreement, as well as approval and clearance of model components such as the Maryland Primary Care Program, are critical to ongoing

success. Maryland requests that CMS work with the State to develop a detailed timeline for the negotiation and clearance effort that supports the pace of implementation that is expected.

IX. Key Implementation Considerations

As Maryland moves from planning to implementation, several key areas identified throughout the Progression Plan (Plan) will need to be fully developed:

- Governance
- Financial Accountability
- Workforce Development
- Transformation Tools

A. Governance

The All-Payer Model Agreement (Agreement) of 2014 began a significant evolution of Maryland's historical hospital regulatory structure to a platform for broad system change. The strategic planning efforts that have resulted in this Progression Plan (Plan) have been led by senior leaders of the delivery system, payers, consumers, policy organizations, and State agencies and leadership. The State sought input from the Centers for Medicare & Medicaid Services (CMS) State Innovation Group during this process.

Through the Plan and the Care Redesign Amendment (Amendment), Maryland can leverage the All-Payer Model (Model) to include additional services, physicians and other providers for the purpose of achieving the Model goals. While the HSCRC is the regulatory body for the Maryland hospitals and is positioned to support the State in negotiating changes to the Model, the leadership and oversight for the Plan must have a broader perspective than hospitals.

As physicians, post-acute, long-term care and other providers participate in achieving the goals of the All-Payer Model, the governance will require cooperation and decision-making beyond the current constructs in place. Physicians and other providers will want a stronger voice in providing advice and in decision-making and will not want the Progression Plan to be solely hospital-driven. Yet, this will need to be balanced with the hospitals' continuing responsibilities under the TCOC All-Payer Model. Likewise, consumers and purchasers also have a pivotal role in achieving a responsive person-centered system. The State will place emphasis on using public-private partnerships and broad stakeholder advisory approaches in bringing new governance processes to bear.

Infrastructure will be needed to implement various elements of the Progression Plan, including the Care Redesign Amendment, the Maryland Primary Care Program, Medicare Performance Adjustment, Dual Eligible Alignment, Medicare total cost of care oversight, and other Plan elements. The State will place emphasis on using public-private partnerships and private resources in bringing this infrastructure to bear, similar to Chesapeake Regional Information System for our Patients (CRISP). Some of the infrastructure will be implemented through CRISP. Other aspects of the Plan will require a reorientation of State resources to provide oversight.

The Maryland Department of Health (MDH), with input from stakeholders and guidance from the executive branch and legislative leaders, will lead efforts to establish the appropriate governance and infrastructure approach for the strategies proposed in the Plan and potential new legislation to support

the plan. An efficient governance and infrastructure approach should create transparency, represent the different perspectives, and maintain the flexibility needed to meet the changing demands of the policy and implementation tasks ahead.

B. Financial Accountability

As the Progression Plan is implemented, the State and CMS will need to carefully consider how the various initiatives and accountability structures will interact. Work must be done to determine how the finances of multiple models with shared savings will be handled. It will be important to ensure that shared savings are uniquely attributed to one accountability structure. Measures and monitoring systems will be created to understand the impact of initiatives on Medicare, Medicaid and commercial patients, payers, and providers. This will be facilitated by Maryland's strong data infrastructure and access to patient-level data.

Maryland moved away from a volume-based payment system for hospitals when it developed a global revenue system for hospitals. The costs of this system are currently all captured within the revenue system and distributed through patients' bills. However, CMS is introducing new payment methods that move away from volume-based approaches, such as the Comprehensive Primary Care Plus (CPC+) payment system. These approaches provide payments outside of patients' bills. It will be important to ensure early attention to accounting for the costs that are paid outside of patients' bills to ensure they are captured in related accountability systems.

The All-Payer Model aims to ensure that the statewide goals for total hospital cost of care, Medicare and Medicaid dual eligible total cost of care, and health and care outcomes are achieved. These goals must be driven down to appropriate levels within the State. The Progression Plan lays out a strategy to do that. The HSCRC already does this for hospitals through global revenues and value-based incentives. The State will need to continue to work with stakeholders and advisors to develop mechanisms to monitor and assure that new state-wide goals for total cost of care are also met.

