



# Maryland Primary Care Program (MDPCP)

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# MDPCP Transformed Primary Care across Maryland coordinated with the State's role in Population Health

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## Key elements of Maryland's new system of care

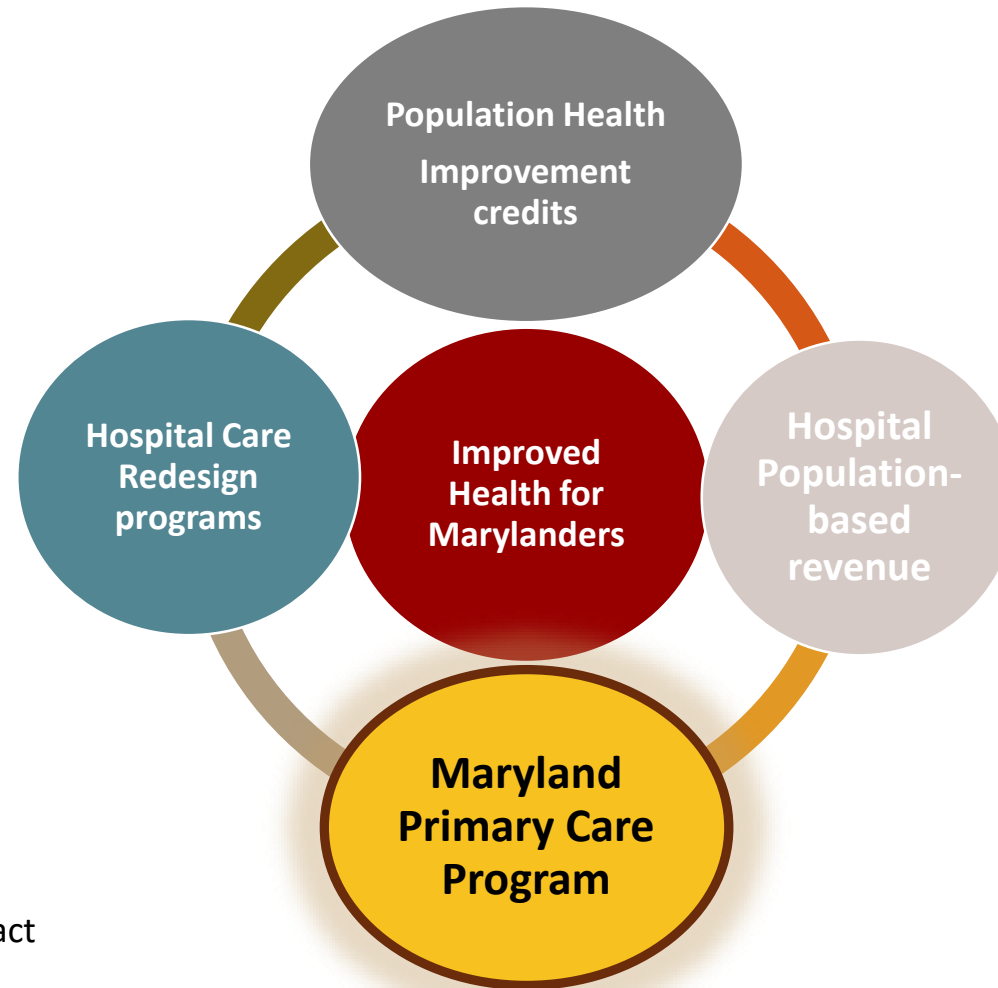
- Investing in primary care practices to build a strong, statewide infrastructure to prevent and manage chronic disease
- Aims to reduce avoidable hospitalization (AH), emergency department (ED) visits, and overall healthcare expenditures
- Innovative hospital/provider partnerships
- **Respond to the Coronavirus pandemic**

## MDPCP expansion

- Federally Qualified Health Centers – application period open in 2020
- CareFirst Blue Cross/Blue Shield joined as aligned payer in 2020 > 1200 practices
- Medicaid Chronic Health Homes (planned) and Dual-Eligible entry into MDPCP (current)

# Total Cost of Care Model Components

“Under this Model, CMS and the State will test whether **statewide health care delivery transformation**, together with population-based payments, improves population health and care outcomes for individuals while controlling the growth of Medicare Total Cost of Care”

