



**Mobile Integrated Health Workgroup
Phase #2**

January 19, 2017

Agenda

State of Maryland

**Maryland
Institute for
Emergency Medical
Services Systems**

653 West Pratt Street
Baltimore, Maryland
21201-1536

*Larry Hogan
Governor*

*Donald L. DeVries, Jr., Esq.
Chairman
Emergency Medical
Services Board*

*410-706-5074
FAX 410-706-4768*

- I. Welcome & Introductions**
Dr. Tim Chizmar
- II. Maryland Community Health Resources Commission - 9:15 am**
Mark Luckner, Executive Director
- III. HSCRC Center for Population Based Methodologies – 9:45 am**
Sule Gerovich, Director
- IV. MIH Phase II Committee Draft Recommendations - 10:15 am**
Andrew Naumann, MIEMSS Region II Administrator
- V. Discussion**
- VI. Next meeting**



SEMSAC MIH Phase #2 Workgroup
Meeting Summary

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Attendees

Ms. Gainer, Dr. Alcorta, Dr. Chizmar, Chief Matz, Ms. Dousa, Mr. Dousa, Chief Frankel, Chief Fletcher, Mr. Goldfeder, Ms. Neely, Ms. Hiner, Ms. Myers, Mr. Naumann, Lt. Baltrotsky, Mr. Magee, Mr. Barto, Ms. Harne, Ms. Ailiff (phone), Ms. King, Ms. Goff.

Speakers

Mark Luckner, Executive Director
Maryland Community Health Resources Commission (MCHRC)

Sule Gerovich, PhD; Director of Population-Based Methodologies
Health Services Cost Review Commission (HSCRC)

Dr. Chizmar welcomed everyone and introductions were made.

Community Health Resource Commission (CHRC) – Mr. Luckner

A paper and electronic copy of the presentation was distributed to the members.

Mr. Luckner said that the CHRC was created by the Maryland General Assembly in 2005 to expand access for low-income Marylanders and underserved communities. The Maryland General Assembly approved legislation (Chapter 28) in 2014 to re-authorize the CHRC until 2025.

Statutory responsibilities of the CHRC include increasing access to primary and specialty care through community health resources; promoting community-hospital partnerships and emergency department programs to prevent avoidable hospital utilization, facilitating the adoption of health information technology and promoting long-term sustainability of community health resources as Maryland implements health care reform.

Mr. Luckner gave an overview of the CHRC, including the impact of CHRC grants, areas of focus and strategic priorities. He also supplied information on grant criteria, the grant application process and types of community health resources. CHRC Grants assist ongoing health care reform efforts, supports all-payer hospital model and health system transformation and supports population health improvement activities.

Mr. Luckner gave an overview of the funding granted to the Charles County Integrated Health Project.

All-Payer Model Performance and Progression Strategy – Dr. Gerovich

A paper and electronic copy of the presentation was distributed to the members.

Dr. Gerovich gave an overview of the Health Service Cost Review Commission (HSCRC) origins and jurisdiction to include budgeting information for InPatient admissions.

Dr. Gerovich explained the new Maryland All-Payer Model approved by the Centers for Medicare and Medicaid Innovation, effective January 1, 2014, which changed the old waiver (per inpatient admission) hospital payment to the new model of all-payer, per capita, total hospital payment and quality.

All-payer model performance to date:

Performance Measures	Targets	2014 Results	2015 Results ¹	2016 Year-to-Date Results (preliminary) ²
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.47% growth per capita	2.31% growth per capita	0.35% growth per capita
Medicare Savings in Hospital Expenditures	≥ \$330m over 5 years (Lower than national average growth rate from 2013 base year)	\$116m (2.15% below national average growth)	\$135m \$251m cumulative (2.22% below national average growth since 2013)	\$178m \$429m cumulative (4.60% below national average growth since 2013)
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	\$133m (1.53% below national average growth)	\$80m \$213m cumulative (0.85% below national average growth since 2013)	\$106m \$319m cumulative (1.63% below national average growth since 2013)
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	30% reduction over 5 years	26% reduction	35% reduction since 2013	49% reduction since 2013
Readmissions Reductions for Medicare	≤ National average over 5 years	20% reduction in gap above nation	57% reduction in gap above nation since 2013	71% reduction in gap above nation since 2013
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	95%	96%	96%

Dr. Gerovich said that the progression plan submitted to CMS in December 2016 included extending the all-payer model to total cost of care metrics, aligning efforts across providers and care settings, focusing on care improvements that will reduce potentially avoidable utilization in higher acuity settings and incorporating stakeholder input.

Strategies Maryland is considering for progression are:

- Transition to increased levels of engagement and responsibility for system-wide costs and outcomes over time

- Develop a focused portfolio of payment and delivery system transformations to support key goals
- Develop and support groups of providers taking system-wide responsibility for cost and patient outcomes
- Harmonize incentives and align activities

Dr. Gerovich said in 2015, the Commission authorized up to 0.25% of total hospital rates to be allocated to deserving applicants under a competitive Healthcare Transformation Implementation Grant Program.

- “Shovel Ready” projects that generate short-term ROI and reduced Medicare PAU
- Involve community-based care coordination and provider alignment and not duplicate care transitions and prior infrastructure funding
- The RFP was released on August 28, 2015 and applications submitted by COB December 21, 2015
- HSCRC received 22 proposals from single-or multiple hospital applicants, addressing needs of particular regions; 10 proposals were funded

Regional Partnership Lists

Round One Funding – June 2016

Partnership Group Name	Hospital(s) in Proposal
Bay Area Transformation Partnership	Anne Arundel Medical Center; UM Baltimore Washington Medical Center
Community Health Partnership	Johns Hopkins Hospital; Johns Hopkins – Bayview; MedStar Franklin Square; MedStar Harbor Hospital; Mercy Medical Center; Sinai Hospital
GBMC	Greater Baltimore Medical Center
Howard County Regional Partnership	Howard County General Hospital
Nexus Montgomery	Holy Cross Hospital; Holy Cross – Germantown; MedStar Montgomery General; Shady Grove Medical Center; Suburban Hospital; Washington Adventist Hospital
Total Eldercare Collaborative	MedStar Good Samaritan; MedStar Union Memorial
Trivergent Health Alliance	Frederick Memorial Hospital; Meritus Medical Center; Western Maryland Hospital Center
UM-St. Joseph	UM St. Joseph Medical Center
Upper Chesapeake Health	UM Harford Memorial Hospital; UM Upper Chesapeake Medical Center; Union Hospital of Cecil County

Round Two Funding – October 2016

Partnership Group Name	Hospitals in Proposal
Calvert Memorial	Calvert Memorial Hospital
Lifefridge Health System	Carroll Hospital Northwest Hospital Sinai Hospital
Peninsula Regional	Atlantic General Hospital McCready Memorial Hospital Peninsula Regional Medical Center
Totally Linking Care – Southern MD	Calvert Memorial Hospital Doctor's Community Hospital Fort Washington Medical Center Laurel Regional Hospital MedStar Southern Maryland Hospital MedStar St. Mary's Hospital Prince George's Hospital Center
West Baltimore Collaborative	Bon Secours Hospital St. Agnes Hospital University of Maryland Medical Center UMMC – Midtown Campus

Care Redesign Amendment:

At stakeholder request, the HSCRC asked CMS to approve an amendment to our All-Payer Model (Model) to obtain comprehensive patient level Medicare data to support care coordination, to allow hospitals to share resources with non-hospital providers, and to allow hospitals to share savings with non-hospital providers. More information on implementation of the Care Redesign Programs is available on HSCRC's website: <http://www.hscrc.maryland.gov/care-redesign.cfm>

CPC+ Program

The Comprehensive Primary Care Plus includes more resources for primary care and non-visit payments.

