MDPCP Program Update

DRAFT

TRACKS 2 AND 3

NOVEMBER 18, 2021

MDPCP Overview

- The Total Cost of Care Model (model) is designed to coordinate care for patients across hospital and non-hospital settings, improve health outcomes, and constrain the growth of health care costs in Maryland
- A key element of the model is the Maryland Primary Care Program (MDPCP), a voluntary program open to all qualifying Maryland primary care providers that provide funding and support for the delivery of advanced primary care and overall health care transformation:
  - MDPCP providers play an increased role in preventative care, chronic disease management, and reducing unnecessary hospital utilization
  - Participation snapshot: Medicare beneficiaries – 396,702; Medicaid enrollees – 335,287; Track 1 practices – 259; Track 2 practices – 266; Total providers – 2,166 *(see MDPCP Performance slides, 15-19 for more information)*

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Track 2 – 2022 Changes

- Care Management Fee (CMF) – calculated based on individual Hierarchical Condition Category (HCC) risk score (i.e., the degree of patient illness), Complex Tier modification:
  - Updated HCC risk scoring categories includes two of the three Complex Tier conditions in Tiers 1-4: substance use disorder and severe and persistent mental illness, only dementia remains in the Complex Tier (Tier 5)
- The addition of a Health Equity Advancement Resource and Transformation (HEART) payment included in the CMF to provide support for serving socioeconomically disadvantaged populations

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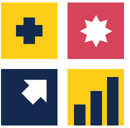

Track 2 – 2022 Changes *(Continued)*

- The addition of a Total Per Capita Cost (TCOC) measure – a payment-standardized, risk-adjusted and specialty-adjusted cost measure:
  - Evaluates the overall costs of care (Parts A and B) during a specified period
  - Observed costs are compared with expected costs and risk-adjusted for beneficiary comorbidities
  - TCOC measure is calculated annually using a Maryland benchmark:
    - Track 2 and Federally Qualified Health Centers (FQHCs) can retain zero, some, or all the performance-based incentive payment *(calculated at 25 percent of the performance-based incentive payment, incentives are paid when observed costs are less than expected costs)*

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Track 2 – 2022 Changes *(Continued)*

- Elimination of the Advanced Alternative Payment Model (AAPM) eligibility status for Program Year 2022:
  - AAPM (part of the Quality Payment Program) offers a five percent incentive for achieving a certain threshold on Part B services; the risk standard requirement increased from three to five percent in 2021
  - Insufficient proportional increase in payment at risk resulted in some practices missing the required AAPM five percent at risk threshold
  - All practices are required to meet the risk standard to maintain AAPM program eligibility *(10 percent program-wide)*
- FQHC participation allowed in Track 2, previously limited to Track 1

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MDPCP Model Goals – Track 3 Aligned With Primary Care First

- Primary Care First (PCF) is a Centers for Medicare & Medicaid Services (CMS) program that aims to improve quality and patient experience of care and reduce expenditures *(see CMS PCF Excerpt slides, 20-25 for more information)* :
  - Supports practices caring for patients with complex and chronic needs
  - Specific approaches to care delivery are determined by practice priorities
  - Incentivizes practices to deliver patient-centered care that reduces acute hospital utilization
  - Comprehensive primary care functions include access and continuity; care management; comprehensiveness and coordination; patient and caregiver engagement; and planned care and population health

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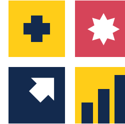

PCF Overview

- PCF aims to be transparent and hold practices accountable through a payment structure that includes:
  - A flat office visit fee (FVF) payment that encourages patient-centered care and compensates practices for in-person treatment
  - A population-based payment (PBP) to provide more flexibility in the provision of patient care
  - Enable and motivate continuous practice improvement by providing practices with identifiable transparent performance information to enable
  - A quarterly performance-based adjustment (PBA) providing an upside of up to 50 percent of model payments and a downside risk of 10 percent of payments aimed to provide incentives to reduce costs and improve quality

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Track 3 Development Progression

- December 2020 – the Program Management Office (PMO) submitted a framework proposal to the Center for Medicare & Medicaid Innovation (CMMI) within CMS
- February 2021 – CMMI notified the PMO that the framework was not accepted; requested greater alignment with PCF
- Efforts to align the framework more closely with PCF have continued throughout the year and include:
  - MHCC staff consultative support to the PMO
  - Meetings of the Advisory Council to provide the PMO with feedback on framework design
  - Weekly policy meetings with CMMI and with Medicaid

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Track 3 Development Progression *(Continued)*

- November 2021 – the PMO plans to submit a revised framework to CMMI by the end of the month
- Second quarter 2022 – CMMI feedback anticipated on the framework

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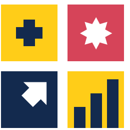

Key Track 3 – Design Principles

- Payment Goal – total Track 3 spending level should maintain Track 2 aggregate spending ($141M); individual practice total payment may vary from Track 2 to Track 3
- Elements:
  - PBP and a fixed FVF combined into a total primary care payment
  - PBA includes quality (50 percent), utilization (25 percent) and efficiency component (25 percent: Total Per Capita Cost)
  - Level of financial risk consistent with PCF
  - A HEART payment included in the CMF
  - Inclusion of Care Transformation Organizations (CTOs)
  - Mandatory Track 3 progression based on start year in the program

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CMMI Recent Determinations – Track 3

- HEART payment impact on AAPM status (calculated at the program level):
  - Beneficiaries must be in the 4th Tier HCC risk score or the Complex Tier (dementia diagnosis) and fall into the highest deprivation quintile of the Area Deprivation Index (ADI), which is a measure of socioeconomic neighborhood deprivation
  - Payment amount $110 per beneficiary
- AAPM risk level (program): 10 percent
- FVF payment amount:
  - Non-facility - $52.80
  - Facility - $42.07

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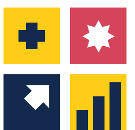

CMMI Recent Determinations – Track 3

(Continued)

- CTO and practice sharing arrangement of CMF – 50/50 or 70/30
- Transition to Track 3 timeframe – Track 1 no longer available in 2024 and all Track 2 practices must transition by the beginning of 2025:
  - Phase in Track 3 based on practice start date: 2019 – 2023, 2020 – 2024, 2021- 2025, 2023 – 2025

