A Journey Together: Addressing the Needs of Complex Patients and Improving Chronic Care

DRAFT STRATEGY DOCUMENT

February 2015

Objective and Aspirations

- Regional management of services for persons living with serious chronic conditions is a priority for improving lives and also reducing preventable hospitalizations
  - Persons living with serious chronic conditions are restricted to what is available in their homes
  - Regional coordination can allow a reasonable number of “people around the table” to lead the endeavor
  - Data on performance of the service delivery system for a geographic region gives the coordinating body a very different perspective, a focus on patients rather than data on particular providers

Background and Overview of Key Strategies

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Year 2 Focus: 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 and enhancing 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, the mental health system, and community health and service organizations are critical to creating effective and scalable approaches.

Alignment Opportunity: Common Interests for Improving Care

- Accountable Care Organizations, Medical Homes, and Hospitals share a common interest in:
  - **identifying** patients with high needs
  - reducing avoidable utilization through **better community based care**
- Medicare introduced **care management fee** effective 1/1/15 to pay physicians who provide the required services for patients with 2+ chronic conditions.
  - About $500 per year
  - More than $100,000 of revenue for a primary care provider with 200 Medicare patients enrolled, could bring more than $100 million into practices in Maryland
- Integration of care between hospitals and long term and post acute providers and community mental health with somatic health are critical to success

Initial Focus: Medicare

- Two thirds of high needs patients are Medicare (calculated from HSCRC data sets)
  - Patients can benefit coordination and interventions
  - Improvements can generate savings
- New Chronic Care Management fee for Medicare for physician practices
  - Improvement benefits patients
  - Contributes to funding efforts of community based practices
- The same care processes can be used for other populations, but we will need to coordinate with commercial carriers and Medicaid MCOs

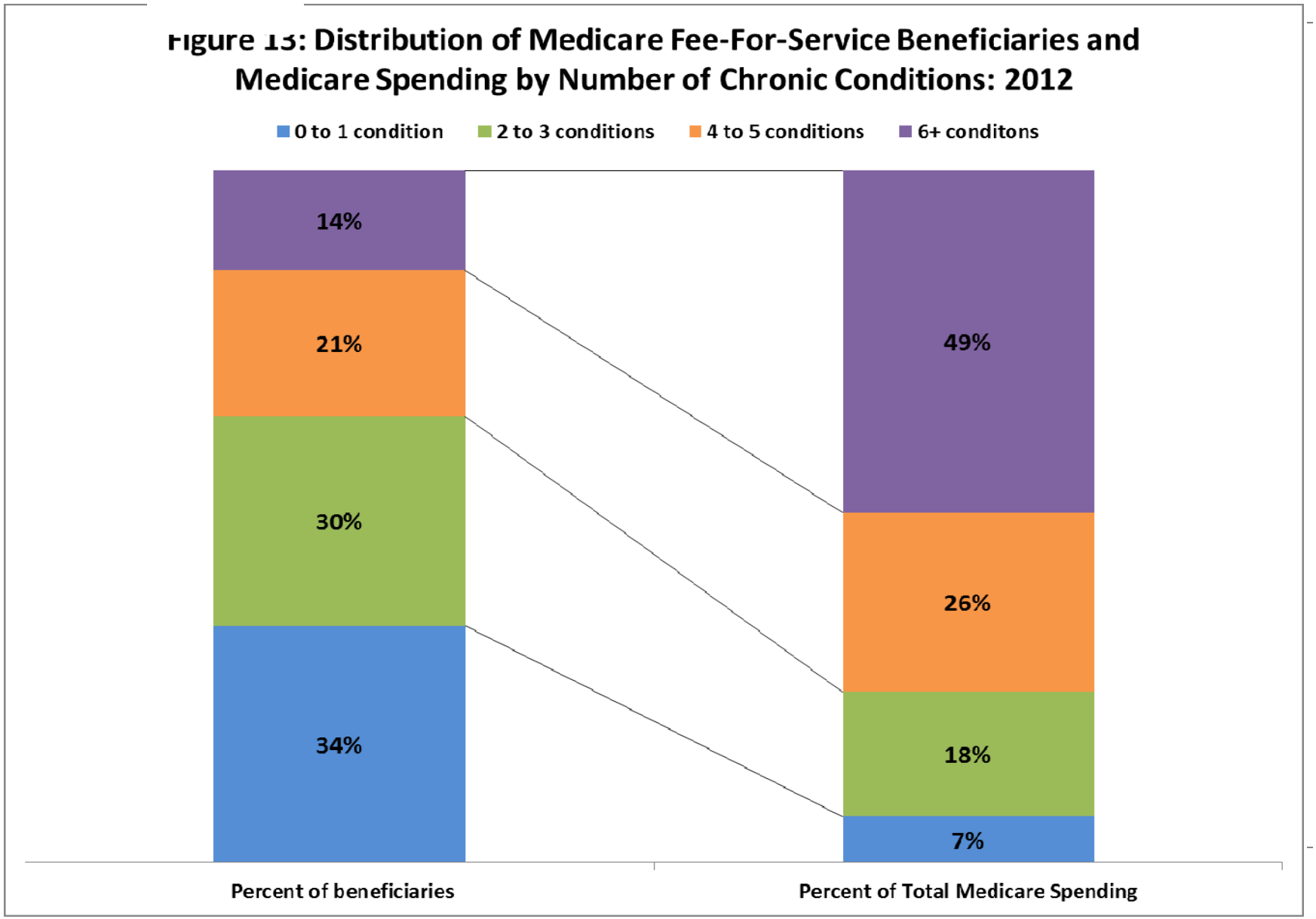
Context: Two-thirds of High Hospital Utilizers Are Medicare or Dual Eligible

