Project Narrative

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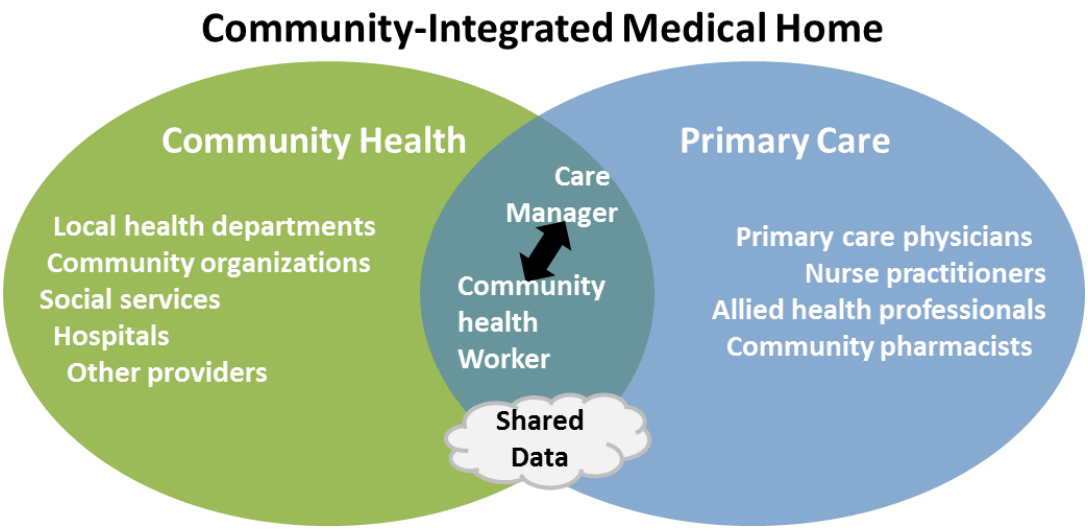
1. Overview

The state of Maryland envisions a transformed health system that integrates patient-centered primary care with innovative community health initiatives. The four pillars of this vision are (1) primary care, (2) community health, (3) strategic use of data, and (4) workforce development.

With this award, we will design a statewide, multi-payer Community Integrated Medical Home program. Through this program, primary care providers will lead a team of health professionals focused on coordinating personalized care that meets the complex needs of patients. Community Integrated Medical Homes will engage with enhanced local health improvement coalitions, which will offer complementary supports to high-risk patients, be able to identify and respond to hot spots of health needs, and monitor community and population health.

Figure 1: Conceptual Model



Research suggests that integration of community-based services may be a determining factor in whether or not a PCMH model results in cost savings. If patients do not have additional tools and resources from the community to manage their health, they may not improve and may

repeatedly require care in an acute setting. The solution is to both strengthen primary care and invest in community health coalitions, building on efforts already underway in our state.

One such effort is the Health Enterprise Zone program, which will target resources to areas that experience unacceptable health disparities, based on a plan developed by a community coalition. We anticipate that our Model Testing proposal will seek to expand the Health Enterprise Zone program and apply lessons learned to statewide initiatives.

The strategic use of data will improve health outcomes and lower health costs. We propose to develop advanced mapping capacity, upgrade our All-Payer Claims Database and enhance community health data resources. An enhanced community health workforce will be essential to our success. Our model will seek to develop opportunities for a wide range of community health staff, who will serve on the front lines of care provision, coordination, and integration.

Several ongoing initiatives and policy levers position Maryland to successfully integrate patient-centered primary care with community health. The state currently has several CMS waivers, two large PCMH initiatives, four Accountable Care Organizations (ACOs), a State Health Improvement Process and local health improvement coalitions, which consist of diverse stakeholders and serve as a baseline community health infrastructure. We have a nation-leading statewide health information exchange, which now includes data from all admitting hospitals. We have centered our public health strategy around key outcome measures, with 18 active local coalitions across the state. In addition, we have in development a health insurance exchange the Health Enterprise Zones program to address health disparities, and initial improvements to our All-Payer Claims Database. Together, these existing resources and policies provide a strong foundation for this new and integrated initiative.

