

Uniquely Similar: New Results from Maryland's All-Payer Model and Paths Forward for Value-Based Care

By Mark Japinga and Mark McClellan

Policy Points

- > The evaluation of the Maryland All-Payer Model provides evidence that implementing value-based payment models can facilitate care transformation and lower costs.
- > A state's priority should be identifying the best model to support broad-based, predictable, and substantial payment reform given its own circumstances.

ABSTRACT

In November 2019, the Centers for Medicare and Medicaid Services released the final evaluation of Maryland's All-Payer Model, which established a global budget for hospitals with the goal of lowering Medicare costs while improving quality and access. Medicare spending fell 2.8% relative to a comparison group, driven by a 4.1% reduction in total hospital expenditures, and contributed to slower spending growth systemwide. The model had only a modest impact on quality metrics; readmissions fell for healthier patients, but hospitals struggled with sicker patients, and population health metrics also did not improve. While the Maryland model is often touted as unique for state health care systems, the evaluation also showed that hospitals took similar steps and followed similar pathways as organizations nationwide participating in a wide range of payment models. Successful participants have lowered costs by focusing on reducing avoidable hospital admissions, professional services, and postacute care utilization. They build competencies like data infrastructure and patient-centered delivery models with the help of strong leadership. They also report similar struggles, including engagement and care for complex patients and alignment across health systems. Overall, Maryland's approach offers one viable way to implement payment models—placing accountability on providers through a spending cap and requiring participation—but it is not the only way. Maryland crafted an innovative policy based on the unique needs of its health care system, and state-level policymakers across the country are well positioned to do the same.

INTRODUCTION

Since the 1970s, Maryland has set prices for all payers for hospital services, supported by a waiver from the Centers for Medicare and Medicaid Services (CMS). However, even with price regulations, costs continued to rise, and Maryland consistently finished among the top 20 highest-spending states in the country.¹ One key reason was the lack of utilization control. Many hospitals responded to fixed prices by increasing the volume of services offered.²

To address these trends, Maryland introduced the All-Payer Model in January 1, 2014, also the implementation date of the Affordable Care Act coverage expansions. The model set fixed Medicare global budgets for hospitals—a set annual amount of funding to cover the vast majority of inpatient and outpatient services—based on historical spending trends and with the aim of limiting cost increases and unnecessary utilization. States and hospitals agreed to limit cost growth to less than 3.58% and generate \$330 million in Medicare savings over five years.³

