Getting Ready for the Maryland Primary Care Program

Regional Provider Meeting Series

January 25, 2018

Southern Region
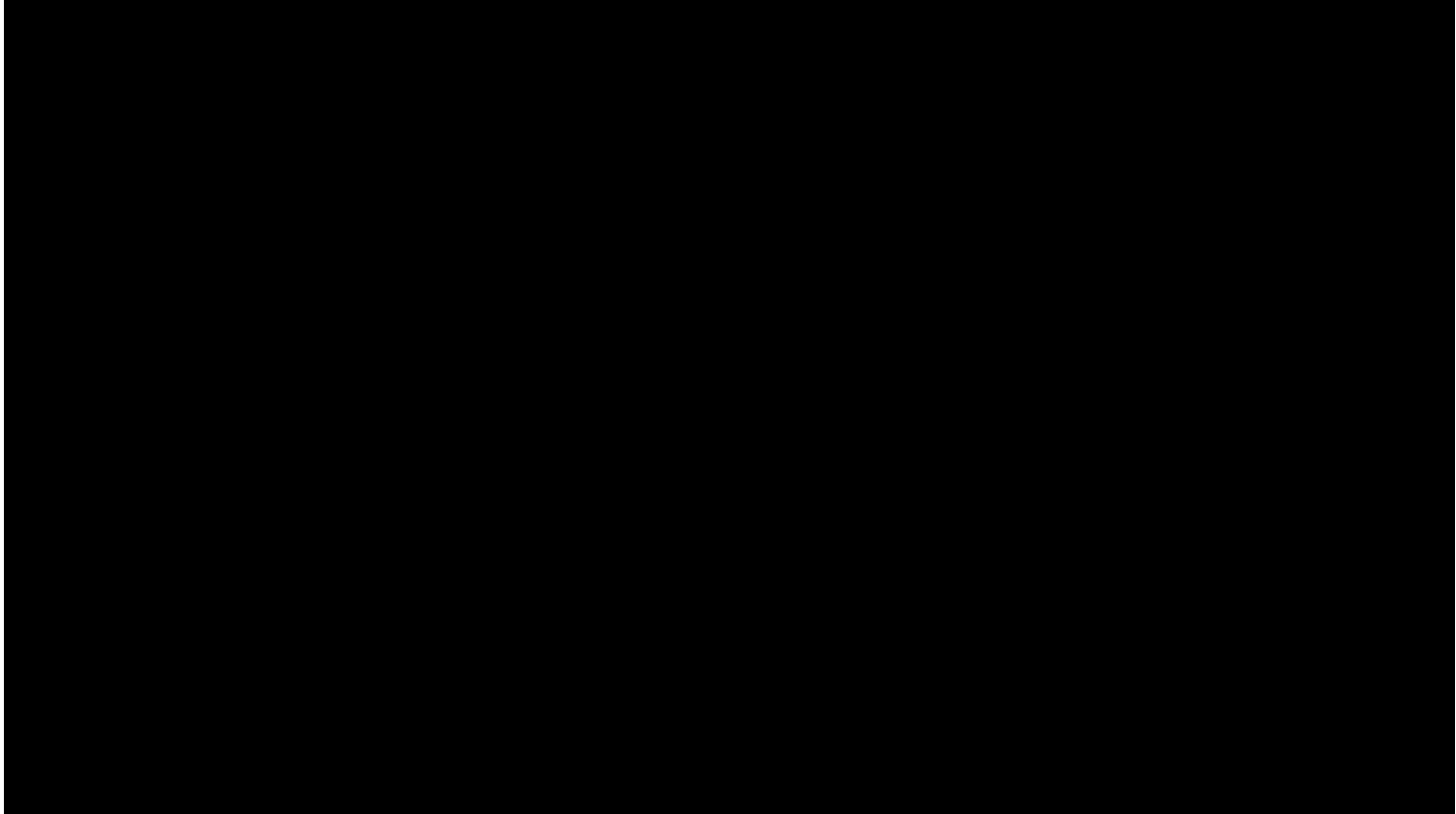
Maryland Department of Health/Maryland Health Care Commission

Agenda

- Introductions

- Overview

- Program Components

- Participation

- Next Steps

- Questions and Answers

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

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Put your "Why" before your "What"!

