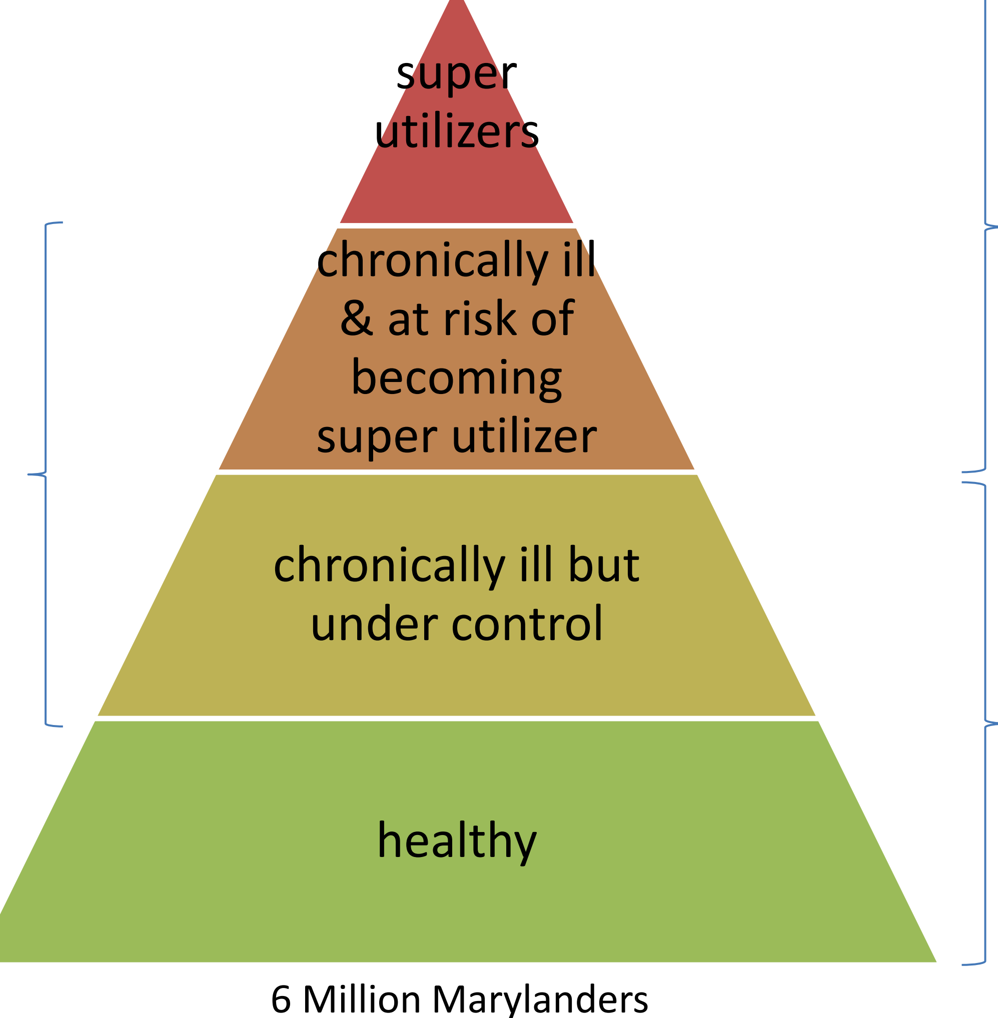
Maryland’s SIM State Health Innovation Plan

Version 1.0

Population Health Improvement at All Levels of Health Need

A

Secondary Prevention and Effective Care Coordination – Aim for 80% PCP participation in medical home (currently at 50%)--including a new state-certified PCMH--to cover 80% of Marylanders. Enhanced community-based preventive interventions in collaboration with PCMH



6 Million Marylanders

B

"Hot Spotting" – Deploying effective complementary community-based supports that "wrap around" the primary care medical home; patient assessment determines range of services offered

C

Promoting and Maintaining Health through the Built Environment, Structured Choice & Effective Primary Prevention – Aim for 80% uptake of USPSTF grade A/B preventive services. Make the healthy choice the easy choice by creating defaults through effective town planning and other behavioral economic approaches.

Community-Integrated Medical Home

Community Health

Local Health Departments
Community Organizations
Social Services
Hospitals
Other providers

Care Manager

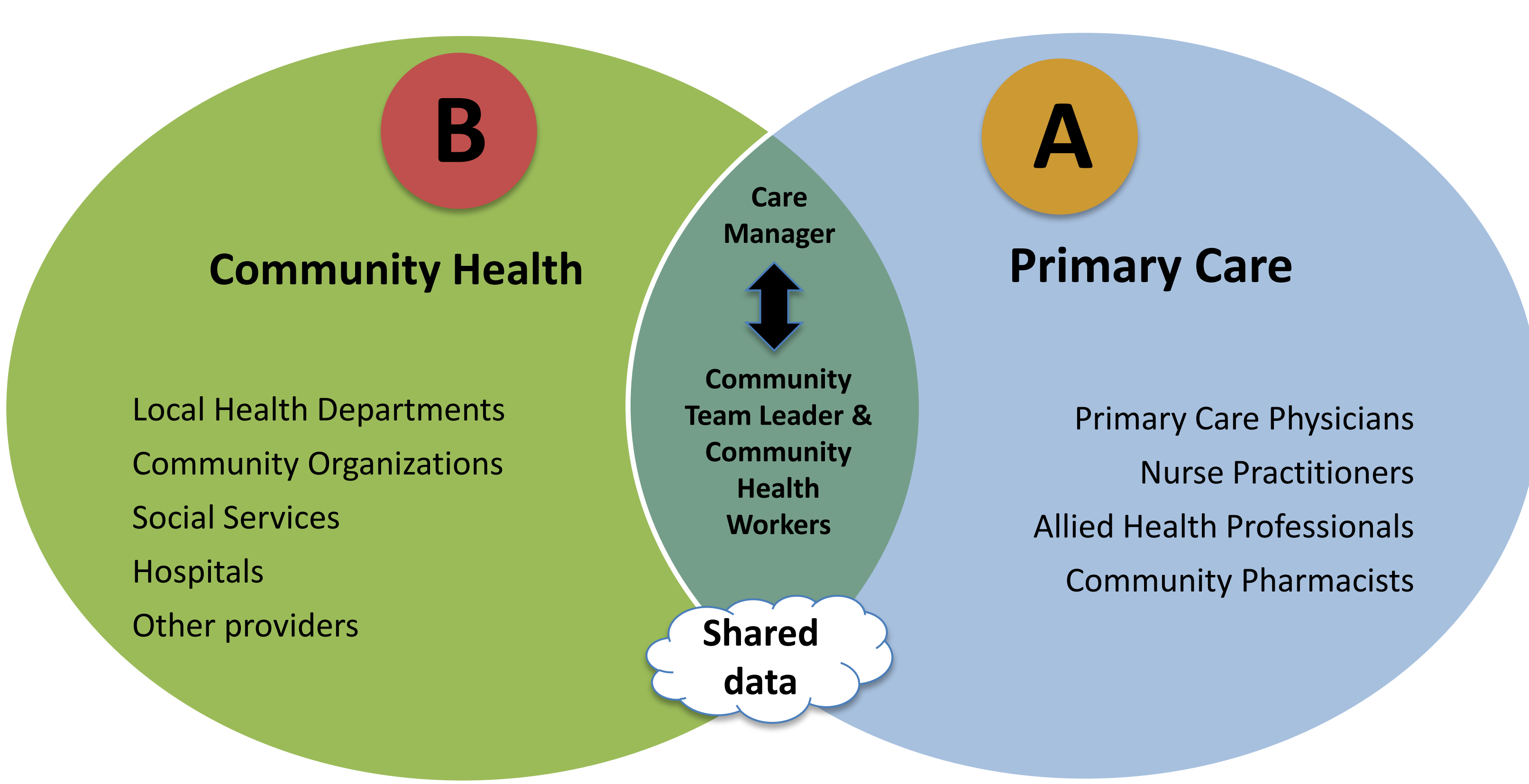
Community Team Leader & Community Health Workers