2. Model Design Strategy

2.1 The Vision for a Community Integrated Medical Home

The centerpiece of our innovation plan will be a new statewide Community Integrated Medical Home (CIMH). The CIMH program will move away from a medical model for improving health to a personalized, team-based approach in the primary care practice that is integrated with an enhanced community health infrastructure. This infrastructure will include enhanced capacities for local health improvement coalitions and local health departments, and robust data infrastructure of health care utilization data and population health indicators to facilitate local health planning and bringing new patients into CIMHs.

To successfully implement the CIMH, a comprehensive plan will be developed through an inclusive approach. The strategy to develop a plan will engage both payers and providers and local health improvement coalitions. Through these processes, the details of the operation of the CIMH and the enhancement and integration of community health will be defined. In addition, we will establish a governance structure for CIMH, criteria for participation, a public utility to conduct analytics, and programmatic standards, including quality assessment and shared savings methods. Developing a plan ready for implementation will also require modeling of health care costs to estimate cost savings from CIMH plans, expansion of current data resources, development of prototype tools, and planning for the scaling-up of current workforce development initiatives. At the end of the Model Design funding period, we will hold a summit of all stakeholders to present findings, finalize programmatic and policy decisions, and develop recommendations that will form the state innovation plan in anticipation of a Model Testing grant submission in spring 2013.

2.2 Engagement of Payers and Providers

Multiple private and public payers, as well as the associations for primary care physicians and hospitals, have committed to participating in designing the structure and operation of the CIMH. The Maryland Health Care Commission (MHCC) currently has statutory authority to recognize single carrier PCMH programs and operate a statewide multi-payer PCMH program. During the Model Design period, the Department of Health and Mental Hygiene (DHMH) will work with MHCC to engage payers, including Medicaid, Medicare, CareFirst Blue Cross and Blue Shield, United Healthcare, and other payers as interested to establish a governance structure for the CIMH and set programmatic standards.

2.2.1 Establishing a Governance Structure. This governance structure will make programmatic decisions about the operation of the CIMH program. For each decision, we anticipate conducting a review of current procedures in existing initiatives, reviewing best practices, and considering practical issues. Our goal is to establish a clear set of minimum standards, with room for innovation and flexibility where appropriate.

2.2.2 Establishing a Public Utility. We envision creating a new public utility that will help streamline analytical work and other administrative activities of the CIMH program. This public utility may be housed in DHMH, MHCC, or be created as a new entity; the governing body will help develop plans for its creation.

2.2.3 Setting Programmatic Standards. The following are a selection of programmatic standards to be considered by the governing body. Standards to be established include, but are not limited to (a) practice inclusion, (b) analytics, (c) quality assessment, and (d) shared savings.

(a) Practice Inclusion. The CIMH governing body will develop criteria for admission of practices and carriers/ACOs into the proposed CIMH program. Minimum criteria are expected to include NCQA recognition or other recognition models, functional use of HIT (to be specified), and reporting of quality measures.

(b) Analytics. The public utility should be able to accept and process claims and quality data, reconcile commercial and public plan participation, create reports, and support evaluation program efforts. One key component to the success of a multi-payer program from a provider's perspective is the establishment of unified reporting on patient care, disease management and health education activity. Providers need consistent, actionable data in order to most fully implement a CIMH. These key decisions will be made by the CIMH governance structure. Establishment of a public utility to carry out this analytical work is facilitated by Maryland's own progress in developing an All-Payer Claims Database, which already plays an analytic role in the state's existing PCMH pilot. The progress is discussed in detail in *Section 2.4.1*.

(c) Shared Savings. The CIMH governance structure will establish standards for patient attribution, risk adjustment, patient selection, and other processes that are required for shared savings calculations. Within this framework, payers may elect to administer the shared savings themselves or they may elect to utilize a public utility for administration. To instill confidence in the process, payers that calculate shared savings directly will agree to document results and to submit their results for review. The availability of data in the APCD will provide a method of verifying results when questions arise. This balanced approach will assure that incentives all point in the same direction, while preserving innovation in payment,

(d) Quality Assessment. Meeting quality standards will be a requirement for receipt of shared savings. Having a set of core quality metrics will result in consistent expectations and quality improvement activities across participating medical homes. To establish core quality metrics, the CIMH governance structure will review data options, survey the quality metrics used by existing programs and other states, and identify sources of data through EHRs, registries, or claims data. The governing body will also establish standards for improvement targets, reporting intervals, and other assessment practices.

