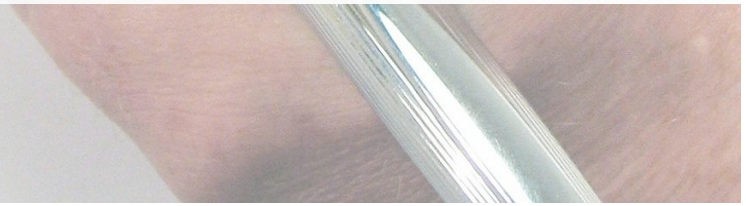
MARYLAND HEALTH CARE COMMISSION

IMPROVING QUALITY AND PREPARING FOR THE MARYLAND PRIMARY CARE PROGRAM



DECEMBER 9, 2019

ABOUT MHCC

- Advancing innovative value-based care delivery models and health information technology statewide
- Provide timely and accurate information on availability, cost, and quality of health care services to policy makers, purchasers, providers, and the public

AGENDA

- Overview of quality improvement activities in Maryland
- Quality care improvement in federally qualified health centers (FQHCs)
- Q&A
- Maryland Primary Care Program
- Q&A

CONTINUING MEDICAL EDUCATION CREDITS

- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society and the Maryland Health Care Commission. MedChi is accredited by the ACCME to provide continuing medical education for physicians.
- MedChi designates this web-based educational activity for a maximum of 1 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity

MedChi
The Maryland State Medical Society

Jointly sponsored by MedChi

DISCLOSURE STATEMENT

- The following presenters have reported no relevant financial relationships to disclose:
  - Anene Onyeabo, MPH, PMP
  - Dan Morhaim, MD
  - Howard Haft, MD
- They will not be making any offlabel references. The planners and reviewers for this activity have reported no relevant financial relationships to disclose

BACKGROUND

- Value based health care is changing the way providers deliver and are reimbursed for care, focusing less on volume and more on health outcomes and coordinated care
- Broad and effective primary care is vital to care transformation and achieving the Total Cost of Care quality goals
- FQHCs vary in their experience, readiness for change, and available resources to implement value based health care

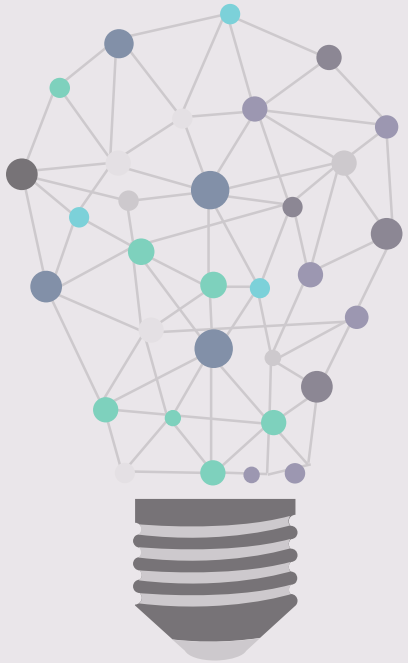
LEARNING OBJECTIVES

- Topics for Quality Care, Dan Morhaim, M.D.
  - Describe the value of taking steps to coordinate with local emergency departments
  - Define the value of collective versus individual quality evaluations
  - Introduction to compassionomics, anemia during pregnancy, and the National Board of Physicians and Surgeons (NBPAS)
- Maryland Primary Care Program, Howard Haft, M.D.
  - Discuss the practice benefits to FQHCs of participating in the Maryland Primary Care Program (MDPCP)
  - Explain opportunities for FQHCs to integrate into broader primary care delivery system
  - Highlight tools, resources, and support available to FQHCs in the MDPCP

TOPICS FOR QUALITY CARE

Topics for Quality Care

Dan Morhaim, M.D.



LEARNING OBJECTIVES

- Value of taking steps to coordinate with your local emergency departments (EDs)
- Value of collective vs. individual quality evaluations
- Introduction to compassionomics, anemia during pregnancy, and the National Board of Physicians and Surgeons (NBPAS)

INTRODUCTION

- Chair, Franklin Square ED, 1981-1994
- Delegate, Maryland General Assembly, 1994-2018
- Sinai ED physician, 1995-now
- Other medical work: Navajo Indian Reservation, Health Care for the Homeless, EMS, Hopkins Public Health Faculty 2002-2018
- Author:
  - *The Better End: Surviving (and Dying) On Your Own Terms in Today's Modern Medical World* (Hopkins Press), with new version due 2020
  - Numerous articles for medical journals and general media
- Chair, Baltimore County Behavioral Healthcare Advisory Council, 2019-now
- **Contact:** danmorhaim@gmail.com

QUALITY

- Constant pressure to report various measures
- Among other challenges: trying to manage social issues in medical setting
- Poverty, jobs, education, and substance abuse

QUALITY *(Continued)*

In 1994, John Ehrlichman, the Watergate co-conspirator, unlocked for me one of the great mysteries of modern American history: How did the United States entangle itself in a policy of drug prohibition that has yielded so much misery and so few good results?

“ **You want to know what this was really all about?** he asked with the bluntness of a man who, after public disgrace and a stretch in federal prison, had little left to protect. “**The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I’m saying? We knew we couldn’t make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did**.

Excerpt from Harpers Magazine by Dan Baum ”

CONCERN

- Over ED utilization by FQHC members: why?
- My anecdotal experience: unavailability of prompt appointments

RECOMMENDATIONS

- Coordinate with EDs – visit: set up meeting with local ED Directors and Nursing
- Coordinate with hospitals to identify frequent users, test results, etc.
- Use CRISP tools and access to HIE
- Full medication list being worked on by MHCC
- Collective data is useful but incomplete
- Analyze individual as well as collective data
- Sit down with your doctors, NPs, PAs and carefully review patient charts for completion

END OF LIFE CARE: ADVANCE DIRECTIVES

- Everyone is in this cohort
- Studies show lower minority participation for advance directives and hospice
- Introduce hospice and palliative care sooner
- Use of advance directives respects personal values, patients and families, and reduces unwanted and unnecessary expenses

MEDICAL CANNABIS

- Legal in Maryland, likely used by FQHC patients: how is this monitored?

