Guiding Principles for Effective Implementation and the Future Direction of Maryland's All-Payer Model

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

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Introduction and Statement of Purpose

The Advisory Council was formed in November 2013. The purpose of the Council is to develop key principles to guide the Maryland Health Services Cost Review Commission (HSCRC) in the implementation of the All-Payer Model Agreement, agreed to by the State of Maryland and the federal government in January 2014.

The Advisory Council membership represents a variety of diverse stakeholders in the Maryland health care system, including hospitals, physicians, post-acute care providers, mental health experts, health plans, consumer organizations, and health care policy experts. Senior executives from these organizations met five times in the period from November 2013 through January 2014. The Council issued its first report on January 31, 2014.[1] The Council also held a follow-up meeting in November 2014.

The Advisory Council is now reconvened in 2016 by HSCRC and Department of Health and Mental Hygiene (DHMH) to review the progress of the All-Payer Model after two years of experience and make recommendations to guide the effective implementation and progression of the Model, broadening the focus to system-wide outcomes and cost. By December 31, 2016, Maryland is required to submit a proposal to the Centers for Medicare and Medicaid Services (CMS), which shall limit, at a minimum, the Medicare per beneficiary total cost of care growth rate, to take effect no later than January 2019. A list of the current Advisory Council members appears in Appendix A.

This document is an interim report of the Council to HSCRC and DHMH, based on key points of consensus emerging from three meetings held in February and March 2016. Additional meetings are planned during this year.

The Council observes that the All-Payer Model has shown early accomplishments and considerable promise in achieving the targets in the 2014 Model Agreement. All hospitals were placed under global revenue caps early in 2014, covering about 95 percent of revenue. The first year metrics were met: all-payer revenue growth was held to 1.47 percent per capita, compared to the 3.58 percent per capita ceiling; Medicare realized savings in hospital spending of $116 million, a substantial contribution to the five-year requirement of $330 million; quality measures for hospital acquired conditions were achieved and hospital readmissions declined. Results for the full year 2015 are not yet available.

The Council believes that it is likely to take more than five years to achieve the fundamental transformation of the health care system envisioned in the All-Payer Agreement with CMS.

Recommendations

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

- Vision
- Focus

[1] Guiding Principles for Implementation of Population-Based and Patient Centered Payment Systems: A Report from the Advisory Council to the Maryland Health Services Cost Review Commission. January 31, 2014.

- Person-centered care
- Data
- Accountability
- Alignment

Vision

The Council believes in a fundamental transformation of our health care system away from rewarding ever more volume toward rewarding value and continuous performance improvement. Improving the health of the population should be a key goal, and we can make progress toward this goal by both redesigning the health care system and moving upstream to address the forces outside that system that drive people into it. Patients should be engaged and empowered to participate in the decisions about their treatment.

The Council recognizes that a considerable amount of health care provided lacks an evidence base, and is frequently inefficiently delivered. A strong effort is needed to reduce avoidable care in high-cost settings. Encouraging the integration and coordination of care and linking payments to value will lead to better health outcomes and lower total spending.

This effort should be led by leaders in the Maryland health care system. The State should play the important role of a facilitator, with innovations emerging from private sector initiatives.

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

Focus

The Advisory Council strongly emphasizes the need to focus efforts to achieve this vision on a few realistic and achievable goals. The Council warns against a "scattershot" approach in which a lot of small initiatives are simultaneously pursued with insufficient coordination and scale to bring breakthrough changes. A better approach is to identify some clear objectives, draw a careful roadmap of how to achieve them, and establish workable strategies for moving down the path to success as rapidly as possible.

The Council stresses the need to build on models that Maryland health care leaders are already doing such as Global Budget Revenue (GBR); Accountable Care Organizations (ACOs); and patient-centered medical homes (PCMHs). The best strategy is to test these models, identify those that prove successful, build on proven models, and bring them to scale.

The Council also supports concentrating care management efforts first and foremost on the more than 800,000 fee-for-service Medicare patients in Maryland; particular emphasis should be placed on the members of this population with complex medical needs. Another important target where more care management is needed is the population that is dually eligible for Medicare and Medicaid. Within this population, the individuals who are disproportionately using inpatient services should be the immediate focus. The next priority is to identify patients who may not be high-need and high users of health services now, but are on the cusp of becoming so, and need good care management to avert deterioration in their health conditions.