C. Workforce Development

As the Maryland delivery system is transformed, human capital will be needed to support the deployment of new initiatives and tools. There may be reduced needs for some resources in facility settings, but there are increased needs for resources in physicians' offices and in the community. Electronic Health Records (EHRs), work flow technologies supporting care coordination, and team-based care are examples of changes that require extensive workforce training and development. Maryland will need to identify approaches and investments in workforce training and development that can support system transformation with qualified personnel. Implementation will require an organized effort to incorporate workforce development opportunities and to connect them directly to population health outcomes, where possible. For example, existing healthcare staff or new workers may be trained to become community health workers or medical technologists in their home neighborhoods if chronic diseases are prevalent there. Workers with skills in analysis, information technology and performance management will be needed across the State. Nurses, pharmacists, social workers, and others will need to be trained to deliver care coordination and care management services. The delivery system has already identified major gaps in these area of expertise that will need to be filled quickly.

Maryland will devise strategies to meet these needs. It will start by convening stakeholders and advisors as well as secondary schools, colleges and universities, Area Health Education Centers, and other training resources to develop strategies.

D. Transformation Tools

The State's Health Information Exchange (HIE), CRISP, will continue to be developed in support of the Progression Plan. For example, new participants, such as post-acute and long-term care providers, will require intense focus, additional resources and skills training to actively participate in CRISP.

The Maryland Primary Care Program will deploy Transformation tools. Privately operated Care Transformation Organizations (CTOs) will be responsible for providing technical assistance and infrastructure support for primary care practice transformation. Maryland has a number of sophisticated delivery systems and payers that have made and are continuing to make large investments in transformation resources. The State will engage stakeholders to provide advice on additional transformation support needs and how to effectively leverage resources, building on its initial efforts in 2015 with the Coordination Work Group. One area that has already been identified is a critical need for outreach and education of physicians, especially with the national implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) and its implications for Maryland physicians and the All-Payer Model.

Additionally, Maryland should explore other resources that it could leverage, such as the Federally Funded Practice Transformation Networks. Leveraging CMS' Medicare Learning Networks and advisors will provide guidance for Maryland in further developing its plans.

X. Conclusion

Maryland has proposed the strategies in this Plan as part of the State's continued efforts to redesign the health care delivery system to achieve common goals of delivering better care, better health, and lower cost – as designed in the original All-Payer Model (Model). The State has effectively changed the way Maryland hospitals care for patients and the way that hospital care is financed; and while still in the early stages of transformation, Maryland is successfully demonstrating the effectiveness of an all-payer system that is held accountable for the total cost of care on a per capita basis.

From the beginning, Maryland and CMS expected that additional updates would be needed to the Model to more effectively align hospitals, physicians, and other providers to further improve care for Marylanders. This Plan leverages and builds on the hospital per capita model by expanding efforts to support all providers in organizing to engage patients and take on increasing responsibility for system-wide goals. It starts with a strong focus on Medicare beneficiaries, but sets the stage for applicability to all Maryland payers and all health care consumers, with expected improvements in outcomes and lower costs on an all-payer basis.

This Progression Plan has laid out five key strategies: (1) foster accountability for system-wide and patient-level goals; (2) align measures and incentives for providers across the continuum of care; (3) encourage and develop payment and delivery system transformation; (4) ensure availability of transformation tools to support providers in achieving transformation goals; and (5) devote resources to increasing consumer engagement. By proposing an overall strategy for organizing, incentivizing, and supporting all types of providers in health care transformation, this Progression Plan creates an opportunity for Maryland to test a unique model for implementing synergistic, value-based strategies that encompass hospitals, physicians and other providers, and will enable both the State and CMS to evaluate the effectiveness of particular strategies and how they might be replicated as a national model. The Progression Plan also continues to strengthen the approach for rural communities. This is a priority given the unfavorable national trends in rural hospital financial stability, and disparate levels of population health and access to care in rural communities.

