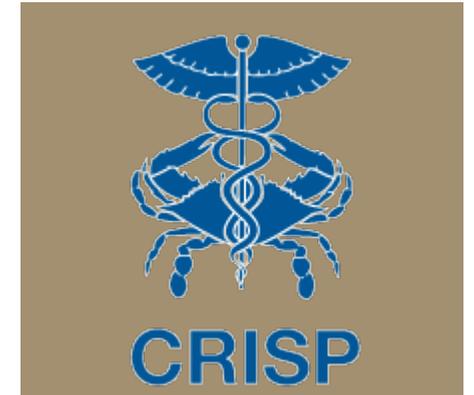


Total cost of care ambulatory practices and CRISP – a brief introduction



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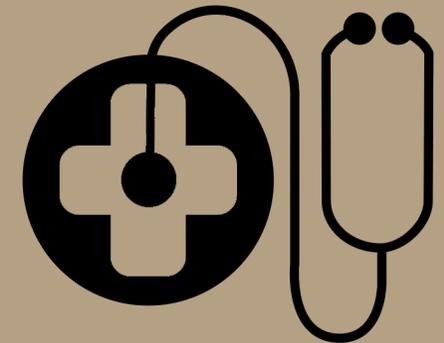
Introduction to MedChi

- MedChi is the seventh oldest medical society, formed in 1799 in Annapolis, MD.
- The Mission of MedChi, The Maryland State Medical Society, is to serve as Maryland's foremost advocate and resource for physicians, their patients, and the public health of Maryland.
- MedChi is the largest physician organization in Maryland
 - Physicians – Primary Care and Specialists
 - Medical Residents and Students
 - Practice Managers and Medical Staff

MedChi

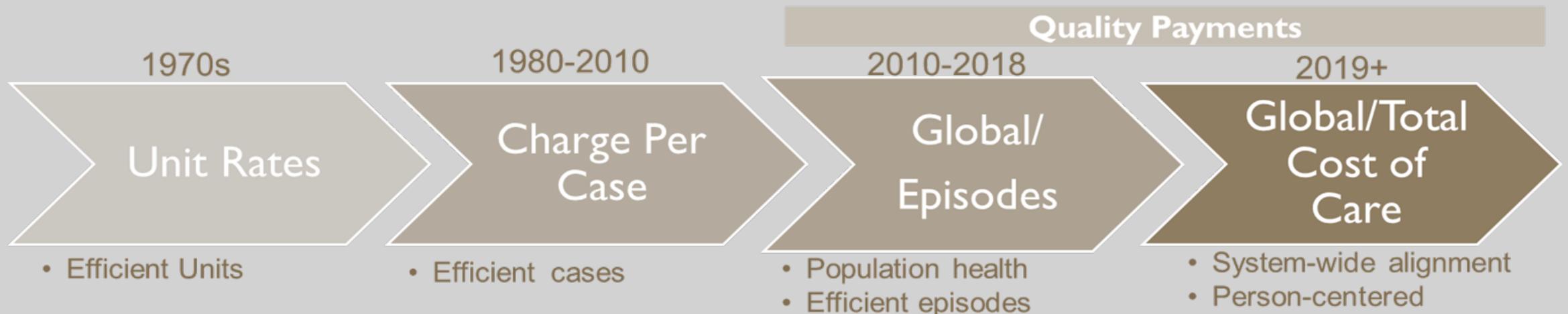
The Maryland State Medical Society

Your Advocate. Your Resource. Your Profession.



Background: Maryland's All-Payer Model

- Since 1977, Maryland has had an all-payer hospital rate-setting system
- In 2014, Maryland updated its approach through the All-Payer Model
 - 5-year state innovation between Maryland & federal government (2014 through 2018) focused on hospital payment transformation
 - Per capita, value-based payment framework for hospitals
 - Provider-led efforts to reduce avoidable use and improve quality and coordination
 - Savings to Medicare without cost shifting
 - Sustains rural health care with stable revenue base



What is the Maryland Primary Care Program?



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(maryland.gov)

The State of Maryland has entered a Total Cost of Care All-Payer Model contract with the Federal Government that is designed to coordinate care for patients across both 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 development of the Maryland Primary Care Program (MDPCP). MDPCP is a voluntary program open to all qualifying Maryland primary care practitioners that provides funding and support for the delivery of advanced primary care throughout the state.

The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.

