



CHANGING  
*Maryland*  
*for the Better*

# Maryland Primary Care Model

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# Goals of Primary Care Model

- **Improve the health of Maryland through:**
  - Person-centric healthcare
  - Team-based support
  - Evidence-based approach
  - Consistent quality and outcome metrics
  - Volume to Value
  - Reduce potentially avoidable utilization
  - Improve management of chronic illness
  - Alignment with Maryland All-Payer Model and Medicaid Duals ACO
  - Alignment with State Population Health Improvement Plan (due to CMMI: 12/31/2016)
- **Timeline:**
  - 12/31/2016: Submit Primary Care Model concept paper to CMMI
  - 2017: Enhanced Infrastructure development begins:
    - Coordinating Entity development
    - Regional Care Management Entity formation / applications
    - Practice adoption/technical assistance
    - HIE Expansion, more primary care providers achieve connectivity
  - 2019 – 2022: Sustainability achieved through long term Return on Investment



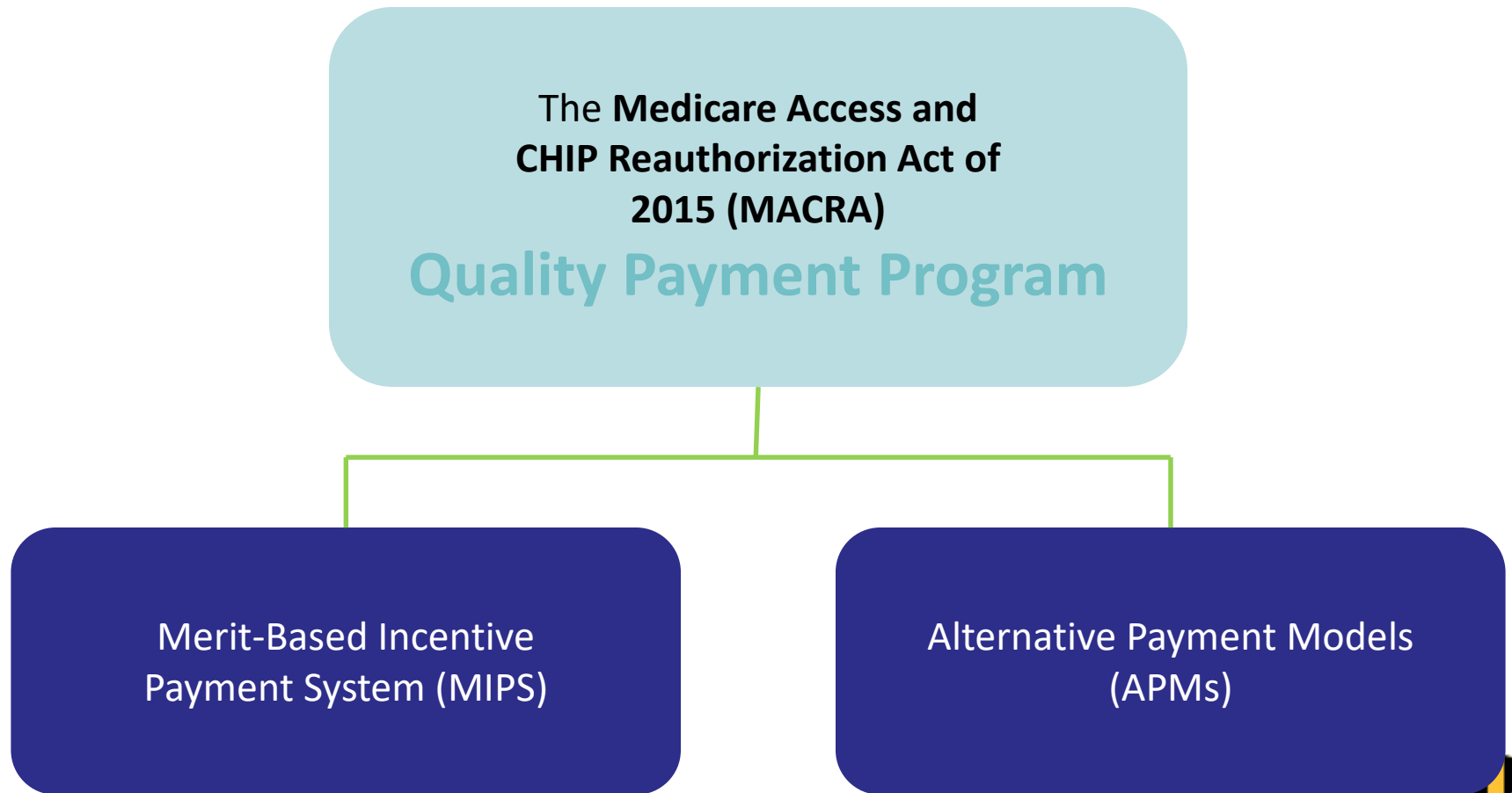
# Relationship to All-Payer Model and Progression Plan

