Maryland Primary Care Program

Program Management Office

Maryland Department of Health

September 27, 2018

MMAC Presentation

Overview

Total Cost of Care Model and MDPCP

- Total Cost of Care Model is the umbrella
- MDPCP is critical to meeting TCOC Model commitments including:
  - Reducing Medicare FFS per capita health costs
  - Improvement on quality and utilization metrics
  - Improvement on population health indicators
- Advanced primary care will help the state:
  - Manage health of high and rising risk individuals in community
  - **Reduce unnecessary hospital and ED utilization**
  - Provide preventive care; address behavioral health and social needs

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Overview

TCOC Contract

- Hospital
  - #1 Global Budgets –GBR
  - Savings warrants
  - Quality
- Practices/Providers
  - #2 MDPCP- Primary Care
  - #3 Care Redesign Amendment – all providers
    - Specialist focus: Bundles Model, HCIP
    - Primary care: CCIP (additional opportunity to work with hospitals)
- Entire State
  - TCOC Model is designed to improve population health
  - Population Health goals- Diabetes, Hepatitis C, Opioid death rates

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CMMI Roles in MDPCP

CMMI responsible for:

- Application process
- Selection of Practices
- Selection of CTOs
- Provision of Learning System
- Provision of all payments
- Provision of data to practices on attribution of patients, HCC scores
- Ongoing MDPCP operations

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State's Role in MDPCP

State responsible for:

- Facilitate and support CMMI in MDPCP activities
- Outreach to practices and CTOs
- Support Education of practices and CTOs
- Practice Coaches
- Data support through CRISP
  - Claims
  - Quality reporting
- CTO-Practice Arrangement template
- Suggest changes in program annually
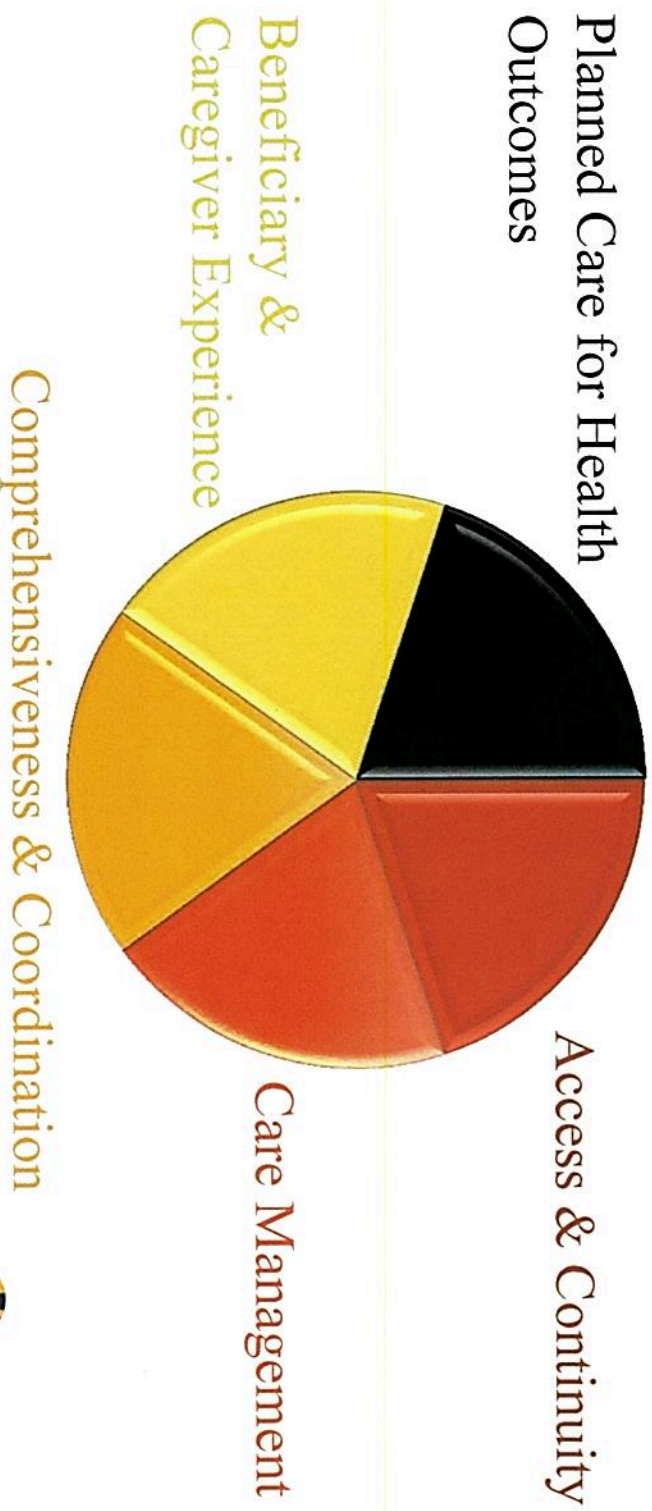- Suggest MDPCP activities that State can assume
- Assemble Advisory Council

