# Advisory Council: Meeting #2

Friday, February 19

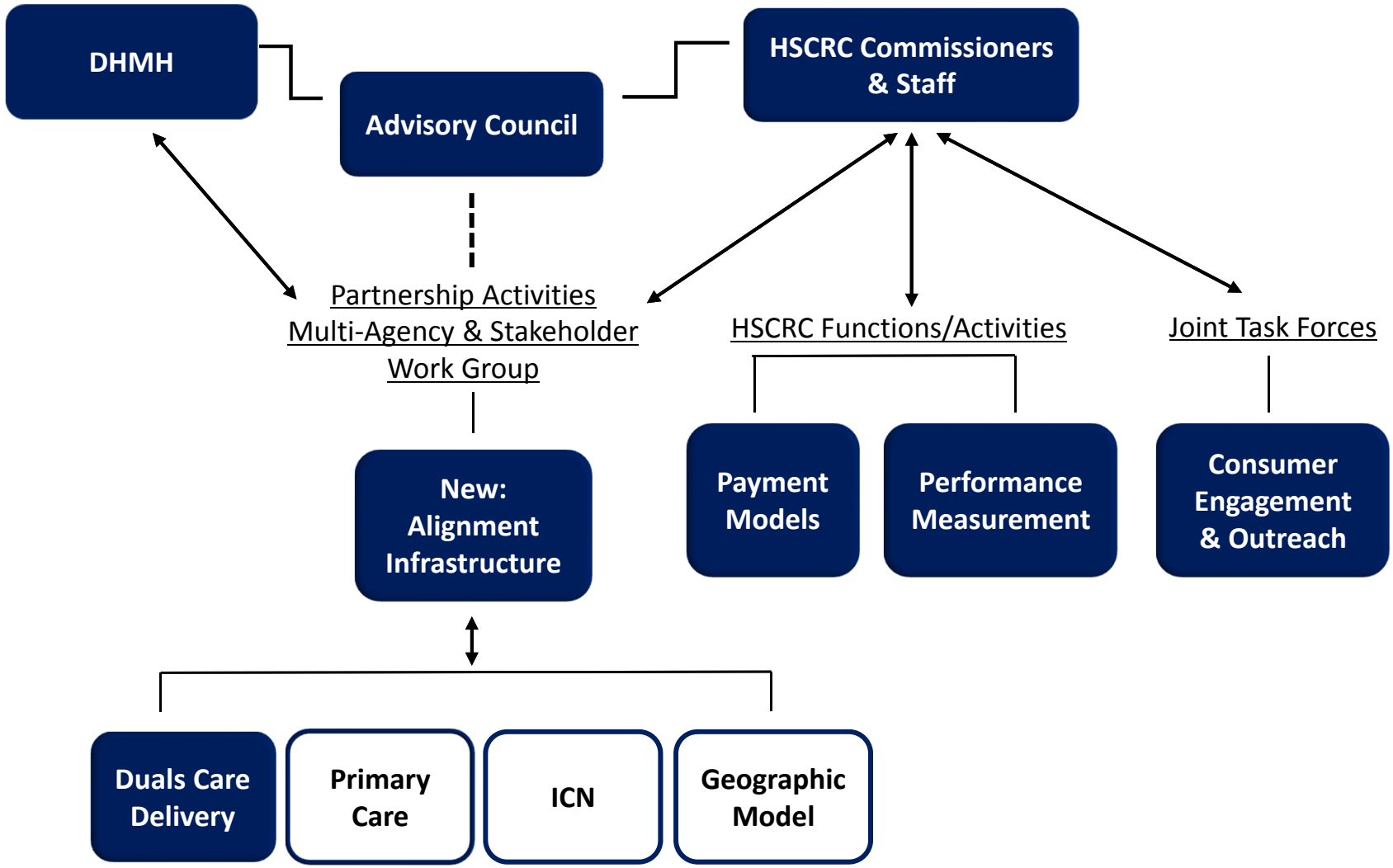
HSCRC
Health Services Cost Review Commission

# Advisory Council Charge

- **Charge**: The purpose of the Advisory Council is to provide DHMH and HSCRC with senior-level stakeholder input on the long-term vision for Maryland's transformation efforts. Continuing successful implementation of a new payment model and meeting the terms of the CMS demonstration will require the input and support of hospitals, payers, providers and other stakeholders, including patients and families.

