Advisory Council Discussion Document
DRAFT FOR STAKEHOLDER INPUT

Progression Strategy Summary

September 12, 2016

HSCRC
Health Services Cost Review Commission

Background

- The All-Payer Model requires Maryland to submit a plan to CMS by December 31, 2016. The plan must address:
  - The All Payer Model's requirement to expand its focus to limit the growth in Medicare total cost of care (TCOC); and
  - The State's focus on limiting the growth in the Medicaid costs for dually eligible beneficiaries.
- Some strategies will require CMS approval and waivers before implementation and CMS could require changes
- The Advisory Council is charged with making recommendations on this strategic progression plan
- This document provides a **high level overview of potential progression plans based on initial stakeholder comments and for additional stakeholder review and comment**
- Content on Dual Eligible Model will be added in next version

Presentation Overview and Purpose

- This presentation suggests a potential outline and initial content for the Strategic Plan to be submitted by December 31, 2016

- Strategic Plan Outline:
  - Background: Current All-Payer Model and Amendment
  - Scope and Strategic Considerations
  - Draft Strategy Recommendations
  - Potential Timeline

- Background Materials in Appendix

Key Discussion Questions

- Content:
  - Are we focused on the right opportunities?
  - Are these the right strategies?
  - Are there other strategies?
  - How do these strategies align with current provider and health plan initiatives?
- Timeline:
  - How should the strategies and models be prioritized? What is the best phased approach? What is the timeline?
- Process:
  - How should we go about developing the plan and the models?

Background: Current All-Payer Model and Amendment

All-Payer Model Status

- All Payer hospital revenue growth contained, even as Medicaid expanded and marketplace enrollees grew under ACA
- Medicare hospital savings on track/non-hospital costs rising
- Quality measures on track
- Stakeholder participation contributing to success
- Delivery systems organizing and transforming
  - All hospitals on global budgets
  - Medical homes for many privately insured
  - Accountable care organizations for ~ 200k Medicare enrollees
  - Clinically integrated networks and regional partnerships forming
  - New Medicare Advantage plans forming
- Well developed hospital regulatory infrastructure
- Sophisticated health information exchange
- Generally positive feedback from CMS

Challenges and Areas to Address

- Need to address the remaining 44% of Medicare services not under global budgets
  - ~56% of Medicare costs under hospital global budgets
- Further progress for Medicare is dependent on advancing care redesign, alignment, and supporting infrastructure
- State lacks strong alignment tools to overcome largely fee-for-service model for non-hospital providers
- Ongoing delays in getting data and alignment tools from CMS
- Gaps in care supports for complex and chronically ill (including those in custodial care) Medicare fee-for-service (FFS) beneficiaries
- Variation among systems in implementation and performance

Care Redesign Amendment Coming Soon

- Providers called for alignment strategies
- Care Redesign Amendment developed and currently in CMS review to allow hospitals to participate in Care Redesign:
  - Access Medicare data
  - Implement Complex and Chronic Care Improvement Program and Hospital Care Improvement Program
  - Amendment allows flexibility for additional care redesign programs
  - Allows hospitals to share resources and pay incentives (if they choose to) based on savings within TCOC benchmarks
  - State working to align Amendment with MACRA requirements

Scope and Strategic Considerations

Progression Plan: Scope of Expenditures

Approximate CY 2015 Figures (for 6 million Marylanders)	
All Payer Hospital Revenues (Maryland Residents in Maryland hospitals)	$14.8 billion
Medicare Non-Hospital Spend (Maryland Beneficiaries anywhere)	$3.9 billion
Medicare Hospital Spend Non-Regulated	$0.5 billion
Medicaid Costs for Dual Eligible Patients	$1.7 billion
Total Costs to be Addressed in the Strategic Plan	**$19.9 billion**

Notes:

1. Hospital revenues incorporate ~$4.8 billion of Medicare spend.
2. Medicare savings requirements incorporates spend for Maryland beneficiaries in Maryland and other locales.
3. Medicare spend includes only payments by Medicare.
4. Medicare non-regulated hospital spend is primarily out-of-state hospital spend. Also includes in-state specialty hospital spend.
5. Medicaid figures are estimated and may be updated. They reflect non-I/DD full duals, but do not remove MA enrollees or ACO members.

Advisory Council Summary and Recommendations for Progression (July 2016)

- Maintain focus
- Retain and strengthen the All-Payer Model
- Set targets and allow flexibility to meet them
- Acquire needed data and use data in hand
- Promote accountability
- Foster alignment
- Modernize governance and regulatory oversight
- Ensure person-centered care

MACRA Provides New Opportunities for Aligning Providers

- Federal legislation referred to as MACRA dramatically alters physician reimbursement for Medicare
- Removes flawed across the board payment reductions for "excess" volume
- Introduces two value-based incentive approaches, both of which encourage the participation in Alternative Payment Models (APMs)
  1. MIPS (Merit-Based Incentive Payment System) provides incentives that could range from +/- 9% over time, and rewards participation in APMs
  2. With participation in Advanced Alternative Payment Models, physicians can opt out of MIPS and receive 5% lump sum bonuses and higher fee schedule updates
- MACRA provides an opportunity to engage physicians in the goals of the All-Payer Model (which is an APM) of better care, better health and lower costs
- Maryland will adapt its approaches to optimize opportunities under MACRA and the All-Payer Model to create Advanced APMs that can harmonize performance goals.
  - Final MACRA regulations are due in November

Aging of the Population Will Have A Profound Effect on Utilization in Maryland

- 18% of Maryland's population >65 years old by 2025
  - 28% increase in proportion age >65 between 2015 and 2025
  - 41% increase in proportion age >65 between 2015 and 2030

- Profound impact on federal and state budgets and delivery systems
  - E.g. the 28% potential increase in utilization/spend by 2025 in Medicare/Medicaid for dually eligible
  - Need to make significant changes in delivery system and community services to address service needs
  - Reduce medically unnecessary care and improve chronic care management in community settings

Draft Strategy Recommendations

Focus on Key Opportunities

- Incorporate/Expand tailored person-centered approach
  - Use data/information to tailor approach, focus on high needs persons
  - Engage consumers, families, community
  - Patient Designated Provider (PCP or other) in community for care coordination/chronic care management

- Approximately 3/4 of Medicare TCOC related to a hospitalization. Key opportunities:
  - Reduce unnecessary and preventable utilization in high cost settings
  - Ensure high quality efficient episodes with optimal outcomes;
  - Utilize expertise and resources of post-acute, long-term care, and home based providers in more flexible and effective ways to meet the growing needs of an aging population

- For dually-eligibles, just under 1/2 of Medicaid costs consist of custodial care in long-term care facilities, approximately 40% in home and community based services. Key opportunities:
  - Reduce the need for preventable high level custodial care
  - Ensuring high quality, well coordinated services

4 Key Strategies Maryland is Considering to Address Total Cost of Care and System-wide Outcomes

I. Incorporate Medicare patients into a Primary Care Home Model to support engaged patients in person-centered care with supporting care teams, data-driven care coordination, focus on high needs persons, and a supporting payment model

