Maryland Primary Care Program
Maryland Health Care Commission Meeting

July 21, 2022

MDPCP Management Office

Chad Perman, Executive Director

MDPCP in 2022

Support infrastructure – 24 Care Transformation Organizations

Statewide – Practices in every county

PARTICIPANTS	2019	2020	2021	2022
Practice sites	380	476	562	545**
Providers in MDPCP	~1,500	~2,000	~2,150	~2,150
FFS beneficiaries attributed†	220,000 (28,717 duals)	356,000 (45,031 duals)	392,000 (60,000 duals)	374,000
Marylanders served	2,000,000 – 3,000,000*	2,700,000 – 3,800,000*	over 4,000,000*	over 4,000,000*

** ***545 sites*** **– 7 FQHC organizations represent 44 site locations (508 official participants)**

* *The Annals of Family Medicine*, 2012 http://www.annfammed.org/content/10/5/396.full

†Data reflects highmark of each year

MDPCP Performance Dashboard

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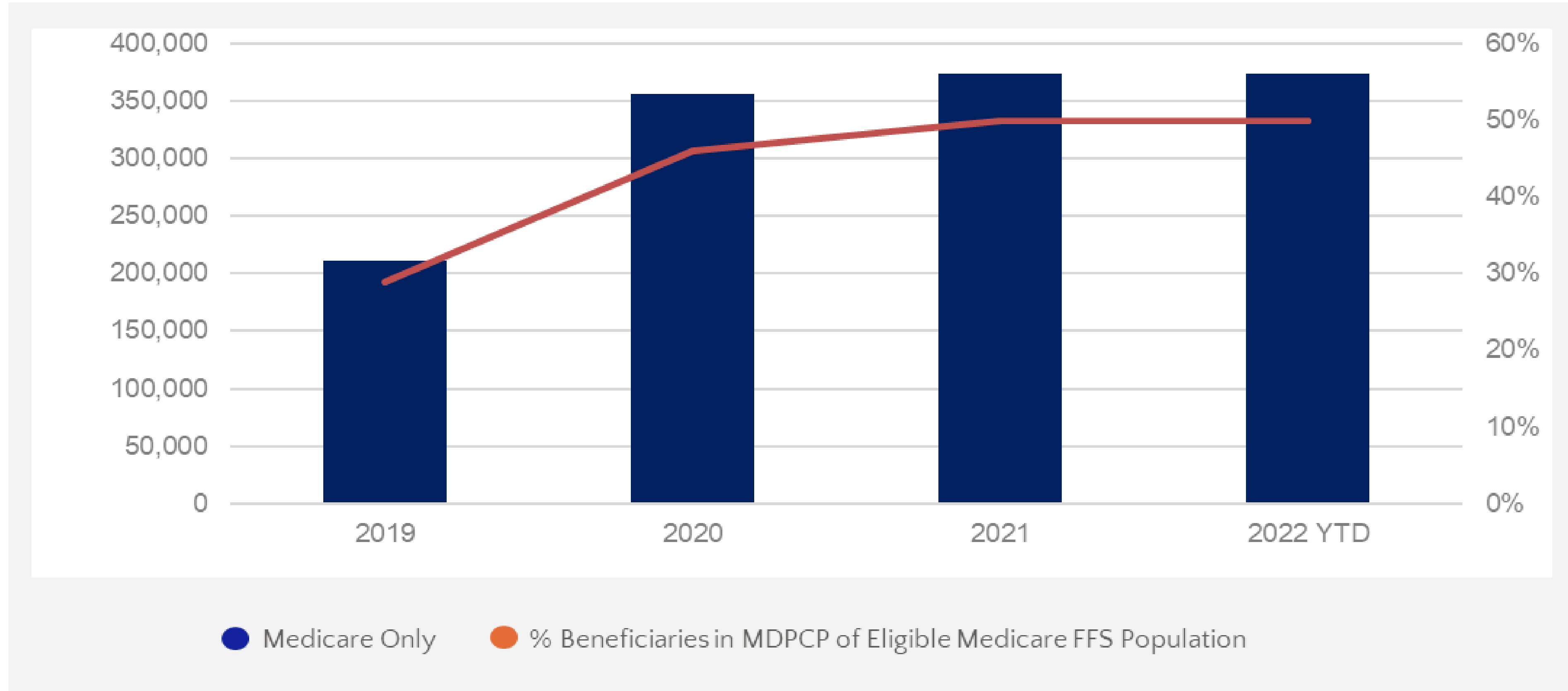
Medicare Fee-for-Service Beneficiaries in MDPCP as a Percent of Eligible Statewide Medicare Fee-for-Service Population*



*Data reflects Q4 attribution of each year

May 2022 - MDPCP Performance Dashboard Update

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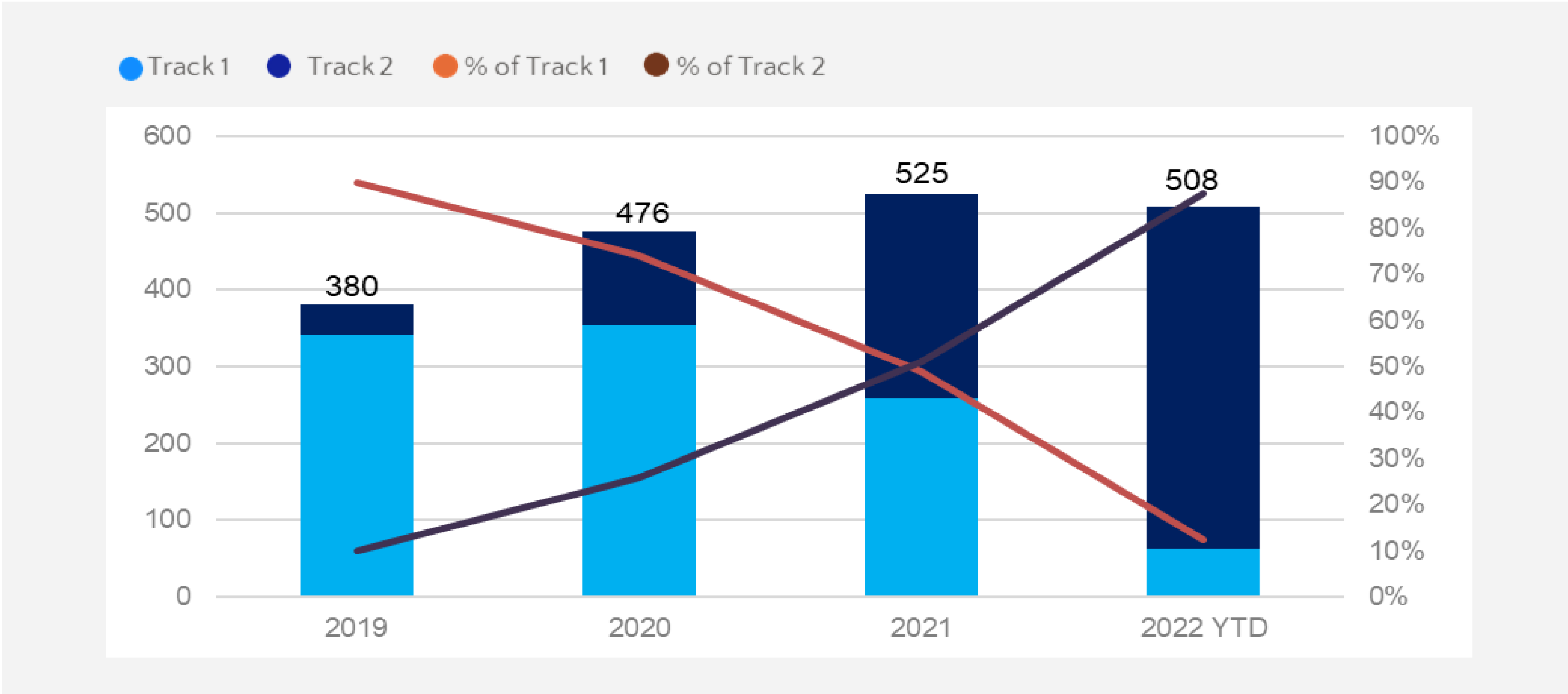
Number of MDPCP Practices by Track