2.2.4 Modeling of Health Care Costs. Maryland plans on contracting with the Hilltop Institute, part of the University of Maryland at Baltimore County, and an outside actuarial firm, to engage in projecting health care cost trends and savings as part of CIMH. DHMH has had a relationship with the Hilltop Institute since 1994. Hilltop assists the Department in developing the payment rates for HealthChoice, its Medicaid managed care program. Maryland will leverage Hilltop's expertise to develop the baseline dataset to track health care costs. An outside actuarial firm will review the baseline dataset and assist in developing trends, projected savings, and estimated returns on investment. Both Hilltop and the outside actuarial firm will work with Maryland throughout the Model Design process. This collaborative effort supports the input to the reform efforts by all participants and facilitates a greater understanding of the impact of such initiatives on health care rates and utilization across all payers.

2.3 Engagement of Local Health Improvement Coalitions

Across Maryland, 18 local health improvement coalitions are mobilized to create local plans for health improvement to meet State Health Improvement Plan (SHIP) targets. These coalitions

include public health, community health, hospital, behavioral health and social service leadership. These coalitions are implementing local action plans, which align public health, hospital, community partner, and state initiatives to reach defined health targets and address health disparities.

This CIMH model will require strong, local foundation in community health to provide wrap-around services and resources to complement medical care, recognizing the limitations of a medical model for improving health status. We aim to enhance the capacity of the local health departments and these coalitions to coordinate with the medical system, provide access to important health resources, steer high-cost patients into the most appropriate channels, and track overall population health goals and progress.

2.3.1 Enhancing Coalition Capacity. We will build on the infrastructure and capacities of the 18 existing coalitions to assure the quality of local health systems in meeting community population health goals. The stakeholder engagement process will be used to develop new avenues and models to enhance the capacity and resources of these coalitions. Coalitions will then select an approach that works best in their community. For example, tone coalition might choose to become a 501(c)3 organizations with the ability to fundraise, hire staff such as community health workers, benefit from tax incentives, and be led by a Board of Directors representing organizations that are part of the coalition. Another coalition might choose integration with the local health department, which would provide dedicated staffing for the coalition.

2.3.2 Defining the Community Health Worker Role. As part of the enhanced capacity of local health improvement coalitions, we envision a strong role for community health workers. CHWs will be able to assess patient needs and link them to the most appropriate social care, such as home

visitation, social service programs, recreation, and disease self-management programs. The social care coordination provided by the CHW will complement – not replace – the medical care coordination activities by care managers working within medical homes. CHWs will have access to new data sources and mapping technologies to locate at-risk individuals through "hot-spotting." These maps, the development of which is described later in this proposal, will show pockets of patients with particular health problems and patients that are over-utilizing emergency departments or other low-value care. PCPs may also refer patients needing social care and community-based services directly to a CHW. As part of the engagement process, standards for education background, training, evaluation of CHWs will be set.

2.4 Enhancing Maryland's Data Infrastructure

Robust data platforms and applications are being developed in Maryland that will help drive the integration of primary care and community health, and these systems will be integrated into the CIMH. An enhanced data infrastructure can provide tools to track health status at individual, practice, community, and population levels in a way that has not previously been possible. Model Design funding would be used to develop prototype applications from these data platforms. In the stakeholder engagement process, prototypes will be presented, reviewed by stakeholders, and refined to best meet their needs. As a result, the data applications will be of maximum utility once developed as part of an innovation plan.

2.4.1 All-Payer Claims Database. The All-Payer Claims Database (APCD) was developed by MHCC to support analysis of health care spending and utilization of services. This database already plays an important role in the current PCMH pilot, as it is one of a very limited number of public

data systems that already used to calculate shared savings. Recent CMS decisions to speed the release of Medicare data will facilitate the more timely access of Medicare claims data that can used for care management and for comparisons of providers based on quality and costs. These data will enable Maryland to integrate information on Medicare beneficiaries into the database and, by extension, the public utility.