- Non-visit-based Care Management Fee (CMF) paid per-beneficiary-per month (PBPM). The amount is risk-adjusted for each practice to account for the intensity of care management services required for the practice's specific population.
- Comprehensive Primary Care Payments are prospective payment based on historical utilization levels paid in a lump sum on a quarterly basis absent a claim.
- Performance-Based Incentive Payment

Dr. Gerovich said EMS would need to remove barriers of reimbursements tied to transports. She suggested the following:

- Create a budget for jurisdictional / regional / state with global model for reimbursement
- Work on partnerships for funding

Dr. Gerovich also suggested exploring the following for “seed monies”

- Robert Wood Johnson Foundation <http://www.rwjf.org/>

MIH Phase II Committee Draft Recommendations - Mr. Naumann

Due to time constraints, Dr. Chizmar asked the Workgroup to review the draft recommendations and strawman training document compiled by Mr. Naumann and bring any recommended changes to the next workgroup meeting on February 2, 2017.

Mr. Naumann said that there are currently no independently sustainable MIH programs in the US, as all are grant funded, suppling seed money to start a MIH program. He added that the draft recommendations document was compiled from information in the MIH survey.

Adjournment

Next meeting: February 2, 2017 at 9am in room 212 at MIEMSS.



All-Payer Model Performance and Progression Strategy

Sule Gerovich, Ph.D.
Director of Population-Based Methodologies

Today's Discussion

- ▶ Maryland's All-Payer Model Performance
- ▶ Big Picture Overview of Efforts to Transform Maryland's Health Care System in the Context of the All-Payer Model
- ▶ Discussion and Input

Health Services Cost Review Commission

▶ Origins

- ▶ Hospitals needed a mechanism to financing Uncompensated Care
- ▶ Business (trustees) wanted a way to contain costs (abandon cost-based payment)
- ▶ Maryland Hospital Association strongly supported legislation

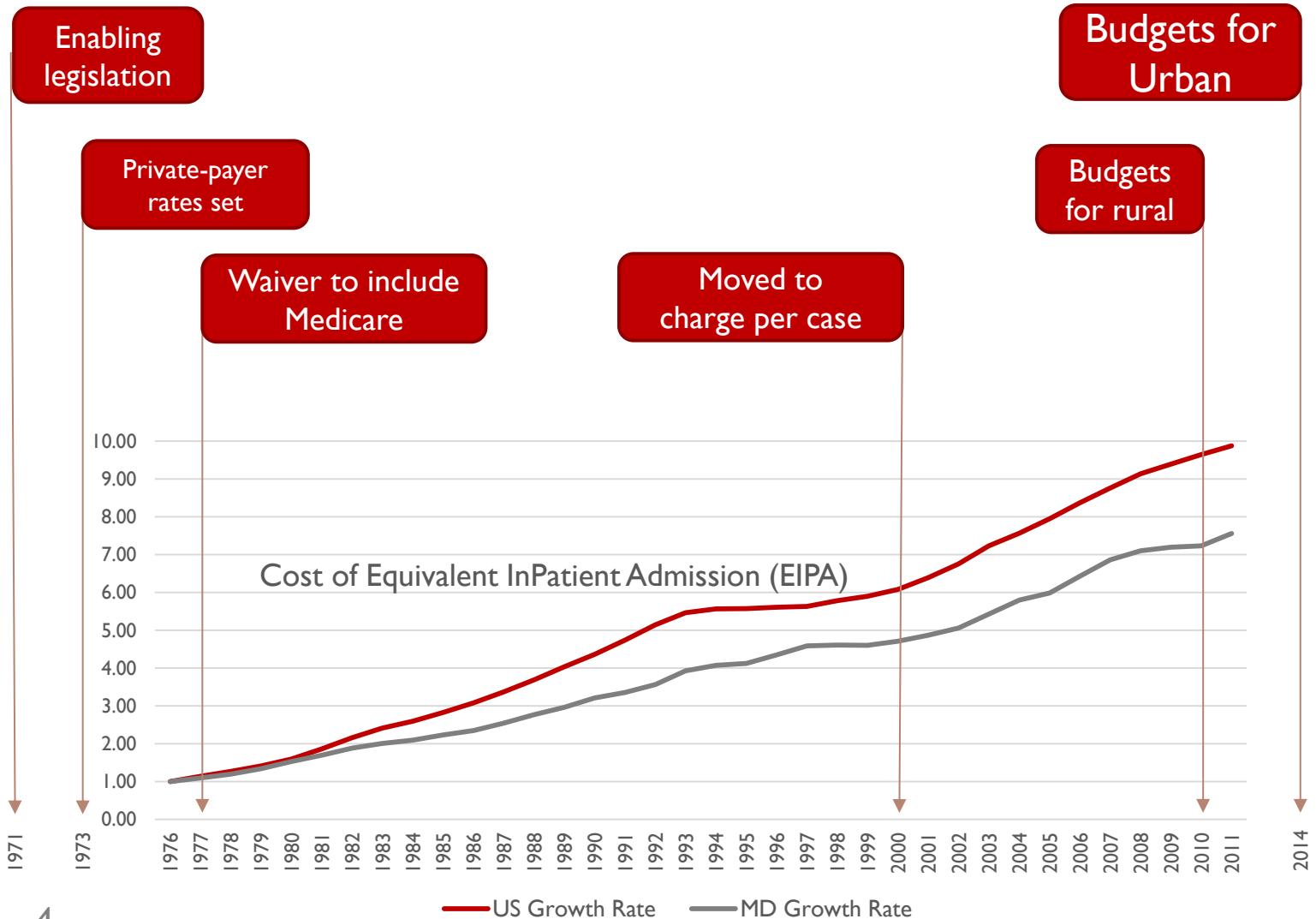
▶ Enabling Legislation 1971

- ▶ Enabling statute – very broad authority and language
- ▶ Created a politically/legally independent agency (“HSCRC” or “Commission”)
- ▶ Unique governance structure - 7 volunteer Commissioners
- ▶ Small experienced staff 35 FTEs (core analytic staff of 10-12)