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Roles

MDPCP Program Management Office

- Responsible for executing state's role in MDPCP
- Program Management Office in MDH
- Operations support through HSCRC
- Reporting directly to Secretary of MDH
  - Executive Director
    - Program Director
      - Manager for Data and Provider Education
        - Practice Coaches
      - Policy Analyst
      - Office Coordinator
      - Interns

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Requirements: Primary Care Functions

Five advanced primary care functions:

Planned Care for Health
Outcomes

Access & Continuity

Care Management

Comprehensiveness & Coordination

Beneficiary &
Caregiver Experience

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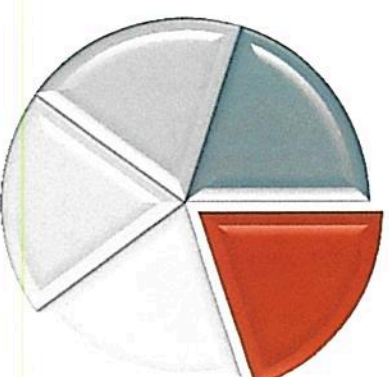Department of Health

Access and Continuity

Track One

- Empanel patients to care teams
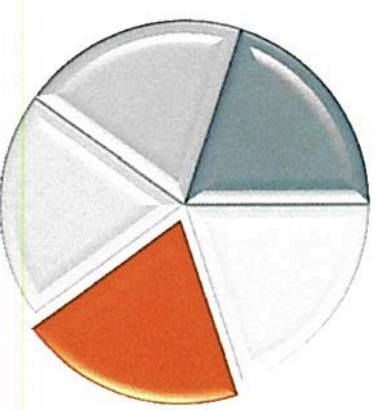
- 24/7 patient access

Track Two (all of the above, plus)

- Alternatives to traditional office visits

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Care Management

Track One

- Risk stratify patient population

- Short-and long-term care management

- Follow-up on patient hospitalizations

Track Two (all of the above, plus)

- Care plans & medication management for high risk chronic disease patients
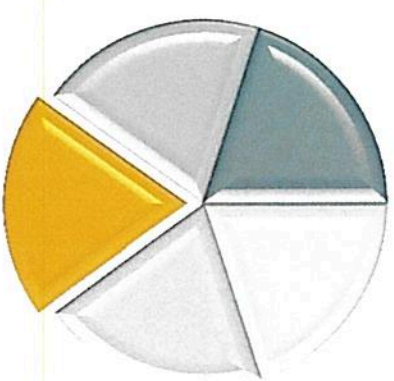
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Comprehensiveness and Coordination —

Track One

- Coordinate referrals with high volume/cost specialists serving population

- Integrate behavioral health

Track Two (all of the above, plus)

- Facilitate access to community resources and supports for social needs
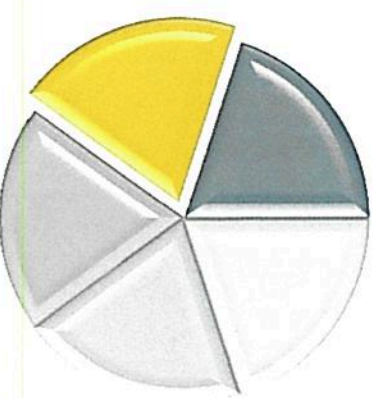
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Beneficiary and Caregiver Engagement —