Shared data

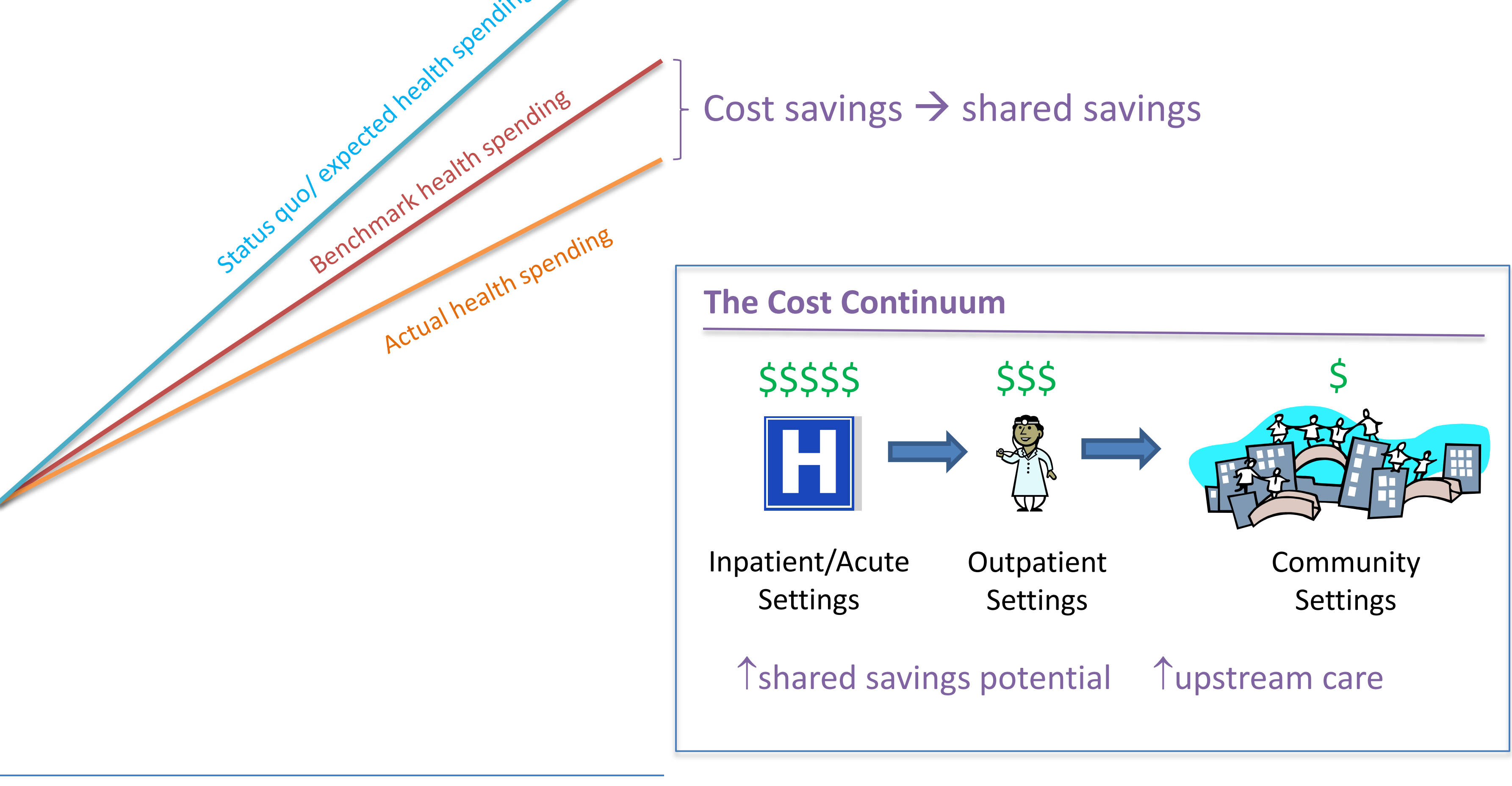
Primary Care

Primary Care Physicians
Nurse Practitioners
Allied Health Professionals
Community Pharmacists

