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Maryland Primary Care Program Advisory Council Meeting

October 26, 2021

Program Management Office

Announcements

- PMO Leadership Update
- Annual Report update
  - Deadline extended to 12/6/21 due to delay in 2020 quality/utilization results
  - Expect updated Draft the Week of 11/15/21

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MDPCP Performance Dashboard Update

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Statewide Statistics Current Year

396,744 [b]
Medicare Benes in MDPCP (**+11%** vs Prior Year End)

338,270 [c]
Medicaid Enrollees in MDPCP (**+36%** vs Prior Year End)

61,254
Total Dual Eligibles (**+36%** vs Prior Year End)

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

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

525
Total Practices (**+10%** vs Prior Year End)

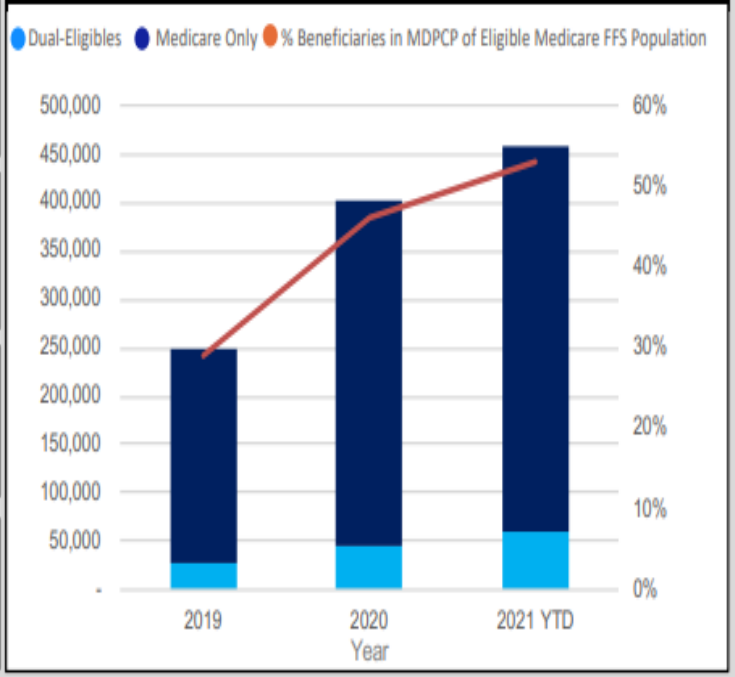
2,166
Total Providers (**+8%** vs Prior Year End)

(a) Reporting period for all Medicare and Medicaid data are from 2019 to September 2021.

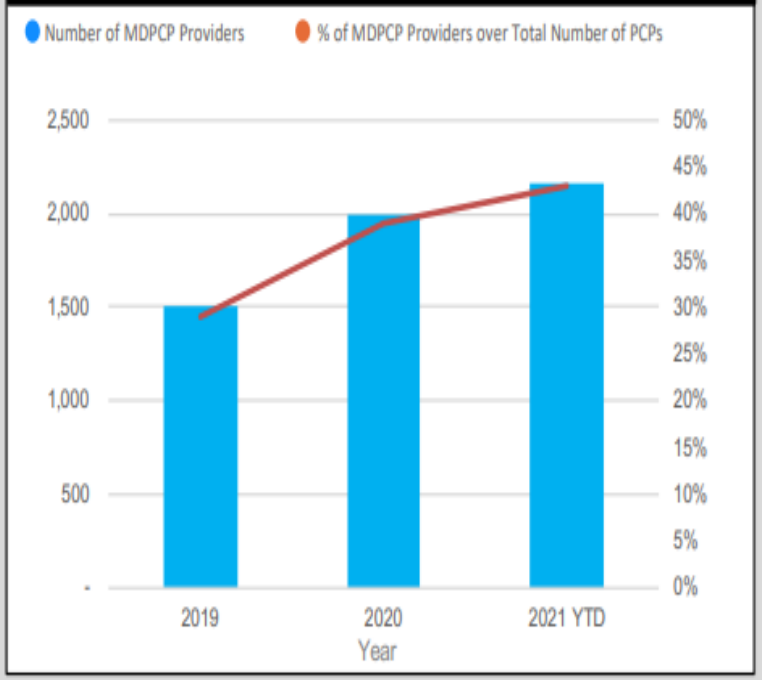
(b) Including Dually Eligible Beneficiaries in MDPCP.

