Maryland Primary Care Program

Overview and Performance Measures

Program Management Office

June 2019

Total Cost of Care Model and MDPCP

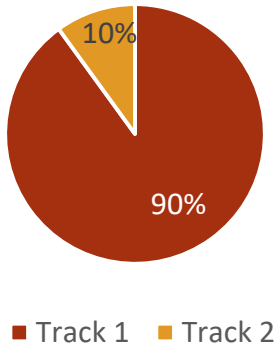
- "The umbrella"
- MDPCP is critical to meeting TCOC Model commitments including:
  - Reduction of Medicare FFS per capita health costs
  - Improvement on quality and utilization metrics
  - Improvement on population health indicators
- Advanced primary care will help the state:
  - Manage health of high and rising risk individuals in community
  - **Reduce unnecessary hospital and ED utilization**
  - Provide preventive care; address behavioral health and social needs

Program Year 1

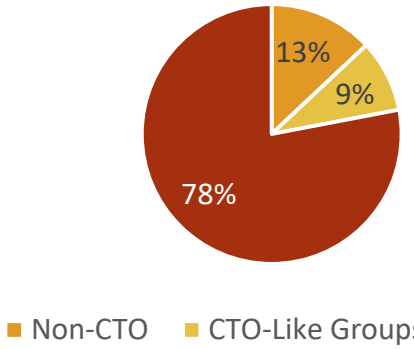
380 Practices Accepted Statewide

- ~ 220,000 Medicare FFS beneficiaries
- ~ 1,500 Primary Care Providers
- ~ 40% employed by hospitals
- All counties represented
- 21 Care Transformation Organizations (min 6/county)
  - 14 of 21 are hospital-based