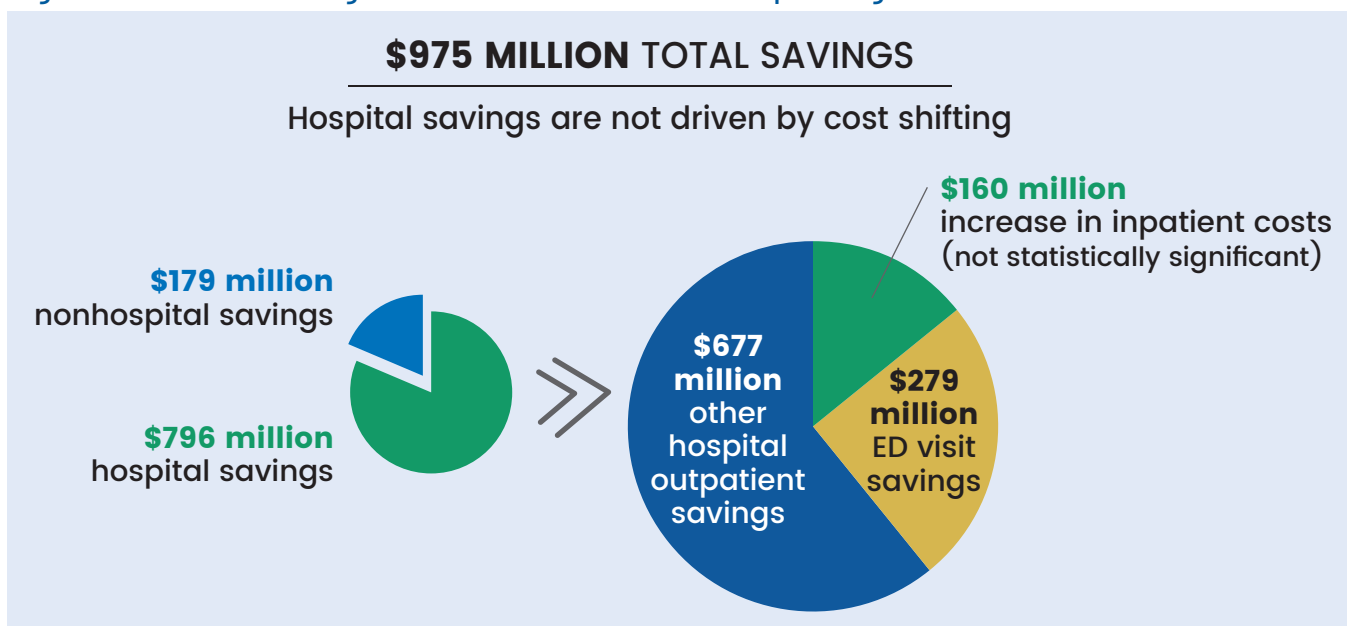
Of the wide range of payment models designed to move hospitals and other providers away from fee-for-service (FFS), Maryland's model has received significant attention for its perceived boldness. The model applies a basic tenet of payment reform—shifting payment away from volume and placing more accountability on health systems and providers—via a spending cap and a requirement that every hospital in the state participate.

The All-Payer Model is just one example of why states are such critical movers in health care policy: states can move more nimbly than national Medicare models, and understand the unique needs of their health care systems, and as a result can craft innovative programs to address those needs. Through these programs, policy-makers can better understand what types of payment models work well, the tools needed to help models succeed, and the speed at which providers can adopt them.

Evaluation Results

CMS released the final evaluation of the All-Payer Model in November 2019, showing the state making notable progress in controlling hospital costs over the program's five-year span.⁴ Spending for Medicare beneficiaries grew 2.8% more slowly than a comparison group, producing \$975 million in savings. The reduction was driven by 4.1% slower growth in total hospital expenditures, which accounted for more than 80% of the total savings. These savings translated into reductions in total health care expenditures—that is, they did not result in cost shifting from Medicare to other parts of the health care system. Directionally similar changes occurred system-wide for commercial populations as well, though total expenditure savings were not statistically significant (Figure 1).

Figure 1. Medicare Savings Reduced Total Health Care Spending



Adapted from: Findings at a Glance: Maryland All-Payer Model Final Evaluation Report (2014–2018). Centers for Medicare and Medicaid Services website. <https://innovation.cms.gov/files/reports/md-allpayer-finalevalrpt-fg.pdf>. Accessed May 11, 2020.

Quality metrics showed modest impact, with mixed results for readmissions and no major changes in performance. All-cause and avoidable hospital admissions both dropped by more than 6%. However, these were largely healthier patients; Medicare payments for inpatient services did not change, an indication that emergency departments (EDs) spent more time treating sicker patients. Hospitals noted they focused on improving outcomes for these patients rather than where they got care. Outcomes improved for those dual eligible for Medicare and Medicaid in particular, and 14-day follow-up visit and 30-day unplanned readmission rates improved for nonteaching hospitals.

Evaluators also did not find improvements in overall population health. To measure this, they used data from the Behavioral Risk Factor Surveillance System to track the change in adults who reported being current smokers and the percentage of Marylanders with a body mass index greater than 25, since these conditions correlate with a higher risk of cardiovascular conditions, cancer, type 2 diabetes, high blood pressure, and other chronic diseases.

