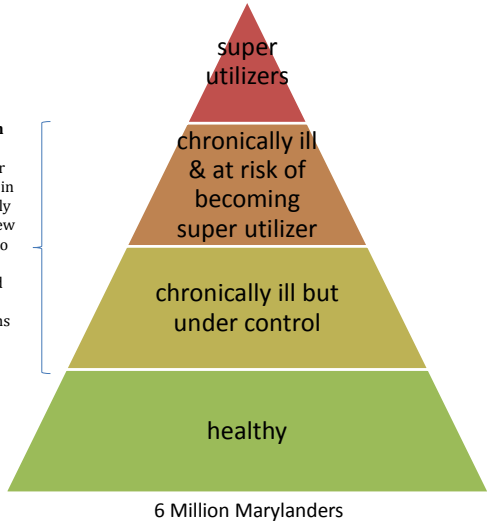
Maryland's SIM State Health Innovation Plan

Version 1.5

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

B

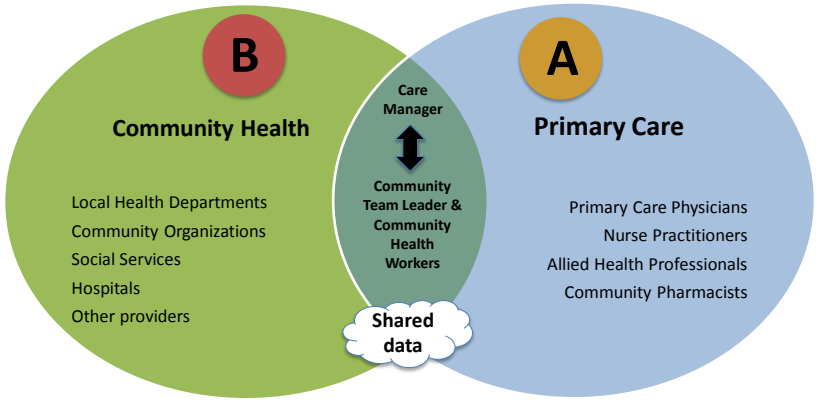
"Hot Spotting" – Deploying effective complementary community-based supports that "wrap around" the primary care medical home; patient assessment determines range of services offered

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.

2

Community-Integrated Medical Home



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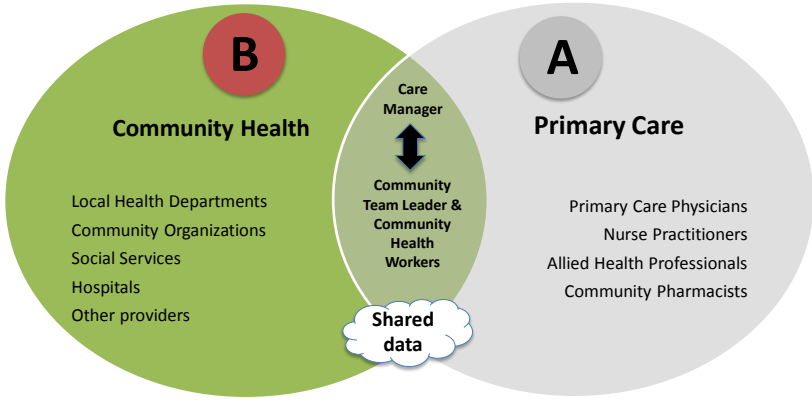

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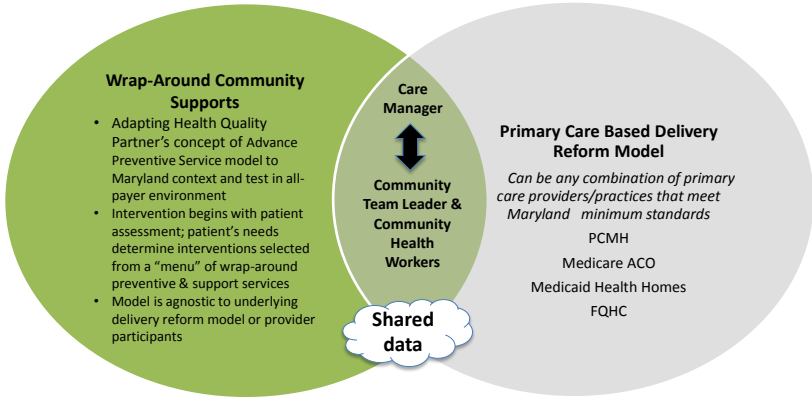
Community-Based & Clinically-Integrated Hot Spotting Model