(c) Medicaid enrollees in MDPCP are Medicaid enrollees who received or are receiving MDPCP services. Dually eligible individuals are excluded.

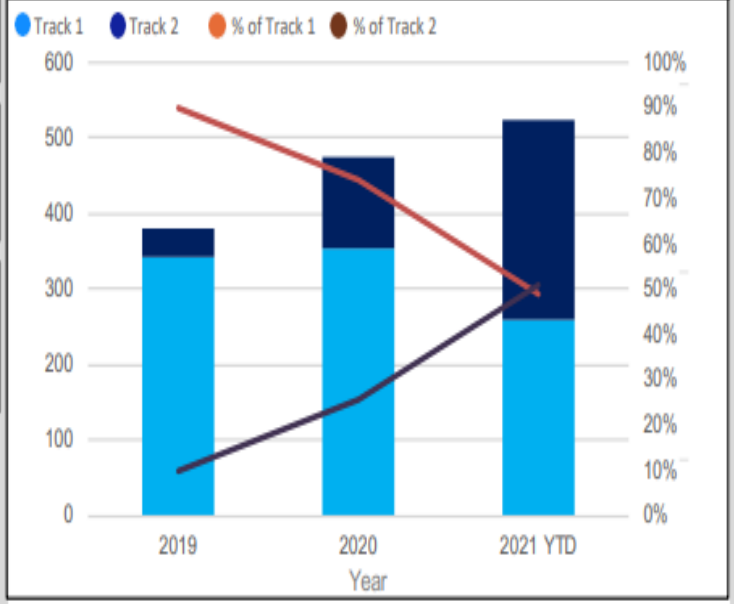
Medicare FFS Beneficiaries in MDPCP as % of Eligible Medicare FFS Population



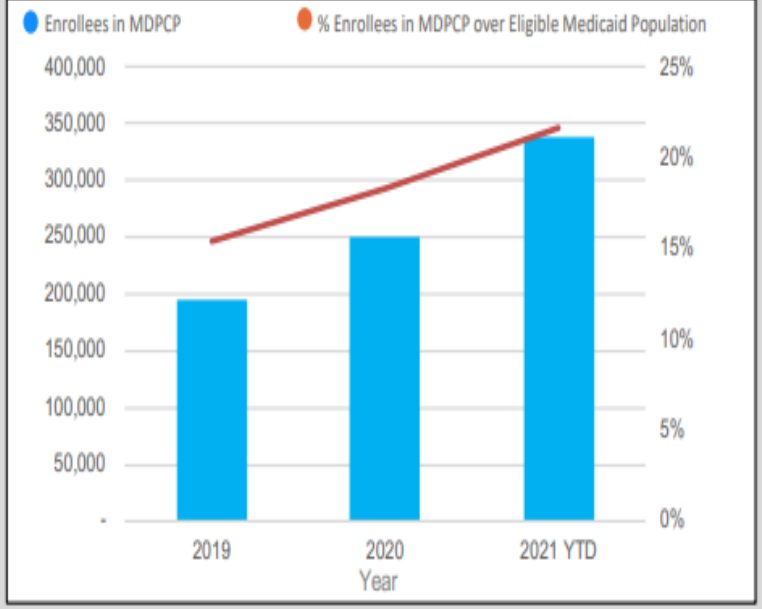
MDPCP Providers as % of Total Number of Primary Care Providers in Maryland



