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MDPCP 2022 Update
MDPCP Advisory Council

MDH Program Management Office

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August 10, 2021

Administrative Updates

- Provider Leadership Academy – September meeting postponed due to COVID
- 2020 Annual Report draft coming soon
- COVID MDPCP impacts manuscript to be published soon
- New grants supporting MDPCP practices:
  - SBIRT and MAT implementation
  - Health equity
  - COVID Point of Care testing

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MDPCP Success to Date

- 394,000 Medicare FFS beneficiaries attributed
- 525 primary care practices including FQHCs
- 40% of Maryland's dual eligible population
- Lower rates of IP and PQI-like utilization compared to equivalent non-participating and State FFS groups
- Preliminary studies show lower costs, even after CMF, in 2020 using DiD methods
- Year over year utilization rates declining in both 2019-2020 and 2020-2021
- 20% of beneficiaries under Longitudinal care management
- Follow-up rate after hospital events (as of Q1 2021)
  - IP – 78.7%
  - ED – 79.8%

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Timeline

- **June 2020** – CMMI and HSCRC requests PMO/Advisory Council develop a Track 3 similar to PCF to increase practice financial accountability with a deadline of September 2020
- **August 2020** – CMMI agrees to extend deadline to 31 December 2020- MDH submits proposal, AC endorses proposal
- **March 2021** – CMMI rejects the proposal to eliminate large practice base revenue variations (-40 to +35%) by adjusting flat fee using historical revenue basis
- **May 2021** –
  - CMMI offers three options for going forward (PCF, Modified track 2, unchanged)
  - State selects Modified track 2 with the addition of a Total Per Capita Cost measure in the PBIP
- **June 2021** – After agreement CMMI reveals new changes including
  - elimination of dementia, SUD and BH in the complex CMF category,
  - the addition of ADI to adjust CMFs
  - the potential loss of AAPM status overall due to some practices failing to meet 5% revenue at risk level
  - shifting 2020 AHU benchmark from historic to concurrent to account for pandemic

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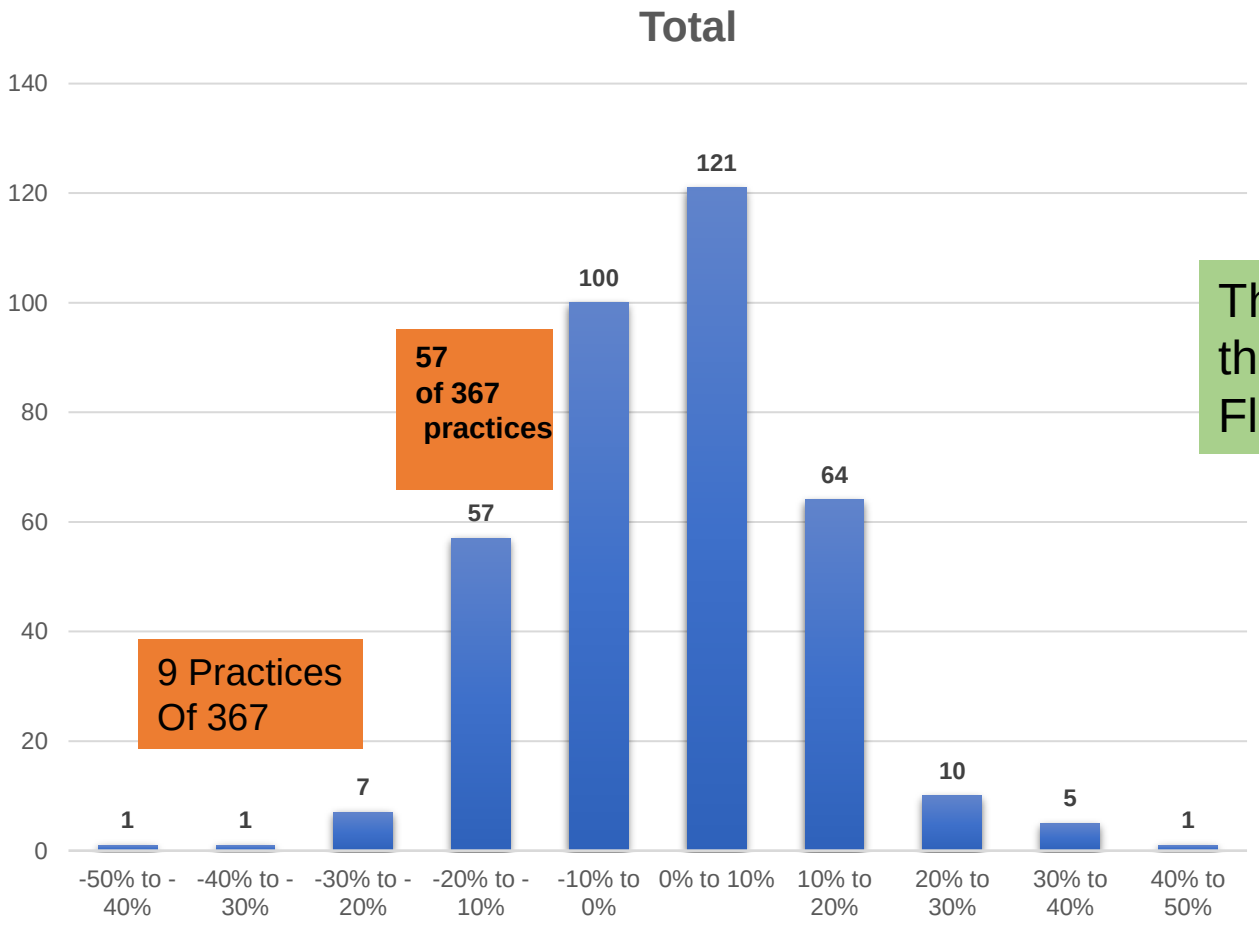
Total Primary Care Practice Level Medicare Revenue Impact in Transition from Track 2-Track 3 (after HCC modifications)