II. Incorporate Medicare TCOC targets and common system-wide outcome goals into all providers' incentive structures

III. Develop a focused portfolio of payment and delivery system transformations to support key goals

IV. Develop/support models that include upside and downside risk or increased levels of incentive tied to performance targets

1. Develop Primary Care Home Model (see separate presentation)

- Create a broadly applied model of person-centered care with supporting care teams, data-driven care coordination, and a supporting payment model.
  - Strive to have a Patient Designated Provider (usually PCP) who takes responsibility for coordinating services from all providers; this "quarterback" should be paid adequately for performing coordination role.
  - Replace CMS' FFS chronic care management fee with a risk adjusted care management payment per beneficiary, consistent performance metrics with incentive payments, and an option for upfront visit payments to facilitate alternative care delivery, similar to CMS CPC+ model
  - Focus on high needs patients and chronic care improvement with hospitals, ACOs, PCMH, payers, and other models.
  - Align with All Payer Model--Adjust MACRA bonus based on overarching provider performance measures including Medicare TCOC
  - Improve access to community-based, behavioral health services and supports

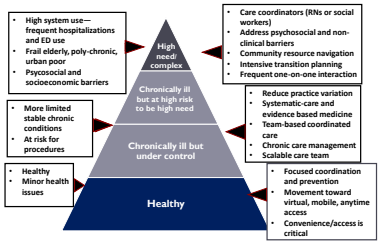
Example: Hospital Global Model Relationship with Primary Care Home Model

Hospital Global Model

Hospitals and care partners focused on population of patients within a geographic area (and their patients)

Common Approaches and Aligned Measures

Person-centered care tailored to needs



Risk stratification (esp for high needs persons)
Care coordination
Chronic care management
Reduction of avoidable utilization
All provider incentives aligned with total cost of care and outcomes goals

Primary Care Home Model

Patient Designated Providers (PDPs) are focused on their panel of patients

Patients

2. All Provider Incentives Aligned with Total Cost of Care and Outcome Goals

Goal: Create a pathway for all providers to align with key goals of All Payer Model and create opportunities for MACRA qualification for bonuses (subject to CMS approval)

Incentive Alignment Concept: Incorporate incentives for all providers based on Medicare TCOC, population health and care outcomes

- A portion of each providers payments would be based on a common set of measures
- Hospitals:
  - Beginning CY 2017/FY 2018, incorporate incentives into global budgets (similar to other quality programs) based on Medicare TCOC. Add population health and other care outcomes measures in 2019.
    - Begin with modest incentive program to allow for learning
- Physicians: (requires CMS approvals and Advanced APM qualification)
  - MACRA bonuses could be scaled up or down based on care outcomes, population health, and Medicare TCOC in a geographic area for those Advanced APMs that are created in Maryland (e.g. Care Redesign Amendment, Primary Care Home Model, Geographic Model, etc.)
- Other non-hospital providers (e.g. SNFs, etc.)
  - TBD- Need to be developed

3. Portfolio of Payment and Delivery System Transformations

- Payment and Delivery Transformation to be accomplished via:
  - Primary care/complex care/chronic care transformation
    - Care Redesign **Amendment** (Complex and Chronic Care Improvement Program) (2017)
    - **Primary Care Home Model** (develop 2016, implement 2018)
    - **Post-Acute** and **Long-Term Care** initiatives (TBD)
    - Other MACRA-eligible programs (TBD)
  - Episode-of-care focus
    - Care Redesign **Amendment** (Hospital Care Improvement Program) (2017)
    - **Post-Acute Care** initiatives (TBD)
    - Other MACRA-eligible programs (TBD)

3a. Optimize the Use of Post-Acute and Long-Term Care Services

- Post-acute and long-term facilities have significant expertise in caring for aging population
- Request that CMS grant Maryland flexibility in utilizing and optimizing these services
  - Request that Maryland be granted authority to relax the 3 day rule, where partnerships of providers agree to take on responsibility of cost and outcomes for acute and post-acute care, with no net negative impact on Medicaid
    - E.g. may be a geographic area or acute/post-acute episodes
  - Provide additional primary care and medical services in long-term care settings that will reduce preventable and unnecessary hospitalizations
- Establish a work group and set a timeline to develop specific models and timelines

4. Models to Incorporate Upside/Downside Incentives or Risk

- **Geographic Model**
  - Elements already included in Care Redesign Amendment through Hospital geographic area guardrail for physician incentive payments
  - State strategy to add +/- incentive payment based on TCOC to GBR—a MACRA qualification strategy that CMS must approve
  - Geographic Model could evolve to include larger upside/downside incentive payments over time, or develop a shared savings model with upside/downside risk similar to ACOs
- **Dual Eligibles** developing ACO/PCHH strategies also transitioning to upside/downside risk over time
- State policy strategies encourage ACO, PCMH, and Clinically Integrated Network use, including capabilities to take on upside/downside risk over time

Overview of Straw Model to Support Progression

Medicare FFS TCOC and Outcomes Focus

		ACOs	Medical Home or other Aligned Models	Duals Model (TBD)	Geographic Model
#benes in models with upside / downside incentives	2017	~50k?/200k*?	0?/35k*?	0?	830k?
	Future	250k?	150k?	80k?	400k?

Supporting Payment/Delivery Approaches with All Payer Applicability

Global Hospital Budgets
All Provider Incentive Alignment
Amendment--Complex/Chronic Care, Hospital Care/Episodes
Primary Care Home--Chronic care,Visit budget flexibility
Post-acute and Long-term Care Initiatives
Other MACRA-eligible programs

