Planning for Population Health Transformation

Developing a Primary Care Model for Maryland

Presentation to Medicaid Advisory Committee

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BY: Public Health Services, DHMH

Office of Population Health Improvement

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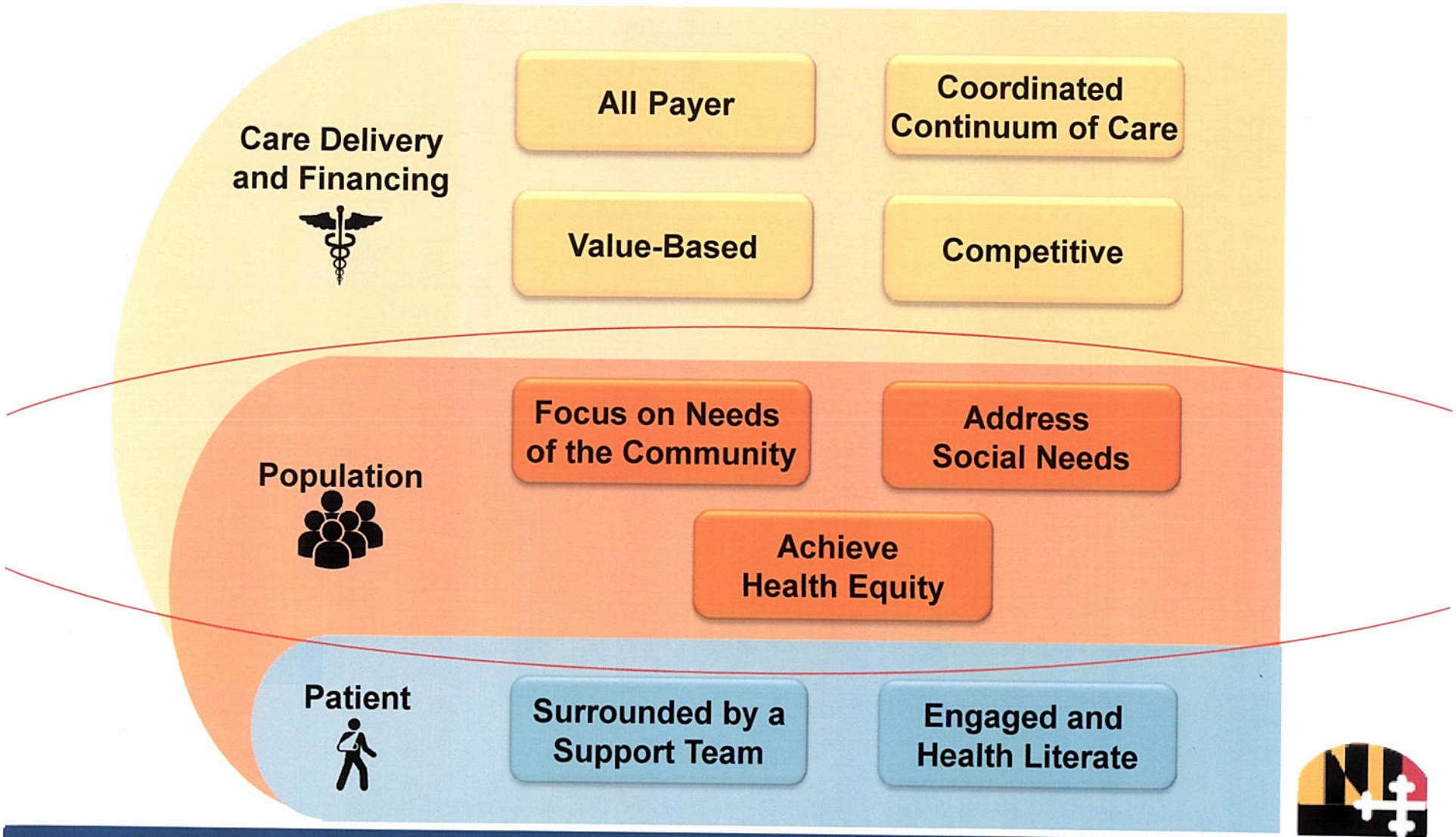
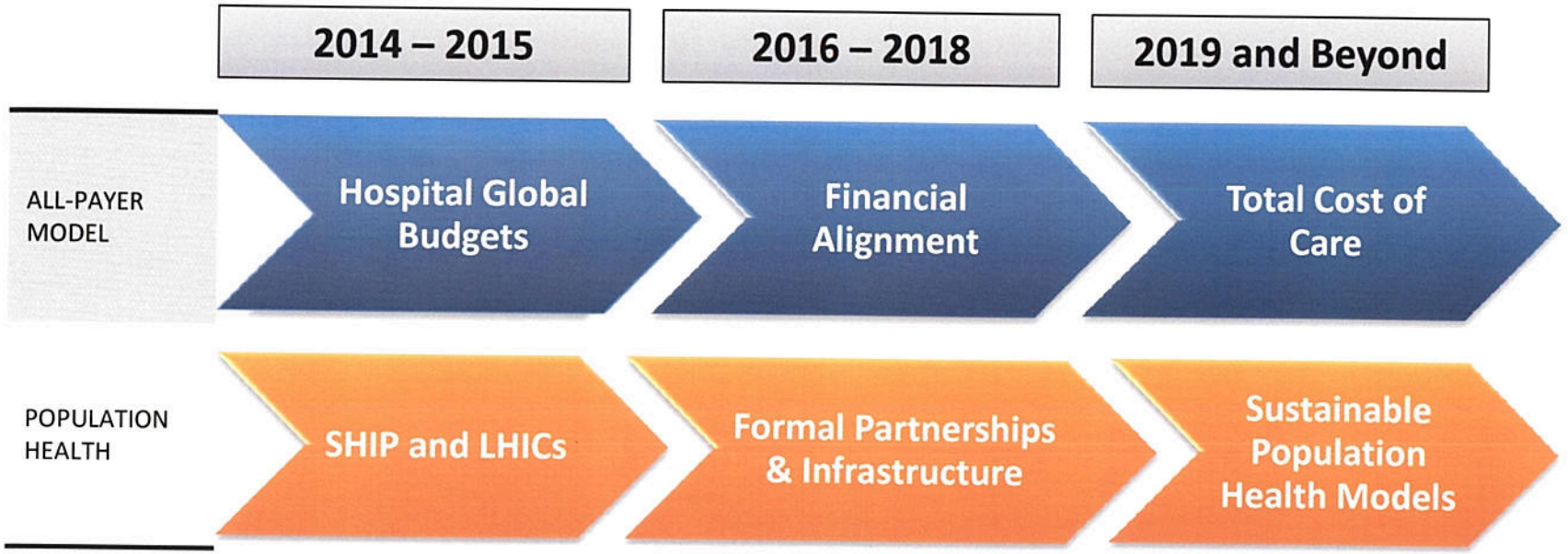
VISION FOR MARYLAND HEALTH SYSTEM