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

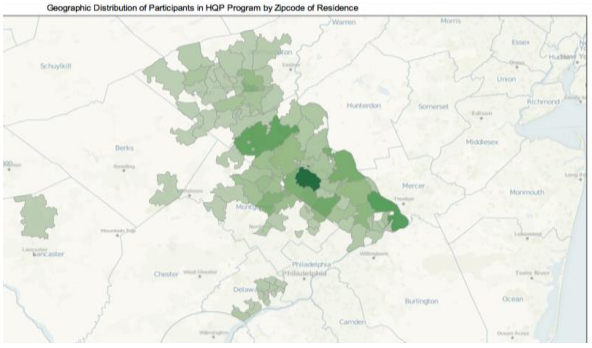
5

Adapting HQP's Advance Preventive Service Model to Maryland Context

- Review of the HQP APS Model
  - Population Served
  - Care team composition
  - Outcomes
- Considerations for designing community intervention models for Maryland
- Scaling and adapting the model in Maryland
- Estimates of magnitude

HQP's APS Model: Population Served

- Traditional Medicare and Medicare Advantage
- Chronically ill with heart failure, coronary heart disease, diabetes, chronic lung disease
  - Other risks as well; prior admission or high risk score
  - Median age 81 years



Collaborating with 100+ physician practices and 7 health systems

HQP's APS Model: Care team composition and locus

- RN's deliver the care (currently n=16)
- Program is freestanding and delivered throughout the community (home, doc offices, hospital, rehab, community centers, program office)
  - Touchdown space provided by major health system partners
- Significant administrative, management, data, and analytical support – commensurate with HQP's R&D mission
  - Medical Director, CEO (MD)
  - SVP, Program Architect (MSW)
  - Director of Operations
  - Senior Clinical Lead (NP)
  - Director of Care Management (RN)
  - Chief of Finance and Analytics (MBA)
  - Chief of Information Technologies
  - Administrative, Data Collection, and Outreach Support staff

Organizations adopting (rather than developing) the program need less infrastructure:

but strong management and clinical support still important

Outcomes

Population	N	Control PPPM	Deaths	Hospital admissions	ER visits	Part A & B expenditures; excl prgm fees	Part A & B expenditures; incl prgm fees	SNF cost
Medicare Coordinated Care Demonstration (randomized, controlled trial versus usual care)								
All risk levels (low, mod & high)	1,464			-14%		-14% *	Neutral	
	1,721	$731	-25% **	-7 %		-4%	+9%	
Higher-risk 1	502	$900	-30% **	-29% **		-20% *		
Higher-risk 2	248	$1,441	-18%	-39% **	-37% **	-36% **	-28% **	-64% **
Higher-risk 3	695	$1,108		-25% **		-20% **	-10%	
Higher-risk 4	273	$1,363		-33% **		-30% **	-22%	
Aetna (difference-in-differences analysis trended over time against a like comparison group)								
Higher-risk 5	942			-20% °			-18% °	

** P ≤ 0.05, * P ≤ 0.1

° statistics not reported

Third Report to Congress, Deborah Peikes, et al., Jan 1, 2008, Mathematica Policy Research, Inc. (MPR)

Fourth Report to Congress, Jennifer Schore, et al., March 2011, MPR

PLoS Medicine, Ken Coburn, et al., July 2012, 9(7): e1001265. doi:10.1371/journal.pmed.1001265

JAMA, Deborah Peikes, et al., Feb 2009;301(6):603-618 (doi:10.1001/jama.2009.126)

MPR report shared with HQP with CMS permission, 2011 (unpublished)

Health Affairs, Randall Brown, et al., June 2012, 31, no.6:1156-1166

Aetna Medical Economics Team Report 2011 (unpublished)

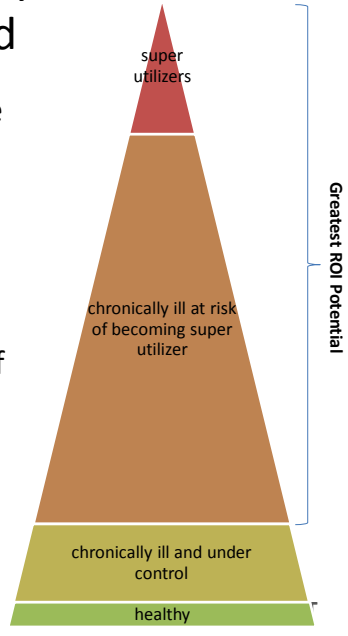
Higher-risk 1; based on geriatric HRA
Higher-risk 2; (HF, CAD, or COPD) AND ≥1 hospitalization in prior year
Higher-risk 3; HF, CAD, or COPD
Higher-risk 4; [(HF, CAD, or COPD) AND ≥1 hospitalization in prior year] OR [(diabetes, cancer (not skin), stroke, depression, dementia, atrial fibrillation, osteoporosis, rheumatoid arthritis/osteoarthritis, or chronic kidney disease) AND ≥2 hospitalizations in the prior 2 years]
Higher-risk 5; (HF, CAD, COPD, Asthma, or diabetes) AND ≥ minimum cut-point on Aetna proprietary risk score