- The Primary Care Model will help sustain the early gains of the All-Payer Model as targets becoming increasingly reliant on factors beyond the hospital
  - Aligns incentives
- Complements the Care Redesign Amendment
  - Community-level alignment to CCIP
- Reduces avoidable hospitalizations and ED usage through advanced primary care access and prevention
  - Components include embedded care managers, 24/7 access to advice, medication mgt., open-access scheduling, behavioral health integration, and social services
- Enhanced version of CPC+ will complement and support hospital global budgets



# 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>

# The Quality Payment Program Provides **Additional Rewards** for Participating in **APMs**



## Potential financial rewards

### Not in APM

MIPS adjustments

### In APM

MIPS adjustments

+

APM-specific rewards

### In **Advanced** APM (AAPM)

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>



# Leveraging Window of Opportunity

- Federal government willing to make substantial financial investment to implement Primary Care Model and help the state manage Medicare and Duals populations
- CMMI willing to allow the State to customize CPC+, which is an approved AAPM model
- Maintaining All Payer Model and broader health transformation in State depend on primary care with strong supports

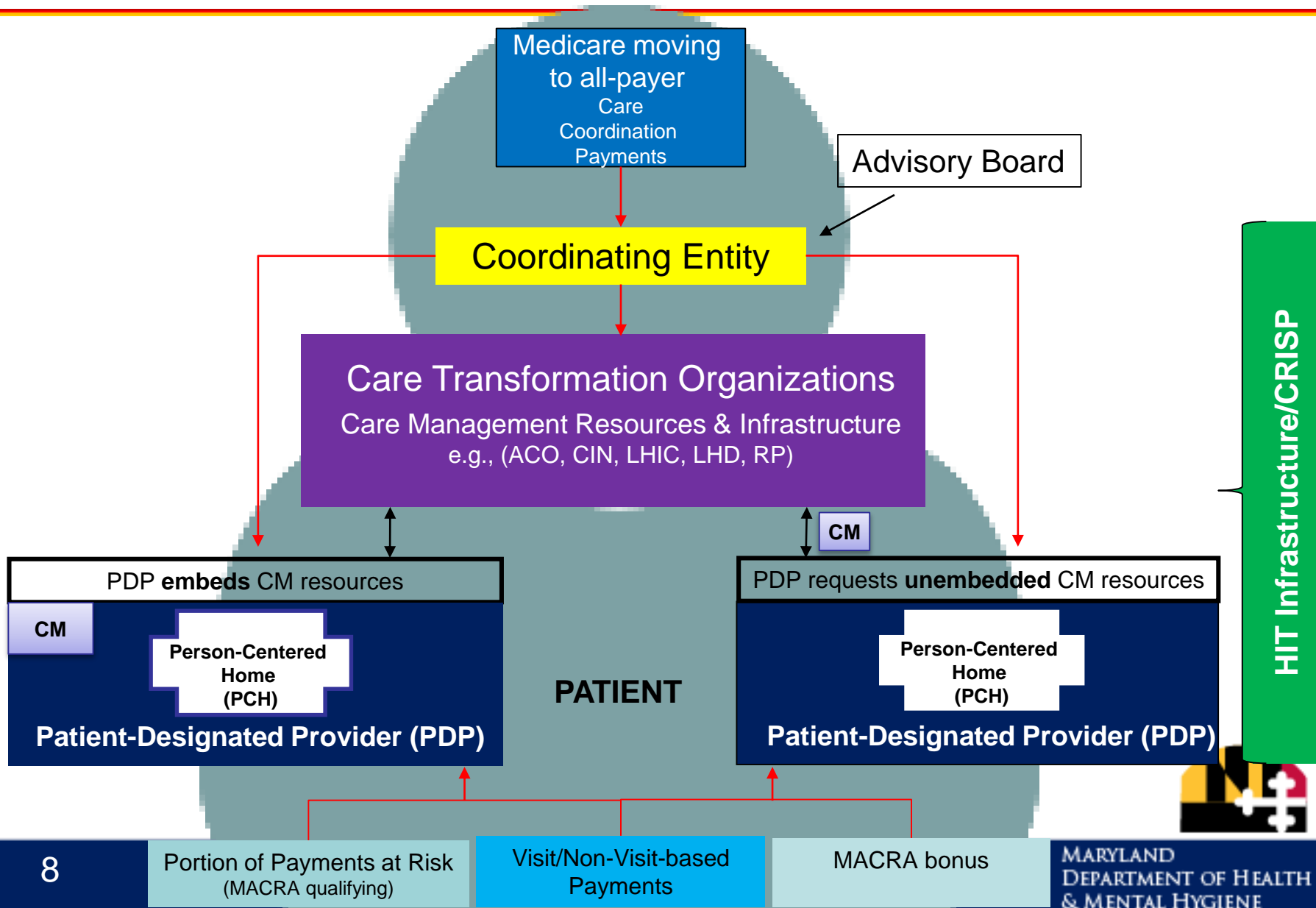


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# OVERVIEW OF PRIMARY CARE MODEL