Most health systems reported investing in population health efforts, ranging from care coordination to discharge planning and collaborations with social services. Many expressed concerns about how much control they had over the health of high-risk patients, these patients' behavior outside of the hospital, and the choices made by frequent ED users. Although Maryland did not develop population health outcomes to drive bonuses or other payment adjustments in this model, such outcomes will play a greater role in the Total Cost of Care Model, the second phase of the All-Payer Model that launched in 2019.⁵

Implications for Payment Reform

Beyond cost control numbers, what stands out just as strongly from the evaluation is that a “radical,”⁶ “innovative,”⁷ and “unique”⁸ payment reform put the state on a very similar trajectory to comparable payment reform models: some spending reduction with limited effects on quality in the early years, with the potential for impact to grow over time through reinforcing reforms and further investments in new care models. These similarities, including systemwide approaches to cost reduction,

the competencies and investments needed to succeed in payment reform, and future steps and challenges are critical for comparing how Maryland's model supports system reform versus comparable efforts.

The trends in this evaluation offer further evidence that there is not one “best” payment reform; rather, efforts to control costs while maintaining or improving quality can happen through a variety of methods designed to move hospitals and other providers away from FFS—Maryland All-Payer included. These reforms encourage organizations to move patients out of high-cost settings and to invest in data infrastructure and new care models that improve care delivery, all done in a predictable way over a predetermined period.

Cost Savings and Utilization

Cost savings from the All-Payer Model largely occurred through reductions in ED admissions, which was achieved by shifting care toward outpatient and ambulatory sites with lower costs. This approach is comparable to those taken by hospitals participating in a range of payment reforms and accountable care organization (ACO) initiatives. Specific savings under the All-Payer Model came primarily from lowering costs for professional services and reducing utilization of postacute care, similar to hospitals operating under bundled payments.⁹ Maryland hospitals increased savings over time, also mirroring the experience of ACO reforms.¹⁰

Where the All-Payer Model stands out from most other models is in its mandatory and all-payer nature. That all hospitals in the state are required to participate may be one reason why Medicare savings are larger here than in voluntary programs like the Medicare Shared Savings Program (MSSP),¹¹ primary care payment and delivery reform programs,¹² and bundled payments.¹³ Moreover, attaching all payments to a global budget puts hospitals at greater financial risk than in ACO shared savings models in which payers and providers share in a smaller percentage of savings or losses. Maryland's results are consistent with CMS data showing that MSSP ACOs with shared two-sided risk had higher savings than those with one-sided risk.¹⁴

Developing Necessary Organizational Competencies to Succeed in Value-Based Payment

New payment models are designed not only to lower costs but also to help organizations build the competencies necessary to deliver higher-value care over the long term, equipping them to improve population health and take advantage of emerging digital and medical technologies. Maryland hospitals, according to the evaluation, generally pursued similar initiatives to transform care, such as prioritizing care coordination, establishing discharge planning and care transition programs, increasing the systematic use of patient care plans, and improving data and analytic strategies, especially to identify high-risk patients. Hospitals also established clinics to see patients postdischarge or as an alternative to the ED, and hired more care coordinators, care managers, social workers, and data analysts.

Any hospital could take on these tasks, but impact takes time and success is not uniform. The evaluation showed the critical differences were leadership, well-prioritized investment, and patience. Hospital executives and physician champions had to make the business case and convince other staff that a system focused on efficiency and value, bolstered by performance metrics and analytics, offered the most promising path forward. Bringing staff and patients on board, implementing new systems, and reforming the workforce all take time, effort, and capital. But five years into the model, many leaders in Maryland, after expressing initial skepticism, agreed that it was here to stay.