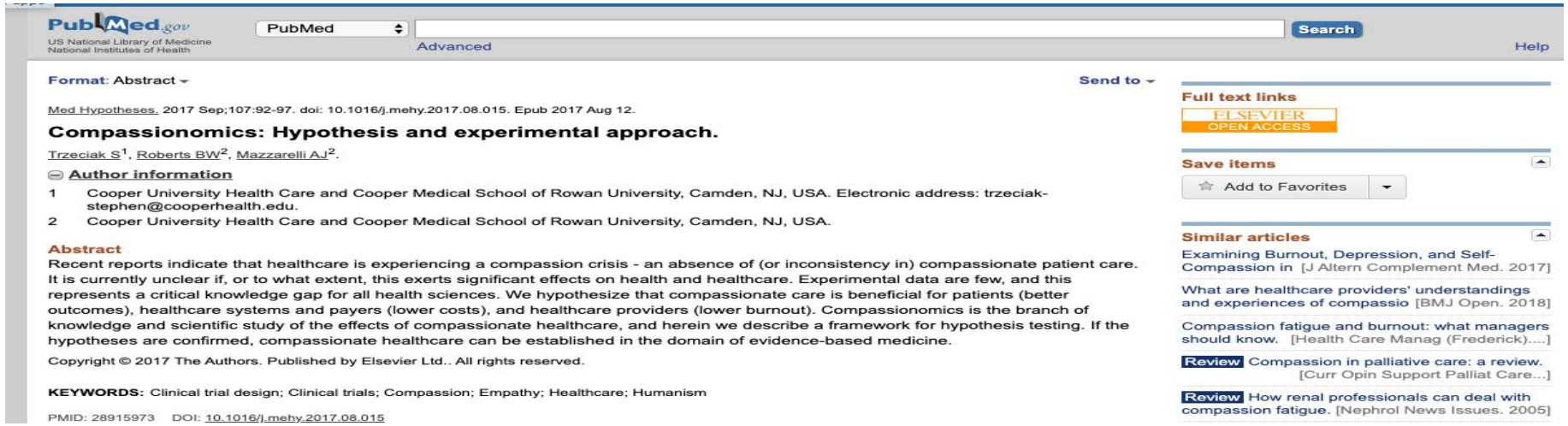
COMPASSIONOMICS

Problem:

- Nearly 50 percent of American patients do not believe that health care professionals provide "compassionate care," according to the Schwartz Center for Compassionate Healthcare in Boston
- 56 percent of physicians say they do not have time to show compassion to their patients, according to a study published by the Journal of General Internal Medicine

COMPASSIONOMICS

- Researchers at the University of California-Davis found patient-centered care lowers annual health care costs and decreases the use of health care services. Patients receive fewer diagnostic tests, specialist referrals and unnecessary hospitalizations – reducing their annual payments. Key health monitors (e.g. HgA1C improved)
- Compassion also may protect health care providers from burnout, a condition experienced by more than half of all providers, according to some studies. Additional research shows that compassionate professionals experience greater resilience and higher levels of well-being – potentially counteracting burnout



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Med Hypotheses. 2017 Sep;107:92-97. doi: 10.1016/j.mehy.2017.08.015. Epub 2017 Aug 12.

Compassionomics: Hypothesis and experimental approach.

Trzeciak S[1], Roberts BW[2], Mazzarelli AJ[2].

Author information

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2 Cooper University Health Care and Cooper Medical School of Rowan University, Camden, NJ, USA.

Abstract

Recent reports indicate that healthcare is experiencing a compassion crisis - an absence of (or inconsistency in) compassionate patient care. It is currently unclear if, or to what extent, this exerts significant effects on health and healthcare. Experimental data are few, and this represents a critical knowledge gap for all health sciences. We hypothesize that compassionate care is beneficial for patients (better outcomes), healthcare systems and payers (lower costs), and healthcare providers (lower burnout). Compassionomics is the branch of knowledge and scientific study of the effects of compassionate healthcare, and herein we describe a framework for hypothesis testing. If the hypotheses are confirmed, compassionate healthcare can be established in the domain of evidence-based medicine.

KEYWORDS: Clinical trial design; Clinical trials; Compassion; Empathy; Healthcare; Humanism

PMID: 28915973 DOI: 10.1016/j.mehy.2017.08.015

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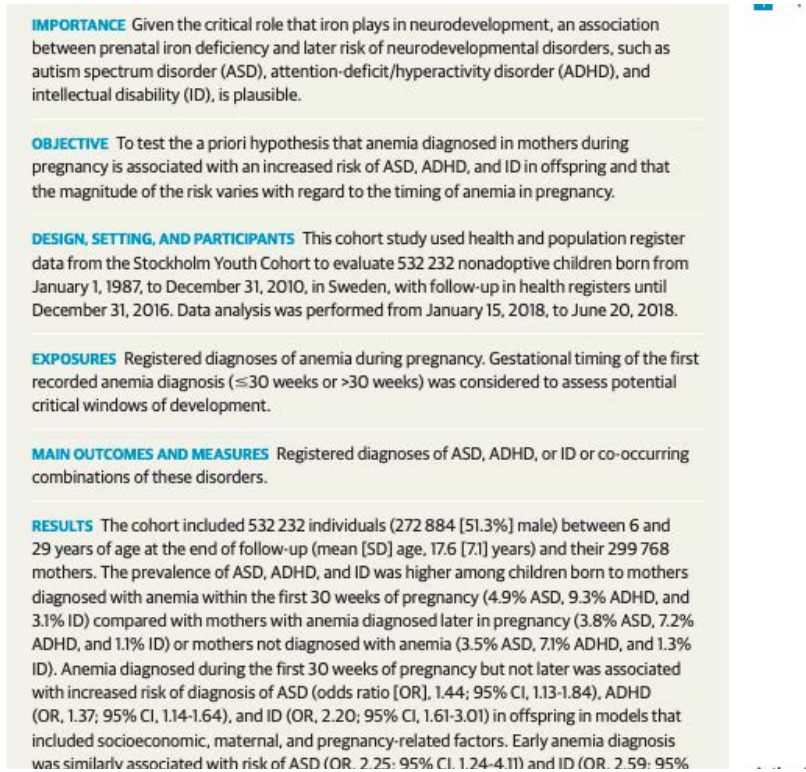
Review Compassion in palliative care: a review. [Curr Opin Support Palliat Care…]
Review How renal professionals can deal with compassion fatigue. [Nephrol News Issues. 2005]

PREGNANCY IRON DEFICIENCY

- Iron deficiency is a common problem especially among reproductive age women
- Besides fatigue (less oxygen carrying capacity), now studies show that anemia in early pregnancy increases risk of neurodevelopmental disorders: autism, ADHD, and intellectual disability



IMPORTANCE Given the critical role that iron plays in neurodevelopment, an association between prenatal iron deficiency and later risk of neurodevelopmental disorders, such as autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), and intellectual disability (ID), is plausible.