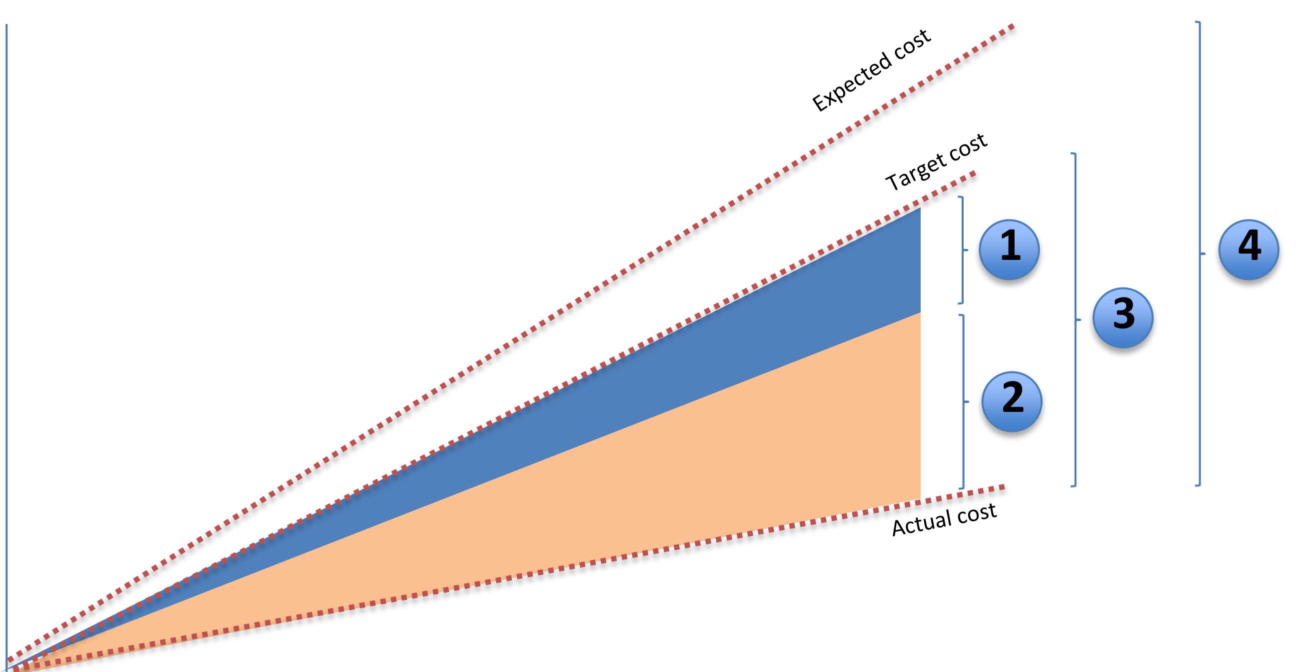
Community-Integrated Medical Home



Community-Clinical Linkages to Advance Delivery and Payment Reform



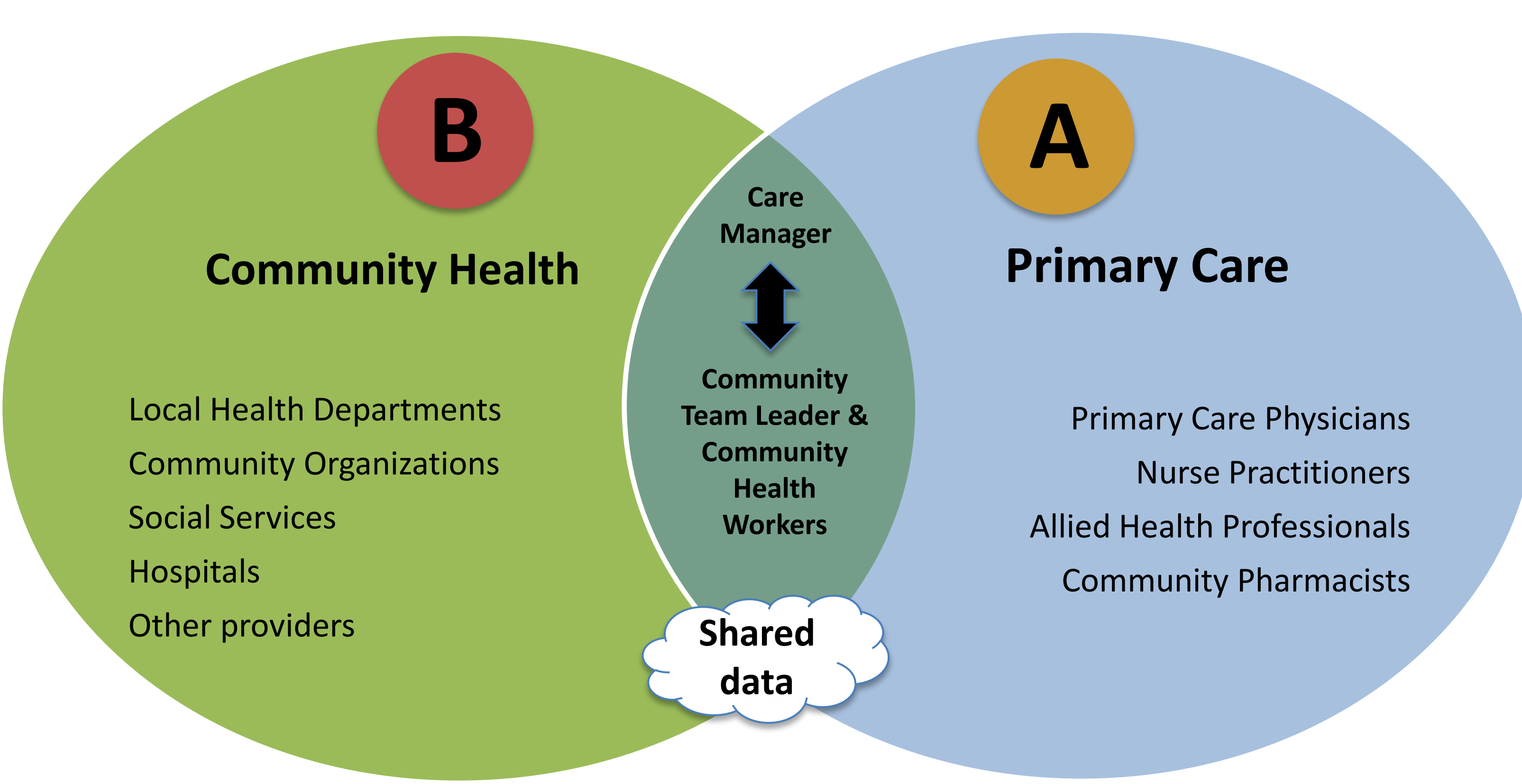
The Value Proposition



1: Savings that payers and clinical providers would have shared without a community-integrated intervention – *"actuarial baseline"*
2: Additional cost savings made possible through community-integrated intervention
3: Total savings available to share as result of community-integration
4: Total savings to the health care system

The value proposition: #3 > #1 and intervention cost < #2

Community-Integrated Medical Home



Community-Integrated Medical Home

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80% PCP & All-Payer Participation in PCMH

Flexibility

- Multiple Entry Points/Inclusion Criteria with minimum shared standards
  - new State-Certified PCMHs
  - Carrier-specific PCMHs
  - Multi-Payer PCMHs
  - Medicare ACOs
  - FQHCs
  - Medicaid Health Homes
- Provider Contracting & Payment
  - Payment methodology, amount, and frequency
  - Bonus amounts
- Patient Attribution Methodology (rests with payer on the basis of claims)
- Care manager: office- and/or community-based

Standardized/Centralized

- Performance reporting and bonuses
  - CIMH Core Measures Set
  - Provider performance reports based on entire patient panel
  - PCP receipt of bonus based on performance across practices within an LHIC
- Minimum standards for payers (including State Health Plan), to include:
  - PCPs can participate in multiple PCMH programs
  - Patient attribution results shared with public utility
  - Data sharing for care coordination and reporting
  - Integrated evaluation of all PCMH models to learn from variation
- Minimum standards for participating practices, to include:
  - Enhanced access to care and care continuity
  - Data sharing for care coordination and reporting
  - Collaboration with community-health professionals
  - Metrics: core set consistently defined
  - Integrated evaluation of all PCMH models to learn from variation
- Roles and responsibilities of care manager and community health professionals