High performers require more than just leadership; a range of new competencies are critical to success in payment reform and are a major undertaking. Many organizations have struggled due to myriad care redesign challenges, while others have avoided payment reform entirely because of concerns they will not succeed. The

Accountable Care Learning Collaborative has laid out a list of competencies necessary for success in ACOs that also applies to models like this one.¹⁵ The key competencies can be broken into four groups:

- *Governance and workforce*: Securing leadership commitment, engaging providers, and fostering culture change to focus on value and person-level results.
- *Finance*: Securing up-front capital, measuring and rewarding performance, and aligning provider contracts with value-based payment goals.
- *Health IT and analytics*: Generating and organizing data, developing shareable and accessible platforms, and incorporating data into care models.
- *Person-focused care delivery*: Designing systems that meet patient needs and ensuring patients are involved as part of continuous improvement.

Given synergies across payment reforms, significant opportunities exist for health systems to collaborate and develop best practices. The up-front payments that come from the All-Payer Model and other payment models can help organizations make some investments, but other supports are necessary, especially for smaller organizations that lack access to capital. State and regional collaboratives can identify and pilot priority interventions or practices to help organizations develop competencies. Third-party organizations like Caravan, Aledade, Agilon, and others base their business models on partnering with health care organizations to develop new capabilities, particularly in care delivery and data analytics. Predictable, broad-based payment reforms will encourage these efforts, which are just as critical to success as the reforms themselves.

CHALLENGES AND NEXT STEPS

Throughout the health care system, organizations face a wide variety of challenges to achieving more significant savings and improving health via payment reform. In the All-Payer Model, these challenges fell into three categories: performance variation, patient engagement, and alignment (Figure 2).

Performance Variation

Teaching hospitals and disproportionate share hospitals generally had poorer outcomes because they tended to treat more complex patients. Hospitals in rural or low-income urban areas performed more poorly on 14-day follow-up visits and 30-day readmissions, in part because of patient population but also because they struggled to connect their patients to other providers and available community resources. Many hospitals also claimed the model was not dynamic enough to account for systems with rising or declining market share. They reported challenges engaging ambulatory providers and other community partners, who were not required to adopt global budgets.

States should consider how best to help poor performers within the confines of the payment model, rather than risk making the model too complex through a range of small modifications. They can look to safety-net hospitals that are succeeding in payment reform by investing in physician support, care teams, and data systems. NYC Health + Hospitals, a large public hospital system, operates an ACO that has achieved savings relative to its spending benchmark in five consecutive years thanks to aligning financial reforms, financially supporting physicians in shifting to new care models, and building data systems that allow for targeted interventions and provide timely feedback.¹⁶ States can also aid struggling health systems by helping them invest in telehealth and empowering a wider range of provider types (such as nurse practitioners) and community organizations to fill service gaps.¹⁷

Patient Engagement

Maryland hospitals often noted their struggle in keeping high-cost, high-need patients out of the emergency room and complying with medication regimens, or using alternative sites of care. They cited interest in

Figure 2. Overcoming Challenges in the All-Payer Model

Challenge	Findings	Paths Forward
Performance variation	Teaching hospitals and safety-net hospitals have struggled to improve outcomes in part because they treat more complex patients.	Supporting investments in a more flexible delivery system through areas like data/IT, telehealth, and workforce can help make health systems more nimble and responsive to the unique needs of complex patients.
Patient engagement	Hospitals often struggle to keep high-need, high-cost patients out of the emergency department or complying with medication regimens, with providers concerned about related performance penalties.	Additional state-level initiatives like North Carolina's Healthy Opportunities Pilots, alongside payer efforts, can help develop best practices for bridging gaps between health systems and social service organizations and help stakeholders better understand what interventions work best.
Alignment	The All-Payer Model covered hospitals only, providing different incentives for providers depending on the site of service.	Maryland's Total Cost of Care Model, launched in 2019, brings more outpatient providers under global budgets, and the state offers a wide range of programs designed to promote care coordination across settings.

developing partnerships with community providers, but struggled to carry out these ambitions fully. Reasons for slow progress included a lack of engagement, provider shortages, and insufficient funding.