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THE END

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MDPCP Performance

Oct 27, 2021

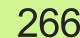
Program Summary

Statewide Statistics Current Year

396,702 [b]
Medicare Benes in MDPCP (**+11%** vs Prior Year End)

335,287 [c]
Medicaid Enrollees in MDPCP (**+10%** vs Prior Year End)

61,415
Total Dual Eligibles (**+22%** 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)

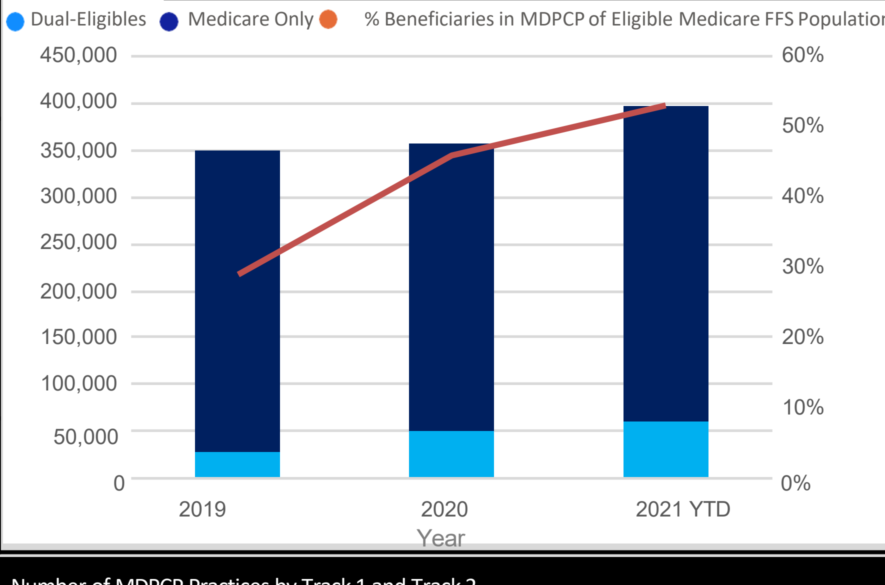
2,166
Total Providers (**+8%** vs Prior Year End)

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

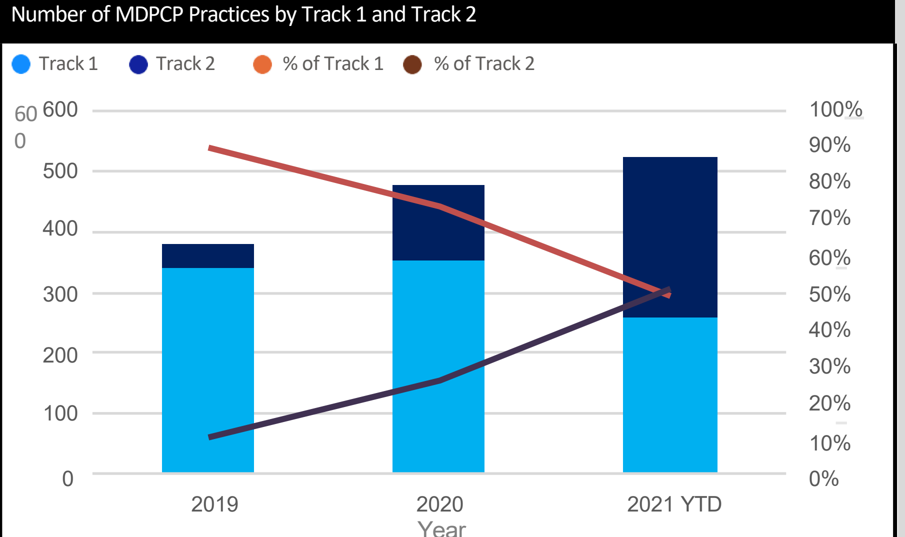
(b) Including Dually Eligible Beneficiaries in MDPCP.

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

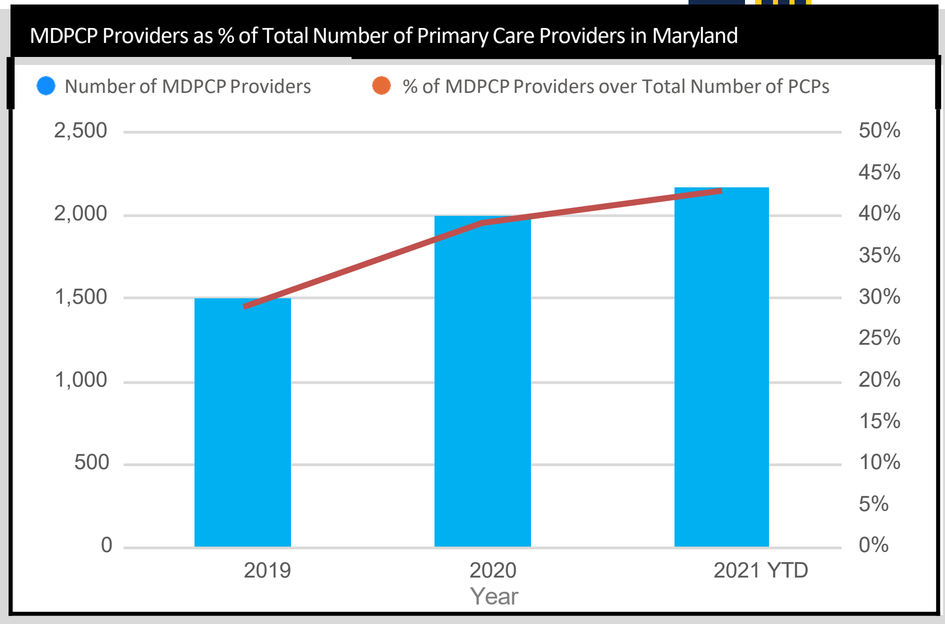
Medicare FFS Beneficiaries in MDPCP as % of Eligible Medicare FFS Population