Reporting Requirements: CIMH Core Measure Set

- Minimum measure set upon which CIMH performance (and performance bonuses) are based
- Criteria for Selection
  - Widely used in multiple national and statewide programs to reduce administrative burden and facilitate state-federal alignment
    - Medicare ACO
    - Meaningful Use
    - Million Hearts
    - CHIPRA
    - Health Choice
    - HEDIS/UDS
    - Maryland PCMH initiatives
  - Endorsed by national consensus organization (e.g. NCQA, NQF)
  - Linked to evidence tying metrics to improvements in health outcomes and lower cost, particularly for those conditions that carry highest mortality and morbidity in Maryland

CIMH Core Measure Set: Adults

Category	Measure
utilization	Use of Imaging for Low Back Pain
	Preventable Hospitalizations – AHRQ PQI Composite Measure
screening & prevention	Body Mass Index (BMI) Screening and Follow-Up
	Influenza Immunization
	Pneumococcal Vaccination for Patients 65 Years and Older
	Breast Cancer Screening
	Colorectal Cancer Screening
	Tobacco Use Assessment & Tobacco Cessation Intervention
cardiovascular conditions	Coronary Artery Disease Composite: ACE Inhibitor or ARB Therapy - Diabetes or Left Ventricular Systolic Dysfunction
	Coronary Artery Disease: Oral Antiplatelet Therapy Prescribed for Patients with CAD
	Coronary Artery Disease Composite: Lipid Control
	Heart Failure: ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction
	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction
ischemic vascular disease	Ischemic Vascular Disease: Use of Aspirin or Another Antithrombotic
	Ischemic Vascular Disease: Complete Lipid Panel and LDL Control
diabetes	Diabetes: Eye Exam
	Diabetes: Foot Exam
	Diabetes: Blood Pressure Management
	Diabetes: LDL Management
	Diabetes: HbA1c Control
hypertension	Hypertension: Controlling High Blood Pressure
asthma	Use of Appropriate Medications for People with Asthma
mental health and substance abuse	Antidepressant Medication Management
	Screening for Clinical Depression and Follow-Up Plan
	Initiation and engagement of alcohol and other drug dependence treatment

CIMH Core Measure Set: Children

Utilization	Appropriate Treatment of Children with Upper Respiratory Infection (URI)
	Preventable Hospitalizations: AHRQ PDI
	Appropriate Testing for Children with Pharyngitis
prevention and screening	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
	Childhood Immunization Status
	6+ Well Child Visits, 0-15 months
	Preventive Care & Screening: Tobacco Use Assessment
	Preventive Care & Screening: Tobacco Cessation Intervention
asthma	Asthma Assessment
	Use of Appropriate Medications for People with Asthma
mental health	ADHD: Follow-up Care for Children Prescribed ADHD Medication

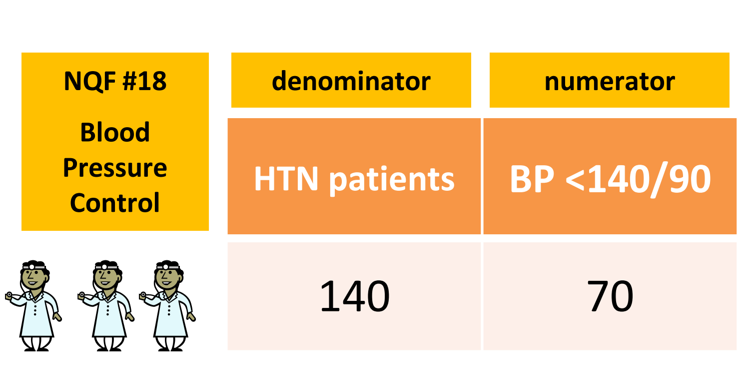
Reporting Requirements: Performance Reports and Bonuses

- Performance reports will be provided by the Public Utility to participating PCMHs at the practice and individual physician levels on a quarterly basis

NQF #18 Blood Pressure Control	denominator	numerator		
	HTN patients	BP <140/90		
	40	20	50%	**Practice/ PCMH** 50%
	40	30	75%	
	60	20	33%	
	140	70		

Reporting Requirements: Performance Reports and Bonuses

- Performance information will be provided for the entire patient population as well as disaggregated by payer



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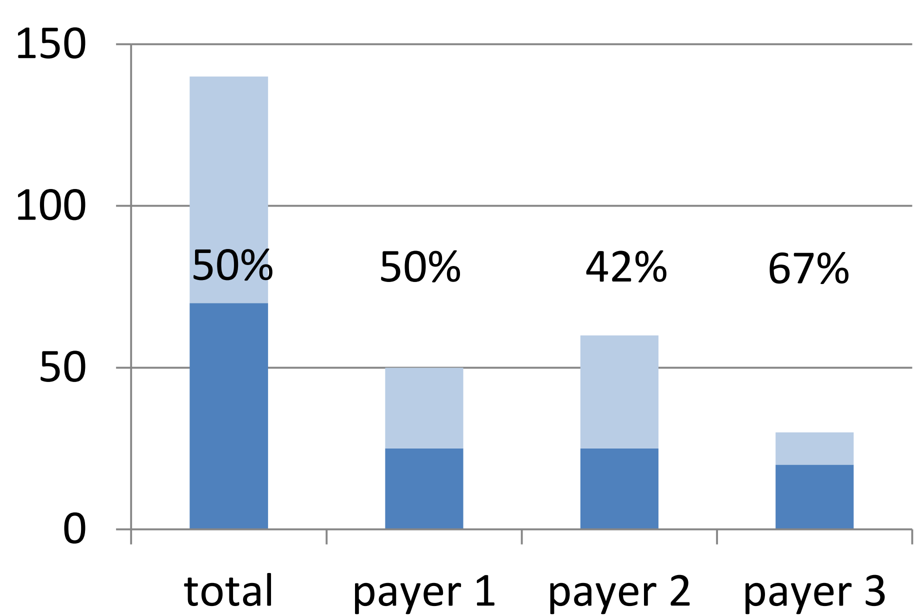
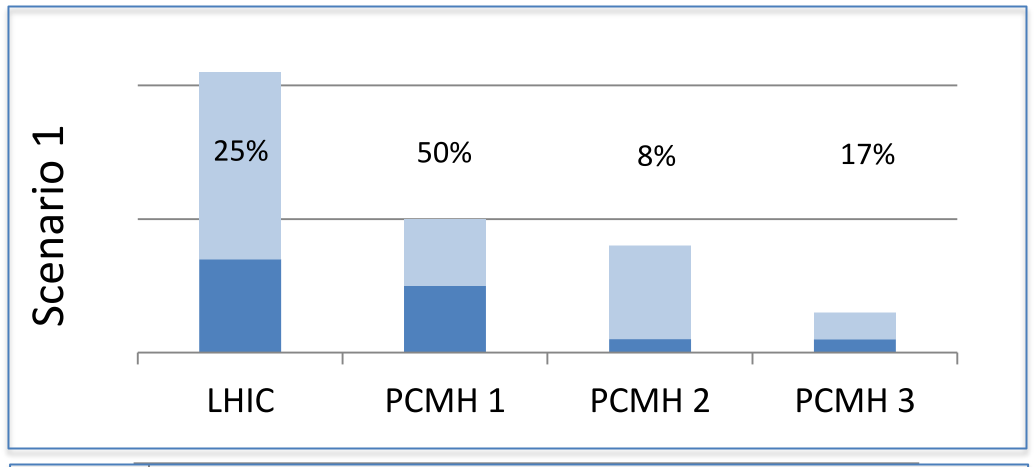
	HTN patients	BP <140/90
	140	70

