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MDPCP Advisory Council - January 2022 Updates

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Guiding Principles MDPCP

- Person and Family-Centered Care
- Concept of “Patient-Designated Provider” (PDP) as Responsible Clinician in a Team-Based Care Model.
- Regional customization and flexibility to match local needs and leverage local infrastructure and resources. (CTO/ACO)
- Steady movement from volume to value
- Incremental all-payer approach

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Guiding Principles MDPCP *Continued*

- Voluntary participation.
- Care Management as a necessary element.
- Provision of evidenced-based care
- Sufficient and timely quality and utilization financial incentives
- Financial and non-financial incentives for practice transformation
- Aligned and consistent set of quality/outcome/utilization metrics.
- Efficient data exchange and robust, connected tools for providers.
- Quality and cost transparency for clinicians and patients.
- Avoidance of unnecessary and duplicative utilization
- Recruitment and retention of primary care providers to address health care access

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PMO Update - Track 3

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Total Spending Level

- CMMI will maintain program level Track 2 funding for Track 3, budget neutral with CMS's commitment to MDPCP.
- Practices' total PBPM amounts will vary and will be a function of their average HCC score and HEART payments.
- Overall Track 2 PBPM amount will be pegged to January 2022.

Population-Based Payments

Population Based Payments (PBP): Refined Practice Average HCC score methodology with five risk tiers using the Track 3 practice average approach based on percentiles (40-20-20-10-10) instead of specified HCC score cut-offs. Payment amounts TBD. Estimated amounts range from $50 - $80 PBPM.

Practice HCC Group	Percentile
1) Low Risk	1-40
2) Low-Moderate Risk	41-60
3) Moderate Risk	61-80
4) Moderate-High Risk	81-90
5) High Risk	91-100

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HEART Payments

The HEART payment will be an additional payment from the PBP. All practices will receive PBPs. Some practices will also receive a HEART payment.

HEART payment - for those attributed Medicare beneficiaries who are in

1) one of the two highest HCC risk tiers (moderate-high risk or high risk) **and**
2) in the highest ADI quintile (among MDPCP beneficiaries) defined as national rank.

The MDPCP Practice and CTO **will not be at risk for the HEART payment**.

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Flat Visit Fee (FVF)

- Basis for FVF:
  - FVF amount will be based on the weighted average of the full list of Select Primary Care Services (SPCS) codes used in Track 2.
  - The FVF (facility and non-facility) amount will not be final until it is calculated based on the full MDPCP practice cohort after the 2023 application period.
- Adjusting payments for facility vs. non-facility location.
- Permitting reimbursement of all E&M billing; does not restrict reimbursement to one billed E&M service per day (CMS will continue to monitor for changes in billing trends).
- Cost sharing accounted for: apply a reduction factor to ensure cost-sharing neutrality for beneficiaries.
- Apply a reduction factor to pay 40% of the weighted average of E&M codes prospectively through the PBP.
- CMS proposes to update the FVF on an annual basis to reflect current billing patterns, reimbursement rates, and full MDPCP practice cohort. This will avoid having an antiquated FVF payment.
- Coinsurance billed at 20% of PFS allowed amount, not the FVF amount.
- Geographic adjustment factor (GAF) applied to the FFS portion of PBP and FVF

Performance Based Adjustment (PBA)

Priorities of PBA policy:

- Incentivize performance on measures.
- Avoid practices potentially beating benchmarks and receiving no adjustments or negative adjustments.
- Mitigate number of practices receiving negative adjustments.

PBA assessed on all metrics:

- **Feedback reports** - CMMI will provide practices with quarterly feedback reports on utilization and cost metrics and with an annual summary report on all measures (utilization, cost metrics, quality, and patient experience).
- **Timing** - PBA is assessed on participants' previous PY's performance and PBP and FVF payment totals (for the entire year) to meet AAPM risk standard. PBA will then be applied going forward, with adjustments made to the next PY PBP payments on a quarterly basis to ensure participants' payment stability, rather than making one large adjustment to the first quarter of payments. If a participant were to voluntarily withdraw following a PY, CMS would issue a demand letter to the MDPCP participant recouping the applicable PY's PBA amount of the previous year's PBP and FVF total.
- **Prospective** - Information on quality measures, benchmarks, and framework for adjustments would be available to the practices before the start of the PY.