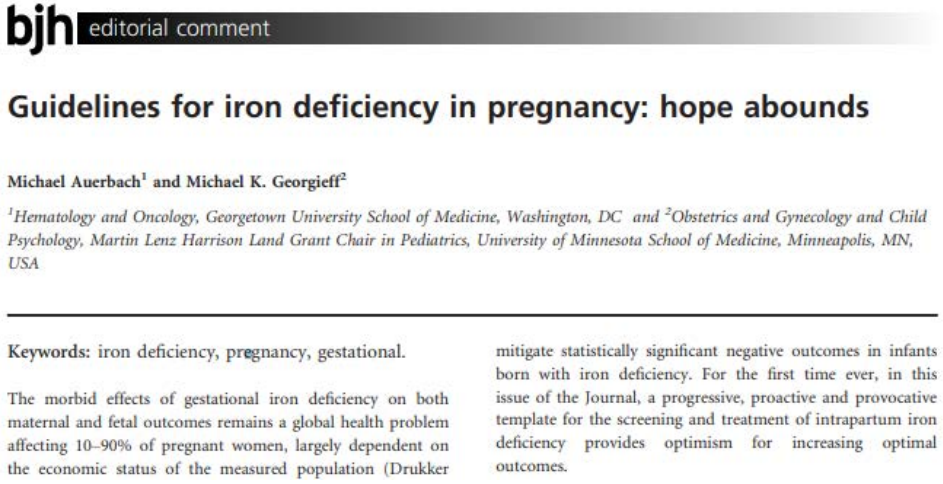
OBJECTIVE To test the a priori hypothesis that anemia diagnosed in mothers during pregnancy is associated with an increased risk of ASD, ADHD, and ID in offspring and that the magnitude of the risk varies with regard to the timing of anemia in pregnancy.

DESIGN, SETTING, AND PARTICIPANTS This cohort study used health and population register data from the Stockholm Youth Cohort to evaluate 532 232 nonadoptive children born from January 1, 1987, to December 31, 2010, in Sweden, with follow-up in health registers until December 31, 2016. Data analysis was performed from January 15, 2018, to June 20, 2018.

EXPOSURES Registered diagnoses of anemia during pregnancy. Gestational timing of the first recorded anemia diagnosis (≤30 weeks or >30 weeks) was considered to assess potential critical windows of development.

MAIN OUTCOMES AND MEASURES Registered diagnoses of ASD, ADHD, or ID or co-occurring combinations of these disorders.

RESULTS The cohort included 532 232 individuals (272 884 [51.3%] male) between 6 and 29 years of age at the end of follow-up (mean [SD] age, 17.6 [7.1] years) and their 299 768 mothers. The prevalence of ASD, ADHD, and ID was higher among children born to mothers diagnosed with anemia within the first 30 weeks of pregnancy (4.9% ASD, 9.3% ADHD, and 3.1% ID) compared with mothers with anemia diagnosed later in pregnancy (3.8% ASD, 7.2% ADHD, and 1.1% ID) or mothers not diagnosed with anemia (3.5% ASD, 7.1% ADHD, and 1.3% ID). Anemia diagnosed during the first 30 weeks of pregnancy but not later was associated with increased risk of diagnosis of ASD (odds ratio [OR], 1.44; 95% CI, 1.13-1.84), ADHD (OR, 1.37; 95% CI, 1.14-1.64), and ID (OR, 2.20; 95% CI, 1.61-3.01) in offspring in models that included socioeconomic, maternal, and pregnancy-related factors. Early anemia diagnosis was similarly associated with risk of ASD (OR, 2.25; 95% CI, 1.24-4.11) and ID (OR, 2.59; 95%



bjh editorial comment

Guidelines for iron deficiency in pregnancy: hope abounds

Michael Auerbach[1] and Michael K. Georgieff[2]

[1]Hematology and Oncology, Georgetown University School of Medicine, Washington, DC and [2]Obstetrics and Gynecology and Child Psychology, Martin Lenz Harrison Land Grant Chair in Pediatrics, University of Minnesota School of Medicine, Minneapolis, MN, USA

Keywords: iron deficiency, pregnancy, gestational.

The morbid effects of gestational iron deficiency on both maternal and fetal outcomes remains a global health problem affecting 10–90% of pregnant women, largely dependent on the economic status of the measured population (Drukker

mitigate statistically significant negative outcomes in infants born with iron deficiency. For the first time ever, in this issue of the Journal, a progressive, proactive and provocative template for the screening and treatment of intrapartum iron deficiency provides optimism for increasing optimal outcomes.

PHYSICIAN MAINTENANCE OF CERTIFICATION (MOC)

What is Wrong with MOC Exams

- The exam questions are often not relevant physician's practice. Questions often relate to parts of their specialty they do not practice.
- We have to study for recertification exams ($/time). We study what we don't know, and what we don't know is what we don't use, so after the test it's forgotten.
- The questions are often outdated. Most of the studying is done to learn the best answer for the test, which is very often not the current best practice.
- Testing often uses "Guidelines" as gold standard but there is a long history of Guidelines changing and often reversing.
- Closed book tests are no longer relevant. We care for patients with input from colleagues and the Internet.
- It's a measure of one's ability to take and pass tests only.
- Depends on each specialty board's methodology, politics, etc.

- Support your physicians – best and worthwhile CME
- MOC not proven but it's expensive time and money

PHYSICIAN MOC *(Continued)*

Boarded to Death — Why Maintenance of Certification Is Bad for Doctors and Patients

Paul S. Teirstein, M.D.

In January 2014, the American Board of Internal Medicine (ABIM) changed its certification policies for physicians. Instead of being listed by the ABIM as "certified," physicians are now listed as "certified, meeting maintenance of certification (MOC) requirements" or "certified, not meeting MOC requirements." MOC requirements include ongoing engagement in various medical knowledge, practice-assessment, and patient-safety activities, on which physicians are assessed every 2 years, and passage of a secure exam in one's specialty every 10 years.

My personal frustration in trying to fulfill the new MOC requirements ultimately led me to create a Web-based petition that now has more than 19,000 anti-

level A data, and these findings relate only to recertification, not the controversial new MOC requirements.