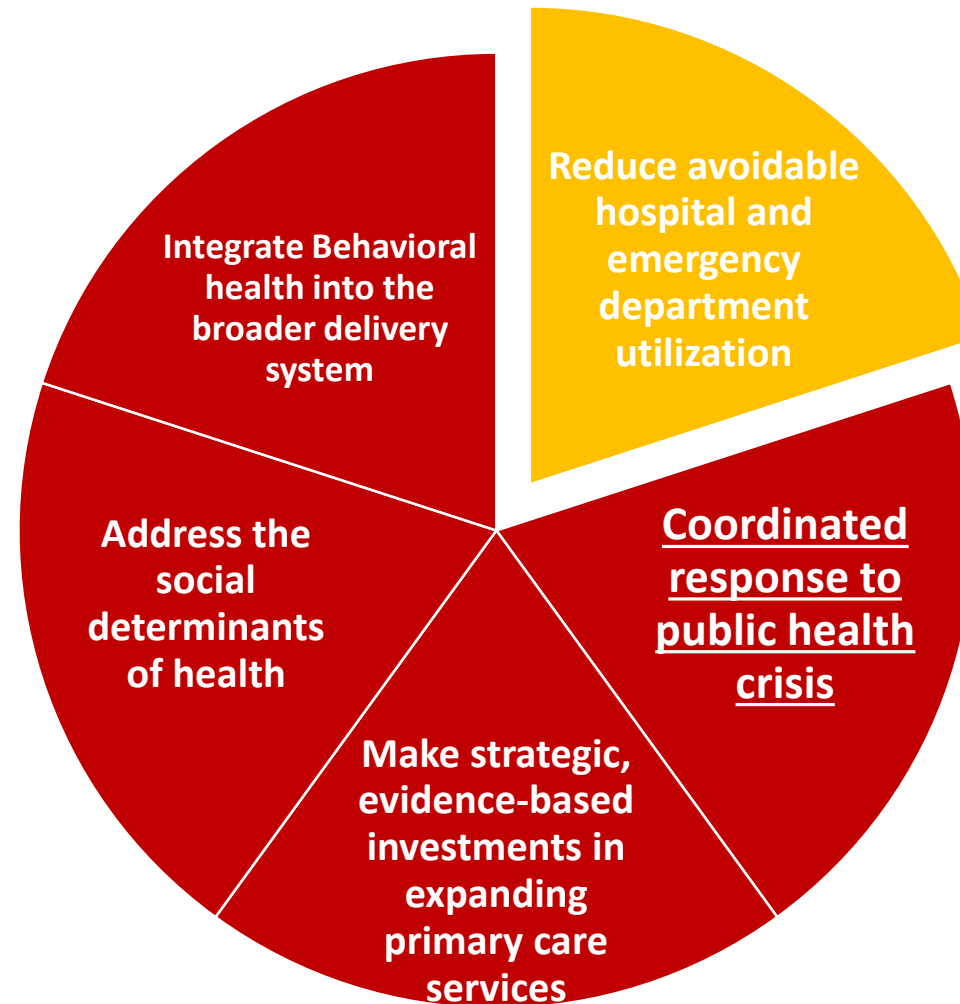


- Reduce Medicare expenditures by an annual run rate of \$300m by 2023
- Innovate hospital/provider partnerships
- Gain credit for improving overall population health
- **Build a strong, effective primary care delivery system inclusive of medical, behavioral and social needs**

