Rural Health Collaborative Meeting Minutes
December 5, 2018
Time: 5:00pm to 8:00pm
Location: Queen Anne's County Health Department, 206 N. Commerce St., Centreville, MD, 21617, 2nd floor conference room

The following Rural Health Collaborative (RHC) members were in attendance:

Victoria Bayless, MHSA
Mary Bourbon
Childlene Brooks
James Chamberlain, MD
Joseph Ciotola, MD
Michael Clark, MS
Scott LeRoy, MPH
Maria Maguire, MD, MPP, FAAP
Shelly Neal-Edwards, LCSW
Sara Rich, MPA
Teresa Schaefer, PhD
April Sharp, LCSW
Anna Sierra, MS, EMT
Mary Thompson, RN
Sonia Lorelly Solano Torres, PhD
Fredia Wadley, MD
William Webb, MS

Also in attendance: Lindsey Snyder, Esq., Assistant Attorney General, Maryland Department of Health (MDH); Cheryl DePinto, MD, MPH, FAAP, Director, Office of Population and Health Improvement, MDH; Pamela Tenemaza, MPA, Policy Analyst, Deputy Secretary's Office, Public Health Services, MDH; Ron Bialek, MPP, Executive Director, RHC, and President, Public Health Foundation (PHF); Kathleen Amos, MLIS, Assistant Director, Academic/Practice Linkages, PHF; Sarah Haas, MSHA, MBA, Manager, Healthcare Payment Redesign Programs, Anne Arundel Medical Center (AAMC); Howard Haft, MD, MMM, FACPE, Executive Director, Maryland Primary Care Program, MDH; Amy Travers, Senior Practice Manager, AAMC; Lauren Canary

Welcome and Introduction of Executive Director Ron Bialek and Kathleen Amos
Fredia Wadley, MD, Talbot County Health Officer

Meeting was called to order at 5:17pm by RHC Executive Committee member Fredia Wadley, MD. Dr. Wadley thanked everyone for attending and welcomed everyone to the meeting. Members of the RHC introduced themselves. Ron Bialek, MPP, President, Public Health Foundation (PHF), and Kathleen Amos, MLIS, Assistant Director, Academic/Practice Linkages, PHF, introduced themselves and PHF, which is providing Executive Director services for the RHC.

Review and Approval of Minutes
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley requested any comments on the draft minutes for the September 24, 2018 meeting. No additions or corrections were provided. The RHC unanimously approved the minutes.

Understanding Maryland's Total Cost of Care Waiver

A. The Primary Care Population Health Component

Howard Haft, MD, MMM, FACPE, Executive Director, Maryland Primary Care Program, Maryland Department of Health

Howard Haft, MD, MMM, FACPE, presented on the Maryland Total Cost of Care (TCOC) model and the Maryland Primary Care Program (MDPCP). Presentation slides are attached. Highlights included:

- The Maryland TCOC model will launch on January 1, 2019 and is designed to improve population health. The MDPCP is one component of the Maryland TCOC model.
- The federal government is willing to provide funding as credits against the TCOC if Maryland is able to improve health measures relative to similarly matched cohorts. Maryland's initial population health goal is addressing diabetes. About 10% of the state population has diabetes, and about 1.6 million Maryland residents have pre-diabetes. If Maryland can reduce those numbers, it can get those cost savings as credits against the TCOC. Additional population health goals include addressing hepatitis C and opioid-related deaths.
- The MDPCP is built on Comprehensive Primary Care Plus (CPC+), with modifications to fit into the TCOC model. Any primary care practice that qualifies can participate in the MDPCP. The MDPCP will have five annual open enrollment periods, the first of which was in 2018. In addition to payment redesign, the MDPCP includes Care Transformation Organizations (CTOs) that are available to assist primary care practices. The MDPCP is starting with Medicare, but is looking to expand to other payers in future years.
- The MDPCP is a joint program between the federal government and the state of Maryland, with the Center for Medicare & Medicaid Innovation (CMMI) being the part of the federal government involved. Program responsibilities are shared between CMMI and the state.
- An advanced primary care practice will have functions in five areas: access and continuity, care management, comprehensiveness and coordination, beneficiary and caregiver experience, and planned care for health outcomes.
- Payment incentives in the MDPCP include care management fees, performance-based incentive payments, and the underlying payment structure.
- CTOs are available by request to assist practices with care coordination services, support for care transitions, data analytics and informatics, standardized screening, and meeting care transformation requirements.

Dr. Haft addressed questions from the RHC on risk stratification, the currency of data in CRISP, metrics, and the process of attributing patients to practices.

B. The Hospital Perspective

Tori Bayless, MHSA, CEO, Anne Arundel Medical Center (AAMC); Sarah Haas, MSHA, MBA, Manager, Healthcare Payment Redesign Programs, AAMC

Tori Bayless, MHSA, provided opening remarks on the Anne Arundel Medical Center (AAMC) perspective of the Maryland TCOC model and introduced Sarah Haas, MSHA, MBA. Ms. Haas presented on the TCOC model from the hospital perspective. Presentation slides are attached. Highlights included:

- Maryland has operated under a waiver since the 1970s, and the TCOC model is the latest iteration in the Maryland waiver system. The TCOC model moves beyond looking only at hospital costs to all the costs a patient might have.
- To operate under the TCOC model, Maryland has metrics to meet related to quality and cost.
- Programs available to help manage TCOC include Medicare Performance Adjustment (MPA); MDPCP; and Care Redesign Programs (CRP), including the Hospital Care Improvement Program (HCIP), Complex and Chronic Care Improvement Program (CCIP), and Episode Care Improvement Program (ECIP).
- AAMC is concerned with delivering high quality, low cost care to meet the needs of the communities it serves, and part of this is defining priorities. One group it looks to in defining priorities is the American Hospital Association, which has priorities for rural health, including telehealth, behavioral health services, new models of care, regulatory relief, workforce recruitment and retention, and prescription drug programs sustainability. AAMC is using state tools including MPA and the CRP programs HCIP and ECIP.
- AAMC is participating in the MDPCP as a CTO with five partner practices on the Eastern Shore and is looking to enhance current services, add new services, and redesign care processes.
- AAMC is looking for innovative ways to work with partners to address needs in the communities it serves and innovative ways to deliver care.