- **Proposed Framework**: Facilitate a forum for discussion and debate among stakeholders that can generate solutions and, when consensus is not possible, identify issues to be taken to the Staff, Secretary, and Commissioners for consideration and action.

# Stakeholder Input Structure



# Themes from Discussion

- Very significant progress, ahead of schedule, in hospital payment transformation to global budgets
  - Success in years 1 and 2 in meeting All-Payer Model goals

- Need to focus on concrete initiatives that can be accomplished within the timeframe
  - Care redesign planning underway
  - Critical to ongoing success
  - Need extended timeline of All-Payer Model to accomplish the scale of care redesign needed to accomplish goals of the Model

# Themes from Discussion (cont.)

- Focus on high need/complex Medicare FFS patients
  - Big opportunity to identify patients at risk
  - Approach should be person-centered
  - Behavioral health needs to be addressed
  - There are different interventions for high needs patients, such as home-based models, LTC interventions, care management, etc.
- Critical need for Medicare data
  - Don't reinvent data analytics tools
- Should not re-invent the wheel
  - Need a forum in Maryland for sharing
  - Bring best practices to scale
  - Existing tools can be leveraged
  - Use Commonwealth Fund, CMS, and other knowledge bases

# Themes from Discussion (cont.)

- Important opportunity to engage physicians
  - PCPs need financial incentives
  - Medical Home Model (such as CareFirst Model) could be evaluated as one alternative
  - Medicare CCM- potential opportunity
  - Specialists should be involved in alignment strategies

- Post-Acute and Long-Term Care play important roles
  - Early partnering activities underway (shared resources)
  - Need for standard data elements to connect and coordinate/Interact
  - Need to fund connections/LTPAC did not get meaningful use monies
  - Medication reconciliation should be a priority
  - Significant opportunities to reduce admissions from LTC as well as readmissions

# Themes from Discussion (cont.)

- Test Accountability Approaches
  - Clinicians working together, not just hospitals
  - Common outcome measures across the system
  - Test multiple models, e.g. ACOs, PCMHs, geographic model
  - Recognize population differences
  - Need to get incentives right with mix of bottom-up and top-down approaches

# Guiding Principles from Stakeholders

# Amalgamation of Principles to Drive the Delivery and Finance Progression

- Care Delivery and Financing
  - ***Person-Centered***: Tailoring care to persons' needs. Shared information, collaborative care coordination.
  - ***Value-Based***: Movement from volume-based care to value, incremental movement towards financial and outcomes responsibility shared by all stakeholders – payers, providers, individuals.
  - ***Competition***: Health competition based on patient satisfaction, quality, outcomes, and cost of care.
  - ***All-Payer***: Hospital initiatives continue on an all payer basis with global budgets used as one tool for alignment with other providers. Non-hospital initiatives build on common principles and measures.