Practice Tracks

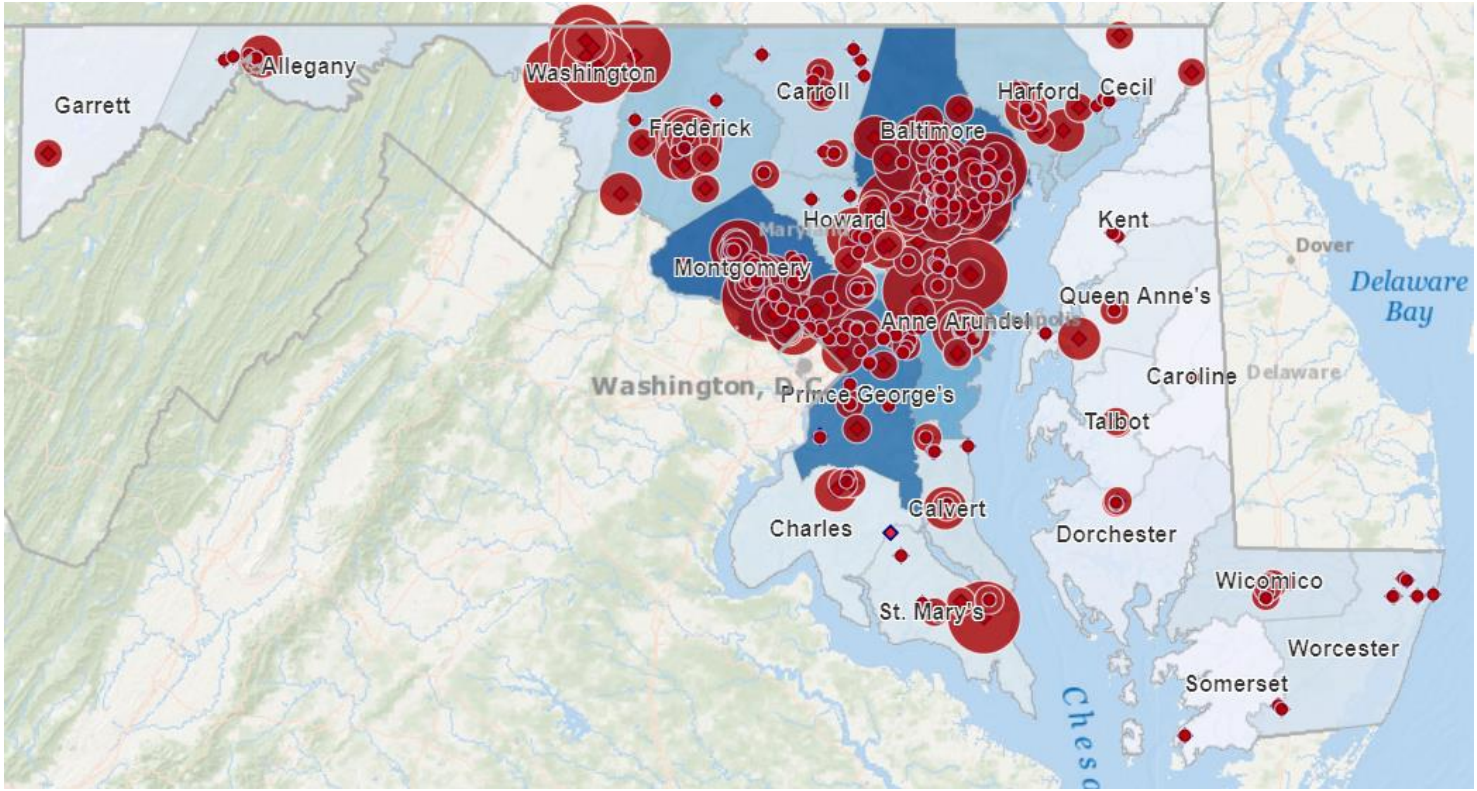


Practices Partnered with a CTO



MARYLAND Department of Health

380 MDPCP Practices



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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?"

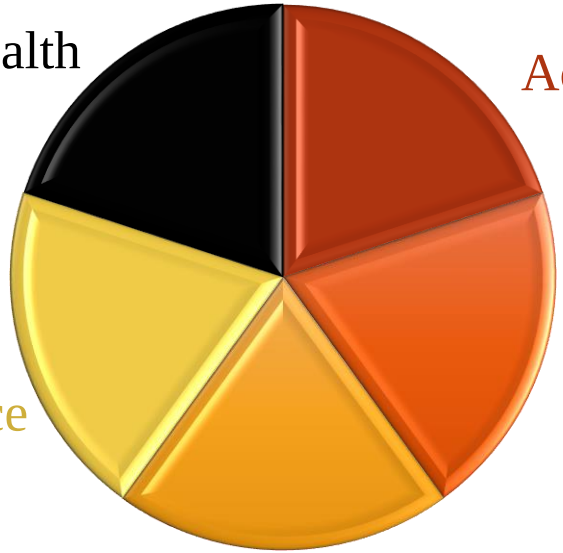
- MDPCP built on the learnings of CPC and CPC+
- MDPCP modified to fit into framework of TCOC model and Maryland's unique environment
  - Program Management Office Leadership
  - CRISP information exchange and data tools
  - Enhanced education and technical support with Care Transformation Organizations and Practice Coaches

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
Track 1 v Track 2	Designated upon program entry	Migration to Track 2 by beginning of Year 4
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 (Other payers encouraged for future years)

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

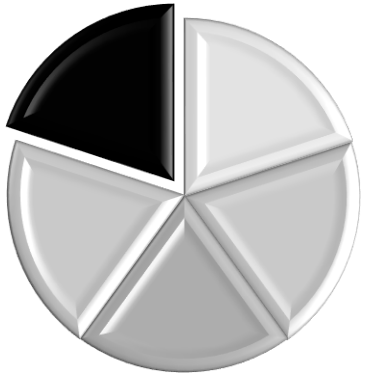
Track Two (all of the above, plus)