Finally, while it is important to target initial efforts on the Medicare and dual eligible populations, the Council believes that all residents of Maryland should receive the best quality and most timely care available. The approaches used to improve care for the Medicare and dual eligible populations should have applicability to all payers. This includes getting regular check-ups and access to an array of important screening tests as well as professional advice on how to remain healthy over time.

Person-Centered Care

Person-centered care is a key element of a strategy to tailor care based on a person's needs and to improve the health of the population. Additional resources are devoted to those individuals with high needs and complexity. Care plans, support services, care management, new delivery approaches, and other interventions for individuals with significant demands on health care resources are provided. Individuals with chronic conditions that put them at risk for advanced illness also need care plans and coordinated interventions with a focus on controlling and minimizing the impact of their conditions so they do not escalate.

This involves setting goals that are prioritized by the patient, educating patients on self-care and management, joint decisions between patients and their care teams, engaging the family and caregiver in care and decisions about care, including functional focus and planning. Connecting patients to a variety of social services is important. We also encourage utilizing analytic and care management resources to help identify individuals with high needs and supporting primary care and other community practices in recognizing, prioritizing and serving these individuals. Primary care and other community providers are busy, and they appreciate and need the help they receive from an organized approach, such as the approach used by CareFirst in its Patient Centered Medical Home, to help them serve high-needs patients better. For healthy individuals, resources are tailored to focus on promoting and maintaining health.

In a person-centered system, the individual is:

Engaged: involved in prevention and self-management of health.

Working with a primary care provider: patients should have a medical home, and an active and trust-based relationship with their primary care physician, physician assistant, or nurse practitioner. There should also be coordination between PCPs and specialist physicians to ensure that patients are receiving the best care possible.

Receiving meaningful care coordination: consistent and coordinated support based on individual need.

Patient as the hub: the care-givers that patients see are frequently in multiple health systems. This is one of the reasons why health systems, providers, and community resources need to work together and collaborate to serve patients in a holistic and organized manner, using the investments made in electronic health records, health information exchange, and care coordination to put the person at the center of care delivery.

Building on innovations that are already underway, regional partnerships, ACOs, PCMHs, and payers in Maryland can fuse together the most promising of the scattered initiatives around the state, share evidence related to program impact, and bring the best-performing strategies to scale.

Data

All of the bold and exciting plans to restructure the health care system in Maryland are heavily dependent upon the availability of timely and usable data. HSCRC is currently receiving Medicare claim-level data to assess and monitor the All-Payer Model. This data, however, is not identifiable at the patient level, and therefore inadequate to support provider care transformation efforts. Maryland does have comprehensive hospital data and has used this to create care coordination tools; however, the data are missing care received in the community.

Maryland is seeking from CMS expanded, frequently updated, patient-identifiable Medicare data, including hospital, non-hospital, enrollment, Hierarchical Condition Categories (HCCs), and prescription drug claims for all Medicare beneficiaries in the state. The receipt of Medicare data files will enable providers and regional partnerships to make considerable progress toward meeting the goals of the All-Payer Model. Access to comprehensive data will facilitate care coordination and point-of-service care based on a complete picture of patients' interaction with the health care system. This data would be a critically important complement to the hospital-only data to which Chesapeake Regional Information System for our Patients (CRISP), the State-designated health information exchange, already has access and uses to support care coordination.

The data from CMS will support a critically important effort to identify patients with complex medical and social needs and develop customized care plans to reduce the likelihood and severity of deterioration and complications of these conditions. The HSCRC Work Group on Care Coordination proposed the development of shared tools requiring Medicare data, such as reports identifying gaps in care, patient profiles, and risk stratification. The focus should be on reducing modifiable risks, integrating care across the spectrum of providers, responding rapidly to changes in patients' conditions, and improving patient self-management and adherence to treatment plans. A shared set of patient-specific care profiles and information facilitates the secure sharing of data across providers in order to foster team-based care, reduce costs, and improve health outcomes.[2]

A three-step sequence can be effective in producing a valuable care coordination system: (1) an effective risk stratification approach to identify people with complex medical and social needs; (2) the development of health risk assessments to ascertain patients' situation, needs, and likely outcomes with various strategies; and (3) the formation of care profiles and care plans addressing the medical and social needs of patients, using each patient's priorities and preferences. Care

[2] Maryland Health Services Cost Review Commission. Investing in Care Coordination Infrastructure to Achieve Integrated Care in Support of Maryland's All-Payer Model. April 2015.

profiles can be constructed in standardized formats, based on information shared through CRISP. This will enable providers to access real-time information on their patients. [3] [4]

The Medicare data described above is needed to facilitate care coordination.