Abbreviations: PPPM= per person per month, ER= emergency room, SNF= skilled nursing facility, HRA= health risk assessment, HF= heart failure, CAD=coronary artery disease, COPD=chronic obstructive pulmonary disease

Designing Community Intervention Models for Maryland

- Best ROI opportunities appears to be among
  - "super-utilizers" (needs further operational definition)
  - chronically ill at higher-risk

  overlap
- Assess, understand, and care for the whole person, addressing all types of risk to health
  - Customize intervention plan based on assessment and participant needs, preferences, and values
  - Mindset is longitudinal not episodic



Intervention Support Needs

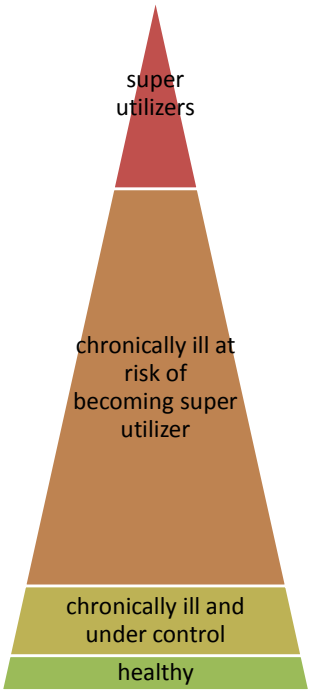
- Oversight
  - Intervention selection and approval (Main, Variations, Experiments)
  - Operational standards
  - Operational management
- IT Support
  - Data capture, retrieval, and decision support from the field using mobile devices; customized to support each intervention
- Data Analytics
  - Program performance, process reliability and variation
  - Outcomes
  - Participant satisfaction / experience
- Training
- Learning Center
  - Insight through analysis of variation and outcomes and narrative reports
  - Evidence-based plan for spread and scale up

DRAFT

Scaling and Adapting the Model to the Maryland Context

Balance: Replication vs. Experimentation

- 1 Main Intervention for each major target group
  - Available to all LHICs
- Few (1-3) additional Variations may also be adopted
  - Available to all LHICs
- Experimental Interventions (significantly different from Main Interventions)
  - Will be negotiated based on existing evidence, experimental plan, and predicted ROI



Estimates of Magnitude and Reach: HQP's APS Model Applied to Maryland	
Pop. Descr.	>= 65 yrs with HF, CHD, DIAB and/or COPD and 1+ hosp. adm. in prior yr.
Pop. Size	Est. 15-20% of Medicare population • counts for LHICs TBD; • State ≈ 129,000 [1]
Intervention	HQP Advanced Preventive Service
Care team composition and reach	nurse care manager (1 to 75 persons)
Intervention Cost	Est. $150 – $220 PPPM
Total $ Savings	$1,320 - $3,960 PPPY x number of participants enrolled = annual savings
ROI	Est. 50-150%

[1] Expecting to enroll about 1 in 4 (25%) of target pop. ≈ 32,250

Potential Variations to Fit Maryland Context

Variation #1: Younger ages, additional target conditions, risk factors, utilization thresholds, or exclusion criteria

Variation #2: Interventions appropriate to population

Variation #3: Care team composition
• appropriate to intervention
• top-of-license workforce

Variations will affect intervention cost, reach, total savings, and ROI

Potential Demand for Services

	A	B	C	D	E	F
County	Population* (2012)	% >=65 yrs* (2011)	Super users (@2%)	HQP population	HQP population all ages **	Total population to serve
		A x B	*2% x A*	*17.5% x B*	*D x 2*	*C + E*
Garrett	29,854	17.7% 5284	597	925	1,849	2,447
Worcester	51,578	23.6% 12,172	1,032	2,130	4,260	5,292
Prince George's	881,138	9.8% 70,491	17,623	15,112	30,223	47,846
Maryland	**5,884,563**	**12.5% 735,570**	**117,691**	**128,725**	**257,450**	**375,141**

* http://quickfacts.census.gov
**See http://www.cdc.gov/nchs/data/databriefs/db100.htm

Initial Superutilizer Analysis

- Initial analysis; more sophisticated analysis to be presented at Stakeholder Summit
- Health Services Cost Review Commission (HSCRC) inpatient and outpatient charge data
  - Includes principal diagnosis, payer(s), demographic information
- Limited to individuals with two hospitalizations in Maryland hospitals
  - Approximately 83,000 individuals (about 1.5% of population)
- Limitations
  - Underestimates overall utilization and cost, likely more for some diseases than others
  - Border issues