States will need to identify and prioritize where to focus, understanding the financial and administrative challenges that come with differing approaches. Housing initiatives are popular but expensive if broadly implemented.¹⁸ Some health care organizations report success focusing on nutrition or transportation barriers.¹⁹ More evidence is needed on what types of interventions improve health or save money under a real global budget in different types of health care organizations. Moreover, hospitals should not be the only organization addressing these issues. Initiatives such as North Carolina's Healthy Opportunities Pilots will help stakeholders to better understand how a more concerted effort from payers and policymakers could also address key social risk factors.²⁰

Reforms will need to support alignment across provider types and settings, with the goal of better outcomes and lower costs across the full spectrum of care delivery. The new Maryland Total Cost of Care Model, which launched in 2019, brings many outpatient providers under global budgets and also includes specific population health metrics that will encourage alignment to address priority issues like diabetes.²¹ It will also either establish or continue a range of programs designed to foster alignment across settings:

- The Care Redesign Program and the Episode Care Improvement Program allow hospitals to convene nonhospital providers, bearing financial risk in exchange for Medicare data and the promise of shared savings if the coalition can lower costs.²²
- The Maryland Primary Care Program resembles CMS's Comprehensive Primary Care Plus (CPC+) program, supporting primary care transformation through care management fees and other incentive payments.²³
- Like the other programs mentioned, the Regional Partnership Transformation Grant Program also allows hospitals to work with community stakeholders on population health issues; however, most of the participating organizations so far are pursuing care integration and coordination efforts for

high utilizers, rather than broader efforts aimed at addressing social risk factors.²⁴

Further payment reforms to bring care out of silos and to support efficient investments will be critical for success in implementing less costly, higher-value care pathways. The goal is to make a health system or group of providers accountable for a population through up-front payments, but allowing this to happen in a variety of ways. Supporting policies to address competition and consolidation can ensure that big, integrated health systems do not dominate the market, and additional performance incentives could help reward arrangements in which small provider organizations could partner with the most efficient hospitals in their region. Addressing these challenges will become even more critical as organizations get beyond many of the reforms that have led to initial savings and undertake more substantial initiatives.

FUTURE DIRECTIONS

The Maryland evaluation provides important evidence that taking meaningful steps to implement new payment models can facilitate care transformation and lower costs. The Maryland All-Payer Model is one approach to doing so: a mandatory, long-term model that includes all payers and enforces accountability for total cost of care. But the legacy of all-payer payment in Maryland makes it significantly easier to implement there than in other states, and the coming years will show whether the state can extend its reforms beyond hospitals and beyond Medicare to make more progress toward broader population health goals. Other states may not be able to implement global budgets as easily but should recognize the importance of broad-based, predictable, and substantial payment reform.

A state's priority should be identifying the best model toward such goals and the means to support it, given its own circumstances, with goals of providing predictability for organizations to invest and participate in these models, making it difficult to remain in FFS, and keeping health spending growth under a prescribed amount. It is no surprise that success requires substantial movement away from volume-based payment and that such movement takes time. Mandatory models and multipayer alignment to reduce burden and increase impact are clearly helpful but not required if states do

Maryland's Response to COVID-19

The All-Payer Model and subsequent Total Cost of Care Model, like many payment models, offer predictability in normal times but are not naturally structured for pandemics and other emergencies that put some parts of the health system under extreme stress and cause massive utilization drops in others. The state's Health Services Cost Review Commission, which administers the current model, has stated the commission "will take all necessary actions to ensure hospitals are appropriately funded" and ease relevant regulatory burdens.²⁵ Almost immediately, the state decided to allow hospitals facing lower patient volumes to make up for lost revenue by temporarily increasing rate corridors, which allows them to charge more, and to create an emergency funding mechanism designed to cover expenses related to temporary capacity expansion.²⁶

On April 2, the state released additional guidance through a set of "frequently asked questions," in which the state announced it would not use data from January 1 until June 30 to determine global budget adjustments for numerous quality programs.²⁷ It will also suspend adjustments for any metric that addresses shifts in hospital volume, since current shifts would not necessarily be indicative of normal hospital case-loads. This is similar to the recent CMS changes to the Medicare Shared Savings Program for ACOs.²⁸