The Medicare Data Can Support Care Coordination

The Medicare data urgently needed from CMS can support care coordination as follows:

- Develop utilization reports for ambulatory providers and hospitals so that they can work together and avoid duplication of services and create tools, reports, and processes to identify utilization patterns and fill gaps in care.
- Enhance existing Health Information Exchange tools, including patient identification and automatic alerts to providers.
- Contribute data for risk stratification to help providers and care managers target their efforts to those most in need of assistance.
- Populate standardized care profiles through CRISP's clinical portal, to help a range of providers anticipate and coordinate the full range of beneficiary needs.
- Support process and outcome measurement.
- Generate total cost of care benchmarks and reports.
- Pay for Outcomes management supporting provider enrollment, beneficiary assignment, process measurement, and results analysis.[5]

In summary, the data is essential to the actual achievement of the widely supported goal of identifying the patients most in need of care coordination and management and getting them the care they need in community settings so that their care team can help them manage chronic illnesses, stay healthy, and avoid the repeated use of the ED and inpatient stays.

Accountability

The Advisory Council places a high value on system-wide accountability. All parties in the health care system should work together to establish accountability for improved patient health, delivering care that is efficient and effective, and empowering consumers to get the care they need and deserve.

Maryland has made an excellent start by developing strong accountability mechanisms for hospitals through global revenue budgets that reward hospitals for cost control accompanied by meeting quality and outcome metrics. Global budgets are adjusted when care shifts from one hospital to another to maintain responsiveness to consumers and other stakeholders. The Council believes that we can build on this hospital-level accountability to bring physicians, other clinicians, consumers, and social service providers into accountability partnerships.

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[3] Ensslin, B. & Barth, S. (Nov. 2014). *Risk Stratification to Inform Care Management for Medicare-Medicaid Enrollees: State Strategies.* Center for Health Care Strategies, Inc.

[4] Cohen, R., Lemieux, J., Schoenborn, J, & Mulligan, T. (2012). "Medicare Advantage Chronic Special Needs Plan Boosted Primary Care, Reduced Hospital Use Among Diabetes Patients". *Health Affairs* 31 (1): 1-10.

[5] CRISP. Medicare Data: Acquisition and Use.

Currently, a considerable number of primary care physicians are participating in PCMH models and ACOs in Maryland. Both of these programs include accountability at the program level for a combination of total spending trends and quality/health measures. Accountability should also be part of the business model in post-acute and long-term care, where it is frequently more difficult to measure outcomes. Over time, all participants in the delivery system should be brought into partnerships in which all parties have responsibility for cost and quality.

Fragmented Delivery of Care and Outdated Payment Systems Work Against Accountability

The Council observes that the combination of a highly fragmented health care delivery system and traditional fee-for-service payment models work against accountability. Under these outmoded approaches, various types of providers work in silos. They are not incentivized or supported to readily share results or work in team-based care in ways that provide holistic and comprehensive care to patients.

Under such systems, accountability is within the narrow confines of each provider's silo and therefore not person-centered or holistic. First, this is bad for the person who has to try to navigate such a fragmented system, frequently bewildered and overwhelmed. Second, it generates wasteful spending in the form of care provided that lacks an evidence base, duplicative tests, flare ups and complications arising from poorly coordinated care, and gaps in care arising as patients get lost in this labyrinthine system.

Patients need to be accountable as well. They need to do the best they can to adhere to treatment regimens (i.e. taking medications as directed, refilling prescriptions). They also can adopt healthy lifestyles (i.e. attempting to give up smoking, healthy eating, and exercise). Many people struggle with conditions that are beyond their control and giving up lifestyles that are unhealthy can be quite difficult. What is needed are efforts to "help people help themselves." Consumers should be accountable for making the effort, and the system should be accountable for helping them succeed.

That system is heavily comprised of the medical community. However, public health, community organizations, volunteers, and the faith-based community can also complement the medical system and be a natural partner in this work. Maryland should encourage partnerships with community organizations. One example of this is Maryland's Faith Community Health Network, which attempts to align efforts to provide timely support for congregants who have been hospitalized.

What Can be Done?