C. Discussion - What does this mean for the Rural Health Model that has to align?
Fredia Wadley, MD, Talbot County Health Officer

- Joseph Ciotola, MD, discussed the mobile integrated health pilot program in Queen Anne's County, which AAMC participates in. This program is a partnership with the Queen Anne's County Health Department, EMS, social services, and other community organizations. The program uses a team approach to address high utilization of 911 and reconciliation of medications post-hospital discharge. One difficulty is that there is no reimbursement for this type of program. There are seven of these programs now running in Maryland, and Dorchester and Talbot Counties are also trying to implement programs, but need funding to do so.
- RHC members discussed the need to shift money to pay for patients who receive care from EMS, but are not transported to the hospital.
- RHC members discussed Medicare rates for rural areas and the issues for rural areas to stay competitive when those rates are not equal to metropolitan areas.
- Ms. Bayless discussed how hospitals receive a set amount of money under the global budget and are supposed to invest cost savings into other programs. AAMC has invested such money into programs that operate at a loss and are not self-sustaining, including palliative care and community-based clinics.
- RHC members discussed the need for AAMC to align efforts with Shore Health and how the RHC can work with two competing medical systems within the same jurisdictions. AAMC has proposed areas for collaboration in the past and worked with UMD.
- Dr. Wadley discussed a Talbot County program that provides services for Medicare beneficiaries who are not eligible for in-home services and the need to utilize existing resources as well as secure additional resources.

Review, Discussion, and Approval of Revised Bylaws
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley discussed the revised bylaws and requested any questions related to the bylaws. The RHC unanimously approved the bylaws.

Process for Establishing the Rural Health Model

A. Guidelines for What We Want the Model to Be

B. Steps to Take to Design

Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley led a discussion about the rural health model and encouraged RHC members to begin thinking about what the RHC wants the model to look like and accomplish. The model will need to align with the TCOC waiver. The RHC discussed potential issues for rural areas, including:

- Transportation
- Shortages of primary care providers
- High need clients and workloads for case managers
- Stable sources of funding for wraparound services

Further discussion focused on the future of the TCOC program and the incorporation of social services, the idea of addressing social determinants of health through primary care practices, and the importance of spending on social services if aiming to reduce healthcare costs and get better outcomes.

Two approaches for a rural health design program that may be needed were discussed:

- A deep end approach to serve complex patients who go from agency to agency
- Early interventions that go back to basics and get the right information to the frontlines of social support systems so they can provide education and have an impact earlier in the system

There was also further discussion on the population health measure related to diabetes. Maryland could gain money as a state if it hits a target of slowing the increase in prevalence compared to a control group. Maryland's control group is synthetic rather than another state. Maryland has not yet gotten to measures for opioids and hepatitis C.

Comments from the Audience
Fredia Wadley, MD, Talbot County Health Officer

Lauren Canary expressed interest in the RHC.

Meeting was adjourned at 7:48pm.

Maryland Primary Care Program

Rural Health Collaborative Presentation

Total Cost of Care Model and MDPCP

- Total Cost of Care Model is the umbrella
- MDPCP is critical to meeting TCOC Model commitments including:
  - Reducing 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

Maryland Total Cost of Care Model

Platform of State wide Policy, Process and Community programs

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TCOC Contract CMMI and Maryland

- Hospital
  - #1 Global Budgets –GBR
  - Savings warrants
  - Quality improvement
  - Population Health focus
- Practices/Providers
  - #2 MDPCP- Primary Care
  - #3 Care Redesign Amendment – all providers
    - Specialist focus: Bundles Model, HCIP
    - Primary care: CCIP (additional opportunity to work with hospitals)
- Entire State
  - TCOC Model is designed to improve population health
  - Population Health goals- Diabetes, Hepatitis C, Opioid death rates

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

How is MDPCP Different from CPC+?

	CPC+	MDPCP
Integration with other State efforts	Independent model	Component of MD TCOC Model
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 starting in 2018
Track 1 v Track 2	Designated upon program entry	Migration to track 2 by end of Year 3
Supports to transform primary care	Payment redesign	Payment redesign 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, Duals, (Other payers encouraged for future years)

CMMI Roles in MDPCP

CMMI responsible for:

- Application process
- Selection of Practices
- Selection of CTOs
- Provision of Learning System
- Provision of all payments
- Provision of data to practices on attribution of patients, HCC scores
- Ongoing MDPCP operations

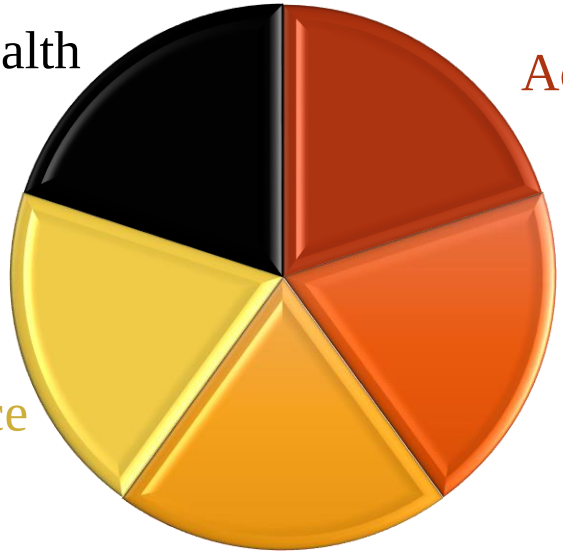
State's Role in MDPCP

State responsible for:

- Facilitate and support CMMI in MDPCP activities
- Outreach to practices and CTOs
- Support Education of practices and CTOs
- Practice Coaches
- Data support through CRISP
  - Claims
  - Quality reporting
- CTO-Practice Arrangement template
- Suggest changes in program annually
- Suggest MDPCP activities that State can assume
- Assemble Advisory Council

Requirements: Primary Care Functions

Five advanced primary care functions:



Access and Continuity

Track One

- Empanel patients to care teams
- 24/7 patient access

Track Two (all of the above, plus)

- Alternatives to traditional office visits

Care Management

Track One

- Risk stratify patient population
- Short-and long-term care management
- Follow-up on patient hospitalizations

Track Two (all of the above, plus)

- Care plans & medication management for high risk chronic disease patients

Comprehensiveness and Coordination

Track One

- Coordinate referrals with high volume/cost specialists serving population
- Integrate behavioral health

Track Two (all of the above, plus)

- Facilitate access to community resources and supports for social needs

Beneficiary and Caregiver Engagement

Track One

- Convene Patient Family Advisory Council (PFAC) and integrate recommendations into care, as appropriate

Track Two (all of the above, plus)

- Advance care planning

Planned Care for Health Outcomes

Track One & Two

- Continuously improve performance on key outcomes

Metrics

- **electronic Clinical Quality Measures (eCQM)** include:
  - Outcome Measures – Diabetes and Hypertension Control
  - Screening and Initiation of treatment for Substance Abuse
- **Patient Satisfaction**
  - Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) – survey of practice patients
- **Utilization**
  - Emergency department visits and Hospitalizations per 1,000 attributed beneficiaries

Current metrics as of 2018 – TBD for 2019

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

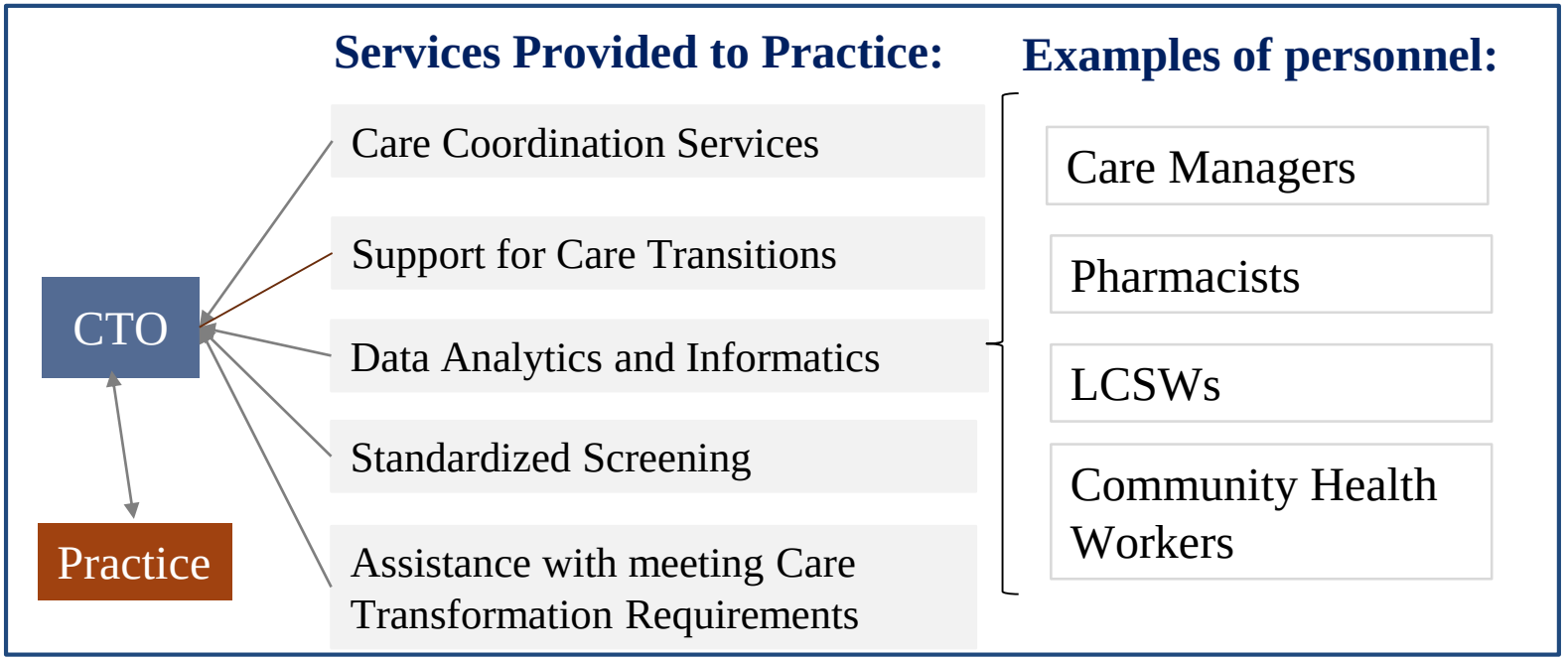
- Track 1: Standard FFS
- Track 2: Partial pre-payment of historical E&M volume with 10% bonus
- Timing:
  - ➢Track 1: FFS; Track 2: prospective