These moves should reassure hospitals that support will remain available, in addition to CMS programs offering advanced Medicare payment.²⁹ Additional action could also better align the state with value-based care principles. The state could incentivize organizations to invest in improving their capacity to test and trace COVID-19 cases, develop metrics for rewarding health systems showing exemplary responses to the pandemic, and generate more evidence on what types of delivery reforms are most productive in creating an effective COVID-19 response.

not feel that this is their role. Rhode Island, Washington, and Massachusetts offer other examples of states leading with regulatory approaches, whereas states like Arkansas, Tennessee, and North Carolina are driven by systemwide, multipayer efforts that try to align existing models to the extent possible.

CMS efforts to support systemwide reform at the state level, through waivers and multipayer reform initiatives, are improving, but the agency could do more. Complementary policies such as support for data and workforce investments in the context of payment reforms will also make the development of new care capabilities easier. All of this will require oversight and investment, which may be difficult to develop anew as states struggle with COVID-19 response, but should be an

integrated part of the responses in states with existing infrastructure, as the current Maryland response shows.

The path toward value-based care is becoming clearer, with a variety of models available to help organizations move forward. Regardless of model, states are tackling similar problems and need to build similar capabilities to succeed. The task now is making the reforms more systematic. State-level policies will be critical for moving efforts forward, and the most proactive states stand to benefit most. Maryland is demonstrating one way to take effective action, and the coming years will be critical for building a robust evidence base, not only to show what other approaches might work, but also to find out how all of them perform once they implement baseline changes and begin to tackle even more difficult problems.

NOTES

- ¹ Health Care Expenditures per Capita by State of Residence, 2014. Kaiser Family Foundation website. <https://www.kff.org/other/state-indicator/health-spending-per-capita/>. Accessed May 11, 2020.
- ² Pauly M, Town R. Maryland exceptionalism: all-payers regulation and health care system efficiency. *J Health Polit Policy Law*. 2012;37(4):697-707. doi:10.1215/03616878-1597502.
- ³ Maryland All-Payer Model. Centers for Medicare and Medicaid Services website. <https://innovation.cms.gov/innovation-models/maryland-all-payer-model>. Published April 23, 2020. Accessed May 11, 2020.
- ⁴ Haber S, Beil H, Morrison M, et al. *Evaluation of the Maryland All-Payer Model, Volume 1: Final Report*. Waltham, MA: RTI International; 2019. <https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf>. Accessed May 11, 2020.
- ⁵ Maryland Total Cost of Care Model. Centers for Medicare and Medicaid Services website. <https://innovation.cms.gov/innovation-models/md-tccm>. Published April 9, 2020. Accessed May 11, 2020.
- ⁶ Maryland's radical all-payer model was just extended through 2023. Advisory Board Company website. <https://www.advisory.com/daily-briefing/2018/05/16/maryland-all-payer-model>. Published May 16, 2018. Accessed May 15, 2020.
- ⁷ What is Maryland's all-payer global budget hospital system and how can we learn from it? Catalyst for Payment Reform website. <https://www.catalyze.org/maryland-global-budget-payment-reform/>. Published July 31, 2018. Accessed May 11, 2020.
- ⁸ Hicks J. Feds approve extension of Maryland's "all payer" hospital model. *Washington Post*, January 8, 2018. https://www.washingtonpost.com/local/md-politics/feds-approve-extension-of-marylands-all-payer-hospital-model/2018/01/08/7ba8bc78-f496-11e7-b34a-b85626af34ef_story.html. Accessed May 11, 2020.
- ⁹ Navathe AS, Troxel AB, Liao JM, et al. Cost of joint replacement using bundled payment models. *JAMA Intern Med*. 2017;177(2):214-222. doi:10.1001/jamainternmed.2016.8263.
- ¹⁰ Bleser WK, Saunders RS, Muhlestein DB, et al. Why do accountable care organizations leave the Medicare Shared Savings Program? *Health Aff (Millwood)*. 2019;38(5). doi:10.1377/hlthaff.2018.05097.
- ¹¹ Bleser WK, Muhlestein DM, Saunders RS, et al. Half a decade in, Medicare accountable care organizations are generating net savings: part 1. *Health Affairs Blog*, September 20, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20180918.957502/full/>. Accessed May 11, 2020.
- ¹² Peikes D, Anglin G, Harrington M, et al. *Independent Evaluation of Comprehensive Primary Care Plus Program: First Annual Report*. Princeton, NJ: Mathematica Policy Research; 2019. <https://downloads.cms.gov/files/cmami/cpcplus-first-ann-rpt.pdf>. Accessed May 11, 2020.
- ¹³ Agarwal R, Liao JM, Gupta A, et al. The impact of bundled payment on health care spending, utilization, and quality: a systematic review. *Health Aff (Millwood)*. 2020;39(1). doi:10.1377/hlthaff.2019.00784. Accessed May 11, 2020.
- ¹⁴ Bleser WK, Muhlestein D, Saunders RS, et al. Half a decade in, Medicare Accountable Care Organizations Are Generating Net Savings: Part 1. *Health Affairs Blog*, September 20, 2018. <https://www.healthaffairs.org/doi/10.1377/hblog20180918.957502/full/>. Accessed May 11, 2020.

