Maryland’s Evolution Towards Value Based and Population Health in Pediatrics

June 21, 2017
Current and Proposed Value-Based Payment Strategies

- Practice Transformation Network (PTN)
- Maryland Comprehensive Primary Care Model (PCM)
- Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP)
- MACRA Awareness and Support Program (MAS)
Maryland in 4th Quintile of States at #31

Health in Maryland

• United Health Foundation – America’s Health Rankings

• Maryland remained at the same spot in 2016

• Ranking based on compilation of national and state validated surveys (e.g. BRFSS) as well as administrative sources (e.g. Vital Statistics)

<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>2016 Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hawaii</td>
<td>0.905</td>
</tr>
<tr>
<td>2</td>
<td>Massachusetts</td>
<td>0.760</td>
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<tr>
<td>3</td>
<td>Connecticut</td>
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<td>4</td>
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<td>5</td>
<td>Vermont</td>
<td>0.709</td>
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<td>6</td>
<td>New Hampshire</td>
<td>0.696</td>
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<td>7</td>
<td>Washington</td>
<td>0.582</td>
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<td>8</td>
<td>Utah</td>
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<td>20</td>
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### Overall Rankings Across Dimensions of Performance

**Overall performance, 2015**

<table>
<thead>
<tr>
<th>Overall rank</th>
<th>State</th>
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<tbody>
<tr>
<td>1</td>
<td>Minnesota</td>
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<tr>
<td>1</td>
<td>Vermont</td>
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<tr>
<td>3</td>
<td>Hawaii</td>
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<tr>
<td>4</td>
<td>Massachusetts</td>
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<td>5</td>
<td>Connecticut</td>
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<tr>
<td>5</td>
<td>Rhode Island</td>
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<td>8</td>
<td>Colorado</td>
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<td>9</td>
<td>Iowa</td>
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<td>10</td>
<td>Washington</td>
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<td>18</td>
<td>Utah</td>
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<td>18</td>
<td>District of Columbia</td>
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<td>California</td>
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<td>23</td>
<td>Virginia</td>
</tr>
<tr>
<td>25</td>
<td>Idaho</td>
</tr>
</tbody>
</table>

- **Top quartile**
- **Second quartile**
- **Third quartile**
- **Bottom quartile**
Relationship to All-Payer Model and Progression Plan

The Primary Care Model

• Will sustain the early gains of the All-Payer Model as targets becoming increasingly reliant on factors beyond the hospital
  – Aligns incentives; important to design in a way that ensures hospitals are not responsible for risks they cannot control

• Complements and supports existing delivery system innovation in State
  – Care Redesign Amendment
  – Hospital global budgets

• Reduce avoidable hospitalizations and ED usage through advanced primary care access and prevention
  – Components include care managers, 24/7 access to advice, medication mgt., open-access scheduling, behavioral health integration, and social services
Background

Figure 1. Evolution of Healthcare Payment Models, 2009-Present

**Precedents**

- **CAPITATION**
  1980s: Payers gave PCPs a fixed PMPM to manage HMO members

- **MEDICARE ADVANTAGE**
  CMS-designated payers who received a fixed PMPM for members and sometimes passed that to PCPs

- **PAY FOR PERFORMANCE**
  Payers withheld some of FFS payments and gave P4P bonus to PCPs if performance goals were met

**Pilots: 2009-2012**

- **PIONEER/MSSP ACOS**
  CMS programs for provider groups treating Medicare FFS patients; shared savings if quality and cost goals met

- **BUNDLED PAYMENTS**
  CMS program to pay hospitals and specialists a fixed fee for designated procedures

- **PCMH PROGRAMS**
  Commercial and CMS programs paying PCPs extra payments for higher levels of care coordination

**Expansion: 2013-Today**

- **PAY FOR VALUE**

- **EPISODE OF CARE**

- **SHARED SAVINGS**

- **TOTAL COST OF CARE**

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1 Throughout this discussion, the term “payer” is intended to mean the “risk-bearing entity that assembles a network to care for patients.” This could be a traditional health insurance company, a Medicare Advantage or Medicaid plan, or a large integrated delivery system that is taking risk for its own employees or other population.