The Council believes that system-wide accountability can be achieved in the following ways:

- Consider various models that feature more accountability for quality and cost control and create a plan for an organized approach to determine the best options and results. Potential models may include PCMH, ACOs, regional partnerships building on global models and geographically organized resources, and others.
- Establish a core set of common quality and patient safety metrics across the system.
- The key point is that there is a need for payment systems that hold specific parties across the delivery system at financial risk if key goals are not met, and reward them if these goals

are met. Cost-cutting alone should not be rewarded without attention to quality and safety. Neither should inappropriate cost-shifting from one sector of health care to another that results in total cost increases. What is needed instead is a system of rewards and penalties creating strong incentives for lowering total spending *while at the same time* improving quality and patient outcomes.

Alignment

A system that creates strong incentives for value and outcomes for one important sector of the health care system, but excludes other important segments from the reforms, will find system-wide success elusive. A successful crew team features everyone in the boat pulling the oars in a synchronized rhythm, a tactic that will lead to successful transformation of the health care system.

The Need for Physician and Provider Alignment

It is vital that Maryland physicians and other providers have incentives and reward structures that are aligned with the All-Payer Model. They also need the tools and support to identify patients with the most complex needs, including knowledge about their patients' use of services outside of the care that they provide directly, including behavioral health, home, and social conditions that may affect their patients' health.

Alignment means that if the goals of the All-Payer Model are being met, Maryland doctors and other providers who are meeting outcome and quality metrics and working to reduce avoidable utilization that results from improved person-centered care should share in the rewards. Without synchronizing providers with a common set of goals, person-centeredness and long-term success would be jeopardized.

Payment models should provide direct rewards to physicians and providers who participate in innovative care delivery and payment models and show positive results from their efforts. Thus, physicians treating patients with diabetes, for example, should benefit when the proportion of their patients with this disease who keep their glucose levels under control rises, and when the proportion who get regular eye and foot exams increases. This may involve close coordination between the patients' primary care provider and an endocrinologist to whom the patient was referred by the PCP.

Patients' family practice providers, internists, pediatricians, obstetricians, and urgent care providers are typically the first point of contact that a patient has with the medical system. It is vital that these primary care providers have incentives to gather all relevant information about their patients in a user-friendly way, and have such information available "in real time" as they are seeing patients. As noted above, physicians need the data in a form that is usable and up-to-date that will enable them to flag and pay special attention to patients whose conditions are resulting in hospitalizations or other advanced care. Primary care providers can use this data to work with other providers serving that patient and develop a care plan that can be followed over a substantial time span to help patients recover from illnesses and manage chronic conditions that in many cases are lifetime in nature.

Specialist physicians and surgeons must also have incentives that are aligned with the All-Payer Model.

The Importance of Regional Collaboration

In order to accelerate effective implementation, Maryland is developing Regional Partnerships that can collaborate on analytics, target services based on patient and population needs, and plan and develop care coordination and population health improvement approaches. The Regional Partnerships for Health System Transformation are a critical part of the state's approach to foster this collaboration. These partnerships include the hospitals in the area, federally qualified health centers, and other community health centers and medical groups, units of local government such as the Office on Aging, and community-based organizations.

Maryland provided planning grants to eight Regional Partnerships in June 2015, resulting in submission of Regional Transformation Plans in December 2015 that describe delivery and financing reforms aimed at reducing utilization and costs and strategies to improve quality and overall population health in the region. In order to fulfill healthcare savings commitments by Maryland to CMS, the initial target populations were identified as complex, high-need patients with multiple hospitalizations, patients with multiple chronic conditions who are at risk of becoming high resource users, frail elders with support requirements, and dual eligible patients with high resource needs.

The Care Coordination Workgroup identified these populations as the most likely to yield the biggest gains from the Regional Partnerships' efforts. The Workgroup also recommended the development of state-level integrated care coordination resources and in some areas recommended standardization and collaboration.[6]

A key element of the Regional Partnerships involves working with CRISP. This organization has the capability to generate patient-specific reports. These can be used by primary care physicians and other providers. The reports can indicate that a physician's patient was hospitalized last month, the length of the stay, the primary and secondary diagnoses, and the setting into which the patient was discharged. The reports may uncover the fact that a certain patient was hospitalized two or three times in the past year, but that each stay was at a different hospital, underscoring the need for regional partnerships in which hospitals in the area can coordinate their approach to such patients.