The variation is driven by the
Flat Fee effect

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May 2021 Options from CMMI – Option 2

- Track 2 with modifications
  - Add the TCOC measure *Total Per Capita Cost* to the PBIP – 25% of PBIP,
  - Maintain the quality component (eCQMs and CAHPS) at 50%,
  - Reduce utilization to 25%.
- Introduces practices to TCOC accountability through the PBIP.
- Begins 2022
- State tentatively agrees with CMMI on Option 2

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Key Changes in CMMI Communication in June 2021

- **Issue #1 – CMF payment's HCC override** – HCC risk scoring version 24 includes two of the three override diagnoses (severe and persistent mental illness and substance use disorder)
  - CMS has determined that the HCC override risks **an inappropriate overpayment** and must be eliminated
  - Override policy currently accounts for 16% of MDPCP revenue (~$42M), which CMS would like to keep invested in primary care.
- **Issue #2 – MDPCP's qualification as an Advanced APM (AAPM)** – the QPP team determined that only 66% of MDPCP practices are meeting the financial risk threshold under MDPCP in 2021. Factors driving this are:
  - The Medical Home Model (MHM) financial risk standard has increased each year per statute, from requiring 3% revenue at risk in 2019 and now 5% in 2021.
  - For the AAPM status to be maintained in 2022, **100% of MDPCP practices with clinicians eligible for QP status would need to meet the 5% risk threshold**.

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CMMI Proposed 2 Options to Resolve Issues

- **Option 1 – Maintain AAPM status by shifting the HCC override funds into PBIP (and thus at risk)** so that practices meet the risk standard and can retain their QP status. However earlier analyses of Track 2 modifications showed that:
  - shifting CMF funds to PBIP would have the unintended consequences of shifting money away from MSSP practices
  - increasing the percentage of program funds going to CTOs rather than practices.
- **Option 2 – Lose AAPM status**, but do not tie the HCC override funds to risk. Instead, **use the HCC override funds to increase CMF payments for those practices that, on average, treat more disadvantaged beneficiaries, as determined by ADI**.
  - Addresses important priorities related to equity
  - Creates a pathway for providers who disproportionately serve low income beneficiaries to participate in a value-based payment arrangement.

Impacts per CMMI Proposal

- Elimination of CMFs for Complex tier for attributed beneficiaries with SUD, Dementia, and Mental Health diagnoses
- Addition of ADI adjustments to CMFs- redistribution of CMFs across practices creating winners and losers
  - State supports the use of ADIs in concept, but…
  - CMS has no experience in applying ADI adjustments on CMFs for small practices
  - Applying an ADI adjustment without extensive testing and education will create confusion
- Loss of AAPM status for 2022
  - 5% bonus for practices who receive AAPM status under the Medical Home rule
  - Additional MIPS reporting adds to workload and and MIPS payment adjustments may misalign MDPCP incentives
- Addition of TPCC measure to PBIP
- Change 2020 AHU benchmark with reduction in PBIP retention in 2021

Next Steps

Mid Summer 2021

- State discussions with CMMI on AAPM status, TPCC and ADI methodology

Late Summer/Early Fall 2021

- CMMI promulgating new Financial Methodology document
- CMMI will communicate to participants regarding the reasons and impacts for programmatic changes
- PMO educating practices and providers on paths to success under the new financial model framework
- Fall 2021
  - New participation agreements go to practices and CTOs for 2022

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Principles for Enhancing MDPCP

- Changes should be
  - Incremental
  - Based on stakeholder feedback
  - Backed by evidence that it will improve program
  - Will not disrupt an already successfully performing program
  - Mutually agreed upon by MDH and CMMI
- Recognizes the population health impacts of MDPCP
  - COVID-19 mitigation efforts
  - SBIRT implementation
  - Critical role in diabetes prevention in SIHIS and equity programs
- Preserves statewide network of advanced primary care for long-term care transformation

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Discussion of Possible Modified Option 2

- Track 2 with modifications as agreed to:
  - Add the TCOC measure *Total Per Capita Cost* to the PBIP – 25% of PBIP,
  - Maintain the quality component (eCQMs and CAHPS) at 50%,
  - Reduce utilization to 25%.
  - This Introduces practices to TCOC accountability through the PBIP.
- Optional considerations for 2022
  - Increase PBIP incrementally (e.g., $1.00 PBPM each year) and add ADI adjustment to both AHU and EDU
  - Keep HCC overrides for dementia, SUD, and MH
  - Keep AAPM status

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Appendix

May 2021 Options from CMMI – Option 1

- Track 3 as previously negotiated with the state, including:
  - Population based payments using the practice average HCC refined groupings,
  - A PBA simplified framework with asymmetric risk including at least -10% downside risk and defined quality metrics, including the introduction of the TCOC measure *Total Per Capita Cost*.
  - Flat visit of $40.82
  - Practice Level Revenue changes remain
  - Begins 2023

