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*Using evidence to improve population health*

# Maryland's Innovative Primary Care Program: Building a Foundation for Health and Well-Being

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## Policy Points

- Built on an agreement with Medicare, the Maryland Primary Care Program makes multiple systematic, coordinated primary care investments to improve the health of state residents.
- Shifting care from high-cost venues like hospitals to well-prepared, adequately resourced, lower-cost primary care venues helps to create a health care delivery system focused on health and well-being.

## ABSTRACT

Maryland Primary Care Program is a statewide advanced primary care program launched in January 2019 by the Maryland Department of Health in collaboration with the Center for Medicare and Medicaid Innovation. By creating a coordinated system of primary care supported by multiple payers, with shared resources and an information-sharing network, Maryland hopes to improve quality and lower costs—and create a foundation for health and wellness. The program is also proving to be nimble in response to emergencies like the COVID-19 pandemic. In this brief, we describe the program's evolution and core components, as well as its potential replicability in other states.

## INTRODUCTION

Health care costs and expenditures throughout the United States are high, rising, and unsustainable over the long-term. The highest costs for health care services are predominantly found in the management of late-stage illness and hospital care rather than in preventive, relationship-based primary care, which has been shown to be effective with these populations. To lower costs while improving health outcomes, the Maryland Department of Health (MDH), in collaboration with the Center for Medicare and Medicaid Innovation (CMMI), launched the Maryland Primary Care Program (MDPCP) in 2019.

The statewide program, designed to span at least eight years, aims to make strategic investments in primary care practices and build a resilient statewide infrastructure to prevent and manage chronic disease. Specific objectives in the MDPCP include:

- Reducing avoidable hospitalization and emergency department (ED) visits
- Building a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to lower Maryland's Medicare Part A and B expenditures by an annual saving target of $300 million by 2023

The MDPCP is operating in a unique health care delivery environment by virtue of being in Maryland. To realize the state's commitment to transform its health care system and address care beyond hospital walls, the state of Maryland and CMMI established the Maryland Total Cost of Care Model, which sets a target for total costs of care reductions for Medicare. The contract for the Maryland Model, as it's known, calls for improved population health outcomes supported by broad, innovative care redesign between hospital and non hospital partners across the state. The Maryland model includes the Hospital Payment Program, in which all hospitals operate with global budgets; the Care Redesign Program, which enables hospitals to make incentive payments to non hospital health care providers; and the MDPCP.

The MDPCP is a multipayer program designed to transform primary care practice for all patients, no matter the payer. Payers are required to submit an application to CMMI and are accepted based on their willingness to align with the program on non visit-based payments, provider financial risk strategies, and quality measurement. This multipayer alignment of payment approaches and reporting requirements reduces the administrative burden for practices.

In the first year of the program, Medicare was the only payer. CareFirst BlueCross BlueShield, the state's largest commercial payer, joined in 2020. In an effort to extend the program to more practices serving vulnerable populations, Maryland's federally qualified health centers will be allowed to apply in 2020 for participation beginning in January 2021. It's anticipated that Medicaid and additional commercial payers will join over time.

## MDPCP STRUCTURE AND OPERATIONS

Fortunately for Maryland, predecessor primary care transformation models supported by CMMI gave the state a template on which to build the MDPCP. The MDPCP was informed by lessons learned from CMMI's Comprehensive Primary Care (CPC) and Comprehensive Primary Care Plus (CPC+) models. For example, evaluations of CPC found that, despite the prospective, per-person payments, it was a challenge for small and medium-sized practices to hire care managers, pharmacists, and other staff. The evaluation also identified the value of being able to move from a standard to advanced program track and the fundamental need for an intensive education and support program to help practices adopt the necessary changes.

Maryland facilitates MDPCP operations and practice transformation through its Program Management Office (PMO) comprising both office-based and field staff. MDPCP received over 700 applications in the program's first two years and has enrolled 476 primary care practices that receive coaching and other outreach and organizational assistance, as well as financial incentives.