- Advance care planning

Planned Care for Health Outcomes

Track One & Two

- Continuously improve performance on key outcomes



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

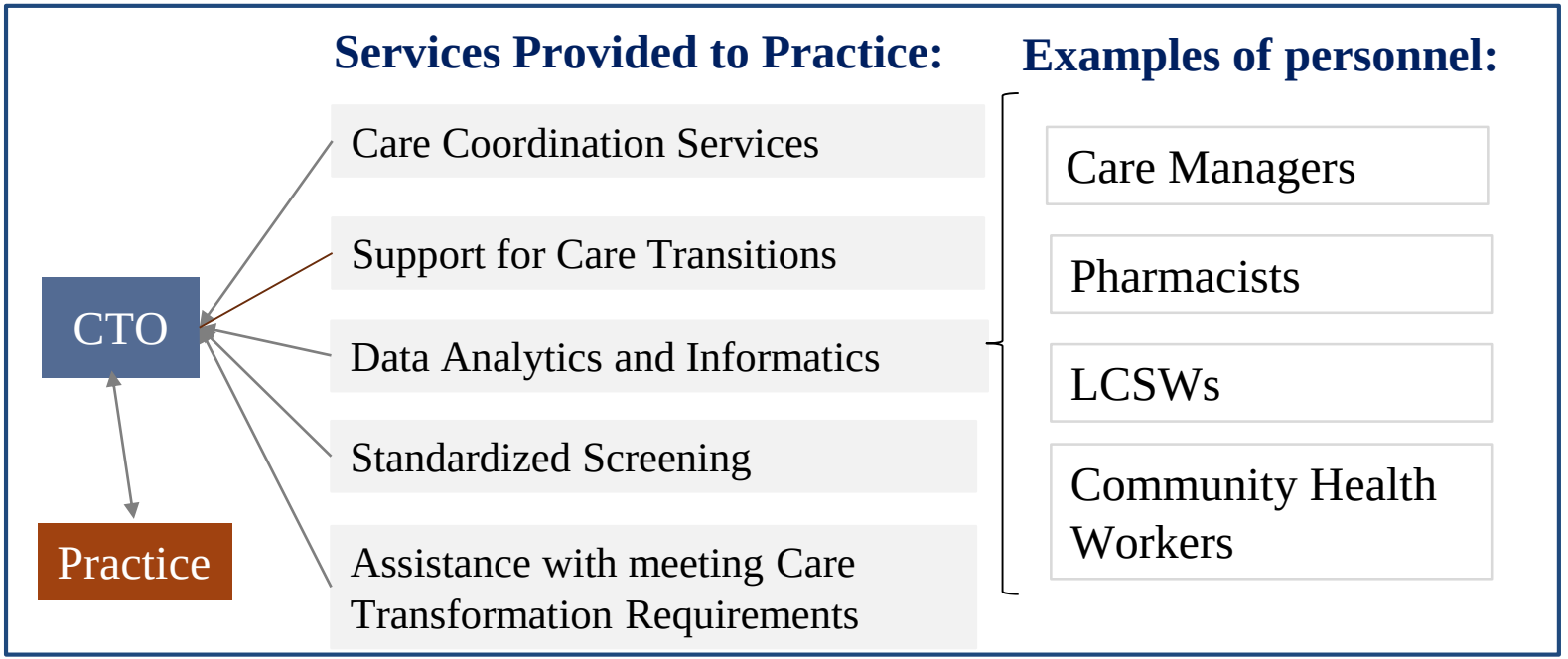
- Track 1: Standard FFS
- Track 2: Comprehensive Primary Care Payment (CPCP) - Partial pre-payment of historical E&M volume with 10% bonus
- Timing: Track 1: FFS; Track 2: prospective

