Getting Ready for the Maryland Primary Care Program

Maryland Academy of Family Practice Presentation

24 February, 2018

Maryland Department of Health/Maryland Health Care Commission

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Physician Survey Results

2. Which best describes how you feel about the future of the medical profession?	MD	National
Very positive/optimistic	6.7%	6.8%
Somewhat positive/optimistic	26.3%	30.4%
Somewhat negative/pessimistic	47.1%	41.4%
Very negative/pessimistic	19.9%	21.4%

14. How familiar are you with the Medicare Accountability and CHIP Reauthorization Act (MACRA)?	MD	National
Very unfamiliar	35.7%	33.4%
Somewhat unfamiliar	22.1%	22.9%
Neither familiar nor unfamiliar	24.8%	23.8%
Somewhat familiar	14.4%	14.0%
Very familiar	3.0%	5.9%

21. Which of the following best describes your current practice?	MD	National
I am overextended and overworked	32.5%	28.2%
I am at full capacity	46.7%	52.4%
I have time to see more patients and assume more duties	20.8%	19.4%

Source: The Physicians Foundation and conducted by Merritt Hawkins, 2016

Total Cost of Care Model (2019-2029)

Improving health, enhancing patient experience, and reducing per capita costs.

2017

HSCRC Models
All Payer – 2014-18
Total Cost of Care – 2019-29
2014 - 2029

- Reduce unnecessary readmissions/ utilization
- Reduce hospital-based infections
- Increase appropriate care outside of hospital

HSCRC Care Redesign Programs
2017 - TBD

- Improve efficiency of care in hospital
- Increase communication between hospital and community providers
- Increase complex care coordination for high and rising risk
- Reduce unnecessary lab tests

Maryland Primary Care Program
2019-2026

- Increase preventive care to lower the Total Cost of Care
- Decrease avoidable hospitalizations
- Decrease unnecessary ED visits
- Increase care coordination
- Increase community supports