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PBA Measures

Single-step PBA with measures consistent with Tracks 1 and 2:

QUALITY - 50% of TOTAL PBA – NATIONAL BENCHMARKS

- Diabetes control (CMS 122) – 17.5% of quality, 8.75% of total
- Diabetes prevention (BMI or similar) (CMS 69) – 17.5% of quality, 8.75% of total
- Hypertension control (CMS 165) – 17.5% of quality, 8.75% of total
- Opioid/SUD/or Depression (CMS 2) – 17.5% of quality, 8.75% of total
- Patient engagement - 30% of quality, 15% of total

UTILIZATION - 25% of TOTAL PBA – MD BENCHMARKS

- Acute Hospital Utilization – 67% of utilization, 16.75% of total
- Emergency Department Utilization – 33% of utilization, 8.25% of total

COST – 25% of TOTAL PBA – MD BENCHMARK

- Total Cost of Care, TPCC – 25%

PBA Risk Framework

PBA Framework:
For the option below, the range is the practice percentile vs. the benchmark and the percentage is the adjustment. Consistent with other CMS program policy, the PBA must be budget neutral. CMS reserves the right to scale positive and/or negative adjustments (rather than altering the benchmarks or breakpoints that establish whether a practice will receive a positive or negative adjustment) to ensure budget neutrality.

Asymmetrical Risk
PROS: Incentivizes improvement and good performance with the potential for up to +25% adjustment.
CONS: More practices must experience downside risk to fund the higher potential upside.

- 0-10: -10%
- 10-40: -5%
- 40-75: 0% (no adjustment)
- 75-90: +5%
- 90-95: +10%
- 95-100: +25%

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Level of Risk and AAPM

- To achieve Advanced APM status under the Medical Home Model (MHM), the required minimum for all practices is 5% of MDPCP revenue at risk [denominator: all MDPCP payments (PBP, HEART, and FVF) and Part B billings for attributed beneficiaries].
- Practices with over 50 clinicians in the parent organization are excluded/not eligible for QP status through MDPCP, though they would be subject to the same level of PBA downside risk and would still be required to meet the nominal risk standard to ensure that all practices in T3 qualify.
- MSSP practices: Will receive full PBP, but will not be subject to PBA.

CTOs

Keep CTO roles/payment amounts consistent with Tracks 1 and 2. Adjustments to the 50/50 and 70/30 options will be required (because CMF, PBIP, and CPCP roll into PBP vs. current split with only CMF). CTOs receive a share of the following practice payments, paid directly by CMS:

- PBP (subject to PBA)
- HEART

CTO split percentages will range across HCC tiers, but with percentages set to ensure CTO funding that is consistent with Tracks 1 and 2 (because a portion of the PBP is based on historic FFS payments that CTOs do not receive).

Approximate percentages shared with CTOs (before PBA is applied):

- 40% (Tracks 1 and 2's 50% option and requirements) and
- 24% (Tracks 1 and 2's 30% option and requirements)

CTOs will continue to sign Participation Agreements with CMS as well as CTO-Practice Arrangements with practices.

Participation Options and Timeline

Request for Applications (RFA): CMS will issue a RFA in the Spring of 2022 for January 1, 2023 practice, CTO, or FQHC start (2023 cohort), and a final RFA in the Spring of 2023 for January 1, 2024 practice, CTO, or FQHC start (final cohort).

Transition Timelines: Practices may apply to Track 1 in response to the 2022 RFA for PY 2023. Track 1 is not an option for potential participant selection in 2023 RFA for PY 2024. Final year of Track 1 operation will be CY 2023.