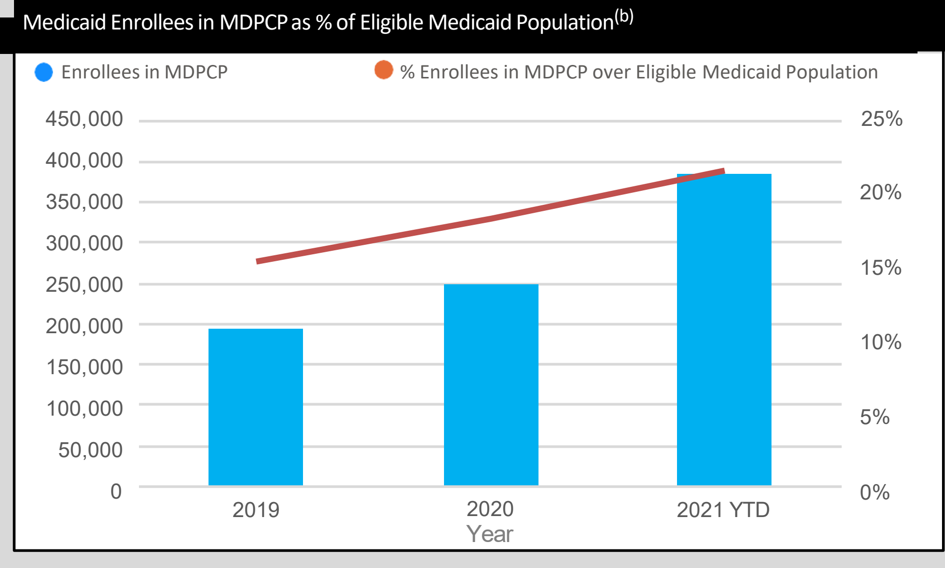
Number of MDPCP Practices by Track 1 and Track 2



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



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