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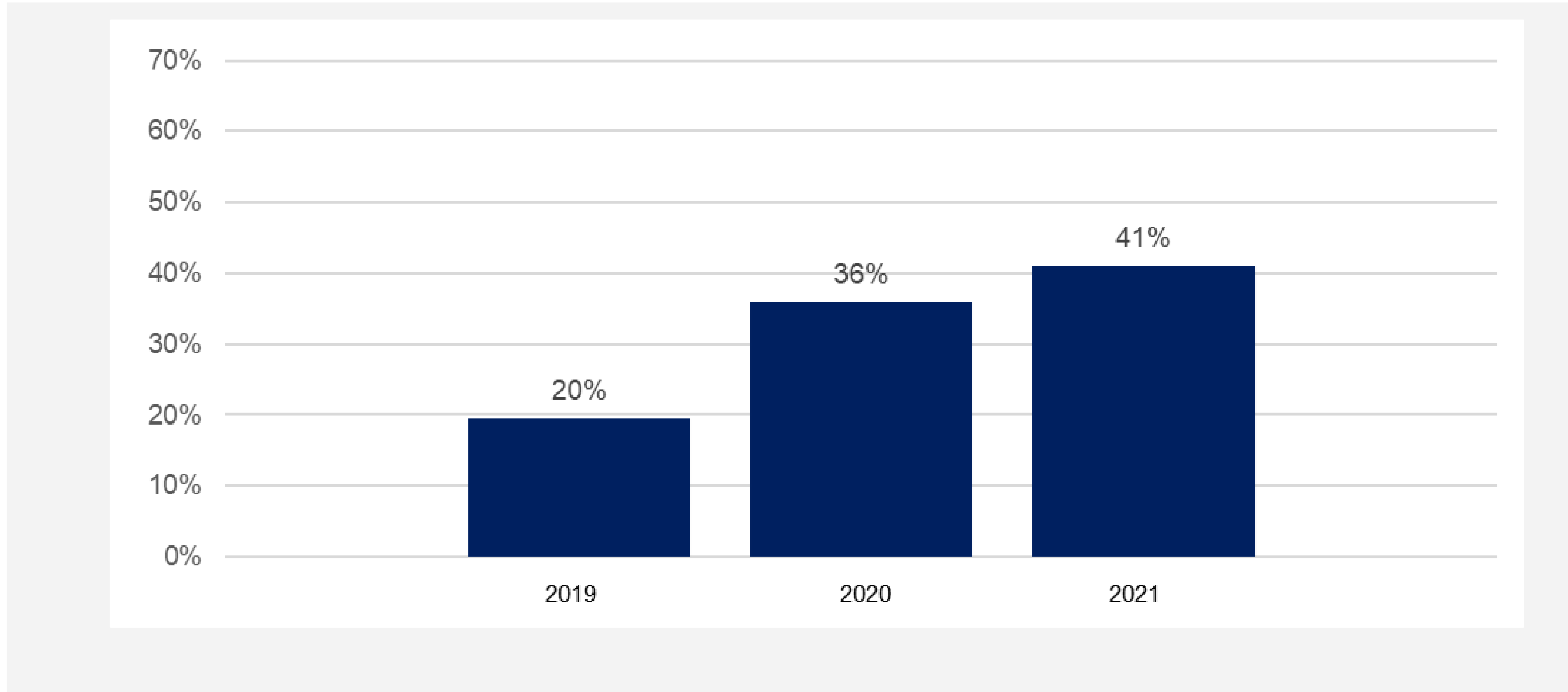
MDPCP-Enrolled Dual Eligibles as % of Total Dual Eligibles*



*Data are through December 31, 2021

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PBPM, CY 2019 vs. CY 2021 (HCC - Risk Adjusted)

Equivalent non-participating population

A subset of the statewide non-participating population, demographically matched to the participating pop by age, sex, dual eligibility, and county of residence

Statewide non-participating population

All Medicare FFS beneficiaries who are eligible for MDPCP and not attributed to a participating provider

HCC Risk-adjustment

CMS assigns all participating beneficiaries an HCC score. The score is based on the community risk model to reflect the beneficiary's clinical profile and care needs. Risk-adjustment is based on the average HCC score of attributed beneficiaries.

Category	Base Year 2019	Measure Year 2021	Percent Change
Statewide FFS population	$1,038	$1,125	8.35%
Statewide Non-Participating Population	$1,001	$1,129	12.75%
Equivalent Non-Participating Population	$1,017	$1,146	12.63%
MDPCP Statewide	**$1,016**	**$1,124**	**10.65%**

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IP Utilization per K, CY 2019 vs. CY 2021 (HCC - Risk Adjusted)

Equivalent non-participating population

A subset of the statewide non-participating population, demographically matched to the participating pop by age, sex, dual eligibility, and county of residence

Statewide non-participating population

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CMS assigns all participating beneficiaries an HCC score. The score is based on the community risk model to reflect the beneficiary's clinical profile and care needs. Risk-adjustment is based on the average HCC score of attributed beneficiaries.

Category	Base Year 2019	Measure Year 2021	Percent Change
Statewide FFS population	248.9	216.8	-12.9%
Statewide Non-Participating Population	247.3	223.3	-9.7%
Equivalent Non-Participating Population	248.1	223.5	-9.9%
MDPCP Statewide	**244.3**	**214.6**	**-12.2%**

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PQI-Like Events per K, CY 2019 vs. CY 2021 (HCC - Risk Adjusted)

Equivalent non-participating population

A subset of the statewide non-participating population, demographically matched to the participating pop by age, sex, dual eligibility, and county of residence

Statewide non-participating population

All Medicare FFS beneficiaries who are eligible for MDPCP and not attributed to a participating provider

HCC Risk-adjustment

CMS assigns all participating beneficiaries an HCC score. The score is based on the community risk model to reflect the beneficiary's clinical profile and care needs. Risk-adjustment is based on the average HCC score of attributed beneficiaries.

Category	Base Year 2019	Measure Year 2021	Percent Change
Statewide FFS population	87.6	63.6	-27.5%
Statewide Non-Participating Population	90.0	67.0	-25.6%
Equivalent Non-Participating Population	86.1	64.8	-24.8%
MDPCP Statewide	**87.0**	**64.1**	**-26.3%**

Chart displays utilization for IP admissions or ED visits that fall into one of 10 PQI categories using 2020 AHRQ specification

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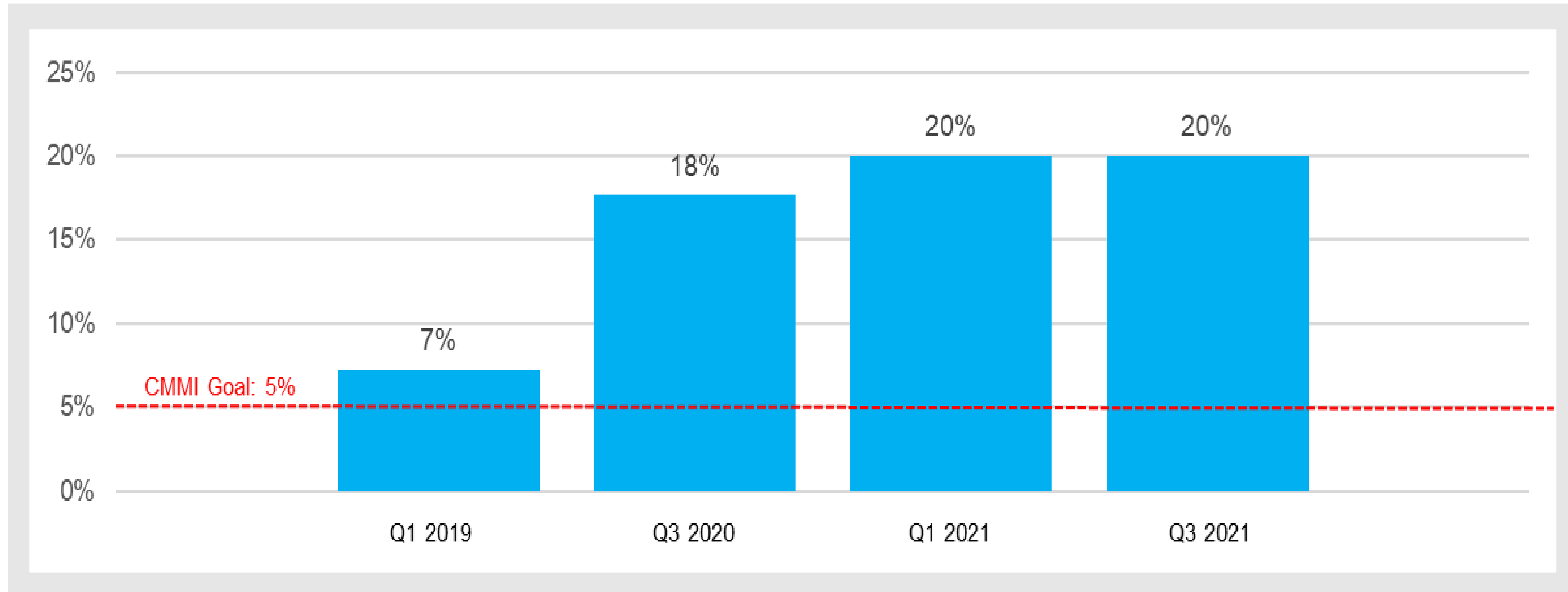
Percent of Beneficiaries under Longitudinal Care Management*



*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.

