Goals of Primary Care Model

• **Improve the health of Maryland through:**
  – Person-centric healthcare
  – Team-based support
  – Evidence-based approach
  – Consistent quality and outcome metrics
  – Volume to Value
  – Reduce potentially avoidable utilization
  – Improve management of chronic illness
  – Alignment with Maryland All-Payer Model and Medicaid Duals ACO
  – Alignment with State Population Health Improvement Plan (due to CMMI: 12/31/2016)

• **Timeline:**
  – 11/30/2016: Public Comment
  – 12/31/2016: Submit Primary Care Model concept paper to CMMI
  – 2017: Enhanced Infrastructure development begins:
    • Coordinating Entity development
    • Care Transformation Organization formation / applications
    • Practice adoption/technical assistance
    • HIE Expansion, more primary care providers achieve connectivity
  – 2019 – 2023: Sustainability achieved through long term Return on Investment
Transformation Progression

2014 – 2015
- Hospital Global Budgets

2016 – 2018
- Financial Alignment
- Formal Partnerships & Infrastructure

2019 and Beyond
- Total Cost of Care
- Sustainable Population Health Models

ALL-PAYER MODEL

SHIP and LHICs

POPCULATION HEALTH

Submit designs of:
- Primary Care Model
- State Population Health Plan
- All Payer Model Progression Plan
- Duals ACO

Dec 31, 2016

2017
- All Payer Model Amendment, Population Health Plan – Design
- Primary Care Model – infrastructure development

2018
- Primary Care Model – Year 1 Operation
- Additional Population Health Plan and VBP - Planning
**Relationship to All-Payer Model and Progression Plan**

- The Primary Care Model will help 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 the Care Redesign Amendment
  - Community-level alignment to CCIP
- Reduces avoidable hospitalizations and ED usage through advanced primary care access and prevention
  - Components include embedded care managers, 24/7 access to advice, medication mgt., open-access scheduling, behavioral health integration, and social services
- Enhanced version of CPC+ will complement and support hospital global budgets
Relationship with CCIP

- Align community providers with Hospital Model goals:
  - Ideal: CTO coordinates between hospital-identified patients and PCHs
- Direct delivery of services in the community
  - Non-office based primary care
  - Align with HSCRC
    - Provide community based care coordination and population health
- Differs in Risk Stratification
  - PCHs must risk stratify their own population, identifying high-risk patients needing:
    - Longitudinal, relationship-based care management
    - Short-term, episodic care management (not depending on risk status)
  - CTOs will support practice management for identified populations
  - CEs will risk stratify to determine care management fee for each PCH
MACRA

Law *intended* to align physician payment with *value*

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

Quality Payment Program

- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Models (APMs)

The Quality Payment Program Provides **Additional Rewards for Participating in APMs**

Potential financial rewards

<table>
<thead>
<tr>
<th>Not in APM</th>
<th>In APM</th>
<th>In Advanced APM (AAPM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS adjustments</td>
<td>MIPS adjustments</td>
<td>APM-specific rewards</td>
</tr>
</tbody>
</table>

If you are a **Qualifying APM Participant (QP)**

5% lump sum bonus

Leveraging Window of Opportunity

• CMMI willingness to allow the State to customize CPC+, which is an approved AAPM model

• Maintaining All Payer Model and broader health transformation in State depend on primary care with strong supports
OVERVIEW OF PRIMARY CARE MODEL
Maryland Primary Care Model

Medicare (Part B) moving to all-payer Care Management Payments

Coordinating Entity

Hospital Chronic Care Initiative (CCIP)
High Risk Patients, Rising Risk Patients PQI Bonuses

Care Transformation Organizations
Care Management Resources & Infrastructure
e.g., (ACO, CIN, LHIC, LHD, RP, Health Plan)

PDP embeds CM resources

CM

Person-Centered Home (PCH)

Patient-Designated Provider (PDP)

xx% CM Funds

Advisory Board

xx% CM Funds

CM

xx% CM Funds

PDP requests unembedded CM resources

CM

Person-Centered Home (PCH)