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May 2021 Options from CMMI – Option 3

- No Changes to MDPCP
- CMMI has indicated that this will not put MDPCP and the Model in good position for expansion

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Comprehensive Primary Care Costs in the Literature

Reference	PBPM	Note
Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care" (*Journal of General Internal Medicine*, Mar. 2007)	$66.67 (2007 dollars) ~ $85 (2021 dollars)	See Table 3, assumes scenario of 1,250 panel with above average patient risk
10% threshold of Maryland Medicare total cost of care (MHCC analysis)	$109.20	Based on 2019 claims, 2019 attribution

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Payment Goal – MDPCP Models

Universe is Track 2 practices (122) and attributed beneficiaries (99,047) as of Q3 2020

Model	Total Dollars	CMF/PBP PMPM	E&M PMPM	Total PMPM
1) Fee for Service Only	$40,882,086	$0	$35.68	**$35.68**
2) PCF (Practice-Group Model)	$63,309,470	$29.76	$24.39	**$54.15**
3) Track 3 (Beneficiary-Group Model)	$84,864,733	$45.97	$26.38	**$72.35**
4) Track 2	$86,065,158	$38.01	$35.68	**$73.70**

Fee for Service E&M Services = Fee for service plus beneficiary cost sharing
PCF E&M Services = Flat fee of $54.20 ($40.82 inflated to 2021) plus beneficiary cost sharing
Track 3 E&M Services = Flat fee of $62.00 plus beneficiary cost sharing
Track 2 = E&M Services = Fee for service plus beneficiary cost sharing

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Statewide Statistics Current Year

394,281
Medicare Benes in MDPCP (+11% vs Prior Year)

314,370
Medicaid Enrollees in MDPCP (+26% vs Prior Year)

60,696
Total Dual Eligibles (+ 35% of vs Prior Year)

259
Total Track 1 Practices (-94 vs Prior Year)

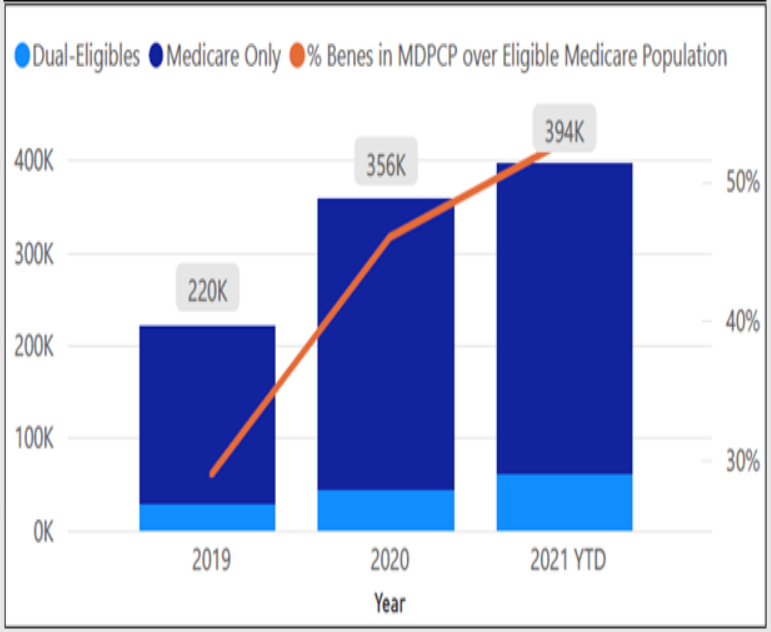
266
Total Track 2 Practices (+143 vs Prior Year)

525
Total Practices (+ 10% vs Prior Year)

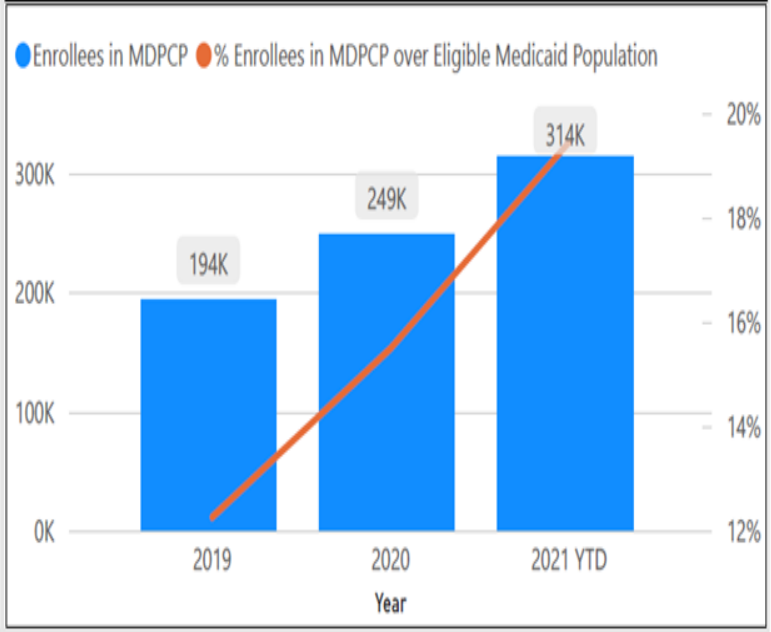
2,166
Total Providers (+ 8% vs Prior Year)

