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Maryland Primary Care Program

MDPCP Advisory Council
Howard Haft, MD – Executive Director
Program Management Office

February 12, 2020

Agenda

- Updates from PMO- CMMI operations
- Comprehensive Care Approaches and Tools
- Recommendations Timeline

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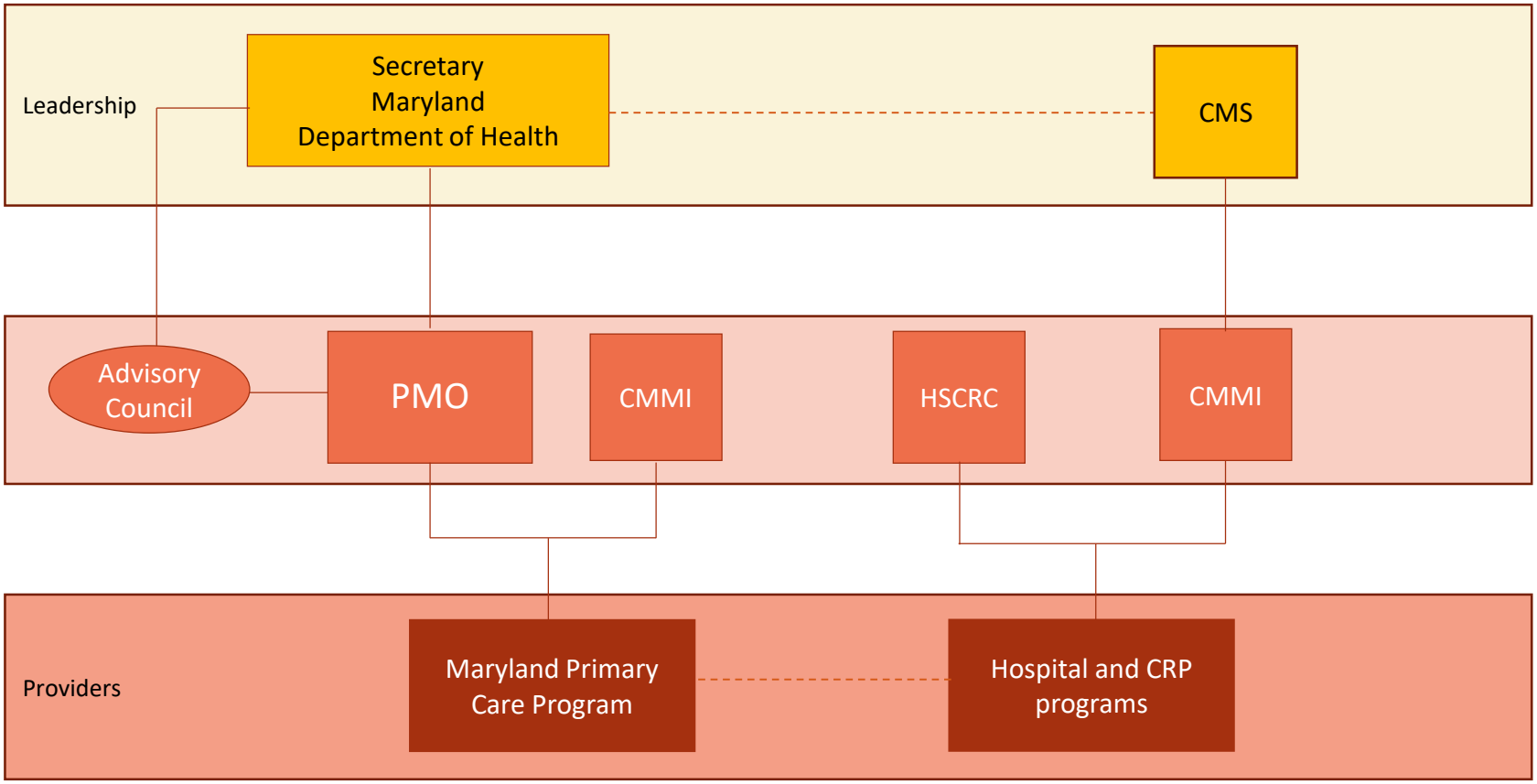
MDPCP Organizational Chart