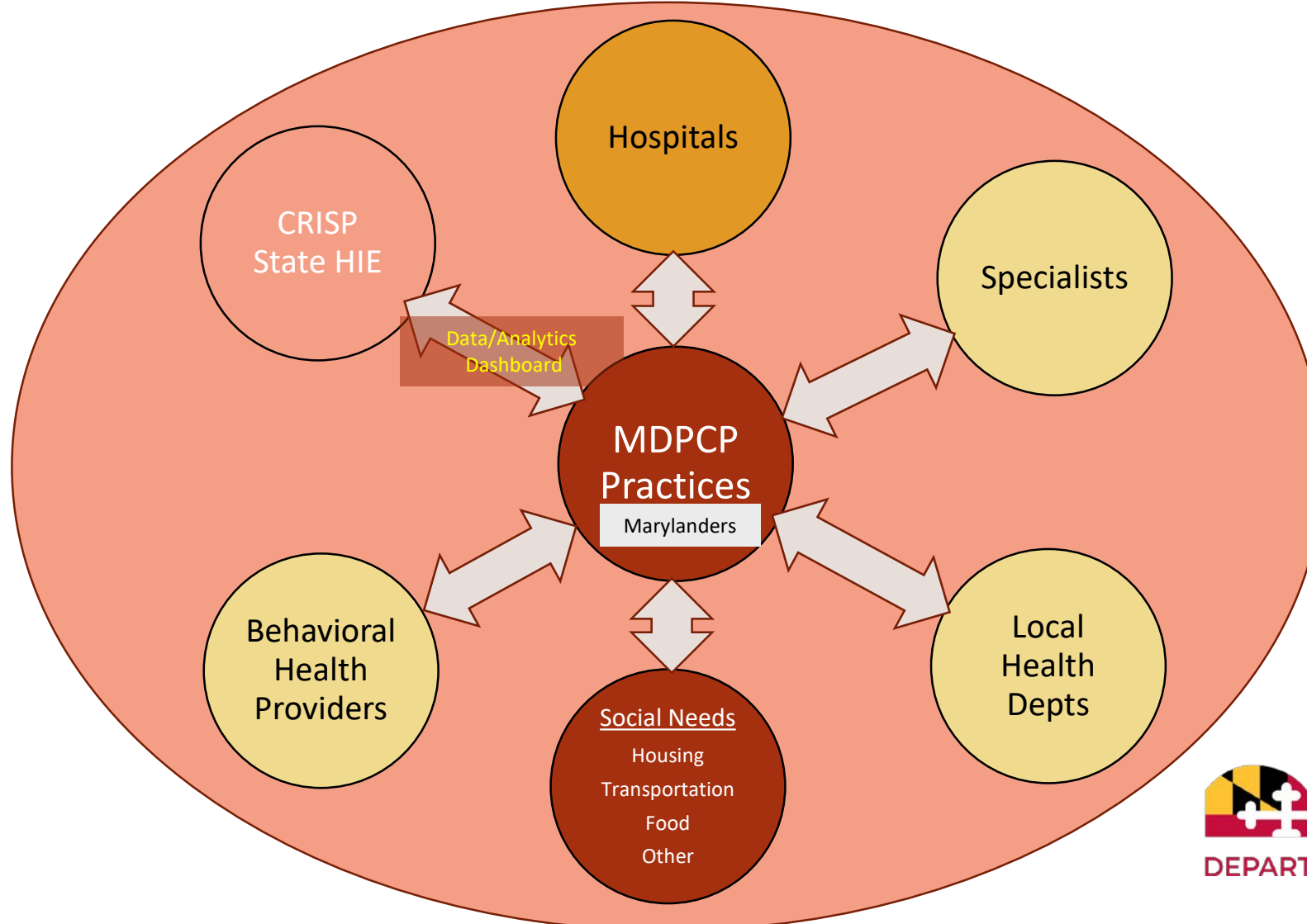
Source: Maryland Model Contract

# Big Picture – Setting an Example for the Nation with a Multipayer Statewide Program

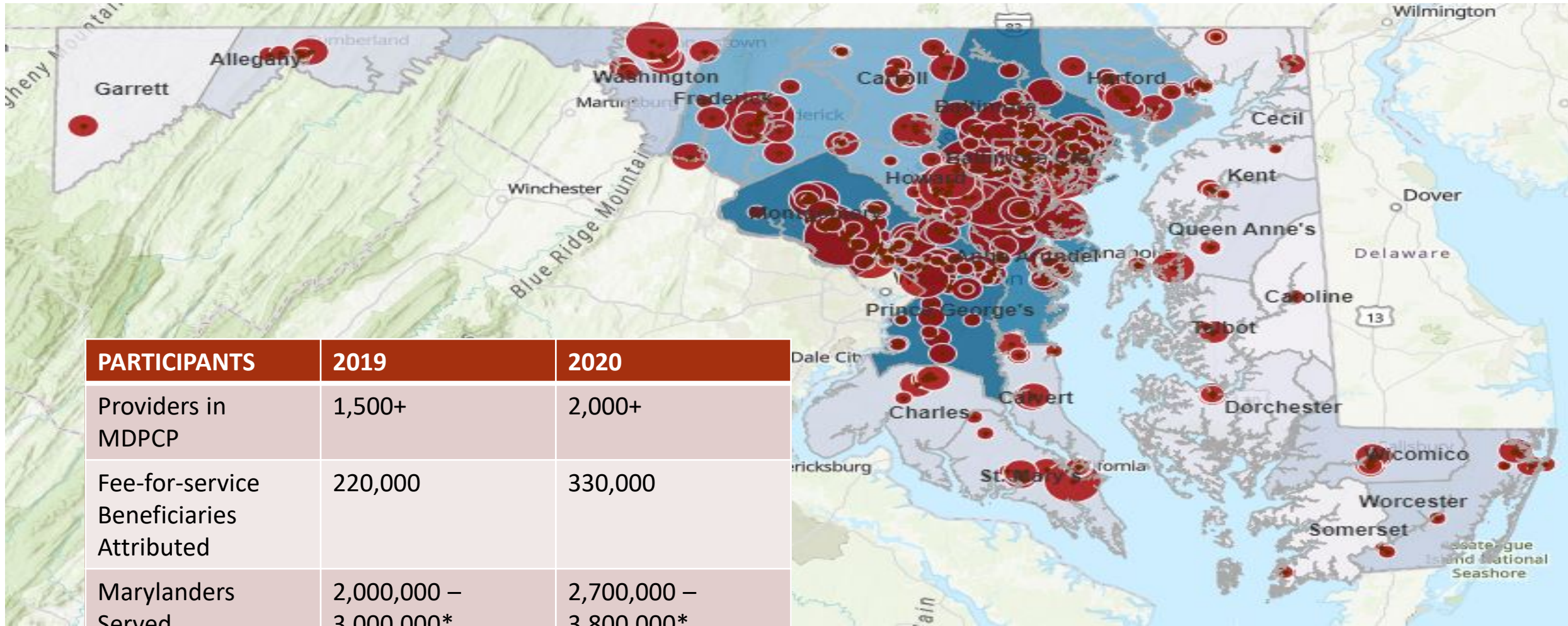
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# MDPCP Creates a System of Care for Marylanders



# MDPCP – 476 Practices currently



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

# Program Year 2

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## 476 Practices Participating

- 330,000 attributed Medicare beneficiaries
- 3,000,000+ patients in practices
- ~ 2,000 Primary Care Providers
- ~ 40% employed by hospitals
- All counties represented
- 24 Care Transformation Organizations (min 6/county)
  - 16 of 24 are hospital-based

### Dual-Eligible Population in MDPCP:

- more than 50% of state now in practices today