- 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

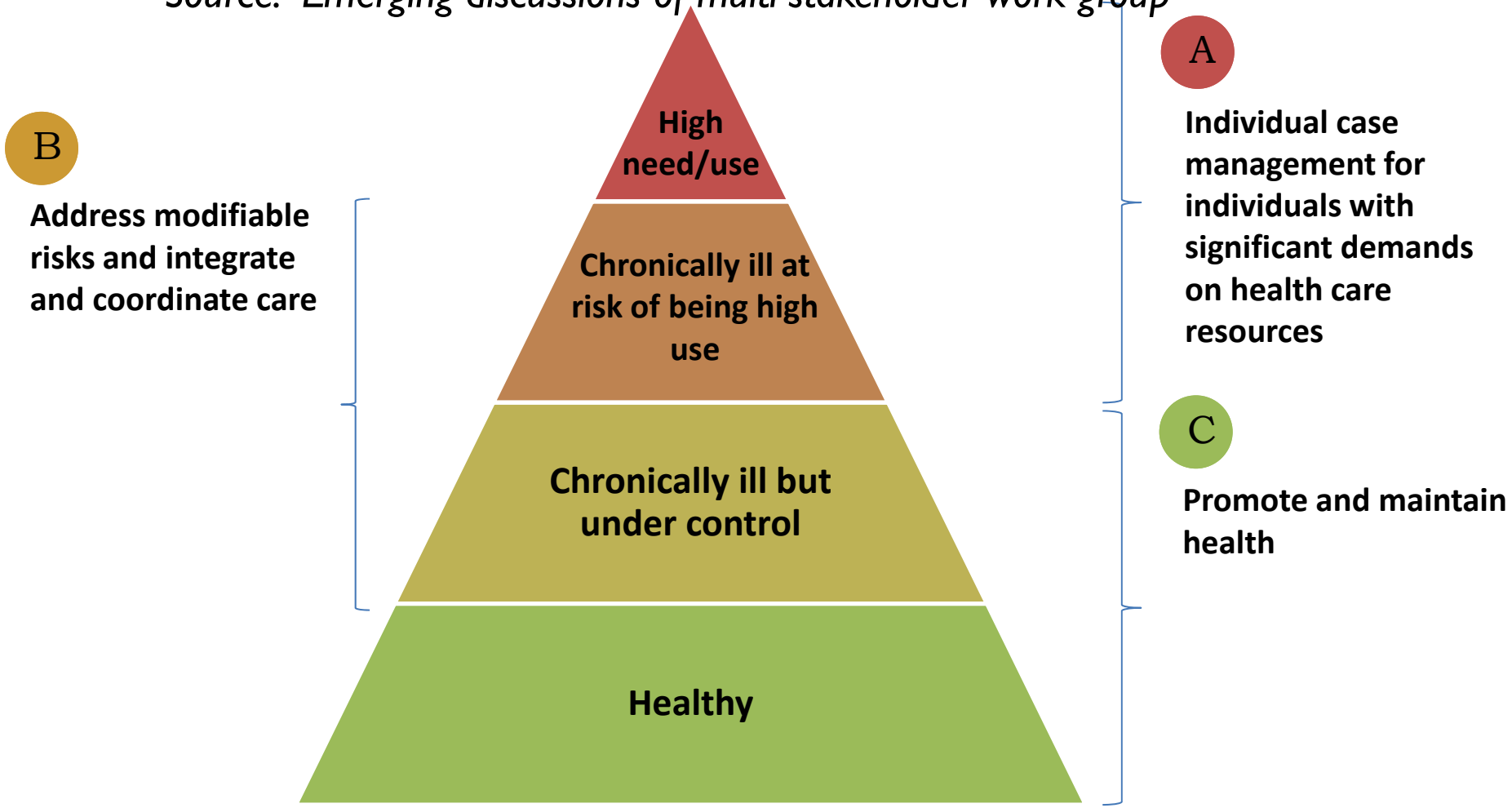
Payer Group	# of Patients	% of Charges	Total Charges	% of Charges
Medicaid, Commercial, Self Pay	**13,731**	**34%**	**$ 1,031,068,643**	**35%**
Medicare	**20,592**	**51%**	**$ 1,419,886,123**	**49%**
Dual Eligible	**6,278**	**15%**	**$ 456,370,192**	**16%**