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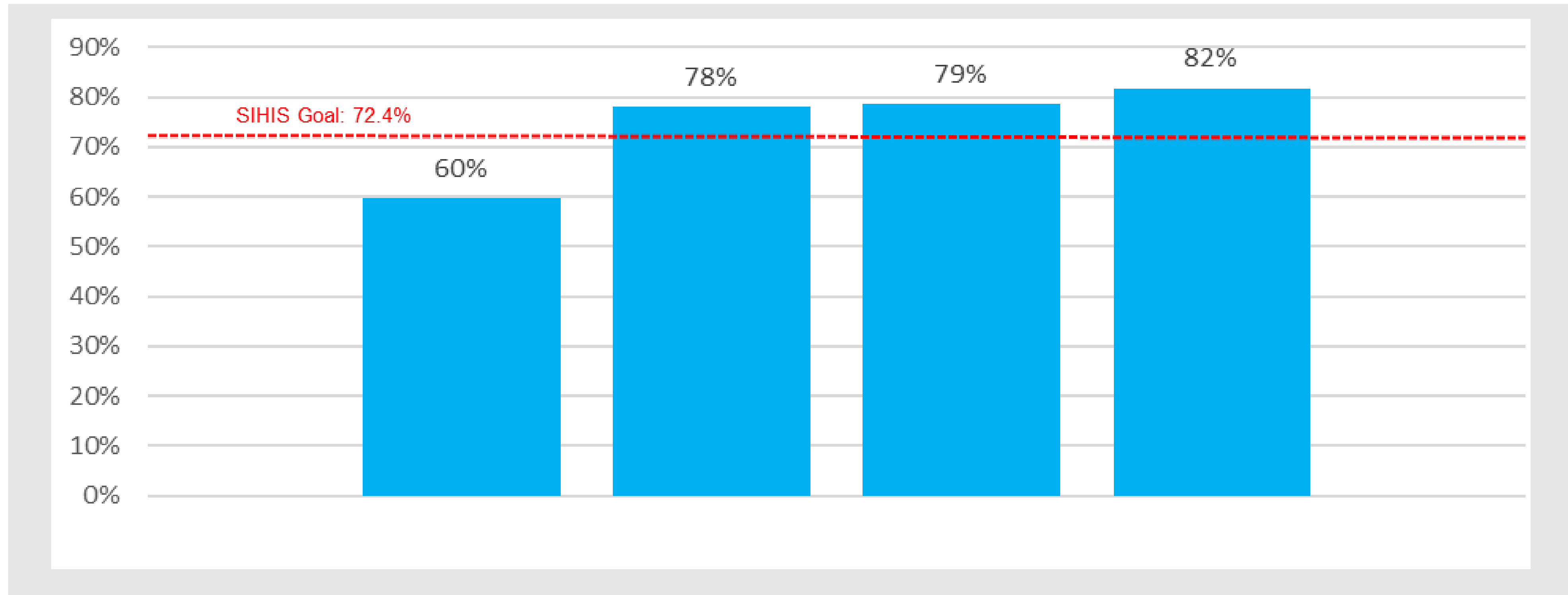
Percent of Beneficiaries with Follow-up after Hospital Admissions within Two Business Days



*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

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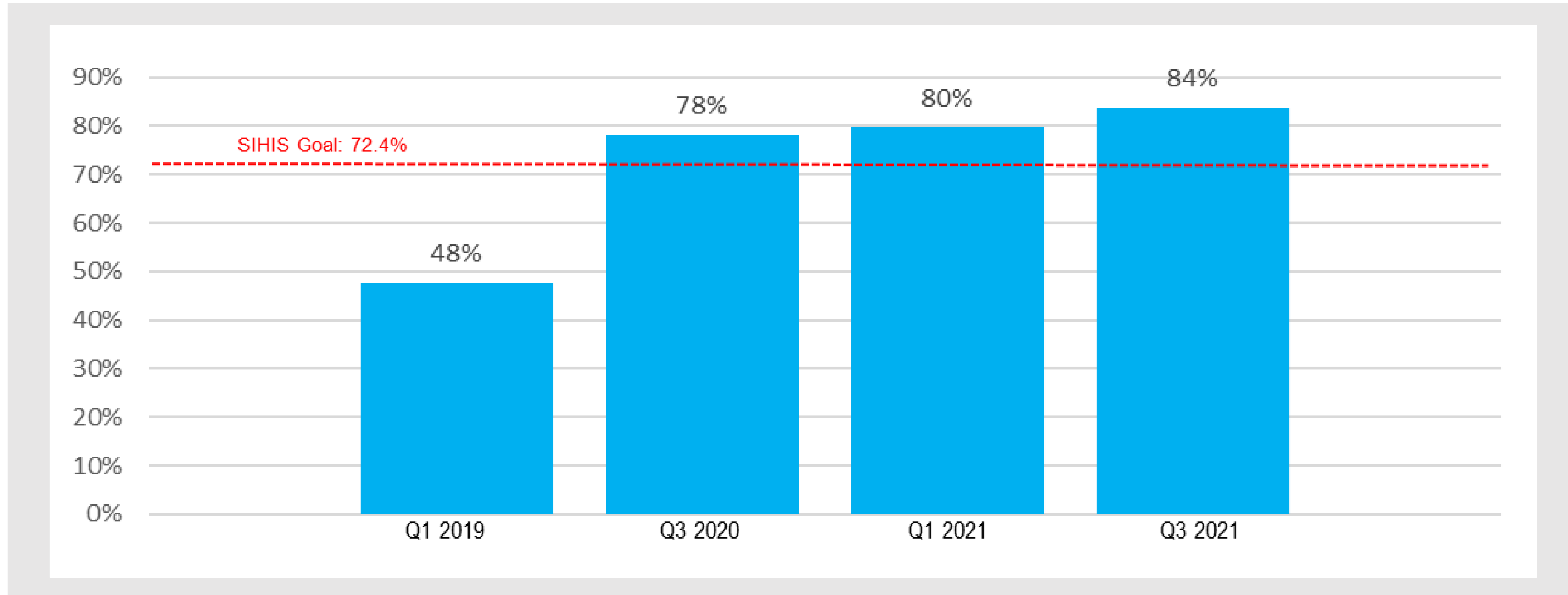
Percent of Beneficiaries with Follow-up after Emergency Department Visits within One Week



*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

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MDPCP Track 3 Update

Overview of Tracks

Payments

TRACK 1

Standard

Implementation of advanced primary care functions including expanded hours, risk stratification, care management and behavioral health integration

- Care Mgmt Fee (CMF)
- Performance Incentive (PBIP)
- Standard FFS billing
- Health Equity Advancement Resource and Transformation (HEART) (if applicable)

TRACK 2

Advanced

Track 1 requirements + addition of offering of alternative care (e.g., telehealth) social needs screening and linkages, comprehensive medication management, and advance care planning

- CMF
- PBIP
- CPCP + FFS billing
- HEART (if applicable)

TRACK 3

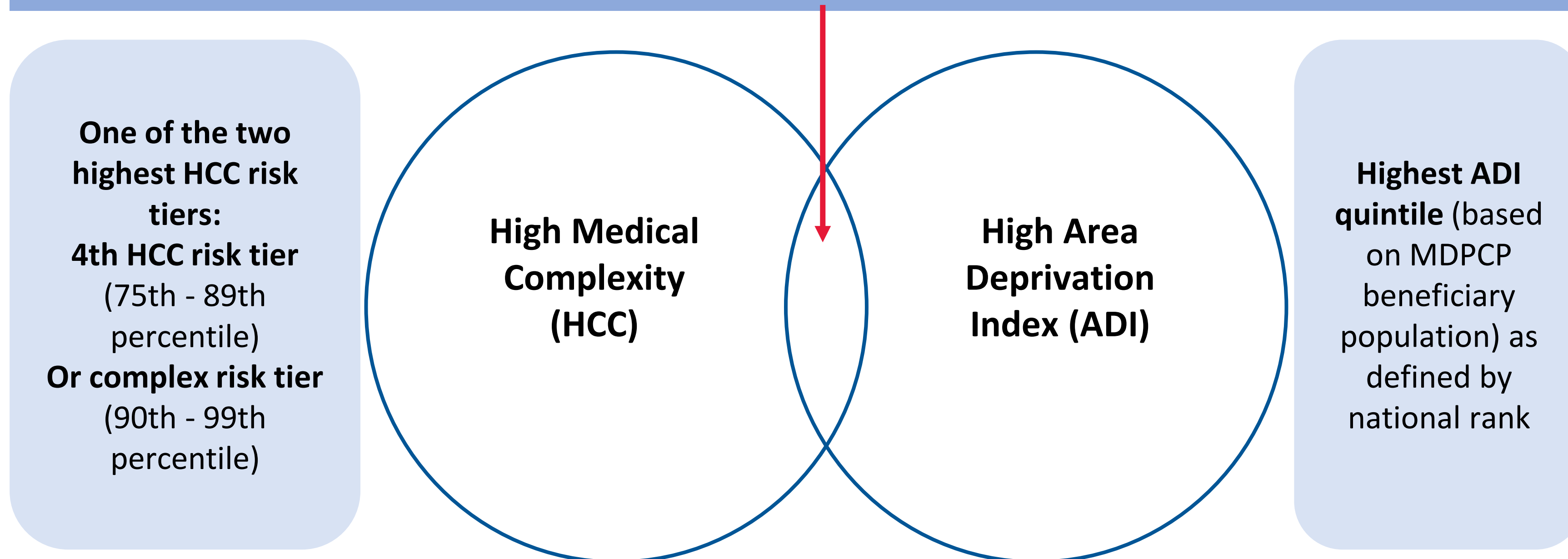
Advanced with Upside & Downside Risk

Track 2 requirements + collection of demographics data, prioritizing health related social needs, & expanded alternative care requirements

- PBP (subject to PBA)
- Flat visit fee (subject to PBA)
- Performance-Based Adjustment (PBA)
- HEART (if applicable)

HEART Payments

<u>The Health Equity Advancement Resource and Transformation Payment (HEART) payment</u> will be an additional payment from the PBP. All practices will receive PBPs. Some practices will also receive a HEART payment.