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

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Total Cost of Care Model (2019-2029)

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

2017

2029

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

- 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

Maryland Primary Care Program

2018-2026

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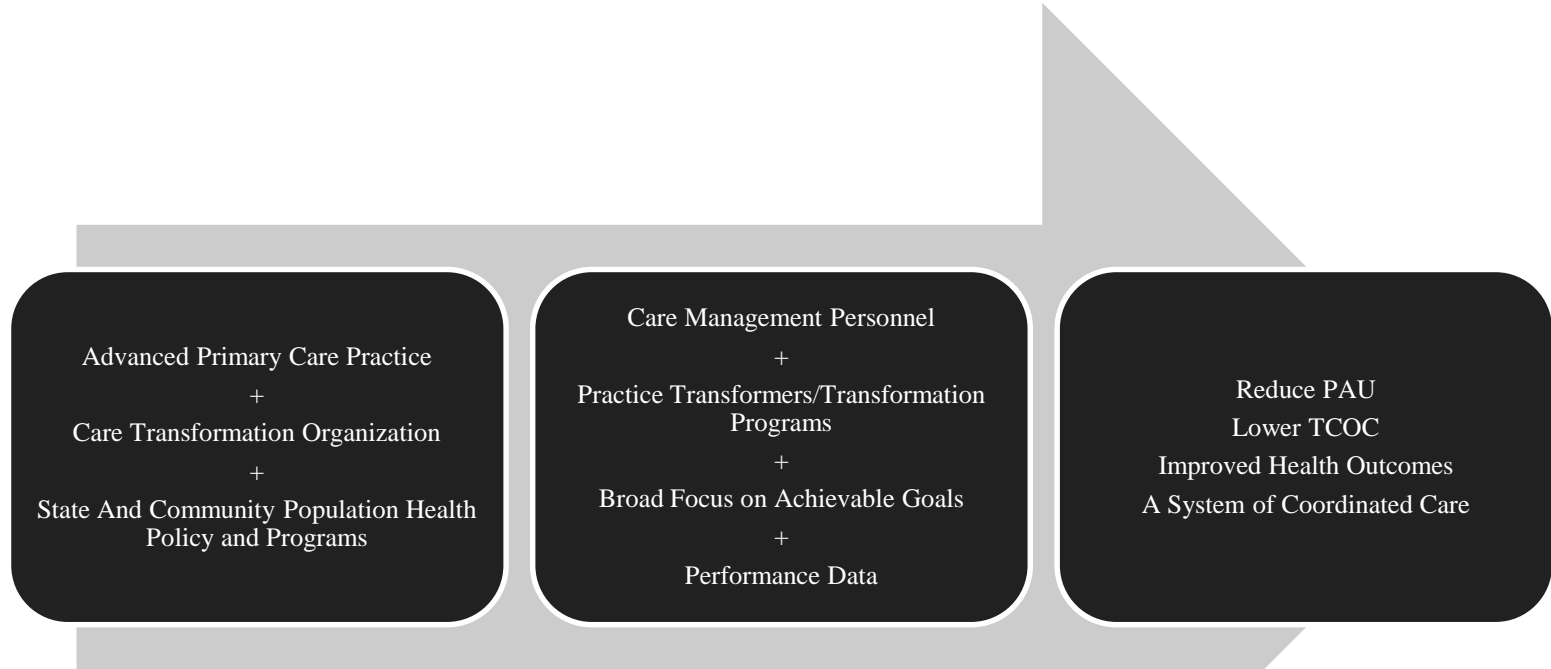- Increase care coordination
- Increase community supports

