The Maryland Comprehensive Primary Care Model
A Care Transformation Organization Environmental Scan

Background

In an effort to further modernize a volume-based payment to a value-based payment, Maryland received a five-year performance period approval from the Centers for Medicare and Medicaid Services (CMS) in 2014 for the new hospital payment model waiver based on global hospital budgets and quality targets, the All-Payer Model (APM). As part of the next phase of the APM, the State of Maryland submitted a proposal for the Maryland Comprehensive Primary Care (CPC) Model to the Centers for Medicare and Medicaid Services (CMS) in December 2016. The Maryland Comprehensive Primary Care Model (CPC) is one of the central features of the APM that is required to improve health care quality and moderate growth in total cost of care per capita spending. A key component of CPC is Care Transformation Organizations (CTOs), which are entities that provide care management services to ambulatory health care practices (i.e., Person Centered Homes: PCH).

In the model, CTOs are entities that will administer care management support and services to ambulatory health care provider practices to achieve better health and deliver higher quality health care to their patients. The CTO is intended to be an organization that will coordinate care for patients across settings, as well as engage in outcomes based contracting and provide technical assistance for practice transformation to practices. CTOs will aim to generate economies of scale in the provision of enhanced care transformation services. Practices without substantial care management infrastructure could receive CTO support through a contractual relationship.

CTOs will provide support and technical assistance to practices that are tailored to the needs of the practice and patient community. CTOs are intended to provide support in the following domains: 1) care management, 2) data tools and informatics, 3) practice transformation technical assistance, 4) social services connection, 5) hospital care coordination. Under the proposed model, it is optional for a practice to receive CTO support. The CPC model allows a practice to offer all the services required under the program independent of CTOs.

Purpose of the Environmental Scan

The Department of Health and Mental Hygiene (DHMH) and the Maryland Health Care Commission (MHCC) seeks information on support activities your organization is already providing practices in health care delivery and in achieving practice transformation. DHMH and MHCC intend to use the information collected from the environmental scan to inform its CTO strategic planning process.

*DHMH and MHCC are asking organizations to complete the environmental scan by **April 7, 2017**. Combined responses should be no longer than 4 pages, double-spaced, not including any attachments or appendices. Please submit responses to:* dhmh.pcmodel@maryland.gov *with the subject: CTO Scan*

General Organizational Information and Operations

1. Describe the legal structure of your organization.

2. If your organization participates in a Medicare Accountable Care Organization, describe your current track level and model.

3. Provide an overview on the population that you serve (i.e., numbers, patients served, demographics, payors, and health status).

4. Describe your current service area and how you determined that service area.

5. Describe the nature of your contact with patients and providers (i.e., care management, hospital follow-up, social service connections, health education, etc.).

Staffing and Partnerships

1. Does your organization work directly with practices? If so, what services do you currently provide?

2. Specifically, identify and describe team members (e.g., Registered Nurse, Community Health Worker, Social Worker, Behavioral Health Specialist, Pharmacist, etc.) employed or contracted by your organization who perform the activities in the domains listed above. If applicable, describe your ratios of staff to beneficiaries as it relates to the domains.

3. Describe how your organization collaborates with social service and community organizations to promote holistic health management.

Data and Quality Measurement

1. Does your organization:

    a. Use electronic health records (EHRs) to manage care and report quality? If so, provide the name of the EHR system.

    b. Educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP)?

    c. Assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network?

    d. Use risk stratification to identify patients for care management?

    e. Collect, report, and interpret quality metrics?

2. How do you utilize data to facilitate quality improvement in the practices that you currently support? Describe the data that you collect and the manner that you use the data to inform your quality improvement initiatives.

3. Describe the technical infrastructure in place to share data with practices, CRISP, and other entities on cost, utilization, and quality at regular intervals (e.g., quarterly).

Practice Transformation Technical Assistance

1. Describe the role of your organization in providing health education and trainings.

2. Do you provide behavioral health support within a provider setting? If so, please describe.

    a. Does your organization promote the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs?

3. What support for social services (i.e., referrals, application assistance, etc.) and core needs (i.e., food insecurity, transportation, housing instability, etc.) do you provide?

4. Do you work with practices that provide care to high and rising needs patients with substantial hospital utilization? If so, describe the support that you provide.

5. What kind of consumer and patient engagement services does your organization provide?

6. Does your organization deliver targeted engagement solutions to disengaged and engaged patient populations?