**Higher figures include all beneficiaries, including those with no downside incentives or revenue at risk*

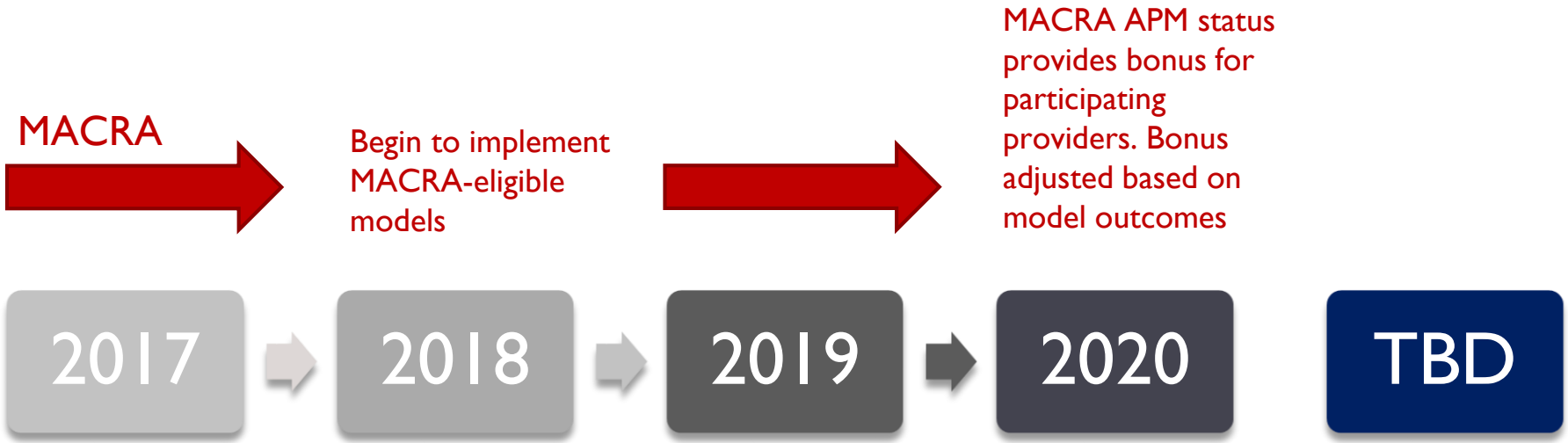
Other Needs to Address

- Develop supporting infrastructure
  - CRISP
  - Administrative/governance infrastructure
  - Transformation resources
- Linkage to public health
  - State Health Improvement Plan
  - Resources
- Consumer and community engagement
  - Patient designated provider
  - Consumer advisory
  - Breath of Fresh Care and other consumer campaigns
- Consider other strategy areas
  - Stakeholder idea, incorporate retail pharmacy savings but not risk
- Continuing refinements to global hospital model
- Integrating and harmonizing administrative, clinical, and financial aspects of care models

Potential Timeline-2016

- Develop progression plan for All Payer Model due to CMS by Dec 31, 2016
  - Develop Primary Care Model for Maryland to file with CMS by Dec 31, 2016 for possible implementation in Jan 2018
  - Develop Dual Eligibles Model for implementation in 2019
  - Progress on Population Health Plan due mid-2017
- Prepare to implement Care Redesign Amendment (no shared savings/gainsharing in 2017)
- Develop incentive approach for Medicare TCOC for implementation in 2017/2018
- Align with MACRA requirements

Potential Timeline



- Care Redesign Amendment without shared savings
  - Complex and Chronic Care
  - Hospital Care Improvement
  - Geographic model tests with incentives

- Primary Care Home model*
- Geographic Population model*
- Shared savings component added to Care Redesign Amendment programs*

- Geographic Model*, ACOs*, and PCMH* models begin to take on more responsibility
- Dual Eligible model*

- Post-acute/Long term care payment models
- Other MACRA eligible models

Note: * Indicates anticipated MACRA-eligible models (Advanced Alternative Payment Models).

Key Discussion Questions

- Content:
  - Are we focused on the right goals/opportunities
  - Are these the right strategies?
  - Are there other strategies?
  - How do these strategies align with current provider efforts and capacity?
- Timeline:
  - How should the strategies and models be prioritized? What is the best phased approach? What is the timeline?
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Appendix

Appendix A- Brief Description of Model Elements and Core Concepts

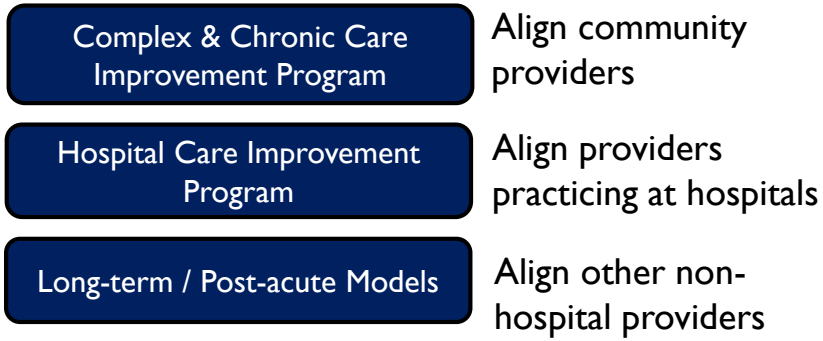
Envisioning Core Strategic Elements to Include in the Progression Plan

- Care Redesign **Amendment** and other MACRA eligible initiatives (developed in 2015/2016 for 2017 implementation)
- **Common Performance Incentives** for All Providers (2016 development for 2017/2018 initiation)
- **Geographic Model** (development ongoing)
- **Primary Care Home Model** (develop 2016 for 2018 implementation)
- **Dual-Eligible Model** (develop 2016 for 2019 implementation)
- **Post-acute** and **long-term care initiatives** (TBD)
- Existing **Global Budgets** with modifications (already deployed and evolving)
- Existing **ACO** and **PCMH** expertise (already deployed and expanding)

Envisioning Core Strategic Elements

Care Redesign Amendment and Other MACRA-Eligible Initiatives

- In response to stakeholder input, the State proposed a **Care Redesign Amendment** to the All-Payer Model, to gain needed approvals (Safe harbors, Stark, etc.) and data for care redesign and alignment (CMS review in process)
- Create a flexible approach to align physicians, hospitals, and other providers in focus on expanded system-wide All Payer Model goals and Medicare TCOC
- Opportunity to align the All Payer Model with MACRA requirements (subject to CMS approval)



- **Tools:**
  - Shared care coordination resources
  - Detailed Medicare data for care coordination
  - Medicare TCOC data
  - Shared savings from hospitals
  - Possible MACRA Advanced APM status

Envisioning Core Strategic Elements (cont.)

All Provider Incentive Alignment

Goal: Create a pathway for all providers to align with key goals of All Payer Model and create opportunities for MACRA qualification for bonuses (subject to CMS approval)

Incentive Alignment Concept: Incorporate incentives for all providers based on Medicare TCOC, population health and care outcomes

- A portion of each providers payments would be based on a common set of measures
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  - MACRA bonuses could be scaled up or down based on care outcomes, population health, and Medicare TCOC in a geographic area for those Advanced APMs that are created in Maryland (e.g. Care Redesign Amendment, Primary Care Home Model, Geographic Model, etc.)
- Other non-hospital providers (e.g. SNFs, etc.)
  - TBD- Need to be developed

Envisioning Core Strategic Elements (cont.)

Geographic Model

- Population-based payment model that creates local responsibility for care outcomes, population health, and Medicare TCOC in an actionable geographic area

Concept:

- Build on existing hospital GBRs and **addresses non-hospital costs** in a defined geographic area
  - GBR already distributes responsibility for ~56% of Medicare costs
  - Address non-hospital costs to help ease into increasing accountability
- Since other provider payment systems are separate and largely FFS, evaluate progress and drive a portion of reimbursement through **incentives for physicians, hospitals, and other providers** based on performance **in aligned measures and goals across the delivery system**, including:
  - Care outcomes
  - Population health outcomes
  - Medicare TCOC

Envisioning Core Strategic Elements (cont.)

Primary Care Home Model (see separate presentation)

- Create a broadly applied model of person-centered care with supporting care teams, data-driven care coordination, and a supporting payment model.
  - Each patient should have a Patient Designated Provider (usually PCP) who takes responsibility for coordinating the services from all providers; this "quarterback" should be paid adequately for performing coordination role.
  - Replaces CMS' FFS chronic care management fee (CCM) with a risk adjusted care management payment per beneficiary, consistent performance metrics with incentive payments, and an option for upfront visit payments to facilitate alternative care delivery, similar to CMS CPC+ model
  - Focuses on Complex and Chronic Care Improvement patients with hospitals
  - Aligns with All Payer Model--Adjust MACRA bonus based on overarching provider performance measures including Medicare TCOC
  - Improves access to community-based, behavioral health services and supports

Envisioning Core Strategic Elements (cont.)