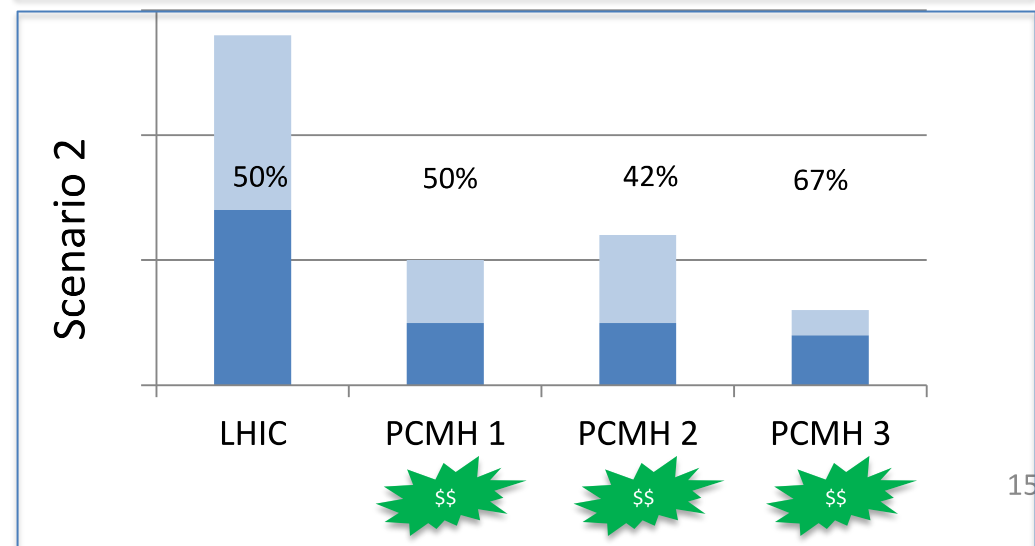


Reporting Requirements: Performance Reports and Bonuses

- Practices will be eligible for annual performance bonuses based on some blend of practice-level performance and their collective performance at the LHIC level over time, to support community-wide health improvement and to improve sample sizes
- Practices will be assigned to an LHIC based on zip code
- Bonus amounts will be set by the payer and can be provided upfront with the possibility of take-back for unsatisfactory performance

Example: target = >50% of hypertensives in LHIC have BP <140/90





Minimum Standards for Payers

- PCPs can participate in multiple PCMH programs: exclusivity provisions will no longer be allowed
- Patient attribution *results* shared with public utility so that all patients can be accounted for; however, patient attribution *methodology* need not be shared
- Data sharing for care coordination and reporting (e.g. provision of claims to all-payer claims database)
- Participation in integrated evaluation of all PCMH models to learn from variation

Minimum Standards for Practices

Dimension	Maryland minimum standards for primary care practices to be a participating provider in a CIMH
Enhance access and continuity	• **Accept Medicaid and Medicare enrollees, to constitute at least x% of total patient panel** • Focus is on team-based care with trained staff
Plan and manage care, including tracking and coordinating care	• Collection and sharing of data for population management • Active engagement in formulating and executing patient care plan • Active engagement in tracking and coordinating tests, referrals, and care at other facilities • Active engagement in managing care transitions • **Collaborate with CIMH Community Team Leader, CHWs, and LHIC**
Provide self-care support and community resources	• **Participate in CIMH** • Assist in providing or arranging for mental health/substance abuse treatment • Assist in counseling patients on healthy behaviors • **Assist in identifying candidates for wrap-around service** • **Collaborate with CIMH Community Team Leader, CHWs, and LHIC**
Measure and improve performance for entire patient population	• **Participate in CIMH** • Use performance data (e.g. CRISP ENS/ERS) to monitor utilization and performance and continuously improve • **Agree to use of common performance metrics** • **Participation in integrated evaluation**

** Most PCMH recognition programs (NCQA, AAHC, URAC, TransforMED) meet or exceed the Maryland state standard. CIMH-specific standards are identified in boldface*

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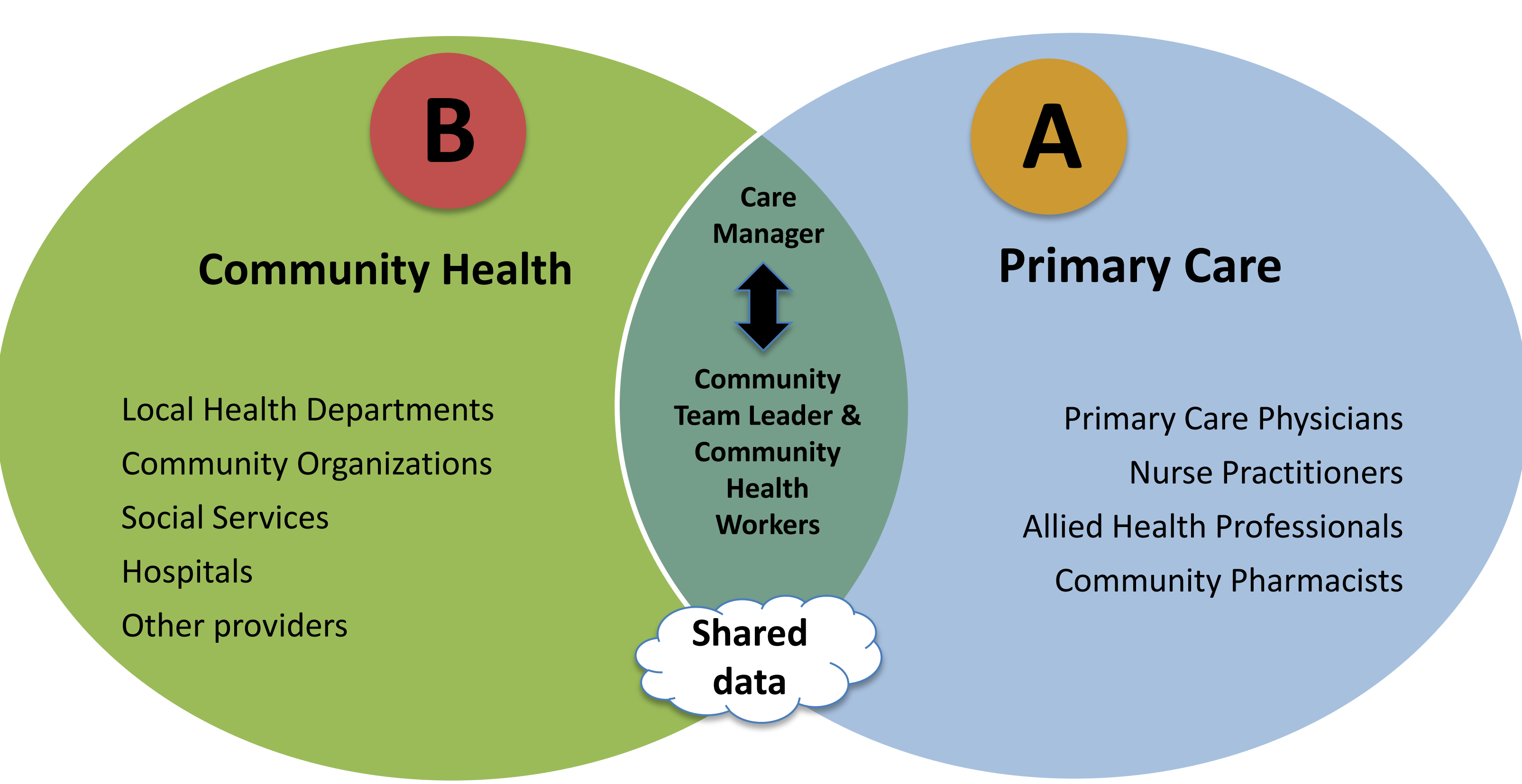