Since the program's launch, the PMO recruited health care practices and practitioners to voluntarily enroll in the MDPCP to better serve their Medicare beneficiaries. Practices are required to provide comprehensive primary care services. Services include expanding patients' access to care; empaneling patients to providers; implementing data-driven, risk-stratified care management; providing transitional care management; coordinating care with specialists; hosting "Patient Family Advisory Councils"; integrating behavioral health; screening for social needs; and using health information technology tools to continuously improve quality.

In exchange for implementing these changes and services, participating practices receive prospective, nonvisit-based payments per attributed Medicare patient known as care management fees (CMF). Practices also have the option to receive operational and administrative support from the PMO and Care Transformation Organizations (CTOs). An extension of the practices, CTOs are private entities that hire and manage the interdisciplinary care management teams that provide care coordination services at the direction of the participating practices. CTOs also offer support for care transitions, standardized beneficiary screening, data tools and informatics, and practice transformation.

Small and medium-sized practices can therefore include team members who they would otherwise have difficulty acquiring on their own such as pharmacists, licensed clinical social workers, community health workers, and data analysts. CTOs are funded by a share of the practices' care management fees; they may also receive performance bonuses based on the aggregate performance of the practices they serve. Twenty-four CTOs are supporting 77% of the practices as of mid-2020.

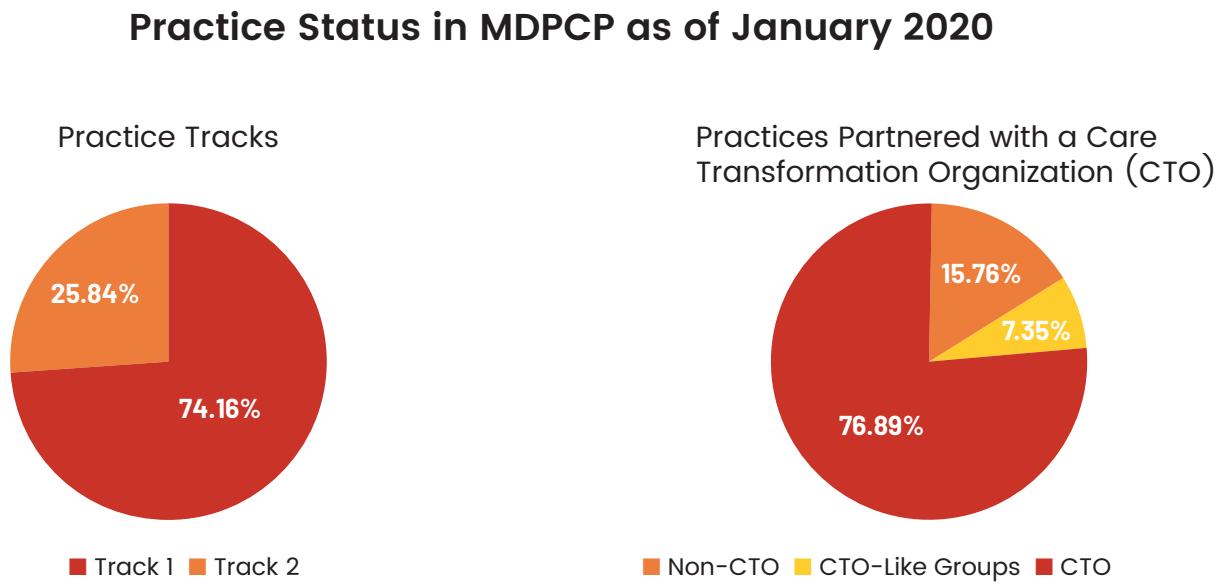
MDPCP, similar to CPC+, has two levels of practices known as track 1, the standard track, and track 2, in which all advanced primary care requirements are met. All participating Maryland practices are required to achieve track 2 status by the end of the third year of participation. Requiring a transition 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 but under the guidance of the MDH. More than one-quarter of practices have already achieved advanced status (Figure 1).