Superutilizers by Disease and Payer

	Medicare		Medicaid		Private		Dual Eligibles	
Heart Disease	8201	$43,855.22	1415	$51,343.85	2019	$46,835.09	1594	$50,295.91
Asthma	543	$34,577.02	621	$29,471.79	367	$26,625.69	214	$33,826.44
COPD/Resp.	4163	$41,355.53	1110	$55,612.94	1125	$47,313.27	934	$47,427.83
Stroke	3239	$40,612.24	434	$58,883.91	816	$51,047.31	469	$49,298.66
Cancer	3205	$66,515.74	883	$91,149.80	2622	$88,849.16	462	$71,709.19
Diabetes	1212	$55,304.64	569	$50,205.89	650	$49,538.85	441	$59,424.43
Behavioral Health	1418	$29,544.92	2915	$26,348.64	1460	$24,514.71	942	$29,636.36
Other	13971	$43,832.21	6841	$43,341.57	9735	$43,931.54	3131	$49,466.79
Overall	35952	$44,966.20	14788	$44,671.22	18794	$49,369.02	8187	$48,434.74

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Superutilizers by County

County of Residence	No. of Superutilizers	% of Total MD SUs	2010 Population	% SU in County	Average Charge
Allegany	1822	2.19%	74012	2.46%	$46,800.19
Anne Arundel	7538	9.06%	621342	1.21%	$44,964.61
Baltimore Co	15339	18.44%	817455	1.88%	$47,891.77
Calvert	1053	1.27%	89628	1.17%	$37,469.85
Caroline	554	0.67%	32718	1.69%	$44,439.46
Carroll	2429	2.92%	167217	1.45%	$46,719.34
Cecil	1232	1.48%	101696	1.21%	$44,031.09
Charles	1571	1.89%	150592	1.04%	$37,929.77
Dorchester	646	0.78%	32551	1.98%	$44,119.28
Frederick	3216	3.87%	239582	1.34%	$42,055.65
Garrett	333	0.40%	29854	1.12%	$40,223.47
Harford	3563	4.28%	248622	1.43%	$44,961.87
Howard	2767	3.33%	299430	0.92%	$47,375.21
Kent	475	0.57%	20191	2.35%	$41,037.06
Montgomery	7403	8.90%	1004709	0.74%	$40,297.03
Prince George's	8183	9.84%	881138	0.93%	$41,682.82
Queen Anne's	586	0.70%	48595	1.21%	$47,022.88
St. Mary's	1206	1.45%	108987	1.11%	$37,675.08
Somerset	368	0.44%	26253	1.40%	$43,521.75
Talbot	790	0.95%	38098	2.07%	$45,820.56
Washington	2451	2.95%	149180	1.64%	$43,351.01
Wicomico	1645	1.98%	100647	1.63%	$44,122.62
Worcester	811	0.97%	51578	1.57%	$48,258.37
Baltimore City	17214	20.69%	621342	2.77%	$51,114.10

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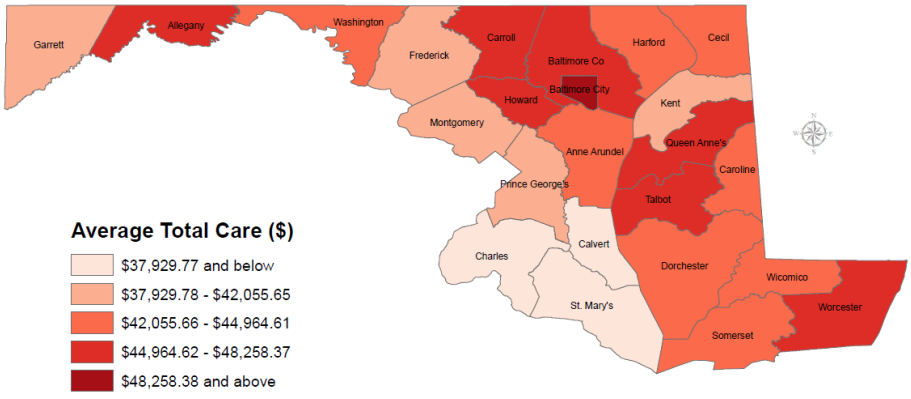


Defining Community-Based Interventions: Next Steps

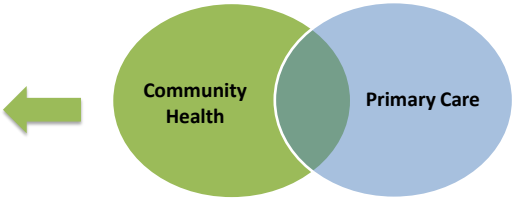
- Analysis of HSCRC data to identify the super-utilizers and determine age, geography, payer mix, and diagnostic profiles
- Determine target populations based on opportunities for health improvement and cost reduction
- Develop list of evidence-based interventions appropriate to target populations based on selection criteria
- Determine appropriate care team composition for the intervention
- Determine ROI based on cost savings relative to cost of interventions and estimate magnitude of population health improvement

Questions or Comments?