http://www.navinet.net/resources/webinars/5-trends-value-based-reimbursements
Physician Revenue

Source: ©2014 The Advisory Board Company, “Results from the 2013 Accountable Payment Survey.” All rights reserved.
Environment Post ACA

- Accept more value-based care arrangements
- Invest in more evolved care-management models
- Establish new partnerships
- Reduce operating costs
- Integrate physicians and hospitals
- Use population health management data to support clinical improvements

Current Child Health Care Value-Based Payment Models

- PMPM for care coordination
  - providing more integrated, responsive and efficient services
- PMPM infrastructure
  - develop new work flow processes as part of practice transformation work, hold team meetings, build data collection capabilities and meet reporting responsibilities.
- Pay for performance
  - performance on clinical process and outcome measures, and sometimes to utilization and cost performance
- Shared savings
  - Practices may share in savings on the total cost of care for their attributed patient population with a given payer if their costs come in below a pre-determined target, or relative to a control group

Source: Value-Based Payment Models for Medicaid Child Health Services; Report to the Schuyler Center for Analysis and Advocacy and the United Hospital Fund: Bailit Health, July 13, 2016
Four Key Challenges to a Pediatric Value-Based Payment Model

- Most children generate little medical expense
- Children with high medical needs are a heterogeneous population
- Present and future health status is largely defined by factors not under the control of clinician
- Many Medicaid providers are not prepared for value-based payment

Source: Value-Based Payment Models for Medicaid Child Health Services; Report to the Schuyler Center for Analysis and Advocacy and the United Hospital Fund: Bailit Health, July 13, 2016
Challenges

• Opportunities for short-term cost savings to fund and sustain a value-based pediatric payment model do not exist to the same extent that they do for adults due to focus on developmental screening, preventive care and anticipatory guidance.

• Most savings found in smaller, higher-cost sub-groups within the Medicaid pediatric population, including children with severe asthma and children with medical complexity.

• Infrequent inpatient service use means that adult-driven value-based payment models cannot be expected to generate substantial annual savings.

Source: Value-Based Payment Models for Medicaid Child Health Services; Report to the Schuyler Center for Analysis and Advocacy and the United Hospital Fund: Bailit Health, July 13, 2016
Value-Based Payment Model for All Children

Without Medical Complexity
- Capitated primary care payment
- Care coordination payment
- Performance incentive bonus

With Medical Complexity (1-5% of pediatric population)
- Total Cost of care
  - Sufficiently large population
  - Would not be full risk due to the impact of high-cost outliers.
  - Earned savings based on performance relative to a measure set that addresses measures relevant to the health status of the target population
- Care coordination payment

Source: Value-Based Payment Models for Medicaid Child Health Services; Report to the Schuyler Center for Analysis and Advocacy and the United Hospital Fund: Bailit Health, July 13, 2016
PRACTICE TRANSFORMATION NETWORK
Funding opportunity announced in October 2014

Designed to support 150,000 clinicians achieve large-scale health transformation

CMS will invest up to $685 million in providing hands-on support to practices for developing the skills and tools needed to improve care delivery and transition to alternative payment models

Improve health outcomes for millions of Medicare, Medicaid and CHIP beneficiaries and other patients

Reduce unnecessary hospitalizations for five million patients

Generate $1 to $4 billion in savings to the federal government and commercial payers
TCPI (Continued)

• Sustain efficient care delivery by reducing unnecessary testing and procedures

• Build the evidence base on practice transformation so that effective solutions can be scaled

• Ready providers to participate in incentive programs and practice models that reward value

• TCPI is one of the largest federal investments uniquely designed to support clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation
The New Jersey Innovations Institute (NJII)

