MDPCP Track 3

Policy Discussion

Overview

The State MDPCP Program Management Office, in conjunction with and supported by the MDPCP Advisory Council, offer the following Policy Statements to guide the development of an MDPCP Track 3.

As requested by CMMI, it is important to note that from the onset of this process and consistently over the past six months that every effort was made to maintain fidelity to the design of the soon to be launched, Primary Care First model (PCF). Aligned with PCF, the MDPCP Track 3 policies offered here maintain that fidelity in the following areas:

- shift from FFS to Population based risk stratified payments with a fixed flat fee for face to face visits
- combining those payments into total primary care payments and applying a performance based adjustment
- asymmetric risk payment adjustments for practice performance.

Departures from PCF occur in the details that derive from the divergent goals of PCF and MDPCP/TCOC. The requested changes are supported by policy decisions made by the State in conjunction with stakeholders in the MDPCP Advisory Council. Modifications from the PCF design are recommended in order to conform to the State's population health goals and fit within the broader goals and design of the TCOC contract.

The Policy statements are presented in the following order:

1. Track 3 Payment Goal
2. PBP payment structure based on payment goal: Practice-level vs. Beneficiary-level
3. Balancing Flat fee and Population Based Payment
4. Asymmetric Risk
5. Performance based adjustment and quality framework
6. Track 3 mandatory status and phasing out Track 1 and Track 2
7. Care transformation Organizations role in Track 3

Track 3 Payment Goal

Policy: To provide sufficient resources for primary care to do the work of longitudinal care management, acute care and prevention, Track 3 should make primary care investment above current Track 2 MDPCP level (prior to Performance Based Adjustment) based on an average overall program PBPM equivalent. The additional funds will assure that this voluntary program is sufficiently attractive to primary care practices and providers across the state to insure sustained broad implementation. Investment above Track 2 could then be determined in accordance with literature supported estimates of investment needed to provide comprehensive primary care to a Medicare FFS population.

PBP payment structure based on payment goal: Practice-level vs. Beneficiary-level

Policy: The State recommends using beneficiary-level HCC score risk adjusted payments as the framework risk to ensure that appropriate adjustments are received for high-risk patients and not adversely affected by average risk scores. Adjustments to the payment levels within the beneficiary HCC bands would be made to meet the payment goal. The HCC score corridors under PCF may be maintained with adjustments made to the payments in each tier to meet the overall investment goals of the program.

Balancing Flat fee and Population based payments

Policy: The population based payment (PBP) should account for the majority of the total primary care payment. The flat visit should provide neither an incentive nor disincentive to the provision of face to face visits and represent less than 50% of the Total Primary Care Payment. The fee should be adjusted for 2021 and regional variation. The exact level of the fee can be constructed based on overall investment strategy, the goal of having the majority of payments as population based and the impact on the setting of payments within HCC tiers.

Asymmetric Risk

Policy: The State supports an asymmetric risk framework while adding the ability of practices to select from a menu of downside risk levels, ranging from negative 1% to negative 10% and their corresponding upside risk levels ranging from 5% to 50%. Practices would be required to increase their risk over time as they adjust to new budgeting and payment strategies Similar to the CPCP, practice risk should ramp up over time in a stepwise manner. The top tier risk levels would be allowed to differ between practices but must achieve a minimum of 5% down and 25% upside over 5 successive annual steps. Practices would not be permitted to reduce levels of risk. The details on the minimum risk and the ramp up sequence can be discussed in a subsequent iteration.

Performance Based Adjustment and Quality Framework

Policy: Due to the extreme complexity of the PCF PBA and an over-reliance on AHU, the State recommends a performance-based adjustment that mirrors the current MDPCP adjustment with meaningful, easily measurable, actionable, weighted quality and utilization measures aligned with the States Integrated Health Improvement Strategy. The State agrees with the adjusting the Total Primary Care Payment based on this performance framework. The State further recommends that performance adjustments be made on an annual basis in order to stabilize budgeting for practices and simplify reporting and reduce administrative burdens.

The State recommends a simplified performance based adjustment (PBA) that accounts for quality and utilization performance. Adjustments would be made on an annual basis. The framework would align directly with the State's population health goals and support integration with existing Track 1 and 2 performance measurement. The measures would apply to all tracks in MDPCP. The State recommends using a performance adjustment that mirrors the current MDPCP performance adjustment methodology used for the PBIP, but encompasses an adjustment of the total primary care payment, not just a PBIP. This adjustment should use measures that are aligned with the state's goals, have high impact, and are actionable by primary care. Measures should be individually weighted based on impact and action, the ability to be influenced by primary care. We would eliminate the "all or none" Quality Gateway model in favor of the weighted individual measure model.

CTO Role in Track 3

Policy: Retain the role of CTOs as formal partners in MDPCP. The State believes this novel system and CTO structure has worked well to-date, and adds relatively minimal cost in exchange for the tremendous benefits and support system provided to primary care practices. As we move to Track 3, the portion of Total Primary Care Payment that practices chose to share with CTOs for their support on a voluntary basis will need to be modeled and refined. Since the TPCP is already linked to the PBA there will not be a need to add a separate PBIP for CTOs. The State will continue to manage the "arrangements" between practices and CTOs as well as the overall statewide CTO organizational structure, meetings, and communications.

Track 3 is mandatory for all participating practices

Policy: Track three will be phased in between 2023 and 2026 and will be the only track thereafter. The ~550 practices (as of PY 2021) that are currently in MDPCP will have the opportunity to apply to Track 3 beginning in 2023. Any new applicants beginning in 2023 will only have the Track 3 option. Track 2 will phase out ending in 2025 with all practices required to apply for Track 3 during 2025 or exit the program.

Track 1 will be offered in the RFA for new practices for the last time in 2021. 2021 Track 1 starters will be allowed only 2 years to achieve track 2 status or will be required to exit the program. These practices will then be in Track 2 no later than 2024 and will be required to enter track 3 no later than 2026.

Current Track 1 practices that began in 2019 will have entered Track 2 no later than 2022 or have exited the program. Current Track 1 starters during 2020 will have entered Track 2 no later 2023 or have exited the program. Both of these program year 1,2 starters will then also be required to enter Track 3 by 2026 or exit the program.

Track 3 will be the only track for MDPCP beginning in 2026 for current MDPCP practices and the only track offered in subsequent RFAs. The table below lays out the recommended transitions and options.

Table: Summary of Options for Track 1 practices

Track 1	Transition to T2 by this PY	Transition to T3 by this PY	Time in T3
2019 starters	2022	2025	2 years
2020 starters	2023	2026	1 year
2021 starters	2024	2026	1 year
2022 starters	2024	2026	1 year

2023 starters	2024	2026	1 year

*There will be no more Track 1 starters beginning in 2024. Track 1 2022 starters have 2 years to transition to T2. Track 1 2023 starters have 1 year to transition to Track 2.

Table: Summary of Options for Track 2 practices

Track 2	**Transition to T3 by this date**	**Time in T3**
2019 starters	2023	4 years
2020 starters	2023	4 years
2021 starters	2024	3 years
2022 starters	2025	2 years
2023 starters	2026	1 year

*2019-2023 starters are required to transition to Track 3 by the end of the 3rd year of participation in Track 2.

Table: Summary of Options for Track 3 practices

Track 3	**Time in T3**
2023 starters	4 years
2024 starters	3 years
2025 starters	2 year
2026 starters	1 year