626.5M [b]
Cost Differential (MDPCP vs Non-MDPCP)

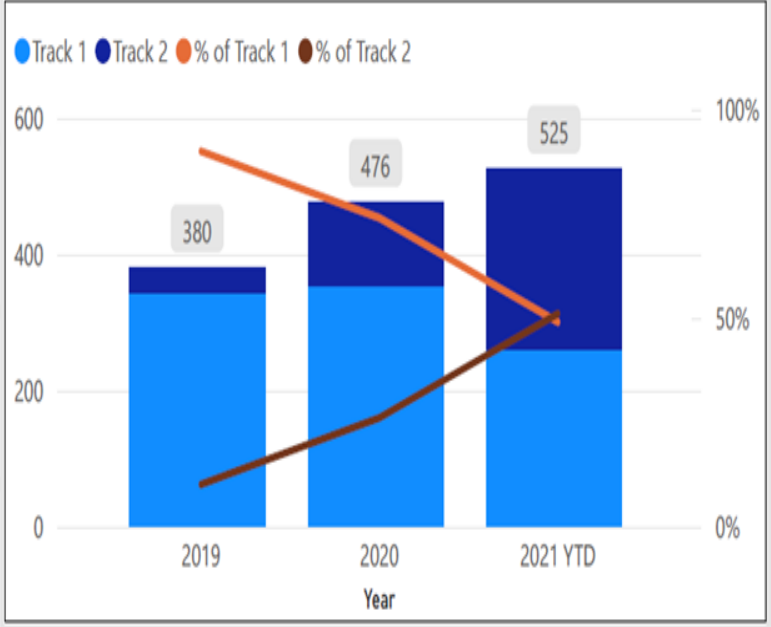
Medicare FFS Beneficiaries in MDPCP as % of Eligible Medicare FFS Population



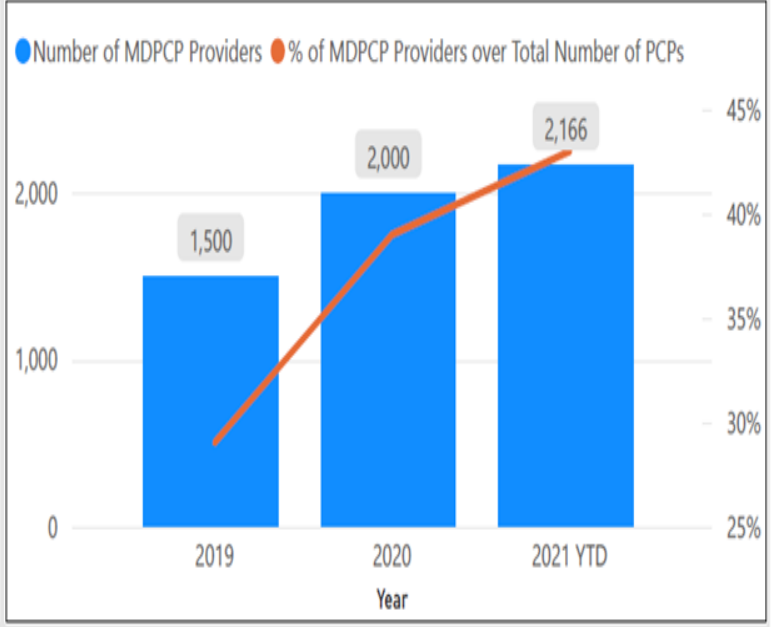
Medicaid Enrollees in MDPCP as % of Eligible Medicaid Population [a]



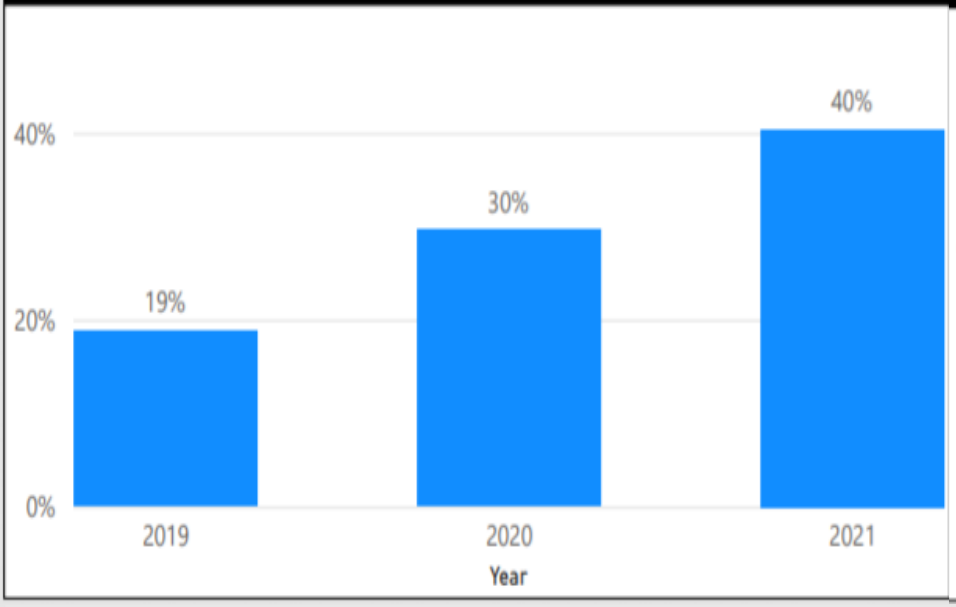
Number of MDPCP Practices by Track 1 and Track 2