Total Cost of Care Model

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

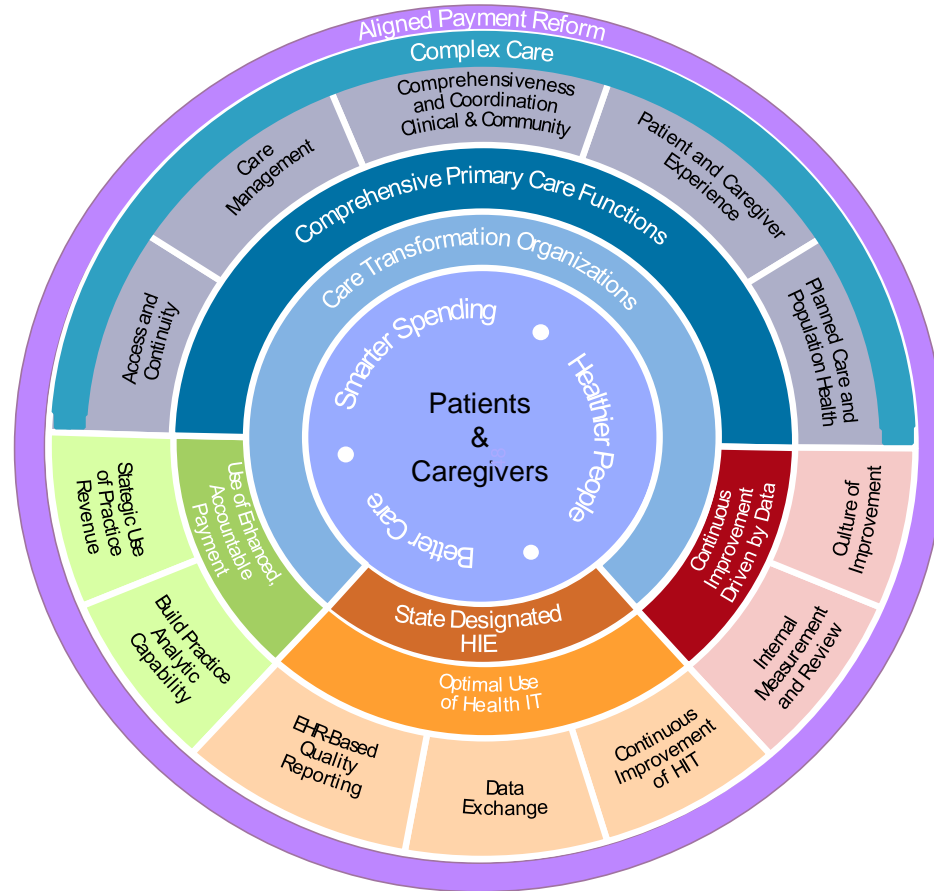- Require Participation Agreements for practices and CTOs

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Population Health Transformation

Advanced Primary Care Practice
+
Care Transformation Organization
+
State And Community Population Health Policy and Programs

Care Management Personnel
+
Practice Transformers/Transformation Programs
+
Broad Focus on Achievable Goals
+
Performance Data

Reduce PAU
Lower TCOC
Improved Health Outcomes
A System of Coordinated Care

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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)

