Maryland's New All-Payer Model
A Journey Together for Care Improvement

Focus on Clinical Improvement and Infrastructure

- HSCRC has completed its initial payment model changes that place all hospitals on global revenue models with enhanced quality and outcomes requirements.
- The focus now is on coordinating and integrating care as well as improving community based care to reduce hospitalizations.
- Solutions should be patient focused, and approaches to engage and educate patients will be needed.
- Partnerships with physicians and practitioners, long term and post acute care providers, and community health and service organizations are critical to creating effective and workable strategies, infrastructure, and operations.

Coordination of Efforts is Essential to Success

Accountable Care Organizations and Medical Homes

New All Payer Hospital Model

Medicare

Care Management Fees

State Health Improvement Process-Public Health

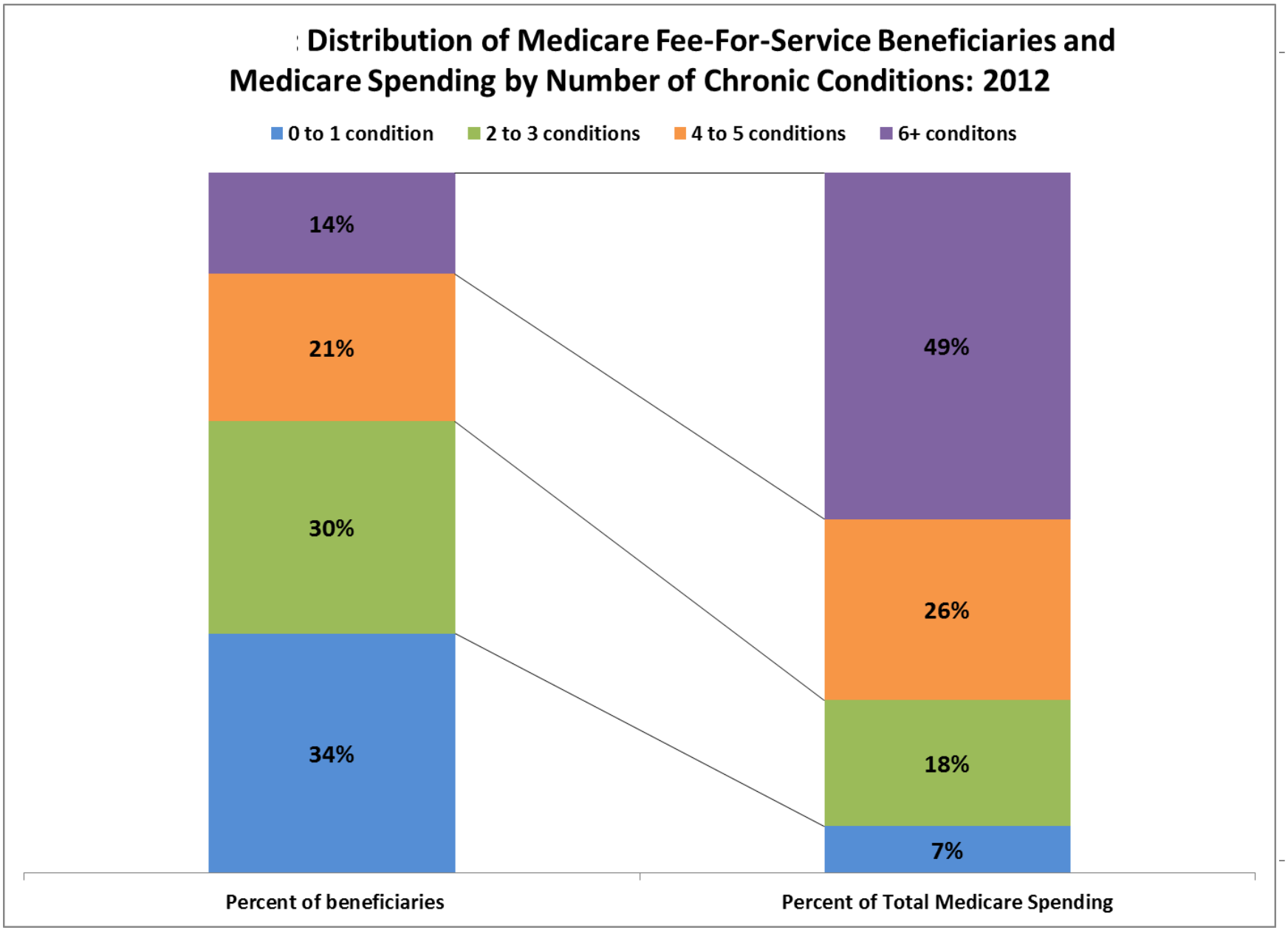
Health Information Exchange--CRISP

Consumer Engagement, Education, and Outreach

Initial Focus is Medicare

- Two thirds of high needs patients are Medicare (calculated from HSCRC data sets)