Context: 14% of Medicare Patients Drive Half of Cost



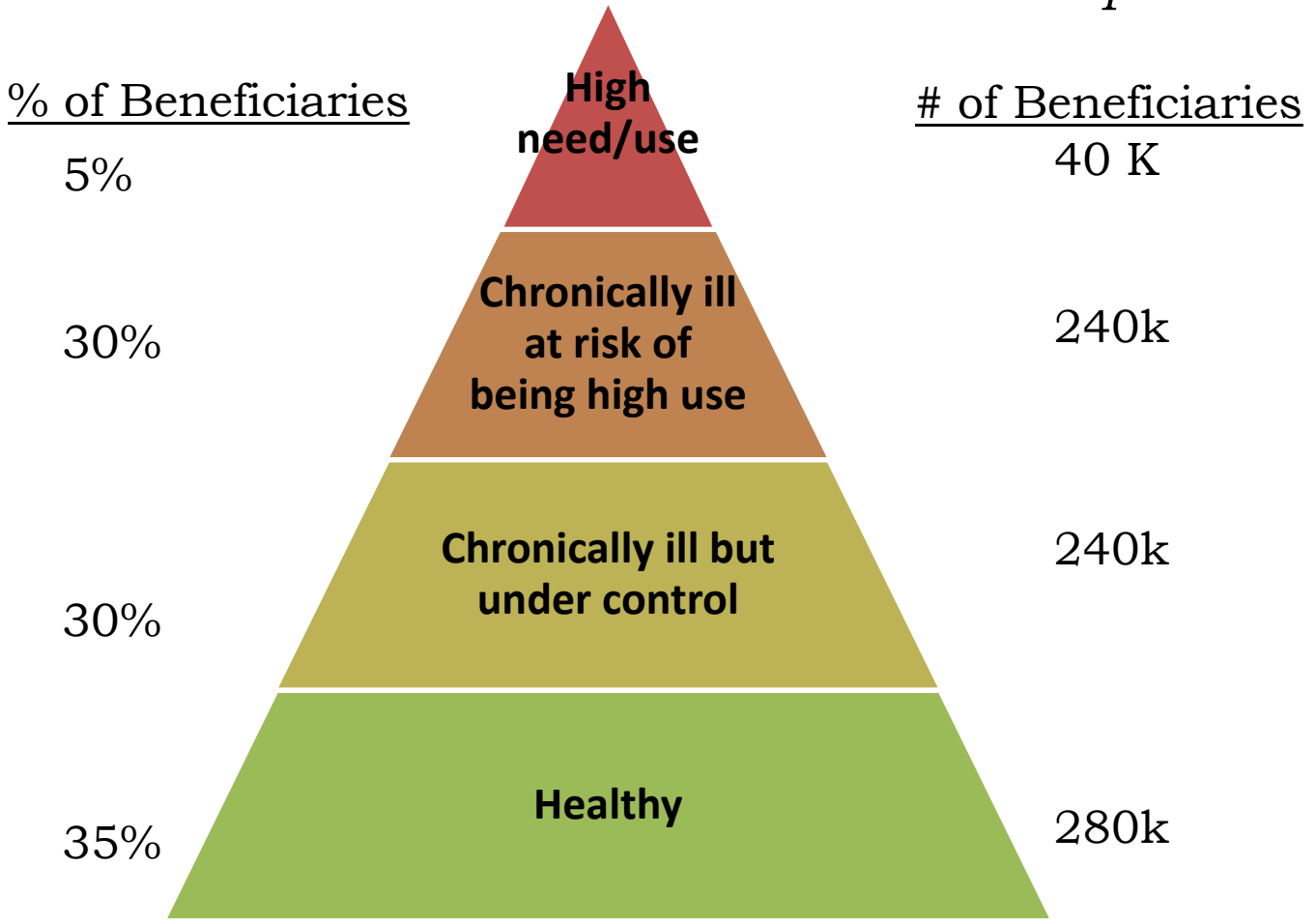
Key Strategies: Target Resources Based on Patient Needs