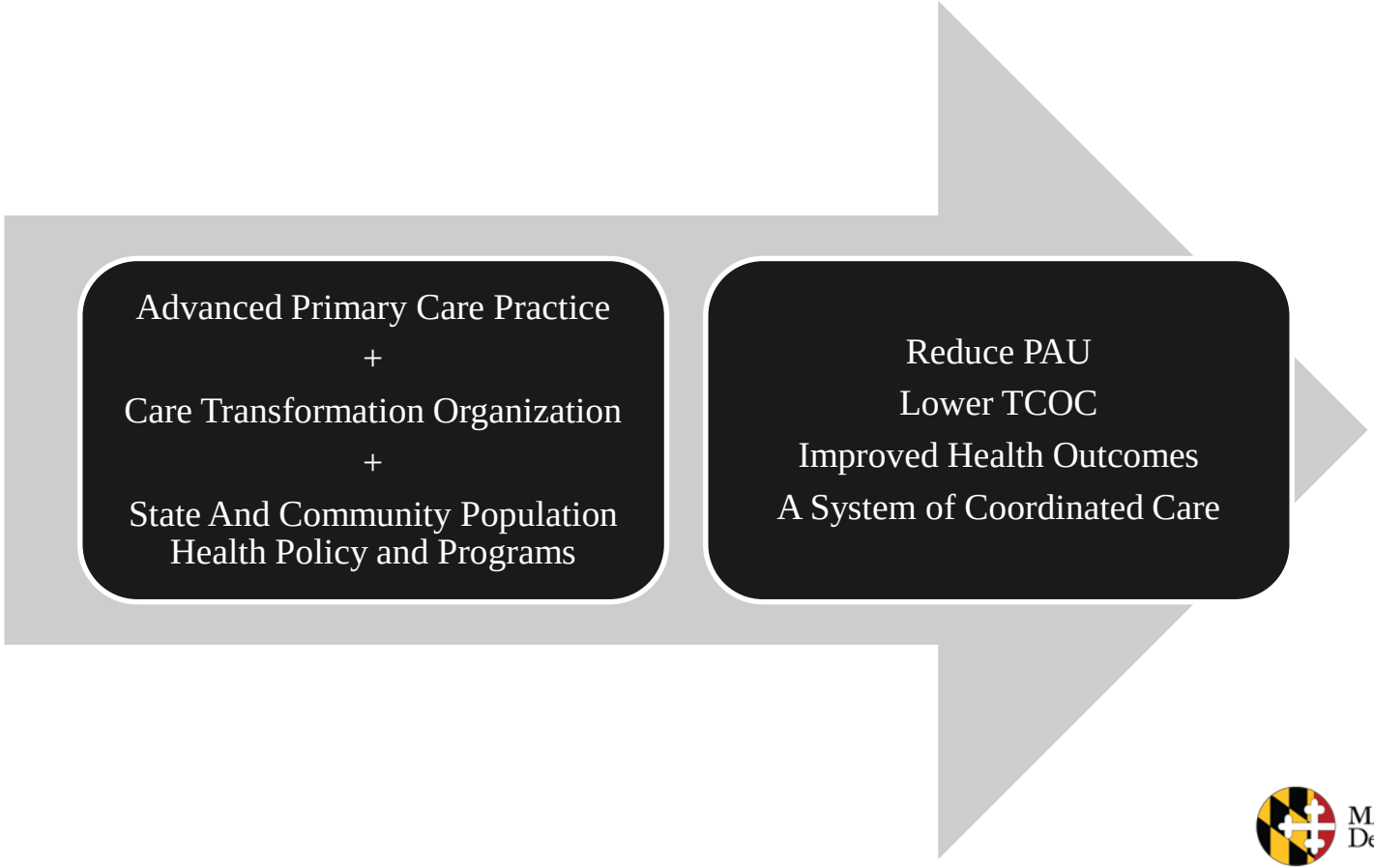
2029

Total Cost of Care Model

Total Cost of Care Model is the umbrella

- Maryland Primary Care Program (MDPCP) is a distinct contract element
- Care Redesign Amendment is an element
- Population Health Improvement goals are an element

Population Health Transformation



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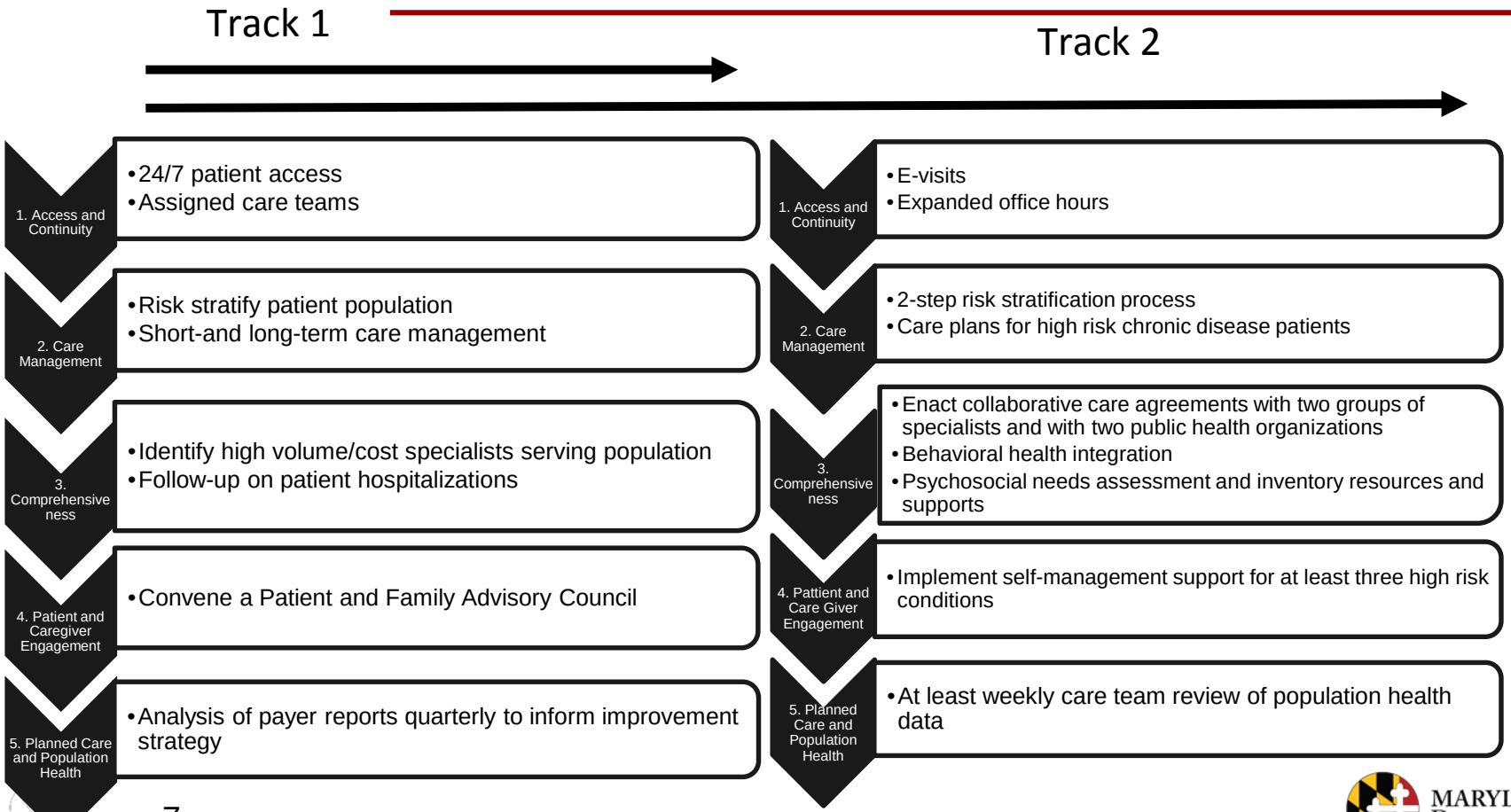
How is MDPCP Different from CPC+?