- growing to 88% of non-institutionalized

# MDPCP Priorities

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## Capabilities:

- Expanded Access - Telemedicine prepared and executing now
- Risk Stratified Care Management - knowing and reaching out to vulnerable
- Behavioral Health Integration (BHI) - remote support through Collaborative Care
- Use of CRISP tools – to identify those in need
- Social Needs screening and referrals
- Advanced Care Planning

## Outcomes:

- Reduced Prevention Quality Indicators (PQIs)
- Improved management of diabetes, hypertension and substance use disorders (SUD)
- Ability to respond in a coordinated and directed manner in crisis



# MDPCP is Building Key Capabilities

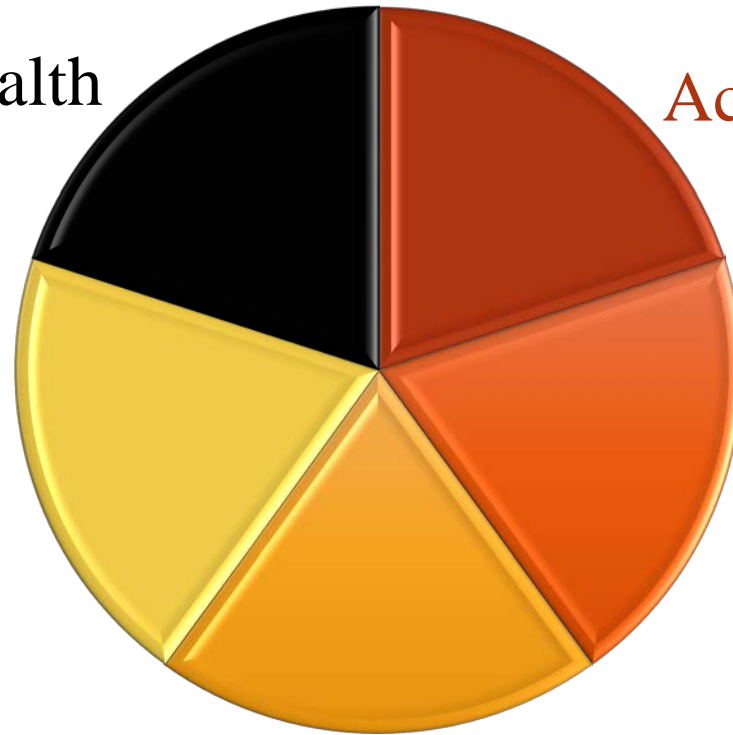
## Primary Care Functions:

Planned Care for Health  
Outcomes

Advanced Health Information  
Technology  
Continuous Quality Improvement

Beneficiary &  
Caregiver Experience

Patient and Family Advisory  
Council



Access & Continuity

Expanded Access  
Alternative Visits

Care Management

Risk-Stratified Care Management  
Transitional Care Management

Comprehensiveness & Coordination

Behavioral Health and Social Needs  
Medication Management

# Big Changes = Big Impact

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**For a big impact there must be a large, comprehensive program with sufficient support:**

- Statewide program supporting the TCOC Model
- Program Management Office supports all aspects of the program
- Care Transformation Organizations created to assist practices with staffing and support
- Extensive coaching support to practices to assure prompt transformation
- All practices share data across the continuum of care using state health information exchange (HIE) services (CRISP)

# Program Management Office

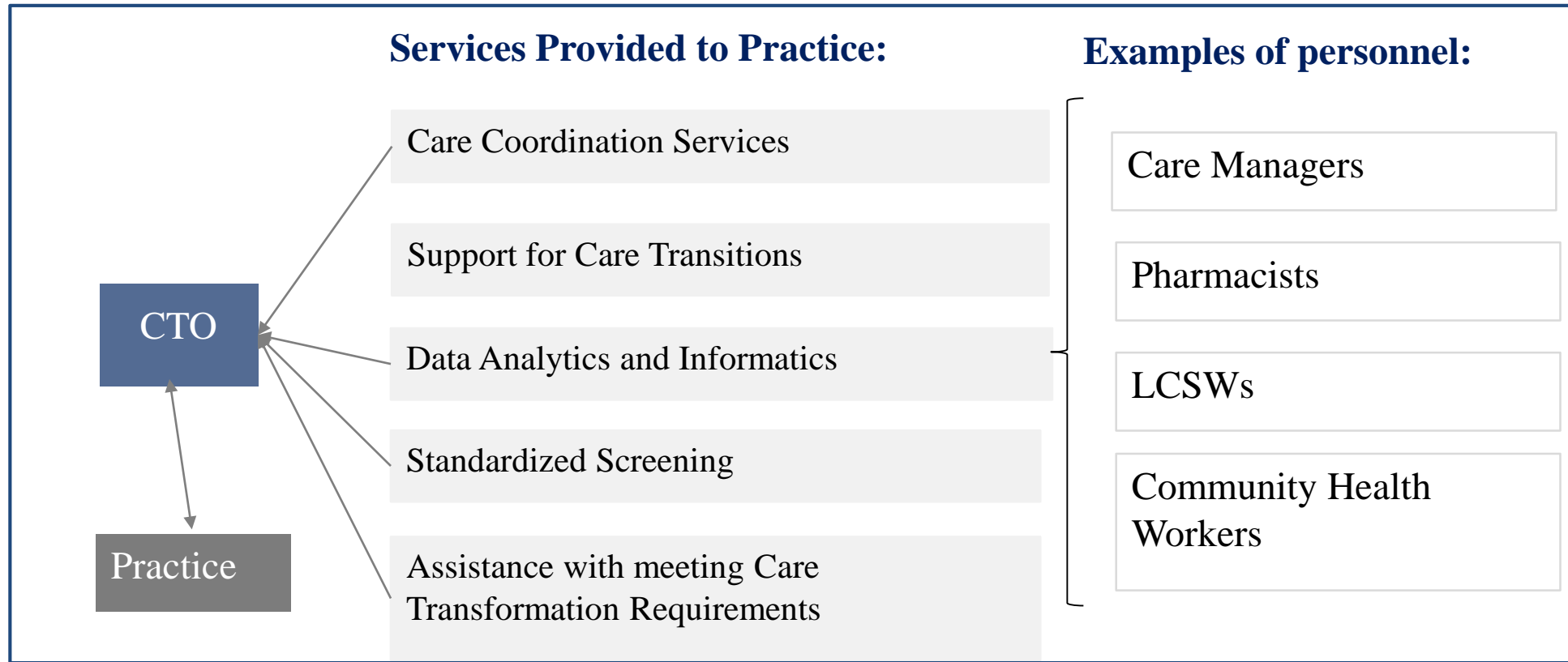
Coordinates and leads critical operational work and infrastructure building to support Practices