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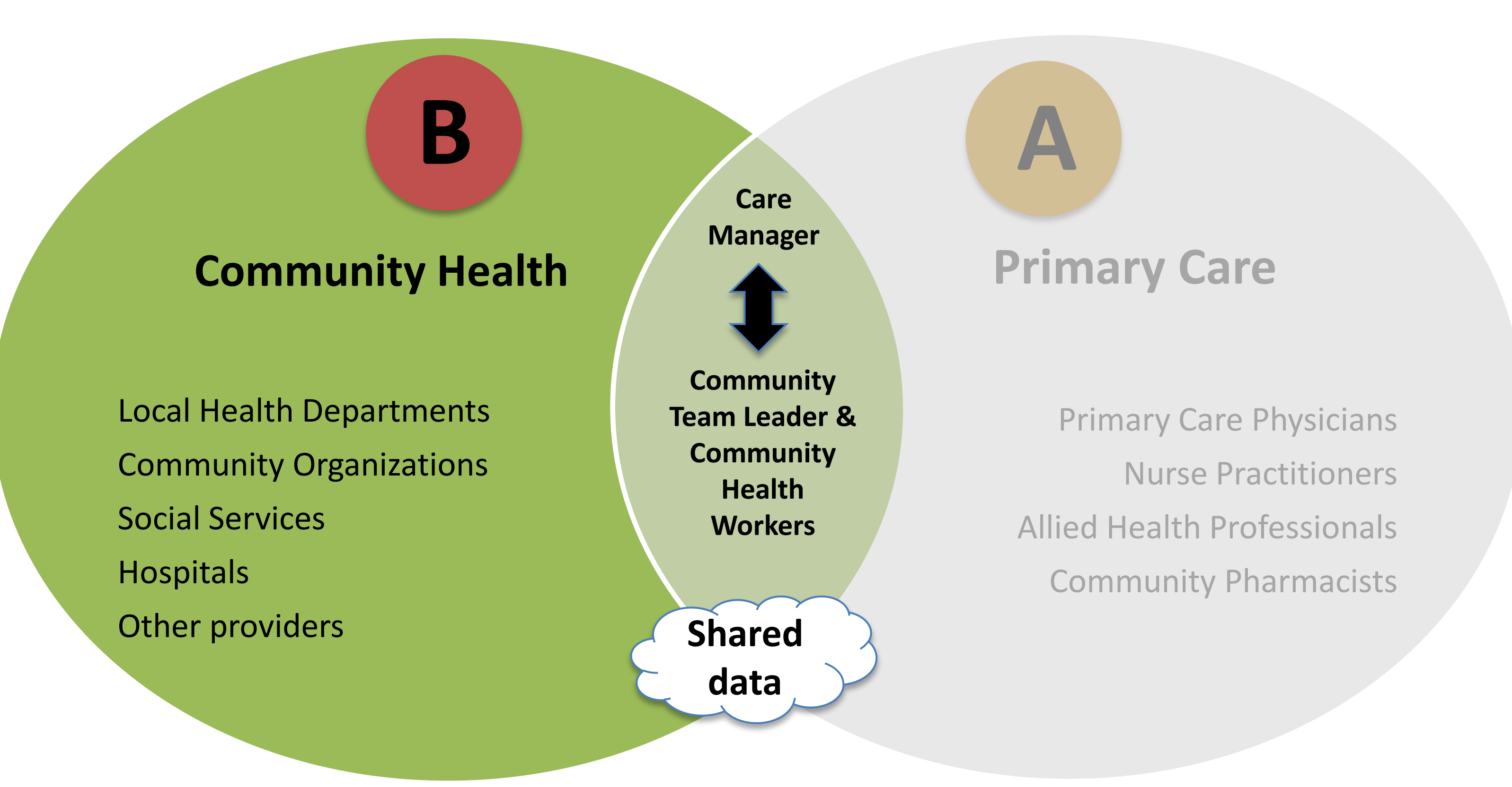

B Community-Based & Clinically-Integrated Hot Spotting Model

B

Wrap-Around Community Supports

- Adapting Health Quality Partner's concept of Advance Preventive Service model to Maryland context and test in all-payer environment
- Intervention begins with patient assessment; patient's needs determine interventions selected from a "menu" of wrap-around preventive & support services
- Model is agnostic to underlying delivery reform model or provider participants

Care Manager

Community Team Leader & Community Health Workers

Shared data

A

Primary Care Based Delivery Reform Model

Can be any combination of primary care providers/practices that meet Maryland minimum standards

PCMH

Medicare ACO

Medicaid Health Homes

FQHC

Benefits of agnostic/community model include:

- Model does not rely on PCMH practice transformation, for which ROI is unclear and can take 2-3 years
- Reduced demand on practice by high need patients
- Potential for greater payer/provider buy-in: does not "interfere" with existing models; lots of upside, little downside