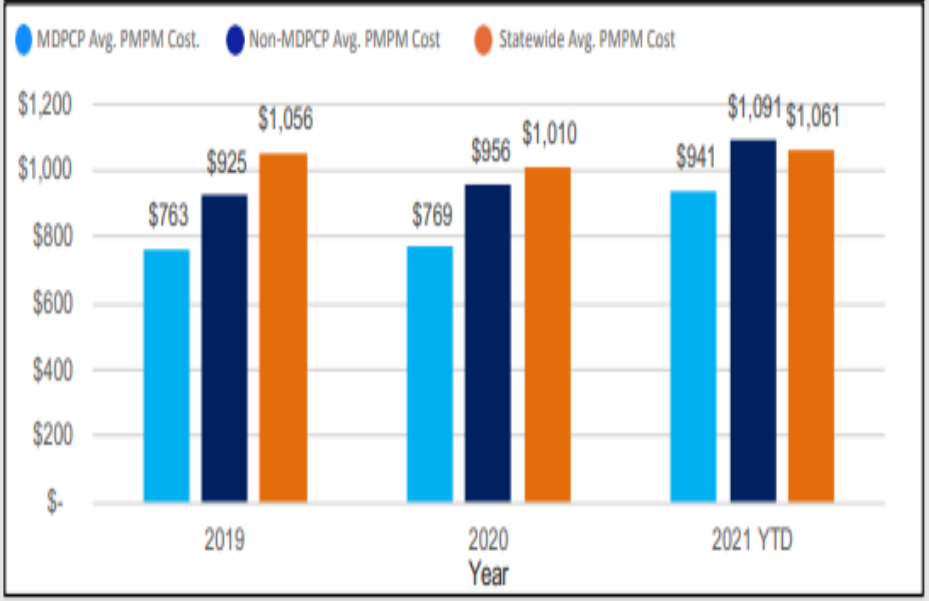
Number of MDPCP Practices by Track 1 and Track 2



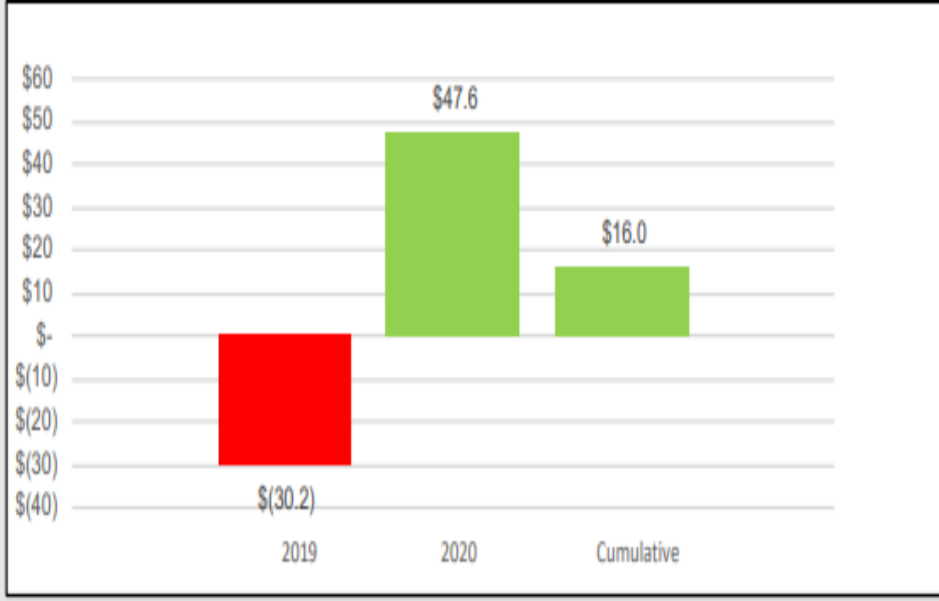
Medicaid Enrollees in MDPCP as % of Eligible Medicaid Population[b]



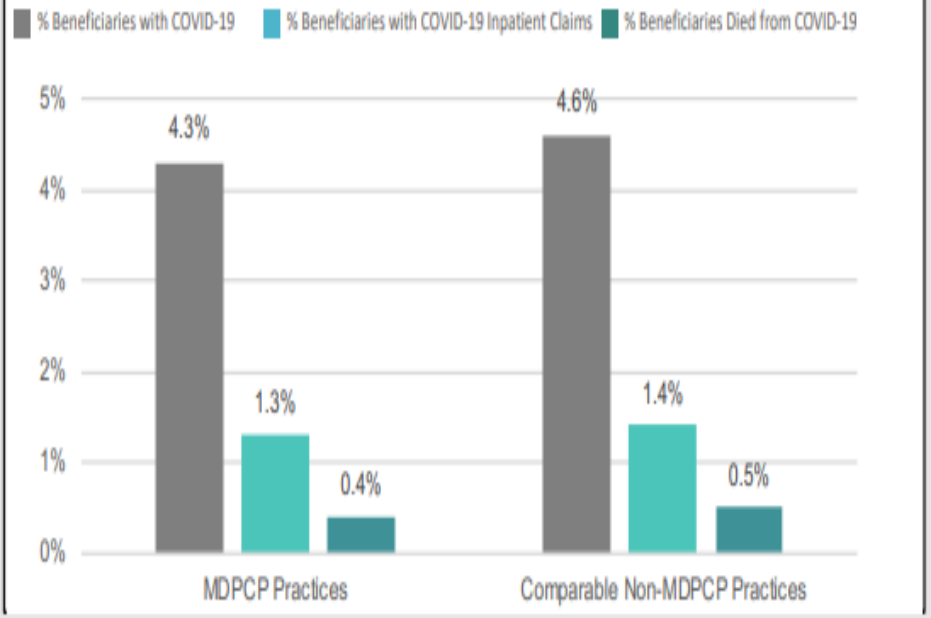
Medicare Average PMPM Cost for MDPCP, Comparable Non-MDPCP, and All Practices Statewide [a] [e]