The ABIM claims that a ma-

10 years, others strongly believe that the exam questions are not relevant to their practice or a reliable gauge of physicians' knowledge. The ABIM describes its

MHCC: FINDINGS AND RECOMMENDATIONS OF PHYSICIAN MAINTENANCE OF CERTIFICATION WORK GROUP

Maryland Health Care Commission Report

To the extent that a hospital requires continued maintenance of board certification as part of its credentialing requirements for medical staff, physicians must maintain this certification to maintain their employment or privilege status with the hospital. Because medical staff are self-governing, physicians have the option to propose changes to hospital policies, following the process outlined in each hospital's medical staff by-laws and subject to approval by the hospital board.

There is no evidence that a hospital's Joint Commission accreditation status would be affected by a change in recertification process.

MHCC: FINDINGS AND RECOMMENDATIONS OF PHYSICIAN MAINTENANCE OF CERTIFICATION WORK GROUP (*Continued*)

Additional finding: most health insurers in Maryland do not require board recertification

It appears that most insurers in Maryland are not currently requiring board recertification. The exception is the one insurer (Kaiser) that employs all of its own physicians.

Conclusion

MHCC supports steps that reduce physician burden and improve physician retention while maintaining quality of care. With respect to physician board certification requirements, key stakeholders in the work group were unable to reach compromise on a legislative approach. Physicians have non-legislative means to change recertification through modernizing requirements within traditional board certifying organizations, encouraging acceptance of alternative board certification organizations with reduced recertification requirements by hospitals and other health facilities, and through changes to hospital medical staff by-laws that could provide physicians with greater flexibility in recertification or relief from recertification requirements altogether.

PHYSICIAN MOC (*Continued*)

Department Of Justice letter states:

MOC may have the effect of "harming competition and increasing the cost of healthcare services"

ABMS may do so "by imposing overly burdensome conditions on physicians who wish to maintain their certification."

DOJ opinion letter inspired a class action lawsuits

Maryland
Hospital Association

November 16, 2018

Gene M. Ransom
Chief Executive Officer
MedChi, The Maryland State Medical Society
1211 Cathedral Street
Baltimore, Maryland 21201
RE: Maintenance of Certification

Dear Mr. Ransom,

On behalf of the Maryland Hospital Association, I am writing to demonstrate MHA's willingness to participate in educational outreach activities to increase awareness of board recertification programs for physicians.

As you may know, at the request of the Health and Government Operations Committee, the Maryland Health Care Commission (MHCC) formed a work group to study physician maintenance of certification and board certification requirements. MHA and MedChi were represented on the work group. Although no consensus was reached on a legislative approach to this issue, members were able to clarify initial positions and identified non-legislative approaches to remedy the current impasse.

One of the proposed solutions was to encourage awareness of the National Board of Physicians and Surgeons (NBPAS). NBPAS is a non-profit created in 2014 to provide an alternative pathway to board recertification. Under current law, the Maryland Board of Physicians (BoP) has the authority to recognize specialty certification boards, in addition to the American Board of Medical Specialties (ABMS) and the American Osteopathic Association (AOA) if that specialty board submits an application to the BoP. It is our recommendation that NBPAS submit an application to the BoP to encourage utilization of the program.

We would like to partner with MedChi to ensure physicians and hospital administration are aware of the alternative recertification option offered by NBPAS as part of the qualification for physician privileging. The Maryland Hospital Association is committed to disseminating information about the program to our membership. We think a partnership with MedChi will bolster these efforts and help remedy a noted barrier for Maryland's physicians

Sincerely,

Jennifer Witten
Vice President, Government Affairs

6820 Deerpath Road, Elkridge, MD 21075 ▪ 410-379-6200 ▪ www.mhaonline.org

MARYLAND HOSPITAL ASSOCIATION

- Creating awareness about NBPAS

NBPAS

- National Board of Physicians and Surgeons (NBPAS) is an alternative certification board that replaces continuous testing with AACME accredited CME.
- NBPAS supports initial ABMS board certification and requires it to qualify for NBPAS certification.
- NBPAS opposes the testing required by MOC
- www.NBPAS.org

BALTIMORE COUNTY BEHAVIORAL HEALTH ADVISORY COUNCIL

- We would appreciate your input on this, and if you want to participate actively, let me know:

Dan Morhaim, M.D. - danmorhaim@gmail.com

MARYLAND PRIMARY CARE PROGRAM

Maryland Primary Care Program

FQHC Lunch and Learn

MHCC

Agenda

- Brief introduction to FQHC landscape in Maryland
- Introduction to MDPCP
- MDPCP Opportunity
- Next Steps

MARYLAND'S HEALTH CENTERS

Percentage of Patients by Race & Ethnicity			
Non-Hispanic White	36.0%	36.5%	34.9%
Hispanic/Latino Identity	16.9%	18.2%	19.9%
African American	51.3%	48.8%	49.4%
Asian	2.7%	2.8%	2.9%
American Indian/Alaska Native	1.5%	1.6%	1.4%
Native Hawaiian/Other Pacific Islander	0.3%	0.3%	0.4%
More than one race	1.2%	2.2%	2.3%
Services			
Medical	88.5%	88.7%	87.2%
Dental	14.3%	15.3%	15.5%
Mental Health	5.8%	6.4%	7.1%
Substance Abuse	0.8%	0.7%	0.9%
Enabling			

MACHC
Mid-Atlantic Association of Community Health Centers

Patient Profile			
	2015	2016	2017
Total Patients	303,352	313,411	328,152
Percent of Patients by Special Populations			
School Based Health Patients	3.3%	3.3%	3.2%
Veterans Patients	1.5%	1.5%	1.4%
Percent of Patients by Age			
Children (<18 years of age)	30.4%	30.0%	30.2%
Adult (18-64)	62.2%	62.2%	61.6%
Geriatric (age 65 and over)	7.4%	7.8%	8.2%
Percent of Patients by Insurance Status			
Uninsured	18.7%	18.1%	17.2%
Children Uninsured (age 0-17 yrs.)	15.9%	15.4%	13.4%
Medicaid/CHIP	49.9%	48.4%	48.5%
Medicare	9.6%	9.9%	10.1%
Dually Eligible (Medicare and Medicaid) (of Medicare)	3.6%	3.4 %	3.5%
Other Third Party	21.8%	23.6%	24.2%

FQHC Landscape

- 17 Organizations, over 100 Sites
- FQHC governmental beneficiaries:

	Medicare FFS	Medicaid	Dual Eligible	Total
Maryland	**33,042**	**159,168**	**11,457**	**44,499**