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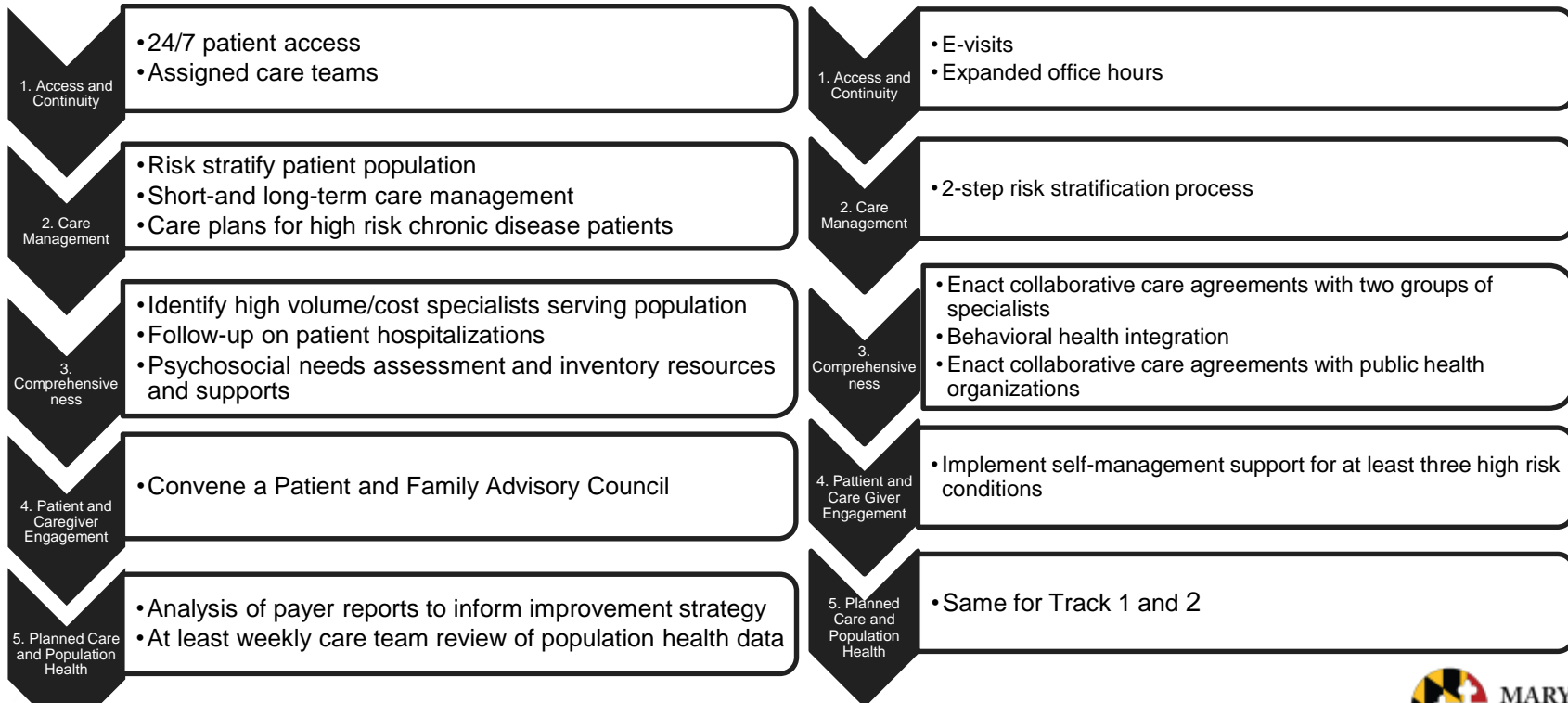
Questions?

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Program Components

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MDPCP Driver Diagram

Requirements: Primary Care Functions

Track 1

Track 2

1. Access and Continuity	•24/7 patient access •Assigned care teams
2. Care Management	•Risk stratify patient population •Short-and long-term care management •Care plans for high risk chronic disease patients
3. Comprehensiveness	•Identify high volume/cost specialists serving population •Follow-up on patient hospitalizations •Psychosocial needs assessment and inventory resources and supports
4. Patient and Caregiver Engagement	•Convene a Patient and Family Advisory Council
5. Planned Care and Population Health	•Analysis of payer reports to inform improvement strategy •At least weekly care team review of population health data