Year that a Practice Began Participation in Track 2*	T3 Start Deadline	Min Time in T3 (thru 2026)
2019 starters	1/1/2023	4 years (max of 4 years in T2)
2020 starters	1/1/2023	4 years (max of 3 years in T2)
2021 starters	1/1/2024	3 years (max of 3 years in T2)
2022 starters	1/1/2025	2 years (max of 3 years in T2)
2023 starters	1/1/2026	1 year (max of 3 years in T2)
2024 starters	1/1/2026	1 year (max of 2 years in T2)

**2025 - Track 2 participants may remain from previous years and would be required to transition to Track 3 by January 2026.*

Track 1 - final year of operation is CY 2023.
Track 2 - final year of operation is CY 2025.
FQHCs will not be eligible to participate in Track 3 in 2023. CMMI and MDH will revisit for possible start in 2024. Existing MDPCP Practices/FQHCs wishing to participate in Track 3 will complete a transition application similar to the current Track 2 transition application. CMMI and MDH will collaborate to develop the transition application

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PMO Update - 2020 Annual Report

- **Infrastructure Enhancement -** Continuing to build a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to controlling the growth of Maryland's Medicare Part A and B costs
- **Care Transformation -** Improving population health through continuous, relationship based primary care that proactively addresses both medical and behavioral health needs, social needs, and provides continuity of care
- **Quality and Utilization Improvement -** Establishing data tools and quality improvement processes that allow practices to monitor their performance
- Additionally, the emergence of COVID-19 in Maryland in March 2020 prompted MDPCP to adopt an ad hoc objective for PY2: **Support practice and CTO efforts to address COVID-19,** thereby mitigating the disease's impact on the state.
- The MDPCP 2020 Annual Report details the growth, accomplishments, and outcomes for the program's second year. Read the **Full Report** or **Executive Summary** or view our **Snapshot Slides**.

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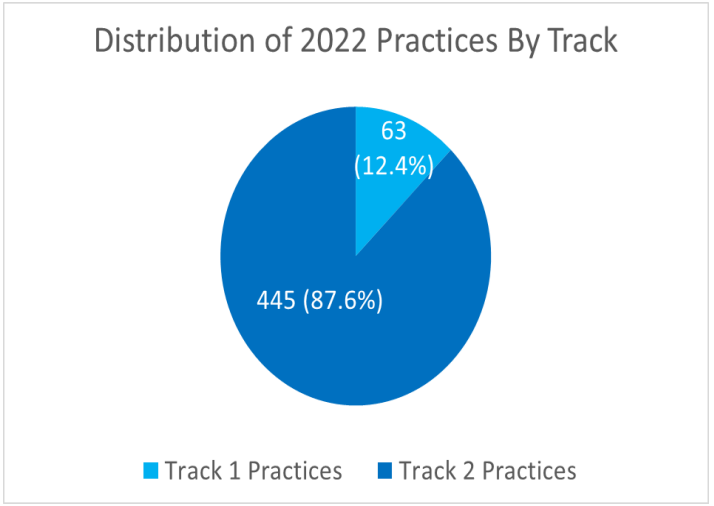
PMO Update - 2022 Participation

- 508 practice participants
  - 7 of these are FQHCs that represent 44 individual site locations, for a total of 545 participating site locations
- 24 CTOs
- 63 (12%) T1 vs 445 (88%) T2 practices
- 373,666 MDPCP-attributed beneficiaries*
- ~2,100 providers*



**denotes Q4 2021 attribution as Q1 2022 is not yet available*

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Medicaid MCO Alignment

- Work is underway by the Department on an MDPCP Medicaid Alignment Model, we should have more information to share with the Advisory Council at the next meeting

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Medicare Advantage Alignment

- Benefits
  - Measure alignment for practices
  - Payment alignment for practices
  - Broader set of resources to support patients
- Potential Areas of Alignment with MDPCP
  - Participate as an Aligned Payer
  - Others?
- Next Steps
  - Secretary Schrader to meet with stakeholders

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Thank you!

General Updates and More Information:

https://health.maryland.gov/MDPCP

Questions: email mdh.pcmodel@Maryland.gov

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