- Won a $50 million grant from the Centers for Medicare & Medicaid Services to implement the requirements of the PTN
- The cooperative agreement’s stated goal is to save the health care system $250M
- Target is 11,500 eligible providers
- One of 29 PTNs nationwide
- Invited Maryland to partner in reaching it’s goals by engaging clinicians statewide in the PTN
• University of Maryland School of Medicine Department of Family & Community Medicine

• Maryland Health Care Commission

• MedChi, The State Medical Society

• Montgomery County Medical Society
Eligibility

• PTN is looking for the following types of providers:
  – Primary Care providers (Internal Medicine)
  – Internal Medicine sub specialties (Cardio, Pulmo, Endo, Neph)
  – Specialists
  – Any provider who is required to submit PQRS

  – Note:
    • Providers already enrolled in a Medicare Shared Savings Program
    • Providers already enrolled in Comprehensive Primary Care Initiative
    • Any providers who are earning over 20% of revenue from Medicare Risk programs, bundled payments, etc.
Our Approach

Assess
- Collaborate with the QIO perform practice assessments
- Create Practice/Physician Profiles
- Baseline Performance
- Evaluate Practices’ technical capabilities

Collect
- Establish Collection Methodology (DDE vs. Interface)
- Build Interfaces when required
- Educate practice on collection method

Transform
- Implement CMS Change Package
- Use best practices from Healthy NJ 2020
- Align with payer remuneration opportunities
- Implement Transition of Care and Chronic Care Mgt

Measure
- Implement measures management process
- Central monitoring of quality measures
- Practice Coaches monitor remediate practice deficiencies
Value - Financial

• Additional revenue opportunities such as TCM and CCM

• Transitional Care Management by Medicare (TCM)
  – Additional codes for taking ownership of discharged patients
  – ~$150 to $250 per beneficiary
  – TCM Clearinghouse and best practices

• Chronic Care Management by Medicare (CCM)
  – ~20 minutes per beneficiary per month
  – Coordinate care and engage with patients
  – ~$43 per beneficiary per month
Value – Guidance & Direction

• Teams of support – nurses/coaches, technology, hybrid
  – Clinical Operations Director
  – Practice Transformation Coaches
Value - Deliverables

• Data capturing tools to help collect important data
• Data sharing tools to allow seamless sharing
• Workflows to ensure patient care and engagement
PTNs

PTNs are peer-based learning networks designed to:
coach, mentor and assist clinicians in developing core
competencies specific to practice transformation.

This approach allows clinician practices to become actively
engaged in the transformation and ensures collaboration
among a broad community of practices that creates, promotes,
and sustains learning and improvement across the health care
system.
TCPI Approach

Transforming Clinical Practice would employ a three-prong approach to national technical assistance.

- Aligned federal and state programs with support contractor resources
- Practice Transformation Networks to provide on the ground support to practices
- Support and Alignment Networks to achieve alignment with medical education, maintenance of certification, more

This technical assistance would enable large-scale transformation of more than 150,000 clinicians’ practices to deliver better care and result in better health outcomes at lower costs.
The Four Year Timeline

CMS Transformation Track

2016
- Enrollment
- Assessment
- Set quality goals
- Data collection

2017
- Work plan execution
- Monitor progress
- Measure QI
- Analyze data
- Readiness

2018
- Alternative payments
- Value-based modifiers
- Participant in the Medical Neighborhood

2019
- Incentive programs
- 90% of payments tied to quality

2020
- ACO
- Bundled Payments
- Value Based Contract
- PCMH
WHY

• Immediate Term
  – Transitional Care Codes
  – Chronic Care Management Codes
  – Advanced Directives Billing

• MACRA readiness
  – APMs
General Information

• Project length – four years

• Participants in an Accountable Care Organization are not allowed to participate in the PTN

• Clinicians must sign a participation agreement and complete an EHR system status questionnaire

• Report selected process and outcome metrics monthly via a reporting measures tool – to be provided later in the year

• Inform as to any clinician changes (terminations, resignations, new hires) in the practice within 30-days