The Center for Consumer Information and Insurance Oversight (CCIIO) recently awarded Maryland a Level 2 Establishment grant. Maryland will use a small portion of Level 2 funding to develop a unique patient identifier in the APCD to establish a common, consistent way to identify patients across all submitters and allow for the inclusion of Medicaid claims data. The unique patient identifier will be developed using the master patient index methodology used in Maryland's Health Information Exchange. This unique collaborative will enable Maryland to exploit complementary technologies that will lead to an efficient data utility.

Model Design funding will be used to assess current capabilities and limitations in Maryland's APCD for supporting provider measurement on cost and quality. Use of an APCD for provider measurement requires reliable and consistent data submission and sophisticated analytics to ensure that legitimate differences in provider cost and quality are reflected in measurement tools. We will also pursue enhancements of the APCD that may allow tools for clinical decision-making. Stakeholders will provide input into measurement procedures, as well as reports and other tools available as part of CIMH.

2.4.2 Maryland Health Information Exchange. Maryland has been planning and developing its statewide health information exchange (HIE) since 2007, becoming one of the earliest and most

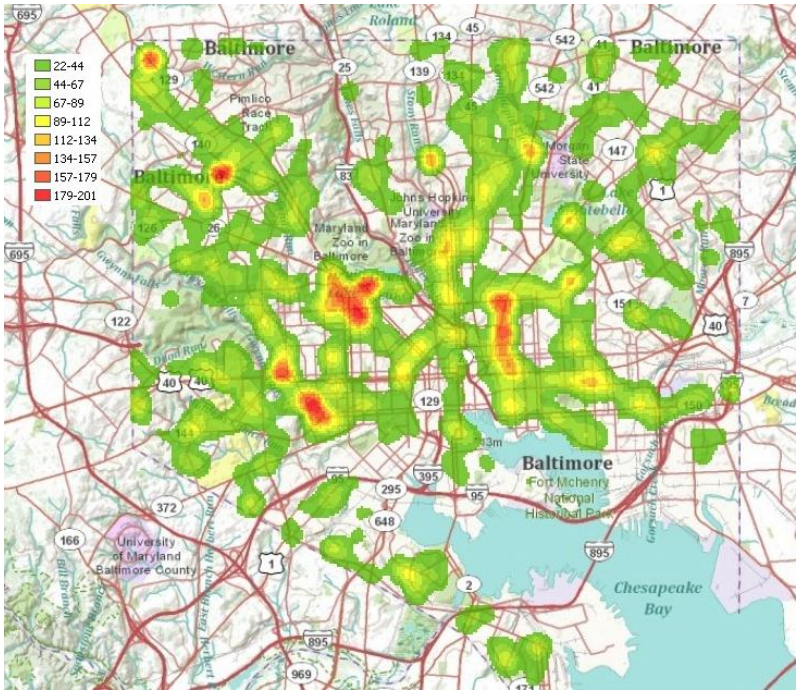
successful states to implement a query-based HIE infrastructure and establish broad based connectivity and clinical data flows. The Chesapeake Regional Information System for Our Patients (CRISP), a private not-for profit designated to run the HIE, has deployed a statewide master patient index (MPI) currently housing roughly 4 million unique identities. In January 2010, Maryland became the first state in the country to enable connectivity and live data exchange with all of its acute care hospitals. CRISP currently receives real-time patient demographic data feeds from all 46 hospitals in the state, and over 90 clinical data feeds from hospitals, other large radiology centers and laboratories, and long-term care centers. The CRISP query portal is currently being used in 19 hospitals with plans to expand to all hospitals rapidly. The data feeds offer an opportunity to create rich applications that would benefit CIMH providers and community health entities.

The CRISP Encounter Reporting System (ERS) proof-of-concept that is currently deployed relies on basic data to create powerful insights. As CRISP receives real-time HL7 Admission-Discharge-Transfer (ADT) messages from all hospitals, a copy of those raw ADT messages are routed at the time of receipt and stored in the ERS transactional database. From this database, ADT data can be extracted for various time periods and processed to produce consolidated reports showing in-patient encounters, ER encounters, or other utilization data for the entire state.

