Maryland
DEPARTMENT OF HEALTH

ANNUAL REPORT 2019

MARYLAND PRIMARY CARE PROGRAM

ACKNOWLEDGEMENTS

The 2019 Maryland Primary Care Program Annual Report was written as a collaborative effort between the Program Management Office at the Maryland Department of Health and many partners, including the Maryland Primary Care Program Advisory Council. Sincere gratitude is extended to all who contributed to the Annual Report, as well as the primary care practices doing the important care transformation work for patients in Maryland.

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Special Thanks to Sophia Bi for developing the design and expertly compiling the final report.

EXECUTIVE SUMMARY

The 2019 Maryland Primary Care Program (MDPCP) Annual Report provides data and analysis on the process and outcomes of transforming the delivery of primary healthcare through 380 primary care practices across the state of Maryland. The MDPCP was created as a major element in the Total Cost of Care contract in order to support willing and eligible primary care practices to provide better care and expanded access to a wide range of services including data driven, targeted care management, behavioral health services, and attention to the social needs of patients. Participating practices are supported jointly by the Center for Medicare and Medicaid Innovation (CMMI) MDPCP team and the Maryland Department of Health Program Management Office (PMO). Unique to the MDPCP, practices also have the opportunity to partner with Care Transformation Organizations (CTOs) to assist with staffing and technical assistance needs. The State also provides practice support through a team of dedicated practice coaches, the extensive services of the state designated Health Information Exchange (CRISP), the expert analytics from The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) and contractors supporting additional needs.

MDPCP is designed to run from 2019 through 2026 with annual open enrollments for practices during the first five program years. Practices may enter the program in the advanced (Track 2) level or the basic (Track 1) level. Practices that enter in Track 1 must meet stringent care delivery, quality, and administrative requirements and advance to Track 2 by no later than the end of their third year of program participation. Track 2 provides the practices with greater financial support and requires practices to accept a partial prepayment for basic evaluation and management services. Requiring a transition to fully advanced primary care is driven by the expectation that through this program the State will have an organized, identifiable, and fully operational advanced primary care workforce functioning independently while under the guidance of MDH and CMMI and working collaboratively with MDH and CMMI. Additional details on payments and care transformation requirements are found in the body of the Annual Report.

MEETING THE MDPCP'S THREE YEAR 1 OBJECTIVES

The report that follows provides details on the rapidity of broad based healthcare delivery transformation that occurred during the first program year of MDPCP (Program Year 1, or PY1). Notably the initial Request for Applications had 595 applicants. Of those, 380 met the initial program requirements and ultimately participated, with the majority (90%) entering as Track 1 practices. The first quarter of PY1 was consumed with onboarding and all the usual complexities associated with the start of a large, multifaceted program jointly supported by state and federal partners. By the middle of PY1, the practices began to make substantial gains and finished the year meeting the following first year objectives of the program:

- Infrastructure Development - Building a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to controlling the growth of Maryland's Medicare part A and B costs
- Care Transformation - Improving population health through continuous, relationship-based primary care that proactively addresses both medical and behavioral health needs, as well as social determinants of health and provides continuity of care
- Quality and Utilization improvement - Establishing data tools and quality improvement processes that allow practices to monitor performance

Infrastructure Development

The first program year was one of growth, innovation, and partnership development. The first six months of the program included administrative onboarding for practices and introduction to this new program. Still, in just this first year, the MDPCP has fostered a robust statewide network of dedicated primary care practices who are eager to transform care to better serve their patients. To facilitate care transformation, the MDPCP has engaged in a number of public-private partnerships in healthcare delivery. One of the keys to MDPCP's early success has been the development of a broad set of partners. These partnership activities include the following:

- CRISP - suite of beneficiary claims reports designed for MDPCP practices
- The Hilltop Institute - development of a model for predicting avoidable hospital events
- Mosaic Group - implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to address behavioral health needs
- Electronic Medical Record (EMR) optimization vendor - assisting practices with implementation, connectivity, and interoperability
- Community-based organizations - supporting social needs through electronic referrals

Care Transformation

The primary goal of the MDPCP is the sustainable transformation of the delivery of primary care across the state to include all of the elements of advanced primary care to support the health needs of Marylanders. MDPCP practices must submit quarterly reporting on questions pertaining to meeting the program's five Care Transformation Requirements (CTRs) in order to show their progress in implementing care transformation. MDPCP practices' responses to CTR questions demonstrate that their capacity to meet the program's five CTRs improved significantly over the course of PY1. Key takeaways from practices' responses to the CTR questions include the indications that over the course of 2019:

- Patient access to practices improved, with increasing percentages of practices offering same or next-day appointments (increased from 59.6% of practices to 68.6%) and telephone advice outside of regular work hours (increased from 66.5% of practices to 78.7%)
- Practices offered patients an increasingly wide range of medical treatment settings, including telehealth (the percentage of practices offering video-based teleconferencing increased from 38.6% to 47.6%, and the percentage of practices offering medical visits over an electronic exchange increased from 47.3% to 54.3%)
- Practices' use of care management increased, with the percentage of patients under longitudinal care management growing from 7.2% in the first quarter to 10.0% in the fourth quarter
- Nearly all practices (95%) integrated behavioral health into the delivery of primary care by the end of the fourth quarter, ushering in a new era of statewide behavioral health integration

Prior to the MDPCP, one of the most important issues facing high risk and rising risk Marylanders was the paucity of care management. By the end of PY1, MDPCP practices had brought 10% of Medicare fee-for-service (FFS) beneficiaries into care management using data driven strategies for risk stratification. In recognition of a shortage of behavioral health services, MDPCP practices were required to integrate behavioral health services into each and every brick and mortar office to promote a major improvement in access to this important care. By the end of PY1, over 95% of practices had begun or completed behavioral health integration. It is notable that with support from the State's contractor, 117 of the practices fully implemented an evidence-based protocol known as Screening, Brief Intervention, and Referral to Treatment (SBIRT), creating another line of defense against the opioid crisis. To the best of our understanding, this is the largest implementation of SBIRT in primary care in the nation. The Annual Report to follow will provide much more detail on care transformation successes and remaining needs.

Quality and Utilization Improvement

In addition to the quarterly reporting on care transformation requirements, MDPCP practices were required to submit biannual rosters for Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and annually submit quality measures. Due to the quality measure submission period overlapping with the onset of the COVID-19 pandemic, practices were encouraged to focus their attention on pandemic response in priority over quality data submission. The quality data submitted therefore represents only a partial sampling of the overall program. The results of the partial sample highlight the stronger performances of the advanced Track 2 practices in the important areas of diabetes and hypertension control.

The practices were also evaluated on the hospital and emergency department utilization of their attributed Medicare beneficiaries under a HEDIS-like framework (Healthcare Effectiveness Data and Information Set) using a synthetic comparison group composed of virtual statewide practices. Of interest, the MDPCP practices were provided both technical assistance and a specific artificial intelligence data driven tool to focus their attention on ambulatory sensitive, avoidable emergency department and hospital visits. Key takeaways from practice quality and utilization results include the following:

- **Clinical Quality (compared to national MIPS reporting)**: Practices performed well on chronic disease management quality measures: 67% surpassed the 50th percentile for controlling high blood pressure and 85% surpassed the 50th percentile for diabetes A1C control. In fact, half of all MDPCP practices scored in the 80th percentile or above for A1C control.
- **Utilization (compared to all practices with Maryland FFS beneficiaries)**: On inpatient utilization, 57% of practices performed better than the 50th percentile of benchmark Maryland FFS practices. On emergency department visits, 69% of practices performed better than the benchmark.
- **Patient Satisfaction (compared to CPC+ practices)**: On the CAHPS summary score, 37% of practices beat the 50th percentile of the benchmark practices. Note that over 50 practices were exempted from CAHPS scoring in 2019 due to surveys taking places in other CMS programs.

RECOMMENDATIONS

As we move through the second year of the MDPCP amidst a pandemic, economic hardships, and social and racial justice movements, healthcare transformation takes center stage and has brought a sharp focus on the recommendations to enhance and sustain the work that is being done within MDPCP. The recommendations fall into three broad categories:

Recommendations to improve operations

First, recommendations to improve operations focus on building on the work that has already been started to reduce administrative burden and allow practices to maximize their focus on comprehensive patient care. Changes could include reducing the number of questions asked in care transformation requirements reporting, streamlining other administrative reporting requirements, broadening the use of care management fees, and providing care transformation data feedback reports to practices.

Recommendations to improve quality and utilization measurement

The second group of recommendations are focused on continuing to align the quality, utilization and consumer satisfaction measures to align with the state's population health goals. There is opportunity for better alignment between varied programs and payers by allowing the State to drive determination of the measurement framework.

Recommendations pertaining to governance, administration, and delegation to the State

The final group of recommendations seek to develop a more collaborative governance structure between MDH and CMMI in order to coordinate effective policy decisions. Specifically, MDH recommends establishing a joint and equitable structure that facilitates mutually agreeable decisions.