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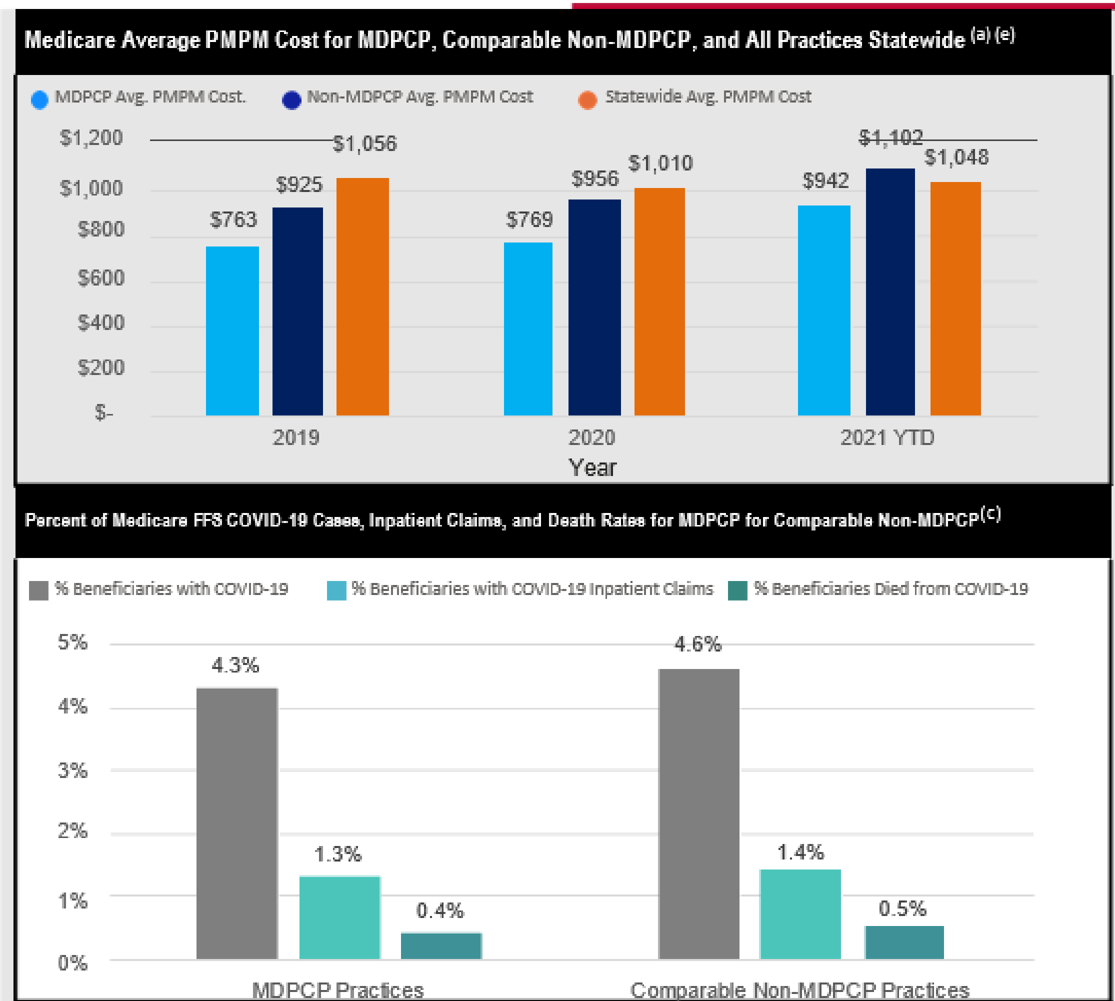
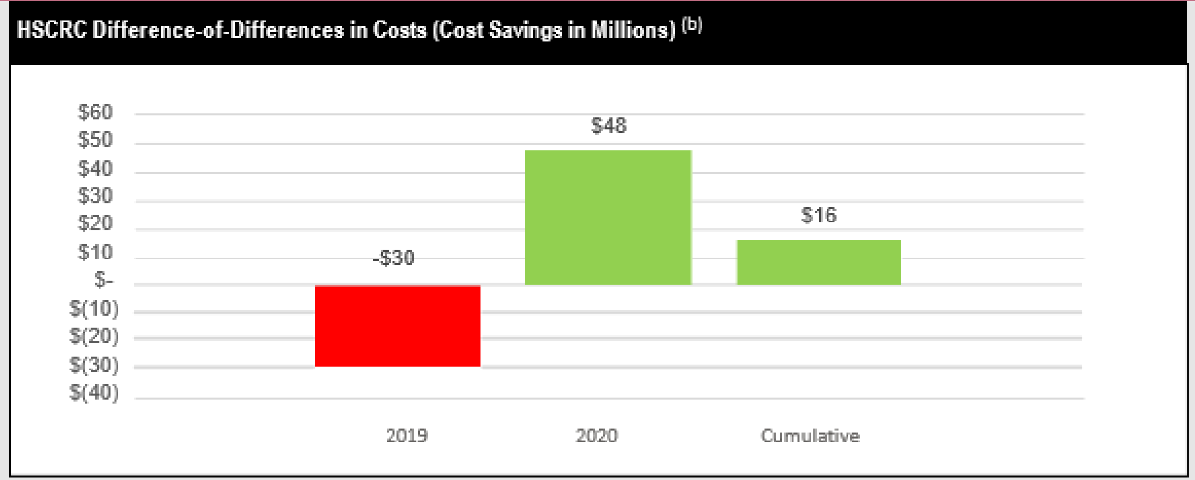
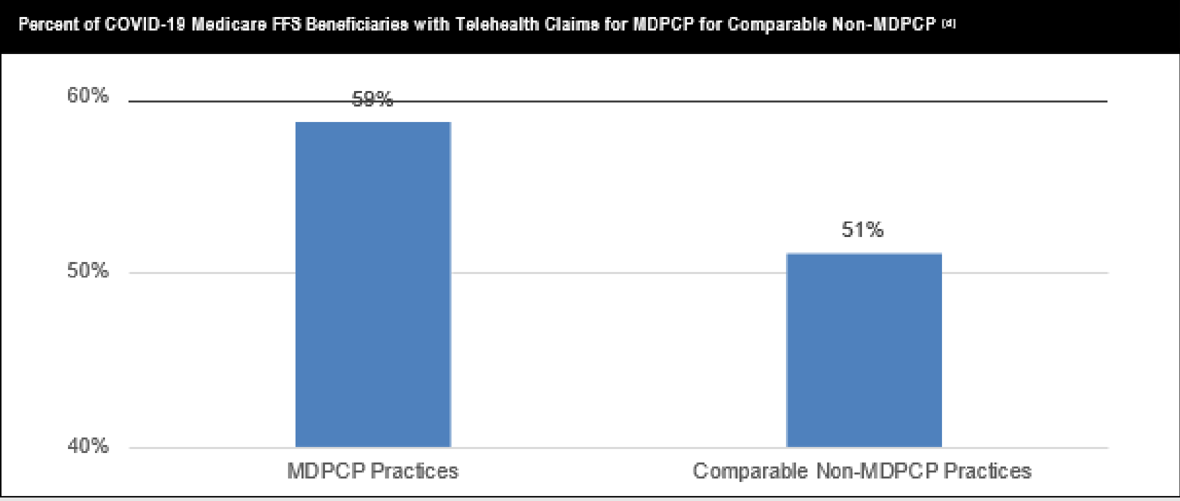
Costs Savings & COVID-19 Data