By expanding the ERS data model to include new data elements and by deploying an enterprise reporting solution, the HIE infrastructure can create net new insights into underlying details of hospital service utilization on a statewide basis. With Model Design funding, the HIE will have the ability to depict a given community's utilization curve (i.e. what percentage of patients are accounting for what percentage of inpatient admissions or ER visits), the ability to generate reports

showing the most prevalent high-utilizer inpatient and ER diagnoses, and the ability to geographically depict utilization and hot spots of high utilization at very granular (such as block-by-block or building-by-building) levels. *Figure 2* presents an early prototype of a hot-spotting map for high in-patient utilization. During the stakeholder engagement process, CRISP will present these capabilities and seek feedback on these tools so that they are refined and ready to be implemented alongside the innovation plan.

Figure 2. Prototype of In-Patient Utilization "Hot-Spotting" in Baltimore City



The Encounter Notification System (ENS) is designed to provide real time notifications for care coordination and quality improvement purposes when patients are admitted, discharged, or transferred to, from or within a hospital. Currently, providers may not know when one of their patients is admitted to a hospital, or alternatively they may find out well after the admission and/or have incomplete data. CRISP can generate a real-time alert to those with care coordination or quality improvement responsibilities for that patient. Funding has been requested through HITECH Medicaid Meaningful Use 90/10 funding to support the development of additional data elements from hospitals. The enhancements that will be pursued if the 90/10 funding is approved by CMS will include the capture of chief complaint, discharge diagnosis, discharge disposition, and race/ethnicity data.

In ENS Version 1.0, notifications are sent to a Direct (i.e. the CMS/ONC defined secure messaging standard) inbox. For most recipients, this inbox is accessed via a secure website and a Direct address credentialed by CRISP. While aligned with the national direction vis-à-vis secure messaging, there is a significant gap in the ability to support mobile communications with providers. To enable the ability to communicate with providers and care coordinators through mobile technology, Model Design funding will be used to enhance ENS service to support communications to mobile devices on multiple applications built on the iOS and Android platforms. As part of the stakeholder process, these applications will be deployed as prototypes, reviewed by providers, and refined by CRISP.

2.4.3 Public Health Data Warehouse. Within the Department of Health and Mental Hygiene, the Virtual Data Unit is aggregating several public health data sources to create a new Public Health Data Warehouse (PHDW), which will have the capacity to provide a range of data to inform individual prevention, care, and treatment choices of providers and patients. At the same time, insights from the data could help shape local health improvement plans, monitor progress and program, plan interventions, and hot-spot areas of high need.

The PHDW will incorporate public health data as well as select health administrative data, population and demographic data, and survey data. This new system will also incorporate existing Medicaid and SCHIP data. Model Design funding would allow DHMH to hire temporary staff to develop prototypes for use by local health improvement coalitions and local health departments. We anticipate a continual improvement process for the prototypes based on ongoing feedback.

2.5 Workforce Development

2.5.1 Primary Care Workforce. Maryland faces a significant shortage of primary care providers. By the year 2020, it is estimated that about 360,000 Maryland residents will be newly insured as a result of the Affordable Care Act. In November 2011, a task force convened by Governor Martin O'Malley released a report entitled "Preparing Maryland's Workforce for Health Reform: Health Care 2020," which outlines the extent of workforce shortages and makes recommendations for meeting future needs. [1]

Some of the recommendations included in the report include additional funding for loan repayment and other incentive programs, changes to educational programs to train allied health workers to practice at the top of license, changes to scope of practice laws, and other initiatives. The stakeholder engagement process will help build support and develop strategies for implementing key recommendations.

2.5.2 CIMH Readiness and Training. The Maryland Learning Collaborative (MLC), housed in the University of Maryland, School of Medicine, was established in March 2011 to support the existing state PCMH pilot. Over the last year, the MLC has engaged in outreach, educated the primary care workforce on practice transformation, and disseminated best practices. The MLC has developed procedures for collaborative learning, embedded care management, practice reorganization with teamwork, leadership development, implementation of EHR, HIT optimization, and HIE adoption. Integration of the existing PCMH with behavioral health and with the state's

[1] Governor's Workforce Investment Board. "Preparing Maryland's Workforce for Health Reform: Health Care 2020." November 2011. Available at www.gwib.maryland.gov/pub/healthreformcare2020.pdf.

public health infrastructure are in progress, but further efforts are needed to have a full. Model Design funding will be used to refine MLC's existing programs to include the CIMH concept.