Track One

- Convene Patient Family Advisory Council (PFAC) and integrate recommendations into care, as appropriate
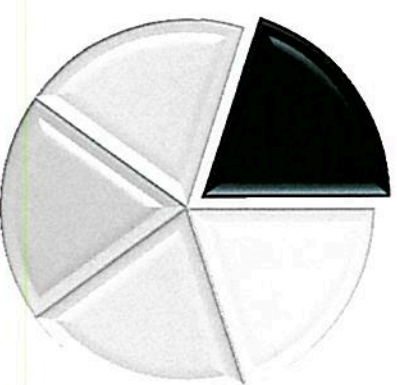
Track Two (all of the above, plus)
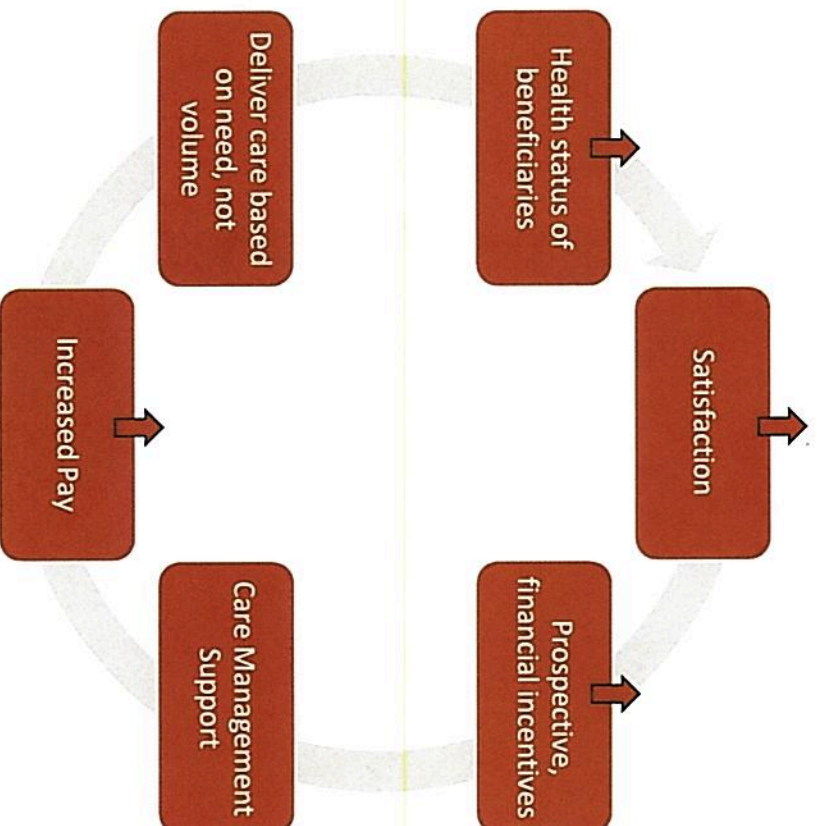
- Advance care planning

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Care Delivery Redesign

Planned Care for Health Outcomes

Track One & Two

- Continuously improve performance on key outcomes

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Program Benefits

Benefits to the Provider

Health status of beneficiaries

Deliver care based on need, not volume

Increased Pay

Satisfaction

Care Management Support

Prospective, financial incentives

Eligible Specialties
Family Medicine
General Practice
Geriatric Medicine
Internal Medicine
OB/GYN
Pediatric Medicine
Co-Located Psychiatry

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Benefits to Patients

- Freedom of choice
- No cost sharing on enhanced services like care management
- Team care led by my Doctor
- Expanded office hours
- Alternative, flexible care options
  - Telemedicine, group visits, home visits
- Records are available to all of my providers
- Care Managers help smooth transitions of care
- Medication management support
- Community and social support linkages (e.g., transportation, safe housing)
- Behavioral health care led by my practice

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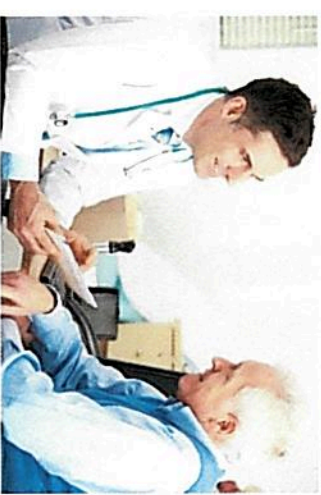
Metrics

- ## electronic Clinical Quality Measures (eCQM) include:

  - Outcome Measures – Diabetes and Hypertension Control

  - Initiation of treatment for Substance Abuse

- ## Patient Satisfaction

  - Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) – survey of practice patients

- ## Utilization

  - Emergency department visits and Hospitalizations per 1,000 attributed beneficiaries