Working with CRISP, providers can use secure texting, receive care alerts, and learn what the patient's care manager accomplished in a recent visit. There may also be information about services the patient received that were outside of the standard medical model, such as indications that the patient lacks transportation to keep medical appointments, or has a language barrier that is impeding the fulfillment of a care plan.

Physicians and other providers should be directly involved with CRISP, which has the ability to help them improve their care delivery. Many will need help in tapping into CRISP information, which will facilitate data sharing across providers. Physicians should be able to determine which of their

[6] The Care Coordination Workgroup's final report can be found at: http://www.hscrc.state.md.us/documents/md-maphs/wg-meet/cc/Care-Coordination-Work-Group-Final-Report-2015-05-06.pdf.

patients are designated as having complex medical and social needs, beginning with patient-identified, HIPAA-protected information on the full range of health services used by such patients.

Important Opportunities for Physicians

There are several important physician incentive programs in which Maryland physicians can participate:

Medicare Payments for Chronic Care Management

Effective January 1, 2015, Medicare made a very significant change to primary care payment when it introduced a non-visit-based payment for chronic care management (CCM). This change has the potential to align efforts by physicians and hospitals around the opportunity to improve chronic care and reduce hospitalizations.

CCM payments permit Medicare to pay for non-face-to-face care management services such as medication reconciliation, coordination among providers, arrangements for social services, and remote patient monitoring. Arranging for such services requires physicians' time as well as the time of office staff, administrative costs, and technology outlays. Prior to this CMS billing code and payment system for care management, medical practices have had to absorb these costs without any reimbursement.

The new CCM payments create helpful incentives for physicians to coordinate with other medical providers and organizations providing complementary social services, potentially fostering a more holistic and comprehensive approach to meeting patients' needs. To the extent CCM is done well, more continuity of care will be provided for patients with complex needs and ongoing chronic conditions who might otherwise go from one episode of ED use and/or hospital admission to another, with little care management in between a series of complications.[7]

One concern about the CCM payments involves the affordability of the patient co-payments. Many lower-income patients will be obligated to pay co-payments (likely to be $8) that for some, could pose a barrier to their willingness to participate in this chronic care management initiative. Consideration should be given to finding a way to waive the patient cost-sharing for such patients.

MACRA and MIPS

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) establishes a Merit-Based Incentive Payment System (MIPS) that consolidates existing Medicare fee-for-service physician incentive programs. MACRA also establishes a pathway for physicians to participate in alternative payment models (APMs) such as PCMH.

Council members noted that Maryland should be aligning MACRA, MIPS, and APMs. This will help physicians participate in new approaches to care delivery and payment.

[7] Maryland Health Services Cost Review Commission. Investing in Care Coordination Infrastructure to Achieve Integrated Care in Support of Maryland's All-Payer Model. April 2015.

Harmonizing Quality Metrics across Payers and Delivery Models

In February 2016, CMS and America's Health Insurance Plans (AHIP), as part of a broad Core Quality Measures Collaborative, released a set of Core Quality Measures. These measures support multi-payer and delivery model alignment on core measures primarily for physician quality programs. This work is facilitating CMS' efforts to implement MACRA. Quality measures are frequently not aligned across payers and delivery models, resulting in confusion and complexity for clinicians. The first set of measures is in the following domains: ACOs, PCMHs, and Primary Care; cardiology; gastroenterology; HIV and Hepatitis C; medical oncology; obstetrics and gynecology; and orthopedics.[8]

Important Opportunities for Post-Acute Care and Long-Term Care Providers

The importance of aligning providers of post-acute care and long-term care with the goals of the All-Payer Model is also very important. This includes skilled nursing facilities, home care, rehab hospitals, and nursing home care, as well as durable medical equipment. This sector is fragmented and frequently disconnected from acute care medicine.

Hospital discharge presents one of the biggest challenges to patient care management if not properly handled. About one of six Medicare patients discharged from a hospital is readmitted in the 30 days following discharge. Under the All-Payer Model, Maryland is required to sharply reduce hospital readmissions rates to a level that is in line with the national average.

Patients in long-term care facilities are frequently sent by ambulance to the emergency room for escalation of conditions that might be prevented or for adjustments that can be safely done in their facilities with some additional support. Many such trips to the ER result in an admission to the hospital that could have been avoided with the proper guidance and clinical support. Evidence-based care transition approaches can reduce such hospital readmissions from long-term care facilities. Examples of successful programs that reduce such poor outcomes include the Interventions to Reduce Acute Care Transfers (INTERACT) program and Project Re-engineered Discharge (RED).