Patient-Designated Provider (PDP)

HIT Infrastructure/CRISP

Quality Payments at Risk (MACRA qualifying)

Visit/Non-Visit-based Payments

MACRA Bonus Payments
Dollar Flow and Contracting

CM Dollar Flows
- CTOs will have a *prescribed* amount of the % dollars
  - This is determined by the CE, with stakeholder input
- Dollars will be *capped* based on suite of services offered
- Practices will receive *bonus* dollars

Contracting
- Providers/Practices can contract directly with the Coordinating Entity (CE)
- More flexibility in the model
- Providers/Practices will have to meet all the care transformation requirements and services
  - Set by the Governing Body
- If practices are able to do this they will *not* have to contract with a CTO
PATIENT DESIGNATED PROVIDERS
Patient Designated Providers (PDPs)

- The most appropriate provider to manage the care of each patient
- Provides preventive services
- Coordinates care across the care continuum
- Ensures enhanced access
- Most often this is a PCP but may also be a specialist, behavioral health provider, or other depending on patients health needs

Percentage of Patient-Designated Providers by Specialty

- Internal Medicine: 38%
- Family Practice: 19%
- Obstetrics/Gynecology: 8%
- Cardiology: 9%
- Family Medicine: 1%
- Geriatric Medicine: 1%
- Hematology/Oncology: 4%
- General Practice: 1%
- Nephrology: 2%
- Nurse Practitioner: 7%
- Pulmonary Disease: 2%
- Gastroenterology: 5%
- Pediatrics: 3%
- Psychiatry: 0%

n~ 4700 Providers
Person Centered Home

• Person-Centered Home (PCH)
  – An individual provider or group of providers that deliver care as a team to a panel of patients
  – The PCH must have at least one PDP
  – PCH practices must meet the requirements laid out by the Model – CPC+ like
  – Practices may span multiple physical sites in the community
Practice Transformation is Key

• Practices will NOT be expected to be transformed on day 1 or program start

• Leveraging existing transformation networks

• The State is committed to designing a system to provide assistance with practice transformation:
  – Care Transformation Organizations (CTOs) will be approved to assist practices
  – Practices will choose the best CTO for them
  – CTOs will ensure that practices meet requirements under program by developing high functioning services including:
    • Care management resources and people
    • Technical assistance on practice transformation
    • IT supports (CTO and CRISP)
The Role of Care Managers

- Care managers will work very closely with physicians, NPs, PAs, nurses and other members of a primary care team.
- They will assist the clinicians, patients, and family members in the development and implementation of care plans tailored to each patient’s needs.
- Care managers will arrange for services such as transportation, nutrition, and help smooth transitions of care.
- Care managers can be embedded in PDP practices; an alternative approach for the deployment of care managers to practices on an as-needed basis.
Building an enhanced version of CPC+

• Under Maryland’s version of CPC+, the addition of the CTOs will provide PDPs with both technical assistance from the CTOs and financial assistance from the federal government.

• This will help practices cover the cost of non-visit care management activities; this can be coupled with open access scheduling and extended hours to help make practices more accessible to patients.

• The Care Management Fee and the performance-based incentive payments under CPC+ will also help finance these practice enhancements.
I am a Patient: What does a transformed practice look like to me?

- I am a Medicare beneficiary
- Provider selection by my historical preference
- I have a team caring for me led by my Doctor
- My practice has expanded office hours
- I can take advantage of open access and flexible scheduling:
  - Telemedicine, group visits, home visits
- My care team knows me and speaks my language
- My records are available to all of my providers
- I get alerts from care team for important issues
- My Care Managers help smooth transitions of care
- I get Medication support and as much information as I need
- I can get community and social support linkages (e.g., transportation, safe housing)
I am a Provider: What does a transformed practice look like to me?