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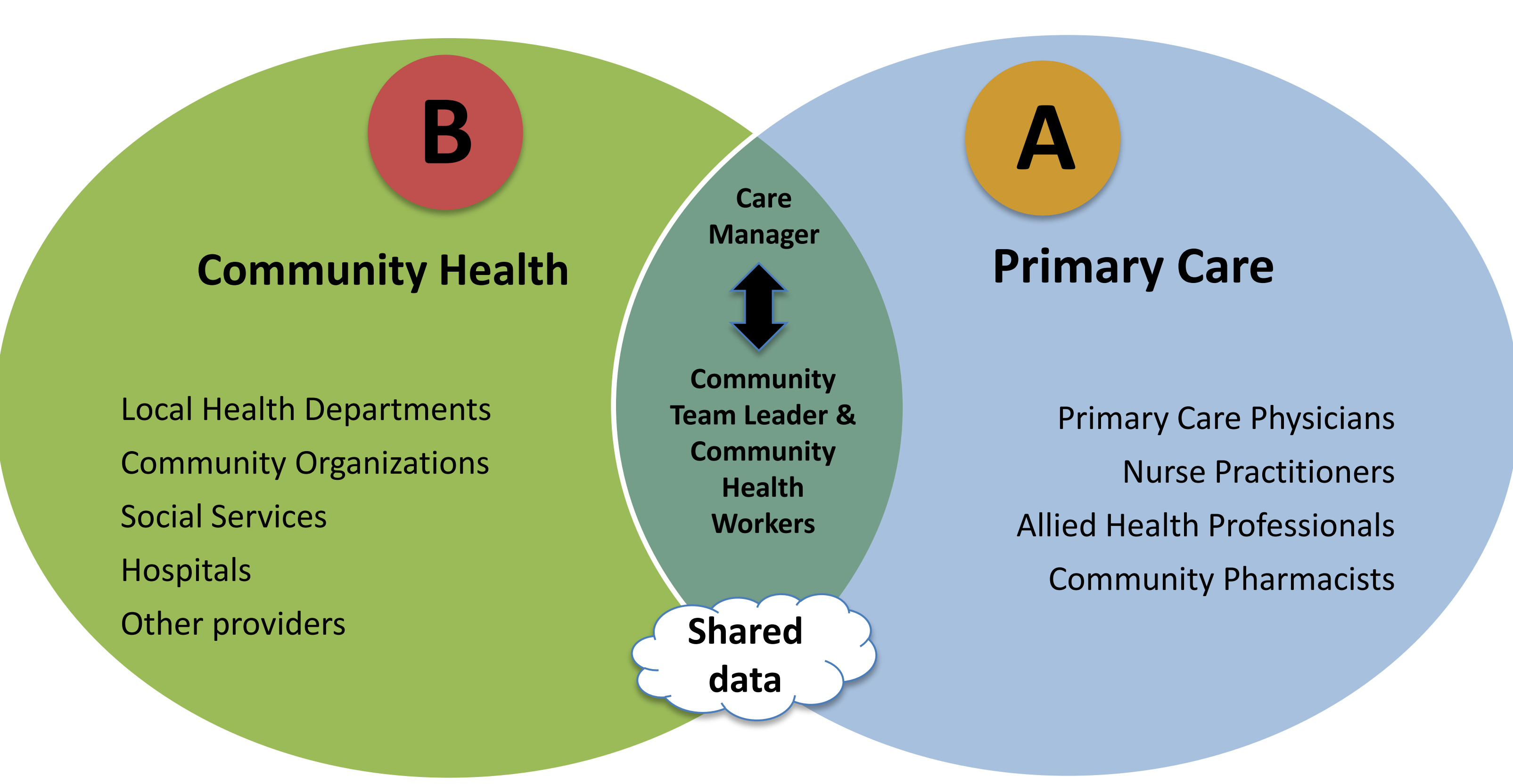

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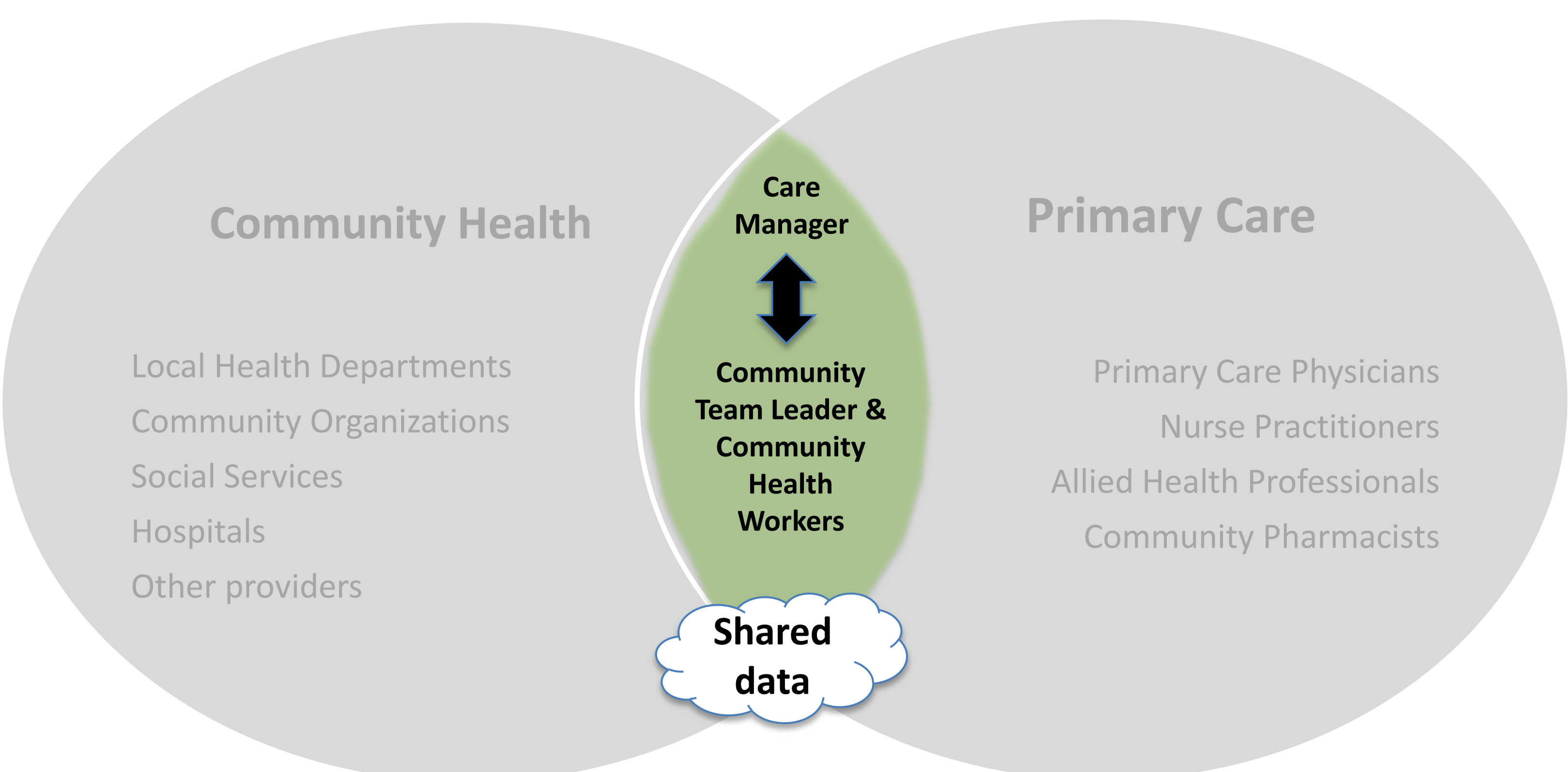
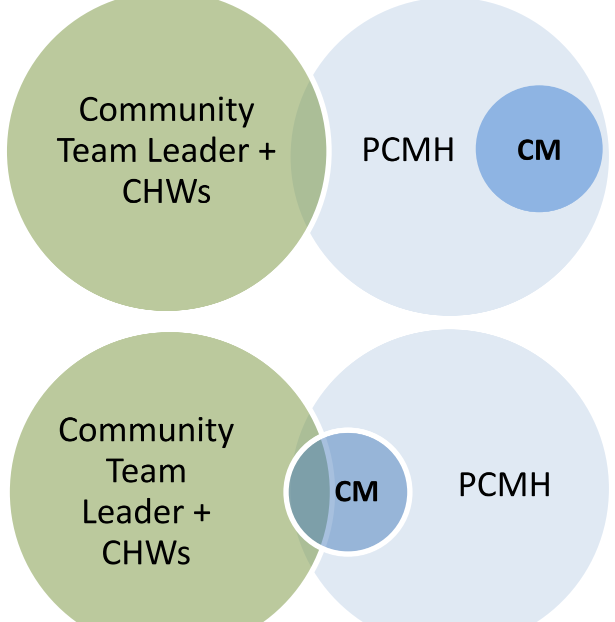
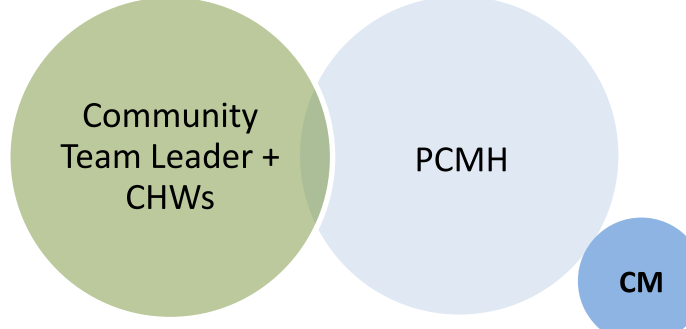