Information technology is also important to improving post-acute care and establishing stronger bridges between acute and post-acute and long-term care. CRISP can be helpful in this process.

Behavioral Health

The Advisory Council believes that better management of behavioral health conditions is critically important to improving health outcomes and controlling spending. In our fragmented health care system, behavioral health is frequently "carved out" of the health benefits package and treated as if it were unconnected to acute care medical conditions. Yet, we know that physical health and challenges around mental health and substance use disorders are frequently inextricably intertwined.

Behavioral health needs adequate funding and linkages to the somatic health care system across the full continuum of care. This includes smooth handoffs from primary care physicians to behavioral

[8] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-02-16.html

health providers. Primary care physicians should be trained to recognize patients who frequently present only somatic health conditions but also have mental and emotional issues, and to make timely and appropriate referrals to behavioral health providers. Behavioral health providers treating people with serious mental illness should also recognize the numerous physical health problems that frequently emerge from mental health treatment, as when medications generate side effects such as substantial weight gain, diabetes, and other illnesses, and make appropriate referrals to primary care and specialist physicians so that those conditions are controlled and managed. In addition, people leaving the hospital after a stay related to a severe episode involving mental health and/or substance abuse problems should be linked to ongoing care and affordable medications to help avoid repeated hospitalizations.

Barriers to care frequently emerge from an insufficient number of behavioral health providers in communities. Even where there may seem to be an adequate number of such providers in the aggregate, many do not accept Medicaid and do not see uninsured patients. Further, they may be clustered around urban centers, but quite remote from people living in smaller towns or rural areas.

Summary and Recommendations

The Advisory Council recognizes the significant progress made by the State of Maryland during the first two years of the All-Payer Model. In this report, the Council has highlighted the major challenges that lie ahead as the State strives to achieve a fundamental transformation of the health care system over the next several years.

Recommendation 1: Focus

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

Recommendation 2: Data

The Council believes that the timely acquisition of Medicare data that covers all major areas of health services in a patient-identifiable format is critical to making further progress toward meeting the goals of the All-Payer Model. Maryland has agreed to very tight targets in the All-Payer Model. As we approach the halfway point in the five-year agreement between the federal government and the State, it is crucial that the federal government give Maryland a chance to perform as expected by quickly providing the data necessary to do so. Effective care management for Medicare patients with complex medical needs is absolutely vital to reducing avoidable care in high-cost settings. Yet, such an outcome requires the acquisition and timely updates of data required to identify such patients, their utilization patterns, diagnoses, and other vital information. This is a top-priority recommendation.

Recommendation 3: Accountability

The Council recommends that Maryland develop a plan for system-wide accountability for quality improvement and long-term cost control. This will require a rapid transformation from both the fragmented delivery system and the traditional fee-for-service silos, both of which work against

accountability. It is important to transcend the silos that separate service providers and thwart efforts to coordinate care delivery. It is also important to facilitate the shift of health care into integrated care models with consistent outcomes requirements and shared savings and risk-sharing arrangements. These steps promote accountability across the system.

The key is to develop common measures of expected outcomes and systems of rewards and penalties for all of the key sectors in health care. It is also important to link the providers inside the health care system to community-based organizations that address the factors frequently driving people into that system.

These elements of accountability should be woven together to meet the goal of person-centered care. Through provider collaboration, the initiatives of health plans, and government activities, the silos can be transcended in a way that focuses on the patient's needs. Regional partnerships can help bring the players in the health care and social service systems together to meet these needs.

Recommendation 4: Alignment

The Council believes that alignment of incentives across providers is vital. If some provider organizations have incentives to reduce avoidable use of care and improve quality while others do not, the potential for slippage and cost-shifting is significant. Moreover, if those who are needed to make the All-Payer Model work are stuck with the incentives in the old-fashioned system, many of the good efforts of those who have converted to more modern approaches could be frustrated.

Physicians and allied medical personnel should be rewarded for spending time on care management, rather than required to donate time to this effort. They also need a pathway and a reward structure to encourage participation in alternative payment models.

Alignment of incentives in the long-term and post-acute care system is also vital to reducing hospital readmissions and an avoidable deterioration in health conditions in these settings. The Council recommends that greater attention be paid to improving care and aligning incentives across the acute and post-acute care and long-term care settings.

Appendix A

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