CSAC Updates

Nov 2017

HSCRC
Health Services Cost Review Commission

Population Health under TCOC Model

MARYLAND

Update on Maryland Primary Care Program

Total Cost of Care Model (2019-2029)

Improving health, enhancing patient experience, and reducing per capita costs.

2017

2029

HSCRC Hospital Model
2014 - 2029

- Reduce unnecessary readmissions/ utilization
- Reduce hospital-based infections
- Increase appropriate care outside of hospital

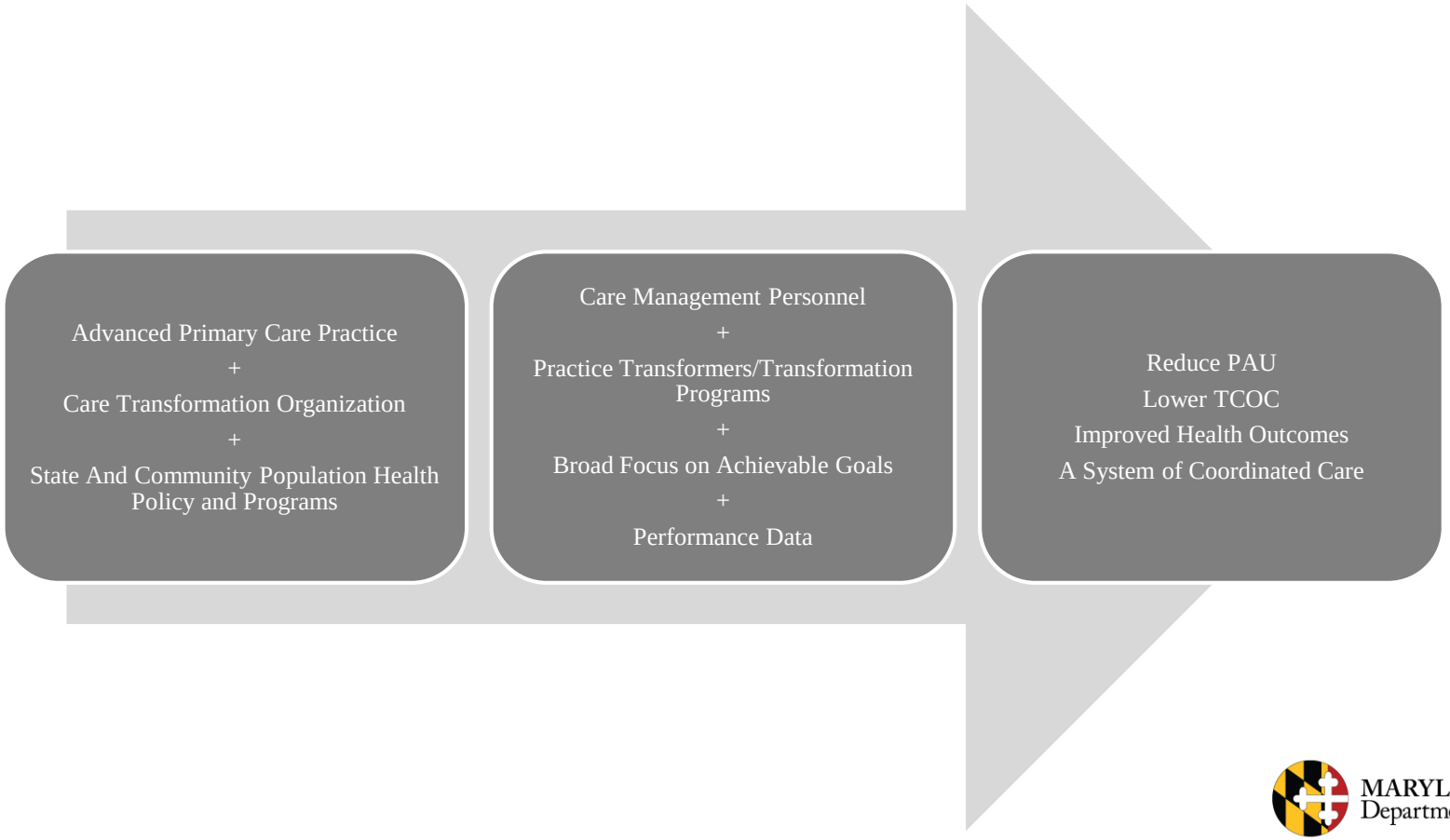
HSCRC Care Redesign Programs
2017 - TBD

- Reduce unnecessary lab tests
- Increase communication between hospital and community providers
- Increase complex care coordination for high and rising risk
- Improve efficiency of care in hospital