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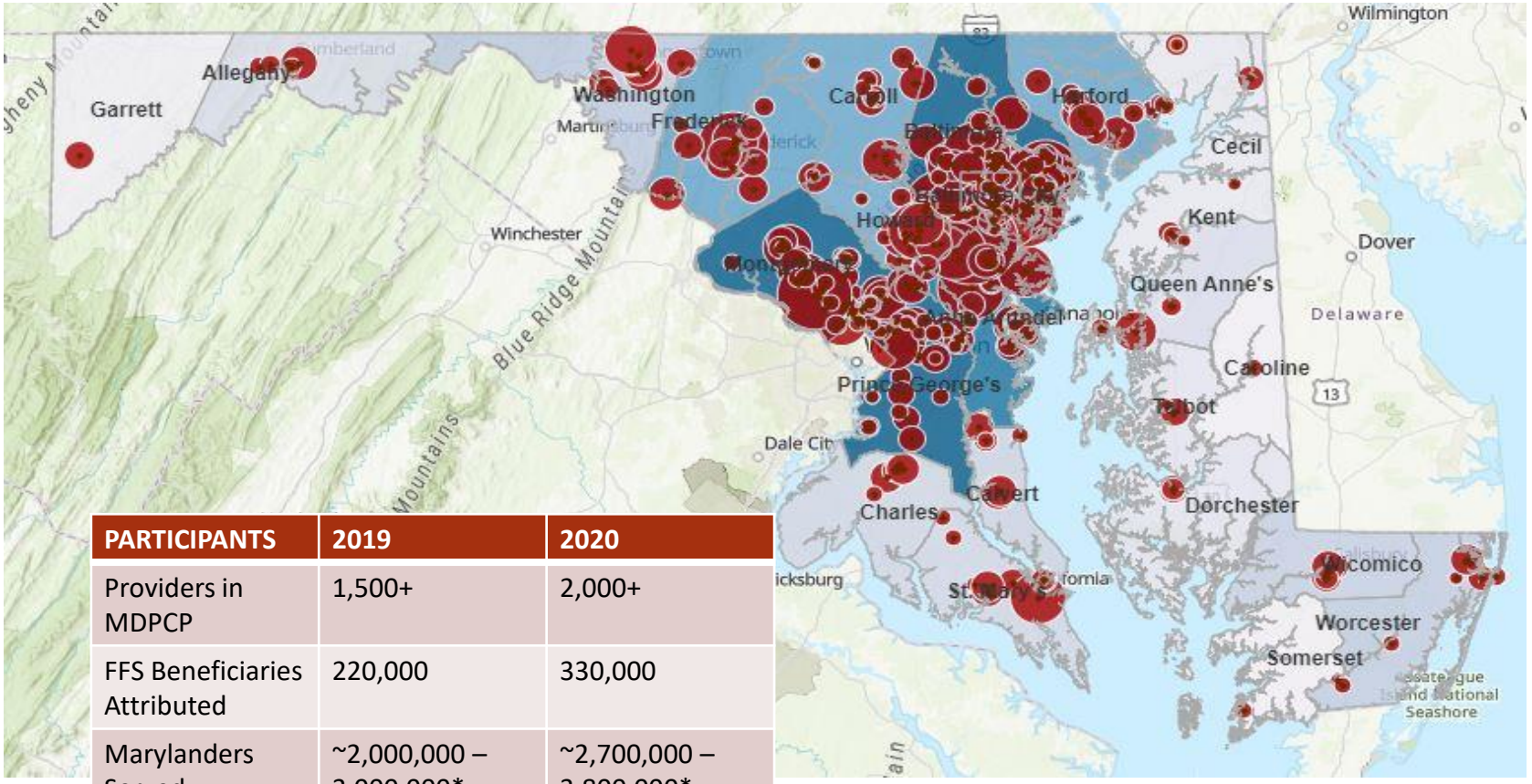
MDPCP – 476 Practices currently



PARTICIPANTS	2019	2020
Providers in MDPCP	1,500+	2,000+
FFS Beneficiaries Attributed	220,000	330,000
Marylanders Served	~2,000,000 – 3,000,000*	~2,700,000 – 3,800,000*

** The Annals of Family Medicine, 2012*
http://www.annfammed.org/content/10/5/396.full

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Updates through January 2020