	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)

Requirements: Primary Care Functions



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1. Access and Continuity

Track One

- Achieve and maintain > 95% empanelment to care teams
- Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR
- Build a care team responsible for a specific, identifiable panel of patients to optimize continuity

Track Two (all of the above, plus)

- Regularly offer at least one alternative to traditional office visits such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends

2. Care Management

Track One

- Risk-stratify all empaneled patients
- Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management
- Provide episodic care management along with medication reconciliation to a high and increasing percentage of empanelled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management
- Ensure patients with ED visits receive a follow up interaction within one week of discharge.
- Contact at least 75% of patients who were hospitalized in target hospital(s), within 2 business days

2. Care Management

Track Two (Track 1, plus)

- Use a two-step risk stratification process for all empanelled patients:
  - Step 1 - based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition);
  - Step 2 - adds the care team's perception of risk to adjust the risk-stratification of patients, as needed
- Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management

3. Comprehensiveness and Coordination

Track One

- Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payer's data
- Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payer's data

3. Comprehensiveness and Coordination

Track Two (Track 1, plus)

- Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports
- Choose and implement at least one option from a menu of options for integrating behavioral health into care
- Systematically assess patients' psychosocial needs using evidence-based tools
- Conduct an inventory of resources and supports to meet patients' psychosocial needs
- Characterize important needs of sub-populations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time

4. Patient and Caregiver Engagement

Track One

- Convene Patient Family Advisory Council (PFAC) at least annually and incorporate recommendations into care, as appropriate
- Assess practice capability + plan for patients' self-management

Track Two (the above, plus)

- Convene a PFAC in at least two quarters in PY2018 and integrate recommendations into care, as appropriate
- Implement self-management support for 3 or more high risk conditions

5. Planned Care and Population Health

Track One

- Use quarterly feedback reports to assess utilization and quality performance, identify practice strategies to address, and identify individual candidates to receive outreach, care management

Track Two (the above, plus)

- Regular care team meetings to review practice and panel-level data, refine tactics to improve outcomes and achieve practice goals

Quality Metrics

electronic Clinical Quality Measures (eCQM) (75%)

- Group 1: Outcome Measures (2) – Report both outcome measures
- Group 2: Other Measures (7) – Report at least 7 of 17 process Measures
- Measures overlap closely with MSSP ACO measures

Patient Satisfaction (25%)

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Patient-Centered Medical Home Survey
- CMS will survey a representative population of each practice's patients, including non-Medicare FFS patients

Current metrics as of 2018 – TBD for 2019

Quality - eCQM Metrics – Group 1

Report both outcome measures

CMS ID#	Measure Title
CMS165v6	Controlling High Blood Pressure
CMS122v6	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

Current metrics as of 2018 – TBD for 2019

Quality - eCQM Metrics – Group 2

Report at least 7 Other process Measures:

CMS ID#	Measure Title
Cancer	
CMS125v6	Breast Cancer Screening
CMS130v6	Colorectal Cancer Screening
CMS124v6	Cervical Cancer Screening
Diabetes	
CMS131v6*	Diabetes: Eye Exam
CMS134v6	Diabetes: Medical Attention for Nephropathy
Care Coordination	
CMS50v6	Closing the Referral Loop: Receipt of Specialist Report
Medication Management	
CMS156v6	Use of High Risk Medications in the Elderly
Mental Illness/Behavioral Health	
CMS2v7	Preventive Care and Screening: Screening for Depression and Follow- Up Plan
CMS160v6	Depression Utilization of the PHQ-9 Tool
CMS149v6	Dementia: Cognitive Assessment
Substance Abuse	
CMS138v6	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
CMS137v6	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Safety	
CMS139v6	Falls: Screening for Future Fall Risk
Infectious Disease	
CMS147v7	Preventive Care and Screening: Influenza Immunization
CMS127v6	Pneumococcal Vaccination Status for Older Adults
Cardiovascular Disease	
CMS164v6	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
CMS347v1	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Utilization Metrics

ED Visits

- Emergency department utilization (EDU) per 1,000 attributed beneficiaries

Hospitalizations

- Inpatient hospitalization utilization (IHU) per 1,000 attributed beneficiaries

Utilization measures require no reporting on the part of practices

Calculated by CMS and its contractor at the end of each program year

Payment Incentives for Better Primary Care

Practices – Track 1

Care Management Fee (PBPM)

- $15 average payment
- $6-$50 PBPM
  - Tiered payments based on acuity/risk tier of patients in practice including $50 to support patients with complex needs
- Timing: Paid prospectively on a quarterly basis, not subject to “clawback”

Performance-Based Incentive Payment (PBPM)

- Up to a $2.50 PBPM payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis, subject to “clawback” if measures are not met

Underlying Payment Structure

- Standard FFS
- Timing: Regular Medicare FFS claims payment

AAPM Status under MACRA Law to be determined – potential for additional bonuses

Payment Incentives for Better Primary Care

Practices – Track 2

Care Management Fee (PBPM)

- $28 average payment
- $9-$100 PBPM
  - Tiered payments based on acuity/risk tier of patients in practice including $100 to support patients with complex needs
- Timing: Paid prospectively on a quarterly basis, not subject to "clawback"

Performance-Based Incentive Payment (PBPM)

- Up to a $4.00 PBPM payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis, subject to "clawback"