(a) Comparable Non-MDPCP practices represent primary care practices that do not participate in the MDPCP program but serve patients that are demographically comparable to those served by MDPCP practices.

(b) These data represent cost savings calculated by HSCRC (after care management fees) that can be attributed directly to MDPCP.

(c) The difference in rates are statistically significant at the 5% level. More information can be found here: https://www.milbank.org/publications/improving-covid-19-outcomes-for-medicare-beneficiaries-a-public-health-supported-advanced-primary-care-paradigm/

(d) Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and to manage health care.

(e) Data are through May 2021.

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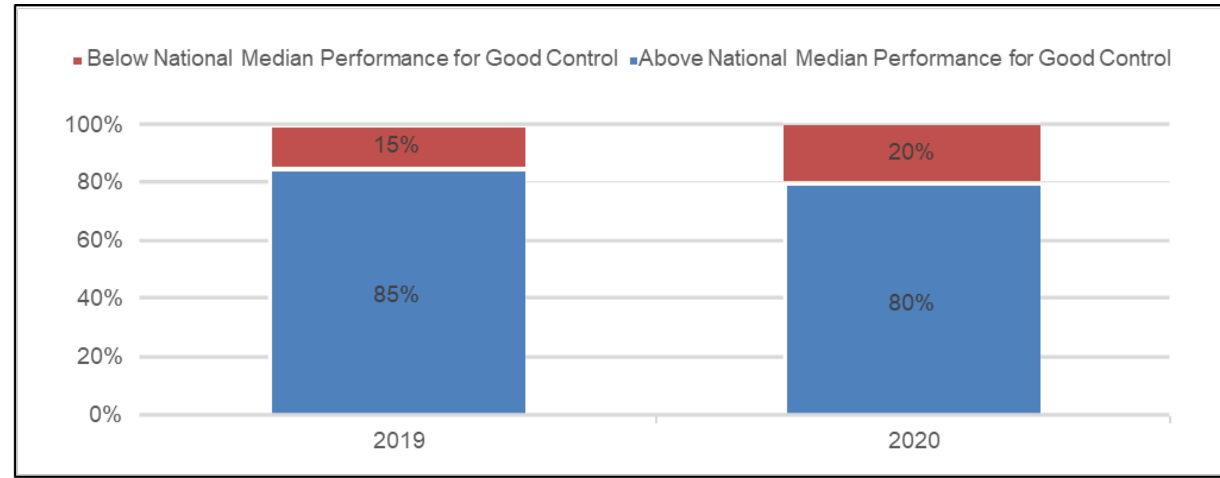
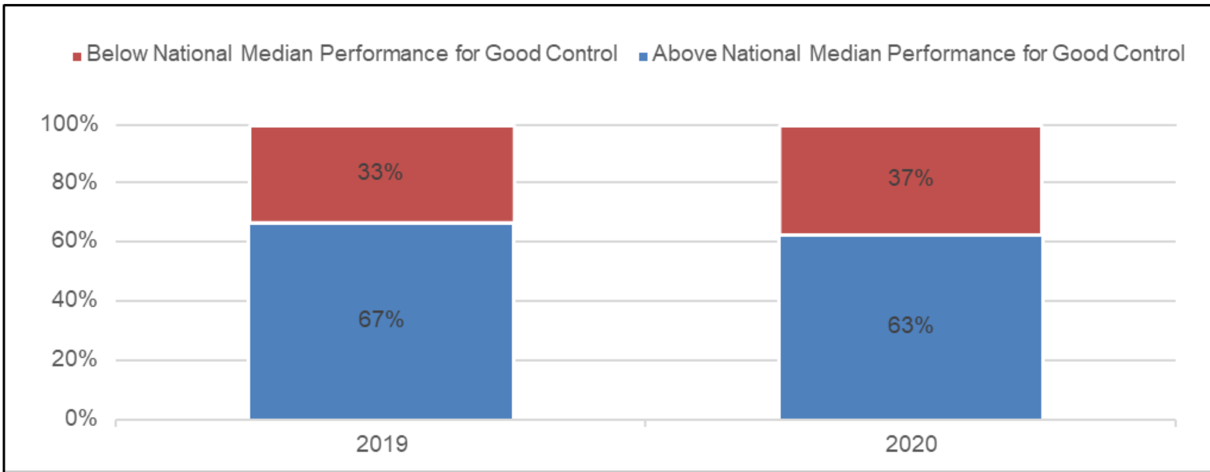
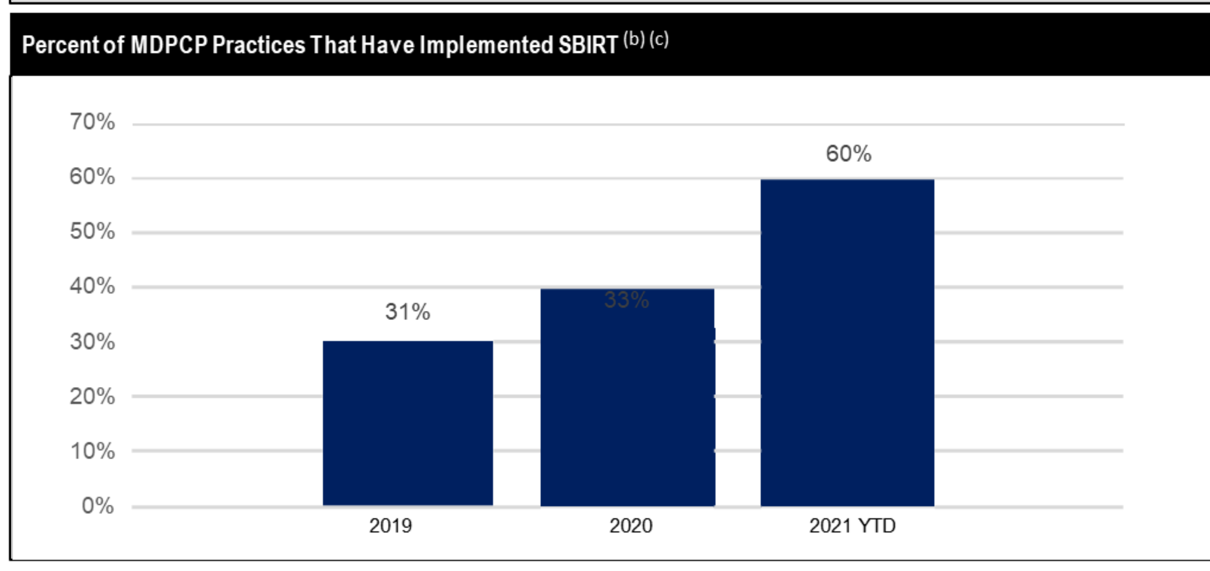
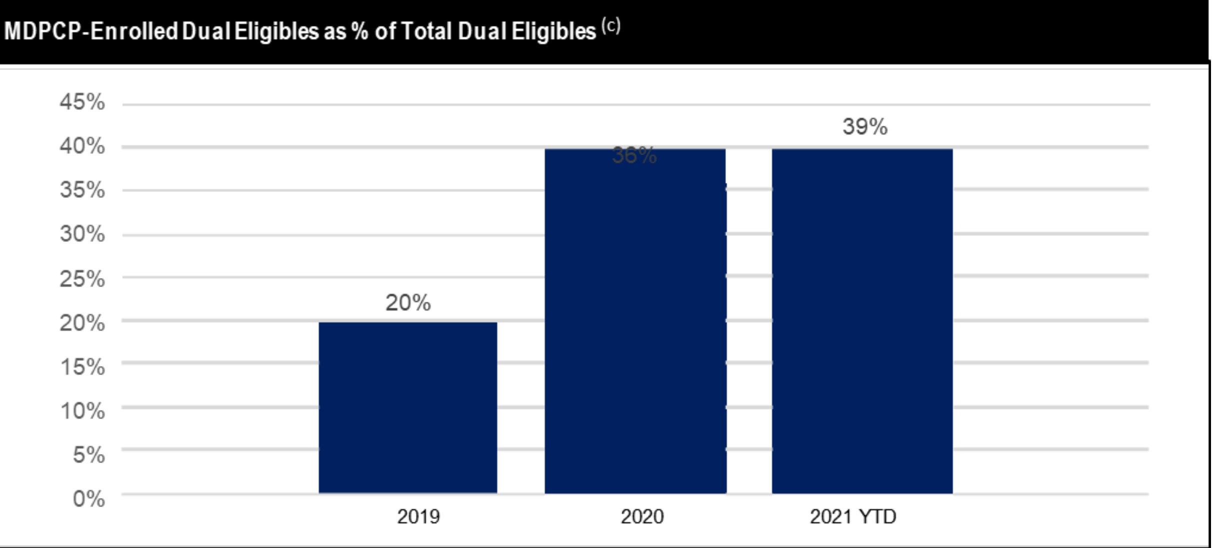
Practices Quality