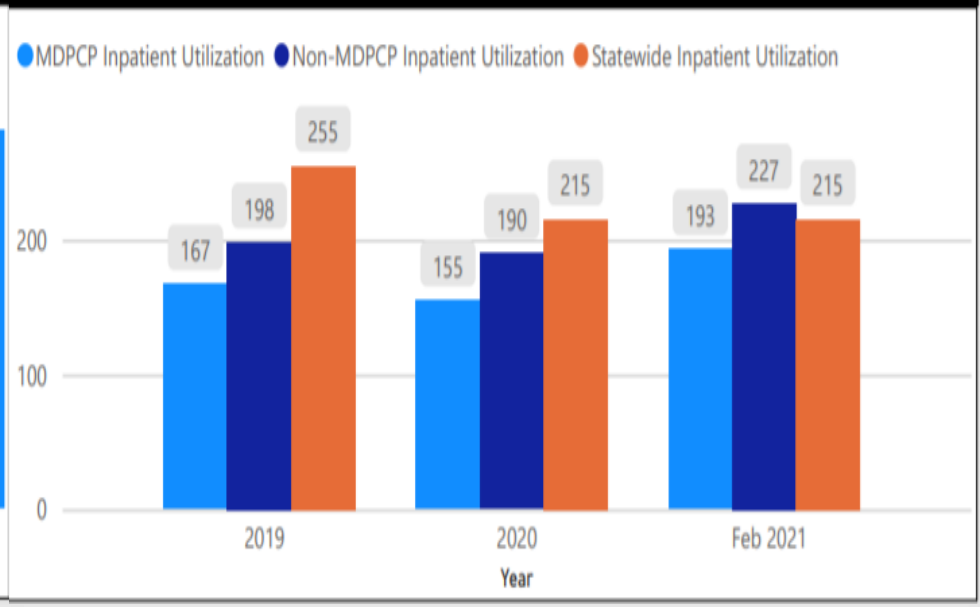
MDPCP Providers as % of Total Number of Primary Care Providers in Maryland



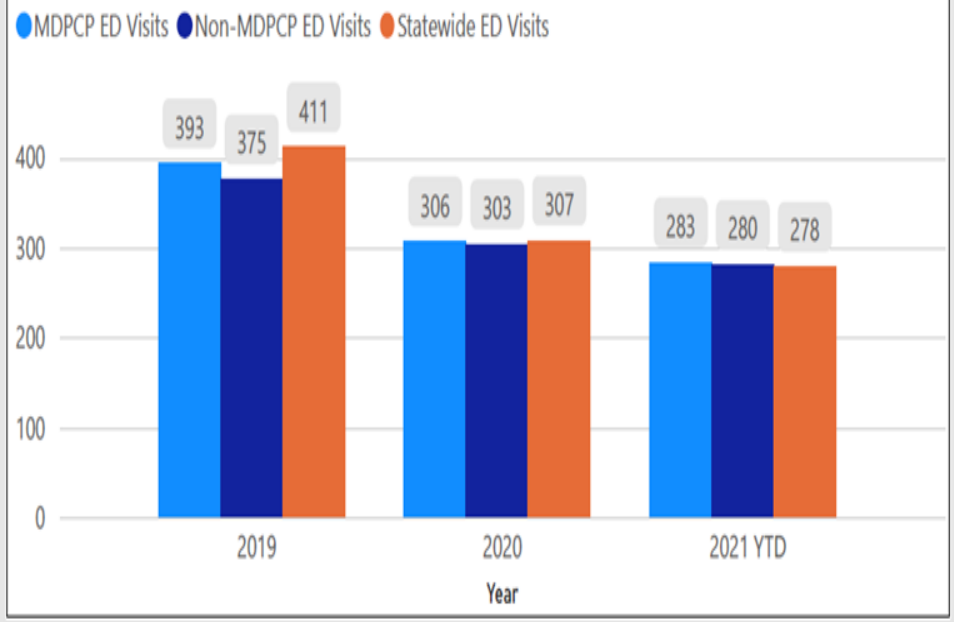
MDPCP Dual Eligibles as % of Total Dual Eligibles