• Termination in the program requires a 30-day notification
MARYLAND PRIMARY CARE MODEL
The MCPC Model

Person Centered Homes

Care Transformation Organization (leverage existing entities)

Person Centered Homes

Project Management Office/ MDoH

CMMI

Care Transformation Organization

Person Centered Homes

PATIENTS

CMMI

$\$$

$\$$
Relationship to All-Payer Model and Progression Plan

The Primary Care Model

- Five key functions: access & continuity, comprehensiveness & coordination, care management, patient & caregiver engagement, planned care & population health

- Will sustain the early gains of the All-Payer Model as targets becoming increasingly reliant on factors beyond the hospital
  - Aligns incentives; important to design in a way that ensures hospitals are not responsible for risks they cannot control

- Complements and supports existing delivery system innovation in State particularly the Hospital Global Budget

- Reduce avoidable hospitalizations and ED usage through advanced primary care access and prevention
  - Components include care managers, 24/7 access to advice, medication mgt., open-access scheduling, behavioral health integration, and social services
Builds from the CMMI CPC Plus Model

- MCPC will build off CMMI’s CPC Plus program
  - 14 regions in 01/2017
  - 4 regions in 01/2018
- Over 2,900 practices engaged, up to 1,000 more practices in 2018
- Maryland’s CPC program will offer more flexibility to primary care practices than CPC Plus
  - Program begins with Medicare beneficiaries
  - Rolling application for practices
  - Care transformation organizations (CTOs) will support practices – Practice Transformation, Care Management, Informatics, Hospital Transitions, Social Services Integration
  - CMMI will take responsibility for establishing the program and gradually transition responsibility to the State
Primary Care Functions

Track 1

1. Access and Continuity
   • 24/7 patient access
   • Assigned care teams

2. Care Management
   • Risk stratify patient population
   • Short-and long-term care management
   • Care plans for high risk chronic disease patients

3. Comprehensiveness
   • Identify high volume/cost specialists serving population
   • Follow-up on patient hospitalizations
   • Psychosocial needs assessment and inventory resources and supports

4. Patient and Caregiver Engagement
   • Convene a Patient and Family Advisory Council

5. Planned Care and Population Health
   • Analysis of payer reports to inform improvement strategy
   • At least weekly care team review of population health data

Track 2

1. Access and Continuity
   • E-visits
   • Expanded office hours

2. Care Management
   • 2-step risk stratification process

3. Comprehensiveness
   • Enact collaborative care agreements with two groups of specialists
   • Behavioral health integration
   • Enact collaborative care agreements with public health organizations

4. Patient and Caregiver Engagement
   • Implement self-management support for at least three high risk conditions

5. Planned Care and Population Health
   • Same for Track 1 and 2
Care Transformation Organizations

Care Transformation Organization Design

Services Provided to PCH:
- Care Management
- Data Tools and Informatics
- Practice Transformation TA
- Social Services Connection
- Hospital Care Coordination

Provision of Services By:
- Care Managers
- Pharmacists
- LCSWs
- Transformation Agents
- CHWs
# Payment Incentives for Better Primary Care

<table>
<thead>
<tr>
<th>Practises</th>
<th>Care Management Fee (PBPM)</th>
<th>Performance-Based Incentive Payment (PBPM)</th>
<th>Underlying Payment Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track 1</strong></td>
<td>Payment: $28 average; including $100 to support patients with complex needs</td>
<td>Payment: $2.50 opportunity</td>
<td>Payment: Standard FFS</td>
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<tr>
<td></td>
<td>Timing: Paid prospectively on a quarterly basis</td>
<td>Timing: Paid prospectively on an annual basis;</td>
<td>Timing: Regular Medicare FFS claims payment</td>
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<tr>
<td><strong>Track 2</strong></td>
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<td>Payment: Reduced FFS with prospective “Comprehensive Primary Care Payment” (CPCP)</td>
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<tr>
<td></td>
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<td>Medicare FFS claim is submitted normally but paid at reduced rate</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Timing: CPCP paid prospectively on a quarterly basis;</td>
</tr>
<tr>
<td><strong>CTOs</strong></td>
<td>Payment: up to 50% of Practice Care Management Fee; depends on 3 option chosen by practice (3)</td>
<td>Payment: $1.50+ for outcomes and population health measures opportunity</td>
<td>N/A</td>
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<tr>
<td></td>
<td>Timing: Paid prospectively on a quarterly basis</td>
<td>Timing: Begins Year 2 of Program</td>
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### Proposed Payment Levels for Practices and CTOs