Year



Year

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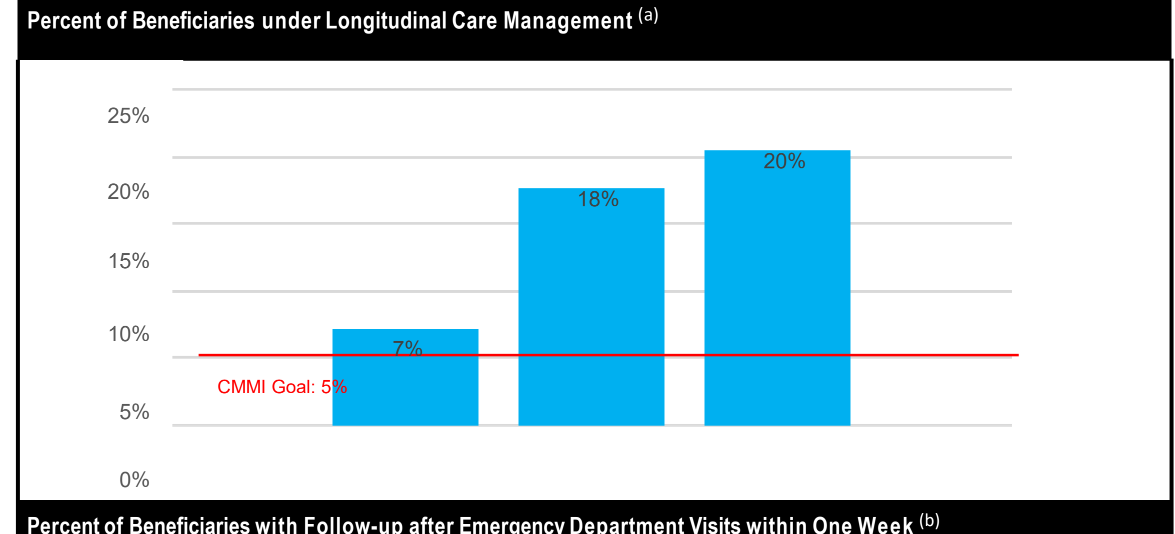
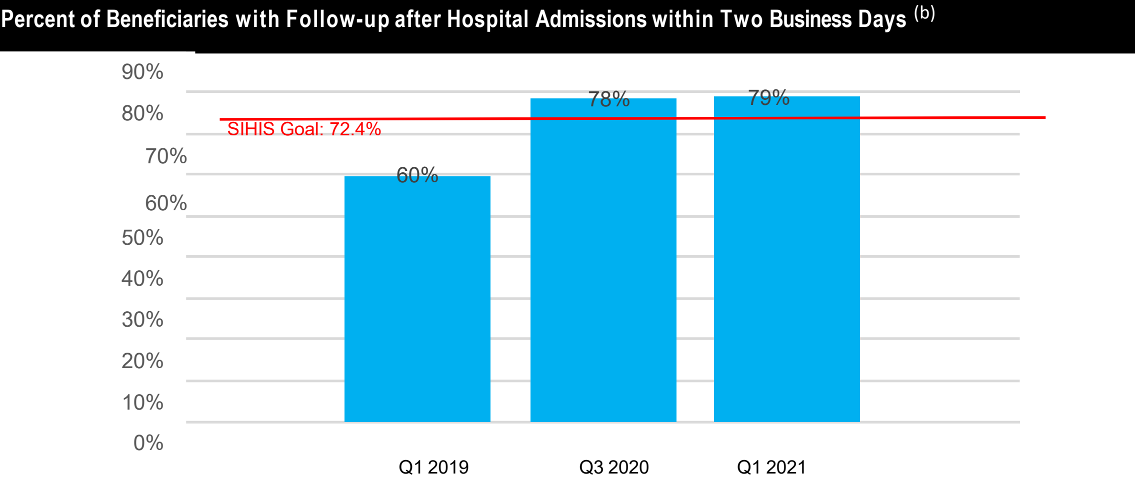
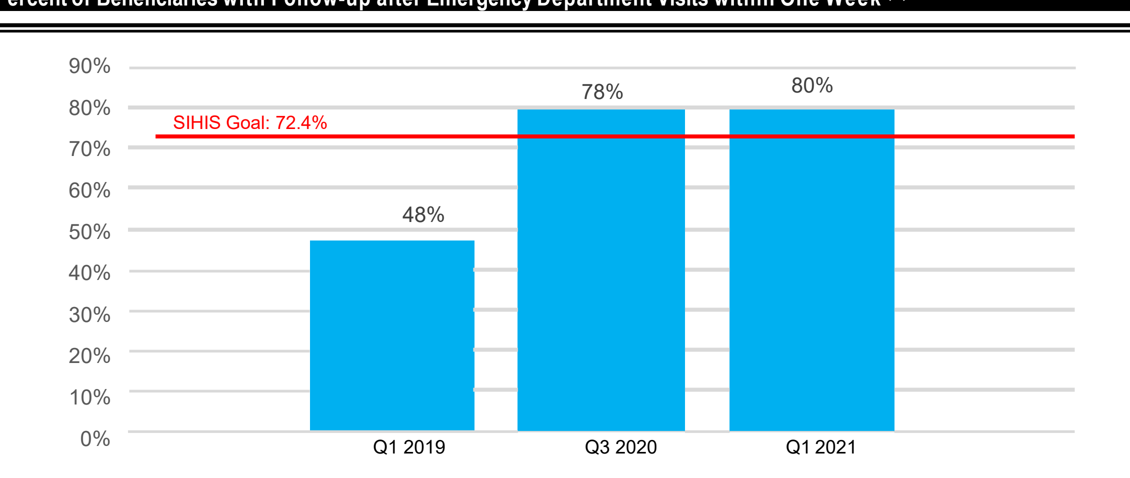
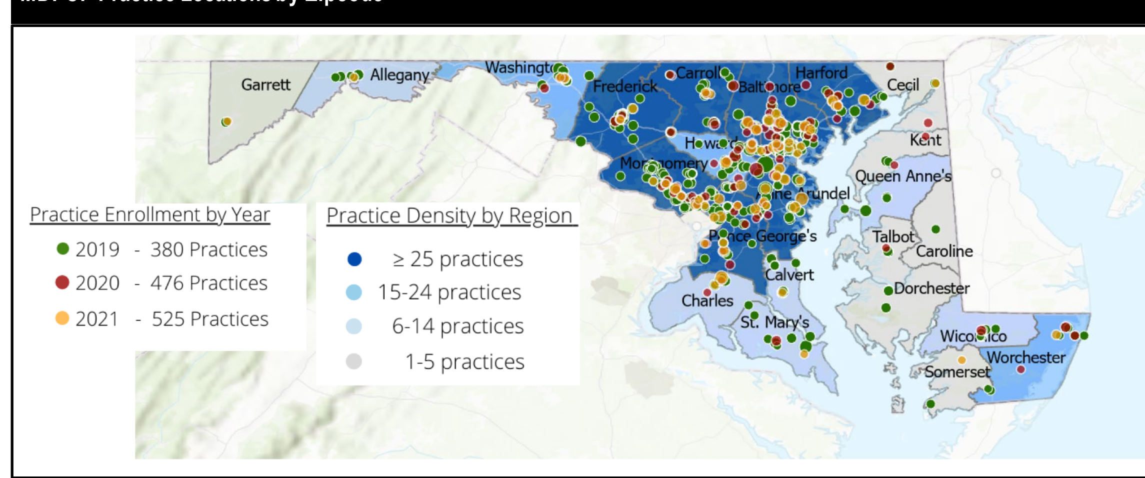
Practices Follow Up









(a) CMMI (Centers for Medicare & Medicaid Services Innovation Center) develops and tests new healthcare payment and service delivery models to improve patient care and reduce costs.