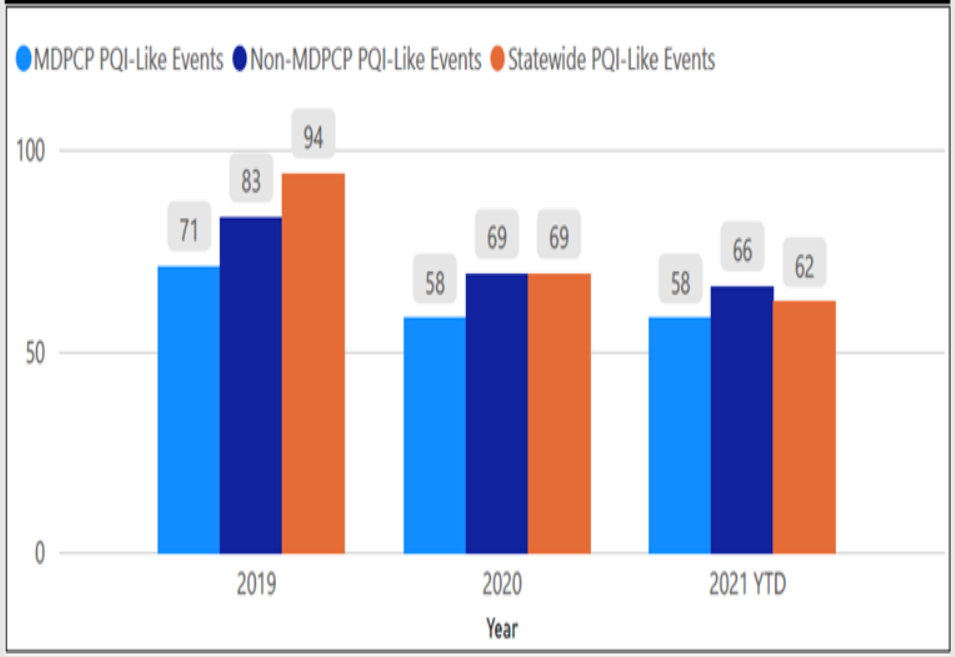
Inpatient Utilization for MDPCP, Non-MDPCP, and Statewide Per Thousand Beneficiaries [a]



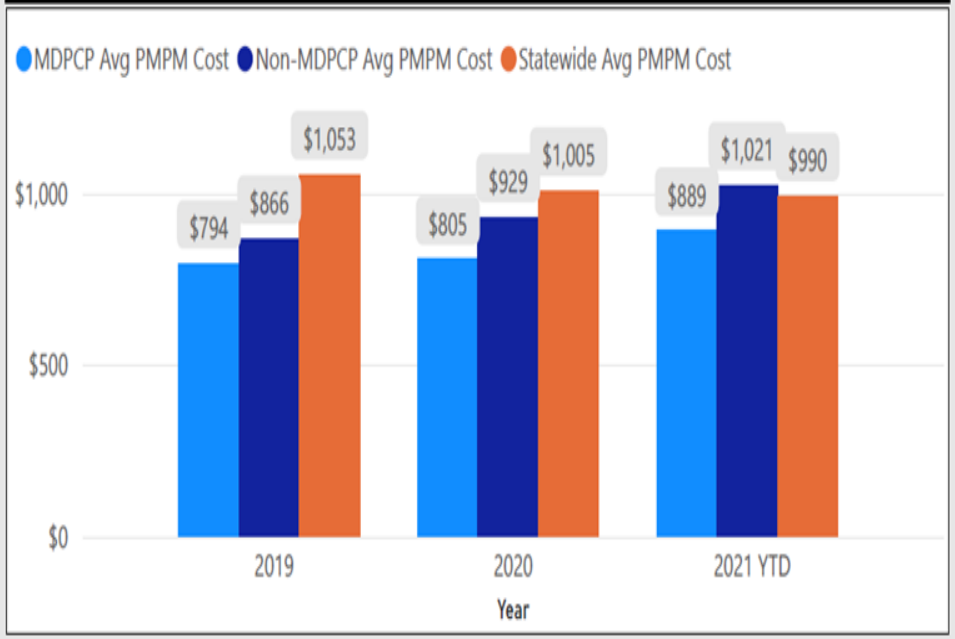
Emergency Department Events for MDPCP, Non-MDPCP, and Statewide Per Thousand Beneficiaries [a]



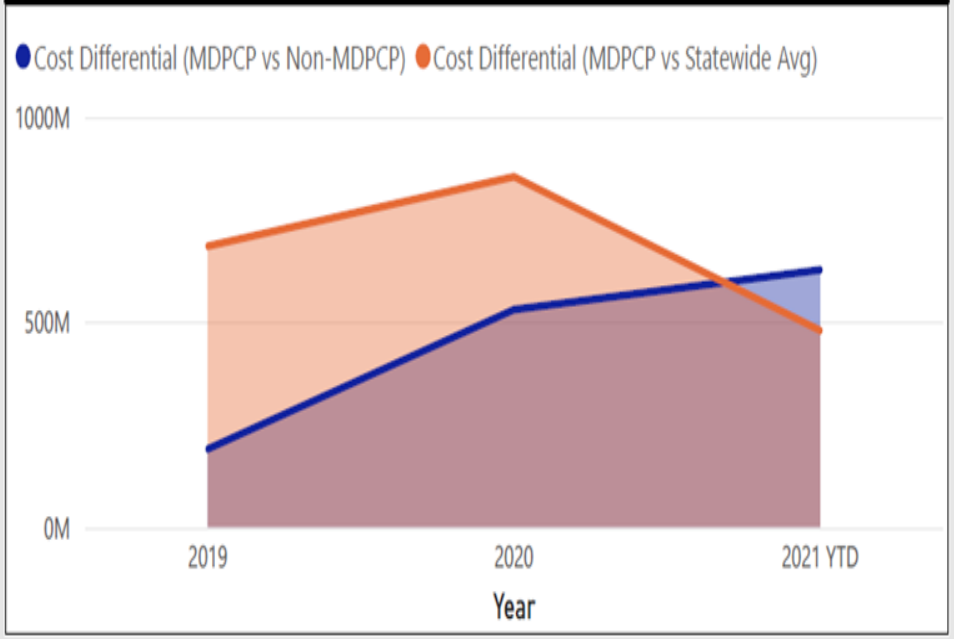
PQI-like Events for MDPCP, Non-MDPCP, and Statewide Per Thousand Beneficiaries