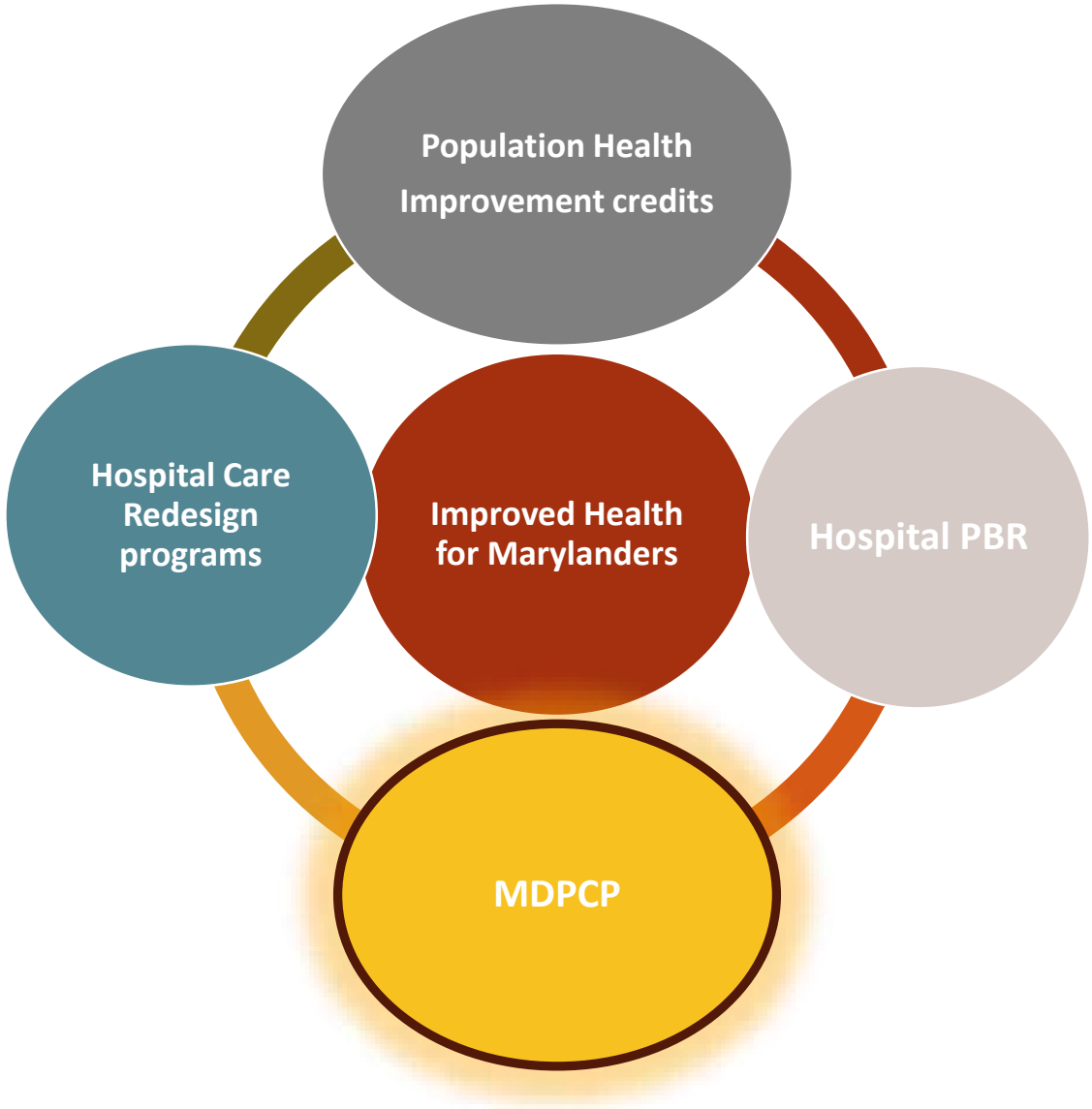
Source: https://bphc.hrsa.gov/uds/datacenter.aspx?year=2017&state=MD

Total Cost of Care Model and MDPCP

- "The umbrella"
- MDPCP is critical to meeting TCOC Model commitments including:
  - Reduction of Medicare FFS per capita health costs
  - Improvement on quality and utilization metrics
  - Improvement on population health indicators
- Advanced primary care will help the state:
  - Manage health of high and rising risk individuals in community
  - **Reduce unnecessary hospital and ED utilization**
  - Provide preventive care; address behavioral health and social needs

Future

Total Cost of Care Model Components



MARYLAND Department of Health

Maryland Primary Care Program

CMMI Testing:
" Can Primary Care payment and care delivery transformation in concert with hospital payment and care delivery redesign produce TCOC savings while improving quality?"

- MDPCP built on the learnings of CPC and CPC+
- MDPCP modified to fit into framework of TCOC model and Maryland's unique environment
  - Program Management Office Leadership
  - CRISP information exchange and data tools
  - Enhanced education and technical support with Care Transformation Organizations and Practice Coaches

How is MDPCP Different from CPC+?

	CPC+	MDPCP
Integration with other State efforts	Independent model	Component of MD TCOC Model Generous State supports
Enrollment Limit	Cap of 5,000 practices nationally	No limit – practices must meet program qualifications
Enrollment Period	One-time application period for 5-year program	Annual application period 2019-2023
Track 1 v Track 2	Designated upon program entry	Migration to Track 2 by beginning of Year 4 in program
Supports to transform primary care	Payment redesign	Payment redesign, PMO, State and CTOs
Payers	61 payers are partnering with CMS including BCBS plans; Commercial payers including Aetna and UHC; FFS Medicaid, Medicaid MCOs such as Amerigroup and Molina; and Medicare Advantage Plans	Medicare FFS (Other payers encouraged for future years)