#### PRACTICES

**Care Management Fees (CMF)**

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<thead>
<tr>
<th>Risk Tier</th>
<th>Criteria</th>
<th>CMF $s</th>
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<tbody>
<tr>
<td>Tier 1</td>
<td>01-24% HCC</td>
<td>$9</td>
</tr>
<tr>
<td>Tier 2</td>
<td>25-49% HCC</td>
<td>$11</td>
</tr>
<tr>
<td>Tier 3</td>
<td>50-74% HCC</td>
<td>$19</td>
</tr>
<tr>
<td>Tier 4</td>
<td>75-89% HCC</td>
<td>$33</td>
</tr>
</tbody>
</table>

**Complex/SUD/BH**

90+% HCC or Dementia $100

**Average**

$28

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#### Performance Based Incentive Payments (PBIP)

<table>
<thead>
<tr>
<th>Risk Tier</th>
<th>Utilization PBPM $</th>
<th>Quality PBPM $</th>
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</thead>
<tbody>
<tr>
<td>Track 1</td>
<td>$1.25</td>
<td>$1.25</td>
</tr>
<tr>
<td>Track 2</td>
<td>$2.00</td>
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</table>

**Funding Source**

Practice PBIP

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#### CTOs

**Performance Based Incentive Payments (PBIP)**

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<thead>
<tr>
<th>Risk Tier</th>
<th>Utilization/ Quality Measures PBPM $</th>
<th>Outcomes Measures PBPM $ (2019-)</th>
<th>State Population Health PBPM $</th>
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<tbody>
<tr>
<td>Track 1</td>
<td>Up to 50% of CMF or $14 on average</td>
<td>$1.50</td>
<td>TBD</td>
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<tr>
<td>Track 2</td>
<td>Up to 50% of CMF or $14 on average</td>
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**Funding Source**

CMF

CTO PBIP

**Population**

Attributed Practices

Attributed Practices

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#### Comprehensive Primary Care Payment (CPCP)

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<tr>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
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<tbody>
<tr>
<td>CPCP% / FFS%</td>
<td>10%</td>
<td>90%</td>
<td>25%</td>
<td>75%</td>
<td>40%</td>
</tr>
<tr>
<td>Options available to practices</td>
<td>25%</td>
<td>75%</td>
<td>40%</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

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**Notes:**
- HCC: High-Cost Case
- SUD: Substance Use Disorder
- BH: Behavioral Health
- CPCP: Comprehensive Primary Care Payment
- CMF: Care Management Fee
- PBIP: Performance Based Incentive Payments
- CTO: Care Team Organizer
CRISP HIT Supports and Services for Practices

Supports

Data Exchange Support Programs (DESP)
- This program will provide funds directly to practices who want to connect with CRISP.
  - The payments are fixed amounts, which the practice can use any way they’d like to offset connectivity costs.
  - In return, the practice will provide and maintain data feeds to CRISP.