(b) SIHIS (Statewide Integrated Health Improvement Strategy) is designed to engage state agencies and private-sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs.

(c)Green represents the MDPCP practices that enrolled in 2019, red represents those that enrolled in 2020, orange represents those that enrolled in 2021.

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CMS PCF Excerpt

Primary Care First

Foster Independence. Reward Outcomes.

Model Briefing

Center for Medicare & Medicaid Innovation

Primary Care First Rewards Value and Quality Through an Innovative Payment Structure

Primary Care First Goals

1. To **reduce Medicare spending** by preventing avoidable inpatient hospital admissions
2. To **improve quality of care and access to care** for all beneficiaries, particularly those with complex chronic conditions and serious illness

Primary Care First Overview

5-year alternative payment model

Offers greater **flexibility**, increased **transparency**, and **performance-based** payments to participants

Payment options for practices that specialize in **patients with complex chronic conditions** and high need, **seriously ill populations**

Fosters **multi-payer alignment** to provide practices with resources and incentives to enhance care for all patients, regardless of insurer

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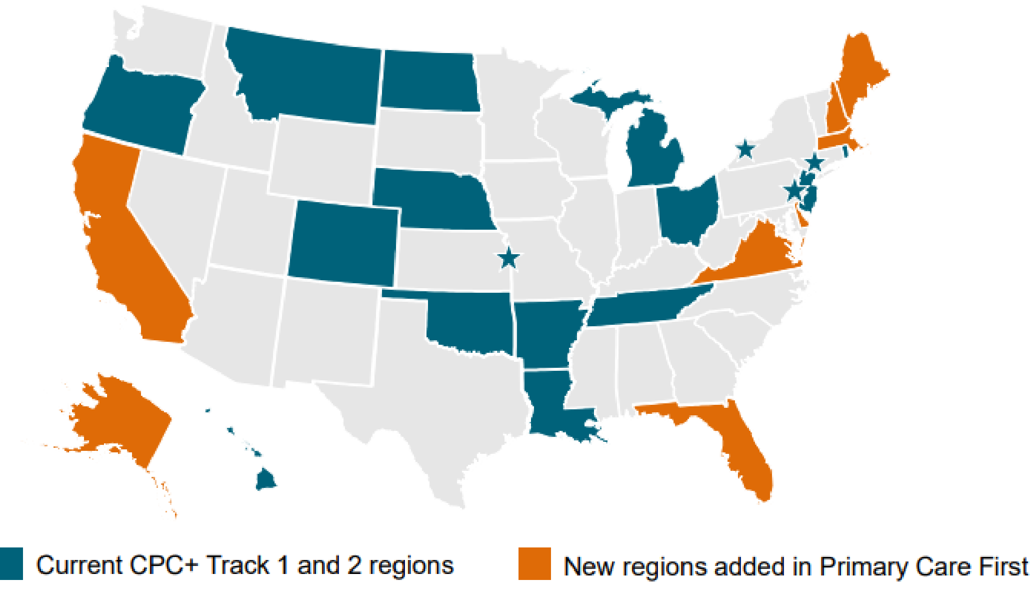
Primary Care First Will Be Offered in 26 States and Regions Beginning in 2021

In 2021, Primary Care First will include 26 diverse regions:



Current CPC+ Track 1 and 2 regions

New regions added in Primary Care First

Total Primary Care Payment Promotes Flexibility in Care Delivery

The Total Primary Care Payment is a hybrid payment that incentivizes advanced primary care while **compensating practices with higher-risk patients**.

Population-Based Payment

Payment for service in or outside the office, adjusted for practices caring for higher risk populations. This base rate is the same for all patients within a practice.

Practice Risk Group	Payment (per beneficiary per month*)
Group 1: Average Hierarchical Condition Category (HCC) <1.2	$28
Group 2: Average HCC 1.2-1.5	$45
Group 3: Average HCC 1.5-2.0	$100
Group 4: Average HCC >2.0	$175

Payment will be reduced through calculating a "leakage adjustment" if beneficiaries seek primary care services outside the practice.

+

Flat Primary Care Visit Fee

Payment for in-person treatment that reduces billing and revenue cycle burden.

$40.82

per face-to-face encounter

Payment amount does not include copayment or geographic adjustment

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on billing and coding and more time with patients

* PBPM = Per Beneficiary Per Month

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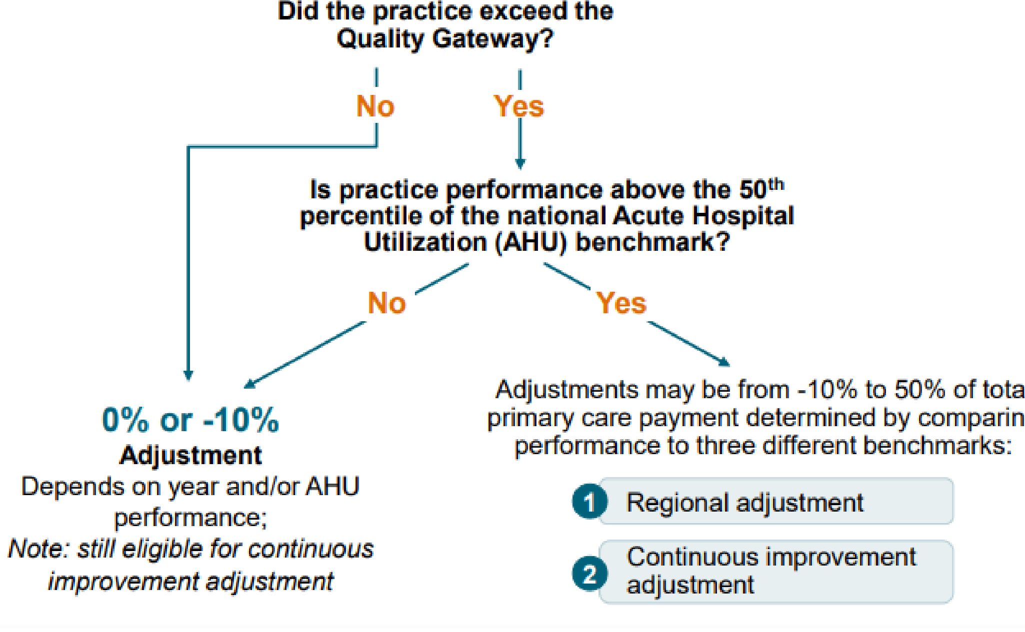
Performance-Based Payment Adjustments Are Determined Based on a Multi-Step Process