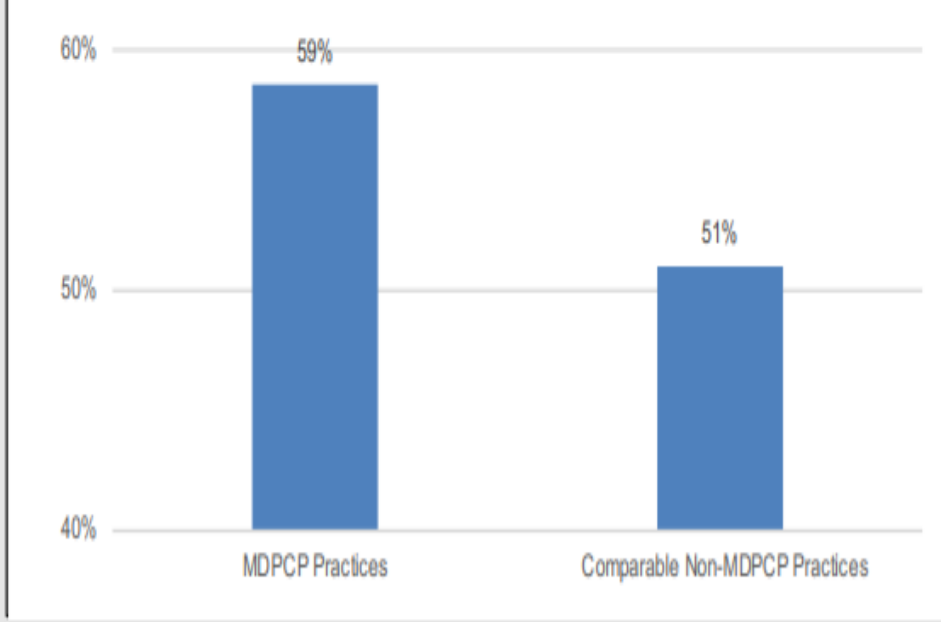
HSCRC Difference-of-Differences in Costs (Cost Savings in Millions) [b]



Percent of Medicare FFS COVID-19 Cases, Inpatient Claims, and Death Rates for MDPCP for Comparable Non-MDPCP [c] [e]



Percent of COVID-19 Medicare FFS Beneficiaries with Telehealth Claims for MDPCP for Comparable Non-MDPCP [d]



Policy Updates

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PY 2022 Policy Updates

1. Care Management Fee (CMF) – HCC Override Update
2. New Health Equity Advancement Resource and Transformation (HEART) Payment within CMF
3. Total Per Capita Cost (TPCC) Measure for Track 2 Practices
4. Loss of Advanced Alternative Payment Model (AAPM) status for PY 2022
5. Federally Qualified Health Centers (FQHCs) in Track 2

More information at CMMI Office Hours on October 28th, 12-1pm – Register here

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Track 3 – Spending and Population Based Payments

<table>
<tr><th>Issue</th><th>Status/Notes</th></tr>
<tr><td>Total Spending Level</td><td>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.. Projected at ~$70 PBPM</td></tr>
<tr><td>Population Based Payments</td><td><u>Refined Practice Average HCC Score</u>
Use the 40-20-20-10-10 percentile structure for Refined Practice Average HCC.