▶ Jurisdiction

- ▶ Inpatient and outpatient hospital services (no Physicians services)
- ▶ 47 Acute Care Hospitals - \$15 billion in revenue

Historical background

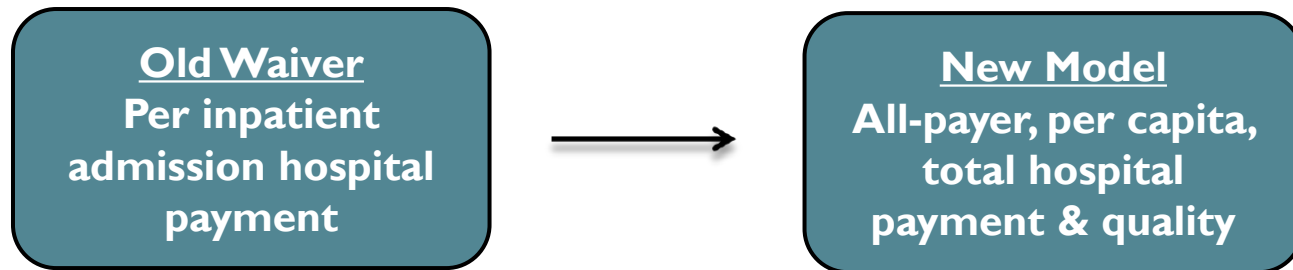


New All-Payer Model

- ▶ **New Model Approved by CMS January 1, 2014**
 - ▶ Implementation effective January 1, 2014
- ▶ **Phase 1 (5 years)**
 - ▶ 2014-2018
 - ▶ Hospital inpatient and outpatient
- ▶ **Phase 2**
 - ▶ Proposal submitted end of 2016
 - ▶ Focus on controlling growth in total health spending
 - ▶ If approved, would begin in 2019

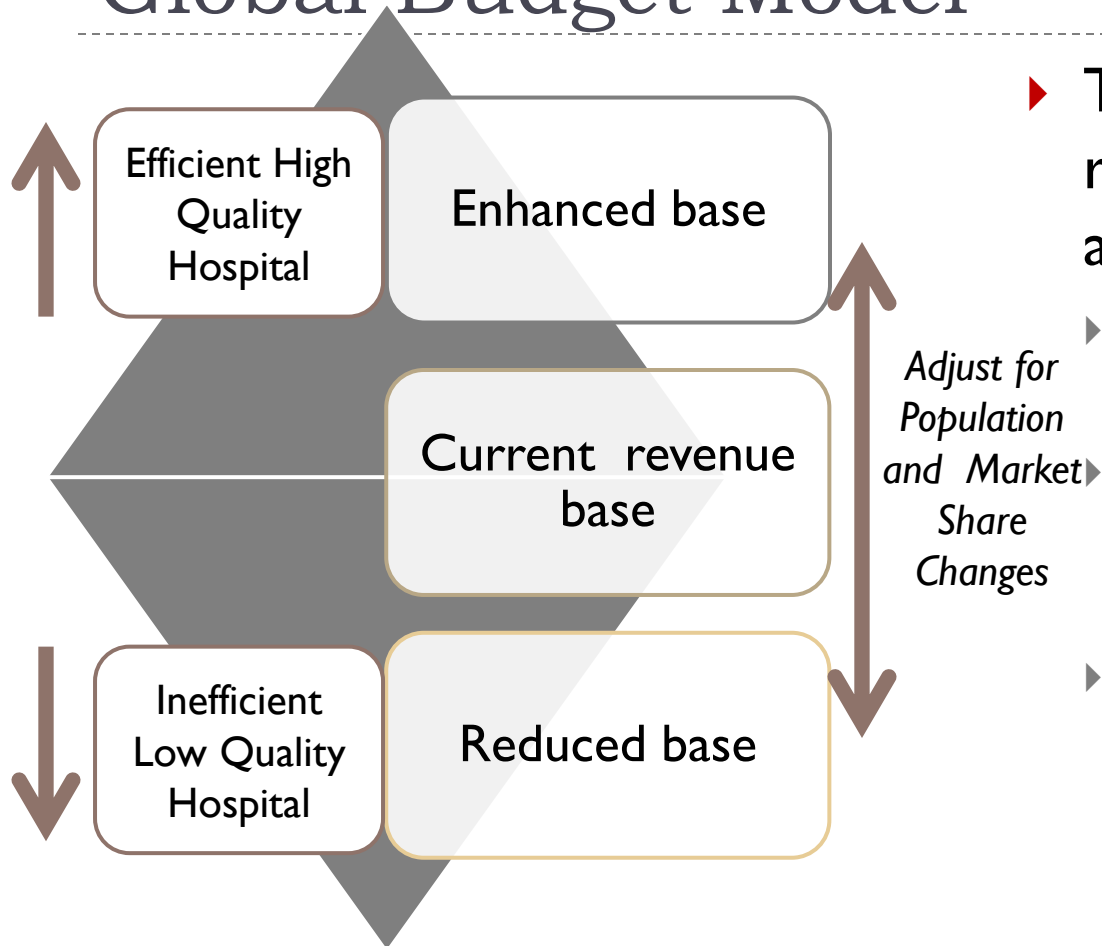
Unique New Model: Maryland's All-Payer Model

- ▶ Maryland is implementing an All-Payer Model for hospital payment
 - ▶ Approved by Center for Medicare and Medicaid Innovation (CMMI) effective January 1, 2014 for 5 years
 - ▶ Modernizes Maryland's Medicare waiver and unique all-payer hospital rate system



- ▶ Key provisions of the new Model:
 - ▶ Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least \$330 million to Medicare over 5 years
 - ▶ Patient and population centered-measures to promote care improvement
 - ▶ Payment transformation away from fee-for-service for hospital services
 - ▶ Proposal covering all health spending due at the end of Year 3 for 2019 and beyond

Global Budget Model



- ▶ **The Global Budget Model: revenue budget with annual adjustments**
 - ▶ *The initial revenue budget would be based on historical revenue*
 - ▶ *This budget could be enhanced or reduced based on hospital efficiency and utilization*
 - ▶ *The budget would be adjusted annually for changes in market share, population and quality*

Maryland Quality-Based Payment Initiatives

Quality Based Reimbursement (QBR)

- Patient Experience of Care (HCAHPS)
- Mortality
- Health Care Associated Infections
- Safety
- Clinical Process of Care

Maryland Hospital-Acquired Conditions (MHAC)

- 65 Potentially Preventable Complications

READMISSIONS

Shared Savings
Reduction Incentive
Program

All-Payer Model Performance to Date

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Model Progression

Progression Plan Highlights

- ▶ **Progression Plan submitted to CMS in December 2016**
 - ▶ Plan to extend the All-Payer Model to total cost of care metrics, and align efforts across providers and care settings.
 - ▶ Focuses on care improvements that will reduce potentially avoidable utilization in higher acuity settings.
 - ▶ Incorporated stakeholder input.
- ▶ **Incorporates 3 State initiatives**
 - ▶ Primary Care Home Model for implementation in 2018.
 - ▶ Dual Eligible ACO Model for implementation in 2019.
 - ▶ Updated Population Health Plan.
- ▶ **Aligns with MACRA requirements**