Thanks to broad statewide participation serving patients in every Maryland county, MDPCP is reaching a substantial portion of the state's population. MDPCP officially serves more than 340,000 Medicare fee-for-service beneficiaries (under direct attribution), over 49,000 dual-eligible beneficiaries, and approximately 3 million Marylanders overall.[1]

## PROGRAM CORE COMPONENTS

When the Maryland Model was announced in 2018, Maryland committed to addressing broader population health issues, including diabetes, substance use disorders, and other major drivers of poor health outcomes in the state. The MDPCP was enlisted to meet this commitment. The PMO is currently working with partners at MDH and CMMI to incorporate these goals into MDPCP. The PMO is setting up technical assistance webinars with the MDH's chronic disease office, and CMMI and the PMO are considering adding performance measures on prediabetes and substance use disorders. The state has also begun a pilot that allows practices to make electronic referrals

**Figure 1: Practice Status in MDPCP as of January 2020**




Note: CTO-Like Groups are entities that provide services to practices similar to CTOs but are not formal CTO participants in the MDPCP.

> **The primary care workforce, coordinated and supported by the Maryland Department of Health through the Program Management Office, has become a critical part of the public health response to the COVID-19 pandemic. The Maryland Primary Care Program providers have mounted a coordinated telemedicine response, shared best practices, and reached out to at-risk patients.**

to diabetes prevention programs, nutrition services, and other self-management partners. In addition, the PMO hired a contractor in 2019 to help practices implement substance use screening at no charge to MDPCP practices.

To help realize the broader state goals, MDPCP offers its CTOs and practices enhancements and supports that are creating a holistic, comprehensive primary care system. Core components of MDPCP that differentiate it from other primary care models include:

- A robust health information system, including data infrastructure, care coordination tools, and analytics
- A tool to reduce avoidable health services use
- Partners to help address behavioral health and social needs
- Supportive state leadership and dedicated practice coaching

## Health Information System

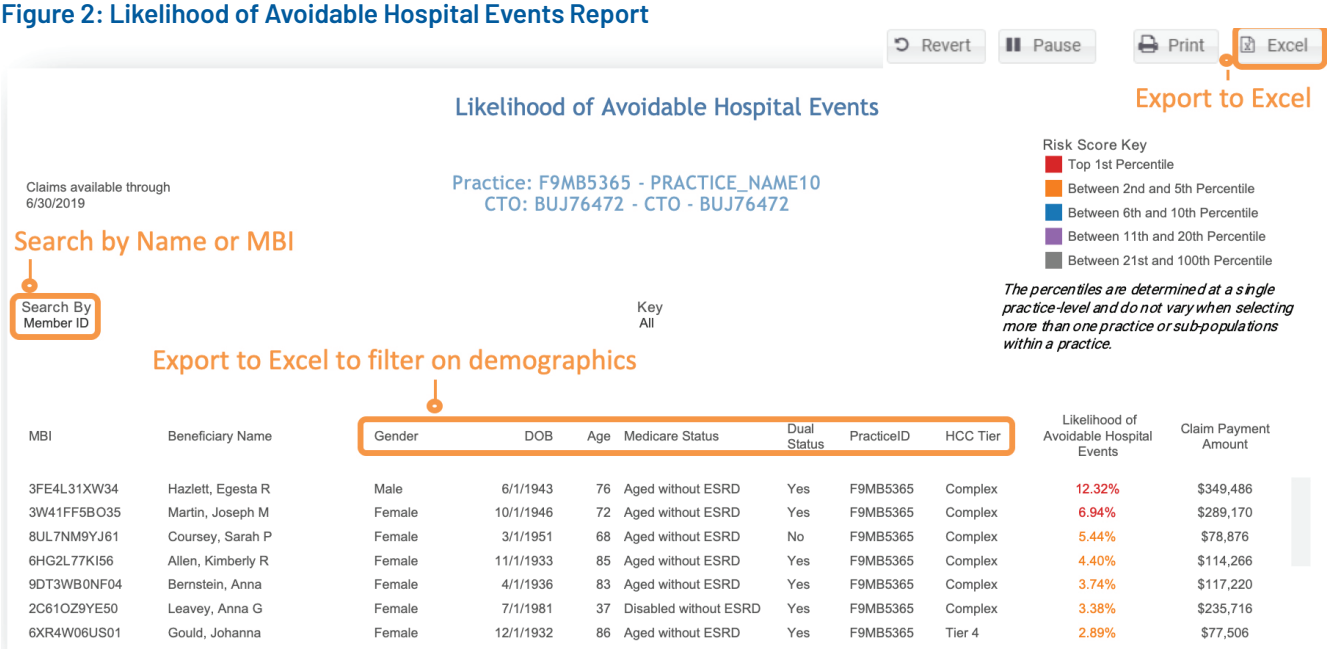
The MDPCP requires all practices to participate in the state-designated health information exchange known as the Chesapeake Regional Information System for Our Patients (CRISP). CRISP provides all practices with a package of health information technology tools including a nearly real-time event notification system, clinical queries, care alerts and patient summaries, and prescription drug monitoring program. Practices and CTOs can also use a suite of tools that includes a quality data upload portal, utilization and cost data visualizations, predictive analytics, and a bidirectional community-based organization electronic referral system. Claims data are refreshed monthly, allowing practices to track their hospital and ED utilization compared to peers and the state overall, as well as identify high-cost patients and high-volume, high-cost specialists. This is an attempt to focus attention on the relative costs between specialists and to have providers engage specialists in conversations and cooperative agreements about creating value.