Maryland Primary Care Program
2018-2023

- Increase preventive care
- Decrease avoidable hospitalizations
- Decrease unnecessary ED visits
- Increase care coordination
- Increase community supports

Population Health Transformation – Vision under Maryland Primary Care Program



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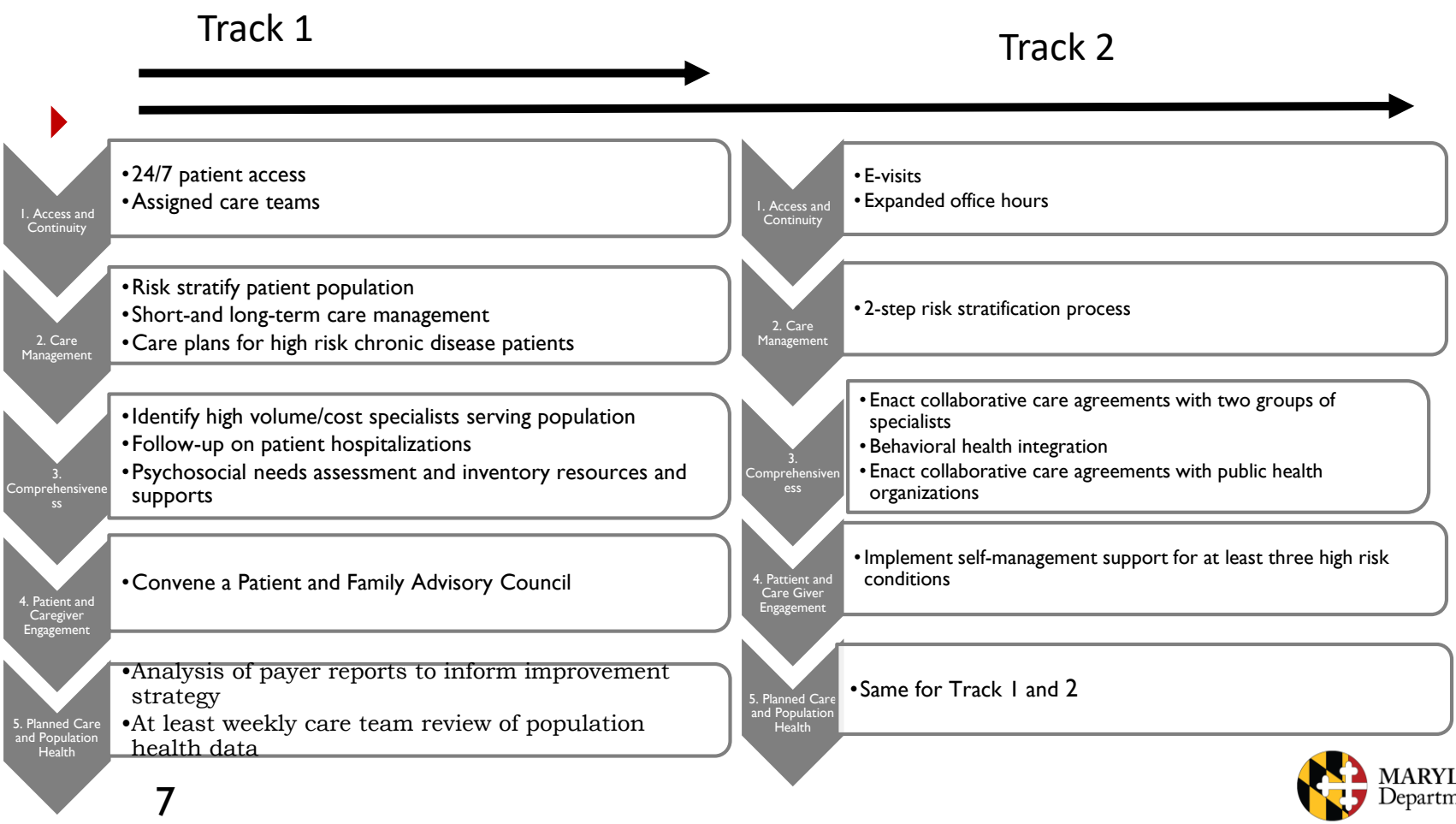
Maryland Primary Care Program (MDPCP)