Dual Eligible Model (see also separate presentation)

- Goal: Create a care delivery strategy for Maryland's dual eligibles* that will improve quality of life and link payment to the total cost of care for Medicare and Medicaid combined ($2.26 billion**)
- Hybrid Model: Duals Accountable Care Organization (D-ACO) and Managed Fee-for-Service (MFFS)
  - Leverages Medicaid mandating authority to enroll beneficiaries in a D-ACO or MFFS according to place of residence, with D-ACOs active in more densely-populated areas of Maryland
  - Encompasses all providers serving duals (physical, behavioral, specialty care, long-term care) and incorporates social supports to achieve whole-person care
  - Utilizes Person-Centered Health Homes as its foundation and works in tandem with the State's Primary Care Home Model
  - Provides front-end investments and shares savings with providers who achieve cost and quality targets, with D-ACOs subject to downside risk by Year 3
  - Applies real-time, comprehensive data and health IT for predictive analytics, enrollment and attribution, care coordination and quality measurement and reporting
- Aims to qualify as an Advanced APM under MACRA

** Full-benefit, non I/DD duals*

*** 2012 data; excludes partial duals, the I/DD population and duals enrolled in Medicare Advantage*

Envisioning Core Strategic Elements (cont.)

Long term care (LTC) initiatives—*Medicaid* opportunity (28,000 SNF beds, ~15,000 full time equivalent persons in custodial care for Medicaid)

- Opportunity to migrate some long term care to community settings and opportunity for Medicaid, which spends >$72k per year for persons in nursing homes, estimated >$1b in 2015. Should be addressed through dual eligible model.
- Most inbound persons to long term care settings originate from hospitalization. Additional post hospitalization care coordination and support may result in reduced need for long term care.
- Opportunities may be substantially addressed through **Dual Eligible Model.** Reducing inbound patients may require additional model design together with core All-Payer Model to reduce or defer custodial care through better care management and other home based supports.

Envisioning Core Strategic Elements (cont.)

Long term care (LTC) initiatives—*Medicare* opportunity (LTC) (28,000 SNF beds, 21,000 assisted living beds). Custodial care persons are mostly high needs individuals, "typical" profile is 87 year old woman, needs assistance with activities of daily living, multiple chronic conditions (Source: Lifespan)

- Medicaid figures for nursing home residents ~11,000 hospital admissions in 2012. (Hilltop analysis). Rough estimate of assisted living admissions =11,000. (~50% use-rate for Medicare 85 and over) Total hospital admissions estimated >$300 million.
- Represents a focused opportunity for reducing hospitalizations through providing more timely and comprehensive interventions in custodial care and additional preventive services.
- Requires increased investments in medical supports and care coordination in these settings. Ideal for joint investments, shared savings with hospitals, additional medical reimbursements in LTC settings or potential waiver of 3 day rule to allow temporary increased level of care at SNF level rates.

Envisioning Core Strategic Elements (cont.)

Post-Acute Care Initiatives--Post-acute care costs (SNF, home health, and hospice) represent ~12% of Medicare TCOC in Maryland. Costs have risen above national Medicare levels since 2015. SNF costs ~ $.8b in 2015

- Opportunities lie in service optimization and better care coordination, an ideal opportunity for partnerships and shared savings between hospitals and SNFs. Payment modifications with Medicare and waivers may be required. Geographic models may create approaches to services at a per beneficiary level that could be ideal for experimentation and control.
  - Reduced readmissions from SNFs requires better hand-offs, medication reconciliation, and increased medical supports for SNF patients
  - SNF LOS can be reduced considerably, based on managed care experience
  - Controlled release of 3 day rule could give needed supports to some Medicare patients who can not currently access those services, improving outcomes and avoiding more costly settings
  - Some patients could avoid a SNF setting and be directly discharge to home settings with additional home support

Envisioning Core Strategic Elements (cont.)

Global Budgets--Global budgets represent a continuing core model element, creating a predetermined budget for hospitals related to historic service levels, population, and other factors.

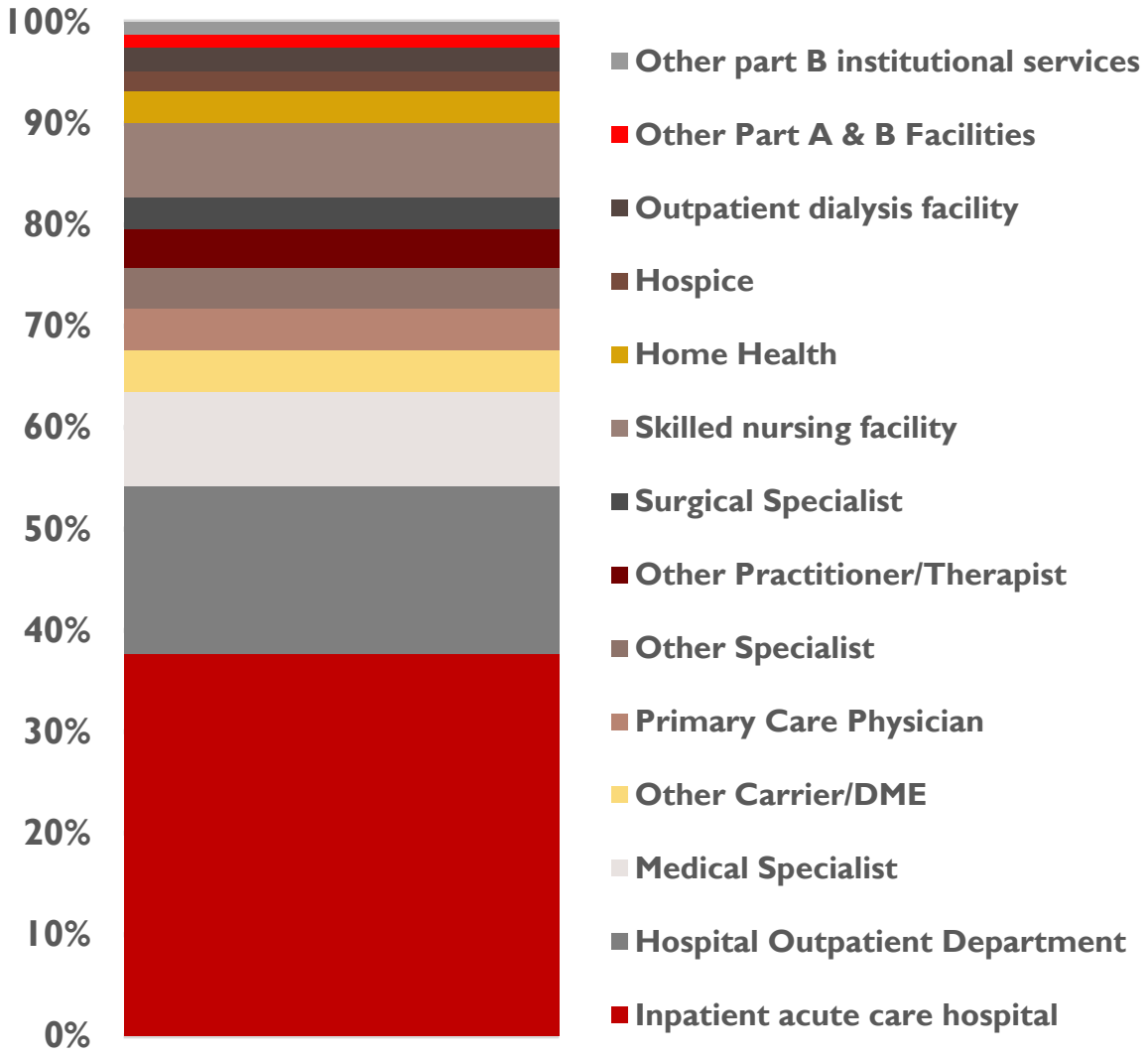
- Continue relevance in progression and source of funding for hospitals' infrastructure investments, with modifications.
- Provide a cornerstone for an Advanced Alternative Payment Model under MACRA, a tool for physician alignment.
- Global budget mechanisms need to be refined
  - Need to add performance incentive for Medicare TCOC/outcomes to qualify for MACRA and align with progression goals. (see Geographic Model).
  - Improved measures and incentives for reducing potentially avoidable utilization (PAUs), shifts to unregulated settings, and expected growth vs. decline in some services (e.g. cancer related services)
  - Efficiency needs to be measured in new ways, considering new measures such as episode costs and condition based costs.