Finally, the state engaged a contractor to help practices optimize their electronic medical records. Under this engagement, practices have upgraded their systems and developed integrations with other systems including CRISP.

## A Tool to Reduce Avoidable Health Services Utilization

Recognizing the challenges that prior programs have experienced in avoiding unnecessary hospital and ED utilization, Maryland contracted with The Hilltop Institute at the University of Maryland, Baltimore County to create a user-friendly tool to identify patients at risk for avoidable hospitalization (AH) or ED visits. The "Pre-AH" tool uses artificial intelligence to analyze claims, demographics, diagnoses, and pharmacy and environmental/social data sets to predict AH and ED events (Figure 2). Primary care providers can then target their resources to help prevent ED visits or AH. The tool is available to all practices free of charge on their CRISP dashboards and is updated monthly.

**Figure 2: Likelihood of Avoidable Hospital Events Report**




| 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 |

## Partners to Address Behavioral Health and Social Needs

Unmet behavioral health and social needs can lead to significant morbidity, mortality, and avoidable hospital and ED use.[2] The MDPCP provides practices with a menu of evidence-based methods of behavioral health integration. For example, to help practices combat Maryland's statewide opioid epidemic, the state engaged a contractor experienced in integrating into primary care the evidence-based protocol for substance use known as Screening, Brief Intervention, and Referral to Treatment. By the end of 2019, 115 Maryland practices had fully implemented this process. In fact, 95% of practices reported having integrated behavioral health into their practice workflows. Many practices have also implemented the Psychiatric Collaborative Care Model and the behavioral health co-location model. The Collaborative Care Model focuses on defined patient populations tracked in a registry, measurement-based practice, and treatment to target. Primary care providers and behavioral health professionals provide evidence-based medication or psychosocial treatment supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.

Acknowledging the significant impact of nonmedical factors such as housing and food insecurity on health, MDPCP practices are required to screen for and address their patients' social needs. To facilitate linkages to community-based organizations to meet social needs, the state developed a bidirectional referral tool available through the CRISP platform. The referral tool provides easy, secure referrals to organizations to meet food insecurity, housing, and other needs. MDPCP has begun collaborating with Meals on Wheels, community self-help programs, the State Department of Housing, diabetes prevention programs, and Catholic Charities. It plans to continue to build relationships with other government and nongovernment organizations to address patients' social needs.