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

Potential for additional bonuses via AAPM Status under MACRA Law

Care Transformation Organization (CTO)

On request – assisting the practice in meeting care transformation requirements



Existing CRISP HIT Services for Practices

Maryland Prescription Drug Monitoring Program
Monitor the prescribing and dispensing of drugs that contain controlled dangerous substances

Encounter Notification Service (ENS)
Be notified in real time about patient visits to the hospital

Query Portal
Search for your patients' prior hospital and medication records

Direct Secure Messaging
Use secure email instead of fax/phone for referrals and other care coordination

Additional MDPCP HIT through CRISP

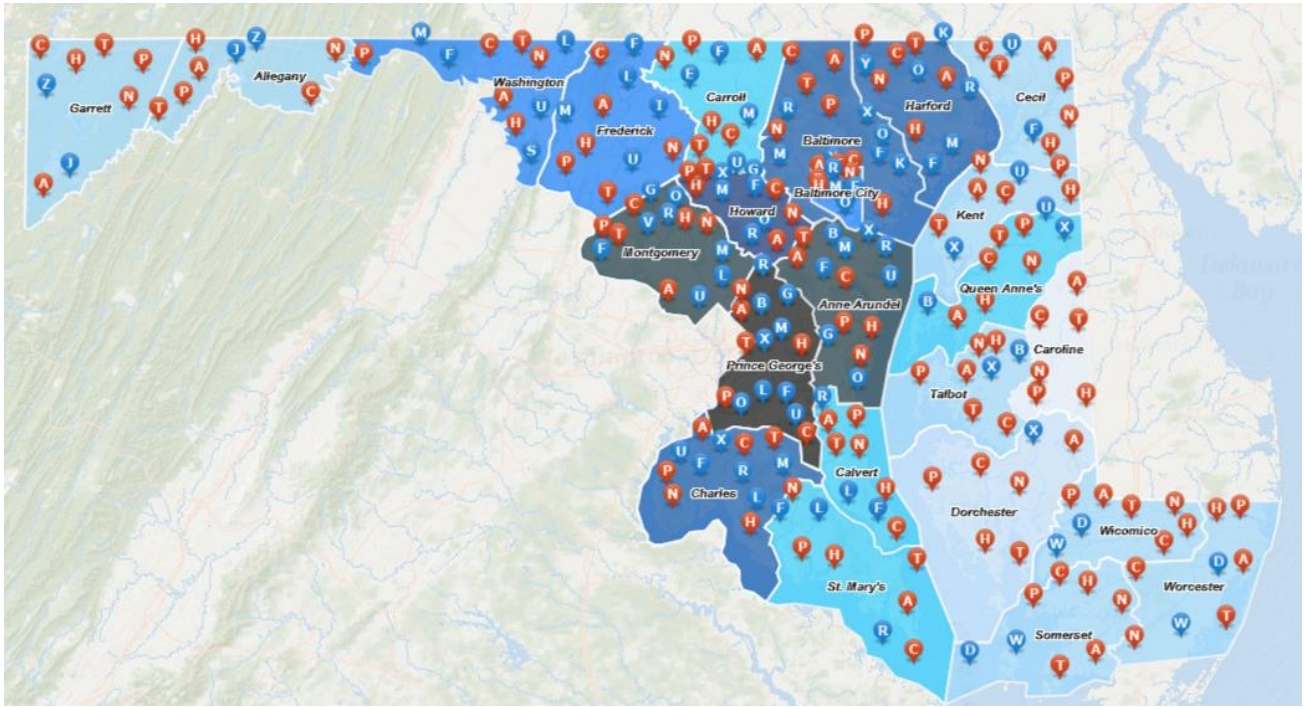
- Quality Measures Reporting to CMMI
- Hospital and Emergency Department Utilization Data
- Specialists costs and utilization
- Risk Stratification for Medicare and Medicaid beneficiaries
- Social Determinant Screening and Resource Directory
- Care plan and Care Alert sharing
- Others tbd

Application Status Program Year 1

- 595 Practice applications (80% of eligible practices)
  - Early estimates – 591 qualified
    - All counties represented
    - ~90% Track 1
    - ~40% employed by hospitals
    - ~2,000 PCPs
- 25 Care Transformation Organizations (min 6/county)
  - Early estimates-
    - 20 of 25 were selected as first choice by practices
    - 14 of 25 are hospital-based