Payment Model

Payment Model for Community-Based Intervention

- Like a public utility, all those deriving benefit from the operation of the CIMH would help pay for it
- Risk-adjusted per capita surcharge levied on payers to cover cost of the intervention
- Medicare currently pays for HQP's community-based intervention using a similar approach



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Medicare Payment for APS

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Care team composition and reach	nurse care manager (1 to 75 persons)
Intervention Cost	Est. $150 – $220 PPPM
Total $ Savings	$1,320 - $3,960 PPPY x number of participants enrolled = annual savings
ROI	Est. 50-150%

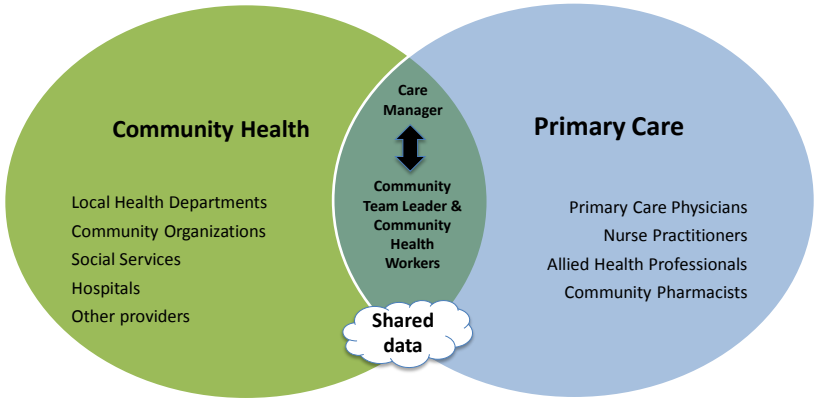
Medicare currently pays for the APS community-based intervention using a severity-adjusted per person per month fee

25

Questions or Comments?

Public Utility

Community-Integrated Medical Home



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Public Utility Core Functions

Community-Based	Practice-Based
• Certification of Local Health Improvement Coalitions • Performance measurement & feedback at the *population-level* • Oversight of community-based services – Quality assurance metrics – Standards and training for community health workers	• Certification of practices • Performance measurement & feedback at the *practice-level* • Oversight & monitoring – patient attribution: a virtual common roster – Validation of payer or practice-generated aggregate data

Governance & Staffing

A method or process for exercising control, authority, or management

Accountability for actions taken to achieve an aim

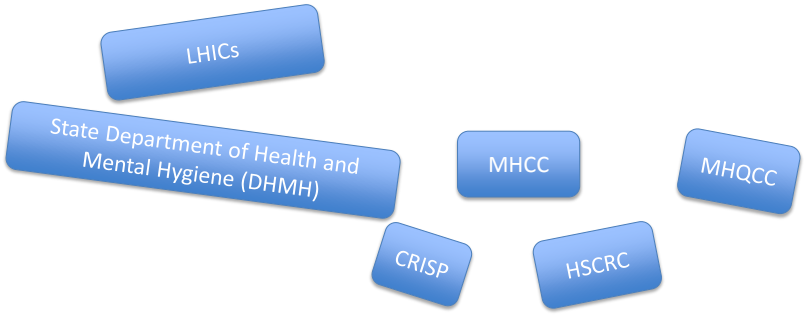
Governance & Staffing

- Several dimensions to a large complex undertaking such as the CIMH model
  - Location
    - State and Local
  - Elements
    - Strategic
    - Financial
    - Operational
    - Aspirational

ADDING TO BOTH THE COMPLEXITY AND POSSIBILITY:

- Many key Maryland resources will contribute to a successful CIMH model.
- These resources must be coordinated and aligned by means of a governance 'framework'.

Arrange these assets (and/or others?) to achieve an effective CIMH governance framework



LHICs – Local Health Improvement Coalitions
MHCC – Maryland Health Care Commission
MHQCC – Maryland Health Quality and Cost Council
HSCRC – Health Services Cost Review Commission
CRISP – Chesapeake Regional Information System for Patients

Effective, reliable, and adaptive implementation of Community Health Interventions 'on the ground'

Policies, data flows, financing, and PCMH measurement and support enabling CIMH system success

Governing Body: New Entity or Modification of Existing

Public Utility

Community-Based	Practice-Based
• Certification of Local Health Improvement Coalitions • Performance measurement & feedback at the population-level • Oversight of community-based services – Quality assurance metrics – Standards and training for community health workers	• Certification of practices • Performance measurement & feedback at the practice-level • Oversight & monitoring – patient attribution: a virtual common roster