Envisioning Core Strategic Elements (cont.)

Existing ACOs and PCMH experience

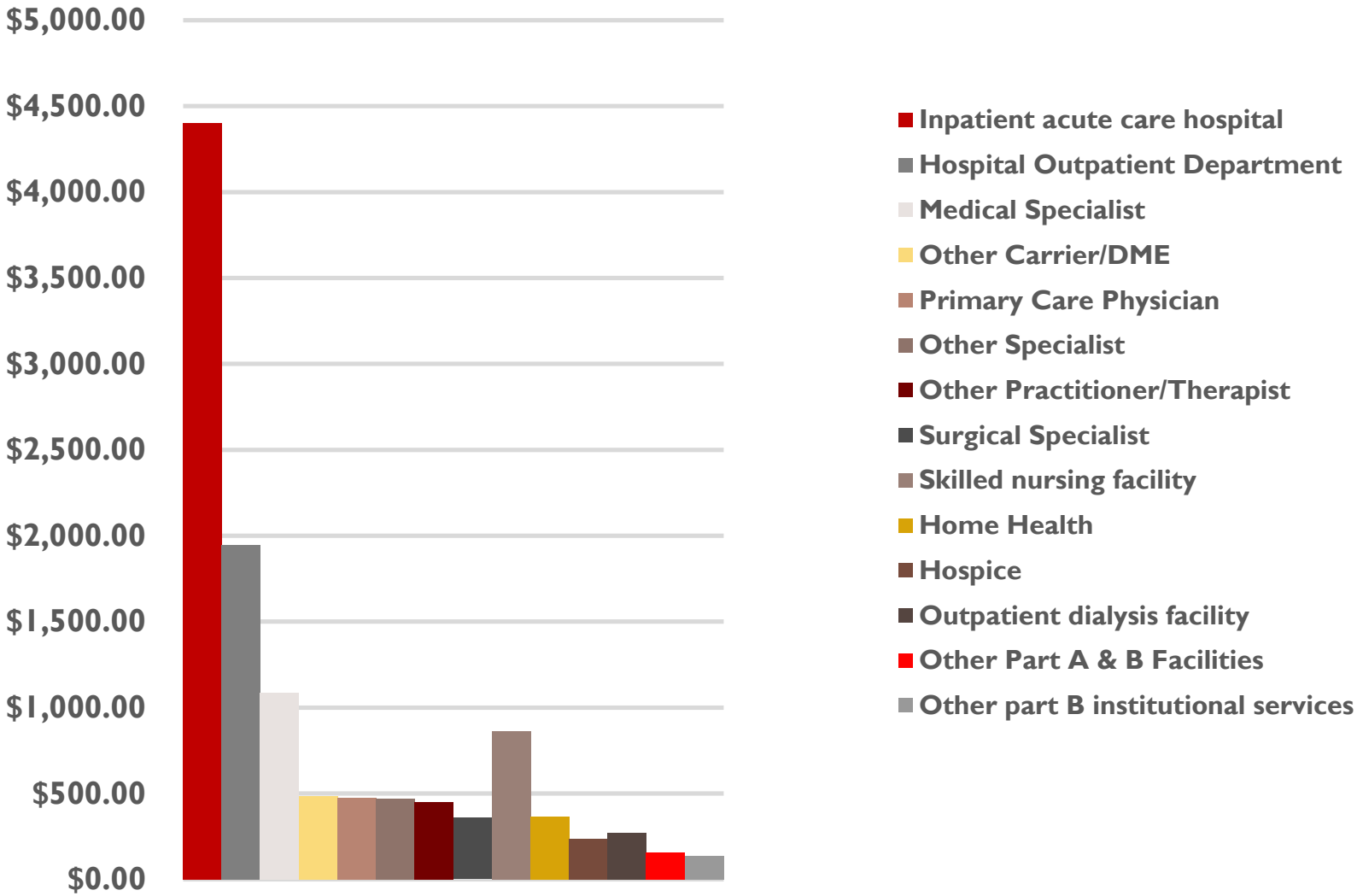
Appendix B - Cost Breakdown for Medicare and Dual-Eligible Medicaid