Source: Emerging discussions of multi-stakeholder work group



Key Strategies: Significant Efforts and Investments Needed to Scale Interventions

Source: Rough estimates of scaling for Medicare in Maryland based on HSCRC data and Medicare Chronic Conditions reports



Key Strategies

- Focus on populations with the greatest opportunity to improve care and achieve return on investments in strategies – those with high need (≅40K)
  - Identify patients at high risk for poor outcomes and avoidable utilization using analytic tools and best practices
  - Stratify patients to customize and focus approaches
- For selected higher risk patients (initially focused on 40k)
  - Perform assessments and develop additional stratification
  - Develop individualized care plans
  - Provide individualized community based 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. Focus on chronically ill/at risk (e.g. ≅240K) that are the target of the Medicare Chronic Care Management Fee
- Monitor outcomes

Organizing Efforts—Statewide and Regional Approaches

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Statewide, Regional, and Local Efforts Needed for Scaling

- HSCRC convened a partnership work group chaired by Dr. Laura Herrera Scott (DHMH) and Carmela Coyle, (MHA) to make recommendations on efforts that could accelerate care coordination and improved chronic care
- Deliberations are still in progress, but several themes are emerging.
- DHMH and HSCRC are focused on encouraging regional collaborations that can facilitate the coordination and implementation of efforts in a cost effective way, avoiding duplication and scaling resources and approaches—leading to current RFP

Efforts that Could be Facilitated with Statewide Infrastructure—Under Discussion

- Data infrastructure and sharing
  - Leverage existing data and new sources (Medicare) to support risk stratification and identification of individuals who would benefit from care coordination
- Care planning
  - Develop patient consent process and standard forms and education materials
  - Develop care plan elements that could be visualized through CRISP
  - Organize training, engagement, and activation approaches
- Encourage collaboration
  - Promote regional efforts to organize and avoid overlap of resources
  - Encourage community and volunteer efforts
  - Develop approaches for integrating care (mental and somatic, hospital and long term/post acute
- Connecting community based providers to CRISP
  - Need to set direction, determine funding sources, and begin work

Regional Efforts

- Develop priorities and approaches on a regional basis or with regional coordination to support high needs patients, with a focus on Medicare and dual eligible patients
  - E.g. frail elders, ESRD, patients in long term care, patients with serious mental conditions, patients with advanced chronic conditions
- Determine staffing and infrastructure needs and approaches and develop organization plans and how to integrate efforts across providers, public health, and community organizations
- Develop coordinated approaches to support practices in addressing the Medicare Chronic Care Management fee requirements

Final Recommendations

- Final recommendations will be provided from the Care Coordination and Infrastructure Work Group.
- These will outline resources and approaches that will be addressed on a statewide basis.
- We expect these recommendations to be available before the regional collaboratives embark on the planning activities outlined in the RFP.