- Medicare patients have high numbers of chronic conditions. Chronic care improvement is essential for patients and also contributes to cost containment when conditions are controlled.
- Medicare patients can benefit from care coordination and customer service mechanisms that have not been supported in the fee-for-service system that is predominant in Maryland.
- Medicare savings test requires reductions in utilization beyond national progress to result in savings of ½% per year relative to the national growth rate in Medicare cost per beneficiary
- The same care processes can be used for other populations, but we will need to coordinate with commercial carriers and Medicaid MCOs

14% of Medicare Patients Drive Half of Cost



Two-thirds of High Hospital Utilizers Are Medicare or Dual Eligible

- High utilizers defined as patients with 3 or more admissions

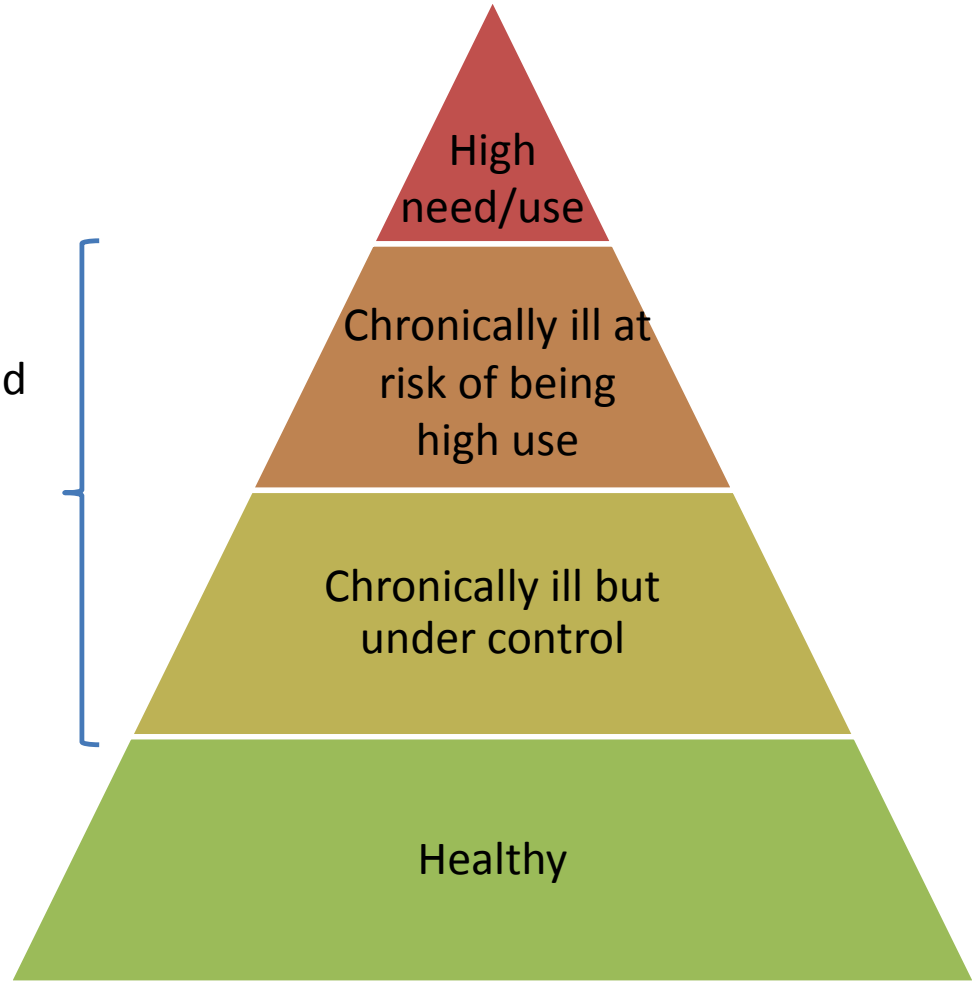
  (Data based on Calendar Year 2012 HSCRC Discharge Data. Includes Inpatient and ER Charges, excludes Obstetrics)
- 2/3 of high utilizers and dollars are Medicare or Dual eligible
- High Utilizers Account for 1/3 of Included Hospital Utilization