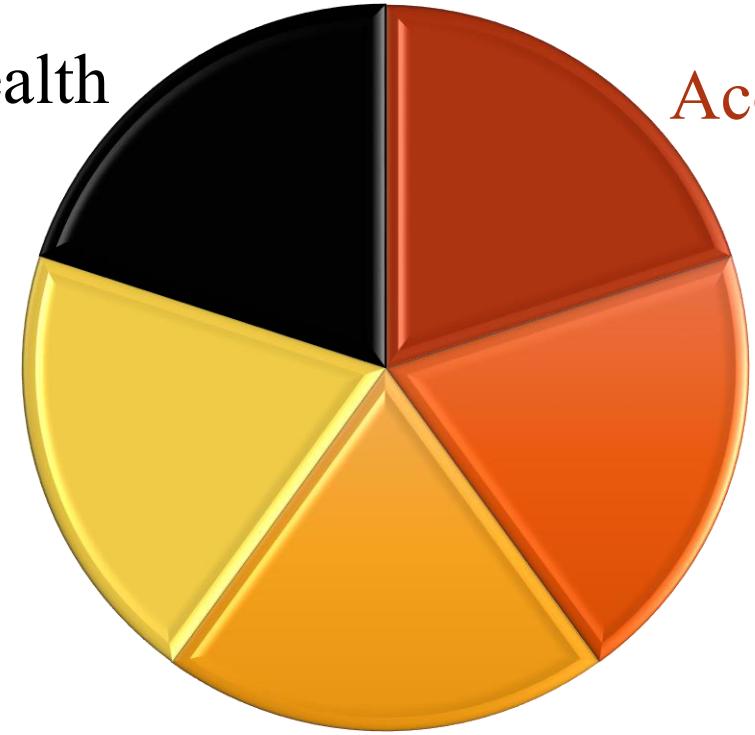
MDPCP Strategic Investments to reduce costs and improve outcomes Statewide

Five advanced primary care functions:

Planned Care for Health Outcomes

Advanced HIT
CQI

Beneficiary & Caregiver Experience



Access & Continuity

Expanded Access
Alternative Visits

Care Management

Risk Stratified Care Management
Transitional Care Management

Comprehensiveness & Coordination

Behavioral Health and SDoH
Medication Management

Metrics

electronic Clinical Quality Measures (eCQM) include:

- Outcome Measures – Diabetes and Hypertension Control (NQF # 0018 & 0059)
- (2019) Screening and Initiation of treatment for Substance Abuse (NQF # 0004)
- (2020) BMI and weight management -tbd

Patient Satisfaction

- Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) – survey of practice patients (NQF #0005)

Utilization

- Emergency department visits and Hospitalizations per 1,000 attributed beneficiaries (HEDIS)

Payment Incentives in the MDPCP

Practices – Track 1/Track 2

Care Management Fee

- $6-$100 Per Beneficiary, Per Month (PBPM)
  - Tiered payments based on acuity/risk tier of patients in practice including $50/$100 to support patients with complex needs, dementia, and behavioral health diagnoses
- Timing: Paid prospectively on a quarterly basis, not subject to repayment

Performance-Based Incentive Payment

- Up to a $2.50/$4.00 PBPM payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis, subject to repayment if benchmarks are not met

Underlying Payment Structure

- Track 1: Standard FFS
- Track 2: Comprehensive Primary Care Payment (CPCP) - Partial pre-payment of historical E&M volume with 10% bonus
- Timing: Track 1: FFS; Track 2: prospective

MSSP ACO practices do not receive the Performance-Based Incentive Payment

Potential for additional bonuses via AAPM Status under MACRA Law

State Support through the PMO

Statewide Contributions of the MDPCP Program			
CTOs	**CRISP**	**Contractors**	**Coaches**
• Furnish care coordination services • Support care transitions • Provide data and analytics support to practices • Assist with practice transformation	• Central place to report Quality Measures to CMMI • Has portal to access claims data reports • Provides SDoH screening tools and resource directories • Offers PDMP, Query Portal, Secure Messaging, ENS Services • Has Preventable Hospital Utilization Tool integrated into Claims Reports	• Implement Provider Leadership Academy and staff training academies • Provide educational materials on complex program issues • Develop and conduct Behavioral Health Integration webinar series • Offer SBIRT assistance • Help optimize EMRs • Billing and Coding guidance	• Facilitate escalation process to CMS • Offer strategies to reduce administrative burden • Deliver hands-on in-person assistance and support • Encourage quality improvement • Assist with HIE tool implementation

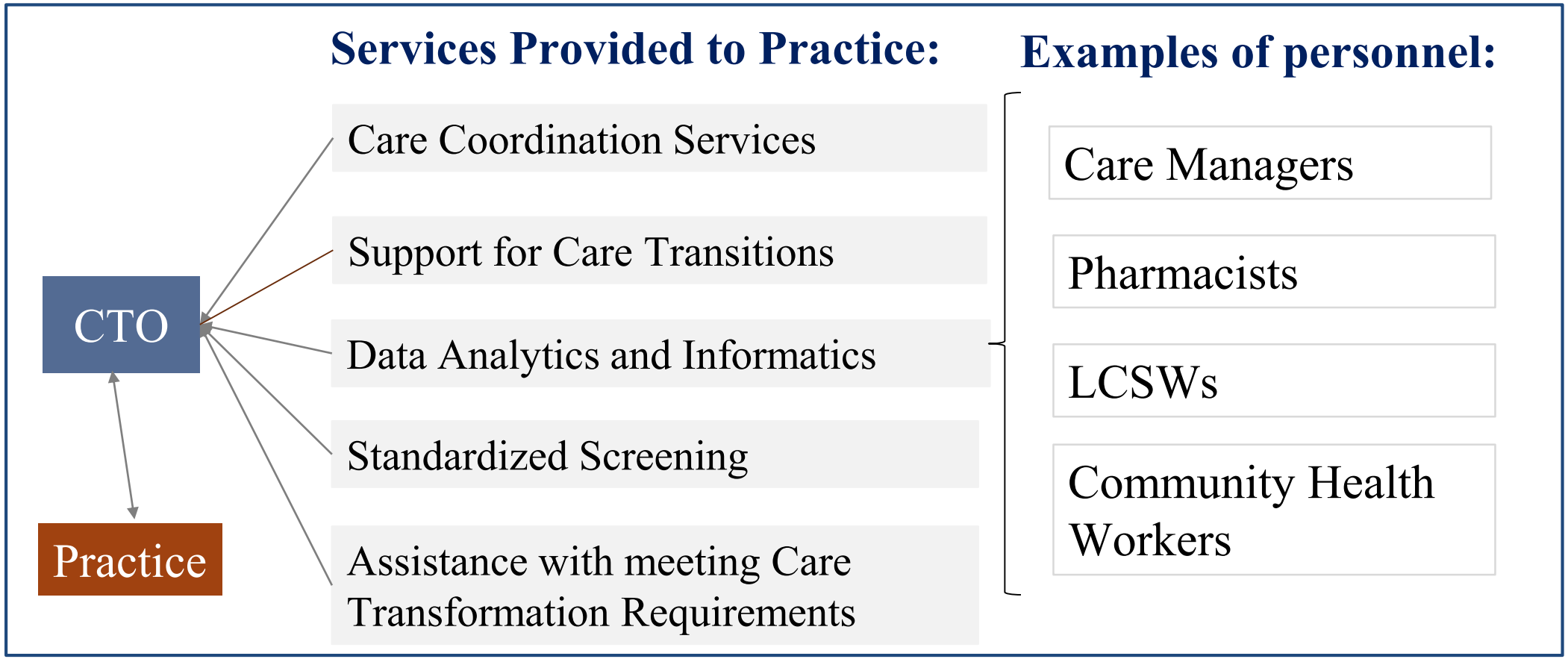
Likelihood of Avoidable Hospital Events tool