Keep Focus on Key Opportunities

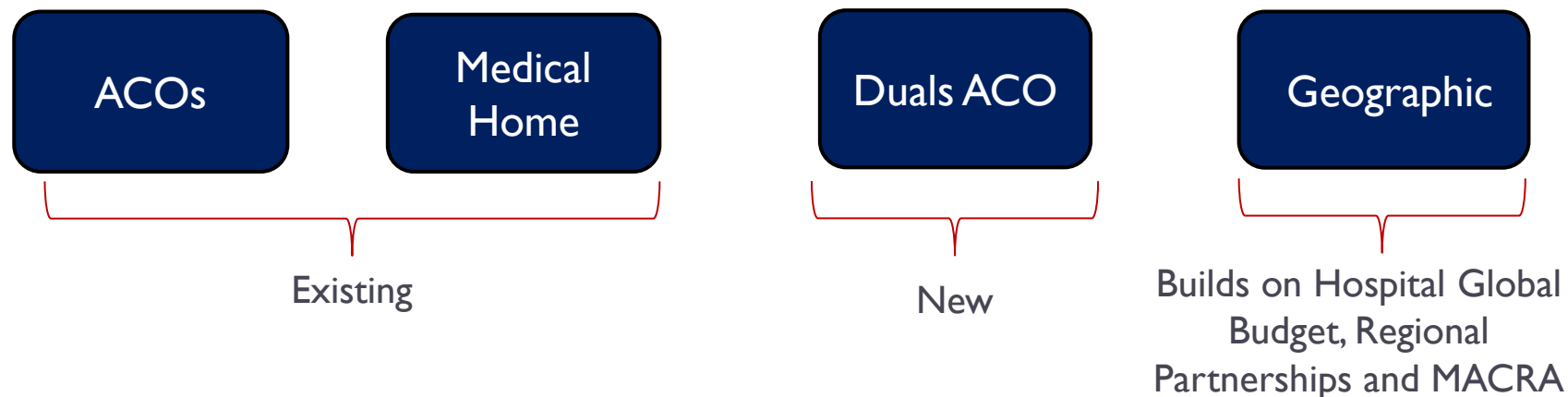
- ▶ Incorporate/expand tailored person-centered approach
- ▶ Approximately 3/4 of Medicare TCOC related to a hospitalization. Key opportunities:
 - ▶ Reducing potentially avoidable hospitalizations
 - ▶ Ensuring high quality, efficient episodes with optimal outcomes
- ▶ For dually-eligibles, just under 1/2 of Medicaid costs consist of custodial care in long-term care facilities, approximately 40% in home and community based services. Key opportunities:
 - ▶ Reducing the need for high level custodial care
 - ▶ Ensuring high quality, well coordinated services

Strategies Maryland is Considering for Progression

- ▶ Transition to increased levels of engagement and responsibility for system-wide costs and outcomes over time
 - ▶ Develop a focused portfolio of payment and delivery system transformations to support key goals
 - ▶ Develop and support groups of providers taking system-wide responsibility for costs and patient outcomes
 - ▶ Harmonize incentives and align activities

Overview of Progression Components

Support Groups of Providers Taking Responsibility for Cost and Outcomes of Medicare Fee-for-Service Beneficiaries



Supporting Portfolio of Payment/Delivery Approaches with All Payer Applicability

Global Hospital Budgets and **Regional Partnerships**
Amendment--Complex/Chronic Care, Hospital Care/Episodes
Primary Care Home--Chronic care, Visit budget flexibility
Incentive Harmonization
Post-acute and Long-term Care Initiatives
Other MACRA-eligible programs



Leverage Mutually Beneficial Approaches

Hospital Global Model, ACOs, PCMH

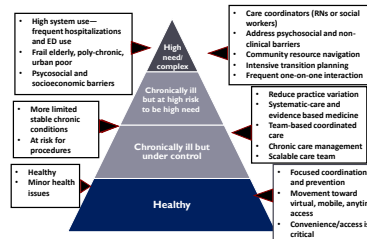
Hospitals, care partners, regional partners and payers focused on population of patients



Service Area/
Population

Common Approaches and Aligned Measures

Person-centered care tailored to needs



Risk stratification (esp for high needs persons)

Care coordination

Complex/Chronic care management

Reduction of avoidable utilization

Harmonized incentives aligned with total cost of care, health, and outcomes goals

Primary Care Home

Patient Designated Providers (PDPs) are focused on their panel of patients



Patients



Potential Timeline

Care Redesign and Infrastructure Development

Increasing System-Wide Responsibility Over Time

MACRA



Begin to implement MACRA-eligible models

Second Phase of All-Payer Model Begins

2017



2018



2019



2020-2024

- Care Redesign Amendment
- Continuing infrastructure development and transformation
- **Increase supports for high need patients**

- Primary Care Home model
- Begin Incentive Harmonization
- Developing and organizing geographic and regional efforts

- Increasing responsibility for Medicare and Dual Eligible Total Cost of Care and outcomes with groups of providers as capabilities mature
- Implement payment and delivery systems to align and harmonize efforts and incentives
- Implement approaches to engage patients, communities and public health

Regional Partnerships

- ▶ In June 2015, the Commission authorized up to 0.25% of total hospital rates to be allocated to deserving applicants under a competitive Healthcare Transformation Implementation Grant Program.
 - ▶ “Shovel-ready” projects that generate short-term ROI and reduced Medicare PAU
 - ▶ Involve community-based care coordination and provider alignment and not duplicate care transitions and prior infrastructure funding
 - ▶ The RFP was released on August 28, and applications were submitted by COB December 21, 2015
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Care Redesign Amendment

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Amendment: Care Redesign Programs

Hospital Care Improvement Program (HCIP)

- **Who?** For hospitals and providers practicing at hospitals
- **What?** Facilitates improvements in hospital care that result in care improvements and efficiency

Complex and Chronic Care Improvement Program (CCIP)

- **Who?** For hospitals and community providers and practitioners
- **What?** Facilitates high-value activities focused on high needs patients with complex and rising needs, such as multiple chronic conditions
- Leverages Medicare Chronic Care Management (CCM) fee*

- ▶ Hospitals can select which program(s) to participate in
- ▶ Through these voluntary programs, hospitals will be able to obtain data, share resources with providers, and offer optional incentive payments
- ▶ *Maryland will modify program as needed to adapt to Medicare's CPC+ program