The level of readiness for CIMH varies across the state of Maryland. MLC will develop partnerships with the existing Area Health Education Centers (AHEC) in eastern Maryland, western Maryland, and the Baltimore region -- areas more prepared than others for practice transformation – to engage and prepare providers to implement the CIMH using its training programs.

In areas of southern Maryland, practices are less ready for transformation. MLC will partner with the Prince George's (PG)-Southern Maryland Educational Program to develop a systematic process in the region to engage and recruit local primary care practices. Through this partnership, MLC will educate the local primary care workforce and practices about core principles of quality measurement and improvement, practice efficiency, access to care, and coordinated health care experience for patients and providers as part of the CIMH.

3. Existing Payment and Service Delivery Models

Existing innovations in health delivery and payment will help facilitate the development and implementation of CIMH. Waivers from the Centers for Medicare and Medicaid Services (CMS) are providing expanded coverage to more individuals and promoting care in community settings. As part of one waiver, Maryland has bundled payment programs for hospitals that incentivize a focus on coordination with primary care and community health. Maryland also has two large PCMH programs, one state-led and one led by CareFirst, the largest private insurance carrier in the state. These PCMH programs will offer lessons learned during the Model Design phase and plans will be developed for their merger with CIMH.

3.1 Existing CMS Waivers

3.1.1 All-Payer Hospital Waiver. Unique among states, Maryland's Health Services Cost Review Commission (HSCRC) administers an all-payer inpatient hospital rate-setting system that includes Medicare, Medicaid, CHIP, and all private payers. This waiver, codified in Social Security Act Section 1814(b), enables Maryland to develop innovative policies and programs to affect health care costs in Maryland. In recent years, HSCRC has developed two large global payment initiatives: Total Patient Revenue (TPR) and Admission/Readmission Revenue (ARR) strategies for hospitals.

TPR establishes a Global Budget for all inpatient and outpatient hospital services for a facility and creates an incentive for participating hospitals to reduce length of stay, ancillary testing, unnecessary admissions and readmissions. Coupled with links to quality metrics and monitoring of service use metrics, it allows participating hospitals to improve efficiency in the provision of services while treating patients in a manner consistent with appropriate, high quality medical care. Ten hospitals are currently participating.

The ARR is a new incentive that bundles payments for the initial admission and any subsequent readmissions within 30 days. The goal is to generate cost savings for those participating hospitals that prevent readmissions. The incentive, available to hospitals not participating in TPR, has resulted in innovative readmission prevention activities across state hospitals as well as multiple community partnerships. Thirty one hospitals are currently participating, and outcomes from the first year are currently being assessed.

The level of participation in these incentive programs shows the commitment of hospitals in Maryland to reducing costs and improving quality. These initiatives allow Maryland's rate system to

align incentives for the triple aim by removing the current financial barriers and construct more coordinated and integrated care. It is for this reason that Maryland's hospitals provided start-up funding for the local health improvement coalitions in 2011.

Maryland and the HSCRC are in the process of developing a new conceptual framework to propose to CMMI to modernize the existing all-payer hospital waiver in a way that complements the all-payer vision articulated in this grant proposal. In the event the modernized hospital waiver is approved by CMMI prior to the conclusion of the Model Design grant period and prior to the submission of Maryland's Model Testing application, the terms and conditions of the new hospital waiver will be incorporated in that Model Testing application.

3.1.2 1115 Waiver: Maryland Health Choice. Maryland Health Choice enrolls most mandatory Medicaid populations into a capitated managed care program to create efficiencies in the Medicaid program and enable the extension of coverage and/or targeted benefits to certain individuals who would otherwise be without health insurance or without access to benefits tailored to specific medical needs. This waiver includes participation by the managed care organizations in the state's PCMH model. In addition, the waiver expands primary care coverage to childless and non-custodial adults with income up to 116 % of the FPL that would otherwise be ineligible for Medicaid coverage.

3.1.3 1915(c) Home and Community Based Services (HCBS) waivers. Maryland operates nine distinct HCBS waivers that serve different targeted populations and provide opportunities for Medicaid beneficiaries to receive long-term services and supports in the community rather than in an institution. These waivers ensures that services follow an individual into community-based

services, organized in collaboration with a case manager/care coordinator, and therefore support a person-centered approach to care in the community that naturally integrates into a community integrated medical home.