- **Jan 2020 – CareFirst joined as an aligned Commercial Payer**
- Every major health system in Maryland is participating as a CTO
- Approximately two-thirds of Maryland practices/practice are participating in MDPCP
- MDPCP currently serves over 49,500 dual eligible beneficiaries or approximately 1 in 2 in Maryland.
- Over 350 practices in MDPCP have integrated Behavioral health including 122 that have formal processes for Substance Use Disorder
- Federally Qualified HealthCare Centers can apply in 2020

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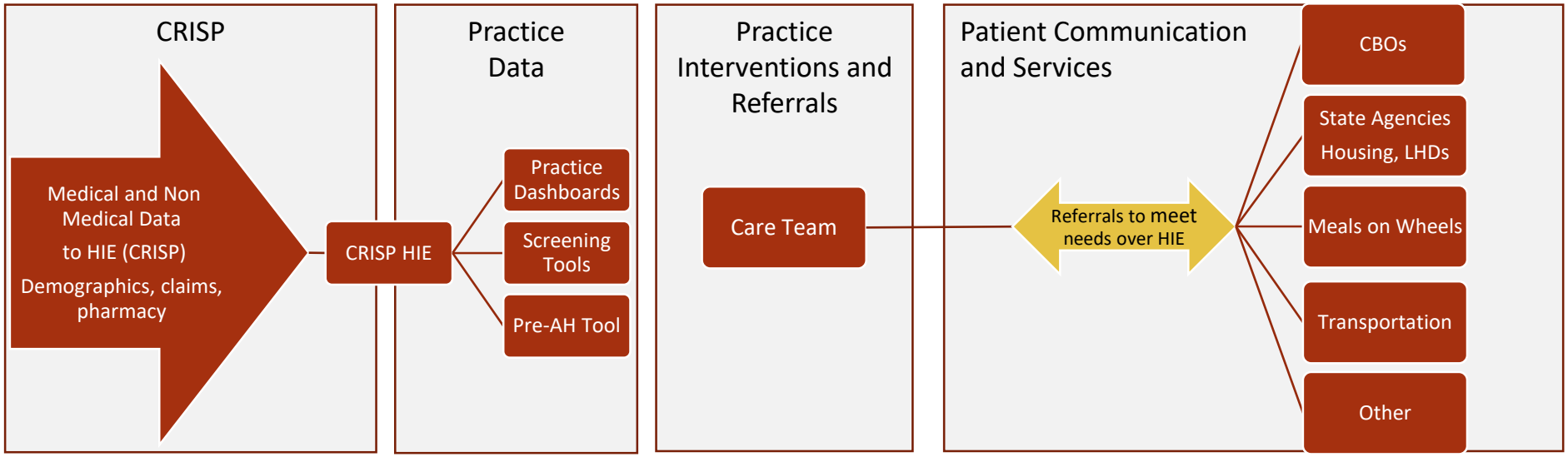
Social Needs Workflow in MDPCP

Data on Unmet Social Needs | Social Needs Identified | Social Needs Addressed



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Pre-AH Dashboard Integrated with MDPCP Reports on CRISP

The percentiles are determined at a single practice-level and do not vary when selecting more than one practice or sub-populations within a practice

Search By: Beneficiary ID ▾ **Key**: (All) ▾

MBI	Beneficiary Name	Gender	DOB	Age	Medicare Status	Dual Status	PracticeID	HCC Tier	Likelihood of Avoidable Hospital Events	Claim Payment Amount
[redacted]		Male	6/8/1956	63	Disabled without ESRD	No	T1MD0724	Complex	99.94%	$371,816
		Female	7/1/1993	26	Disabled without ESRD	Yes	T1MD0279	Tier 4	99.94%	$567,832
		Male	7/11/1956	63	Disabled without ESRD	No	T2MD0081	Complex	98.98%	$380,307
		Female	3/28/1968	51	Disabled without ESRD	Yes	T1MD0512	Tier 4	98.12%	$115,980
		Female	11/7/1963	55	Disabled without ESRD	Yes	T1MD0638	Tier 4	91.08%	$189,116
		Male	4/22/1949	70	Aged without ESRD	Yes	T1MD0723	Complex	90.52%	$168,049
		Female	9/23/1947	72	Aged without ESRD	No	T1MD0239	Complex	89.86%	$142,900
		Female	12/5/1970	48	Disabled without ESRD	Yes	T1MD0389	Complex	88.81%	$204,176
		Female	5/28/1929	90	Aged without ESRD	No	T1MD0253	Tier 4	85.92%	$86,803
		Male	9/24/1949	70	Aged without ESRD	Yes	T1MD0698	Tier 3	82.04%	$205,541
		Male	9/29/1958	61	Disabled without ESRD	Yes	T2MD0298	Complex	81.54%	$116,121
		Male	9/22/1940	79	Aged without ESRD	No	T1MD0638	Complex	79.34%	$48,111
		Female	10/7/1969	50	Disabled without ESRD	Yes	T1MD0591	Complex	74.22%	$224,685
		Male	6/4/1952	67	Aged without ESRD	Yes	T1MD0144	Complex	69.43%	$491,105
		Male	12/26/1950	68	Aged without ESRD	No	T1MD	PowerPoint Presentation - Adobe Acrobat Pro 2017	7,666	