Priorities for Public Health

- Near-term focus:
  - Bolster All Payer Model including population health management initiatives
  - Develop a Customized State Primary Care Model for CMMI submission 12/31/16
- Longer-term effort:
  - State Population Health Improvement Plan for CMMI submission 12/31/16
    - How do we improve health outcomes and health equity for all Marylanders?
    - How do we make sustainable investments in health improvement that reinforces the All Payer Model goals?
    - How can we catalyze this work today, knowing this is a long-term effort?

TRANSFORMATION PROGRESSION



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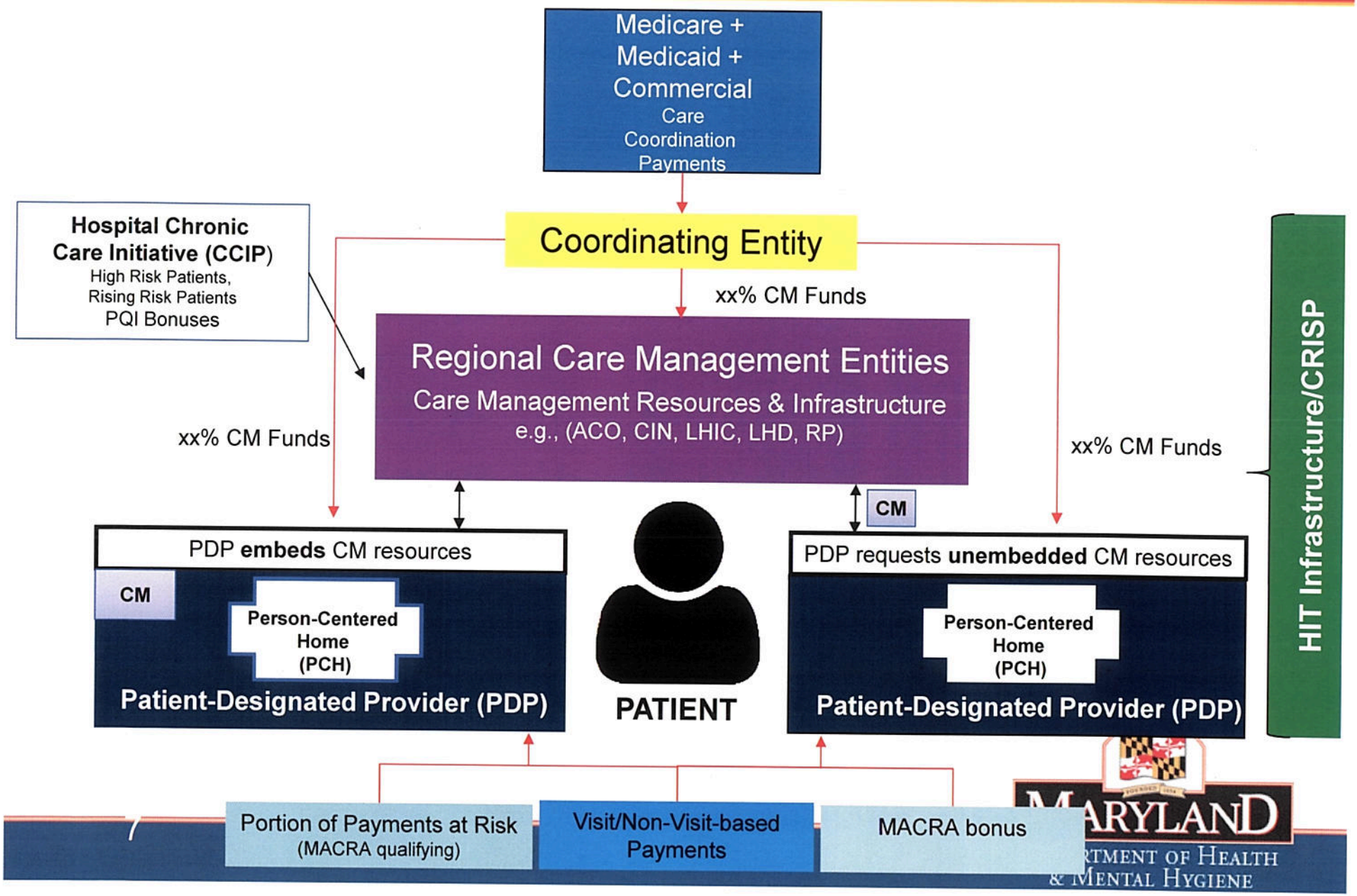
PRIMARY CARE MODEL

Guiding Principles

- Broad-based provider participation design- Patient Designated Provider
- Person and Family Centered base of care
- Bringing Primary Care into alignment with hospital incentives supports the Phase 2 Progression Plan
- Enhanced population health management functions
- All-payer capable in alignment with Phase 2 of waiver
- Care Management as a necessary element
- Regional Care Coordination Resources
- Aligned and consistent set of quality/outcome metrics
- Efficient data exchange and robust, connected tools for providers
- Financial and non-financial incentives to encourage practice transformation
- Quality and cost transparency for providers and patients