- ¹⁵ ACLC competencies. Accountable Care Learning Collaborative website. <https://www.accountablecarelc.org/aclc-competencies>. Accessed May 11, 2020.
- ¹⁶ Japinga M, Saunders R. *Serious Illness Approaches by ACOs: NYC Health + Hospitals ACO (HHC ACO)*. Washington, DC: Duke-Margolis Center for Health Policy and Leavitt Partners; 2019. https://healthpolicy.duke.edu/sites/default/files/u31/case_study_3_-_nyc_health_hospitals_hhc_aco_inc_0.pdf. Accessed May 11, 2020.
- ¹⁷ Kadakia KT, Shah SA, Richman BD. Hot-spotting North Carolina's Medicaid transformation. *Health Affairs Blog*, November 5, 2019. <https://www.healthaffairs.org/doi/10.1377/hblog20191029.338902/full/>. Accessed May 11, 2020.
- ¹⁸ Hawryluk M. Why hospitals are getting into the housing business. *Kaiser Health News*, October 4, 2019. <https://khn.org/news/why-hospitals-are-getting-into-the-housing-business/>. Accessed May 11, 2020.
- ¹⁹ LaPointe J. How addressing social determinants of health cuts healthcare costs. *Rev Cycle Intelligence*, June 25, 2018. <https://revcycleintelligence.com/news/how-addressing-social-determinants-of-health-cuts-healthcare-costs>. Accessed May 11, 2020.
- ²⁰ Healthy Opportunities Pilots. North Carolina Department of Health and Human Services website. <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots>. Accessed May 11, 2020.
- ²¹ Wunderlich K, Peterson C. Maryland's experience and progress in implementing value-based healthcare reform. Health Services Cost Review Commission, July 18, 2019. https://mhcc.maryland.gov/mhcc/pages/home/commissioners/documents/20190718/Ag7_MD_Model_Overview_MHCC_20190710_Katiev2.pdf. Accessed May 11, 2020.
- ²² Care Redesign Program. Maryland Health Services Cost Review Commission website. <https://hscrc.maryland.gov/Pages/CareRedesign.aspx>. Accessed May 11, 2020.
- ²³ Maryland Primary Care Program. Maryland Department of Health website. <https://health.maryland.gov/mdpcp/Pages/home.aspx>. Accessed May 11, 2020.
- ²⁴ Regional partnerships. Maryland Health Services Cost Review Commission website. <https://hscrc.maryland.gov/Pages/regional-partnerships.aspx>. Accessed May 11, 2020.
- ²⁵ Kane A, Wunderlich K. Letter to CEOs and CFOs. Dated March 27, 2020. Health Services Cost Review Commission. <https://hscrc.maryland.gov/Documents/COVID-19/HSCRC%20-%20CEO-CFO%20Letter%20-%20203-27-2020.pdf>. Accessed May 11, 2020.
- ²⁶ Kane A, Wunderlich K. Letter to CEOs and CFOs. Dated March 19, 2020. Health Services Cost Review Commission. <https://hscrc.maryland.gov/Documents/COVID-19/HSCRC%20-%20CEO-CFO%20Letter%20-%20203-19-2020.pdf>. Accessed May 11, 2020.
- ²⁷ Health Services Cost Review Commission. *COVID-19 Frequently Asked Questions*. Baltimore, MD: Health Services Cost Review Commission; 2020. https://hscrc.maryland.gov/Documents/COVID-19/2020_04_02%20HSCRC%20COVID-19%20FAQ_FINAL.pdf. Accessed May 15, 2020.