Application Status Program Year 1

CTO Applications



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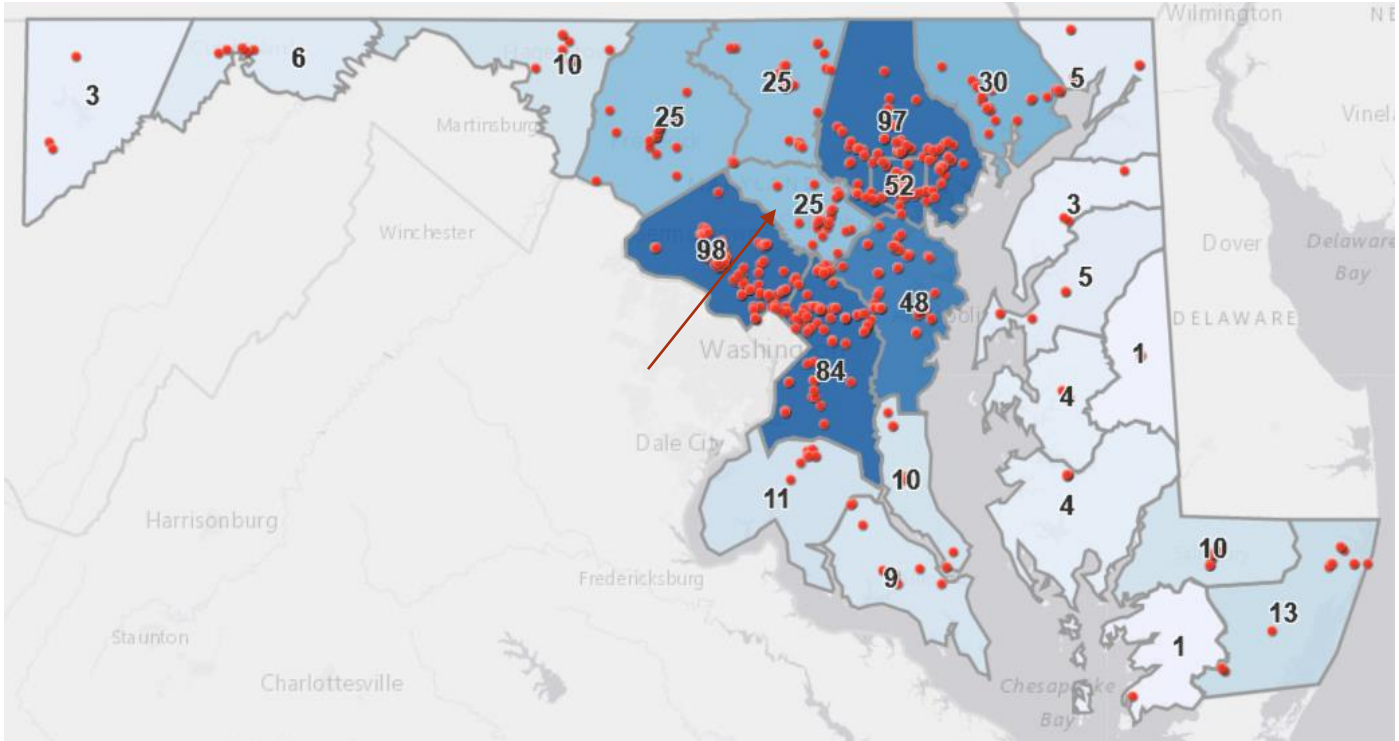
Practice Applications



** <20 applications could not be mapped due to inaccurate application data*

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Timeline

Activity	Timeframe
Release Applications	June 8, 2018
CTO Application Period Open	June 8 - July 23, 2018
Practice Application Period Open	August 1 - 31, 2018
Select CTOs and Practices	Summer/Fall 2018
Sign Agreements	Fall 2018
Initiate Program	January 1, 2019
Annual Enrollment	2020 - 2023
Program Participation	2019 - 2026

Remember the “Why”

- Strengthen Primary Care in Maryland
- **Provide the best quality health for all Marylanders**
- **Shift from an ever increasing volume demand to rewards for value based care**
- **Avoid unnecessary emergency department and hospital visits**
- Show the nation that Maryland can be the leader in healthcare

- We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win. JFK Rice Univ. 1962

Thank you!

Updates and More Information:

https://health.maryland.gov/MDPCP

Questions: email MarylandModel@cms.hhs.gov

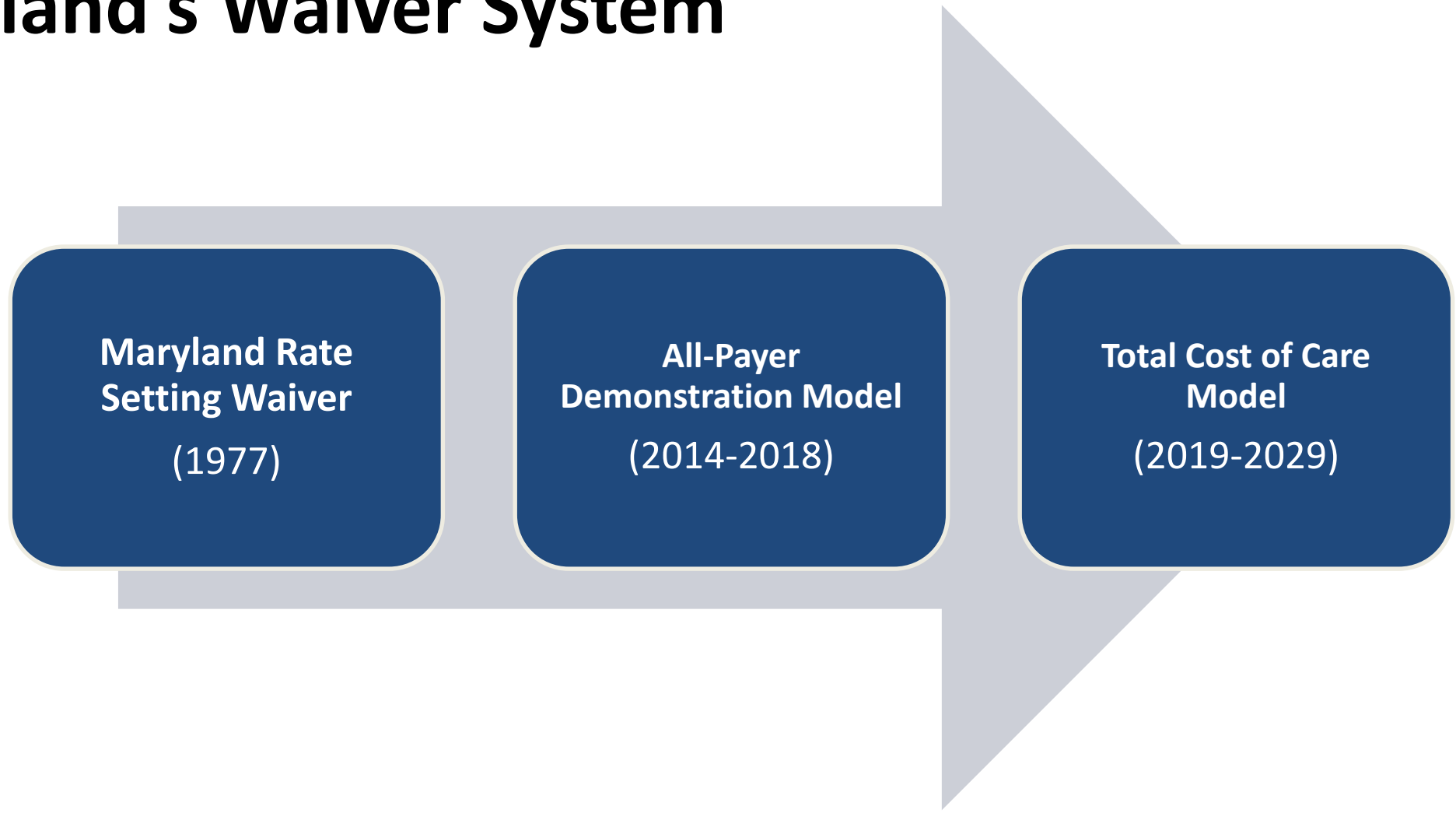
MARYLAND Department of Health

Understanding Maryland's Total Cost of Care Model: The Hospital Perspective

Rural Health Collaborative

December 5, 2018

Maryland's Waiver System



Maryland Waiver Performance Dashboard

Cumulative Performance – Jan 2014 to Most Recent Data Available

	Maryland Performance	Cumulative Target	
ALL-PAYER HOSPITAL SPENDING GROWTH PER CAPITA (compared to base year Maryland – CY 2013) ✓	**8.49%** spending growth	**19.23%** spending growth or below	**PERIOD** Jan '14 – Jul '18 vs. 2018 Ceiling **DATA** HSCRC Monthly Financial Data
MEDICARE HOSPITAL SPENDING GROWTH PER BENEFICIARY (compared to national) ✓	**$1,131** million in cumulative savings	**$330** million in cumulative savings at year 5	**PERIOD** Jan '14 – Jun '18 vs. 2017 Target **DATA** CMS Data[1]
MEDICARE ALL-PROVIDER SPENDING GROWTH PER BENEFICIARY (compared to national) ✓	**0.89%** favorable variance	**0%** growth limit above the nation in CY 2018	**PERIOD** Jan '18 – Jun '18 vs. 2018 Target **DATA** CMS Data[1]
MEDICARE READMISSION RATE (compared to national) ✓	**12.58%** decrease	**10.96%** decrease or more	**PERIOD** Jan '14 – May '18 vs. 2013 Base Year **DATA** CMS Data, V.6[1]
MARYLAND HOSPITAL ACQUIRED CONDITIONS RATE (compared to base year Maryland – CY 2013) ✓	**52.72%** decrease	**30.00%** decrease or more	**PERIOD** Jan '17 – Dec '17 vs. Jan '13 – Dec '13 **DATA** HSCRC Data

October 2018

[1] Data contain summaries provided by the federal government that have been prepared for Maryland, but are not official federal data. Data are preliminary and contain lags in claims. There may be material differences in results when final data are received.

Total Cost of Care (TCOC) Model

wtop NEWS TRAFFIC WEATHER LISTEN

Home » Maryland News » Maryland governor signs federal...

Maryland governor signs federal all-payer health contract

AP By The Associated Press
July 9, 2018 5:08 pm

Maryland Gov. Larry Hogan, center, signs a contract with the federal government for the state's unique all-payer health care model in Annapolis, Md., on Monday, July 9, 2018. Seema Verma, administrator of the federal Centers for Medicare and Medicaid...

Beyond Hospital Costs

Hospital Care 39¢

Physician/Clinical Services 22¢

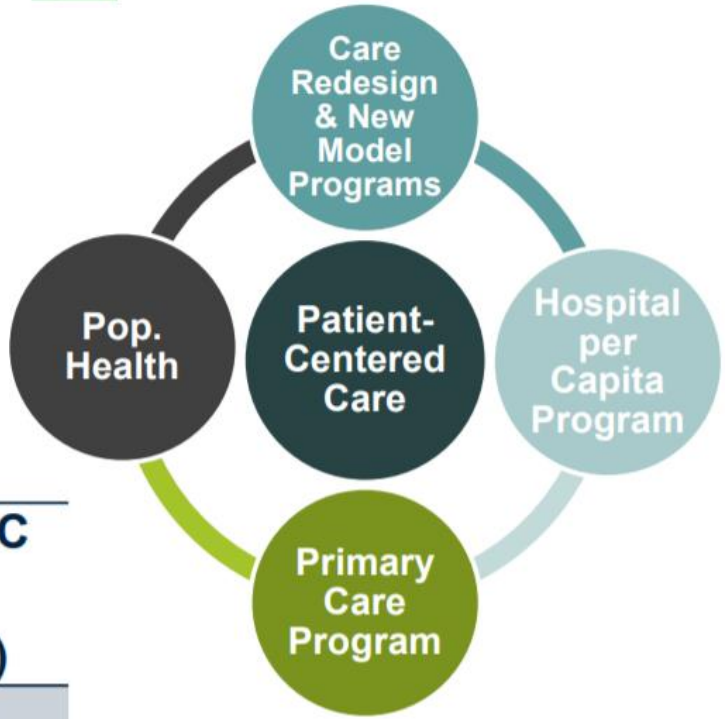
Prescription Drugs^ 21¢

6¢ Dental Services

2¢ Other Medical

10¢ Government and Insurance Administration*

Total Cost of Care (TCOC) Model

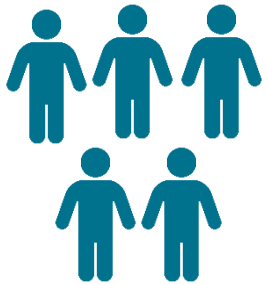


Goals:

- 3.58% per capita growth cap
- Medicare TCOC savings of >= $300M
- Reduction in hospital-acquired infections
- Reduction in readmissions
- Improvement on population health metrics

Annual Medicare TCOC Savings Targets (relative to 2013 base)		
2019	PY 1:	$120 million
2020	PY 2:	$156 million
2021	PY 3:	$222 million
2022	PY 4:	$267 million
2023	PY 5:	$300 million

Programs to Manage TCOC



Medicare Performance Adjustment (MPA)

- Attributes Medicare benes to hospitals through providers
- 0.5% Medicare revenue at-risk

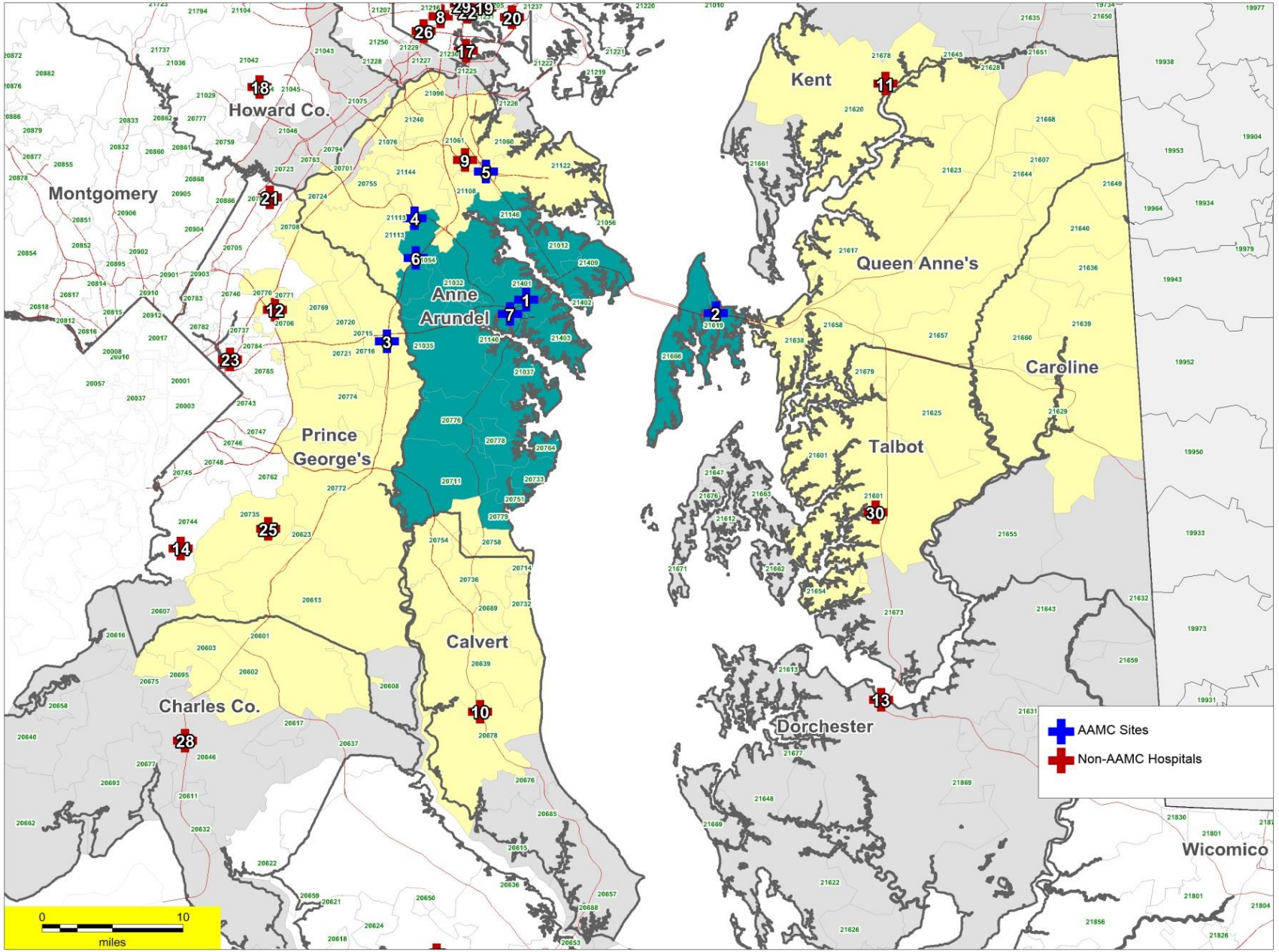
Maryland Primary Care Program (MDPCP)

- 578 Practices
- 25 Care Transformation Organizations (CTO)

