

November 5, 2014

## **HSCRC Implementation of Population-Based and Patient-Centered Maryland All-Payer Model HSCRC Charge to Care Coordination Workgroup**

**Need.** The purpose of this Workgroup is to facilitate multi-stakeholder discussions regarding efficient and effective implementation of population-based and patient-centered Care Coordination to support the new Maryland All-Payer Model that began on January 1, 2014. The HSCRC's focus on Care Coordination is based on the consensus that was achieved through the Advisory Council and multiple workgroups that this should be top a top priority, including the potential for shared infrastructure and common approaches.

In the Advisory Council meetings, members advised that care coordination is an area where we should focus attention on models that have demonstrated success rather than many untested and different strategies, while at the same time allowing for and encouraging innovations that lead to success. This will facilitate the adoption of best practices and generate efficiencies in both speed and scale. The Data and Infrastructure Workgroup, as well as the Physician Alignment and Engagement Workgroup, also recommended considering shared infrastructure and common approaches to care coordination. Based on this advice, the HSCRC's goal is for this Care Coordination Work Group to facilitate consideration of efficient and effective approaches, implemented as soon as possible, using shared infrastructure and common approaches, and focused especially on the Medicare FFS population.

In referencing the broad term of Care Coordination, the Advisory Council and Workgroups highlighted the need for data / predictive modeling, technology, and multi-disciplinary care teams (e.g. Care Coordination that is both "high tech" and "high touch." A key focus has been on multi-disciplinary care teams, and the development of care plans, care coordination, and transition management.

Beginning in late 2013, in advance of the new All-Payer Model's approval, the HSCRC convened an Advisory Council, to develop Guiding Principles for implementation of the new globally budgeted all-payer model. The Advisory Council put forth a Final Report on January 31, 2014, shortly after approval of the new All-Payer Model, and this Care Coordination Workgroup's structure and activities are at the core of the Advisory Council's Recommendations, which are as follows:

- Focus on meeting early Model requirements (Note: including through hospitals being on global budgets supported by multi-disciplinary Care Coordination, especially for high-risk Medicare FFS patients, to enable meeting the state-wide global budget targets)
- Meet budget targets while making important investments in infrastructure and providing flexibility for private sector innovation
- HSCRC should play the roles of regulator, catalyst and advocate
- Consumers should be involved in planning and implementation
- Physician and other provider alignment is essential
- An ongoing, transparent public engagement process is needed

As a first phase of implementing the Advisory Council's recommendations, the HSCRC convened four Workgroups -- Payment Models, Physician Alignment & Engagement, Performance Measurement, and Data and Infrastructure. Care Coordination was a key part of each of the Workgroup's discussions, including the Information Technology and Human Capital aspects of Care Coordination. As part of the Workgroup process, a number of national and local experts were brought in to present evidence-based best practices. Subsequently, the HSCRC commissioned a paper from Health Management Associates, titled *Clinical Management: Review of the Evidence and Policy Recommendations*, which highlights Key Elements of Successful Approaches to Care Coordination.

The HSCRC believes a top priority is to serve in the role of Catalyst and Advocate to facilitate a multi-stakeholder discussion related to the implementation of cost-effective and evidence-based care coordination.

The HSCRC and other stakeholders, as part of the workgroup process to date, believe it is worth considering the identification of industry-wide approaches to care coordination, in order to be more efficient and effective. This does not imply a "one-size-fits-all" approach. Rather, the idea is to present a menu of evidence-based care coordination approaches and avoid a situation in which each stakeholder "reinvents the wheel". Also, the idea is to consider using shared infrastructure and common approaches, where applicable to take advantage of efficiency of scale, and to limit confusion and ineffectiveness due to the existence of multiple uncoordinated approaches, that would be expensive as well as problematic for providers and patients. Consistent with the history of the HSCRC, the approach to care coordination in the new Global Budget environment could benefit from balancing a "public good" with a "market based" approach.

As discussed by the Advisory Council and subsequent workgroups, and as highlighted in the HMA Clinical Management paper, the following are three crucial and sequential steps, which may lend themselves to state-wide collaboration:

- The identification of the patients with the most complex medical needs
- The development of patient-centric health risk assessments using face-to-face, in-depth interviews
- The early development of customized, individualized, multi-disciplinary care coordination plans, that include medical, social, behavioral, and patient / family supports

**Overview of Proposed Framework.** The purpose of the Care Coordination Workgroup is to provide a forum for education, discussion and debate among stakeholders, to facilitate decision-making related to collaborative approaches for care coordination.

The purpose of this document is to describe how this group will work together and with the Commission, and propose the charge for the Workgroup. The Workgroup will need to begin its work immediately.

**Membership:** The size of the Work Group membership should balance the need to gain input from a wide variety of stakeholders, yet support an effective working relationship among its members. Appointments to the Work Groups will be made by the HSCRC staff, with alterations to workgroup composition made upon request of Commissioners. Membership may not be designated to a substitute representative.

**Consensus:** The Workgroup should seek to find consensus on key issues. When consensus cannot be achieved, their report to the HSCRC should reflect the different perspectives that were provided. The Workgroup is not a decision-making organization, and therefore, will not be expected to vote on implementation activities.

**Leadership and Staff:** The Workgroup should be co-chaired by key stakeholders. Staff or consulting experts will be designated to facilitate the meetings of the Workgroup. Experts will also be designated to support the

deliberations of the group as needed. These lead staff will actively participate in the HSCRC project management team and provide routine updates to the HSCRC to ensure coordination with the HSCRC and among the groups.