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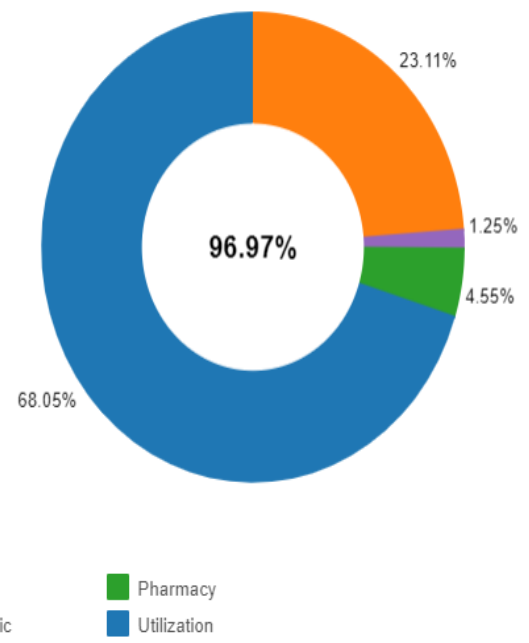
Pre-AH: Drill Down on Patient – Reasons for Risk

Likelihood of Avoidable Hospital Event: 96.97%

Distribution of Risk by Reason Category



Primary Reasons for Risk

Reason for Risk	Category
Prior avoidable hospitalizations	Utilization
Risk related to chronic obstructive pulmonary disease (COPD) and bronc..	Condition
High risk prior hospital admission	Utilization
Number of primary care visits (high or low numbers)	Utilization
Risk related to heart failure	Condition
Polypharmacy	Pharmacy
Risk related to diabetes	Condition
Risk related to hypertension	Condition
Risk related to tobacco use	Condition
Risk related to arrhythmia	Condition
Discontinuous primary care with several different providers	Utilization
Uses insulin	Pharmacy