2015 Maryland Medicare Dollar-%



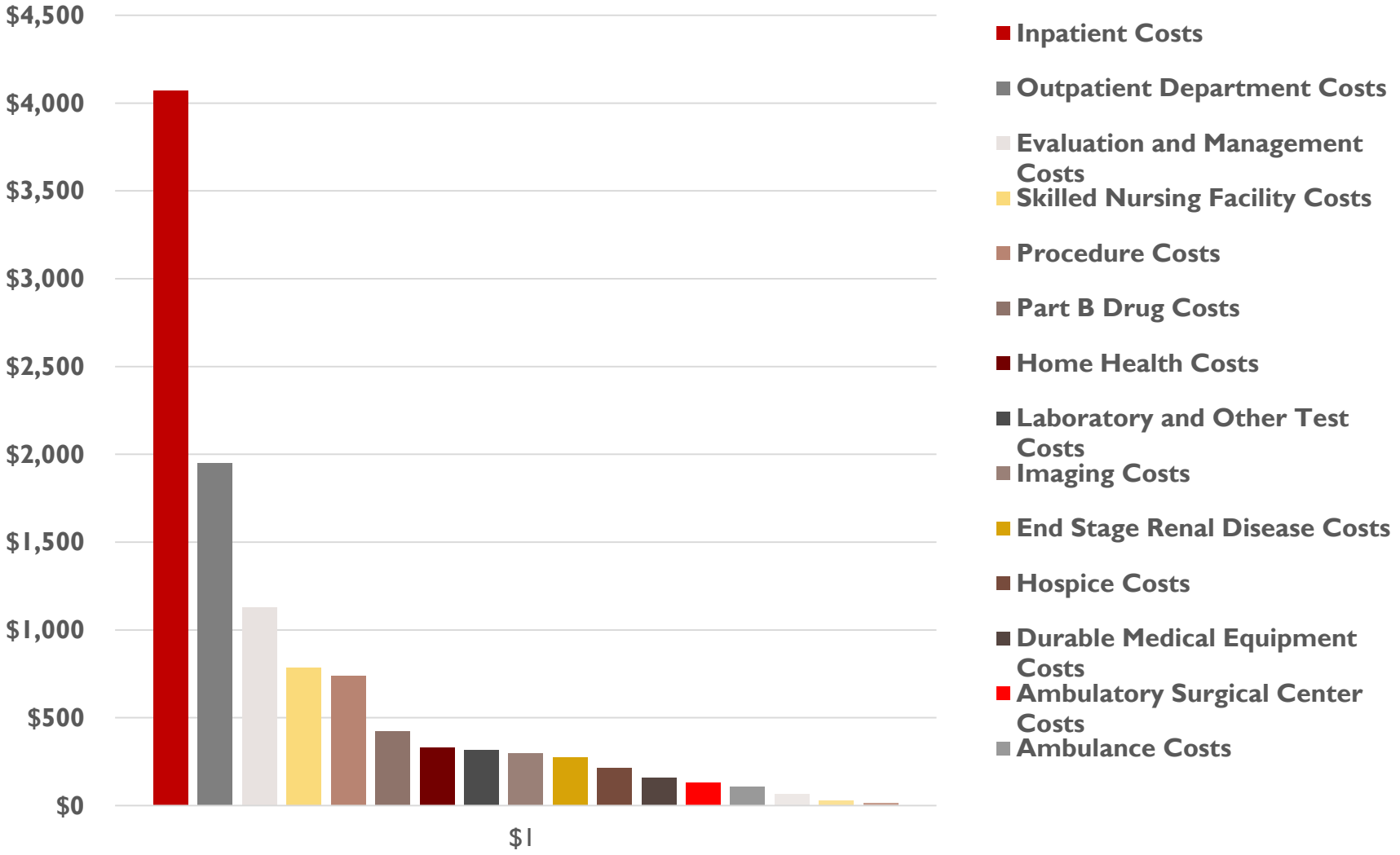
- Approximately 75%+ of Medicare expenditures are tied to a hospitalization
- **Hospital expenditures account for 56%** of the Medicare per capita total cost of care.
- **Post-acute expenditures account for 12%** of the Medicare dollar.
- Of the 28% Medicare expenditures that are for physicians, an estimated **10% are related to hospitalizations.**

2015 Maryland Medicare Dollar-Per Beneficiary / Provider Categories



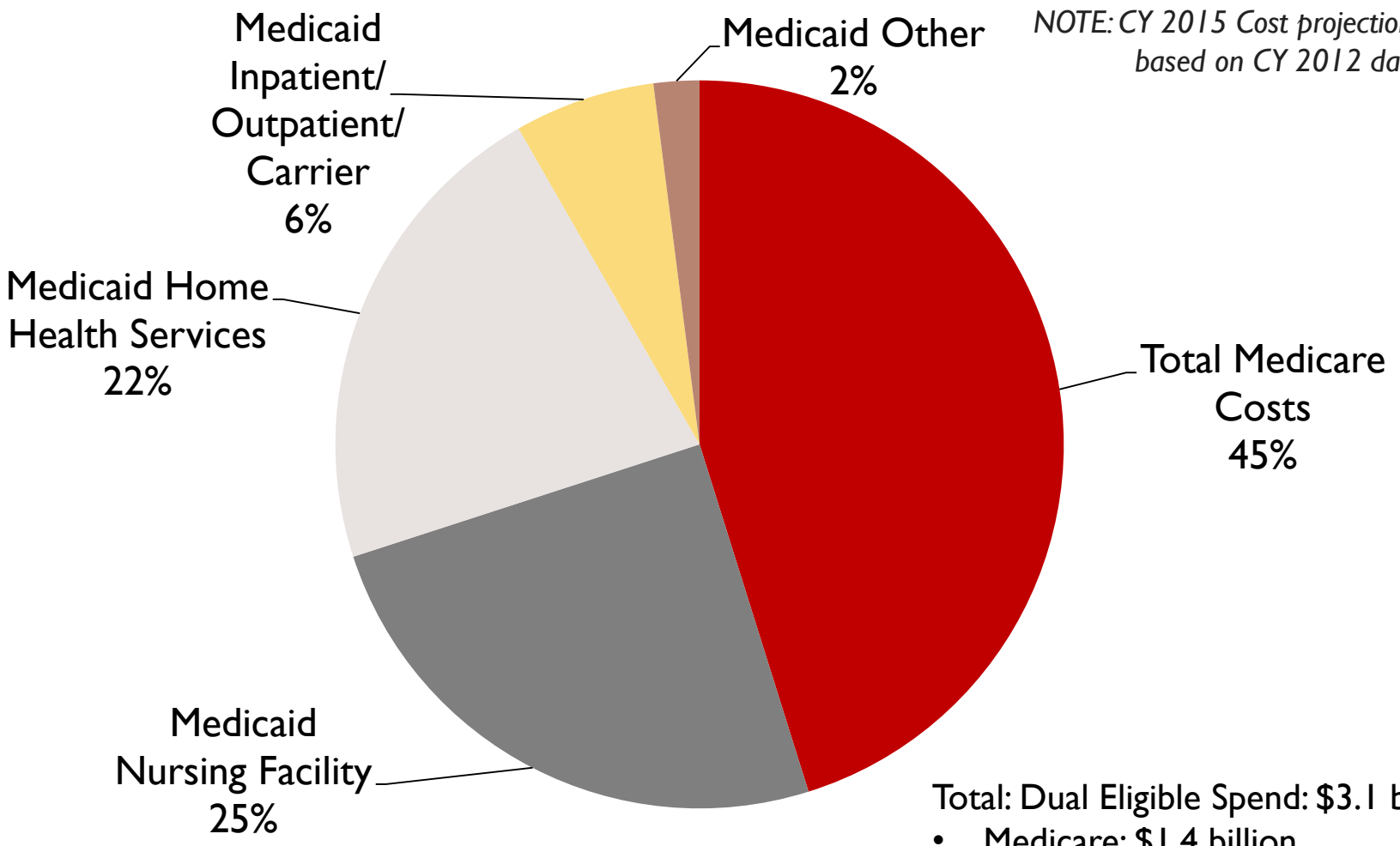
Note: Table uses Part B beneficiaries to calculate per beneficiary figures while following HSCRC table uses both A/B figures. The underlying figures are consistent though the scale is slightly different.

2015 Maryland Medicare Dollar-Per Beneficiary / Service Categories



Note: Table uses Part A/B beneficiaries to calculate per beneficiary figures while the previous CMS figure uses B figures. The underlying figures are consistent though the scale is slightly different.