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



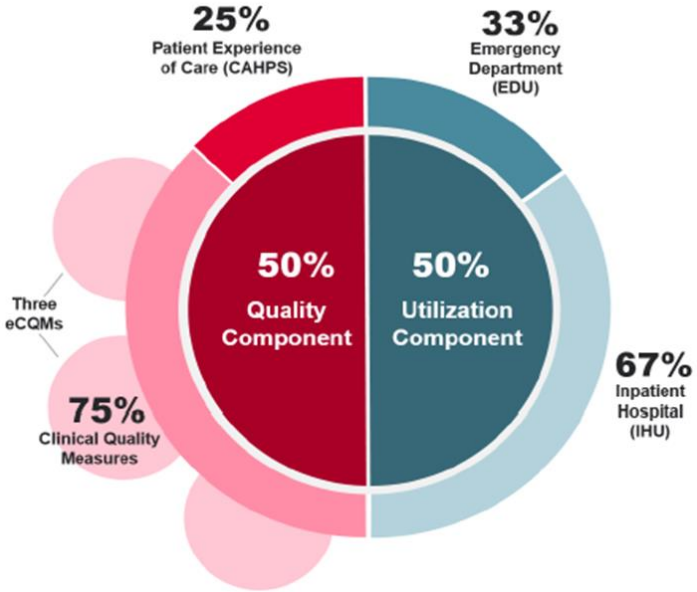
Additional MDPCP HIT through CRISP

- 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
- Others TBD

Timeline

Activity	Timeframe
Release Applications (RFA)	May 10, 2019
Application Period	May 10 – June 28, 2019
Qualified Practices and CTOs Notified	Late Summer/Early Fall 2019
Agreements & Onboarding Documents	Fall 2019
Initiate Program Year 2	January 1, 2020
Annual Enrollment	2020 - 2023
Program Participation	2020 - 2026+

2019 Metrics



electronic Clinical Quality Measures (eCQM) include:

- Outcome Measures – Diabetes and Hypertension Control (NQF # 0018 & 0059)
- Screening and Initiation of treatment for Substance Abuse (NQF # 0004)

Patient Satisfaction

- Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) – survey of practice patients (NQF #0005)

Utilization

- Emergency department visits and Hospitalizations per 1,000 attributed beneficiaries (HEDIS)

2019 MDPCP benchmarks

Measure	Benchmark Population	Year of Benchmark Data
CG-CAHPS®	National, all payer	2019 or most recent data
eCQMs	National, all payer	2019 or most recent data
Utilization	Maryland, Medicare only	2019

PBIP Payment Amounts

- Must meet quality and utilization metrics to keep incentive payment
- Payments are made prospectively on an annual basis, subject to repayment

Table 5-2: PBIP PBPM by Components for Quality and Utilization

Track	Quality Component (PBPM)	Utilization Component (PBPM)	Total PBIP (PBPM)
Participant Practices - Track 1	$1.25	$1.25	$2.50
Participant Practices - Track 2	$2.00	$2.00	$4.00
CTOs	$2.00	$2.00	$4.00

PBIP Calculations

Performance	Performance Score	Percentage Retained	Measure Type
<50th Percentile	0%	0%	Quality – CAHPS
50th – 80th Percentile	50-80%	12.5%-20%	Quality – CAHPS
>80th Percentile	100%	25%	Quality - CAHPS
<50th Percentile	0%	0%	Quality – eCQMs
50th – 80th Percentile	50-80%	24.75% - 56.25%	Quality – eCQMs
>80th Percentile	100%	75%	Quality – eCQMs
<50th Percentile	0%	0%	Utilization - Hospital
50th – 80th Percentile	50-80%	33.5%-53.6%	Utilization - Hospital
>80th Percentile	100%	67%	Utilization - Hospital
<50th Percentile	0%	0%	Utilization - ED
50th – 80th Percentile	50-80%	16.5%-26.4%	Utilization - ED
>80th Percentile	100%	33%	Utilization - ED

MDPCP compared to other approaches

	Current HSCRC core quality	CPC+	MDPCP 2019	MDPCP 2020
Performance Benchmark Reference Population	National or state depending on program/data availability	National, excluding CPC+ practices	eCQM: National, including MDPCP practices Utilization: Maryland	TBD
Performance Benchmark Time Period	Historical data	Historical data	Concurrent (e.g., 2019 for 2019 Performance)	TBD
Performance Benchmark Communication	Prospective	Early in year (currently available)	Early 2020?	TBD

Underlying goals of alignment

- Strengthen provider and hospital collaboration that will lead to better health and reduced unnecessary hospital utilization through:

Common goals and language across settings of care

Sharing of best practices

Clear financial incentives for high value care

Innovative programs and resource use

Thank you!

Updates and More Information:

https://health.maryland.gov/MDPCP

Questions: email MarylandModel@cms.hhs.gov

MARYLAND Department of Health