MBI	Beneficiary Name	Gender	DOB	Age	Medicare Status	Dual Status	PracticeID	HCC Tier	Likelihood of Avoidable Hospital Events	Claim Payment Amount
3FE4L31XW34	Hazlett, Egesta R	Male	6/1/1943	76	Aged without ESRD	Yes	F9MB5365	Complex	12.32%	$349,486
3W41FF5BO35	Martin, Joseph M	Female	10/1/1946	72	Aged without ESRD	Yes	F9MB5365	Complex	6.94%	$289,170
8UL7NM9YJ61	Coursey, Sarah P	Female	3/1/1951	68	Aged without ESRD	No	F9MB5365	Complex	5.44%	$78,876
6HG2L77KI56	Allen, Kimberly R	Female	11/1/1933	85	Aged without ESRD	Yes	F9MB5365	Complex	4.40%	$114,266
9DT3WB0NF04	Bernstein, Anna	Female	4/1/1936	83	Aged without ESRD	Yes	F9MB5365	Complex	3.74%	$117,220
2C61OZ9YE50	Leavey, Anna G	Female	7/1/1981	37	Disabled without ESRD	Yes	F9MB5365	Complex	3.38%	$235,716
6XR4W06US01	Gould, Johanna	Female	12/1/1932	86	Aged without ESRD	Yes	F9MB5365	Tier 4	2.89%	$77,506

MARYLAND Department of Health

Care Transformation Organization (CTO)

On request – assisting the practice in meeting care transformation requirements

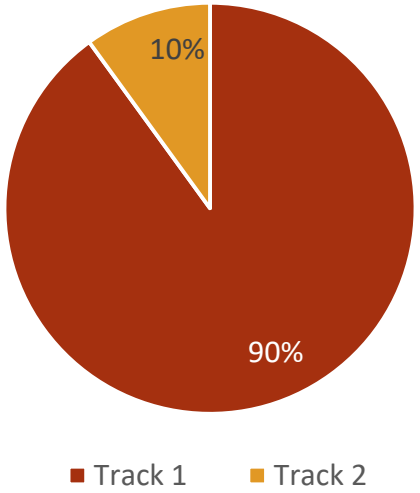


Program Year 1

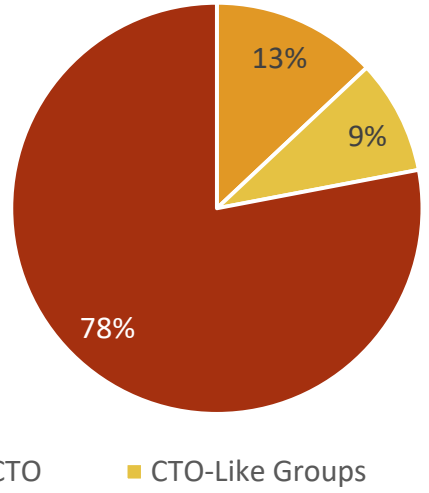
380 Practices Accepted Statewide

- ~ 220,000 FFS beneficiaries
- ~ 1,500 Primary Care Providers
- ~ 40% employed by hospitals
- All counties represented
- 21 Care Transformation Organizations (min 6/county)
  - 14 of 21 are hospital-based

Practice Tracks



Practices Partnered with a CTO



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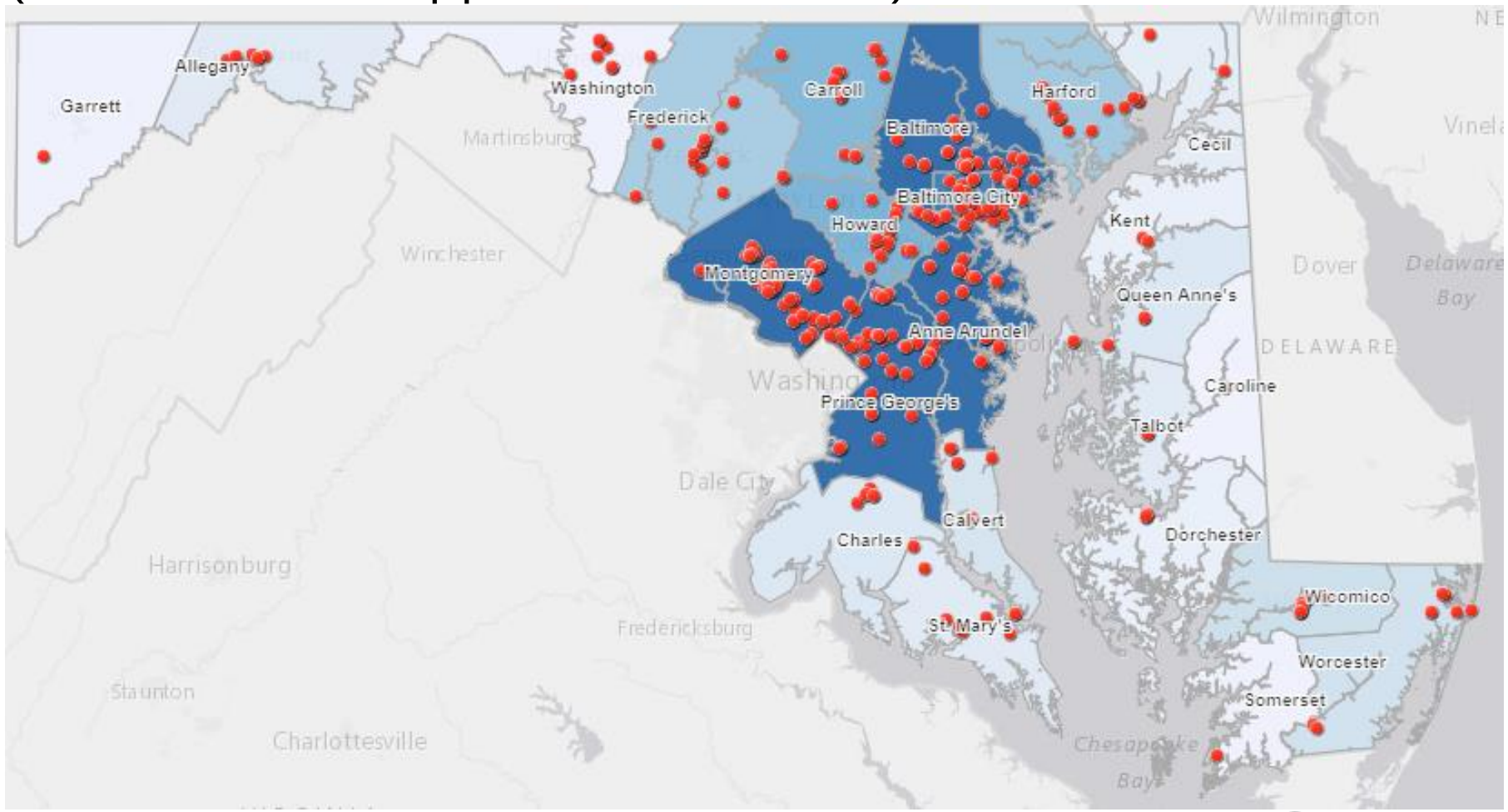
Current MDPCP Practices