## State Leadership and Dedicated Practice Coaching

MDPCP leadership, operations, and staff are all housed operationally within the PMO, and its physician executive director reports directly to the Secretary of Health. This unique reporting arrangement allows primary care practices to identify a single source of leadership for the state that offers both clinical guidance and the power of state government.

To provide hands-on support to practice leaders and staff, the PMO began even before the start of the program providing technical assistance and guidance with practice coaches who work directly and daily with practices. At the same time, the PMO offers regular

webinars focused on areas of implementation such as behavioral health and other topics. Additionally, contractors offer staff training programs, webinars, and provider leadership academies in locations across the state (see Table 1).

COVID-19 webinars cover topics such as provider, staff, and patient safety; identifying high-risk patients; and communicating with patients. The webinars have recently shifted to allow practices the opportunity to speak to their peers and share their experiences. Approaches on

**Table 1: State Contributions to the MDPCP Program**

| CTOs | CRISP | Contractors | State Coaches |
|---|---|---|---|
| • Furnish care coordination services<br>• Support care transitions<br>• Provide data and analytics<br>• Assist with practice transformation | • Central place to report quality measures to CMMI<br>• Has portal to access claims data reports<br>• Provides social determinants of health screening tools and resource directories<br>• Offers prescription drug monitoring programs, query portal, secure messaging, ENS services<br>• Has preventable hospital utilization tool integrated into claims reports | • Implement provider leadership academy and state training academies<br>• Provide educational materials on complex program issues<br>• Develop and conduct behavioral health integration webinar series<br>• Offer Screening, Brief Intervention, and Referral to Treatment assistance<br>• Help to optimize electronic medical records<br>• Provide billing and coding guidance | • Facilitate escalation process to the Centers for Medicare and Medicaid Services<br>• Offer strategies to reduce administrative burden<br>• Deliver hands-on, in-person assistance and support<br>• Encourage quality improvement<br>• Assist with health information exchange tool implementation |

## MDPCP POISED TO RESPOND QUICKLY TO COVID-19

The primary care workforce, coordinated and supported by the MDH through the PMO, has become a critical part of the public health response to the COVID-19 pandemic. MDPCP providers have mounted a coordinated telemedicine response, shared best practices, and reached out to at-risk patients.

Since March, the vast majority of practices in Maryland have implemented or expanded their telemedicine offerings. Based on a recent survey of practices, more than 472 practices are offering virtual care; others have stayed open using telephone and limited in-person visits to care for their patients.

The PMO held its first COVID-19 informational webinar for practices on March 12, when Maryland had 12 virus-infected individuals. Since then, MDPCP has hosted COVID-19 update webinars three to five times a week led by the PMO executive director and attended by 200 to 300 primary care practice providers and staff. The issues such as how best to triage patients in parking lots and outdoor environments have been honed by the practices during these virtual events. (See our companion feature article for more on MDPCP's response to COVID-19.)

### Importance, Scaling, and General Applicability

Maryland is an active proving ground for the concept of increasing primary care investment to improve health while reducing the costs of care. It's anticipated that MDPCP clinical quality, consumer satisfaction, and utilization data for performance year one (2019) will be available by late summer 2020. As the health of the population improves and the rate of avoidable utilization of health services declines, Maryland intends to reduce overall spending with a focus on avoidable and unnecessary high-cost utilization.

If successful in Maryland, the MDPCP could be scaled and replicated elsewhere. Admittedly, Maryland is unique in its ability to directly regulate hospital spending under

the Health Services Cost Review Commission and its global budget system. The investments in the MDPCP are included in the total cost of care spending calculations and, under the hospital global budgets, reductions in utilization financially benefit hospitals.