## State Unique Contributions to the MDPCP Program

| CTOs   | CRISP   | Contractors  | State Coaches   |
|--|---|--|---|
| <ul style="list-style-type: none"> <li>• Furnish care coordination services</li> <li>• Support care transitions</li> <li>• Provide data and analytics support to practices</li> <li>• Assist with practice transformation</li> </ul> | <ul style="list-style-type: none"> <li>• Central place to report Quality Measures to CMMI</li> <li>• Has portal to access claims data reports</li> <li>• Provides SDoH screening tools and resource directories</li> <li>• Offers PDMP, Query Portal, Secure Messaging, ENS Services</li> <li>• Has Preventable Hospital Utilization Tool integrated into Claims Reports</li> </ul> | <ul style="list-style-type: none"> <li>• Implement Provider Leadership Academy and staff training academies</li> <li>• Provide educational materials on complex program issues</li> <li>• Develop and conduct Behavioral Health Integration webinar series</li> <li>• Offer SBIRT assistance</li> <li>• Help optimize EMRs</li> <li>• Billing and Coding guidance</li> </ul> | <ul style="list-style-type: none"> <li>• Facilitate escalation process to CMS</li> <li>• Offer strategies to reduce administrative burden</li> <li>• Deliver hands-on in-person assistance and support</li> <li>• Encourage quality improvement</li> <li>• Assist with HIE tool implementation</li> </ul> |

# Care Transformation Organizations (CTO)

On request – helping practices meet care transformation requirements

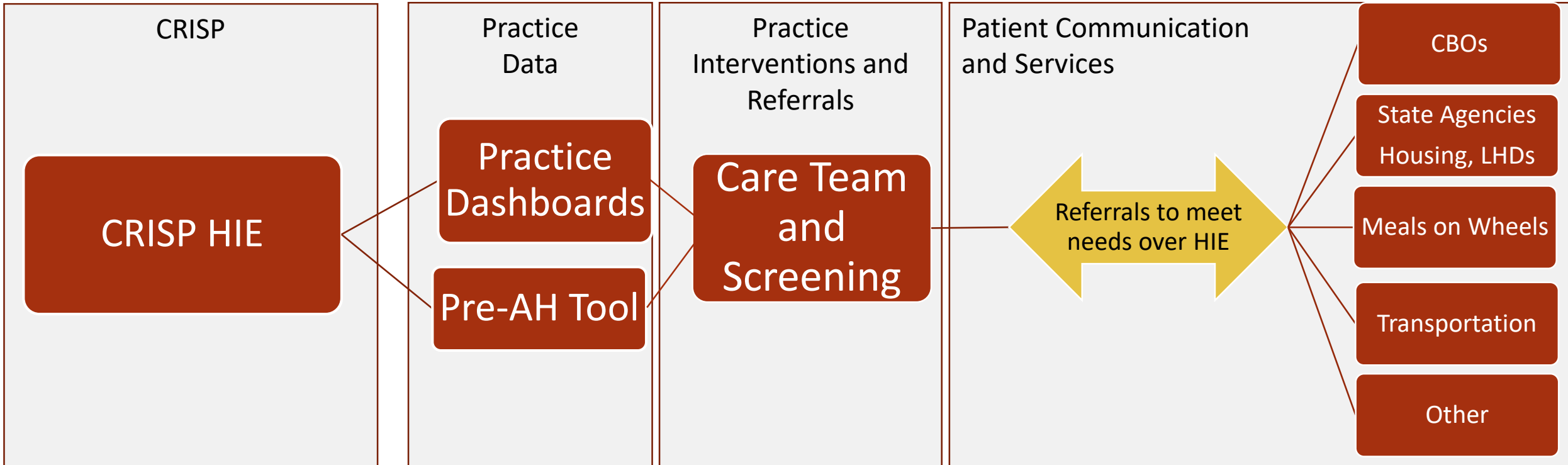


# Social Needs Workflow in MDPCP

Data

Social Needs Identified

Social Needs Addressed



# Prevent Avoidable Hospital Events Tool (Pre-AH): Combining the Power of Data, AI, and the State HIE

- Simple practice care team dashboards on HIE –
  - Identifies risk of avoidable hospital events
  - Reveals underlying reasons for risk, incl. State Dept of Health (SDoH) reasons for risk
  - Allows efficient use of targeted care management resources
- First of its kind – designed specifically for MDPCP participants to improve outcomes and predict unnecessary hospital visits in the state
- Uses databases, including those linked to environmental and non-medical factors, to predict avoidable event risk
- Dashboard integrated with MDPCP reports on CRISP