Roles/Responsibilities for Care Managers & Community Health Professionals

PCMH **with** office-based care manager(s)



PCMH **without** office-based care manager(s)



Community Health Team: Composition & Training

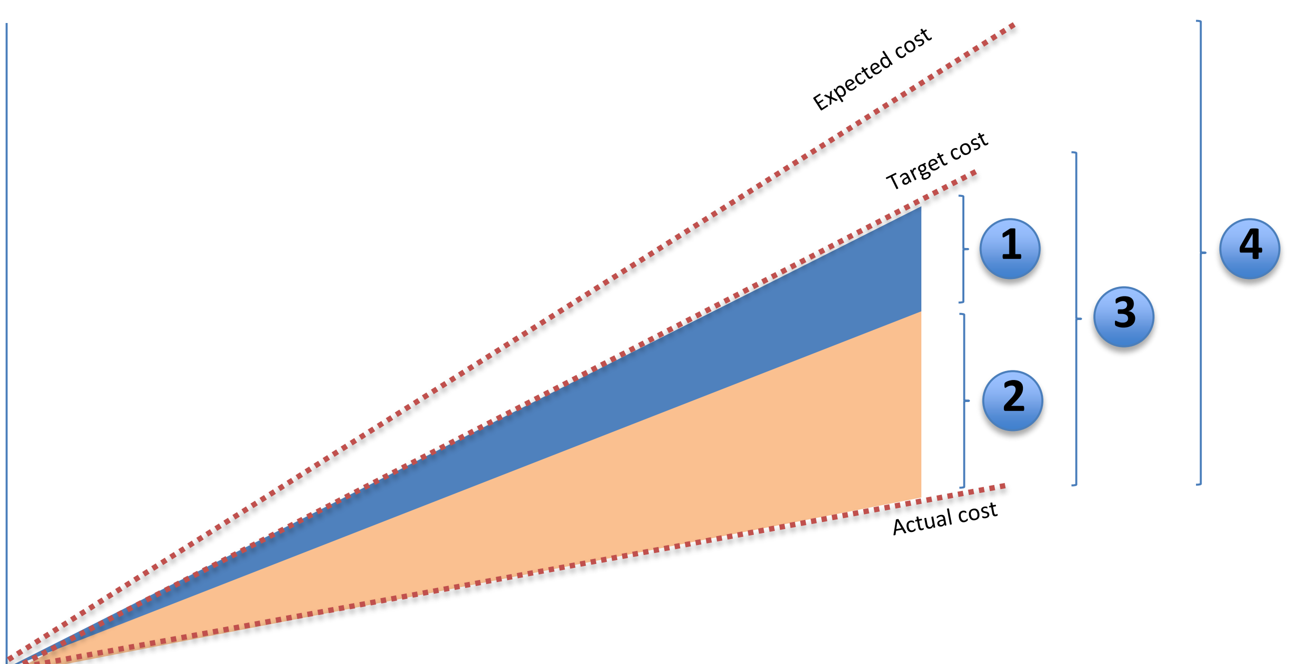
- Community Team Leader (nurse) will be centrally trained/hired by DHMH and lead a team of CHWs
- CHWs will be trained in community colleges
- Training and protocols will be developed for team members through SIM planning grant with ongoing role-specific monitoring to ensure fidelity to the protocols and provide quality assurance

Community-Clinical Integration

- Community Team Leader will interface with CMs whether they are office-based or virtual, or directly with the PCP where there is no CM
- Little overlap between Community Team Leader and existing CMs is expected and will be easily identified by practices/plans because duties of Community Team Leader will be specified in detail.
- Where there is overlap in responsibilities, roles and responsibilities can be negotiated to ensure one master plan tailored to the needs of each patient while minimizing duplication of effort.

Payment Model

Long Term Sustainability through Shared Savings and Investments



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The value proposition: #3 > #1 and intervention cost < #2

Shared Investment: upfront year 1 costs paid for out of SIM, with maintenance costs paid increasingly out of benefit-adjusted savings over time