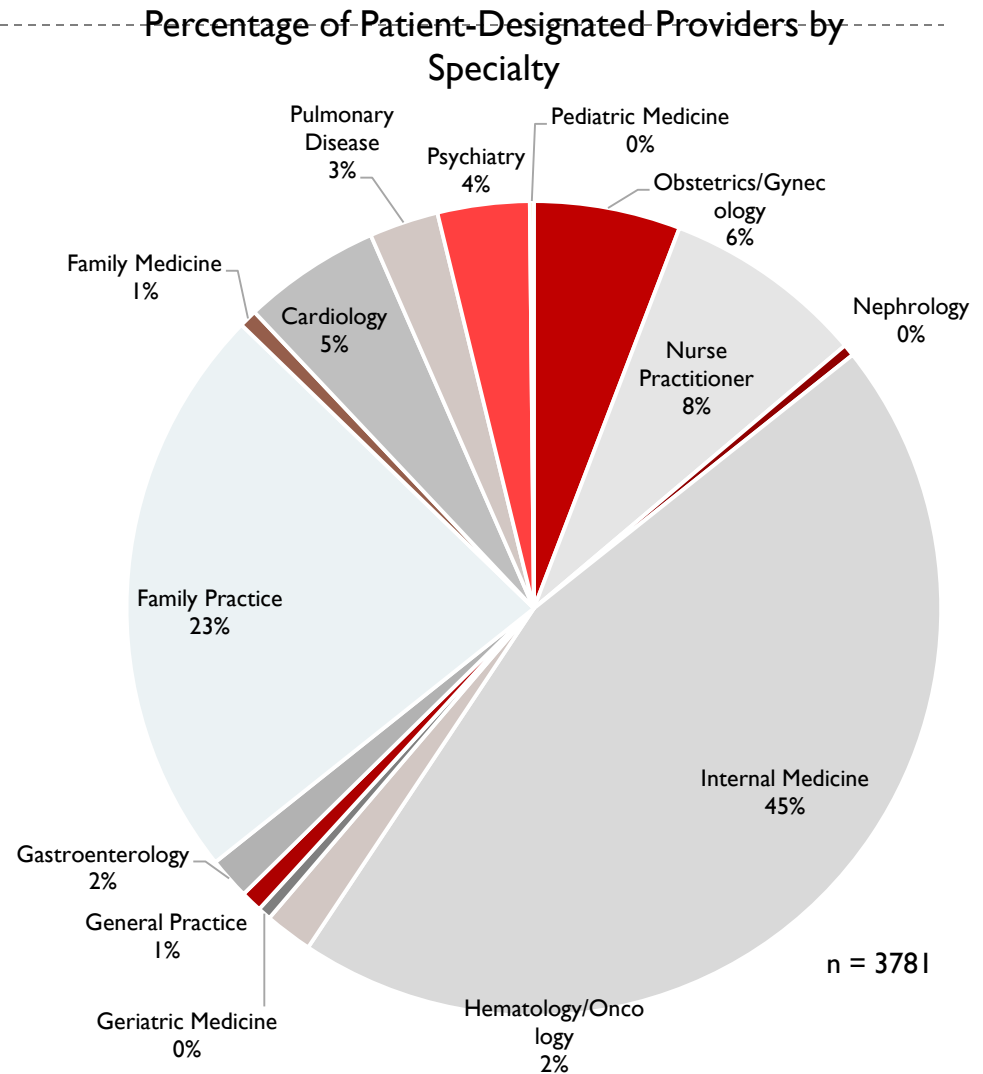
CPC+ Program

- ▶ **Comprehensive Primary Care Plus: More resources for primary care and non-visit payments**
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 - ▶ **Comprehensive Primary Care Payments:** prospective payment based on historical utilization levels paid in a lump sum on a quarterly basis absent a claim.
 - ▶ **Performance-Based Incentive Payment**

The “Who” PDPs

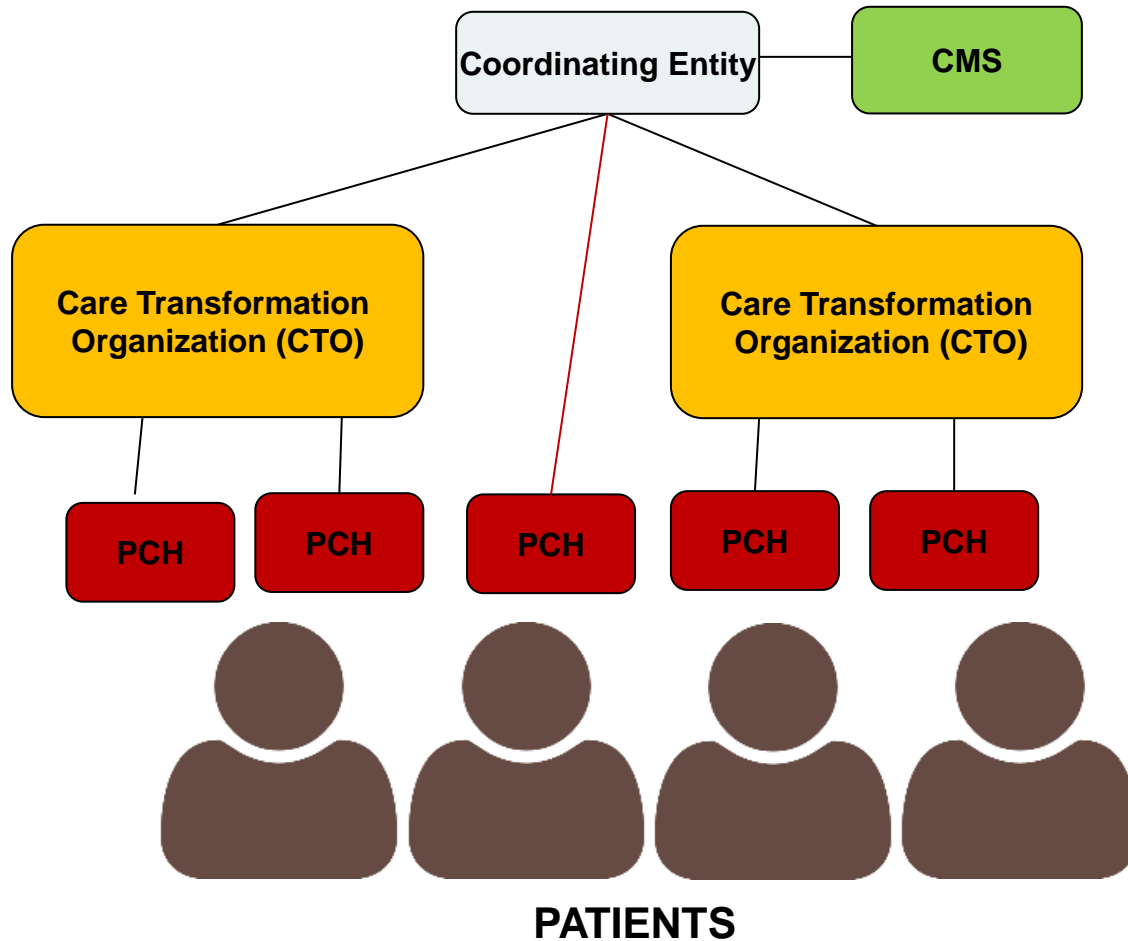
▶ Patient Designated Providers (PDPs)