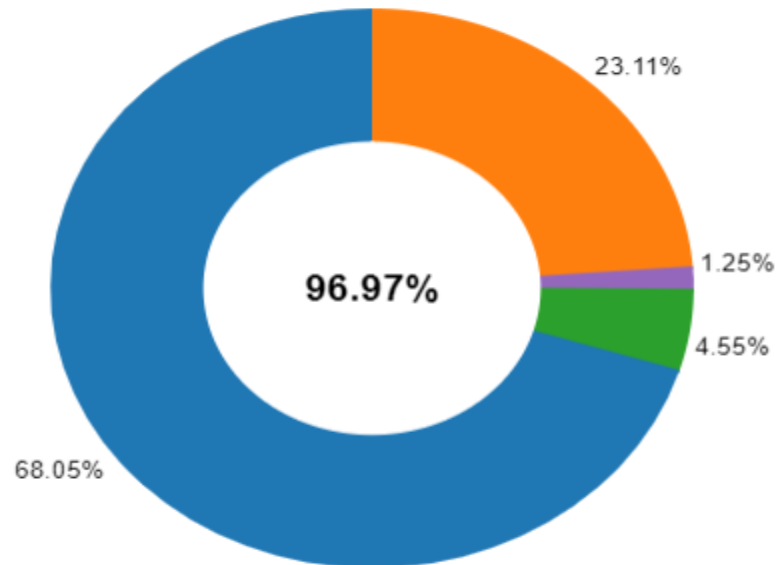
Search By  Key

| MBI | Beneficiary Name | Gender | DOB       | Age | Medicare Status       | Dual Status | PracticeID | HCC Tier | Likelihood of Avoidable Hospital Events | Claim Payment Amount |
|-----|------------------|--------|-----------|-----|-----------------------|-------------|------------|----------|---|----------------------|
|     |                  | 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            |