Current metrics as of 2018 – TBD for 2019

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Payment Incentives in the MDPCP
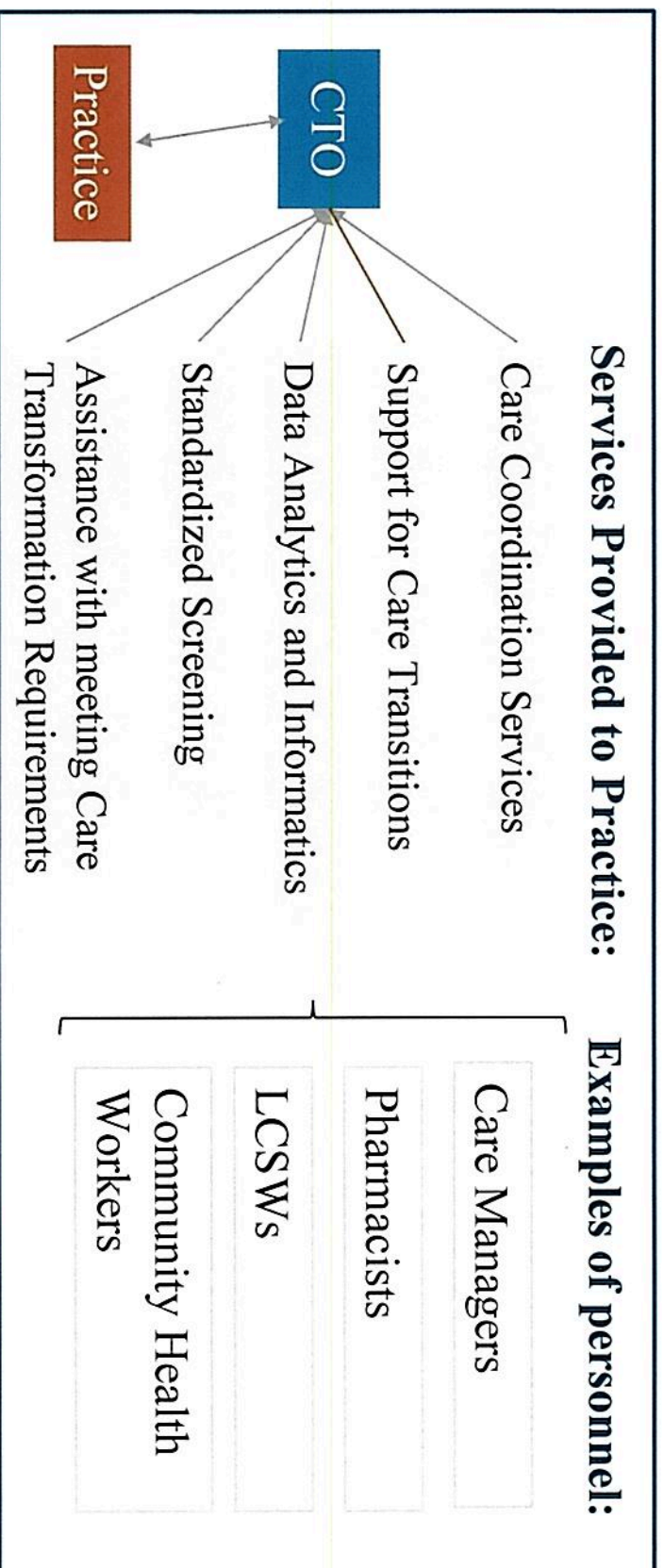
Practices – Track 1/Track 2

Care Management Fee	Performance-Based Incentive Payment	Underlying Payment Structure
• $6-$100 Per Beneficiary, Per Month (PBPM)	• Up to a $2.50/$4.00 PBPM payment opportunity	• Track 1: Standard FFS
➢ Tiered payments based on acuity/risk tier of patients in practice including $50/$100 to support patients with complex needs, dementia, and behavioral health diagnoses	• Must meet quality and utilization metrics to keep incentive payment	• Track 2: Partial pre-payment of historical E&M volume with 10% bonus
• Timing: Paid prospectively on a quarterly basis, not subject to repayment	• Timing: Paid prospectively on an annual basis, subject to repayment if benchmarks are not met	• Timing: ➢ Track 1: FFS; Track 2: prospective

16   *MSSP ACO practices do not receive the Performance-Based Incentive Payment*
Potential for additional bonuses via AAPM Status under MACRA Law

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Care Transformation Organization (CTO) —

On request – assisting the practice in meeting care transformation requirements

Practice

CTO

Services Provided to Practice:

Care Coordination Services

Support for Care Transitions

Data Analytics and Informatics

Standardized Screening

Assistance with meeting Care Transformation Requirements

Examples of personnel:

Care Managers

Pharmacists

LCSWs

Community Health Workers

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Supports for Practices

Existing 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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Additional MDPCP HIT through CRISP