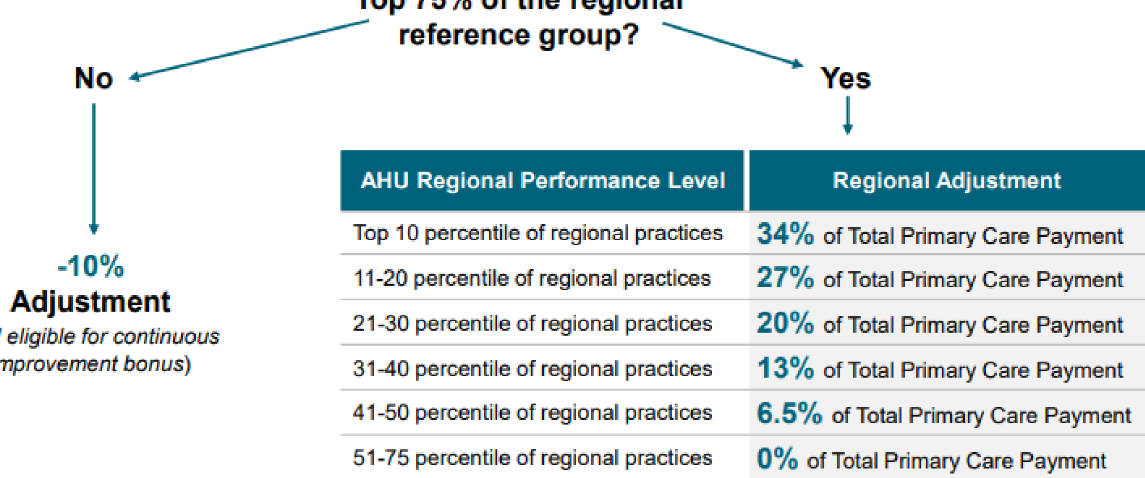
In **Year 1**, adjustments are determined based on **acute hospital utilization (AHU)** alone.
In **Years 2-5**, adjustments are based on performance as described below.



Regional Adjustment Compares Acute Hospital Utilization to a Regional Benchmark

1 Regional adjustment

Practices that exceed the 50th percentile AHU minimum benchmark will earn a PBA based on how they perform relative to regional practices.



AHU Regional Performance Level	Regional Adjustment
Top 10 percentile of regional practices	34% of Total Primary Care Payment
11-20 percentile of regional practices	27% of Total Primary Care Payment
21-30 percentile of regional practices	20% of Total Primary Care Payment
31-40 percentile of regional practices	13% of Total Primary Care Payment
41-50 percentile of regional practices	6.5% of Total Primary Care Payment
51-75 percentile of regional practices	0% of Total Primary Care Payment

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Practices Achieving Improvement Targets are Eligible for a Continuous Improvement Adjustment

2 Continuous improvement adjustment

Practices are also eligible for a **continuous improvement (CI) bonus of up to 16% of the possible 50% PBA amount** if they achieve their improvement target. CMS may use statistical approaches to account for random variations over time and promote reliability of improvement data.

Acute Hospital Utilization (AHU) Regional Performance Level	Potential Improvement Bonus
Top 10 percentile of regional practices	16% of Total Primary Care Payment
11-20 percentile of regional practices	13% of Total Primary Care Payment
21-30 percentile of regional practices	10% of Total Primary Care Payment
31-40 percentile of regional practices	7% of Total Primary Care Payment
41-50 percentile of regional practices	3.5% of Total Primary Care Payment
51-75 percentile of regional practices	3.5% of Total Primary Care Payment
Practices performing in the bottom quartile of their region	3.5% of Total Primary Care Payment

The Model's Quality Strategy for Practice Risk Groups 1-2 Includes a Focused Set of Clinically Meaningful Measures

The following measures for **Practice Risk Groups 1-2** will inform performance-based adjustments and assessment of quality of care delivered.

Measure Type	Measure Title	Model Years
Utilization Measure for Performance-Based Adjustment Calculation (Calculated Quarterly)	**Acute Hospital Utilization** (AHU) (HEDIS measure)	Years 1-5
Quality Gateway (Calculated Annually)	**Patient Experience of Care Survey** (CAHPS® with supplemental items)	Year 2-5
	Diabetes: Hemoglobin A1c (HbA1c) **Poor Control** (>9%) (eCQM)	
	Controlling High Blood Pressure (eCQM)	
	Advance Care Plan (MIPS CQM measure)	
	Colorectal Cancer Screening (eCQM)	

Practices in Risk Groups 3-4 and practices accepting SIP patients are evaluated on a different set of quality measures— see the next slide for details.

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Quality Measures for Practice Risk Groups 3-4 (and SIP) Account for Patients' Clinical and Supportive Needs

Practices in **Risk Groups 3-4** and practices accepting SIP patients are evaluated on a different set of quality measures than Risk Groups 1-2.

Measure Title	Model Years
Advance Care Plan (MIPS CQM measure) *(also used for Practice Risk Groups 1-2)*	Years 1-5
Total Per Capita Cost (MIPS claims measure)	Years 1-5
CAHPS® (beneficiary survey)	Years 2-5 (but administered in Year 1)
24/7 Access to a Practitioner (beneficiary survey)	Years 3-5
Days at Home (claims measure)	Years 3-5

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