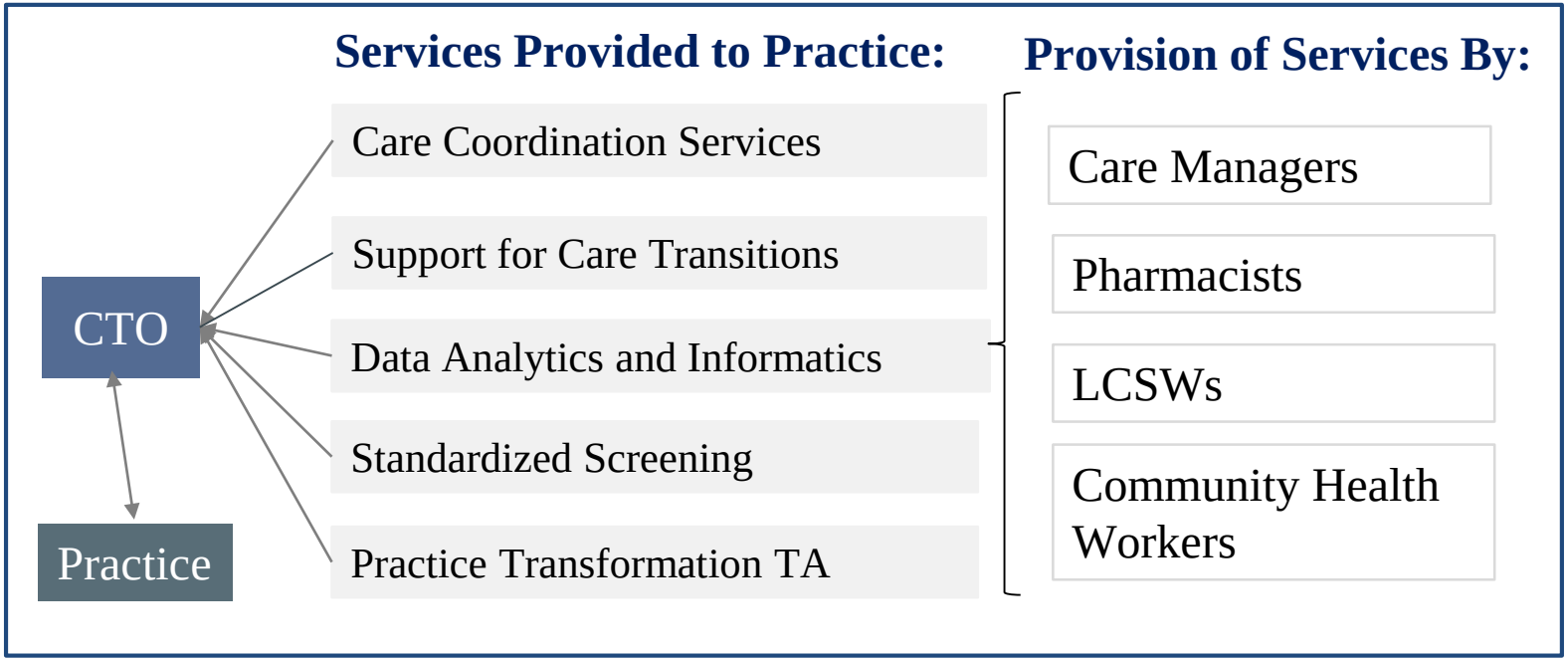
Underlying Payment Structure

- "Comprehensive Primary Care Payment" (CPCP)
- Partial pre-payment of historical E&M volume
- 10% bonus on CPCP percentage selected
- Timing: CPCP paid prospectively on a quarterly basis, Medicare FFS claim submitted normally but paid at reduced rate

AAPM Status under MACRA Law to be determined – potential for additional bonuses

Care Transformation Organization

Designed to assist the practice in meeting care transformation requirements



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Payment Incentives for Better Primary Care

CTOs

Care Management Fee (PBPM)

- Up to 50% of a practice's care management fee; depends on option chosen by practice
- Timing: Paid prospectively on a quarterly basis

Performance-Based Incentive Payment (PBPM)

- Receives a payment for Track 1 and Track 2 practices engaged with CTO
- Timing: Paid prospectively on an annual basis; CTO will be required to repay funds if they do not meet annual performance thresholds

Restrictions on Participation

- Not charge any concierge fees to Medicare beneficiaries
- Not be a participant in certain other CMMI initiatives including
  - Accountable Care Organization [ACO] Investment Model
  - Next Generation ACO Model
  - Comprehensive ESRD Care Model
- Not participating at a Rural Health Clinic or a Federally Qualified Health Center

CRISP HIT Supports for Practices

Data Exchange Support Programs (DESP)

- This program will provide funds directly to practices who want to connect with CRISP.
- The payments are fixed amounts, which the practice can use to offset connectivity costs.
- In return, the practice will provide and maintain data feeds to CRISP.

Goal: Establish 200 ambulatory practice connection
Requirement: CEHRT

Funding
Milestone 1 - $3,000
Milestone 2a - $4,000
OR
Milestone 2a+2b - $7,000

Total = up to $10,000

- **Milestone 1** – sign-up/agreements
- **Milestone 2** – Either encounter or encounter + clinical data integration

Learn more at https://www.crisphealth.org/wp-content/uploads/2017/08/CRISP-Services_Connectivity-Tier-4_3_17.pdf

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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

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Timeline

Activity	Timeframe
Submit Model for Approval from HHS	Summer 2017
Stand up Program Management Office	Fall 2017
Release applications	Spring/Summer 2018
Select CTOs and practices	Summer/Fall 2018
Initiate Program	Jan 2019
Expand Program	2020 - 2023

Thank you!

Updates and More Information:

https://health.maryland.gov/MDPCP

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Useful Videos on CPC+

- Part 1: (Care Delivery Transformation) https://www.youtube.com/watch?v=DWUea_UD_Kw
- Part 2: (Payment Overview) https://www.youtube.com/watch?v=KMNci76w9K8
- Part 3: (Care management fees) https://www.youtube.com/watch?v=NBVNQyNeKJ8&feature=youtu.be
- Part 4: (Hybrid Payment) https://www.youtube.com/watch?v=xPeyjE8couk&feature=youtu.be

Quality Metrics

Measures for 2018

https://innovation.cms.gov/Files/x/cpcplus-qualrptpy2018.pdf