- ²⁸ Centers for Medicare and Medicaid Services. *Medicare Shared Savings Program: CMS Flexibilities to Fight COVID-19*. Baltimore, MD: Centers for Medicare and Medicaid Services; 2020. <https://www.cms.gov/files/document/covid-ifc-2-medicare-shared-savings-program.pdf>. Accessed May 11, 2020.
- ²⁹ Centers for Medicare and Medicaid Services. *Fact sheet: Expansion of the Accelerated and Advance Payments Program for Providers and Suppliers During COVID-19 Emergency*. Baltimore, MD: Centers for Medicare and Medicaid Services; n.d. <https://www.cms.gov/files/document/accelerated-and-advanced-payments-fact-sheet.pdf>. Accessed May 11, 2020.

Funding: This article was supported by the West Health Policy Center and the West Health Institute.

AUTHORS

Mark Japinga is a research associate, Payment and Delivery Reform, at Duke-Margolis. Prior to joining Duke-Margolis, he worked in a variety of capacities in and around state legislatures. He has worked for legislators in the Texas Senate and Wisconsin State Assembly, for the Texas Legislative Council doing bill analysis, for AARP Wisconsin doing policy research and work on its state advocacy initiatives, and for Stateside Associates researching and tracking state health care legislation across the country. He received a master's in public affairs from the University of Wisconsin-Madison in 2016, and his Bachelor's in Political Science from Grinnell College in 2009.

Mark Japinga

1201 Pennsylvania Ave NW, Suite 500

Washington, DC, 20010

mark.japinga@duke.edu

Phone: 616-648-7485

Mark McClellan, MD, PhD, is the Robert J. Margolis Professor of Business, Medicine, and Policy, and founding director of the Duke-Margolis Center for Health Policy at Duke University. Before coming to Duke, he served as a Senior Fellow in Economic Studies at the Brookings Institution, where he was Director of the Health Care Innovation and Value Initiatives and led the Richard Merkin Initiative on Payment Reform and Clinical Leadership.

Dr. McClellan is a former administrator of the Centers for Medicare & Medicaid Services and former commissioner of the U.S. Food and Drug Administration (FDA), where he developed and implemented major reforms in health policy. These reforms include the Medicare prescription drug benefit, Medicare and Medicaid payment reforms, the FDA's Critical Path Initiative, and public-private initiatives to develop better information on the quality and cost of care. He previously served as a member of the President's Council of Economic Advisers, Senior Director for Health Care Policy at the White House, and Deputy Assistant Secretary for Economic Policy at the Department of the Treasury.

Mark McClellan

Duke-Margolis Center for Health Policy, Washington, DC

1201 Pennsylvania Ave NW, Suite 500

Washington, DC, 20010

mark.mcclellan@duke.edu

Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022
www.milbank.org