# Maryland Primary Care Model



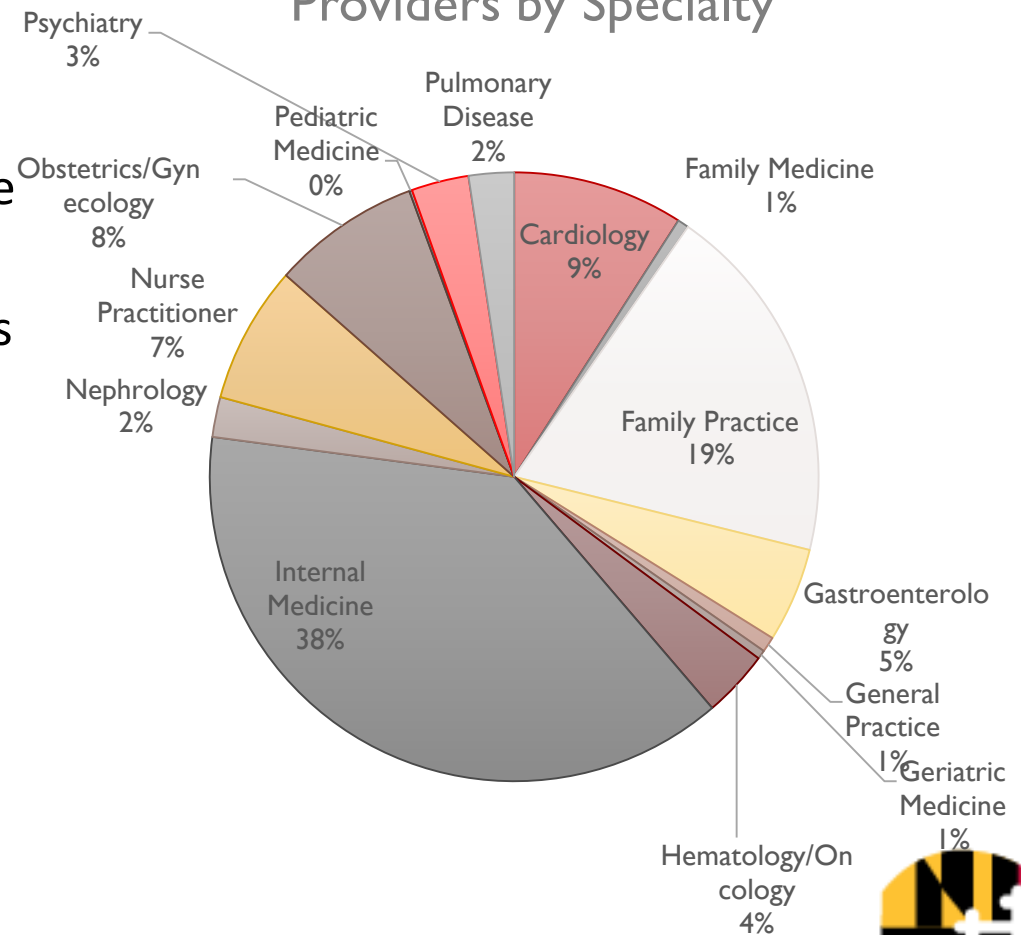


# PDPs

- Patient Designated Providers (PDPs)

- The most appropriate provider to manage the care of each patient
- Provides preventive services
- Coordinates care across the care continuum
- Ensures enhanced access
- Most often this is a PCP but may also be a specialist, behavioral health provider, or other depending on patients health needs

Number of Patient-Designated Providers by Specialty



# Practice Transformation is Key!

- Practices will **NOT** be expected to be transformed on day 1 or program start
- The State is committed to designing a system to provide assistance with practice transformation:
  - Care Management Entities (RCMEs) will be approved to assist practices
  - Practices will choose the best RCME for them
  - RCMEs will ensure that practices meet requirements under program by developing high functioning services including:
    - Care management resources and people
    - Technical assistance on practice transformation
    - IT supports (RCME and CRISP)



# I am a Patient: What does a transformed practice look like to me?

- I am a Medicare beneficiary
- Provider selection by my historical preference
- I have a team caring for me led by my Doctor
- My practice has expanded office hours
- I can take advantage of open access and flexible scheduling:
  - Telemedicine, group visits, home visits
- My care team knows me and speaks my language
- My records are available to all of my providers
- I get alerts from care team for important issues
- My Care Managers help smooth transitions of care
- I get Medication support and as much information as I need
- I can get community and social support linkages (e.g., transportation, safe housing)



# I am a Provider: What does a transformed practice look like to me?

- Voluntary participation
- Able to spend more time with patients
- Patient care management support based on severity index
- Care managers embedded in my practice and part of my care team
- Practice incentives:
  - 5% MACRA participation bonus (lump sum); CPC+ participation
  - Quality and Utilization incentive bonus \$2.50 or \$4 PBPM (Track 1, Track 2, respectively) – Prepaid
  - Track 2 comprehensive payment – Prepaid
  - Care Management payment PBPM risk adjusted
  - Care management infrastructure
  - Practice transformation support
  - Healthier patient population
  - Reimbursement for non-office based visits