Total Dual Eligible Spend Medicare and Medicaid



NOTE: CY 2015 Cost projections based on CY 2012 data

Total: Dual Eligible Spend: $3.1 billion

- Medicare: $1.4 billion
- Medicaid: $1.7 billion

Cost Breakout for Full Duals

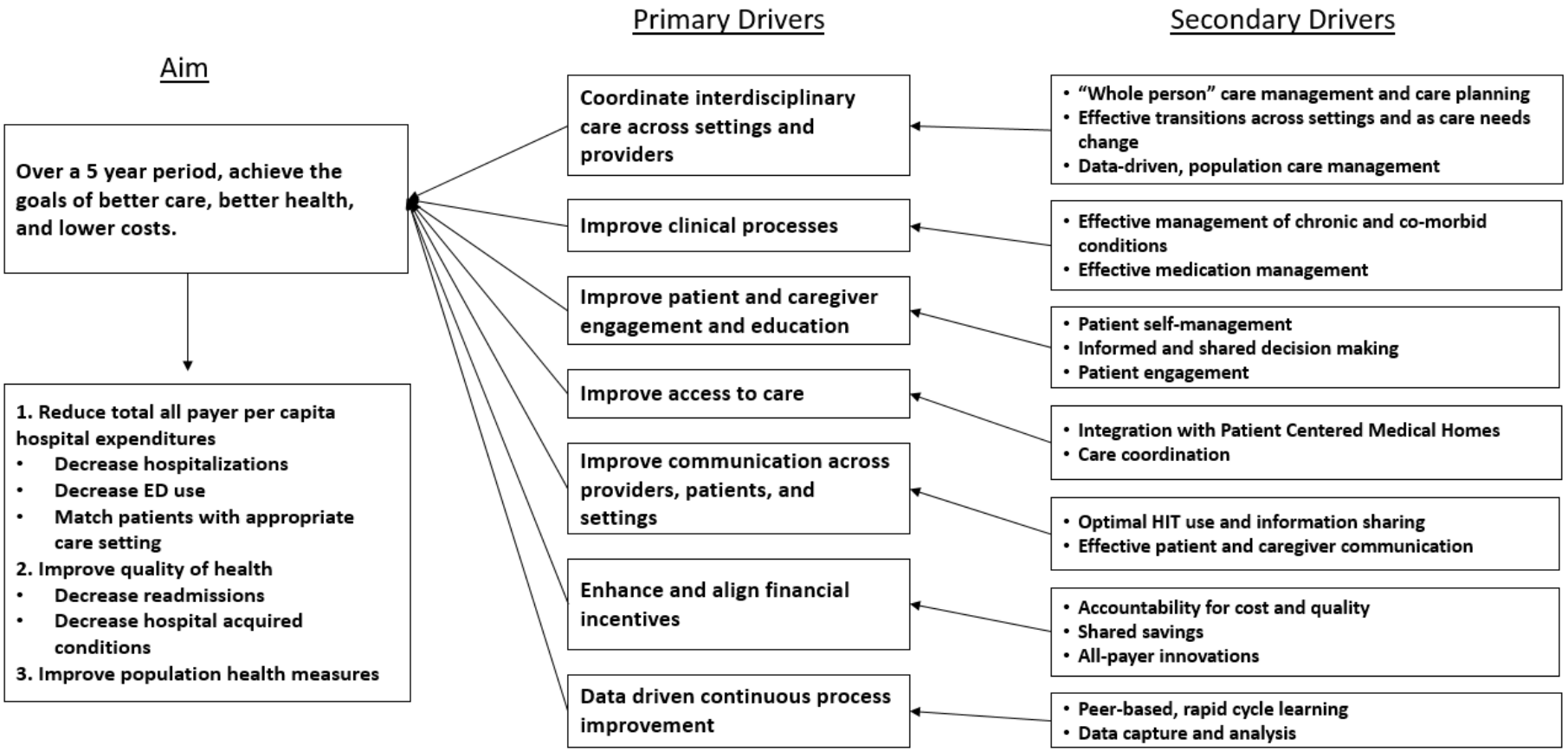
Cost presented below from Hilltop and reflects 2012 data and includes the I/DD population and Medicare Advantage enrollees.

	Medicaid Expenditures	Percentage of Medicaid Expenditures	Medicare Expenditures	Percentage of Medicare Expenditures	Total Expenditures	Percentage of Total Expenditures
Dental	$121,004	<1%	$0	<1%	$121,004	<1%
Durable Medical Equipment	$385,725	<1%	$32,917,711	2%	$33,303,437	1%
Home Health Services*	$642,478,730	40%	$28,625,905	2%	$671,104,636	23%
Hospice	$21,928,227	1%	$30,334,906	2%	$52,263,133	2%
Inpatient	$49,440,570	3%	$574,994,940	43%	$624,435,510	21%
Outpatient/Carrier	$136,000,050	8%	$502,592,047	38%	$638,592,097	22%
Pharmacy	$8,025,303	<1%	$0	<1%	$8,025,303	<1%
Nursing Facility	$734,315,146	45%	$157,470,123	12%	$891,785,270	30%
Special Programs	$29,749,404	2%	$0	<1%	$29,749,404	1%
Total	$1,622,444,159	100%	$1,326,935,634	100%	$2,949,379,794	100%

Appendix C - Other Background

Recap: Original All-Payer Model Application: Maryland's Strategy

Aim: Over a 5 year period, achieve the goals of better care, better health and lower costs.