Option #1 – New Entity & Staffing

- Create a new entity modeled after corporate/governance structure of state's Health Benefit Exchange
- A public corporation and a unit of state government with new and separate staff
  - Adhering to *selected* sections of the State Finance and Procurement Article
- Board (as configured for the Benefit Exchange; by way of example)
  - Secretary of Health and Mental Hygiene
  - Commissioner
  - Exec Dir of MHCC
  - Appointed by the Governor with advice and consent of Senate
    - 3 members representing interests of employers and individual consumers
    - 3 members with expertise in health insurance (incl purchasing and enrollment), health care financing, public health
  - Board Chair designated by the Governor
- Exec Dir selected by the Board with Governor approval
  - Structure provides greater hiring and contracting flexibility
- Specified Advisory Committee and stakeholder engagement

Option #2 – Build on Existing Capacity

DHMH Secretary
Deputy Secretary for Public Health

Governor-Appointed Commissioners

Health Systems and Infrastructure Administration
Office of Population Health Improvement
Office of Workforce Development

Maryland Health Care Commission

Public Utility

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Governance Organizations

Acronym	Name	Composition	Description
MHCC http://mhcc.dhmh.maryland.gov/SitePages/Home.aspx	**Maryland Health Care Commission** Created 1999 Comprised of 5 Centers; • Hospital Services • Long-Term and Community-Based Care • Health Care Financing and Health Policy • Information Services and Analysis • Health Information Technology	15 members appointed by the Governor with the advice and consent of the Senate	An independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public. The Commission's vision for Maryland is to ensure that informed consumers hold the health care system accountable and have access to affordable and appropriate health care services through programs that serve as models for the nation. MHCC provides oversight and analytic support for Maryland's current PCMH initiatives – both the carrier-specific programs and the multi-payer program.
HSIA http://hsia.dhmh.maryland.gov	**Health Systems and Infrastructure Administration** Created 2012 Comprised of 3 Offices • Office of Population Health Improvement • Office of Primary Care Access • Office of School Health Oversees core funding of local health departments Serves as governing body for Maryland's 2 chronic care hospitals	Housed within DHMH and reports to the Deputy Secretary for Public Health	The Administration was created in 2012 in anticipation of health reform implementation and to focus efforts on population-wide health improvement through greater alignment and integration of public health and medicine. The Administration houses the Office of Population Health Improvement (which oversees the 18 Local Health Improvement Coalitions through the State Health Improvement Process). The Local Health Improvement Coalitions are, in turn, locally governed and typically co-chaired by a local health department health officer and hospital/health care executive. The Administration also houses the Office of Workforce Development (within the Office of Primary Care Access).

Questions or Comments?

Stakeholder Feedback To Date

Feedback: Primary Care Providers

- Confusion among primary care physicians about what they can and cannot "join" – e.g. ACO versus PCMH
- Primary care physicians not on EMRs concerned re: ability to export quality metric data automatically.
- Need to receive timely actionable data that is in the same format for all patients

Feedback: Payment Model

- Very difficult to identify the savings generated exclusively by this program.
- "The savings estimates are not a reliable source of long term funding."
  - "As the model is proven to work and becomes the norm, the variation in costs between different primary care providers will lessen and additional incremental savings will diminish. "
- Pay for service with real $ up front.
  - Steep discount in year 1
  - Evaluation early so can incent payers to continue paying for service
  - ROI—what can we guarantee?

Feedback: Implement the model incrementally

- ID target population
- Address concerns re: availability of CHW
- Performance targets
  - risk adjustment at the community level to accommodate differences in patient populations
- Address concerns about mandates to participate
- Build trust and a high functioning relationship between primary care providers and the Local Health Improvement Coalitions

Feedback: Metrics

- Quality metrics and financial parameters should be the same for all patients.
- Quality metrics should be easy to obtain (EMRs, Claims data)
- Include ER metrics
- Additional requirements and evaluation measures without supportive funding is a concern
- Tier metrics based on sophistication of practice
- The importance of community-based metrics (the metrics proposed so far have been clinically-focused)
- Performance of the entire population and not just those enrolled in a participating PCMH

Feedback: Patient Attribution

- Methodology must be transparent
- Establish systems to adjudicate attribution lists, quality metrics and medical costs.