  **Goal:** Establish 200 ambulatory practice connection
  **Requirement:** CEHRT

  **Funding**
  Milestone 1 - $3,000
  Milestone 2a - $4,000
  **OR**
  Milestone 2a+2b - $7,000
  Total = up to $10,000

• Milestone 1 – sign-up/agreements
• Milestone 2 – Either encounter or encounter + clinical data integration

Services

Maryland Prescription Drug Monitoring Program
- Monitor the prescribing and dispensing of drugs that contain controlled dangerous substances

Encounter Notification Service (ENS)
- Be notified in real time about patient visits to the hospital

Query Portal
- Search for your patients’ prior hospital and medication records

Direct Secure Messaging
- Use secure email instead of fax/phone for referrals and other care coordination
Practice Scenarios – Large Practice, Track 1

- 9 Providers – 6 Family Medicine, 3 Internal Medicine
- 1,150 attributed Medicare FFS beneficiaries
- Hire 2 Care Managers
- Processes include:
  - Using E.H.R. and payer data, identify patients with chronic conditions; recently hospitalized/ED visits
  - Regularly track and communicate with these patients
  - Weekly meetings for all clinic staff including physicians and pharmacists to review high and rising risk patients

<table>
<thead>
<tr>
<th>Care Management Fees</th>
<th>Performance-Based Incentive Payment</th>
<th>Underlying Payment Structure</th>
<th>MACRA AAPM Participation Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on Risk Scores, practice paid on average $28 PBPM</td>
<td>Practice paid an at-risk incentive payment of $2.50 PBPM (at 75% performance)</td>
<td>Practice receives regular FFS Medicare payments</td>
<td>Practice receives a 5% bonus on 2019 E&amp;M revenue, PY for participation - 2018</td>
</tr>
<tr>
<td>CTO Option 1 - Total: $386,400</td>
<td>Total: $25,875</td>
<td></td>
<td>Total: $16,666</td>
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<tr>
<td>CTO Option 3 - $193,200</td>
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</table>

Total New Dollars

- CTO Option 1 - $428,941 ($31.08 PBPM)
- CTO Option 3 - $235,741 ($17.08 PBPM)
Practice Scenarios – Small Practice, Track 2

- 3 Providers – 1 Internal Medicine, 2 Nurse Practitioners
- 250 attributed Medicare FFS beneficiaries
- Hires a NP to perform home visits for large panel of high risk patients including dementia patients
- Processes include:
  - Using E.H.R. and payer data, identify patients with chronic conditions; recently hospitalized/ED visits
  - Clinical care outside of office to address unmet social needs and provide community supports
  - Weekly meetings for all clinic staff including physicians and pharmacists to review high and rising risk patients

Total New Dollars
CTO Option 1 - $100,427 ($33.48 PBPM)
CTO Option 3 - $58,427 ($19.48 PBPM)

Care Management Fees
Based on Risk Scores, practice paid on average $28 PBPM
CTO Option 1 - Total: $84,000
CTO Option 3 - $42,000

Performance-Based Incentive Payment
Practice paid an at-risk incentive payment of $4 PBPM (at 75% performance)
Total: $9,000

Underlying Payment Structure
Practice elects Comprehensive Primary Care Payment (CPCP) at 50% plus additional 5% bonus based on historic E&M revenue of $35,000
Total: $3,623

MACRA AAPM Participation Bonus
Practice receives a 5% bonus on 2019 E&M revenue, PY for participation - 2018
Total: $3,804
Projected Ramp-Up of Providers

<table>
<thead>
<tr>
<th></th>
<th>Track 1</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
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<tbody>
<tr>
<td>Optimistic ramp-up</td>
<td>Track 1</td>
<td>817</td>
<td>980</td>
<td>939</td>
<td>588</td>
<td>466</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Track 2</td>
<td>1,225</td>
<td>1,593</td>
<td>2,083</td>
<td>2,661</td>
<td>2,937</td>
<td>3,198</td>
</tr>
<tr>
<td>Standard ramp-up</td>
<td>Track 1</td>
<td>643</td>
<td>771</td>
<td>739</td>
<td>501</td>
<td>366</td>
<td>141</td>
</tr>
<tr>
<td></td>
<td>Track 2</td>
<td>643</td>
<td>1,093</td>
<td>1,537</td>
<td>2,032</td>
<td>2,205</td>
<td>2,366</td>
</tr>
<tr>
<td>Conservative ramp-up</td>
<td>Track 1</td>
<td>327</td>
<td>425</td>
<td>464</td>
<td>379</td>
<td>267</td>
<td>114</td>
</tr>
<tr>
<td></td>
<td>Track 2</td>
<td>218</td>
<td>446</td>
<td>674</td>
<td>923</td>
<td>1,094</td>
<td>1,185</td>
</tr>
</tbody>
</table>

