Getting Ready for the Maryland Primary Care Program

Maryland Academy of Family Physicians

American College of Physicians, Maryland Chapter

October 30, 2017

MARYLAND Department of Health

Agenda

- Introductions
- Overview
- Program Components
- Next Steps
- Questions and Answers

All of the components described in this presentation are subject to federal approval

Overview

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%

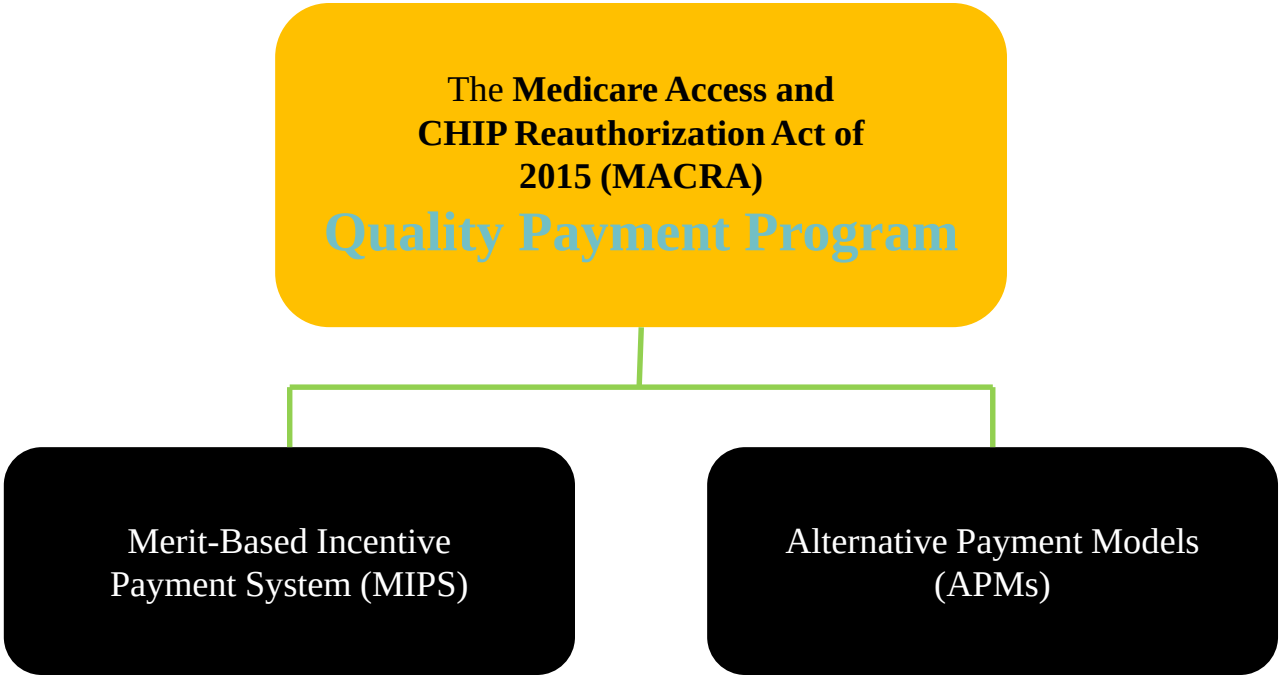
14. How familiar are you with the Medicare Accountability and CHIP Reauthorization Act (MACRA)?	MD	National
Very unfamiliar	35.7%	33.4%
Somewhat unfamiliar	22.1%	22.9%
Neither familiar nor unfamiliar	24.8%	23.8%
Somewhat familiar	14.4%	14.0%
Very familiar	3.0%	5.9%

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

MACRA

Law *intended* to align physician payment with *value*



Source: CMS webinar slides, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

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The Quality Payment Program Provides Additional Rewards for Participating in APMs

Potential financial rewards

Not in APM	In APM	In Advanced APM (AAPM)
MIPS adjustments	MIPS adjustments	
	+	
	APM-specific rewards	APM-specific rewards
		+
		5% lump sum bonus

If you are a **Qualifying APM Participant (QP)**

Source: CMS webinar slides, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MACRA-NPRM-Slides.pdf

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Total Cost of Care Model (2019-2029)