- Voluntary participation
- Opportunity to select CTO
- Patient care management support based on severity index
- Care managers embedded in my practice or provided via CTO
- 3800 “eligible” practices in Maryland
  - Minimum 150 beneficiaries
  - At least 60% E&M visits + VX + Standard Tests
- Practice incentives:
  - 5% MACRA participation bonus (lump sum); CPC+ participation
  - Quality and Utilization incentive bonus $2.50 or $4 PBPM (Track 1, Track 2, respectively) – Prepaid
  - Track 2 comprehensive payment – Prepaid
  - Care Management payment PBPM risk adjusted
  - Care management infrastructure
  - Practice transformation support
  - Healthier patient population
  - Reimbursement for non-office based visits
## Provider Definition

### Primary Care and Specialists as designated by Patient

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total Providers</th>
<th>Providers in practices &gt;= 60% services</th>
<th>Providers in practices with Def 4 AND 150 benes</th>
<th>Providers in practices with Def 5 AND 150 benes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>% of spec</td>
<td>#</td>
<td>% of spec</td>
</tr>
<tr>
<td>Cardiology</td>
<td>428</td>
<td>177</td>
<td>174</td>
<td>207</td>
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<tr>
<td>Family Medicine</td>
<td>30</td>
<td>28</td>
<td>26</td>
<td>27</td>
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<tr>
<td>Family Practice</td>
<td>974</td>
<td>906</td>
<td>829</td>
<td>868</td>
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<tr>
<td>Gastroenterology</td>
<td>238</td>
<td>52</td>
<td>49</td>
<td>63</td>
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<tr>
<td>General Practice</td>
<td>62</td>
<td>56</td>
<td>32</td>
<td>32</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>22</td>
<td>17</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>170</td>
<td>39</td>
<td>38</td>
<td>72</td>
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<tr>
<td>Internal Medicine</td>
<td>1921</td>
<td>1675</td>
<td>1552</td>
<td>1703</td>
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<tr>
<td>Nephrology</td>
<td>101</td>
<td>10</td>
<td>10</td>
<td>18</td>
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<tr>
<td>Nurse Practitioner</td>
<td>373</td>
<td>296</td>
<td>266</td>
<td>303</td>
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<tr>
<td>OB/GYN</td>
<td>430</td>
<td>234</td>
<td>192</td>
<td>220</td>
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<tr>
<td>Pediatric Medicine</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>6</td>
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<tr>
<td>Psychiatry</td>
<td>236</td>
<td>213</td>
<td>119</td>
<td>138</td>
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<tr>
<td>Pulmonary Disease</td>
<td>113</td>
<td>98</td>
<td>97</td>
<td>104</td>
</tr>
<tr>
<td>Total</td>
<td>5105</td>
<td>3805</td>
<td>3405</td>
<td>3781</td>
</tr>
</tbody>
</table>

% of spec% of spec% of spec% of spec
CARE TRANSFORMATION
ORGANIZATIONS
How do I become a Care Transformation Organization?

- Certification by external accrediting body
- Bi-directional accountability CTO <-> Practice / Providers
- CTOs cannot apply on behalf of Practices / Providers
- CTOs are non-regionally based
- CTO internal competition
- Apply through Coordinating Entity (CE)
  - CE holds CTO accountable for requirements and outcomes
- Market Share Assessment: On-going
  - Subcontracts: Coordinating Centers, Local Health Departments, HCAM
- Ability to provide following services includes:
  - Care management infrastructure
    - Nurses, pharmacists, nutritionists, Community Health Workers, LCSWs, Health educators
  - Technical assistance for 24/7 after-hours access
  - Social support connections – Community Health Workers
  - “Hot-spotting” areas with high and/or specific needs
  - Pharmacist support for medication management and consultations
  - Assisting practices in meeting Primary Care Model requirements
  - Physician training resources
  - CRISP connectivity
COORDINATING ENTITY
## Functions of Coordinating Entity