Feedback: CHW

- Practices will benefit financially from the services of a well-trained and monitored team of CHWs deployed geographically
  - not have to recruit, hire, train and monitor
- Embedded vs not embedded
- Scalability
- How will their role overlap with CM

Feedback: LHIC

- Educate and promote provider engagement in LHIC efforts
  - reinforce the value of this model in community health improvement
- Demonstrate the value added of community integrated interventions
- Guide data integration across systems
- Providing a connector to state and local initiatives—demonstrating that local and state health goals are aligned
- Scalability
- Certification

Feedback: Duplication of Services

- “Everyone wants to do care management – insurers, health departments, hospitals, and PCPs”
- Increased amount of unreimbursed work
- Ability to sustain care management services in a PCP offices

Feedback: Other

- How do you bring in Self Insured plans?
- Palliative Care
- Implementation of MOLST community wide
- Call center

Questions or Comments?

Getting to Version 2.0 of Maryland's State Health Innovation Plan

Revised Timeline

- CMS will be considering requests for < 2 month extension
- All-Stakeholder Summit rescheduled for **September 10, 2013**

Model Refinement through Concentrated Stakeholder Input

- Establishment of workgroups to provided targeted feedback on key areas of SIM model design
  - Governance
  - Payment model
  - Participation standards
  - The role of the LHICs
  - Phasing in implementation
- Wiki process to solicit feedback
  - August 10 – Wiki released
  - August 19 – feedback due

Maryland SIM Wiki – Online Collaborative Design

A website developed collaboratively by a community of users that allows users to add and edit content

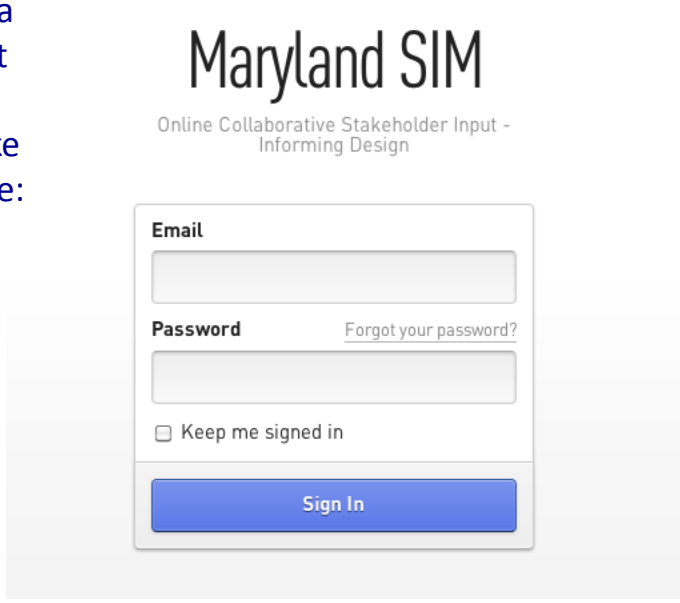
Why experiment with this?

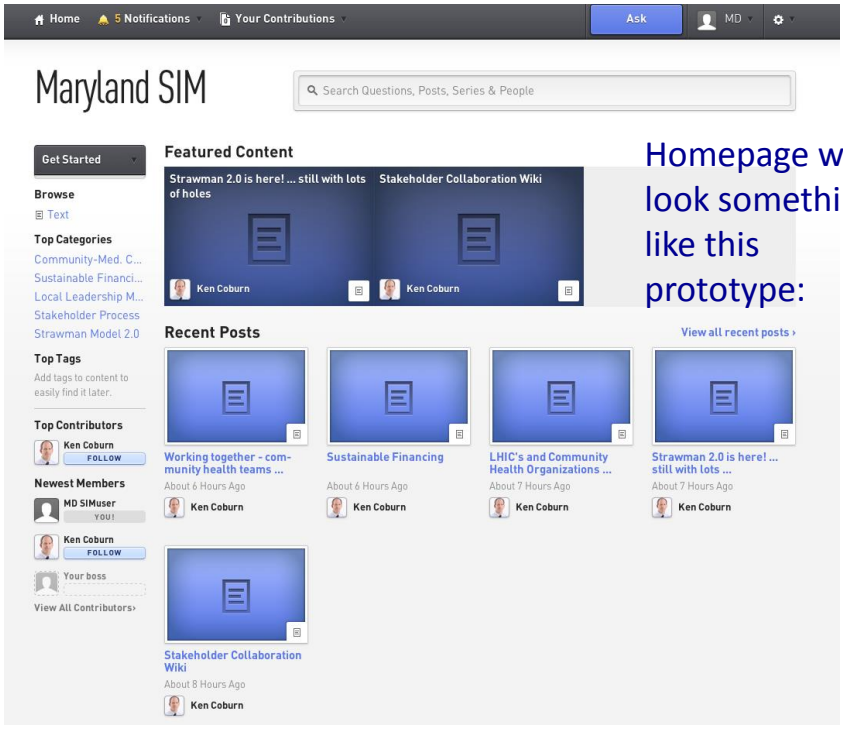
- Still a lot of missing parts to the model that need more stakeholder input
  - We hope this will help us solicit and organize feedback needed to address specific areas requiring more thought and input
- Asynchronous online input is accessible whenever it's convenient for users
- Threads of comments and responses shared among users stimulates thinking and idea generation
- Will help us pull together Strawman model x.0 for the Summit in September!