- Quality Measures Reporting to CMMI
- Hospital and Emergency Department Utilization Data
- Specialists costs and utilization
- Risk Stratification for Medicare and Medicaid beneficiaries

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# Application Status Program Year 1—

- 595 Practice applications (80% of eligible practices)
  - Early estimates – 591 qualified
    - All counties represented
    - ~90% Track 1
    - ~40% employed by hospitals
    - ~2,000 PCPs

- 25 Care Transformation Organizations (min 6/county)
  - Early estimates-
    - 20 of 25 were selected as first choice by practices
    - 14 of 25 are hospital-based

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Application Status Program Year 1

CTO Applications
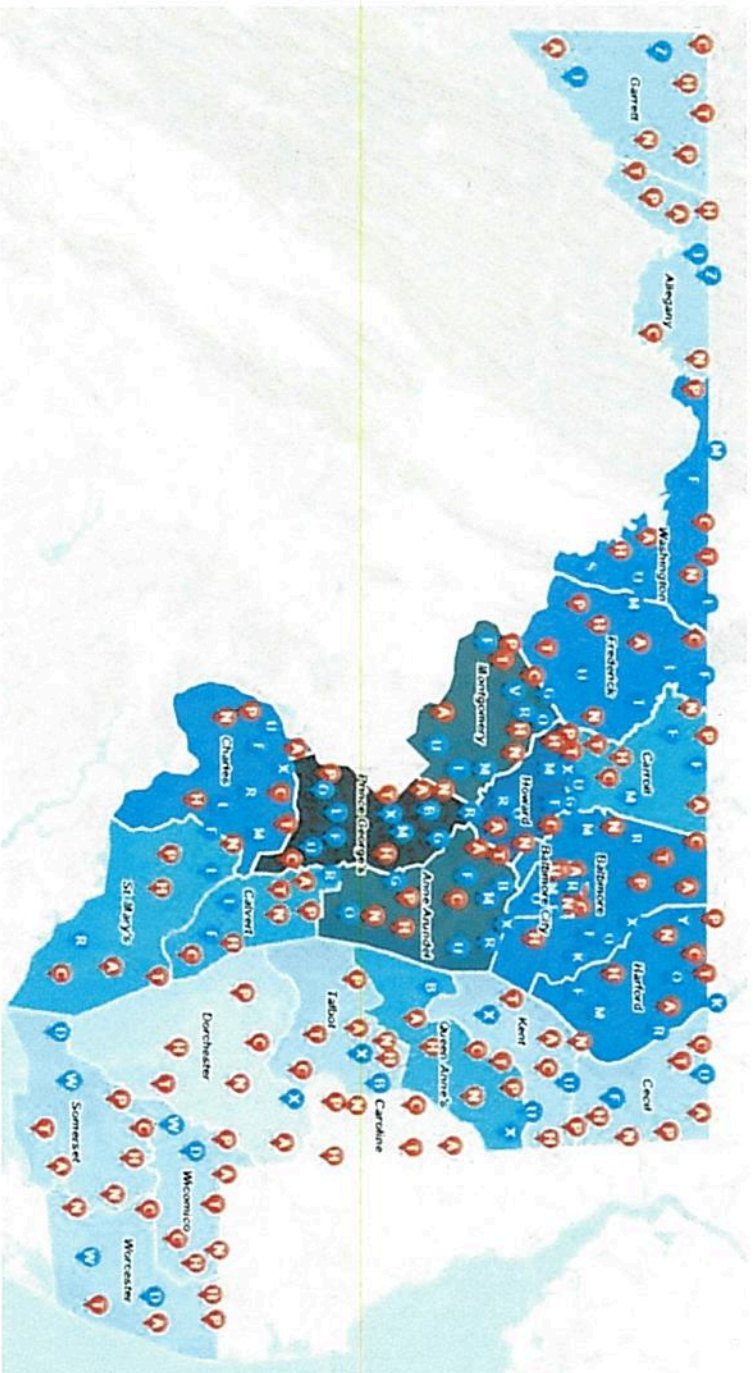