The Plan provides Maryland's overall framework for extending the current Model's to encompass its approach to limit the growth in Medicare total cost of care and Medicaid costs for dual eligibles. The Progression Plan offers an overview of strategies and components that will be developed and implemented to accomplish this. Each component will contribute to the management of total cost of care growth and transforming care delivery. Details regarding specific components, such as the Maryland Primary Care Program and the Dual Eligible alignment will be submitted in concept outlines and other supporting documents.

XI. Appendix

A. Figure 11. Summary of Proposed Strategies, Key Elements, and Actions

Strategy One
Foster Accountability

Key Element 1a: Leverage Existing Provider and Payer Accountability Structures

ACTION:
Explore flexibility of Accountable Care Organizations to accept more financial responsibility.

ACTION:
Adopt an approach in which a payer supports an accountability program for practices participating in Maryland's Primary Care Program.

Key Element 1b: Implement Local Accountability for Population Health and Medicare Total Cost of Care through the Value-Based Incentive

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

ACTION:
Over time, incorporate incentives for improving population health and moderating growth in Medicare total cost of care.

Key Element 1c: Progressively Plan and Implement Dual Eligible Care and Payment Alignment

ACTION:
New Dual Eligible Care and Payment Alignment will be Progressively Planned and Implemented

Strategy Two
Align Measures and Incentives

Key Element 2a: Reorient Hospital Measures to Align with New Model Goals

ACTION:
Increase focus on reducing potentially avoidable utilization by encouraging hospitals to improve care transitions and collaborate with community providers

ACTION:
Reorient hospital value-based measures to episodes of care. This approach incorporates both inpatient and outpatient care, and provides a more meaningful assessment of how care is delivered and experienced.

Key Element 2b: Align Measures across Providers and Programs

ACTION:
Align measures across State initiatives as well as with federal efforts.

Key Element 2c: 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 hospital and community-based specialty physicians.

Strategy Three
Encourage and Develop Payment and Delivery System Transformation

Key Element 3a: Develop a Maryland Primary Care Program

ACTION:
Maryland, equipped with experience and expertise in primary care transformation, now proposes its own version of a Primary Care Program. This foundational payment and delivery system reform is designed to be interoperable with every accountability structure.

Key Element 3b: Develop Initiatives Focused on Post-Acute and Long-Term Care

ACTION:
Seek the expertise of its long-term care and post-acute providers to develop new ways of addressing the increasing needs of an aging population and individuals with of complex needs.

Key Element 3c: Explore Initiatives to Include Additional Physicians and Providers and Services in Care Transformation

ACTION:
Engage diverse specialty practices and other community providers in developing additional Care Redesign approaches to meet All-Payer Model goals.

Key Element 3d: Improve the Financing and Organization of the Behavioral Health Delivery System

ACTION:
Continue to develop and implement plans to improve the financing and organization of the behavioral health delivery system, particularly in the community setting.

Key Element 3e: Promote Investments in Innovation, Technology and Education

ACTION:
Foster investments in innovation, technology and education.

Strategy Four
Ensure Availability of Tools to Support All Types of Providers in Achieving Transformation Goals

Key Element 4a: Enable and Support the Health Care Community to Appropriately Share Data in order to Improve Care

ACTION:
CRISP will continue to build out capabilities and engage providers.

ACTION:
CMS provides timely data for effective care management and total cost management.

Strategy Five
Devote Resources to Increasing Consumer Engagement

Key Element 5a: Transform the Health Care Delivery System with Consumer-Driven and Person-Centered Approaches

ACTION:
Provide a visible and ongoing role for consumers in the: (1) design and implementation of person-centered policies and procedures at all levels for both providers and health plans; and (2) evaluation of the Model as a whole, and its individual strategies, as it is implemented.

Key Element 5b: Engage, Educate, and Activate Patients, Providers, and All Stakeholders

ACTION:
Develop a cohesive, comprehensive, and well-coordinated communication plan to support the implementation of the Progression Plan.

ACTION:
Provide consumers with information that they can use for a personal plan for their health and well-being and to provide them with an understanding of the health care delivery system.