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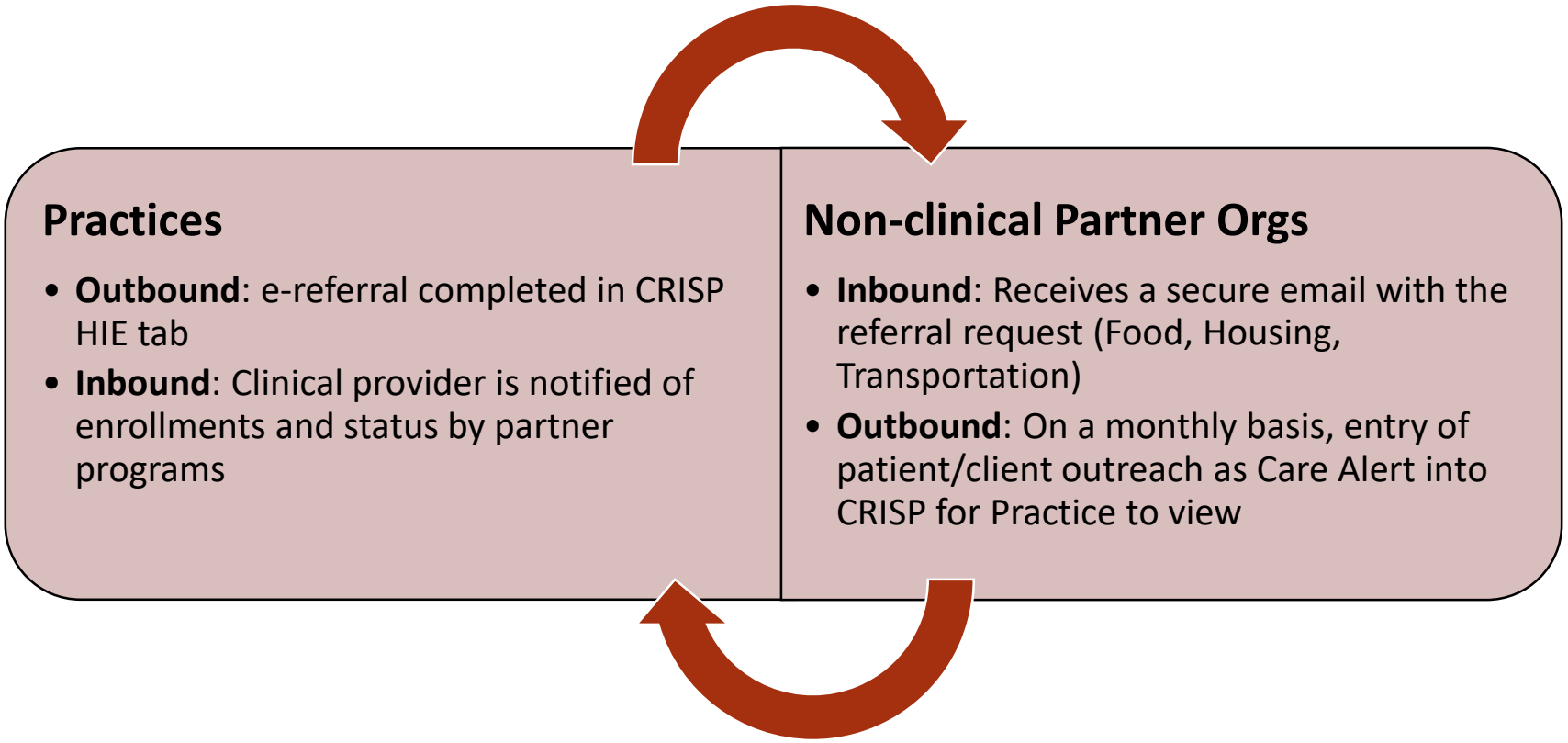
E-referral: Workflow – Screening and Referral Integrated into CRISP



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CRISP Unified Landing Page™ | HOME | PATIENT SNAPSHOT | PROMPT | HEALTH RECORDS | REFERRALS | DC CRS

CRISP Program Referral

Patient Information

* First Name: Gilbert | Middle Name: | * Last Name: Grape

* Date of Birth (Format MM/DD/YYYY): 01/01/1984

* Home Address 1: 4145 EARL C ADKINS DR | * Phone Number: 555-5555555 | * Type: Home

Home Address 2: | Alternate Phone Number: | Type:

* City: River | * State: WV | * Zip: 26000 | Email:

Prefilled demographics

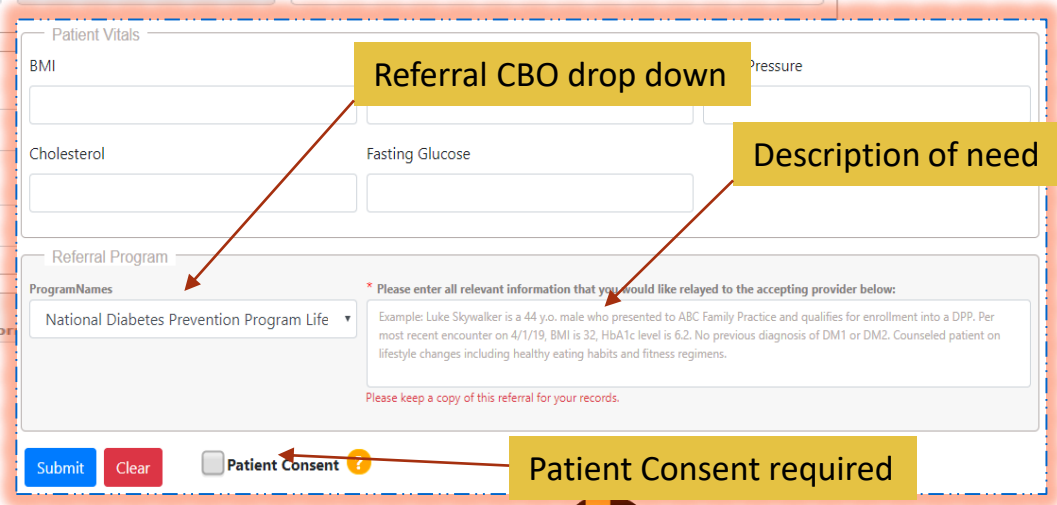
Patient Vitals

BMI | HbA1c

Cholesterol | Fasting Glucose

Referral Program

ProgramNames | * Please enter all relevant infor



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Timeline for Existing Improvements