3.2 Existing Patient-Centered Medical Home Models

3.2.1 Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP). In 2011, Maryland began a 3-year program administered by the Maryland Health Care Commission (MHCC) to test a patient-centered medical home model of care within 52 primary and multispecialty practices and federally-qualified health centers (FQHCs) located across the state. A law was signed by Governor O'Malley required the five major carriers of fully insured health benefit products (Aetna, CareFirst, CIGNA, Coventry, and United Healthcare) to participate in the MMPP. The state Medicaid program is also a participating payer with a significant caveat; there are no fixed transformation payments to FQHC, although Medicaid does participate in shared savings. In addition, the Federal Employee Health Benefit Plan (FEHBP), the Maryland state employee health benefits plan, TRICARE, and private employers such as Maryland hospital systems have voluntarily elected to offer this program to their employees. The lessons learned from this pilot will be applied to the CIMH model, and all relevant MMPP parties will be involved in the stakeholder engagement process to develop CIMH.

3.2.2 CareFirst Patient-Centered Medical Home. In 2011, CareFirst Blue Cross Blue Shield launched its primary care medical home program. Based on lessons learned in their medical home pilot, the program incentivizes primary care providers to focus on the needs of chronic patients and those at greatest risk for chronic diseases. Incentives are similarly based on a fixed component for

setting and monitoring care plans as well as shared savings based on quality and cost outcomes. The implementation of care plans by nurse case managers that can track patients across settings and time is the key element to CareFirst's initiative. To date, approximately 300 medical care panels with approximately 3,300 primary care providers are participating in the program. In June 2012, CareFirst received a $24 million Health Care Innovation Award from CMS. The grant will serve 25,000 Medicare beneficiaries in Maryland as part of their Patient Centered Medical Home. CareFirst will be participate on the CIMH governing body, and anticipates aligning its medical home initiative into the CIMH program.

4. Other Policy Levers and Programs

There are several key policy levers and programs that will facilitate the successful launch of the community integrated medical home program in Maryland. These include laws passed by the General Assembly to allow for medical homes, Accountable Care Organizations (ACOs), and a multi-stakeholder expert panel to help build support and educate the health care community about the new program.

4.1 Maryland Authorizing PCMH

The first policy lever is state law (Health General 19-1A-03) that authorized the Maryland Health Care Commission (MHCC) to establish, monitor and evaluate PCMH models. The law provided MHCC the authority to implement and regulate the Program, required that prominent carriers participate in a mandatory Program, and exempted Carriers from Anti-trust law to allow carriers to collaborate regarding payment and for providers to collaborate regarding payment (within parameters of "state action" doctrine). New legislation may be needed to create the public

utility, depending on how the entity is organized and established. The legislation would be developed during the stakeholder engagement process.

4.2 Data Sharing

Another policy lever comes from the recent passage of legislation (SB 954) that permits carriers to share data with providers for the purposes of care management beginning in October 2012. This new law will enable carriers and primary care practices to exchange data that will facilitate the development of CIMH. This data sharing is necessary to successful CIMH implementation because data held by carriers will be shared by practices to support care management, quality monitoring, and cost comparisons.

4.3 Accountable Care Organizations

The second policy lever is embodied in the Insurance Article 15.1901-1903, which establishes clinically integrated organizations (CIOs). CIOs are the equivalent under state law of Accountable Care Organizations. Clinically integrated organizations evaluate and improve the practice patterns of the health care providers; and create a high degree of cooperation, collaboration, and mutual interdependence among the health care providers who participate jointly to promote the efficient, medically appropriate delivery of covered medical services. This law permits organizations designated by CMS as ACOs to participate with private carriers under a similar framework. The Insurance Commissioner, in consultation with the Maryland Health Care Commission, adopts regulations specifying the types of payments and incentives that are permissible. This authority permits Maryland to allow the four recently designated ACOs to serve the privately insured population.

During the stakeholder engagement process, we will work with the four existing ACOs in Maryland to align shared principles, shared performance measures, and shared savings where possible. The development of the data infrastructure and the work of the local planning coalitions should be aligned to meet to simultaneously meet the goals of the ACOs and the CIMH program to create an overall system that incentivizes value over volume.