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The MDPCP Practice and Care Transformation Organization (CTO) **will not be at risk for the HEART payment**.

Participation Options & Timeline

Request for Applications (RFA):

- 2023 RFA - Spring of 2022 for January 1, 2023 start - Tracks 1, 2 & 3 available
- 2024 RFA - Spring of 2023 for January 1, 2024 start - Tracks 2 & 3 available

Transition Timelines:

- 2023 is the final year of operation for Track 1
- 2025 is the final year of operation for Track 2

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)

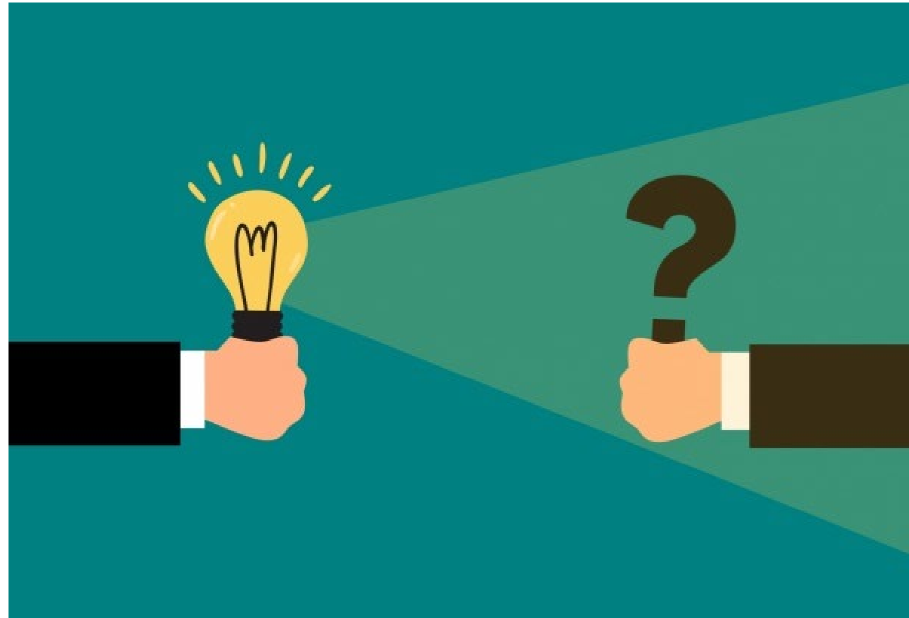
117 practices

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

FQHCs will not be eligible to participate in Track 3 in 2023. CMMI and MDH will revisit for possible future start. FQHCs will be eligible to remain in T2 until further notice.

Thank You!

Check out the MDPCP website for updates and more information



Email mdh.pcmodel@maryland.gov with any questions or concerns

Any questions?

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Appendix

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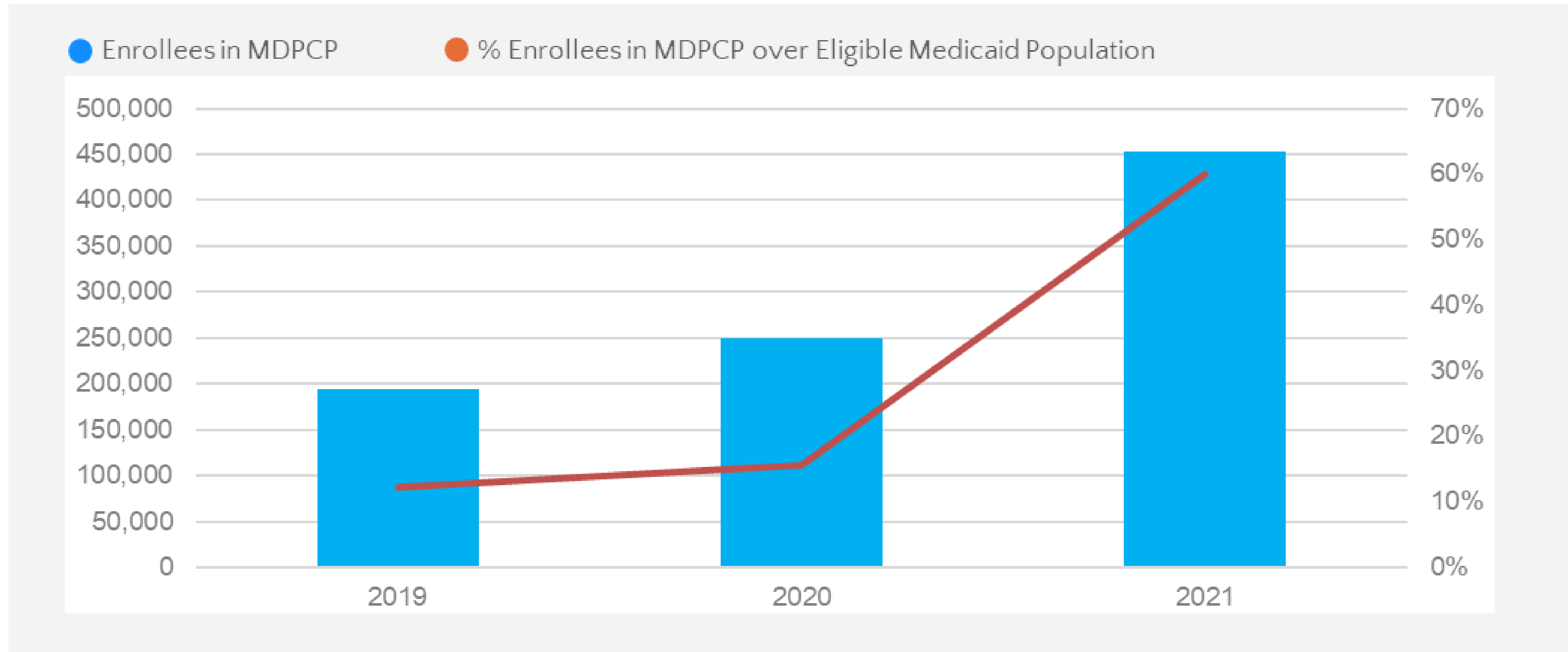
Medicaid Enrollees in MDPCP Practices as % of Eligible Medicaid Population*



*Including dually eligible beneficiaries in MDPCP

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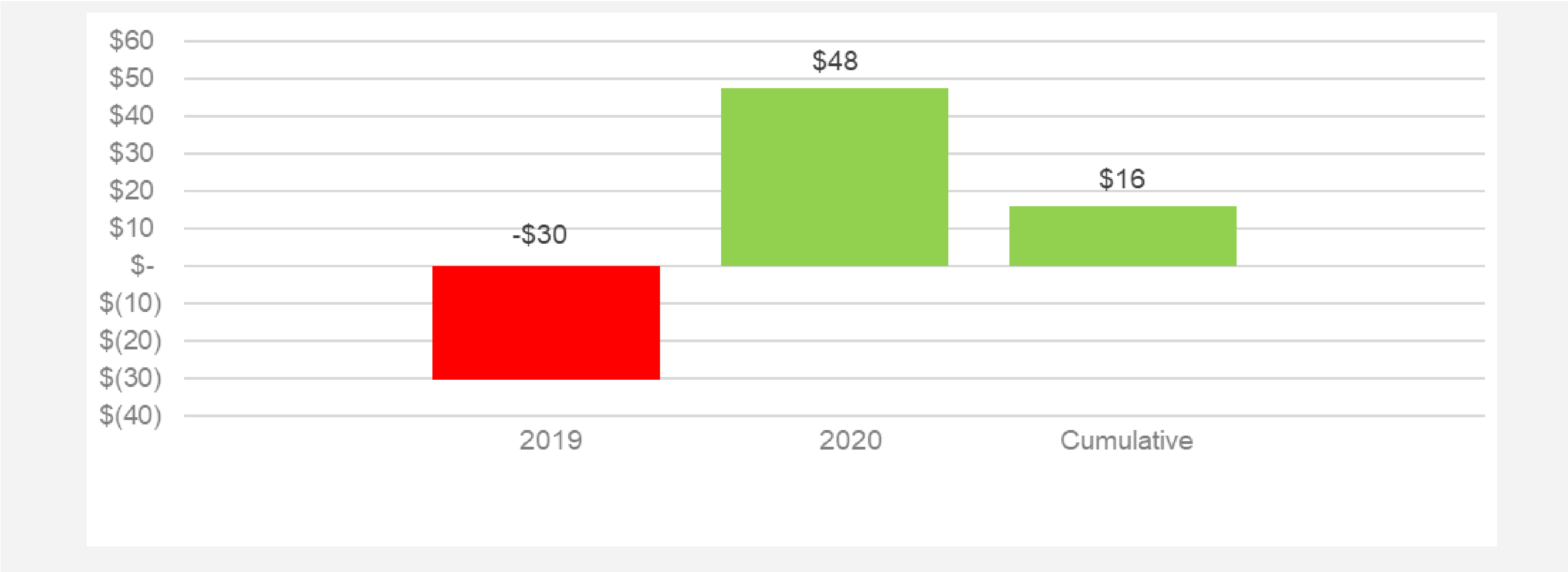
HSCRC Difference-of-Differences In Costs (Cost Savings in Millions)*



*These data represent cost savings calculated by HSCRC (after care management fees) that can be attributed directly to MDPCP.
*Cumulative savings reflect the effects of compounding.