- Strengthens and transforms Primary Care Delivery by moving from volume to value
  - Components include care managers, 24/7 access to advice, medication management, open-access scheduling, behavioral health integration, and social services

- Complements and supports existing delivery system innovation in State
  - Sustain the early gains of the All-Payer Model as targets become increasingly reliant on factors beyond the hospital

Requirements: Primary Care Functions



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MDPCP Measure Set

	CPC+ eCQM Requirements Summary				
	CPC+ eCQM Set - 2017 Performance Period				
	CMS ID#	NQF#	Measure Title	Measure Type/ Data Source	Domain
Report 2 of the Group 1 outcome measures:					
Group 1	CMS159v5	710	Depression Remission at Twelve Months	Outcome/eCQM	Clinical Process/Effectiveness
	CMS165v5	18	Controlling High Blood Pressure	Outcome/eCQM	Clinical Process/Effectiveness
	CMS122v5	59	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Outcome/eCQM	Population/Public Health
Report 2 of the Group 2 complex care measures:					
Group 2	CMS156v5	22	Use of High-Risk Medications in the Elderly	Process/eCQM	Patient Safety
	CMS149v5	N/A	Dementia: Cognitive Assessment	Process/eCQM	Clinical Process/Effectiveness
	CMS139v5	101	Falls: Screening for Future Fall Risk	Process/eCQM	Patient Safety
	CMS137v5	4	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process/eCQM	Clinical Process/Effectiveness
Report 5 of the 10 remaining measures (choice of Group 3 and remaining Groups 1 and 2 measures):					
Group 3	CMS50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report	Process/eCQM	Care Coordination
	CMS124v5	32	Cervical Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
	CMS130v5	34	Colorectal Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
	CMS131v5	55	Diabetes: Eye Exam	Process/eCQM	Clinical Process/Effectiveness
	CMS138v5	28	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/eCQM	Population/Public Health
	CMS166v6	52	Use of Imaging Studies for Low Back Pain	Process/eCQM	Efficient Use of Healthcare Resources
	CMS125v5	2372	Breast Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
Utilization Measures					
			Ambulatory care: summary of utilization of ambulatory care in the following categories: ED visits		
			Inpatient utilization – general hospital/acute care: summary of utilization of acute inpatient care and services in the following categories: total inpatient, maternity, surgery, and medicine		

Timeline

Activity	Timeframe
Submit Model for Approval from HHS	Summer 2017
Stand up Program Management Office	Fall 2017
Draft legal agreements and applications for CTOs and practices	Fall 2017
Release applications	Late Fall 2017
Select CTOs and practices	Winter/Spring 2018
Initiate Program	Summer 2018
Expand Program	2019 - 2023

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Statewide Population Health

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Population Health Opportunity – Broad Improvement Measures