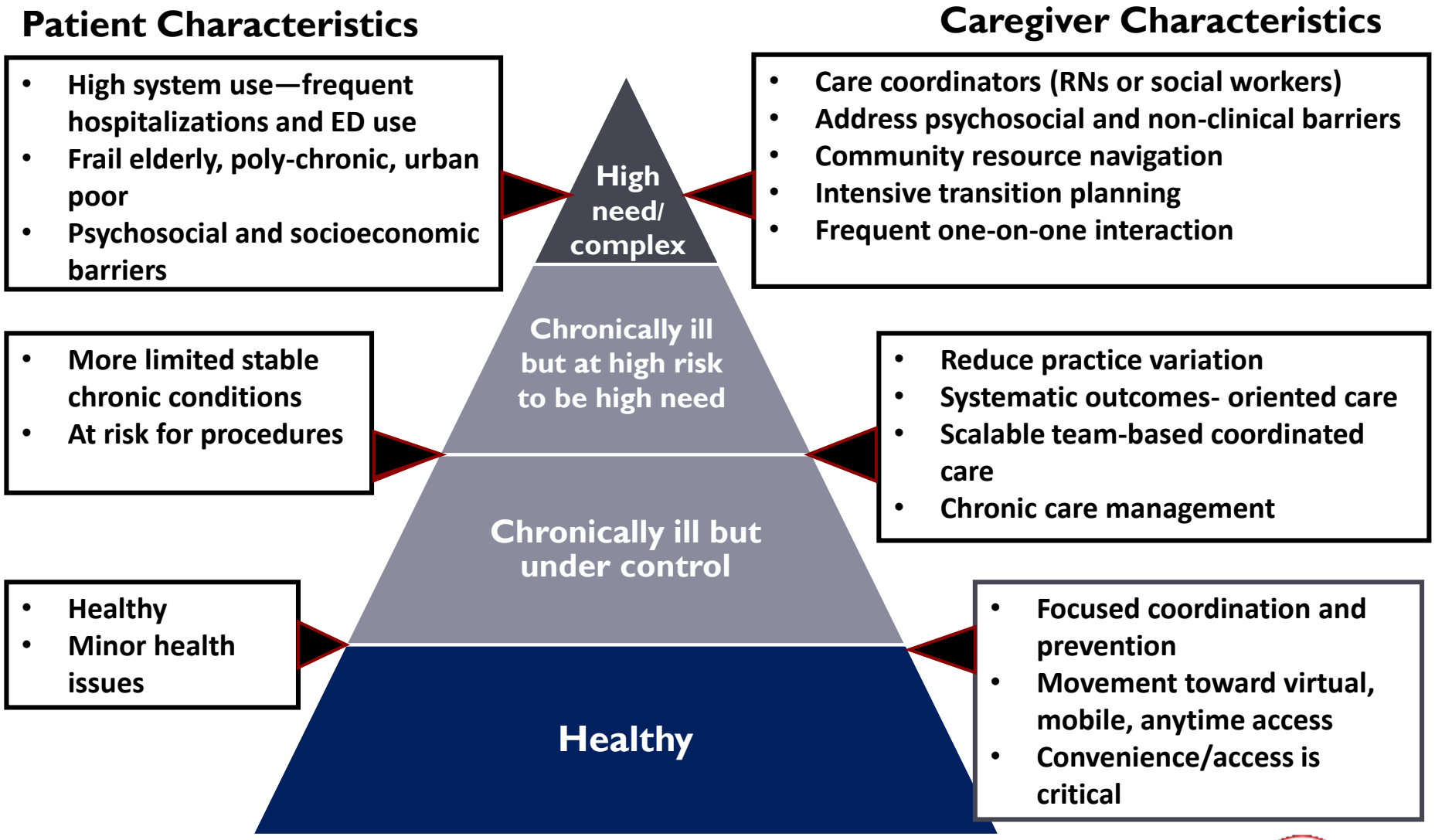


Recap: Stakeholder-Driven Strategy for Maryland

Aligning common interests and transforming the delivery system are key to sustainability and to meeting Maryland's goals

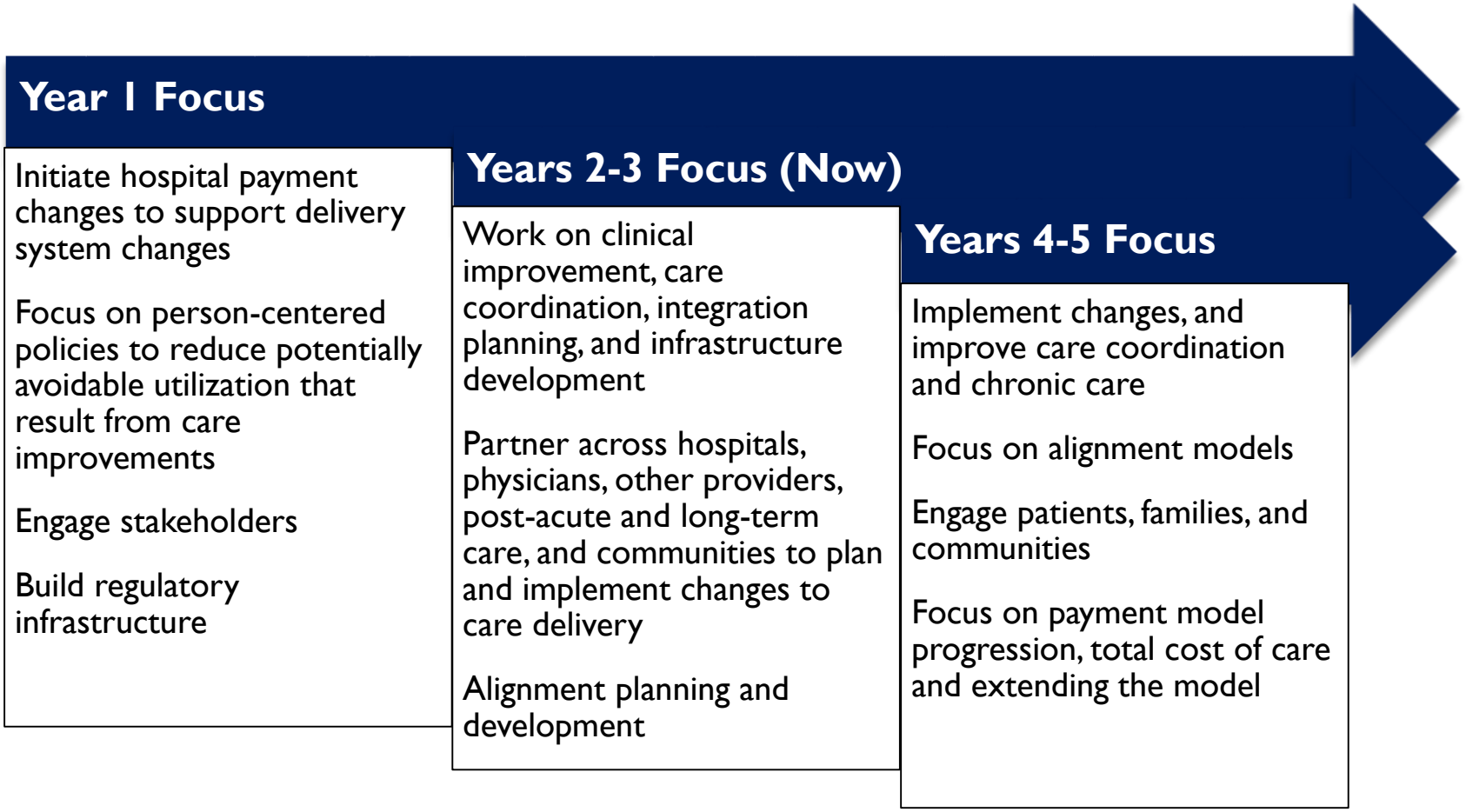
Focus Areas	Description
Care Delivery	• Improve care delivery and care coordination across episodes of care • Tailor care delivery to persons' needs with care management interventions, especially for patients with high needs and chronic conditions • Support enhancement of primary and chronic care models • Promote consumer engagement and outreach
Health Information Exchange and Tools	• Connect providers (physicians, long-term care, etc.) in addition to hospitals • Develop shared tools (e.g. common care overviews) • Bring additional electronic health information to the point of care
Provider Alignment	• Build on existing models (e.g. hospital GBR model, ACOs, medical homes, etc.) • Leverage opportunities for payment reform, common outcomes measures and value-based approaches across models and across payers to help drive system transformation

Recap: Core Approach— Organize resources around population, tailored to individual needs



MARYLAND

Recap: Strategy for Implementing the All-Payer Model



Maryland's Updated Strategy

Updated Aim: Over a 10 year period, 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.

- 1. Reduce total all payer per capita hospital expenditures
  - Decrease hospitalizations
  - Decrease ED use
  - Match patients with appropriate care setting
- 2. Improve quality and efficiency of health care
  - Focus on complex and high needs patients
  - Decrease admissions
  - Decrease health care acquired conditions
  - Improve efficiency and quality of episodes of care
- 3. Improve population health measures
- 4. Limit the growth in Medicare total cost of care, including the Medicaid costs for dually eligible beneficiaries
- 5. Consider all patients, all payer principles and their application in the development of models, measures, and infrastructure

Maryland All-Payer Model Driver Diagram

With Updates for the Model Progression