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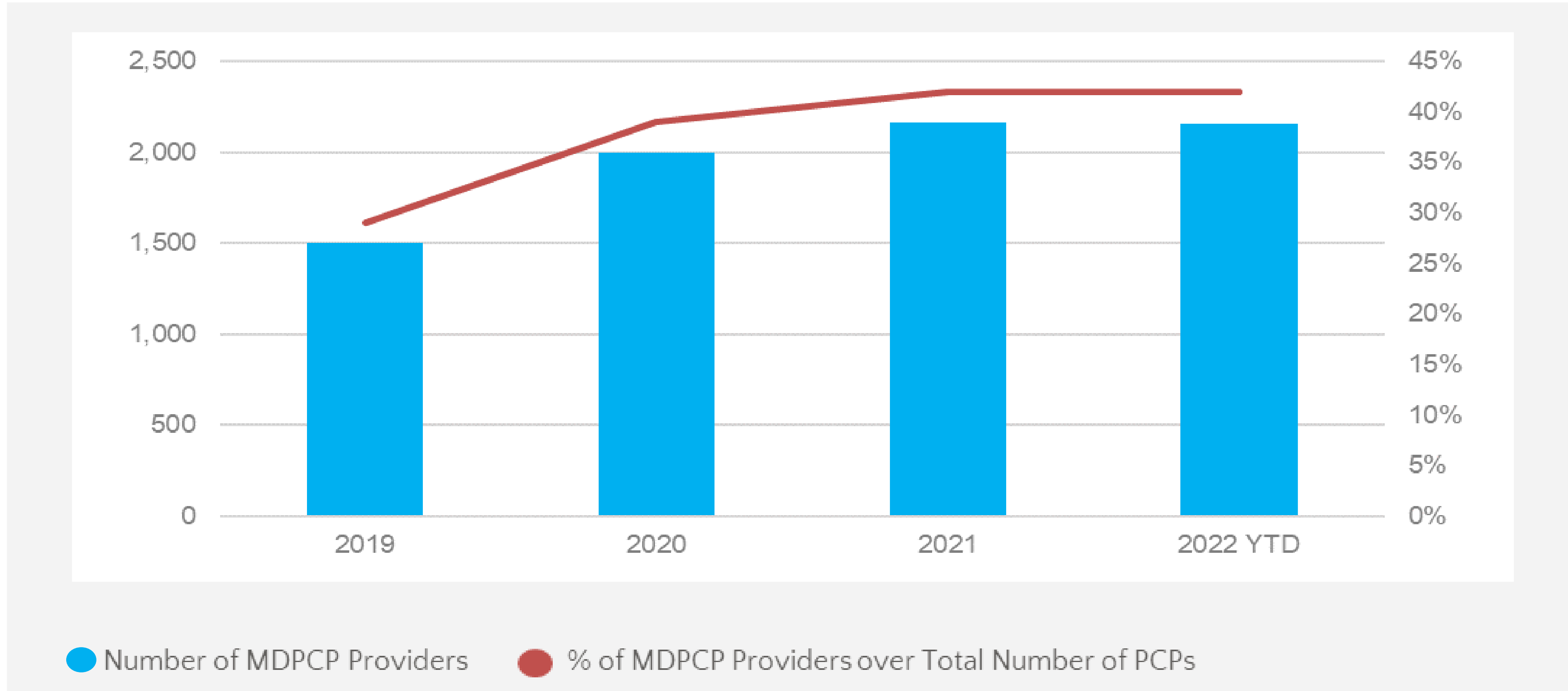
MDPCP Providers as a % of Total Number of Primary Care Providers in Maryland*



*Including all active, board-certified Internal Medicine, Family Medicine, and General Practice physicians in Maryland

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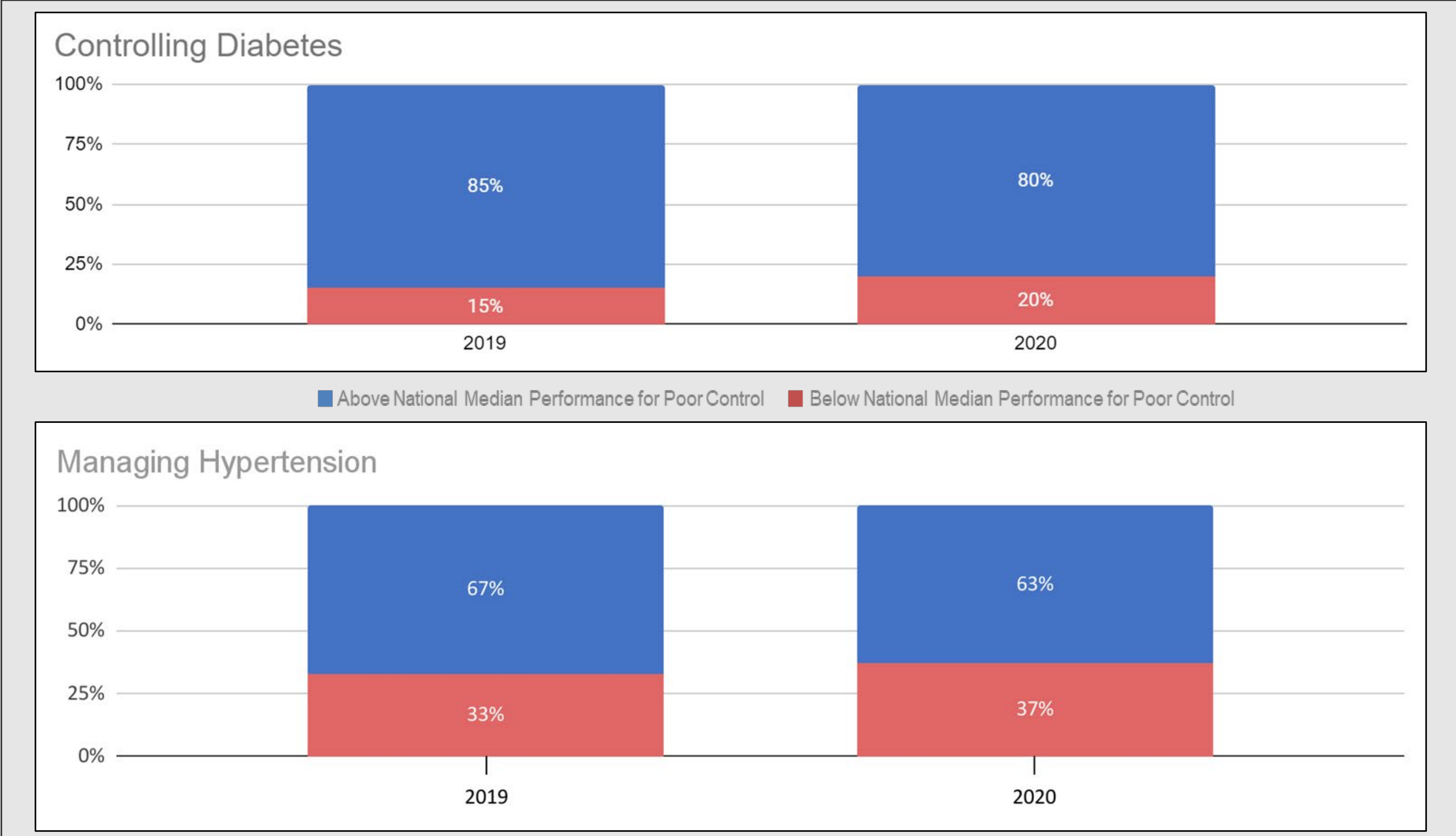
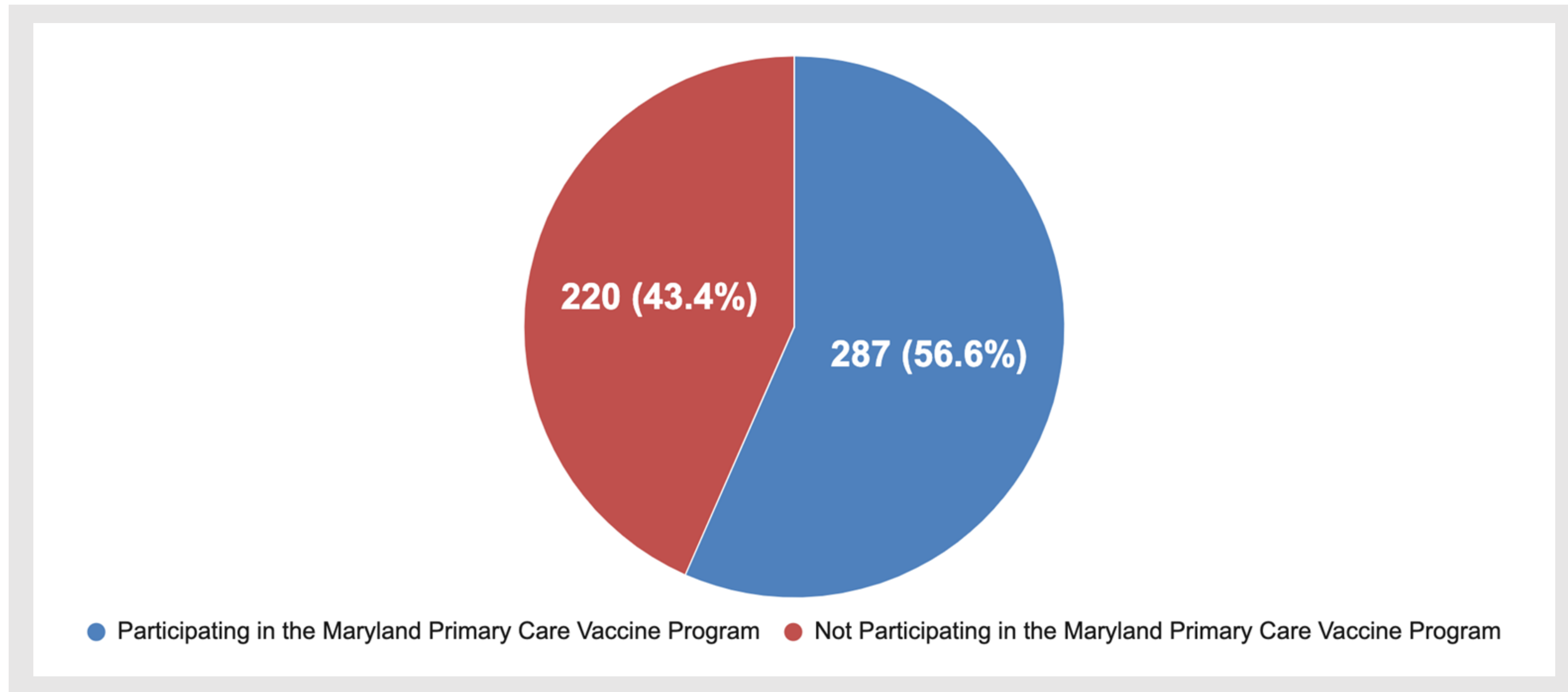
Percent of MDPCP Practices above the National Median in Controlling Diabetes and Managing Hypertension*