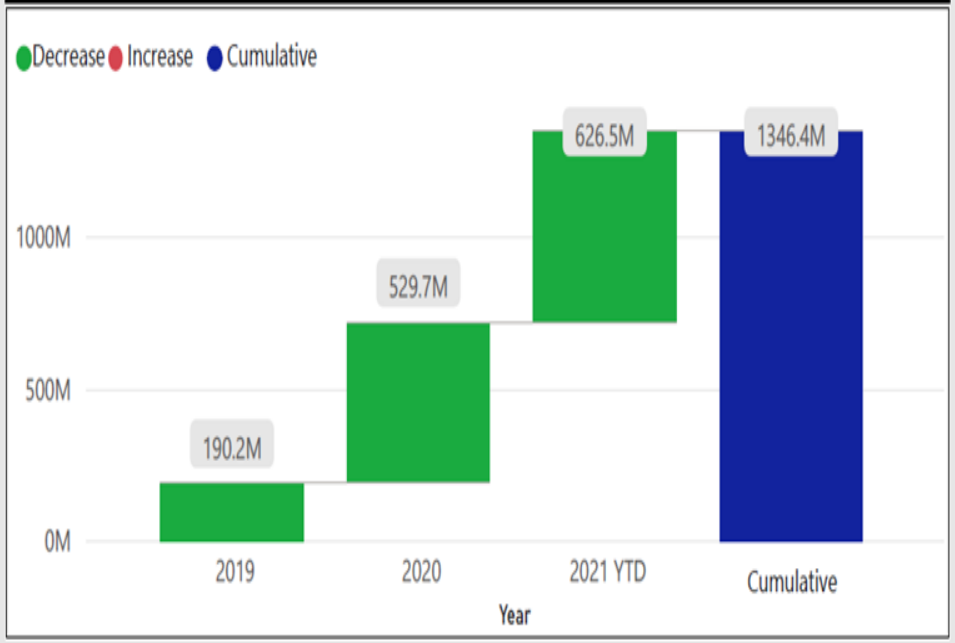
Medicare Average Cost for MDPCP, Non-MDPCP, and Statewide Entire Medicare Population PMPM



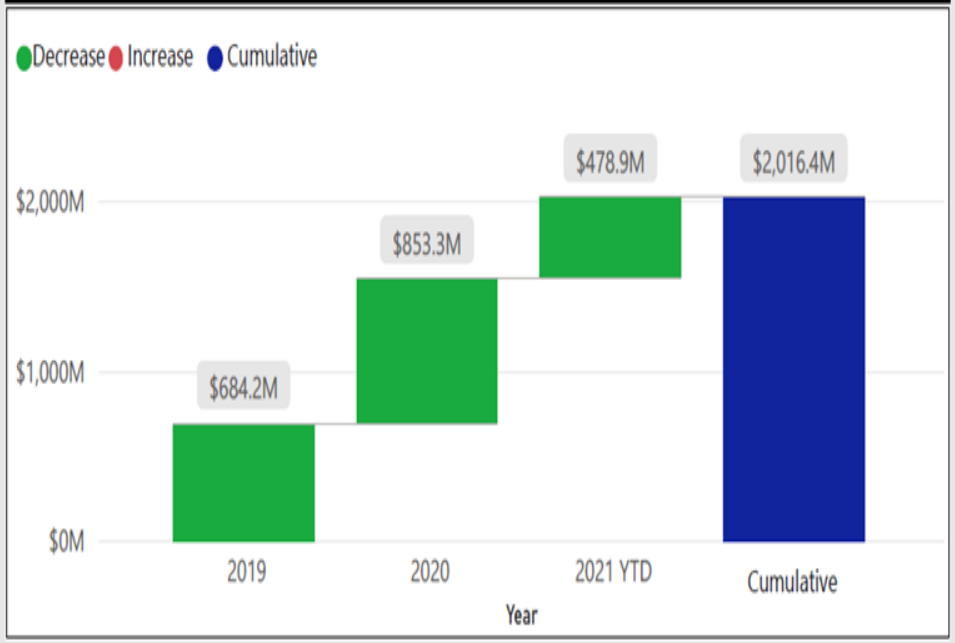
Medicare Yearly Cost Differential



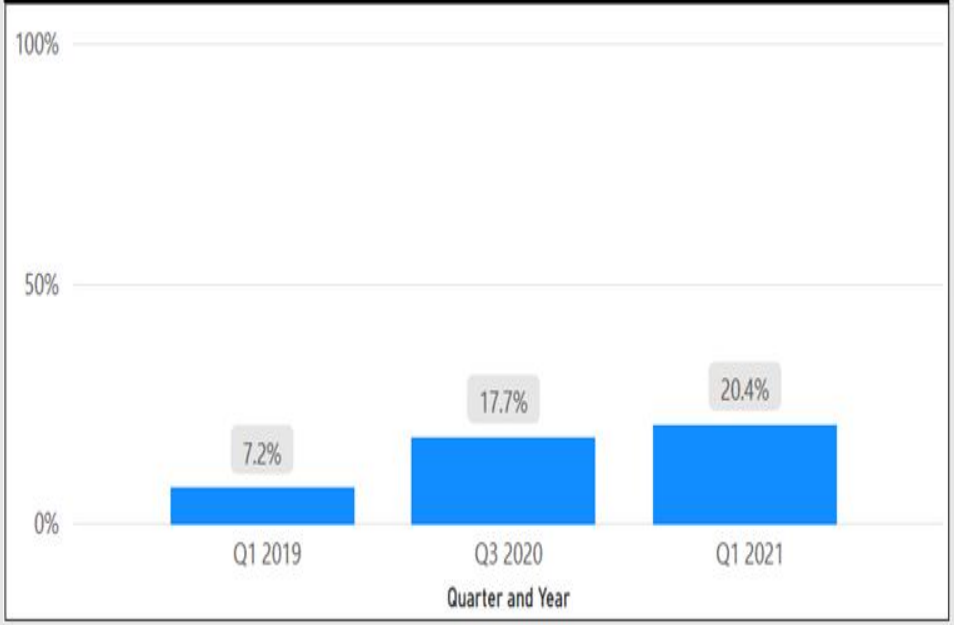
Medicare Yearly Cost Differential - MDPCP vs Non-MDPCP [a]



