Spotlight: Innovative Health Care Delivery Landscape of Maryland

An Information Brief
September 2016

Introduction

Health care delivery is rapidly changing in response to numerous State and federal policy initiatives, in particular the Affordable Care Act.[1] In 2014, U.S. health care spending increased 5.3 percent following growth of 2.9 percent in 2013 to reach $3 trillion, or $9,523 per person.[2] Practice transformation is making forward progress in health care reform by promoting high-quality care that is coordinated, patient-centered, and more efficient.

The goal of practice transformation is to shift the focus from quantity of care delivered to improved health outcomes and coordinated care delivery. The Maryland Health Care Commission (MHCC) embarked on a patient-centered medical home (PCMH) program in 2010, which concluded in 2016[3,4]. The aim of these demonstrations is to prepare ambulatory practices for participation in value-based care delivery models.

This information brief overviews the MMPP [5], the CareFirst PCMH Program, and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Awareness and Support Program. It also includes information on the Centers for Medicare & Medicaid Services (CMS) Transforming Clinical Practice Initiative, which is intended to assist providers in achieving practice transformation to align with the innovative strategies of the Affordable Care Act and MACRA.

Innovative Care Delivery Initiatives in Maryland

Maryland Multi-Payor Patient Centered Medical Home

In 2010, Maryland State legislature authorized the Maryland Health Care Commission (MHCC) to establish a three-year multi-payor PCMH pilot. The MMPP launched in April 2011 and included 52 primary care practices and over 300,000 patients, spanning a range of geographical areas, patient populations, and organizational demographics. By law, the program included

---

[1] Centers for Medicare & Medicaid Services: http://www.hhs.gov/healthcare/about-the-law/read-the-law/. Accessed on September 1, 2016.
[2] Centers for Medicare and Medicaid Services: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/downloads/highlights.pdf. Accessed on September 1, 2016.
[3] Maryland Annotated Code. Health-General. § 19-1A-02., enacted as Senate Bill 855, House Bill 929 (2010). Carriers with over $90 million in written premiums for health benefit plans in the State in the most recent reporting year are classified as large carriers.
[4] The final evaluation of the MMPP pilot was completed by IMPAQ International, a research, evaluation, and technical assistance firm. Available at: http://mhcc.maryland.gov/mhcc/pages/apc/apc/documents/MMPP_Evaluation_Final_Report_073115.pdf.
[5] Maryland Multi-Payor Patient Centered Medical Home (PCMH) Program (MMPP or program).

participation by Medicaid and the four largest commercial health insurance carriers in the State: CareFirst BlueCross BlueShield (CareFirst), Aetna (now merged with Coventry), Cigna, and UnitedHealthcare.[6] Two Federally Qualified Health Centers (FQHCs)[7] participated, as well as private primary care practices in urban, suburban, and rural settings. In addition, the military care plan, TRICARE, the Federal Employees Health Benefits Program, and the Maryland State Employee and Retiree Health and Welfare Benefits Program participated in the MMPP.

Findings from the final MMPP evaluation conducted by IMPAQ International, LLC[8] are consistent with findings from PCMH pilot demonstrations nationally with similar population health goals of improving quality and reducing costs. Findings suggest the MMPP positively impacted practice transformation; provider satisfaction; patient satisfaction with provider communication; chronic disease management; and disparities in care by practice location. The Medicaid results were particularly notable.[7] Highlights of the findings include chronic disease management of some ambulatory care sensitive conditions (ACSCs) improved, along with a reduction in emergency department visits and inpatient stays among Medicaid patients with these conditions. In addition, there was evidence to suggest that the MMPP may have slowed growth of some inpatient and outpatient payments among Medicaid patients. Sustaining programs that achieve progress towards the triple aim is a key component of health care reform.

CareFirst PCMH

CareFirst launched a PCMH program in 2011 (authorized by the same law that created the MMPP).[9] The initiative is designed to incentivize providers to keep high-risk patients with multiple chronic conditions healthier. In 2014, nearly 1.1M Maryland residents were attributed to a CareFirst PCMH practice. CMS awarded CareFirst a Health Care Innovation Award in 2013 to provide services to 35,000 Medicare enrollees in Maryland. CareFirst reports health care costs in its PCMH program were about $345M less than projected in 2014; this was about 6.3 percent less than the expected cost of care for this population of patients.[10]

Transforming Clinical Practice Initiative

CMS awarded 29 Practice Transformation Network (PTN) Cooperative Agreements to organizations to collaboratively lead practices through a transformation process. The MHCC, in partnership with MedChi, The Maryland State Medical Society, and the Department of Family and Community Medicine at the University of Maryland School of Medicine, are working with the New Jersey Innovation Institute (NJII), an awardee of the PTN, as a sub-contractor for

---

[6] Maryland Annotated Code. Health-General. § 19-1A-02., enacted as Senate Bill 855, House Bill 929 (2010). Carriers with over $90 million in written premiums for health benefit plans in the State in the most recent reporting year are classified as large carriers.