- ▶ The most appropriate provider to manage the care of each patient
- ▶ Provides preventive services
- ▶ Coordinates care across the care continuum
- ▶ Ensures enhanced access
- ▶ Most often this is a PCP but may also be a specialist, behavioral health provider, or other depending on patients health needs



The “What”

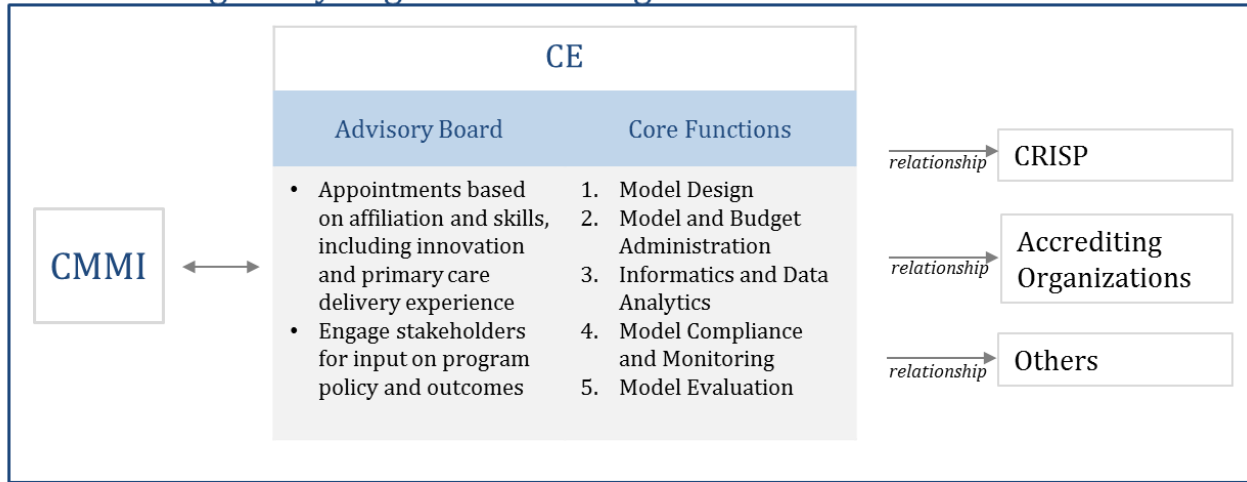
Summary View of Primary Care Program



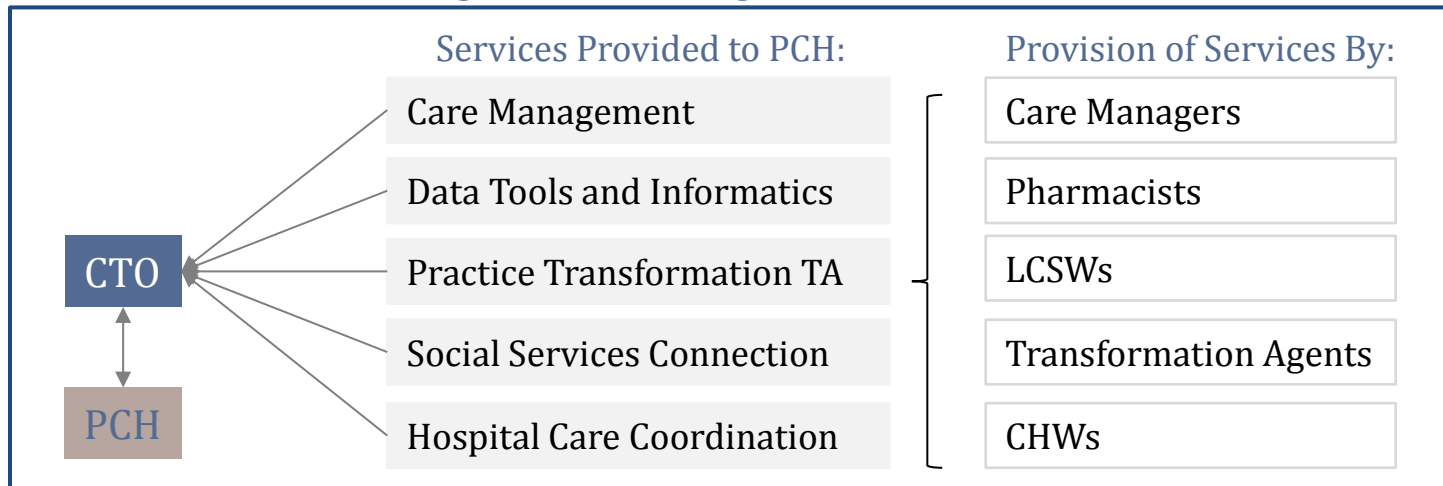
The “Who”

