Making Sense of Social Care Referrals: States Role in Herding the Cats

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Value-Based Care Adoption in Maryland

Maryland Total Cost of Care Model

- Partnership between CMS and the State of Maryland
- Geographic Risk-Based Payment Model impacting Hospitals in Maryland
- Hospitals take risk for the total cost of care for a patient risk pool, aligned with their geographic market reach
- Hospitals receive a fixed population-based payment, which creates incentives to reduce utilization and readmissions

Maryland Primary Care Program

- Program incentivizes primary care providers to offer advanced primary care
- Participants receive an additional per beneficiary per month payment to cover advanced care management
- Performance-based incentive payment to incentivize reductions in hospitalizations
- Track 2 Participants must screen and refer for SDOH interventions

Efforts to address SDOH

- Maryland Primary Care Program Track 2 Participants
  - Must demonstrate adoption of advanced Health Information Technology capabilities and perform advanced care management services
    - **Facilitate access to resources that are available in the community for beneficiaries with identified health-related social needs**
    - **Ensure coordinated referral management for attributed beneficiaries**
- CRISP: State Designated Health Information Exchange for Maryland
  - CRISP facilitates direct referrals to the Maryland Living Well Center of Excellence/MAC, Inc. for Statewide access to a suite of evidence-based falls prevention and health promotion programs
  - CRISP facilitates direct referrals to the Central Foodbank of Maryland to address Food Insecurity

Innovation in Aligning Health Care and Social Services

- **Maryland Statewide ADRC Network: Maryland Access Points**
  - Gateway to Long-term Services and Supports and Medicaid Waiver
  - Money Follows the Person to support nursing home transitions
  - Medicaid Administrative Claiming to support enrollment of Dual-Eligible beneficiaries into one or more Medicaid Waiver programs to reduce utilization of Institutional care
- **Power of Joining Forces**
  - Plan: Maryland Access Points will directly integrate with Hospital Discharge planners
  - CRISP HIE segments the hospital patient population of admitted Duals
  - CRISP exchanges referrals, for dual-eligible beneficiaries at-risk of nursing home placement, with the local ADRC/AAA
  - Early intervention to expedite enrollment in a Medicaid Waiver or Money Follows the Person program
  - Combined Goal: SNF Diversion and Reduced SNF Length of Stay achieved by Early Implementation of Medicaid-Funded LTSS, prior to hospital discharge
  - Innovation: Rapid implementation of Waiver LTSS to achieve SNF Diversion and reduce long-term care expenditures for Duals that are high-risk for long-term nursing home placement

Key Differences Between Health and Social Service Data

Healthcare Data	Social Service Data
Common Funding Sources / Billing	Diversity of Funding Sources
Clinically-Centered Interventions	Person and Community Centered
Largely Mature Data Systems	Scattered Data / Data Systems
Interoperability Push / FHIR	Interoperability? (Few Standards)
Robust Communities of Practice	Data Often as Burden / Afterthought

Missouri Aging Services Data Collaborative