Eligible Specialties



General Practice (01)

Family Medicine (08)

Internal Medicine (11)

Obstetrics and Gynecology (16)

Pediatric Medicine (37)

Geriatric Medicine (38)

Nurse Practitioner (50)

Clinical Nurse Specialist (89)

Co-located Psychiatry (26)*

Physician Assistant (97)

Preventive Medicine (84)

Certified Nurse Midwife (42)

Ensure providers are listed as one of the eligible specialties:

- Specialists with these primary specialty codes are not eligible to participate
- * Practitioners identified with a primary specialty code of Psychiatry (26) must be co-located with an eligible practitioner with a primary specialty code other than Psychiatry in order to participate

Payment Incentives in the MDPCP

Practices – Track 1/Track 2

Care Management Fee

- \$6-\$100 Per Beneficiary, Per Month (PBPM)
 - Tiered payments based on acuity/risk tier of patients in practice including \$50/\$100 to support patients with complex needs, dementia, and behavioral health diagnoses
- Timing: Paid prospectively on a quarterly basis, not subject to repayment

Performance-Based Incentive Payment

- Up to a \$2.50/\$4.00 PBPM payment opportunity
- Must meet quality and utilization metrics to keep incentive payment
- Timing: Paid prospectively on an annual basis, subject to repayment if benchmarks are not met

Underlying Payment Structure

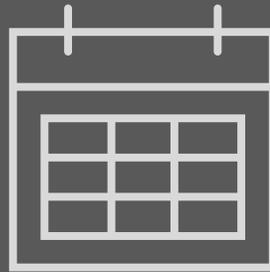
- Track 1: Standard FFS
- Track 2: Partial pre-payment of historical E&M volume with 10% bonus
- Timing: Track 1: FFS; Track 2: prospective

Maryland Primary Care



MARYLAND
Department of Health

- Program has been extended



- Open enrollment coming soon



The Purpose of Episode Quality Improvement Program (EQIP)



Under the Total Cost of Care Model, **Maryland's healthcare system has focused on reducing costs and improving quality of care** for Marylanders who receive care in both hospital and non-hospital settings.

Maryland **physicians largely remain on fee-for-service** reimbursement incentives and, as a result of the TCOC Model, are left out of national, **Medicare** value-based payment programs.

Therefore, it is imperative that the State **creates new value-based reimbursement opportunities to ensure cost containment in non-hospital settings.**

EQIP - The Episode Quality Improvement Program

The HSCRC plans to start a voluntary, episodic incentive payment program for specialist physicians in Medicare, EQIP, in 2022.

Physician ownership of performance

Upside-only risk with dissavings accountability

Alignment with CareFirst's episode payment program

AAPM/value-based payment participation opportunities for MD physicians

EQIP will utilize the Prometheus Episode Grouper approach. The first performance year will include episodes in the following specialty areas:

- Gastroenterology and General Surgery
- Orthopedics and Neurosurgery
- Cardiology

Episodic Value-Based Payment

Physicians Agree to Episodic Payment

- Signed Agreement with a CRP Entity
- Enroll in clinical episodes that will **Trigger** when a specific Medicare beneficiary or procedure is performed

Target Price is Set

- Costs from episodes triggered in the baseline year are aggregated
- A per episode average cost or **Target Price** is set

Performance Assessed

- Performance year episode costs are compared to the Target Price
- Savings are aggregated to determine the **Incentive Payment** due to the physician

- Bundled-payment programs, in-particular, are effective at controlling episodic care and improving quality outcome among physicians via a financial assessment
- Analyses of CMS bundled-payment programs have shown 4-6 percent reductions in gross Medicare spending

CRISP Services Support Physician model engagement

- 1) **Information at the Point of Care**
 - a. Allow providers to search for patient health information, either through the CRISP secure online portal or automatically within their native Electronic Health Record (EHR) system.
 - b. Alert providers to critical information about their patients, such as the dispensing of opioids or other members of the patient's care team.
- 2) **Encounter Notifications for Care Coordination**
 - a. Notify a patient's caregiver when there is an emergency department visit or hospitalization.
 - b. Enable care teams to communicate with each other and community-based organizations.
- 3) **Reporting Services for Population Health**
 - a. Use hospital casemix data to provide consistent, transparent reports to hospitals and the Health Services Cost Review Commission regarding readmissions and avoidable utilization.
 - b. Use Medicare claims data to understand the total cost of care trends and enable providers to design and execute population health interventions.
- 4) **Support for Public Health**
 - a. Deploy services in partnership with the Maryland Department of Health to share immunization and syndromic surveillance data, link community-based care providers, and pilot new programs.
 - b. Provide technology and collaboration across Covid response efforts including data enrichment, reports for local health departments, and information for clinicians.
- 5) **Administration of Care Redesign Programs**
 - a. Make policy discussions more transparent and informed through data-driven collaboration.
 - b. Support the Total Cost of Care Model programs with administrative functions such as file submissions to CMS and analytic tools.

- The Maryland Primary Care program has provided a higher level of service to hundreds of thousands of Medicare patients in Maryland and helped with the response to covid. It is one of the largest and most successful advanced payment models in the country.
- The newly launched Episode Quality improvement program is a new opportunity to include proceduralist in value-based payment. It has been created in an aligned fashion with at least one private insurance carrier.
- CRISP tools are key to physician success to the model



Thoughts/Questions