Coordinating Entity and CTOs

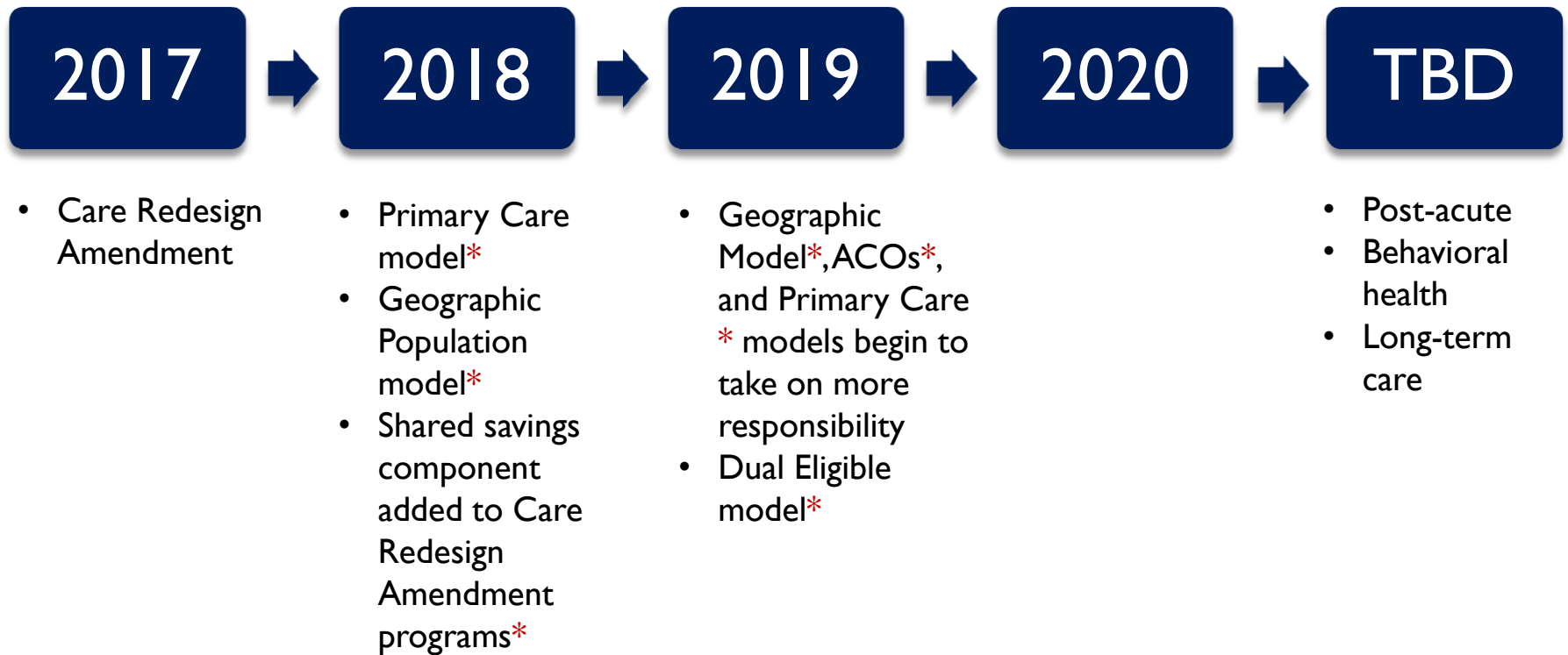
Coordinating Entity Organization Design



Care Transformation Organization Design



Potential Implementation Timeline



Discussion

Community Health Resources Commission

January 19, 2017

Mark Luckner
Executive Director, Maryland Community
Health Resources Commission

mark.luckner@maryland.gov
410.260.6290

BACKGROUND ON THE CHRC

- **The Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access for low-income Marylanders and underserved communities.**
- **Statutory responsibilities include:**
 - Increase access to primary and specialty care through community health resources
 - Promote community-hospital partnerships and emergency department diversion programs to prevent avoidable hospital utilization
 - Facilitate the adoption of health information technology
 - Promote long-term sustainability of community health resources as Maryland implements health care reform
- **The Maryland General Assembly approved legislation (Chapter 328) in 2014 to re-authorize the CHRC until 2025. This vote was unanimous.**

BACKGROUND ON THE CHRC

- **Eleven Commissioners of the CHRC are appointed by the Governor.**
- **Below is a listing of the CHRC Commissioners.**

The Hon. John A. Hurson, CHRC
Chairman, Executive Vice President, Personal Care Products Association

Allan Anderson, M.D., Vice President of Dementia Care Practice, Integrate

Elizabeth Chung, Executive Director, Asian American Center of Frederick

Maritha R. Gay, Senior Director of External Affairs at Kaiser Foundation Health Plan of the Mid-Atlantic States Region

J. Wayne Howard, Former President and CEO, Choptank Community Health System, Inc.

William Jaquis, M.D., Chief, Department of Emergency Medicine, Sinai Hospital

Surina Jordan, PhD, Zima Health, LLC. President and Senior Health Advisor

Barry Ronan, President and CEO, Western Maryland Health System

Carol Ivy Simmons, PhD, President and CEO, Simmons Health Systems Consulting

Julie Wagner, Vice President of Community Affairs, CareFirst BlueCross BlueShield

Anthony C. Wisniewski, Esq., Chairman of the Board and Chief of External and Governmental Affairs, Livanta LLC

IMPACT OF CHRC GRANTS

- **Since 2007, CHRC has awarded 169 grants totaling \$55.8 million. Most grants are for multiple years.**
- **CHRC has supported programs in all 24 jurisdictions.**
- **These programs have collectively served more than 318,000 Marylanders.**
- **The initial grant funding provided by the CHRC has enabled grantees to leverage approximately \$19.5 million in additional federal, private/non-profit, and other resources.**
 - **Charles County Mobile Integrated Healthcare Project obtained \$150,000 from the Charles Regional Medical Center.**

CHRC AREAS OF FOCUS

The CHRC grants have focused on the following public health priorities:



Reducing infant mortality



Integrating behavioral health



Reducing avoidable ED visits and promoting care in the community



Investing in health information technology



Expanding primary care access



Addressing childhood obesity



Increasing access to dental care

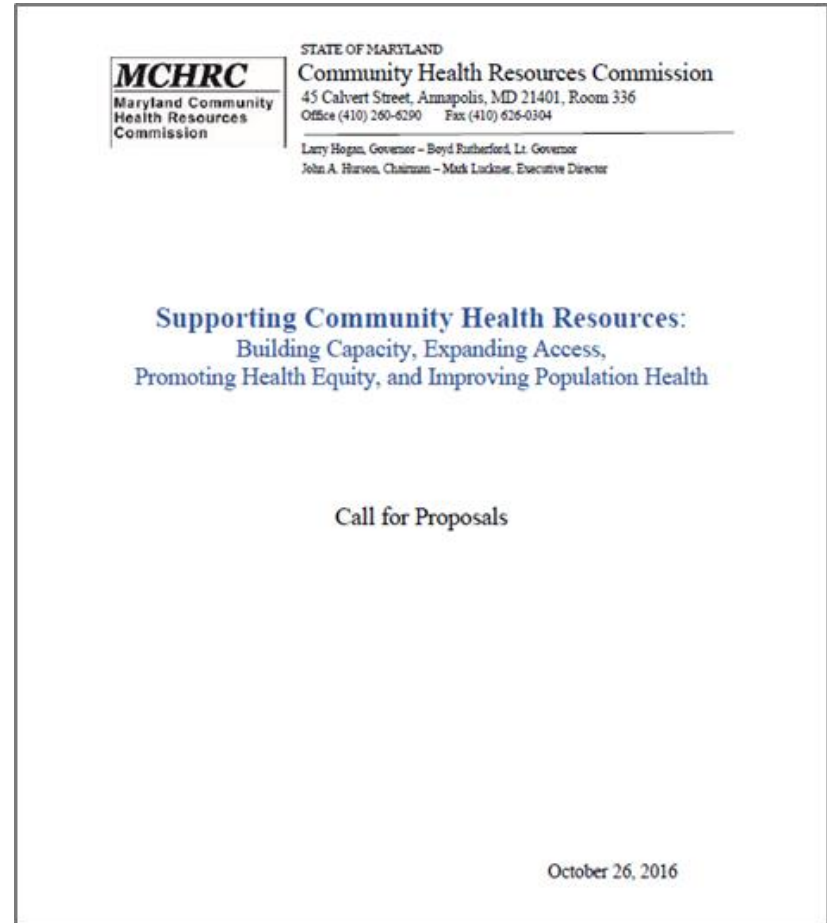


Building safety net capacity

CHRC STRATEGIC PRIORITIES



- (1) Building capacity;
- (2) Addressing health disparities and promoting health equity; and
- (3) Reducing avoidable hospital utilization and promoting innovative community-hospital partnerships.



HOW TO APPLY

Release Call for Proposals

THE CHRC Call for Proposals (RFP) is released once a year, usually in the fall.