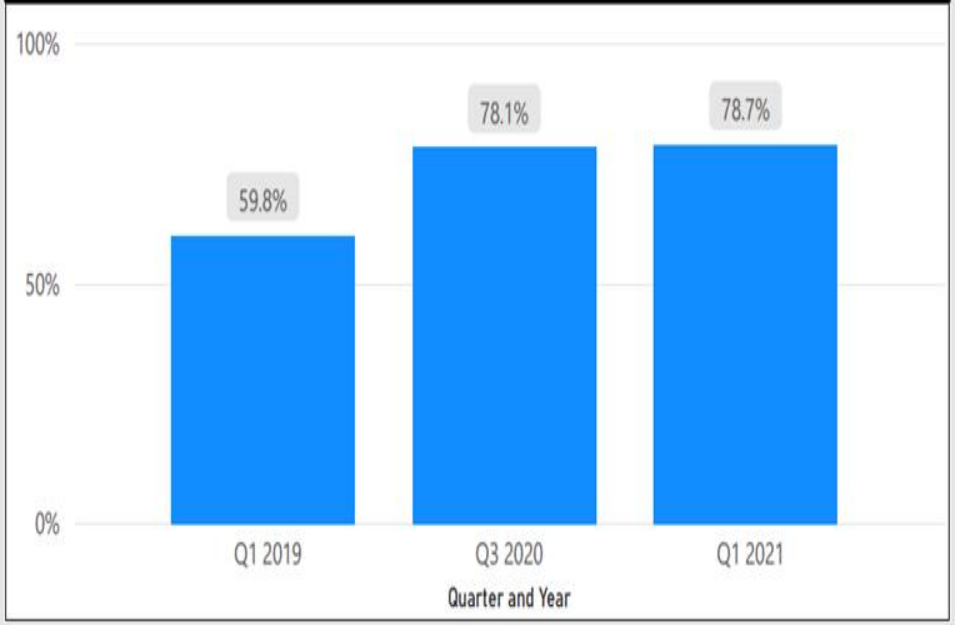
Medicare Yearly Cost Differential - MDPCP vs Statewide [b]



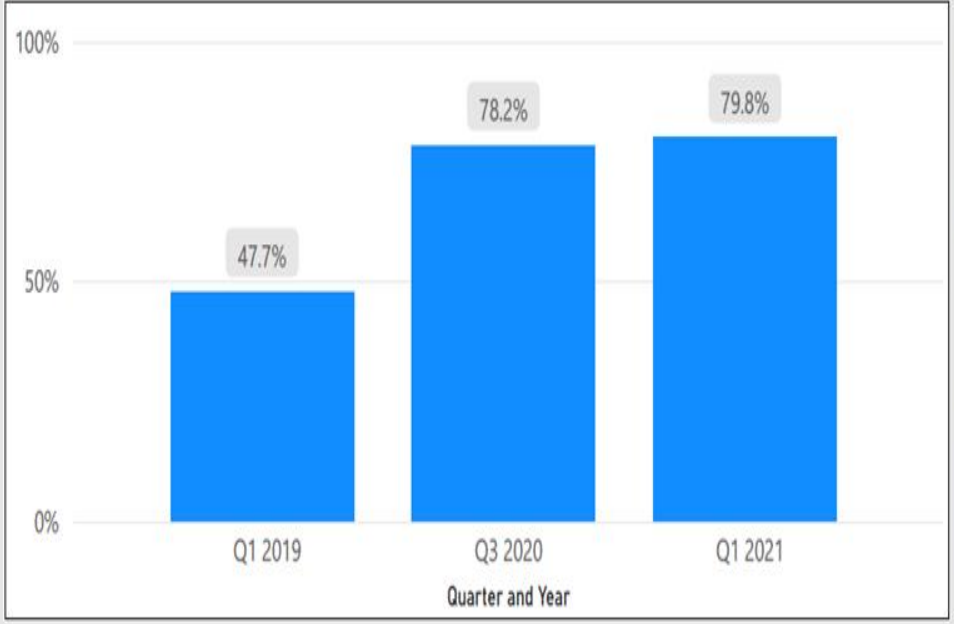
Percent of Beneficiaries under Longitudinal Care Management [a]



Percent of Beneficiaries with Follow-up after Hospital Admissions within Two Business Days [a]



Percent of Beneficiaries with Follow-up after Emergency Department Visits within One Week [a]



MDPCP Practice Locations by Zipcode