4.4 Health Enterprise Zones

The Maryland General Assembly passed a law in 2012 to establish Health Enterprise Zones (HEZs) in areas with poor health outcomes that reflect unacceptable health disparities. To qualify to become a Zone, a community led coalition must set specific goals on health outcomes, health utilization, and costs and then propose a comprehensive plan and budget to meet these targets. Tools available to community coalitions include grant funding, state income tax credits, Loan Assistance Repayment Program (LARP) payments, and additional tax incentives for hiring staff. Community based organizations that lead HEZs will forge partnerships between hospitals, local health departments, nonprofit organizations, and other stakeholders; and develop creative, collaborative, community-driven plans to improve health outcomes and reduce disparities. Two to four HEZs will be established with pilot state funding in late 2012.

The Health Enterprise Zone program represents an existing, concentrated effort to integrate primary care and community health in Maryland's high need communities. We anticipate our Model Testing proposal will seek to expand Health Enterprise Zones to additional communities. We also expect primary practices and community organizations inside Health Enterprise Zones to

provide leadership in the development of the statewide community integrated medical home approach. Key staff and community leaders will participate in the Model Design process.

5. Alignment with State Health Improvement Goals

5.1 State Health Improvement Process

Maryland's Statewide Health Improvement Process (SHIP), launched in September 2011, is a new approach to population health improvement and systems alignment. SHIP provides a framework for continual progress toward a healthier Maryland, focusing on accountability and local community action. Each one of 18 local health improvement coalitions is responsible for meeting targets for Maryland's health in 2014 based on current health measures.

5.1.1 2014 Health Targets. Through a multi-stakeholder process, 39 specific health objectives in six focus areas were identified, including 28 objectives that have been identified as critical health disparities measures. The 6 focus areas are (1) healthy babies, (2) healthy social environments, (3) safe physical environments, (4) infectious disease, (5) chronic disease, and (6) health care access. A full listing of the measures and the 2014 improvement targets can be found at http://dhmh.maryland.gov/ship/SitePages/measures.aspx. These measures are linked to national rankings and Healthy People 2020.

5.2 Linkage to CIMH

The CIMH program will help local communities to meet these health outcome targets. As discussed above, we envision developing data tools to allow local health improvement coalitions and local health departments to continually monitor these targets and identify geographic areas of

high need. The Model Design funding will be used to build prototypes of such tools and refine them with input from community partners.

6. Stakeholders

Two major private payers and Medicaid have already been significantly engaged in the formation of this Model Design proposal and are committed to participation in the process to develop an innovation plan. Local health departments and coalitions across the state expressed enthusiasm for seeing enhanced roles and integration with the medical system. They see this project as pivotal to meeting their 2014 state health improvement goals.

We also have commitments from the physicians association and hospitals to participate. Physicians have expressed readiness to integrate public health into their practices. Due to our bundled payment programs, hospitals have a major stake in developing further integration with primary care and community health, as well as other providers such as nursing homes, home health agencies, and hospice. A list of committed stakeholder partners is presented in *Table 1*.

Table 1: Committed Stakeholder Partners

Payers	CareFirst Blue Cross Blue Shield UnitedHealthcare Medicaid Medicare (via CareFirst)
Providers	Maryland State Medical Society (MedChi) and its members Hospitals across the state through local coalitions Other providers (i.e., behavioral health, nursing homes) through the local coalitions
Government entities	Local health departments and improvement coalitions Maryland Health Care Commission (MHCC) Health Services Cost Review Commission (HSCRC) University of Maryland School of Medicine Members of the Maryland General Assembly
Non-profit organizations	Chesapeake Regional Information System for Our Patients (CRISP) Community organizations though the local health improvement coalitions

7. Project Organization

The project will be directed by the Chief Medical Officer in the Office of the Secretary of the Department of Health and Mental Hygiene. A consultant will be hired for ongoing project management and facilitation of the stakeholder engagement processes and the all-stakeholder summit. They will be asked to develop the innovation plan based on the output of the stakeholder engagement process. *Figure 3* presents an organizational chart for the project. All aspects of the project will come together in planning meetings, the spring summit, and the innovation plan that will be the basis for the Model Testing Award.

Figure 3: Project Organization Chart