*Based on MIPS (Merit-Based Incentive Payment System) reporting. A1C control is a method for treating and controlling blood sugar level for diabetes patients. Data are from 2020

Status of 2022 MDPCP Practices' Participation in the Primary Care Vaccination Program



Data are through June 23, 2022

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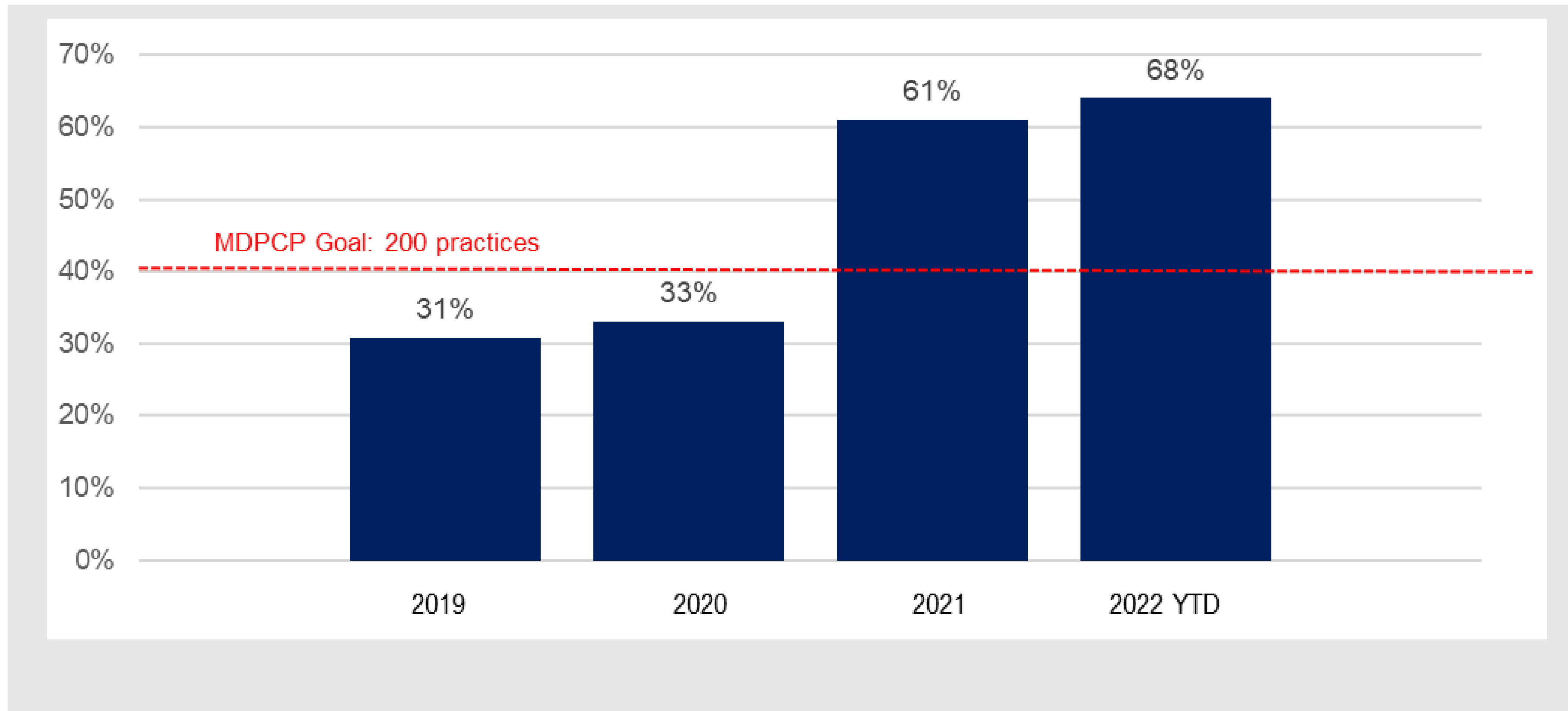
Percent of MDPCP Practices that have Implemented SBIRT*



*SBIRT (Screening, Brief Intervention, and Referral to Treatment) is a best practice used to identify and refer to treatment people suffering from substance use disorder (SUD).

**Data are through May 25, 2022

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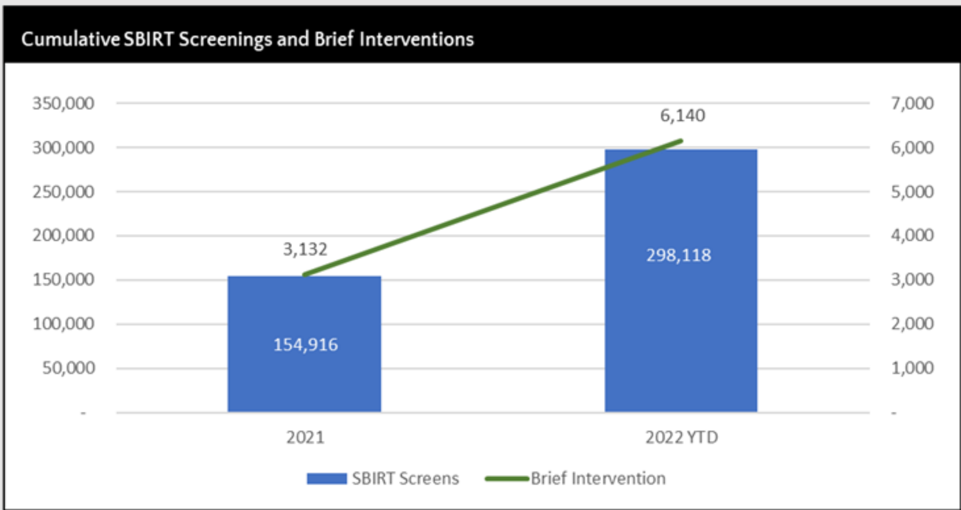
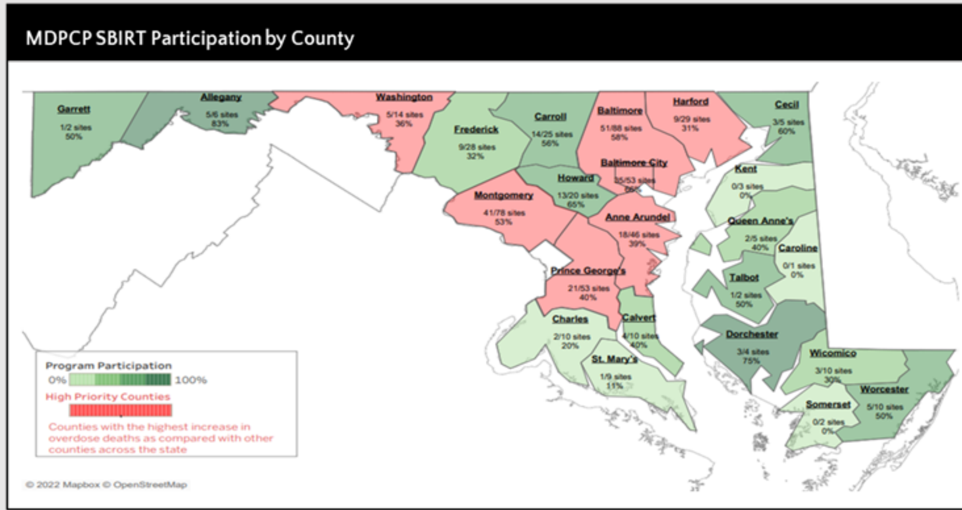
SBIRT Summary