1. Access and Continuity	•E-visits •Expanded office hours
2. Care Management	•2-step risk stratification process
3. Comprehensiveness	•Enact collaborative care agreements with two groups of specialists •Behavioral health integration •Enact collaborative care agreements with public health organizations
4. Pattient and Care Giver Engagement	•Implement self-management support for at least three high risk conditions
5. Planned Care and Population Health	•Same for Track 1 and 2

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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

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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

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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

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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

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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

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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

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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 16 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

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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%)

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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
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

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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

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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

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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
- 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
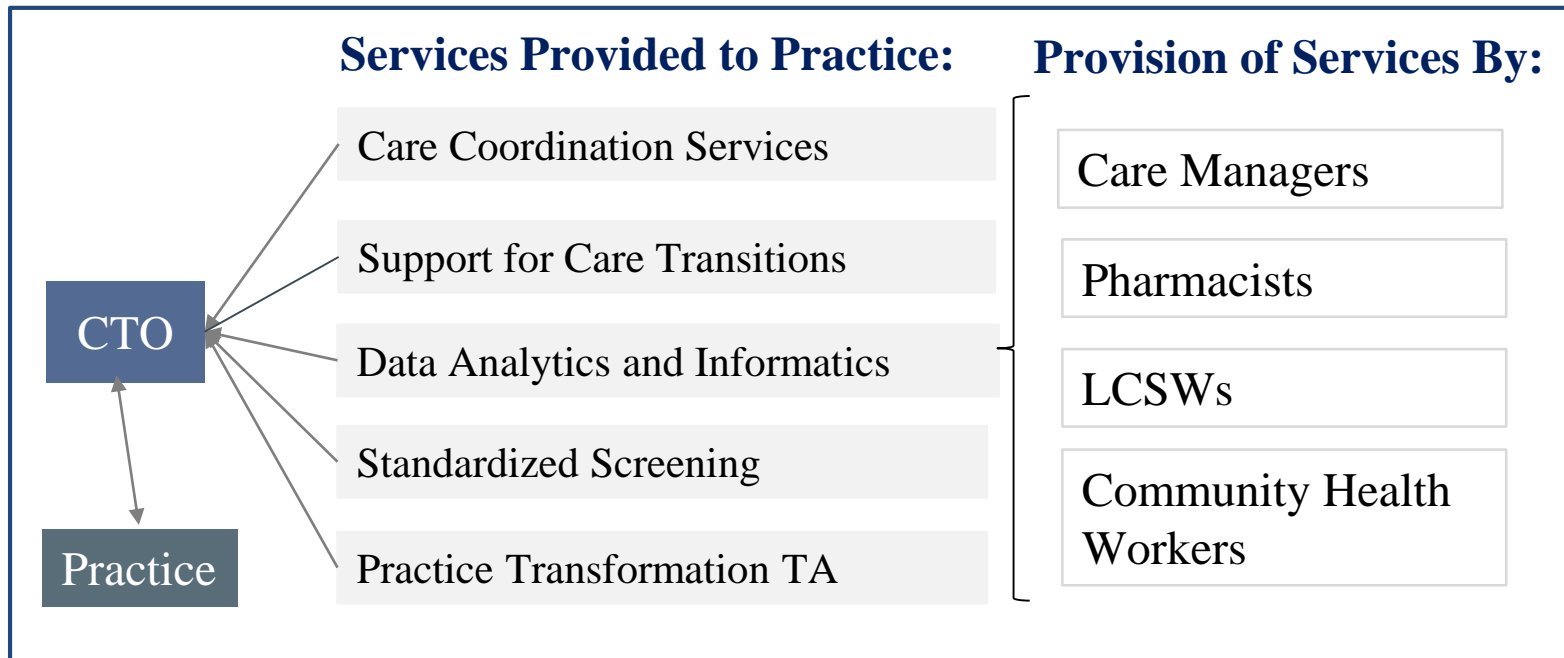
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Application and Track Progression

- Annual application process, practices enroll when they are ready to succeed

- Practices may enter in Track 1 or Track 2

- Practices will progress from Track 1 to Track 2

- Track 1 Practices have three years to reach Track 2

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Care Transformation Organizations