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

2017

HSCRC Hospital Model
2014 - 2029

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

HSCRC Care Redesign Programs
2017 - TBD

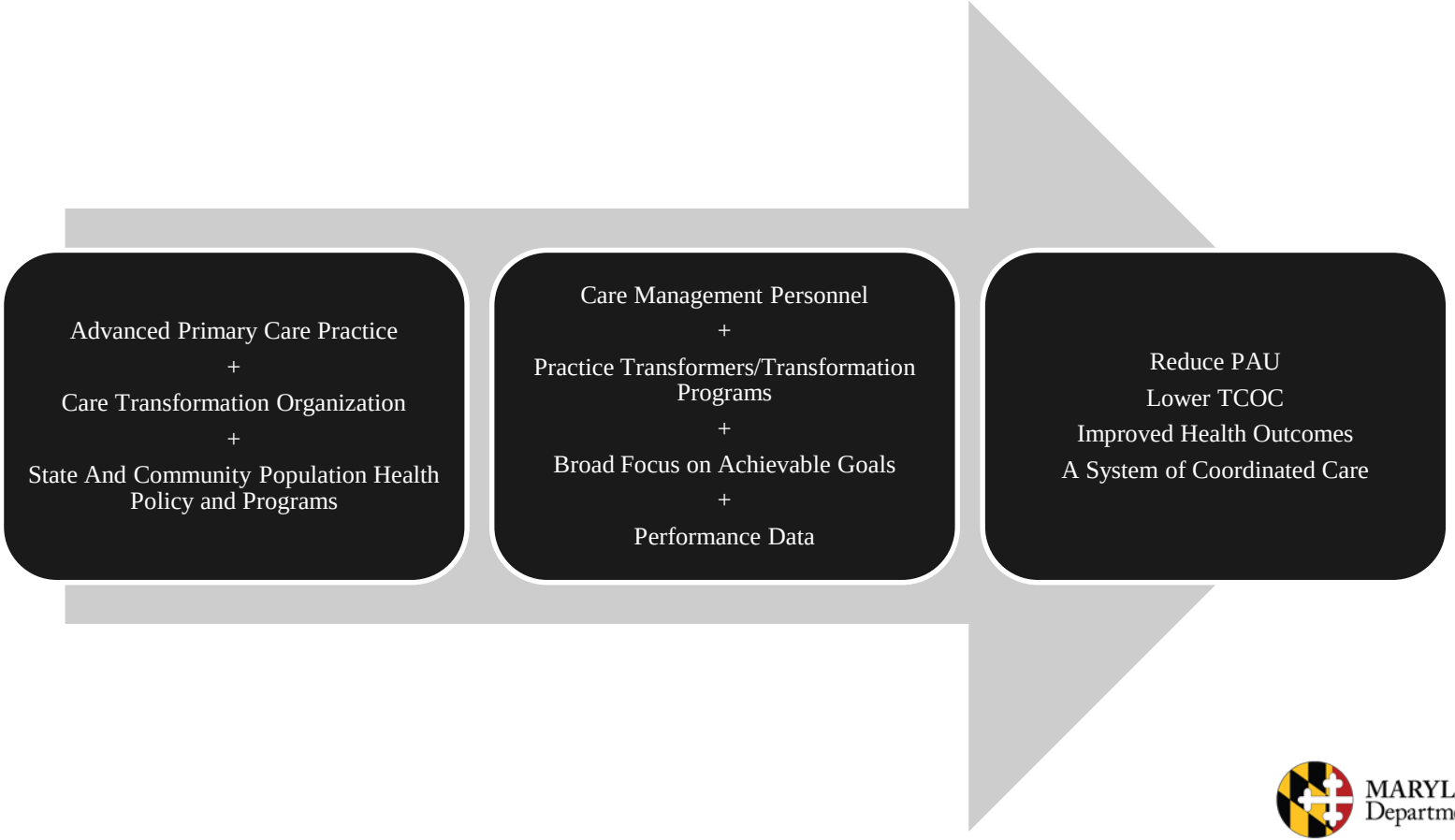
- Reduce unnecessary lab tests
- Increase communication between hospital and community providers
- Increase complex care coordination for high and rising risk
- Improve efficiency of care in hospital

2029

Maryland Primary Care Program
2018-2023

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

Population Health Transformation – Vision under Maryland Primary Care Program



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Total Cost of Care Model and Primary Care Program

Total Cost of Care Model is the umbrella

Maryland Primary Care Program (MDPCP) is a distinct contract element

- Separate contract element of the Maryland Total Cost of Care Model contract between State and CMMI
- CMS will issue Requests For Applications (RFA) for practices and care transformation organizations (CTOs); CMS selects participants
- Require Participation Agreements for practices and CTOs