<table>
<thead>
<tr>
<th>Functions of the CE</th>
<th>Who Performs Them</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Design</strong></td>
<td></td>
</tr>
<tr>
<td>Develop requirements for CTO and PCH participation</td>
<td>Governing Board</td>
</tr>
<tr>
<td>Engage stakeholders through an Advisory Board for input on program policy and outcomes</td>
<td>Governing Board</td>
</tr>
<tr>
<td><strong>Program and Budget Administration</strong></td>
<td></td>
</tr>
<tr>
<td>Design, review and approve CTO and PCH applications</td>
<td>MHCC</td>
</tr>
<tr>
<td>Administer Medicare beneficiary attribution to PCHs</td>
<td>CMS</td>
</tr>
<tr>
<td>Run algorithms for the defined payment logic to determine distribution of care management fees</td>
<td>CRISP or MHCC</td>
</tr>
<tr>
<td>Financial administration (accepting the dollars from CMS or another payer and actually redistributing it to the CTO or PCH)</td>
<td>MHCC or contractor?</td>
</tr>
<tr>
<td>Enter into and monitor contracts with key partners, such as:</td>
<td>MHCC</td>
</tr>
<tr>
<td>• External National Accreditation Organization for CTO certification</td>
<td></td>
</tr>
<tr>
<td>• Other partners as identified by CEO</td>
<td></td>
</tr>
<tr>
<td>Develop boilerplate contracts for relationship between CTOs and PCHs</td>
<td>MHCC</td>
</tr>
<tr>
<td><strong>Informatics/Data Analytics</strong></td>
<td></td>
</tr>
<tr>
<td>Perform ongoing reporting and analysis in support of model-specific goals (in support of Learning System)</td>
<td>CRISP</td>
</tr>
<tr>
<td>Provide CTOs and PCHs with regular reports to inform decision-making (in support of Learning System)</td>
<td>CRISP</td>
</tr>
<tr>
<td>Provide regional population health outcomes/metrics (eCQMs rolled up)</td>
<td>CRISP</td>
</tr>
<tr>
<td><strong>Model Compliance</strong></td>
<td></td>
</tr>
<tr>
<td>Monitor CTO and PCH performance for assessment of compliance with model participation</td>
<td>MHCC or CMMI?</td>
</tr>
<tr>
<td>Recommends corrective action plans where needed</td>
<td>MHCC or CMMI?</td>
</tr>
<tr>
<td><strong>Model Evaluation (tentative)</strong></td>
<td></td>
</tr>
<tr>
<td>Contract with an independent outcome evaluation group to monitor performance against goals of population health, quality of care, and cost targets</td>
<td>MHCC</td>
</tr>
</tbody>
</table>
Coordinating Entity Organization Design

**State**
- MHCC Responsible for CE Operations
  - Program and Budget Administration
  - Analytics
  - Model Compliance
  - Convene Governing Board

**CMMI**

**Governing Board**
- Appointments based on affiliation and skills, including innovation and primary care delivery experience
- Responsible for program design: develops rules and requirements for CTO and provider participation
- Engage stakeholders for input on program policy and outcomes

**Contracting**
- CRISP
- URAC
- Others
Summary View of Primary Care Program
Stakeholder Engagement

- Ongoing meetings with:
  - Providers
  - Health Systems
  - Payers
  - Consumers
  - Local Health Departments

- CMMI meetings on a biweekly basis

- HSCRC, Medicaid, CRISP, MHCC collaboration

- Incorporating Dual Eligibles FFS outside of ACO regions – working with Duals Workgroup
Concept Paper Submission to CMMI

• Finalizing Concept Paper (November 11)
• Draft to be shared informally with CMMI (November 16)
• **Release Concept Paper for public comment (November 30)**
• Submit Concept Paper by December 31, 2016
• Formal proposal to be developed in early 2017
• Track our progress:

  *google us “DHMH OPHI Healthcare Transformation”*

  [http://pophealth.dhmh.maryland.gov/Pages/transformation.aspx](http://pophealth.dhmh.maryland.gov/Pages/transformation.aspx)