Regional Partnerships Funding Opportunity

Overview

- Anticipate 5 awards of about $400,000 each
- Funds are to be used for partnership planning activities
  - Funds may be used for data analysis, operational/strategic planning, health IT/analytics planning, consultants, meetings, and related expenses.
- Funding to be allocated via hospital rates
  - Application should be submitted by a hospital in consultation with partner organizations
- Technical assistance will be provided to awardees
  - Utilization data, models, expert advice/consultation

Application Process

- Timeline
  - Application deadline: April 15, 2015
  - Anticipated award announcement: May 1, 2015
- Submission
  - Email applications to dhmh.pophealth@maryland.gov
- Application Review
  - Multi-stakeholder panel will review applications and make decisions in consultation with HSCRC and DHMH

Application Requirements

- Scope and Need (1-3 pages)
  - Define the target geography (ZIP codes, counties, etc.)
  - Narrative and data on health needs/conditions to be addressed
- Model Concept (3-5 pages)
  - Description of proposed delivery/financing model
  - Target patient population
  - Services/interventions that patients would receive
  - Role of each participating partner
  - Infrastructure and workforce requirements
  - How the concept will advance goals and help meet requirements of the All-Payer Model.

Application Requirements

- Population Health Strategy (2-3 pages)
  - Plan for improving overall population health in the region – not just in the target patient population
  - Incorporate/build upon existing Community Health Needs Assessments and action plans from Local Health Improvement Coalitions and other entities
- Potential for Sustainability (3-5 pages)
  - Proposed financing mechanism(s) to sustain model
  - Partners should demonstrate commitment to sharing resources and addressing alignment of payment models

Application Requirements

- Process and List of Partners (1-3 pages)
  - Describe proposed planning process
    - Number of meetings to be held
    - Analytic work needed for planning activities
    - Decision-making process on model design/financing
    - Role of any consultants that may be used
  - List of participating partners
- Budget Narrative (3-5 pages)
  - Line item budget with anticipated expenses
  - Brief narrative explaining/justifying the expenses

Funding Guidelines

- Successful proposals will:
  - support the purpose of All Payer Model of hospital payment, which is achievement of the three-part aim: improved outcomes, lower costs, and enhanced patient experience;
  - be scalable as the partnerships demonstrate success;
  - support coordinated action in areas where uncoordinated action could lead to additional cost and confusion;
  - have the support of the LHIC(s) in the region; and
  - help to align other parts of the health care system with the goals of the All-Payer Model.

Funding Priorities

- Comprehensive set of partners with standing in region
  - At least one hospital and their affiliated providers, independent ambulatory practitioners, and home care and facility-based providers
  - Also include behavioral health, aging services, health departments, local government, community organizations, etc.
- Multiple high-cost conditions with initial focus on Medicare
  - Priority will be given to proposals with larger scale that address multiple high-cost conditions
  - Initial efforts should focus on Medicare and/or dual eligibles
  - Scalable to include Medicaid and private payers

Funding Priorities

- Integrates primary care, prevention, and addresses multiple determinants of health.
  - Long term sustainability depends addressing multiple determinants of health
  - Integration with primary care and interoperable care plans
  - Interventions to address patients' non-medical needs
- Sustainability concept that builds on the All Payer Model and other delivery/financing models
  - Should build on the All Payer Model, ACOs, etc.
  - Reinvestment of hospital savings generated in the short-term
  - Other examples include pay for performance, physician gain-sharing, shared savings, and regional health trusts.

Awardee Deliverables

- Interim Report (Due Sept 1, 2015)
  - Description of planning process and decisions made to date
- Regional Transformation Plan (Due Dec 1, 2015)
  - Detailed description of delivery/financing model, infrastructure and staffing/workforce needs, and target outcomes.
- More specific guidelines on deliverables will be released in May 2015.
- It should be anticipated that the partnership will be accountable for implementation of its Regional Transformation Plan.

Questions

- FAQ will be available on HSCRC website

- Questions may be submitted to: dhmh.pophealth@maryland.gov

A Journey Together

Thank you for the opportunity to work together to improve care for Marylanders.