Maryland's currently unique regulatory system, however, could be expanded to other states if those states introduce global hospital budgeting or similar mechanisms to reduce unnecessary utilization. Rhode Island, Colorado, and Vermont have all introduced policies, statutes, and regulations that establish "affordability" caps on elements of health care premium spending, for example, that can also lead to lower costs and higher quality. Even in a fee-for-service environment, reductions in unnecessary utilization in high-cost hospital venues may lower costs.

The high cost of health care services in the United States drive the high health care insurance premiums and contribute to Americans' inability to afford and access health care. There is no quick or simple solution to this problem, which has resulted from policy and program decisions made at many levels over the past 50 years. However, shifting care from high-cost venues like hospitals to well-prepared, adequately resourced, lower-cost primary care venues can be a foundation for creating a health care delivery system focused on health and well-being. To that end, Maryland will continue moving forward with its innovative and timely MDPCP.

## NOTES


1. Altschuler J, Margolius D, Bodenheimer T, Grumbach K. Estimating a reasonable patient panel size for primary care physicians with team-based task delegation. *Ann Fam Med.* 2012;10(5):396-400. doi:10.1370/afm.1400.

2. Berkowitz SA, Hulberg AC, Hong C, et al. Addressing basic resource needs to improve primary care quality: a community collaboration programme. *BMJ Qual Saf.* 2016;25(3):164-172. doi:10.1136/bmjqs-2015-004521.

## AUTHORS

**Chad Perman,** MPP, program director for the Maryland Primary Care Program's Program Management Office, co-designed and now manages Maryland's partnership and daily operations. Mr. Perman is a key advisor to the Maryland Department of Health on health transformation and population health initiatives. He previously served as the director of health systems transformation within the department's Office of Population Health Improvement. Before working for the state, Mr. Perman served as a consultant with Health Management Associates. He conducted health policy analyses and provided consulting services to public and private-sector clients focused on publicly financed health care. Mr. Perman has also presented at a variety of state and national meetings. His abstract, "Innovative Payment Mechanisms in Maryland Hospitals," was selected for "The Best of the 2014 Academy Health Research Meeting." He leverages additional expertise in the areas of public policy analysis, consumer engagement, econometrics, and performance measurement through a variety of engagements with federal agencies, universities, and policy institutes. Mr. Perman serves on a variety of workgroups and boards including the Herschel S. Horowitz Center for Health Literacy (University of Maryland) Advisory Board.

**Robert Patterson,** MHS, MA, has worked for 30 years in the global health and development sector as an organizational leader, technical expert, and technical writer for multinational agencies, governments, nongovernmental organizations, foundations, and the private sector. He is a strategic thinker with experience across 25 countries and is fluent in English, French, and Italian. Mr. Patterson holds graduate degrees from the Johns Hopkins University's Bloomberg School of Public Health and Nitze School of Advanced International Studies, as well as an undergraduate degree from Dartmouth College.

**Howard M. Haft,** MD, was appointed by Governor Larry Hogan to serve as deputy secretary for public health services in the Maryland Department of Health in 2015. Since then he has also served as the interim executive director of the Maryland Health Benefit Exchange and most recently as the executive director of the Maryland Primary Care Program. Dr. Haft was the founder and chief medical officer of Conmed Healthcare Management, a publicly traded company. He served as the president of Maryland Healthcare, a multispecialty clinic in Southern Maryland; as president of the Maryland Foundation for Quality Healthcare; and as medical director of Health Partners, Inc. Dr. Haft has also served as chief executive officer of the Ellis Medical Group in New York. He provided emergency medical care for disasters, including Hurricane Katrina and the Haitian earthquake, and in remote Caribbean locations. Dr. Haft received his undergraduate degree at the University of Rhode Island, attended medical school at Pennsylvania State University, and completed post graduate internship and residencies at Brown University. He has a master's degree from Tulane University School of Public Health and Tropical Medicine. He is recognized by the American Board of Physician Executives as a Certified Physician Executive and as a Fellow of the ACPE. He served as an adjunct professor in the McDonough Graduate School of Business and as assistant clinical professor of medicine at Georgetown University School of Medicine.

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