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Care Transformation Organization

Designed to assist the practice in meeting care transformation requirements

Services Provided to Practice:

Provision of Services By:

CTO

Practice

Care Coordination Services

Support for Care Transitions

Data Analytics and Informatics

Standardized Screening

Practice Transformation TA

Care Managers

Pharmacists

LCSWs

Community Health Workers

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CTOs Role in the Program

CTOs will provide services that are integral to meeting the care transformation requirements but do not require the personal professional services of a physician. CTOs shall help practices with personnel and expertise to:

➢ Transform the delivery of primary care

➢ Meet utilization and quality metrics

➢ Improve care coordination and care transitions

➢ Ensure appropriate connections with other providers

➢ Assess and assist practices to manage care

➢ Access non-traditional workforce to enhance care management

➢ Use data to control total cost of care

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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

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Questions?

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Participation

Preview RFA Components

Practices

➢ Apply after CTO selection

➢ Electronic application

➢ Detail on practice

- Ownership

- Demographics

- Capabilities

- Connectivity

➢ Letters of support/commitment

Care Transformation Organizations

➢ Apply before practices

➢ Electronic Application

➢ Detail on proposed CTO

- Ownership

- Legal structure

- Capabilities

- Experience

➢ Letters of support/commitment

Sample RFA questions distributed for your review

See CPC+ RFA for more information:
https://innovation.cms.gov/Files/x/cpcplus-rfa.pdf

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Practice Eligibility

- Meet program integrity standards

- Provide services to a minimum of 150 attributed Medicare FFS beneficiaries

- Letters of Support and commitments from

  - Clinical Leadership

  - Ownership of practice

  - CRISP letter of support for practice

Practice Eligibility *(continued)*

- Experience with specified practice transformation activities for Track 1 must include:

  - Assigning patients to practice panel

  - Providing 24/7 access to patients

  - Supporting quality improvement activities

- All practices must meet care delivery requirements for Track 2 by no later than end of Year 3 participation including:

  - Demonstrated ability to perform two-step risk stratification

  - Accept hybrid payment

- Commitments to submit complete care delivery practice reports, annual budget reporting, and other program requirements laid out in the Participation Agreement

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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, and Comprehensive ESRD Care Model

- Not participating at a Rural Health Clinic or a Federally Qualified Health Center

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Health Information Technology

- Utilize a certified electronic health record

- CRISP connectivity in year one with transition to Tier 3 in year two

- Use the latest eCQM specifications for all measures (including all annual updates)

- Connect to CRISP's CALIPHR quality measures system

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Support You Can Expect

- Information Technology
  - CRISP
  - CMMI Practice Portal
- CMMI Learning System Vendors – educate practices on how to transform
- Additional State supports on practice transformation

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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

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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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Next Steps

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

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Considerations for Participation

Winter/Spring 2018

Assess financial opportunity

Assess practice capabilities

Assess organizational priorities

Review CPC Plus RFA

Review CPC Plus FAQs

Attend meetings on MDPCP

Spring 2018

Review MDPCP RFA

Assess CTO Option

Attend meetings on MDPCP

Spring/Summer 2018

Apply for MDPCP

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Anticipated Selection Process

- CMMI will conduct the technical review of applications and will be solely responsible for selection. All decisions are final, there is no appeal process.

- Practices will indicate preference for a Track; CMMI will assign based on application

- Practices not selected in 2019 may apply for a subsequent year.

- All practices must sign a standard participation agreement prior to participating in MDPCP.

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https://youtu.be/Gs069dndIYk?t=18

Remember...

1978

Maurice White

Allee Willis

Don't let the words get in the way of your groove

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Thank you!

Updates and More Information:

https://health.maryland.gov/MDPCP

Appendix

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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

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Quality Metrics

Proposed measures for 2018

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