SIM Online Collaborative Design

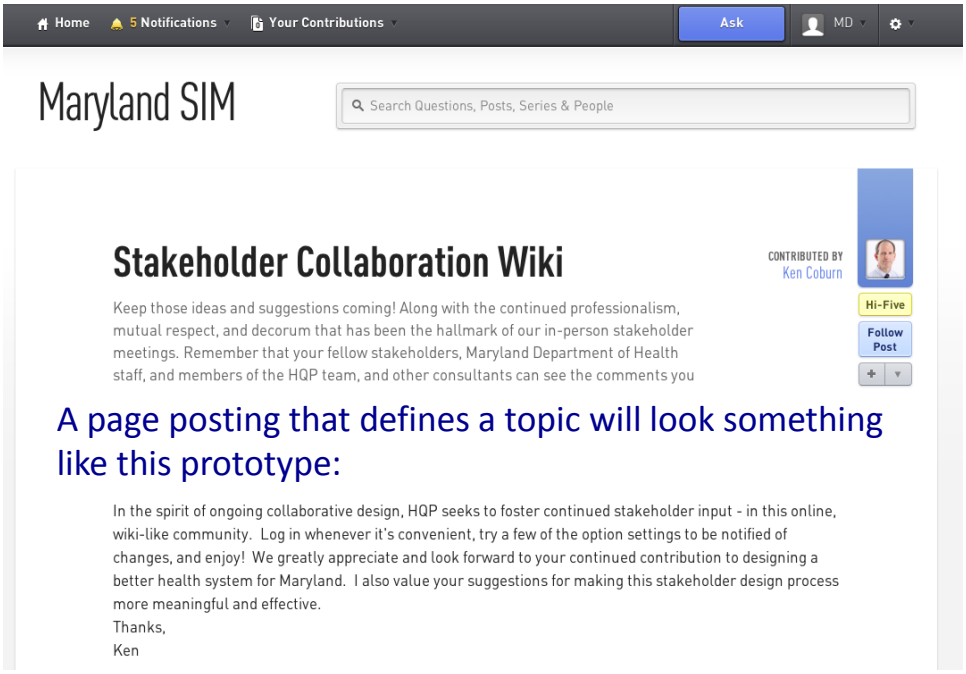
- Website currently undergoing set-up and testing
- Hosted by a service used by HQP and co-managed with DHMH
- Open to SIM Stakeholder participants
  - Login with username/email and user selected password
- Will be a professional/social environment with simple ground rules
  - Comments will be monitored periodically, but will not require approval before posting; VISIBLE TO ALL SITE USERS
  - Creating new pages (starting a new topic thread) will probably require site management approval before being published to the site
  - Respect for all users and contributions; SIM use only; proper decorum
- Information about signing up and using the site will be sent to you by email in the coming weeks

Login will be a webpage that looks something like this prototype:



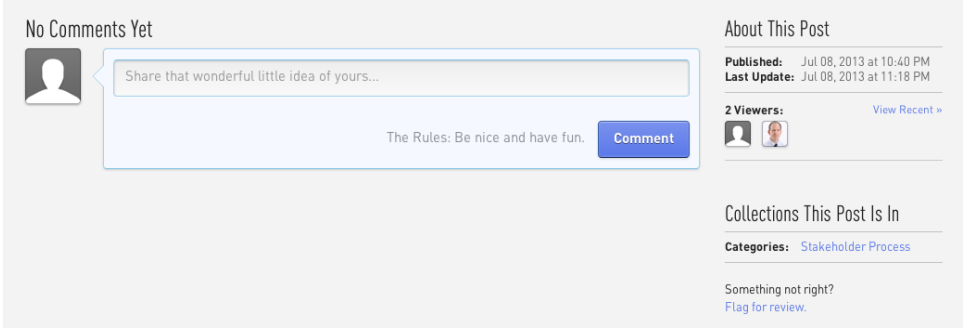


Homepage will look something like this prototype:



A page posting that defines a topic will look something like this prototype:

Comment box used to share your ideas and feedback about a topic (at the bottom of that page/thread), will look something like this prototype:



Thanks!

- More information will be coming to your email inbox in the next few weeks
- We greatly appreciate your time and willingness to give this a try
- We welcome your feedback on how this is working & ways to improve, once we go live
  - Ken Coburn coburn@hqp.org
  - Sherry Marcantonio marcantonio@hqp.org

Questions or Comments?

New Date For SIM Summit

All-Stakeholder Summit rescheduled for

September 10, 2013

Please save the date!