Maryland Comprehensive Primary Care Model FAQs

Model Design

1. What is the Maryland Comprehensive Primary Care Model (PCM)?

The Maryland Comprehensive Primary Care Model (PCM) is designed to improve the health of Marylanders by delivering person-centric, efficient, and cohesive primary care. The PCM leverages the latest developments in advanced primary care medical home models that aim to strengthen primary care providers through multi-payer payment reform and care delivery transformation. The PCM uses a provider framework that allows the patient to designate their own provider, which includes specialists. A provider of primary care is therefore defined as Patient Designated Provider (PDP) throughout the PCM.

The Maryland PCM is based on the requirements of the Comprehensive Primary Care Plus (CPC+) model recently released by the Center for Medicare and Medicaid Innovation.

2. What are some of the goals of the PCM?

To improve the health of Marylanders by:

(1) Delivering person-centric healthcare;
(2) Coordinating quality payments to the PDP and Care Management entity.
(3) Promoting team-based support;
(4) Providing evidence-based approaches with consistent quality and outcome metrics;
(5) Making quality and cost data transparent;
(6) Using shared decision making;
(7) Leveraging advanced healthcare technology for information sharing;
(8) Providing tools for population health improvement;
(9) Reducing avoidable hospitalizations and duplicative healthcare utilizations.

3. Who will this program benefit?

This program will benefit patients and consumers, first and foremost. The program is designed to create a strong, unified health delivery system for PDPs, health systems, and community-based organizations. In year 1 (2018), the program will include Medicare fee-for-service beneficiaries. The goal is to expand to all payers.

4. What is the difference between CPC+ and the PCM ?

CPC+ builds on the foundation of its predecessor, the Comprehensive Primary Care (CPC) initiative, a model tested through the Center for Medicare & Medicaid Innovation (CMMI) that aims to strengthen primary care through a regionally-based multi-payment reform and care delivery transformation. The State is adapting CPC+ to develop the PCM. The PCM adopts most of the features of the CPC+ model, customizing components to fit the unique provider, technology and consumer environment under Maryland's All Payer Model. The PCM is currently limited to Medicare fee for Service beneficiaries, but is designed to match the multi-payer framework of CPC+.

5. What is a Person-Centered Home (PCH) and will individuals have to change providers?

A PCH provides comprehensive and coordinated care around a person's healthcare needs. A primary care provider's office is considered the central hub, or home, where facilitation and coordination to other healthcare professionals takes place. PCHs improve access and efficiency to care by providing more seamless coordination of care and meeting patients where they are. Patients will not be required to change providers. However, a provider must be participating in the program for a patient to receive services under the PCM.

6. As a patient, what can I expect with the PCM?

As a patient of a provider participating in the PCM, you can expect: provider selection, more cohesive care with specialists and social services, expanded office hours, open access and flexible scheduling, culturally and linguistically appropriate care, patient ownership, health record linkage, alerts from care team, care management transitions, medication supports and reconciliation, and community and support linkages.

7. As a provider, what foundation can I expect with the PCM?

As a provider in the PCM, you can expect: voluntary participation, care management support, non-traditional care management resources, practice transformation resources, incentives for non face-to-face care inclusion of specialty and multidisciplinary providers as the PDP, patient care management support based on severity index, and care managers embedded in provider practice or provided by Care Transformation Organization (CTOs).

8. Will the payments under the PCM mirror those under Comprehensive Primary Care Plus (CPC+)? Will the PCM adopt these same payments?

In general, the PCM will mirror payment under CPC+. The PCM will include:

> *Care Management Fees (CMF): The Medicare Care Management Fees will average $15 per beneficiary per month (PBPM) across 4 risk tiers in Track 1 based on HCC scores. The CMFs will average $28 PBPM across 5 risk tiers in Track 2 based on HCC, which includes a $100 CMF for "complex" patients. At the moment, the Model is designed around Medicare FFS and Dual Eligible beneficiaries with the intent of it expanding for all-payers. Other payers do not have to follow this CMF PBPM fee structure and payments may be lower since the acuity level for patients may be lower.*
>
> *Comprehensive Primary Care Payments (CPCP): Track 1 practices will continue to receive Medicare fee-for-service (FFS). Track 2 will have a hybrid payment structure of Medicare FFS and Comprehensive Care Management Payments (CPCP). Track 2 practices will receive a percentage of expected Medicare reimbursement for E&M claims upfront in the form of a CPCP and proportionately reduced Medicare reimbursement amounts for E&M claims. For example if E&M code payments were $100,000 in the prior year, that amount would be increased by 10% to $110,000. The provider would select from a blending scale and if for example chose 50% upfront payment the subsequent quarterly payment would be (¼ x $55,000= $13,750). The payments for all E&M visits during this period would also be reduced by 50%.*

The intent of the CPCP payments is to free up the provider to employ innovative strategies to meet the demands of patients without the need to bill for face to face services. Innovations such as group visits, telemedicine, e-visits, home visits, CHW visits and nurse visits are examples.

Performance-Based Incentive Payments: The incentive payments will be $2.50 PBPM for Track 1 and $4 PBPM for Track 2. These incentive payments will be prepaid at the beginning of a performance year, but CMS will recoup all or a portion of the payments if practices do not meet thresholds for quality and utilization performance. Outcome metrics may be added to the Model.

Advance Alternative Payment Model (AAPM) Participation Bonus: CMS will pay practices a 5% lump sum bonus annually for participating in the program, regardless of track.

9. As a provider, what are the incentives to participate in the PCM?

Payments

- *Practice incentives: 5% MACRA participation bonus (lump sum),*
- *Quality incentive bonus $2.50 or $4 PBPM (Track 1, Track 2, respectively) – Prepaid,*
- *Care management payments, $8-$100/PBPM (adjusted based on the HCC risk index of each attributed patient - average payment in the range of $28 PBPM),*
- *FFS payments or a Hybrid option of FFS/comprehensive payment that is Prepaid.*

Incentives

- *Avoidance of MIPS (downside penalties) – Retrospective,*
- *Financial and technical assistance in building a care management infrastructure,*
- *Practice transformation support,*
- *Healthier patient population.*

10. What is a Care Transformation Organization (CTO) and what does it do?

A CTO provides care management infrastructure (nurses, pharmacists, nutritionists, Community Health Workers, licensed clinical social workers (LCSWs), health educators), and resources such as technical assistance for after-hours, social support connections, "hot-spotting" areas with high and/or specific needs, pharmacist support for medication management and consultations, holding practices accountable to PCM requirements, physician training resources, and CRISP connectivity.

11. What is the Coordinating Entity (CE) and what does it do?

The CE is a state sponsored entity that will administer the Primary Care Model including distribution of payments from payers, analytics and evaluations, contracting, certification of the CTOs and PCHs, and other functions to ensure compliance with CMMI rules. The CE will be directed by a broadly representative Governance Board and work closely with external entities to execute its scope of work.

Participation

12. What individuals are eligible to participate?

Initially, the program will serve Maryland Medicare FFS and dual-eligibles beneficiaries. The State is exploring expanding the program for individuals with other health plans including commercial payers and Medicaid.

13. What providers are eligible to participate?

Participation is voluntary for all providers and providers will apply to participate in the program. Providers who can fit the criteria are eligible to participate. Maryland encourages providers and practices who serve as the primary source of care for patients to think of themselves as the patient designated provider. The following specialties are part of the initial set that are being considered to fit the federal approval:

- ***General Practice***
- ***Family Medicine/Family Practice***
- ***Internal Medicine***
- ***OB/GYN***
- ***Geriatrics***
- ***Psychiatry***
- ***Nephrology***
- ***Gastroenterology***
- ***Nurse Practitioners (Primary Care)***
- ***Pulmonology***
- ***Cardiology***
- ***Hematology/Oncology***

14. What payers are eligible to participate?

Medicare and Medicare-Medicaid will be in the first wave of participating payers. All other payers are encouraged to consider how they can participate in the Model.

Quality

15. What are the quality measures for the program?

Maryland will be using the same measures as the CPC+ program. The State is exploring the need to add additional quality and utilization measures at this time.

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