<table>
<tr><th>Practice HCC Group</th><th>Percentage</th></tr>
<tr><td>1) Low Risk</td><td>40</td></tr>
<tr><td>2) Low-Moderate Risk</td><td>20</td></tr>
<tr><td>3) Moderate Risk</td><td>20</td></tr>
<tr><td>4) Moderate-High Risk</td><td>10</td></tr>
<tr><td>5) High Risk</td><td>10</td></tr>
</table>

Goal is to produce the same level of variation in terms of financial impact on practices as the bene-level grouping proposed by MDH.

<u>Pending issues:</u>
How to incorporate ADI payment to Track 3 PBP?

<u>Principles:</u>
- Clear goal
- Understandable/simple to the practice?</td></tr>
</table>

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Track 3 – Flat Visit Fee

Flat visit fee payments	Additional discussion between MDH and CMMI needed. <u>Initial assumptions:</u> - Basis for FVF: weighted average approach - Permitting reimbursement of all E&M billing; do not restrict reimbursement to one billed E&M service per PCF has - Adjusting payments for facility vs. non-facility location - Cost sharing: apply a reduction factor to ensure cost-sharing neutrality for benes - Apply a reduction factor to pay 40% of the total FVF amount prospectively through the PBP. - MDH to ask hMetrix to update previous modeling w 2021/2022 PFS, etc. <u>Principles:</u> - Look at practice impacts and aggregate effect on MDPCP - PBP vs FVF balance (70/30, 60/40, 50/50) - AAPM risk should be considered (PBA divided by PBP+FVF+Medicare Part B) <u>Next steps:</u> - Analyses to determine appropriate FVF. CMMI to model.

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Track 3 – Performance Adjustment and Risk

Performance Based Adjustment (PBA)	Maintain the simplified, single step MDPCP performance assessment approach, with a PBA that is based on a utili metric, patient experience of care, eCQMs, and a Total Cost of Care metric (TPCC). eCQMs and CAHPS assessed annually; those results hold steady. CMS to run utilization and TPCC on a rolling quart basis. <u>Next steps:</u> Mostly agreed. Need to discuss with CMMI including specifics of metrics, weights, and risk thresholds. Align w Tra
Level of risk required	Additional discussion between MDH and CMMI needed To achieve AAPM status under the Medical Home Model (MHM), required minimum for <u>all practices</u> is 5% of MDF revenue at risk (denominator: all MDPCP payments and Part B billings for attributed benes). Note: Initial determin based on estimated/projected payments and reevaluated annually by QPP, based on actual payments. **Because of** **variation in MDPCP practice revenues, maximum potential risk may need to be higher to protect AAPM status.** team believes 10% downside risk may be required. 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 non risk standard to ensure that all practices in T3 qualify. <u>Principles:</u> - Spread: -10% to 25%? - Align w AAPM risk threshold for all tracks - Risk level (-10%) may be more important than gaining the AAPM status

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Track 3 – CTO Role and Payments

Role of CTOs	Additional discussion between MDH and CMMI needed The State must describe how payments to CTOs will be structured as part of the PBP and/or FVF. Unlike in Tracks 1 Track 3 payments do not include the CMF and PBIP in the form of add-ons; the Track 3 payment structure is purel replacement for certain services, so CTO payment streams could represent a significant revenue reduction for pra Keep CTO roles/payment amounts consistent with Tracks 1 and 2. Adjustments to the 50/50 and 70/30 options wi required (because CMF, PBIP, and CPCP roll into PBP vs. current split with only CMF) <u>Principles:</u> - Share payments like in T1 and T2: - % of PBP and ADI (like CMF) - No % of FVF - CTOs remain an important partner especially for smaller practices. - CTOs enable practices to remain independent from being bought out. - Review of CTOs necessary in future. <u>Next Steps:</u> A proposal from PMO is needed.

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Track 3 – Participation Options

Participation Options	Additional discussion between MDH and CMMI needed FQHCs in Track 3? Given short window for negotiation, CMMI has recommended this be addressed for a future performance year. Track 3 available as early as 2023. Track 1: All current Track 1 Practices will have up to 3 years in Track 1 before being required to make the transitior Track 2. Practices that apply for 2023 will only have 1 year in Track 1. Track 1 is completely phased out by 2024. T1: No longer available as of PY24. T2: No longer available as of PY24 Track 2 practices will be required to transition to Track 3 as follows: • 2019 starters: 2023 • 2020 starters: 2024 • 2021 starters: 2025 • 2022 starters: n/a • 2023 starters: 2025

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