PMO operational improvements in progress

- **Feb-April 2020** – PMO operational improvements in progress
  - PMO will recommend benchmarks for 2020 quality measures so CMMI can communicate as early as possible in 2020
  - HEDIS-like data for 2020 on CRISP Portal – working with CMMI to obtain
  - Coordination with CareFirst to align resources and requirements

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Timeline for Advisory Council Feedback

Recommendations from Council through PMO to CMMI

- **March-April 2020**
  - 2020 Request for Applications (RFA)
    - Policy changes for 2020 RFA inclusion, effective Jan 2021
    - Improvements to 2020 RFA process
  - 2021 Track 2 Transitions
    - Quality/utilization metrics assessment for Track 2 Transition applications in 2020 – How should CMMI consider 2019 performance as part of Transition application?
  - 2021 Operational changes – (e.g., reporting frequency or questions)
- **Early Summer 2020**
  - Payment model changes for 2022 – extensive process
- **Fall 2020** – MDPCP Annual Report
  - Quality/patient satisfaction measures for 2022

Subject to change due to federal processes

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February 13, 2020

MARYLAND PRIMARY CARE PROGRAM (MDPCP) ADVISORY COUNCIL - SUBGROUPS UPDATE

PRACTICE REPORTING SUBGROUP – KEY TAKEAWAYS

Meeting #1: January 29, 2020

- Considerations for developing quality measures
  - Clinically relevant and meaningful
  - Contractually or programmatically required
  - Aligning measures across federal and State programs
  - Focusing on practice level trends rather than comparisons to national benchmarks
  - Improving patient care
  - Using claims data and outcomes data for quality reporting
  - Determining the root cause of administrative reporting burden to inform solutions
- Considerations for facilitating practice reporting
  - Automating electronic reporting
  - Providing technical guidance for reporting
  - Exploring opportunities for funding technology vendors to offset practice costs

PRACTICE REPORTING SUBGROUP – KEY TAKEAWAYS

Meeting #2: February 11, 2020

- Administrative reporting challenges
  - Site-level reporting is difficult from most EHRs; most provide practice level or NPI level reports
  - Too frequent for administrative items that do not change as quickly
  - More direction on engagement survey questions; too open to interpretation
- Opportunities to ease practices' administrative reporting burden include
  - Changing reporting frequency from quarterly to annually for Track 1 practices and to 18 months for Track 2 practices
  - Providing Subgroup input on engagement survey questions
  - Leveraging CRISP data to meet patient panel reporting requirements
- Engaging practices to ensure a collaborative understanding of the program mission and goals

INNOVATIVE PRACTICE ALTERNATIVES SUBGROUP – KEY TAKEAWAYS

Meeting #1: January 30, 2020

- Conduct a provider interest survey to assess interest in Track 3 and Track 4 participation
- Include transparency and simplification in payment models
- Considerations for developing a Track 3 include
  - Timing/pace of practice progression
  - Validating increased investment in primary care
  - Aligning models across programs and payors to reduce administrative burden
  - Potential impacts to care delivery (e.g., patient-provider relationship)
  - Identifying key practice functions needed to assume shared risk
- Involving CTOs as risk-bearers to provide support and reduce burden on small practices

INNOVATIVE PRACTICE ALTERNATIVES SUBGROUP – KEY TAKEAWAYS

Meeting #2: February 10, 2020

- Progression of practices towards transformation and risk should be seen as a continuum
  - Many practices are ready to advance towards models with two-sided risk
- Account for unique needs of practices and their patient populations
- Education to raise awareness among MDPCP participating practices on payor agnostic status of the program
- Establishing a framework for advancement
  - The CMS Health Care Payment Learning & Action Network (HCP-LAN) Framework may serve as a starting point in developing the framework
  - Provide clarity to practices on expectations at each level of advancement