Payer Group	# of Patients	% of Charges	Total Charges	% of Charges
Medicaid, Other, Self Pay	13,731	34%	$ 1,031,068,643	35%
Medicare	20,592	51%	$ 1,419,886,123	49%
Dual Eligible	6,278	15%	$ 456,370,192	16%

Opportunity to Address Common Interests

- Accountable Care Organizations, Medical Homes, and Hospitals all share a common interest in identifying patients with high needs and reducing avoidable utilization through better community based care
- Medicare has introduced a care management fee effective 1/1/15 that can be paid to physicians who provide the required services for patients with 2+ chronic conditions.
  - ~$40 per month.
  - Financial opportunity is real—50,000 patients = $25 million revenue opportunity.
  - NEJM estimates up to 60% of Medicare patients (there are about 800,000 beneficiaries in Maryland) may qualify for this program
- Efforts to align incentives through gain sharing and pay for performance are also needed

Vision –Target Resources Based on Patient Needs to Improve Care



B

Address modifiable risks and integrate and coordinate care

A

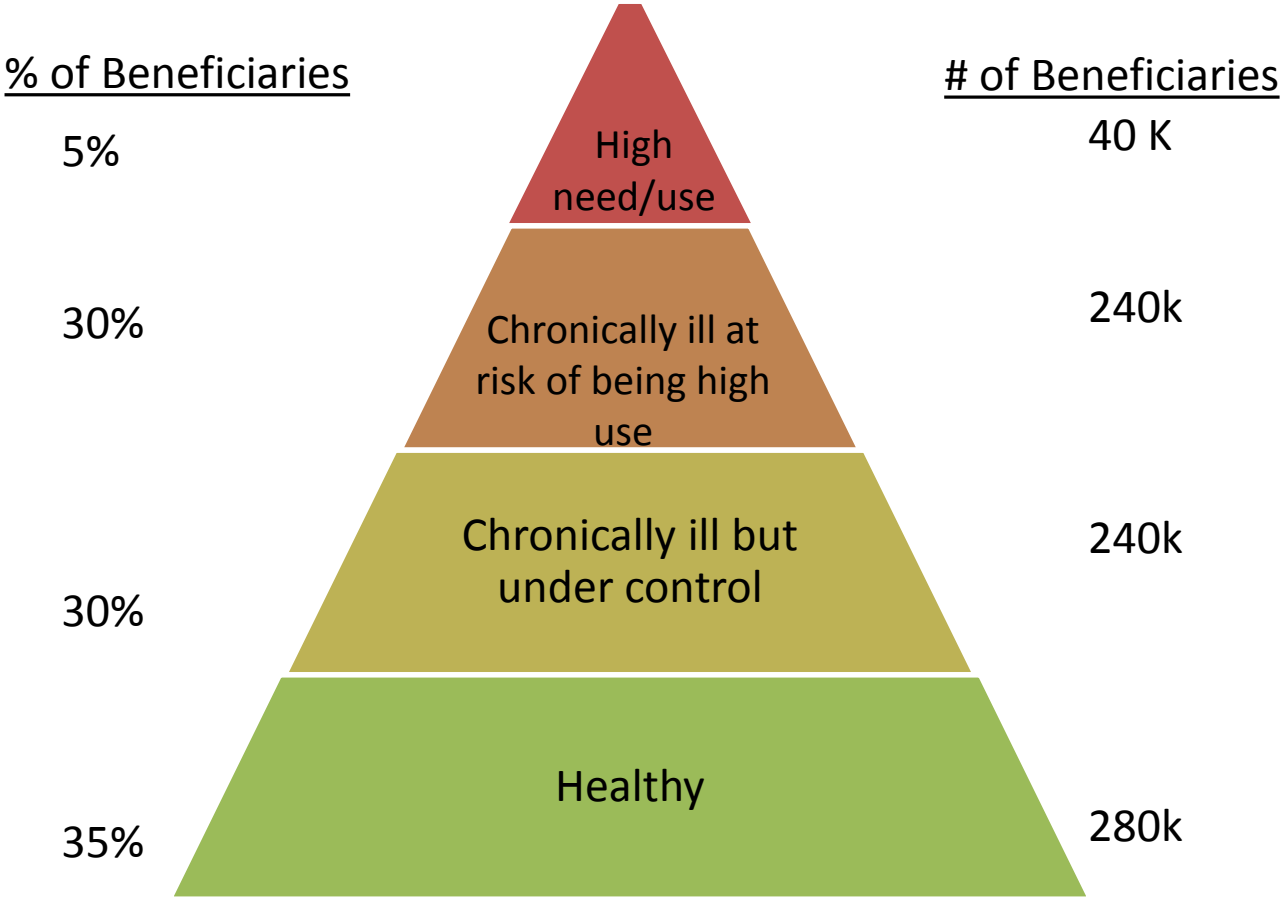
Individual case management for individuals with significant demands on health care resources