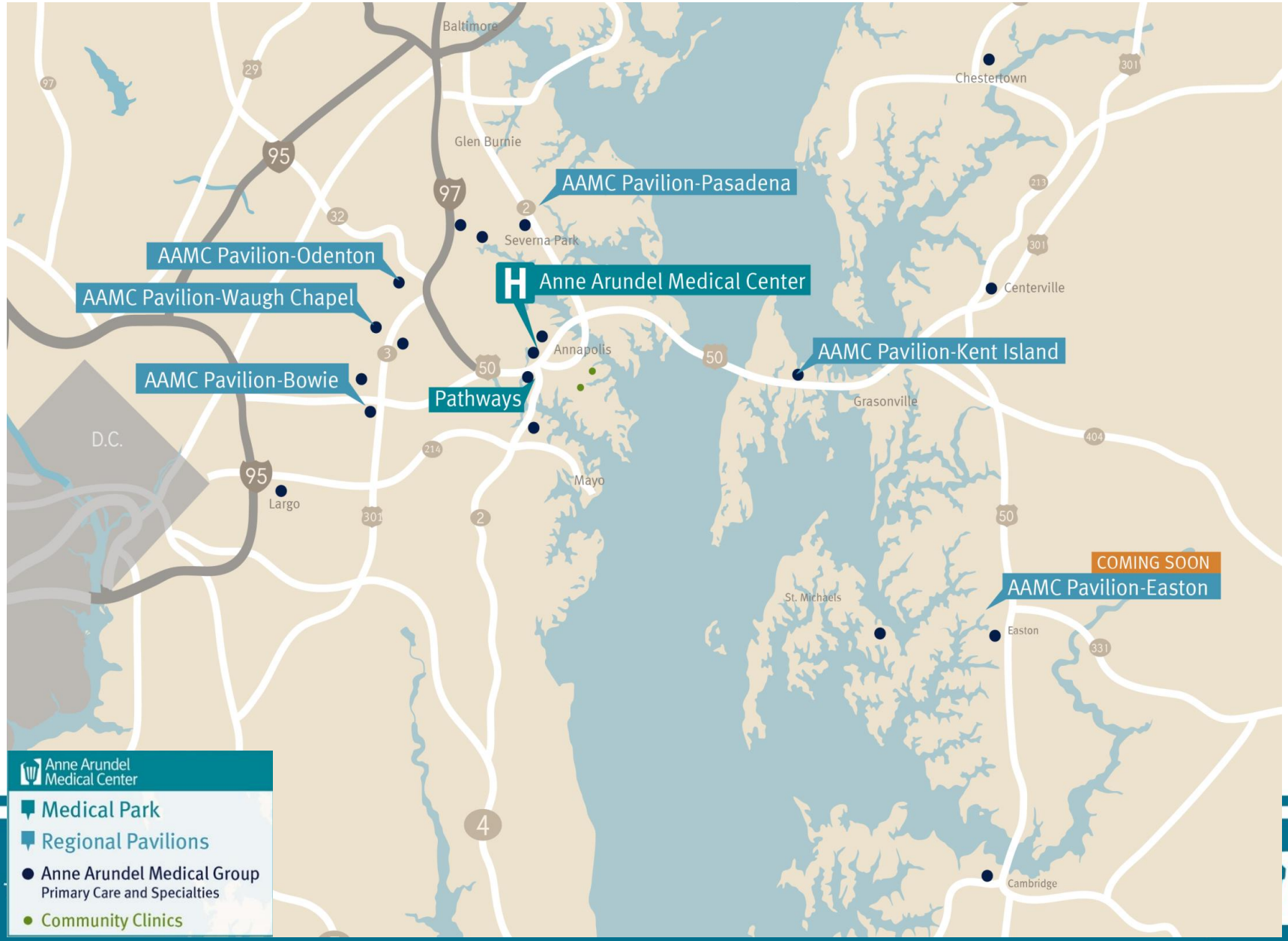
Care Redesign Programs (CRP)

- Hospital Care Improvement Program (HCIP)
- Complex and Chronic Care Improvement Program (CCIP)
- Episode Care Improvement Program (ECIP)

AAMC Service Area



AAMC Locations

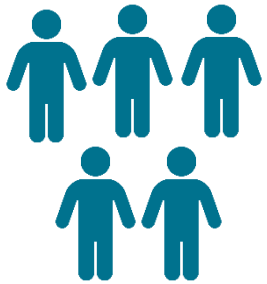


Provide High Quality Low Cost Care

- What are the clinical and social needs of those we serve?
- What can we do to meet their needs?
- What could we be doing better?
- How do we align provider incentives?
- How do we coordinate clinical and non-clinical services?

Define Priorities

Utilize State Tools



Medicare Performance Adjustment (MPA)

- ~40K attributed beneficiaries
- 17% from rural counties

Care Redesign Programs

- Hospital Care Improvement Program (HCIP)
- Episode Care Improvement Program (ECIP)

Advance Primary Care on the Eastern Shore

- AAMC Collaborative Care Network is a CTO
- 5 Eastern Shore partner practices, 19 practices total
- Enhance current services, add new services, and redesign care processes:
  - Care Management Services
  - Social Services
  - Home Care
  - Virtual Care
  - Behavioral Health
  - Care Coordination across Services
  - Patient and Family Engagement

Develop Partnerships

Skilled Nursing Facility
Preferred Provider Program

Deliver Care in New Ways

- ✓ LCSW embedded in Primary Care Practice
- ✓ Community Psychiatrist
- ✓ Behavioral Health Navigators
- ✓ Easton Pavilion-- multi-specialty, diagnostic, and ancillary services
- ✓ Ambulatory Surgery Center
- ✓ Telehealth




Deliver Care in New Ways

- ✓Partnership with Mobile Integrated Health
- ✓Ambulatory Palliative Care Program
- ✓Transition Nurse Navigators for high-risk patients
- ✓Collaboration with community primary care providers under MDPCP
- ✓Collaboration with skilled nursing facilities around transitions of care and bundled payment programs
- ✓“Golden Ticket” for certain conditions, allowing expedited appointments for certain specialties

LIVING HEALTHIER **TOGETHER.**