Call for Applicants

Call for Applicants is held to answer questions about the application process.

Submit Letter of Intent

Applicants submit a Letter of Intent to determine eligibility to apply for funding.

Submit Full Application

Eligible applicants submit a Full Application, which is reviewed by subject experts.

Presentation to the CHRC

Selected grantees are invited to present their programs to the CHRC.

SELECTION CRITERIA

- 1a. **Building capacity.**
- 1b. **Addressing health disparities and promoting health equity.**
- 1c. **Reducing avoidable hospital utilization and promoting community-hospital partnerships.**
2. **Community need.**
3. **Project impact and prospects for success.**
4. **Program monitoring, evaluation, and capacity to collect/report data.**
5. **Sustainability/matching funds.**
6. **Participation of stakeholders and partners.**
7. **Organizational commitment and financial viability.**

TYPES OF COMMUNITY HEALTH RESOURCES

Designated Community Health Resources

FQHCs and FQHC “look-alikes”; CHCs; migrant health centers; health care programs for the homeless; primary care programs for public housing projects; SBHCs; teaching clinics; wellmobiles; community health center-controlled operating networks; historic MD PCPs; outpatient mental health clinics; local health departments; and substance use treatment providers.

Primary Health Care Services Community Health Resource

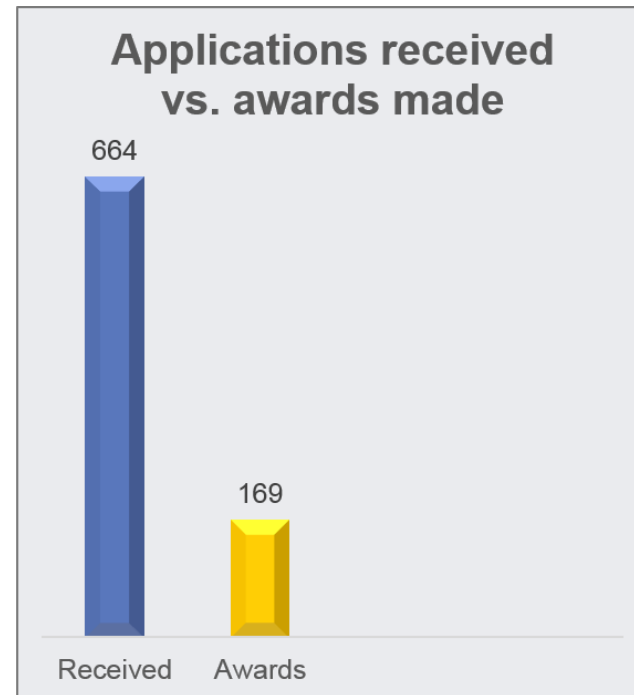
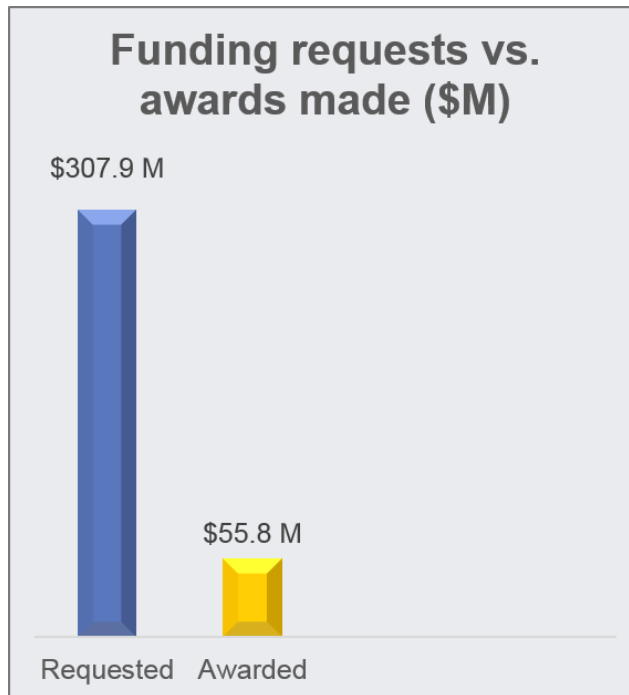
Must demonstrate that they provide primary health care services; offer those services on a sliding scale fee schedule; and serve individuals residing in Maryland.

Access Services Community Health Resource

Must demonstrate that they assist individuals in gaining access to reduced price clinical health care services; offer their services on a sliding scale fee schedule; and serve individuals residing in Maryland.

IMPACT OF CHRC GRANTS

- Demand for grant funding exceeds CHRC's budget.
- The Commission has funded approximately 18% of requests (\$307.9 M requested; \$55.8 M awarded).



Charles County Mobile Integrated Healthcare Project

Purpose of the Program:

- Address the health and social determinants leading to repeated use of emergent care.
- Link high medical service utilizers with care coordination and community health services.
- Assist the target population to better manage their health conditions in an appropriate setting.
- Collaborative, multi-sectoral project:
 - Charles County Department of Health
 - University of Maryland Charles Regional Medical Center
 - Charles County Department of Emergency Services
- Key programmatic performance metrics:
 - Number of unduplicated program participants
 - Number of program participants linked to primary care
 - Number or program participants linked to social services

County receives grant to support public health

Charles County · 07/30/2016 · By Charles County Government



On Wednesday, July 27, the Charles County Department of Health, in partnership with the Charles County Department of Emergency Services, Sen. Thomas "Mac" Middleton, Charles County Commissioners, and the University of Maryland Charles Regional Medical Center announced the launch of the Mobile Integrated Health Care Team. The program is supported by a three-year, \$400,000 grant from the Maryland Community Health Resources Commission, and is expected to serve approximately 80 individuals during the three-year grant.



Pictured (left to right): Dr. Howard Haft, Maryland Department of Health and Mental Hygiene; Amber Starn, Charles County Department of Health; Delegate Elizabeth G. "Susie" Proctor; Sen. Thomas "Mac" Middleton; Joyce Riggs, University of Maryland Charles Regional Medical Center; Mark Luckner, Maryland Community Health Resource Commission; Dr. Dianna E. Abney, M.D., Charles County Department of Health; and John Filer, Department of Emergency Services.

CHRC GRANTS IN LARGER CONTEXT

- **Assist ongoing health care reform efforts**
 - Build capacity of safety net providers to serve newly insured
 - Assist safety net providers in IT, data collection, business planning
 - Promote long-term financial sustainability of providers of last resort
- **Support All-Payer Hospital Model and health system transformation**
 - Provide initial seed funding for community-hospital partnerships
 - Fund community-based intervention strategies that help achieve reductions in avoidable hospital utilization
 - Issued white paper, “Sustaining Community-Hospital Partnerships to Improve Population Health” (authored by Frances B. Phillips)
- **Support population health improvement activities**
 - Align with State Health Improvement Process (SHIP) goals
 - Build infrastructure of Local Health Improvement Coalitions