- Annual application process, practices enroll when they are ready to succeed
- Projections assume that some PDPs will initially enter in Track 1 and others will enter in Track 2
- PDPs will progress from Track 1 to Track 2, Track 1 PDPs have three years to reach Track 2
- Federal government will make a financial investment (up to $750 million over five years) to implement Primary Care Model and in support of Population Health
Learning System

• CMMI to operate Learning System in collaboration with the State using National (Booz Allen) and Regional (Lewin) Learning System contractors
  – Regional contractor may subcontract with local organizations

• Learning System will assist practices in
  – meeting care delivery requirements
  – Transitioning from Track 1 to Track 2

• CMMI will monitor practices for meeting care delivery requirements

• By 2021, the Learning System is expected to transition to State responsibility
Practice Eligibility in MCPC

Qualifiers

• Utilize a certified electronic health record
• CRISP level 3 connectivity --- Use CRISP Portal, ENS, Direct Messaging
• At least 150 attributed FFS Medicare beneficiaries
• Already engaged in specified practice transformation activities

Exclusions

• Charge any concierge fees to Medicare beneficiaries
• Participate in certain other CMMI initiatives (i.e., Accountable Care Organization [ACO] Investment Model, Next Generation ACO Model, and Comprehensive ESRD Care Model)
<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain Approval for Model from HHS</td>
<td>Summer 2017</td>
</tr>
<tr>
<td>Write legal agreements and applications for CTOs and practices</td>
<td>Summer 2017</td>
</tr>
<tr>
<td>Stand up Program Management Office</td>
<td>Summer/Fall 2017</td>
</tr>
<tr>
<td>Release applications</td>
<td>Fall 2017</td>
</tr>
<tr>
<td>Select CTOs and Practices</td>
<td>Late Fall 2017</td>
</tr>
<tr>
<td>Initiate Program</td>
<td>Summer 2018</td>
</tr>
<tr>
<td>Expand Program</td>
<td>2019 - 2023</td>
</tr>
</tbody>
</table>
Getting Ready for MCPC

Consider Track Options

• Apply for Track 1 or Track 2?
• If I choose Track 2, what is the level of engagement with capitated payments?

Assess ability to perform advanced primary care functions?

• Can I employ care managers?
• Should I use a CTO?
  – Who is available in my area?
  – What is the level of participation?

• Consider interplay between MSSP program and MCPC
Useful Videos on CPC+

• Part 1: (Attribution)
  https://www.youtube.com/watch?v=re7XBlJ9j-A&feature=youtu.be

• Part 2: (Care management fees)
  https://www.youtube.com/watch?v=NBVNVyNeKJ8&feature=youtu.be

• Part 3: (Performance Based Incentive Payment)
  https://www.youtube.com/watch?v=qU4hF1d9Xjl&feature=youtu.be

• Part 4: (Hybrid Payment)
  https://www.youtube.com/watch?v=xPeyjE8couk&feature=youtu.be
MACRA AWARENESS AND SUPPORT PROGRAM (MAS)
MAS

- Developed by MHCC to assist ambulatory practices in preparing for MACRA
- The program aims to educate stakeholders on important information and available resources to support the components MIPS and Advanced Payment Models APMs
- The MAS Program will consist of virtual one-hour lunch and learn sessions
- The sessions will include industry experts to present on topics pertaining to health care payment reform that were identified by industry stakeholders as being of interest to the target audience
- MAS will also include online learning modules
Thank You!

Any Questions?

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Maryland Department of Health & Mental Hygiene
Thank You!

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