C

Promote and maintain health

Significant Efforts and Investments Needed to Scale Interventions

Rough Estimates of Scaling for Medicare in Maryland

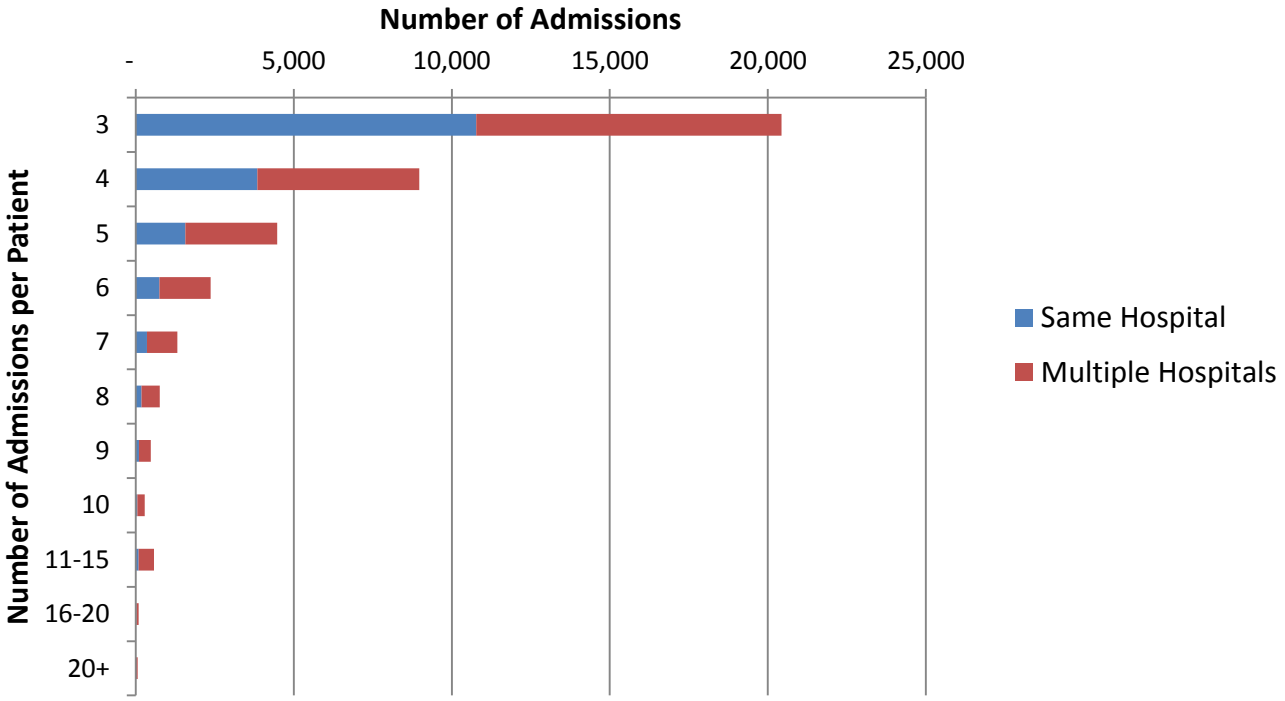


Key Strategies

- Focus on populations with the greatest opportunity to improve care and achieve return on investments in strategies – those with high need (≅40K) and chronically ill/at risk (≅240K)
  - Identify patients at high risk for poor outcomes and avoidable utilization using predictive modeling tools
  - Stratify patients to customize and focus approaches
- For selected higher risk patients (initially focused on 40k)
  - Perform assessments
  - Develop care plans
  - Provide individualized case management
  - Respond rapidly to changes in patient conditions to reduce avoidable use
- Implement approaches and interventions to reduce and modify risks and integrate care across providers and settings
- Monitor outcomes

Need for Collaboration

- High utilizers (in Maryland) with larger number of admissions are more likely to receive care at multiple hospitals
- Medicare beneficiaries (nationally) saw a median of two primary care physicians and five specialists



Oppurtunities to Accelerate Results

- Q: What can we do to accelerate these efforts?
  - Statewide
  - Regional
  - Local

- HSCRC and MHCC planning to initiate RFP and awards to a limited number of regional collaboratives to organize and initiate opportunities regionally

Framework for Discussion of Potential Activities for Collaboration

Activity	Statewide	Regional	Hospital/System

Discussion of Potential Activities for Collaboration

- What are the 3 most important activities for statewide collaboration?
- What are the 3 most important activities for regional collaboration?

Examples of Potential Activities for Statewide Collaboration for Discussion

- Medicare Data acquisition and levering other data sources
- Targeting and stratifying
- Patient attribution to providers
- Data sharing protocols compliant with HIPAA, data use agreements and patient preferences
- Patient engagement protocols
- Outcomes data collection and analysis
- Patient assessment standard

- Care plan tool/standard
- Learning
- Identify care gaps
- Integrating information across providers and settings
  - Collecting selected data from EMRs
  - Connecting community based providers

Examples of Potential Areas for Regional/Local Efforts for Discussion

- Care plan tool
- Call center
- Care coordinators/case managers/care teams
- Pharmacists
- Other disease management support
- Primary care supports
- Care gap analysis and work flow
- Community/faith based supports, volunteers
- Planning for needs of frail elders, assistance with activities of daily living

TO BE CONTINUED—AMBULATORY STRATEGY

- Continue with content on community based physicians, practitioners, long term care, and community supports for next meeting