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)

Program Components

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 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 PY2017 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 and Utilization Metrics

Quality

- 2018 – 18 proposed eCQM measures
- Group 1: Outcome Measures – Report both outcome measures
- Group 2: Other Measures – Report at least 7 Other process Measures in areas of:
- *Cancer*
- *Diabetes*
- *Care Coordination*
- *Mental Illness/Behavioral Health*
- *Substance Abuse*
- *Safety*
- *Infectious Disease*
- *Cardiovascular Disease*

Utilization

- ED Visits
- Hospitalizations

Payment Incentives for Better Primary Care

Practices – Track 1

Care Management Fee (PBPM)

- $20 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

Performance-Based Incentive Payment (PBPM)

- $2.50 payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis

Underlying Payment Structure

- Standard FFS
- Timing: Regular Medicare FFS claims payment

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

Performance-Based Incentive Payment (PBPM)

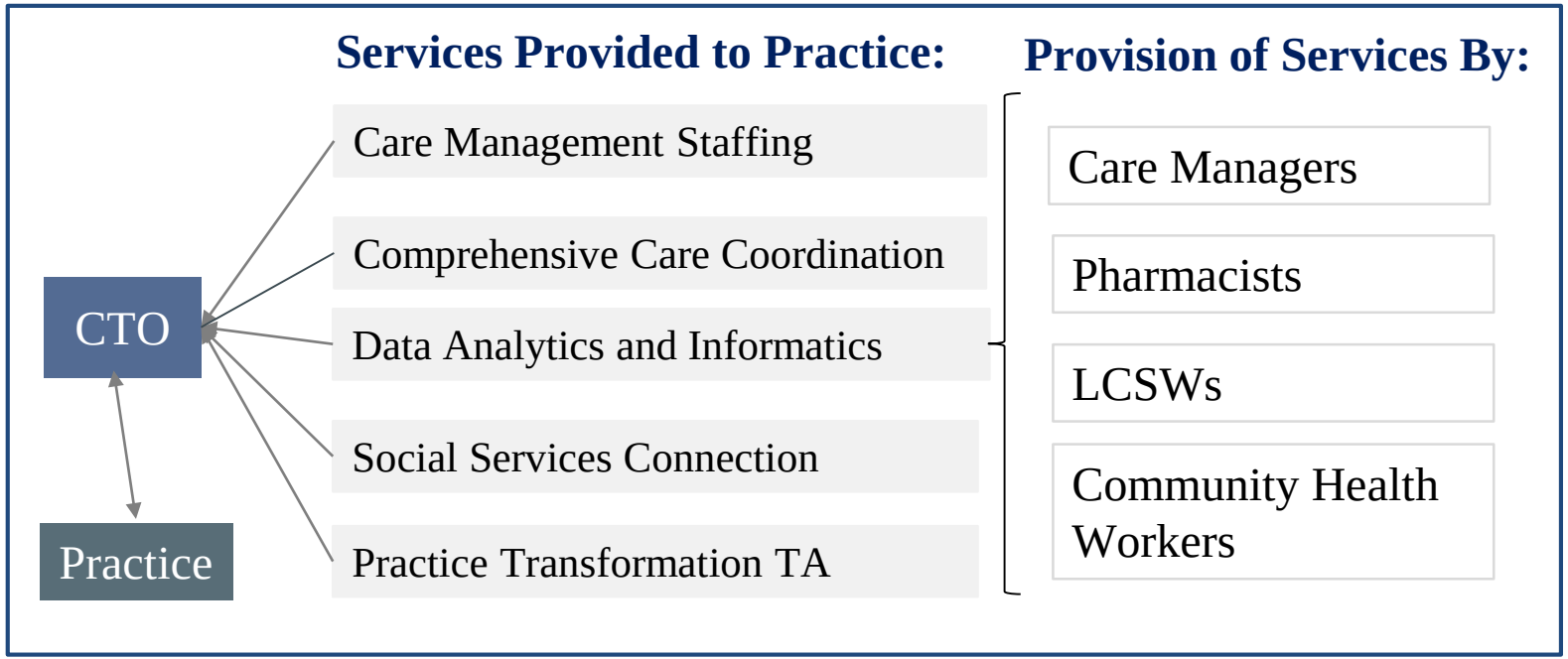
- $4.00 payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis

Underlying Payment Structure

- Reduced FFS on E&M with prospective "Comprehensive Primary Care Payment" (CPCP)
- Timing: CPCP paid prospectively on a quarterly basis
  - Medicare FFS claim submitted normally but paid at reduced rate

Care Transformation Organization- Unique to MDPCP

Designed to assist the practice in meeting care transformation requirements



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CRISP HIT Supports and Services

Supports

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

Services

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

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

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Questions

1. How many CTO service packages should be offered? What services should be included?
2. How often should a practice be able to change their choice of CTO?
3. How should a CTO be evaluated?
4. Additional feedback

Next Steps

Timeline

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

Considerations for Participation

Fall 2017

- Assess financial opportunity
- Assess practice capabilities
- Assess organizational priorities
- Review CPC Plus RFA
- Review CPC Plus FAQs
- Attend meetings on MDPCP

Late Fall 2017/Winter 2018

- Review MDPCP RFA
- Assess CTO Option
- Attend meetings on MDPCP

Winter/Spring 2018

- Apply for MDPCP

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Thank you!

Updates and More Information:

https://health.maryland.gov//Pages/Maryland-Primary-Care-Program.aspx

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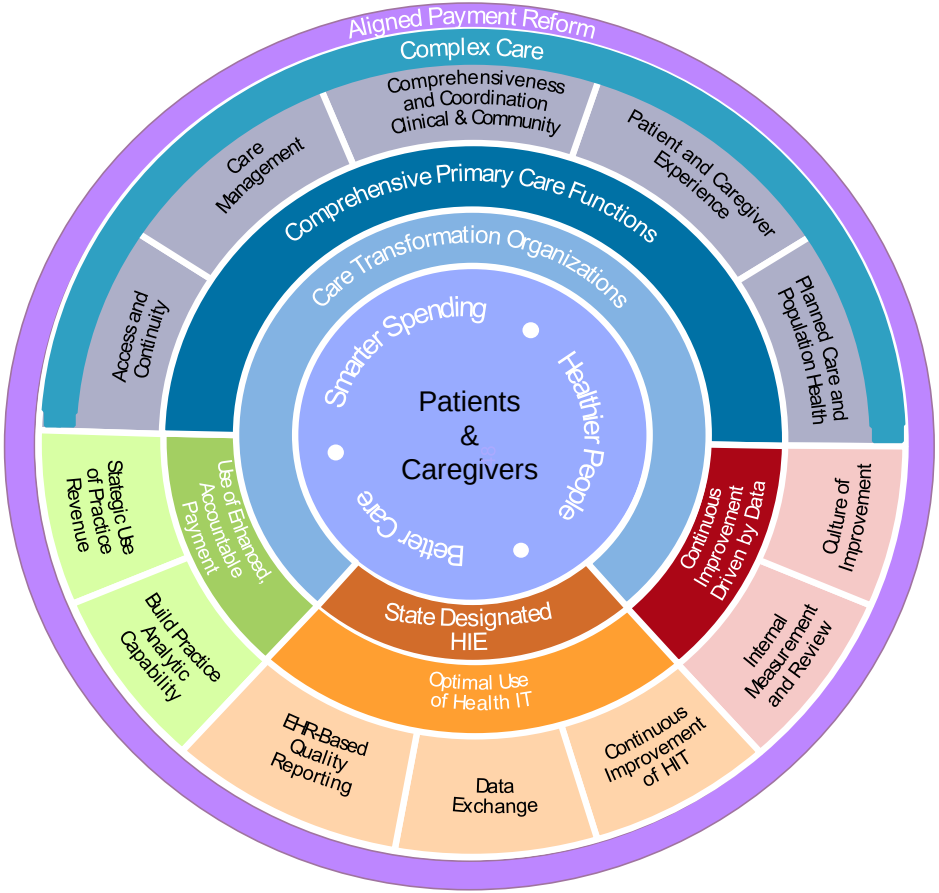
Useful Videos on CPC+

- Part 1: (Attribution) https://www.youtube.com/watch?v=re7XBlJ9j-A&feature=youtu.be
- Part 2: (Care management fees) https://www.youtube.com/watch?v=NBVNQyNeKJ8&feature=youtu.be
- Part 3: (Performance Based Incentive Payment) https://www.youtube.com/watch?v=qU4hF1d9XjI&feature=youtu.be
- Part 4: (Hybrid Payment) https://www.youtube.com/watch?v=xPeyjE8couk&feature=youtu.be

MDPCP Driver Diagram



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Quality Metrics

Link to proposed measures for 2018

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