345	320,626	22,508	6,140
SBIRT Implementation – Total Practices	SBIRT Screenings	Positive SBIRT Screenings	Brief Interventions (BI)

Cumulative SBIRT Screenings and Brief Interventions



MDPCP SBIRT Participation by County



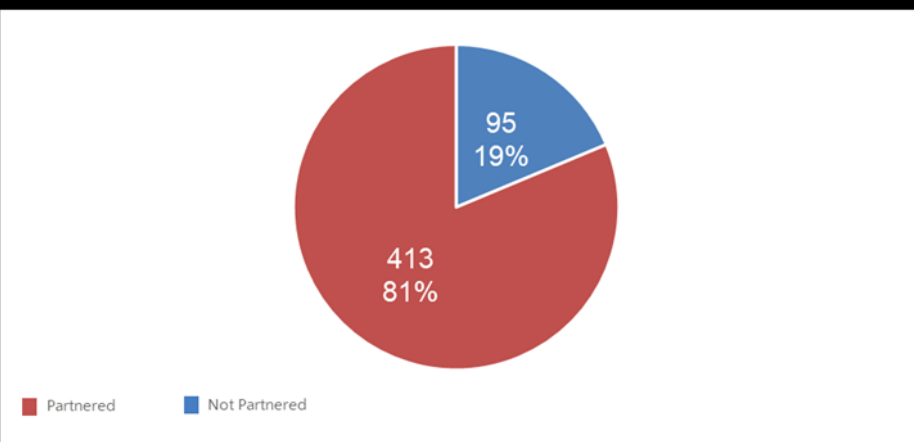
Monthly and Cumulative Statistics

	August – 21	September – 21	October – 21	November – 21	December – 21	January – 22	February – 22	March – 22	April – 22
% SBIRT Screens out of Total Eligible Patients	63%	66%	65%	66%	51%	61%	67%	52%	35%
% Positives out of Total SBIRT Screens	9%	8%	9%	8%	6%	5%	5%	7%	7%
% BI out of Total Positives	37%	29%	23%	20%	23%	26%	29%	36%	28%
Practices Reporting Per Month	112	123	147	154	153	175	200	213	190

*Data are through April 2022

MDPCP Practices Implementing Collaborative Care Model (CoCM) for Mental Health

Status of 2022 MDPCP Practices' Participation in Collaborative Care Model (CoCM)

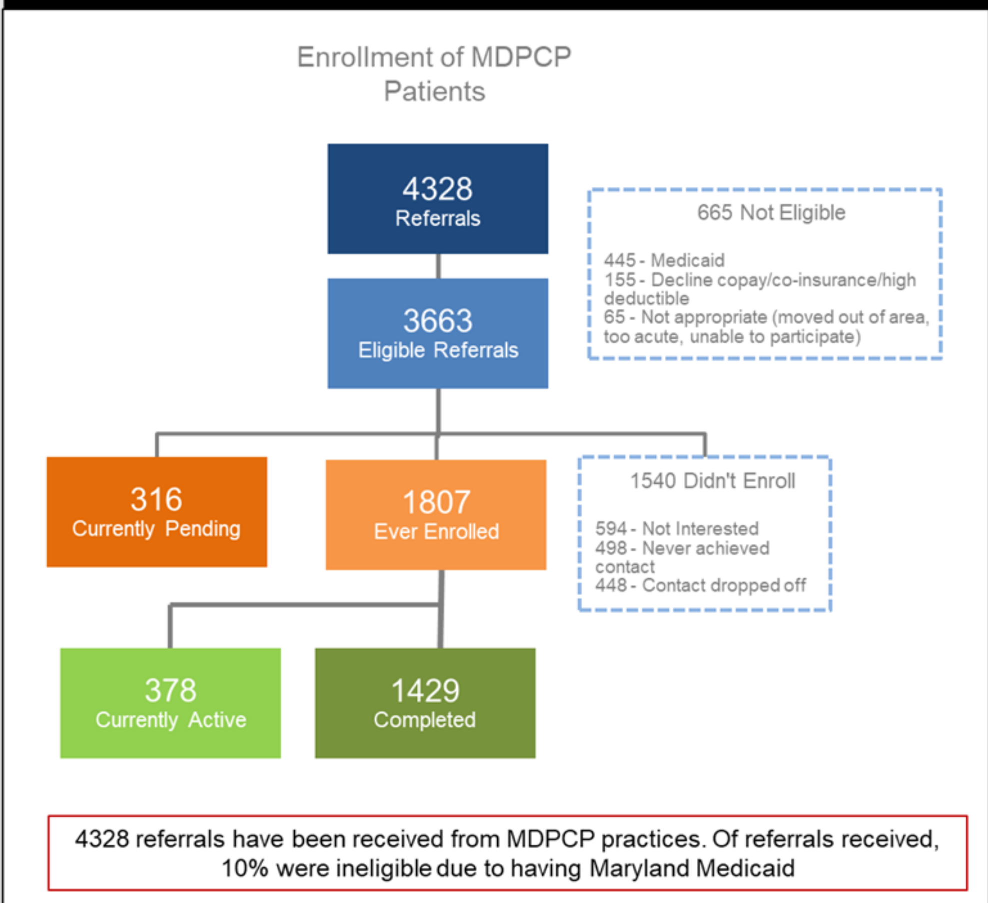


MDPCP Patients – Clinical Improvement under Collaborative Care Model (CoCM)

Days in CCP	30	60	90	120	180
% Patients with PHQ-9 CMR[2]	18%	54%	66%	72%	77%

77% of assessed patients have achieved a Clinically Meaningful Reduction (CMR) in PHQ-9 Score within 6 months in CCP and with 54% achieving CMR within just 2 months

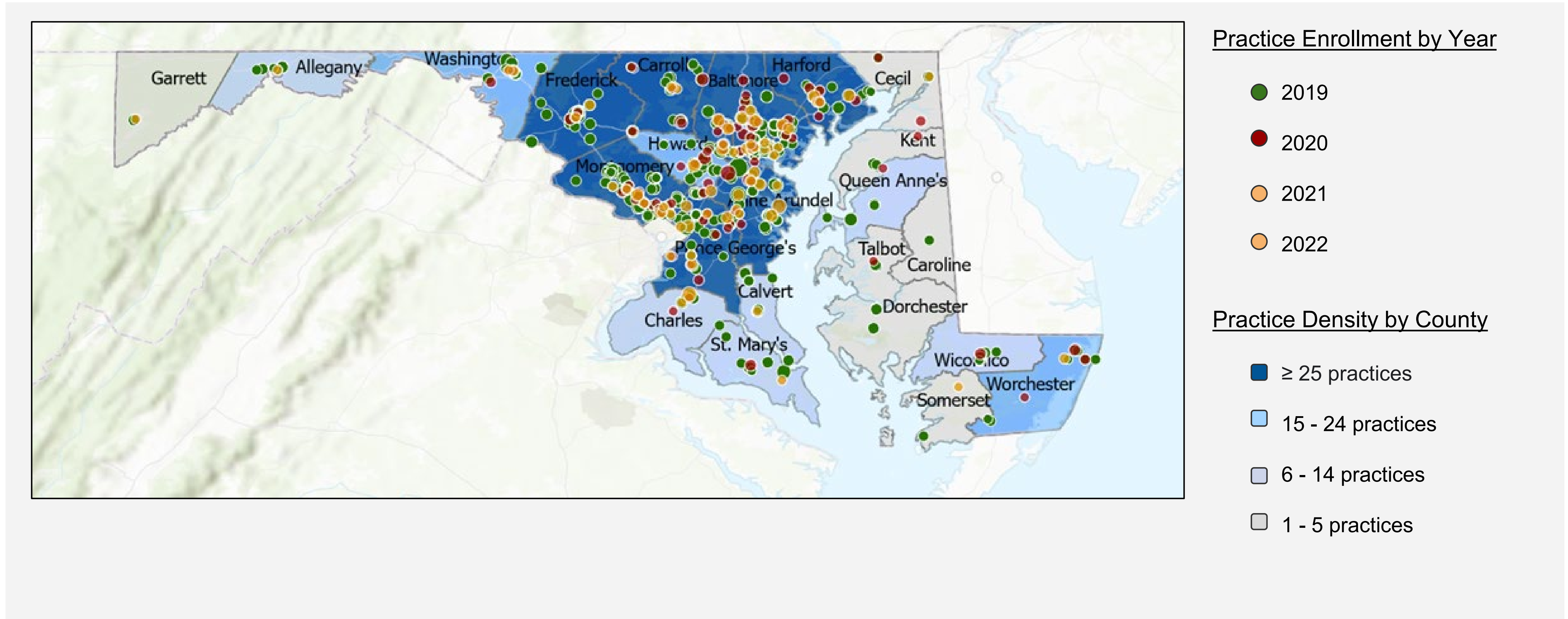
Enrollment and Engagement



4328 referrals have been received from MDPCP practices. Of referrals received, 10% were ineligible due to having Maryland Medicaid