# Drill Down on Patient – Reasons for Risk

Likelihood of Avoidable Hospital Event: 96.97%

Distribution of Risk by Reason Category

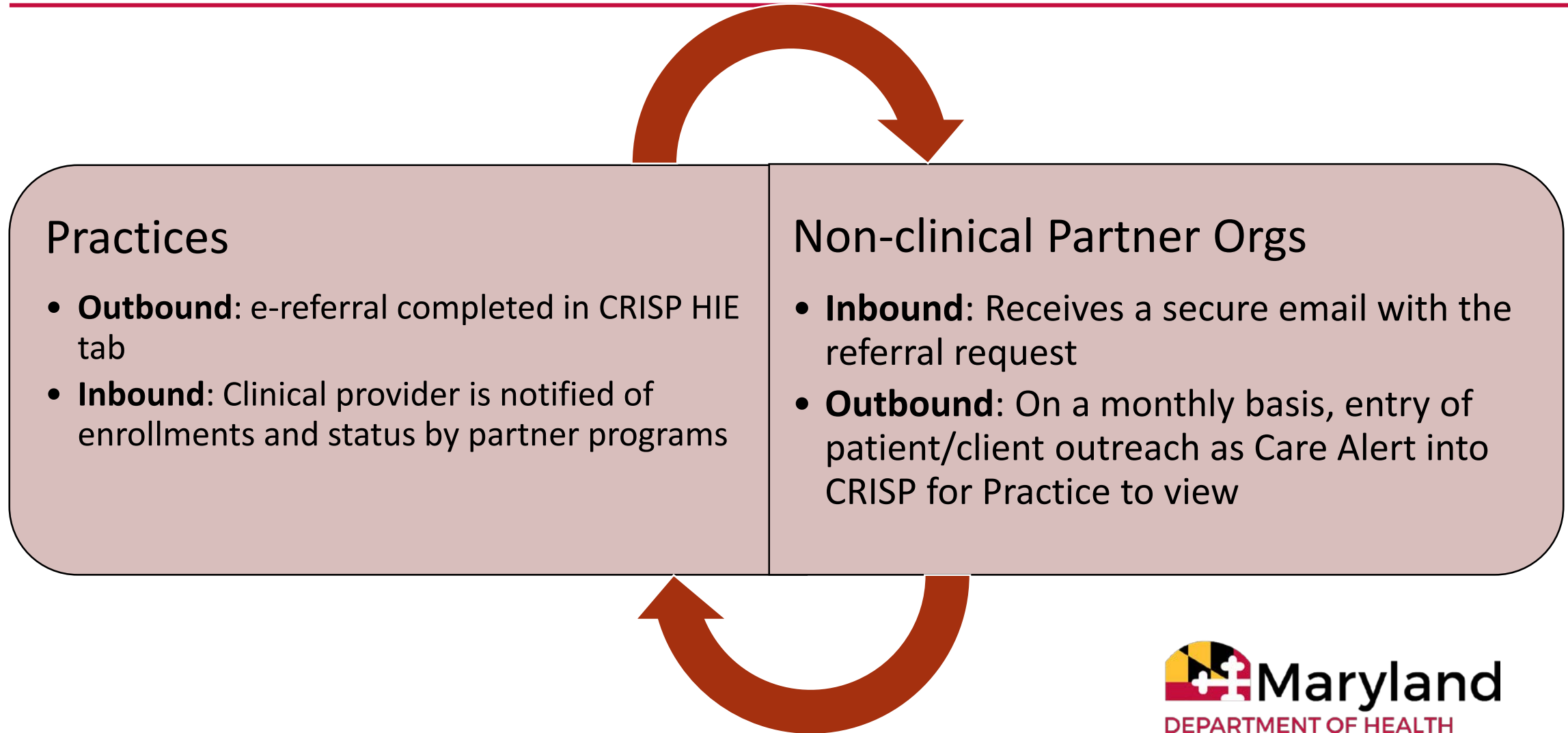


Primary Reasons for Risk

| 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    |

# Electronic referral: workflow – Screening and Referral Integrated into HIE

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# COVID-19 Response

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# MDPCP Responds to COVID-19

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- 476 MDPCP/health practice partnerships already in place
- 2,000+ providers serving 2-3 million patients statewide
- Imperative to quickly provide providers with accurate and complete information and care guidance

## Daily Webinars

- MDPCP launched its first COVID-19 information webinar March 12
- Holding daily weekday webinars since then covering:
  - Identifying and contacting at-risk patients
  - Screening
  - Testing
  - Communications
  - Care
  - Safety

# MDPCP Responds to COVID-19

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## **Communication**

- Daily email updates and information to PCPs
- Ongoing coach support to practices
- Ongoing updated postings and links on the MDPCP website

## **State leadership and coordination**

- Central leadership through Md Department of Health and the Program Management Office
- Integrated into the State's response

## **Alternative care approaches accelerated**

- Telemedicine established in some PCPs with support provided for more to scale up

# Key Takeaways

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- PCPs are on the front line against COVID-19 in Maryland
- PCPs are uniquely positioned to identify these at-risk populations, provide important social distancing information to them, and serve their healthcare needs through telemedicine
- Encouragement - No one can do this better than you!

# EXAMPLE: Today's Key Updates for Maryland

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- COVID-19 continues to spread in Maryland, overwhelmingly through community transmission
- Statistics (as of early 3/25/20)
  - 7000+ tested; 2000-3000 processed in lab so far
  - **423** confirmed cases of COVID-19 infection had been identified total across all regions of the State; 74 new cases since yesterday and the biggest increase so far in one day
  - 67 hospitalized
  - 4 deaths
  - More information at <https://coronavirus.maryland.gov/>

# Example: Key Messaging

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- Elective and non-emergent medical procedures
  - Test Reporting – timely done by the testing labs
  - Testing Priority
  - Personal Protective Order Conservation
    - Extended use – PPE may be used after the expiration date
    - Reuse - is permitted in some circumstances
- <https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html>
- Prioritize facemasks
  - High-risk providers – avoid treating high-risk patients

# Example: What's Important Now (WIN)

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- Identify and proactively contact high-risk patients
- Maximize non-face-to-face visits using telemedicine
- Maximize access to care
- Identify appropriate candidates for testing
- Clinical management of patients
- Stay current, stay safe

# Thank you!

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**Updates and More Information:**

<https://health.maryland.gov/MDPCP>

**Questions:** email [Howard.Haft@Maryland.gov](mailto:Howard.Haft@Maryland.gov)