**Transparency (Public Meetings and Materials):** The Workgroup will convene approximately three or four meetings, from approximately November 2014 through February 2015. Meeting dates and materials will be posted on-line on the HSCRC website. Meeting agendas should include presentations from knowledgeable individuals and experts on policy or methodological issues.

**Project Management Team.** The HSCRC staff will establish a project management team and will engage project management resources. The lead staff for the Workgroups will actively participate in this team to coordinate the activities of the Workgroup. The project management team will develop a management plan to be shared with the Commissioners.

### **The Care Coordination Workgroup**

The Commission is forming the Workgroup because it believes that the Workgroup's input is essential for successful implementation of the new payment model. The Workgroup needs to form and begin its work immediately because the design of the new payment system is so urgent.

**Charge:** The purpose of the Workgroup is to provide the HSCRC with senior-level stakeholder input on guiding principles for the overall implementation of population-based and patient-centered care coordination, with a focus on strategies and priorities that are timely, scalable and best-practices, and especially focused on the Medicare fee-for-service population, while being available on an all-payer basis. Implementing care coordination is essential to meet the terms of the new all-payer model, and will require the input and support of hospitals and other providers, payers, and other stakeholders, including patients and families. As referenced above, in addressing the need for Care Coordination, we include the need for data / predictive modeling, technology, and multi-disciplinary care teams, including for the development of care plans, care coordination, and transition management.

The Workgroup will facilitate a discussion for the purpose of considering implementation of state-wide and / or regional approaches to care coordination, in order to increase efficiency, related to both timing and performance. The Workgroup should pursue how best practices can be implemented in a timely, scalable, and cost-effective manner.

There has been consensus around the need to manage both patients with complex needs who are using a substantial amount of hospital resources (whom the hospitals can more quickly self-identify, and manage with a more "low-tech, high touch" approach), and a broader population of high-risk Medicare beneficiaries and other high-need patients (which will require more time to obtain population-based data and do predictive modeling, and a more "high-tech, high touch" care coordination approach). The Workgroup should develop the timeline for consideration and implementation of needed state-wide and / or regional investments in care coordination (shared infrastructure for data / predictive modeling, technology, and human capital) needed for these two populations. While there is consensus that there is the opportunity to more quickly address the needs of patients in the first group, there is also consensus that ultimate success rests on the ability to more effectively address the broader population of high-risk Medicare beneficiaries and those in Medicaid, commercial insurance, and others who remain uninsured.

While the HSCRC does not regulate how care will be coordinated to make the new globally budgeted all-payer model successful, care coordination is at the core of what is needed to be successful, and the HSCRC sees an opportunity to convene a coordinated discussion, and to facilitate a collaborative approach.

#### **Initial Work:**

1. The initial meeting of the Workgroup should be held by mid-November 2014, and the Workgroup should finish its work, including 3 – 4 meetings and a Final Report, by March 1, 2015.
2. Since this Workgroup is being formed by the HSCRC in their role as catalyst and convener, this is not a policy-making body, and it is up to the stakeholders to determine the care Coordination strategies to be implemented. The Goal of this workgroup is to facilitate a thoughtful approach to identifying promising state and regional approaches to care coordination and to make recommendations for operationally implementing care Coordination activities. Therefore, the Workgroup's final report will not necessarily be in the form of recommendations.
3. Specific issues for the Workgroup to consider include:

##### Strategies & Priorities

- What are the key ingredients and program elements of successful care Coordination strategies?
- What are the barriers, and how can they be overcome?
- Within the initial focus on Medicare fee-for-service, including people with complex medical and social needs, and the broader high-risk population and dual eligibles, what are the target populations?
- Are there other unmanaged or undermanaged priority populations beyond Medicare?
- How can we facilitate an organized approach to the considerable investment that will be needed over an ongoing period of time?
- How do we balance a focus on models that have demonstrated success, with enabling innovation to meet the goals of the new model (e.g., funding R&D within the global budgets)

##### Current Status and Gap Analysis

- What is the current landscape of care coordination, especially for the Medicare fee-for-service population?
- What are the gaps, compared to what is needed?

##### Infrastructure (IT and Human Capital)

- Should we pursue state-wide resources for predictive modeling and care coordination infrastructure?
- What elements of care coordination, including Information Technology and Human Capital, lend themselves to statewide, regional, or provider imbedded deployment? How can we support hospitals, physicians and other health care providers with reports and data from CRISP to aid their efforts and early understanding of high-needs patients and their clinical needs? How can this be augmented with data acquired from CMS, Medicaid, and the APCD?
- What are the health care and non-health care work force requirements to support care coordination?
- How can we think about this in the context of state-wide, regions, and local areas?

##### Timeline & Implementation Plan

- How can we implement Care Coordination in the timeliest fashion? If some approaches require more data or IT systems, are there places we can start today using other data sources and systems? (e.g., for high-cost users of services, high-risk Medicare, and dual eligible populations).
- How do recommendations tie into the Budget Reconciliation and Financing Act of 2014?
- What advice should be given for regional planning efforts conducted under BRFA-based rate grants? What is the timeline for consideration and implementation of collaborative approaches and / or shared infrastructure, including for each of the population with complex needs using substantial hospital resources, high-risk Medicare, and dual eligible populations?