*Data are through April 2022

MDPCP Practice Locations by County



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Summary of Track 2 Payments

Care Management Fee (CMF)

Health Equity Advancement Resource and Transformation (HEART) Payment

Performance Based Incentive Payment (PBIP)

CPCP (Comprehensive Primary Care Payment)

***subject to recoupment*

=

Total MDPCP Revenue to Track 2 Practices

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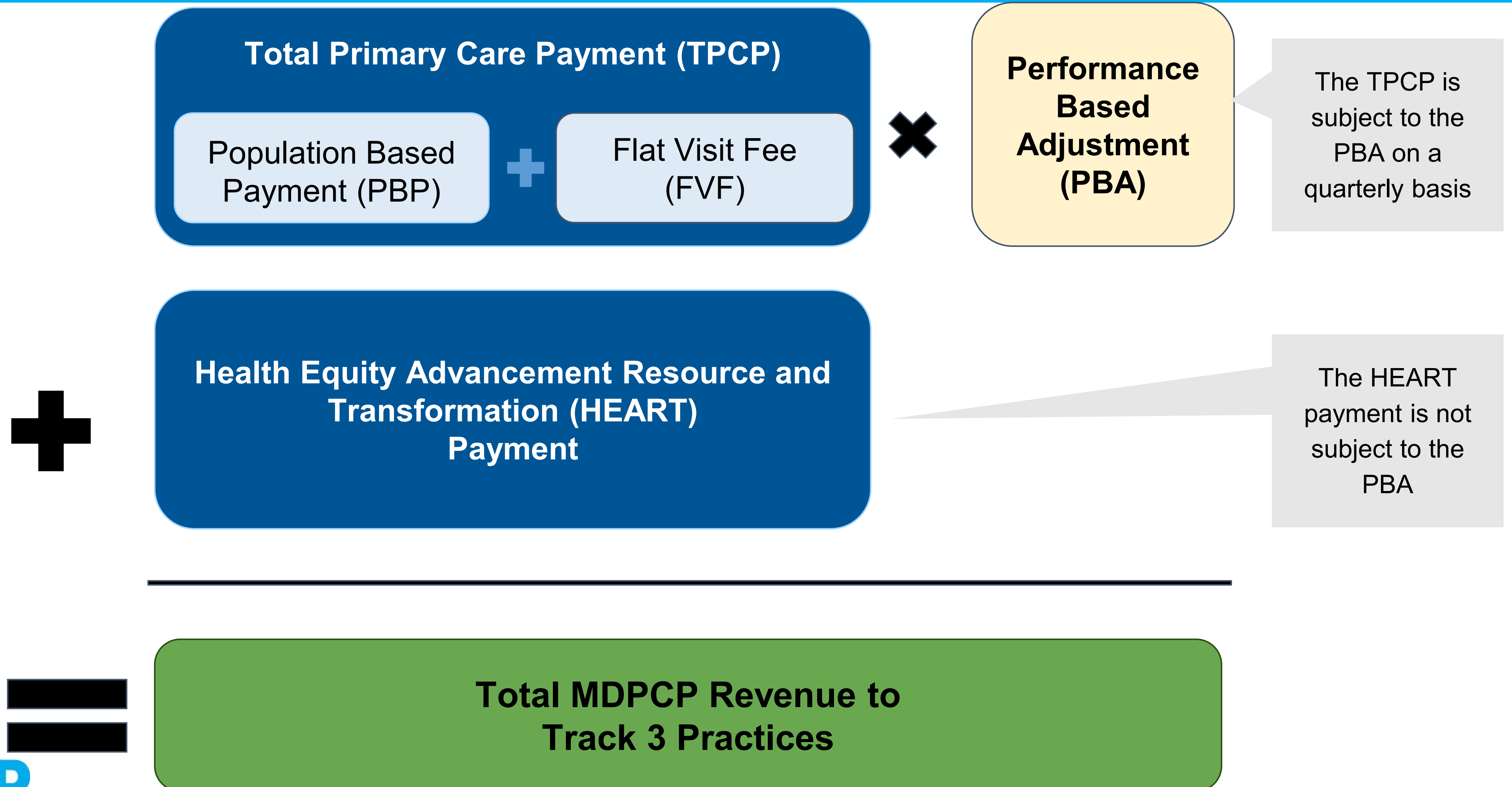
Summary of Track 3 Payments



PBA Measures

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

QUALITY - 50% of Total PBA
National Benchmark

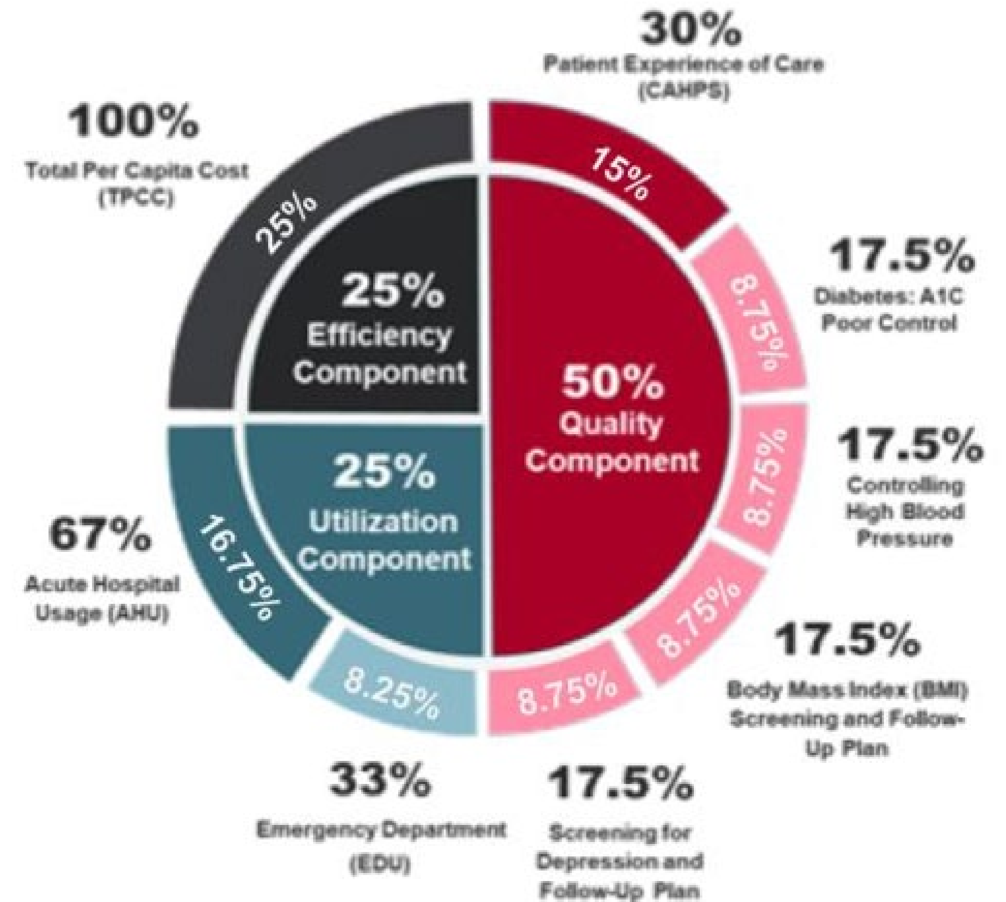
- **Diabetes Control** (CMS 122)
- **Diabetes Prevention** (e.g., BMI) (CMS 69)
- **Hypertension Control** (CMS 165)
- **Opioid/SUD/or Depression** (CMS 2)
- **Patient Experience**

UTILIZATION - 25% of Total PBA
MD Benchmarks

- **Acute Hospital Utilization**
- **Emergency Department Utilization**

COST – 25% of Total PBA
MD Benchmark

- **Total Cost of Care, TPCC**



Note that the percentages in the inner circle depict percent of total and the percentages in the outer circle depict percent of the corresponding component

Glossary

CPCP	Comprehensive Primary Care Payment
FVF	Flat Visit Fee
HCC	Hierarchical Condition Category
HEART	Health Equity Advancement Resource & Transformation
MSSP ACO	Medicare Shared Savings Program Accountable Care Organization
PBA	Performance Based Adjustment
PBIP	Performance Based Incentive Payment
PBP	Performance Based Payment
PBPM	Per Beneficiary, Per Month
PFS	Physician Fee Schedule (Medicare)
TPCP	Total Primary Care Payment