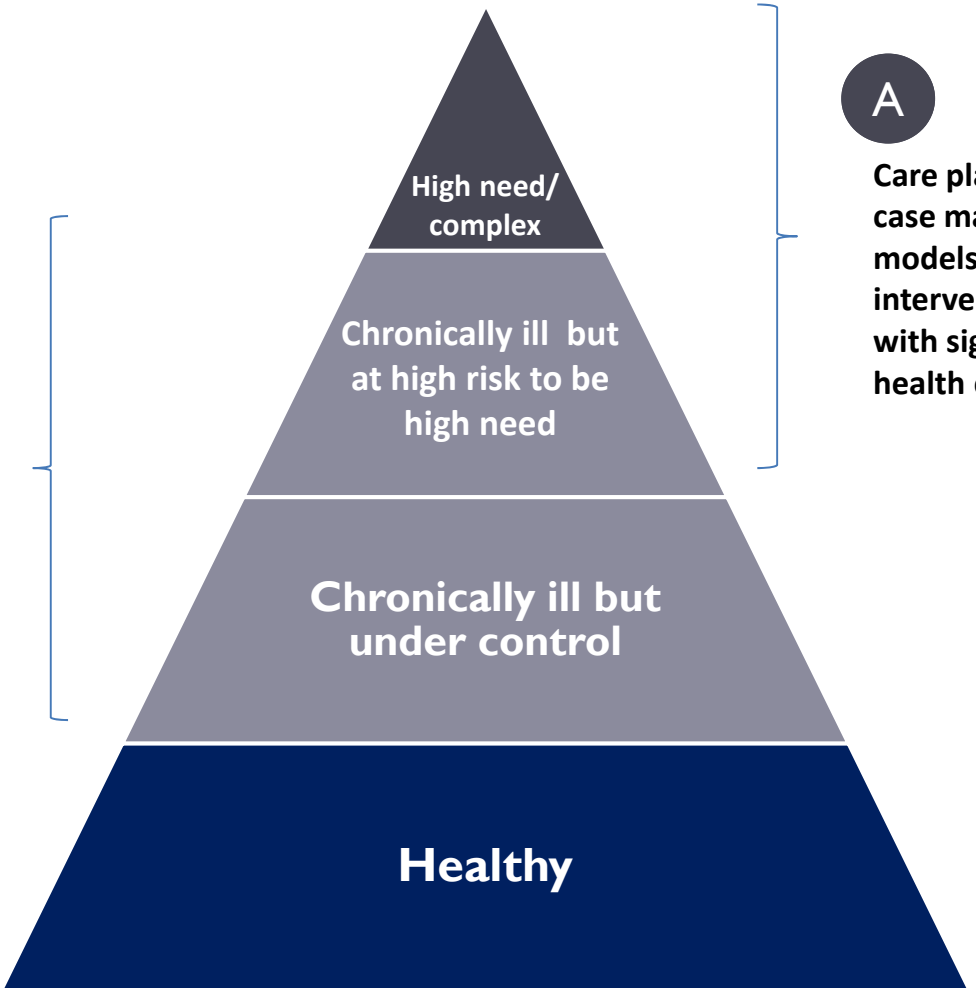
# Amalgamation of Principles to Drive the Delivery and Finance Progression (cont.)

- Population
  - ***Focused on the Needs of the Community***: Community needs known and addressed.
  - ***Supporting Social Needs***: Address social determinants of health.
  - ***Identifying High-Risk Individuals***: Focus on complex patients with high-needs, high-risk, and individuals with chronic disease.

# Amalgamation of Principles to Drive the Delivery and Finance Progression (cont.)

- Patient
  - ***Engaged***: Responsibility for prevention and self-management of health; active relationship with PCP and coordination team.
  - ***Working with a Primary Provider/Team***: PCP, specialists, nurse practitioners
  - ***Receiving Meaningful Care Coordination***: Consistent and coordinated support based on individual need.

# Core Approach-Tailoring Care Delivery to Persons' Needs




A

**Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources**

B

**Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care**

C

**Promote and maintain health (e.g. via patient-centered medical homes)**

# Next Steps, Strategies, and Priorities to Achieve the Vision

# Interim Report Timeline

- *March 14:* Preliminary report draft sent to Advisory Council for review.
  - In this preliminary report, the Council will propose recommendations for the continuing success of the existing All-Payer Model and lay out the foundation and guiding principles of a long-term vision for Maryland's payment and delivery system transformation efforts. The draft report will update the DHMH and the HSCRC on the Council's progress and identify areas of consensus.
- *March 21:* Advisory Council Meeting #3. Discuss and receive feedback on report.
- *By the end of March :* Submit preliminary report to DHMH and the HSCRC.
- *Throughout 2016:* The Council will continue to meet, as needed, to continue to evaluate developments regarding progress under the All-Payer Model.