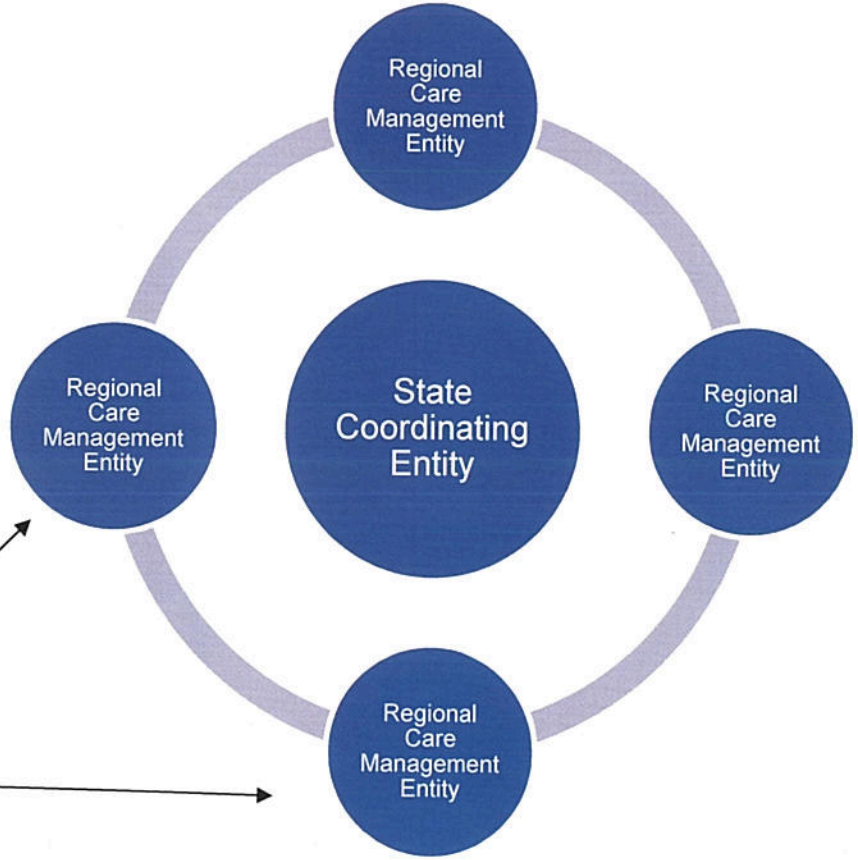
Maryland Primary Care Model



Key Elements of the Model

- **Primary Care Home/ Patient-designated Provider** –
  - The most appropriate provider to manage the care of each patient, provides preventive services, coordinates care across the care continuum, and ensures enhanced access.
  - Practice – means an individual provider or group of providers that deliver care as a team to a panel of patients. Practices may span multiple physical sites in the community
- Coordinating Entity- State sponsored, advisory board managed entity for accounting and program analytics
- **Incenting Value-based Care**
  - Payers
    - CM Funding
    - Funding for Quality and Utilization Improvement
    - Upfront non-Visit based payments- facilitates alternative care delivery
  - Hospitals - chronic Care bonus pool alignment with community
- **Regional Care Management** – Organization that coordinates and provides resources for care management within a region- leveraging existing resources such as ACOs, CINs, LHICs and other regional healthcare programs
- **Population Health Management/HIT** – key data exchanged to all care participants through CRISP, using tools and analytics for risk stratification, improved care, and efficient connection to other services

Overview of Care Management Infrastructure



Care Management Providers
(contract with Regional CME)

Examples include:

- **Regional Partnerships**
- **Health Systems/Hospitals**
- **ACOs**
- **Health Plans**
- **Local Heath Departments**
- **Pharmacy entities**
- **Others**

Process/Next Steps

- Modeling potential participation from provider universe in Maryland including Duals community
- Defining Care Management infrastructure and roles
- Defining Coordinating Entity infrastructure and roles
- Ensuring continuity of PCHH requirements
- Develop Concept Paper by December 31, 2016

Questions for You

- Where do you see opportunities to improve the Model?

- What are your concerns around delivery model alignment?

Additional Comments:

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