Practice Applications
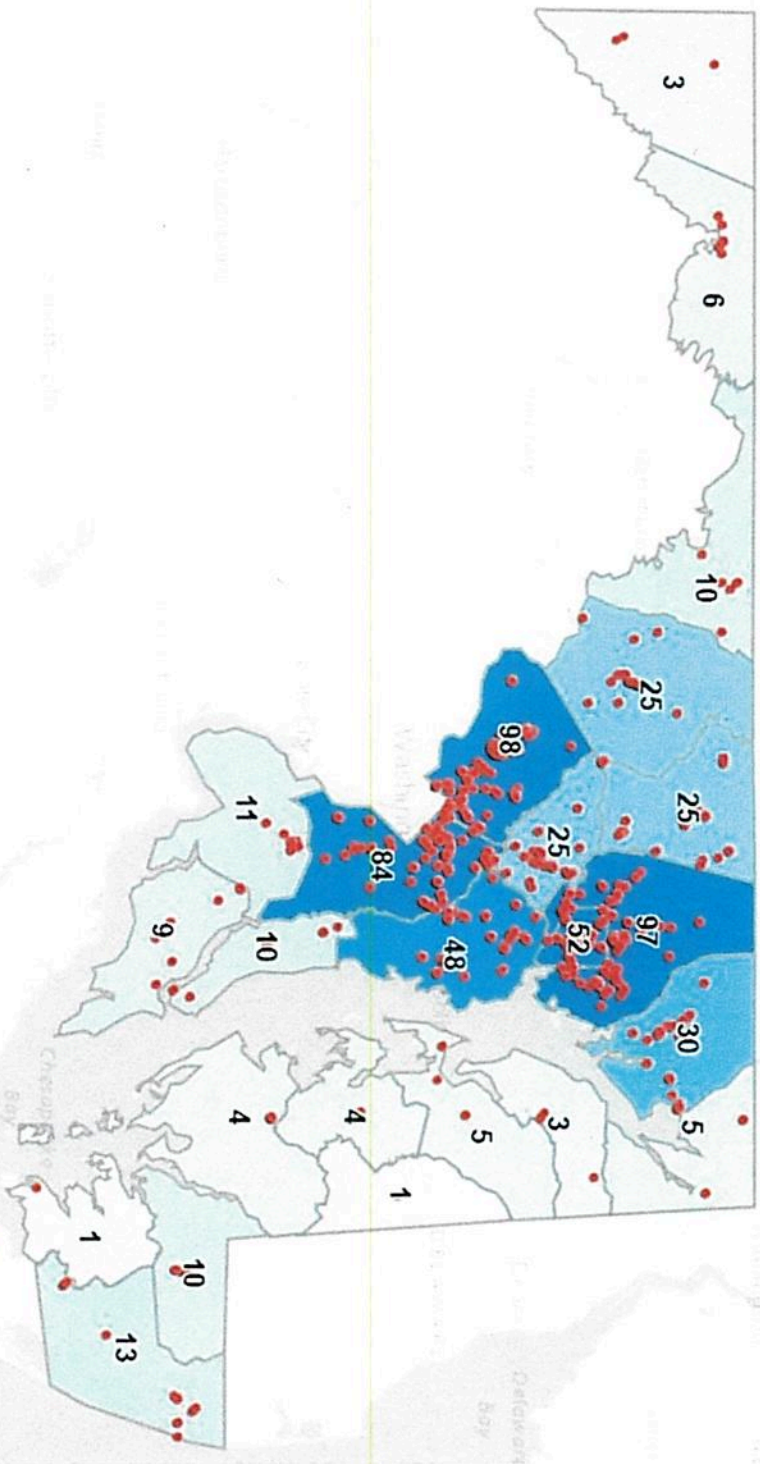
* <20 applications could not be mapped due to inaccurate application data

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Timeline

Activity	Timeframe
Release Applications	June 8, 2018
CTO Application Period Open	June 8 - July 23, 2018
Practice Application Period Open	August 1 - 31, 2018
Select CTOs and Practices	Summer/Fall 2018
Sign Agreements	Fall 2018
Initiate Program	January 1, 2019
Annual Enrollment	2020 - 2023
Program Participation	2019 - 2026

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Thank you!
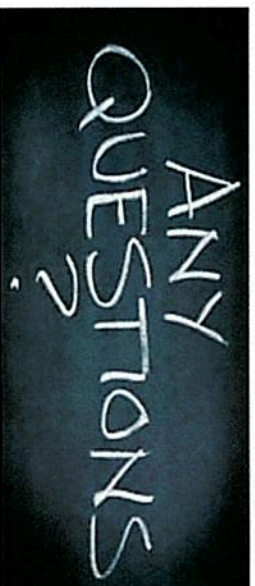
Updates and More Information:

https://health.maryland.gov/MDPCP

Questions: email MarylandModel@cms.hhs.gov

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