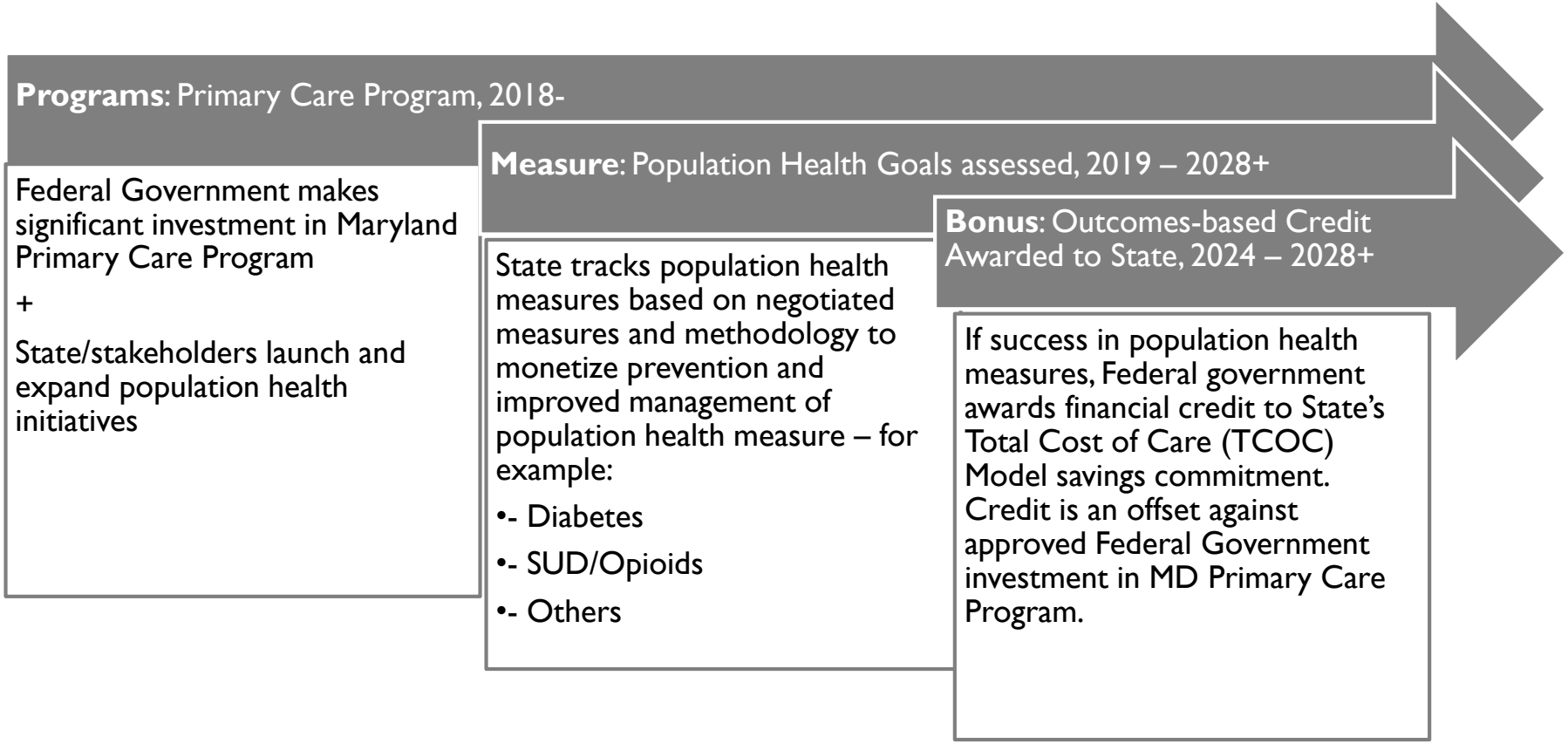
- If the State can demonstrate improvements in all-payer, statewide population health measures, the federal government may reduce the MDPCP Medicare dollars against Maryland's Medicare Total Cost of Care.
- Another route for achieving credit on TCOC and health status
- Components
  - Demonstrate improvement in population health
  - Assign a cost value to improvement in population health

Examples	Effect on Disease Prevalence	Effect on TCOC
System helps manage people with diabetes so fewer have complications	None - patients already have diabetes	Short Term Reduced hospital utilization, incentive payments to PCP
People with pre-diabetes lose weight and they do not progress to diabetes	Lowers or restricts growth in prevalence	Longer Term Control