(150 additional applicants for 2020)



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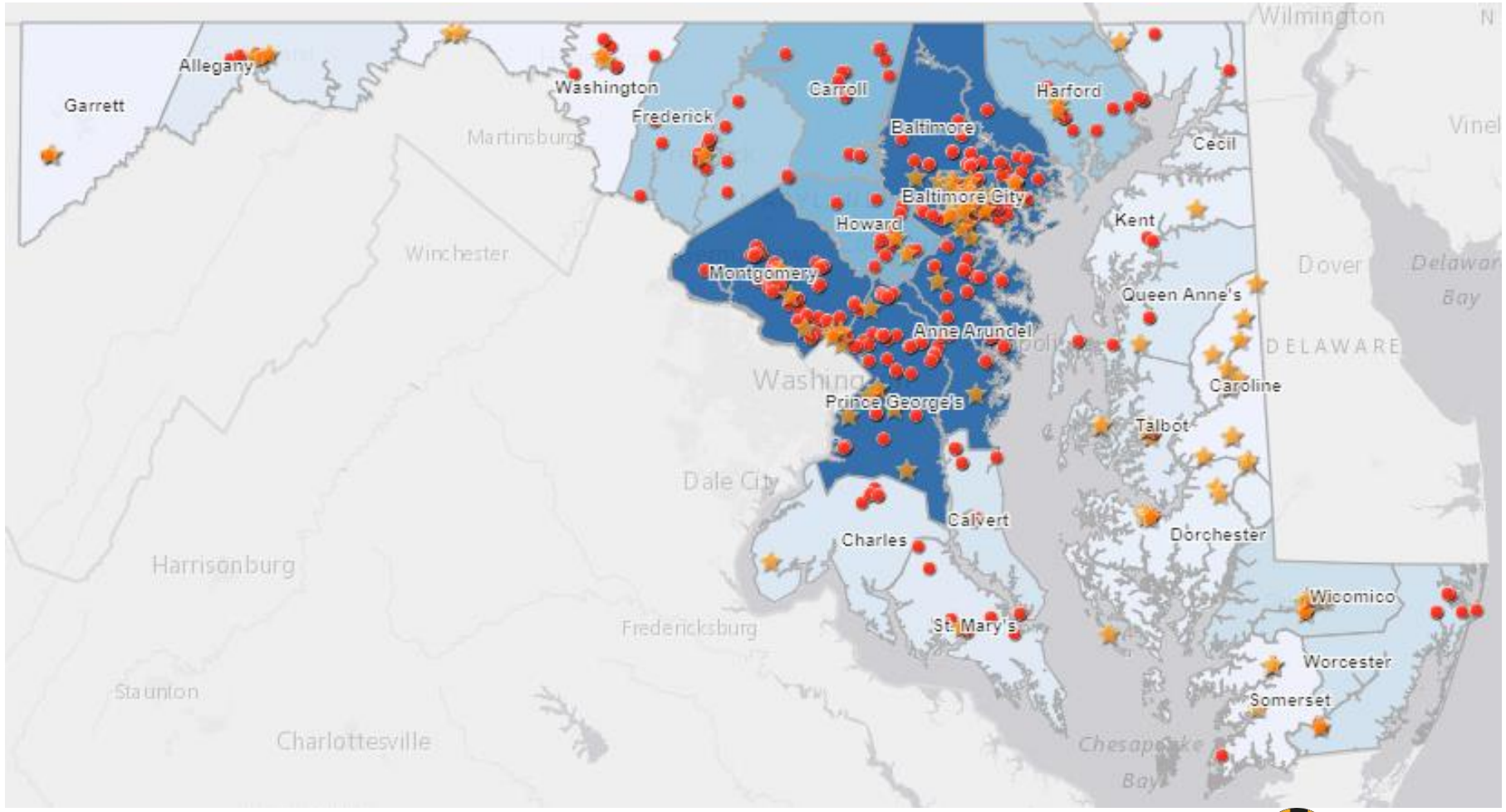
Current MDPCP Practices & FQHCs



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What are the opportunities for Maryland, FQHCs and HHS?

- Address high cost Medicare FFS patients including Dual Eligibles
- Integrate FQHCs into the broader primary care delivery system
- Enhance access to advanced primary care around state, especially underserved and rural regions
- Align FQHC payment with TCOC Model
- Provide FQHCs with State and CMMI tools, resources and support
- Provide a starting point for journey from volume to value
- Innovate a model that could be replicated in other states

Next Steps

- Initial Workgroup Meetings: May – July 2019
  - Develop shared vision
  - Break into smaller workgroups to develop proposal for CMS
    - Payment
    - Delivery
- Develop written proposal by Sept 2019 for CMS
- CMS Review and approval of proposal: Fall 2019-Winter 2020*
- Include in 2020 RFA*
- FQHCs apply in Spring 2020*
- Start January 2021*

*Assumes CMS approval of proposal

Thank you!

Updates and More Information:

https://health.maryland.gov/MDPCP

Questions: email mdh.pcmodel@Maryland.gov

MARYLAND Department of Health

THANK YOU

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