[7] FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors." –federal Health Services and Resource Administration definition.

[8] The MHCC contracted with IMPAQ International, LLC to complete the final evaluation of the MMPP pilot. Available at: http://mhcc.maryland.gov/mhcc/pages/apc/apc/documents/MMPP_Evaluation_Final_Report_073115.pdf

[9] Program description and guidelines: https://provider.carefirst.com/providers/care-management/pcmh.page?. Accessed on September 14, 2016.

[10] CareFirst website: https://member.carefirst.com/carefirst-resources/pdf/pcmh-program-performance-report-2014.pdf. Accessed on August 26, 2016.

implementing practice transformation activities in Maryland. The PTN contract was awarded to NJII in September 2015 and runs through 2019. Nearly 1,800 providers in Maryland have expressed an interest in the PTN. Providers that participate in the PTN are offered customized coaching, support for measuring outcomes for value-based payments, preparedness for alternative payments models, assistance in navigating reporting programs for CMS compliance, and data analysis for quality, work-flow, and revenue improvement.

MACRA Awareness and Support Program

In April 2015, Congress passed MACRA. This legislation aims to significantly progress health care delivery payment reform starting with Medicare and then expanding to Medicaid and commercial payors. Among other things, MACRA repealed the sustainable growth rate formula, which annually calculated cuts of up to 21 percent for physicians and other health care providers with Medicare reimbursement.[11] The legislation also established two new tracks for physician payment, the Merit-Based Incentive Payment System and the Alternative Payment Model. The U.S. Department of Health & Human Services (HHS) is relying on MACRA to transform physician payment when it is implemented in 2017 and accelerate movement toward value-based payments across payors. HHS has goals to move 30 percent of Medicare payments into alternative payment models by 2016 and 50 percent by the end of 2018.[12]

A survey conducted by a national consulting firm, Deloitte, found that half of physicians are unaware of MACRA.[13] Further, there are concerns around potential difficulties to comply with the MACRA timeline particularly with the time required to update physician reporting systems. Practices in Maryland, especially small practices located in rural or underserved areas and/or not affiliated with a hospital, need technical and administrative support to transform practice workflows and optimize the use of health IT.

The MHCC is embarking on a MACRA Awareness and Support Program (MAS) initiative to help physicians comply with MACRA by providing policy awareness, education and support. The MAS Program will assist stakeholders subject to MACRA, such as ambulatory practices, in adjusting their current approach and practice management based upon MACRA's specifications. The MAS Program will offer support specific to the two key components of MACRA, the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). MIPS combines elements of three existing programs: the Physician Quality Reporting System (PQRS), the Value Modifier (VM or Value-based Payment Modifier), and the Medicare Electronic Health Record (EHR) Incentive Program. MIPs adjusts fee-for-service provider payments based on composite scores of four weighted performance categories: quality, resource use, clinical practice improvement, and advancing care information. Advanced APMs combine new payment

---

[11] Centers for Medicare and Medicaid Services: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf. Accessed on August 22, 2016.
[12] Ibid.
[13] HealthData Management, *HIT Think Why the MACRA start date debate misses the point,* August 2016. Available at: http://www.healthdatamanagement.com/opinion/why-the-macra-start-date-debate-misses-the-point?reading_list=%5B%2700000156-77c6-deac-ab7e-ffc6ffe30000%27%2C%2700000156-7611-deac-ab7e-ff11fb510000%27%2C%2700000156-794f-d1d9-a57f-fb6f16fc0000%27%2C%2700000156-794a-deac-ab7e-f94a29080000%27%2C%2700000156-7605-deac-ab7e-ff05f6e40000%27%2C%2700000156-7413-d61b-a75e-765b0aa90000%27%2C%2700000156-7504-d1d9-a57f-f726a4bc0000%27%5D. Accessed on August 22, 2016.

approaches that incentivize quality and value similarly with MIPS while also requiring providers to assume more financial risk for the cost and quality of care.

Remarks

Payors and providers in Maryland are making progress in transforming health care delivery through the implementation of innovative value based care delivery models. Both public and private payors are designing programs that reimburse for value versus volume of care delivered. The MHCC's MAS program are anticipated for release in the first quarter of 2017 and are expected to help providers address the challenges with MACRA. The CareFirst PCMH and MMPP evaluation results show that patients are increasingly becoming more engaged in their health care, providers are coordinating and delivering care more efficiently. Insights gained from these innovative care delivery initiatives will provide valuable lessons learned to new evolving models of care.

This information brief (brief) was completed by Melanie Cavaliere, Chief, Innovative Care Delivery, within the Center for Health Information Technology & Innovative Care Delivery under the direction of the Center Director, David Sharp, Ph.D. For information on this brief, please contact Melanie Cavaliere at 410-764-3282 or by email at melanie.cavaliere@maryland.gov.