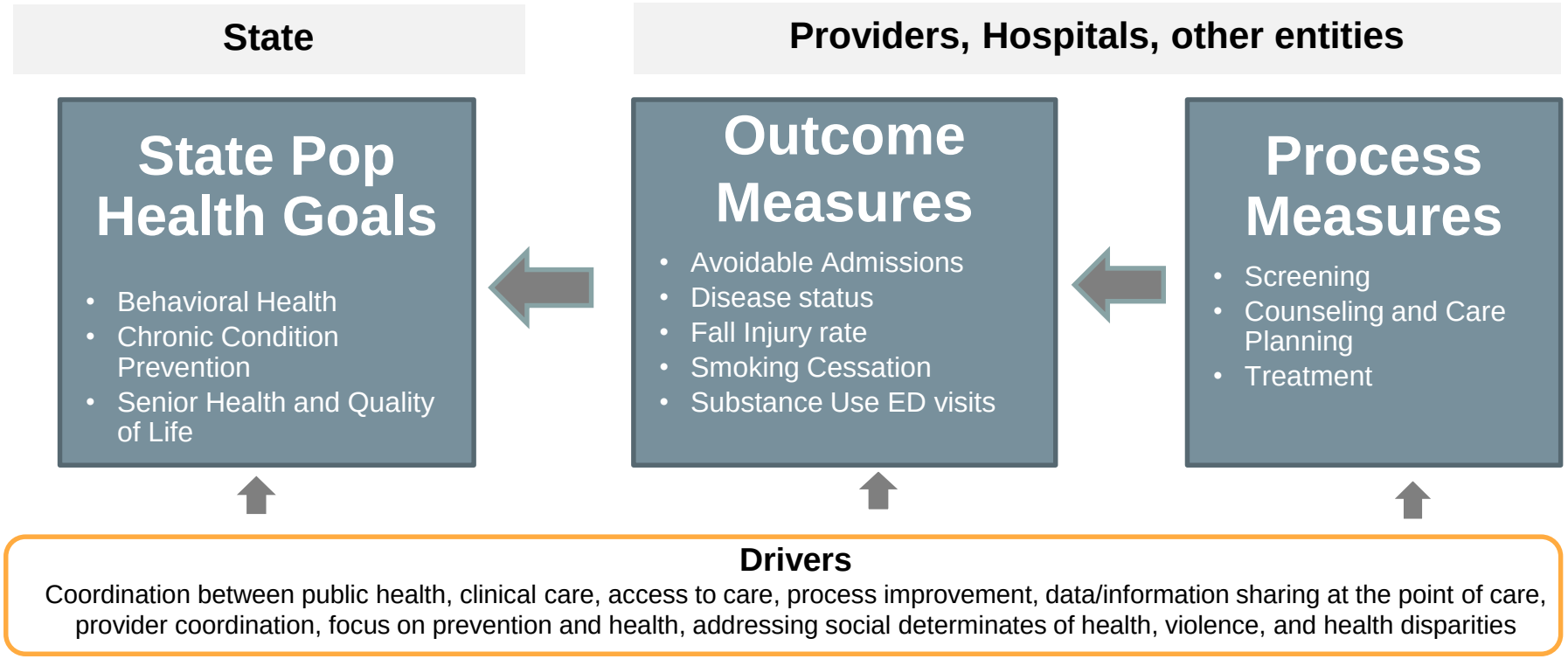
Total Cost of Care, Primary Care, and Population Health Improvement

- Success requires Statewide participation of clinical care and public health system, state health programs leadership, and stakeholder focus
- Opportunity for **statewide alignment of the delivery system, community, and public health** to focus on Population Health Goals
- Key points:
  - Upside only financial "credit"
  - No additional upfront investment for population health goals from CMS (doesn't preclude other investments)
  - All-payer, population-wide measures

Alignment of Priorities to Population Health Goals



Guiding Framework for Population Health



Timeline under the New Model

- State will submit at least one statewide measure with methodology for Population Health Credit by the end of 2017.
  - Anticipate approval of 1st measure – 2018
  - Other measures to be explored – 2018
  - Performance begins in 2019
  - Evaluation as early as 2023

CSAC's Role in Pop Health

- Avenue for feedback on
  - Population health infrastructure and ability to impact
  - Opportunities for measure alignment
- Educate public on measure goals once approved