MDPCP Update

CRISP Summit 2024

Maryland Primary Care Program Management Office
Chad Perman, Executive Director

April 23, 2024

Key Facts

- MDPCP is the largest state-based Medicare advanced primary care program in the nation
- Covers over 50% of the eligible Medicare FFS population
- MDPCP is in the 6th year of operation and spans every Maryland county
- Cumulative reduction in avoidable hospital utilization = 28% (2019-2022)
- Approved through December 2026
- Opportunity to continue beyond 2026 under AHEAD Model

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MDPCP Recent Accomplishments

- **New Participants onboarding** - Onboarded 25 new MDPCP practices and 1 CTO for 2024 program year
- **Behavioral Health Integration**-
  - Reached milestone of over 1,000,000 MDPCP beneficiaries screened for risky alcohol use and illicit substance use through SBIRT - data reported via CRISP
  - 338 current MDPCP practices have implemented SBIRT
- **Health Equity** - Partnered with 211MD to update over 1,000 resources in their directory of social service resources and help 211MD establish key partnerships in Eastern and Western Maryland - resources linked to CRISP
- **Learning System** - Hosted the 2023 Advanced Primary Care Staff Training Academy
- **CRISP Tools and Reports**-
  - Implementation of the Prediabetes and Non-Fatal Overdose Smart Alerts
  - New reports and tools: SBIRT dashboard, Multi-payor reports platform, Medication Synchronization Opportunity Summary and High Risk Medications-Top 100 Prescribers reports, TPCC report
- **Practice Coaching** - Successfully engaged all practices that needed to transition tracks - 99% pass rate

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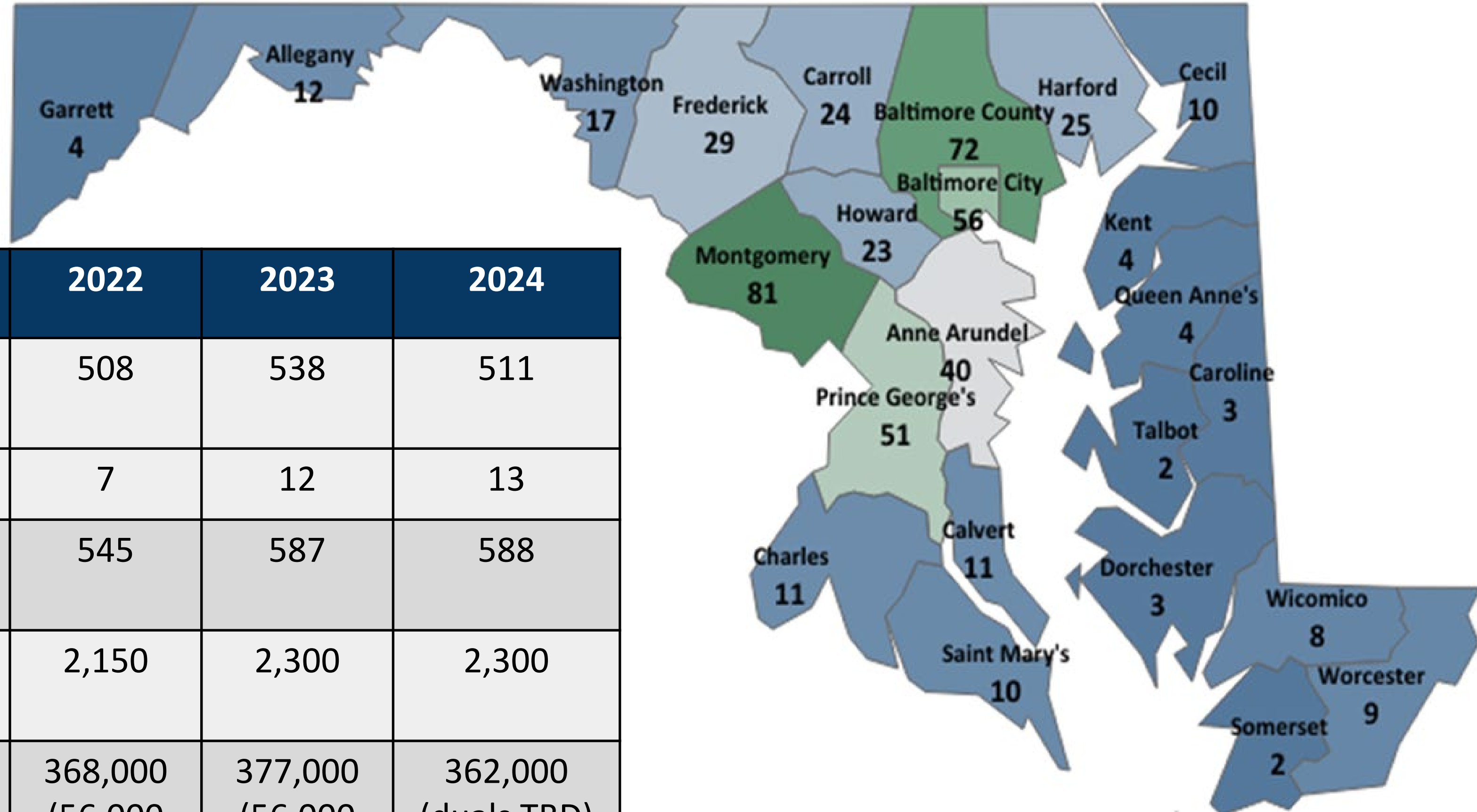
MDPCP in 2024 - 511 Participating Practices

Support infrastructure – 26 Care Transformation Organizations

Statewide – Practices in every county



PARTICIPANTS	2019	2020	2021	2022	2023	2024
Practices	380	476	525	508	538	511
FQHCs	-	-	7	7	12	13
Total sites	380	476	562	545	587	588
Providers*	1,500	2,000	2,150	2,150	2,300	2,300
Medicare Beneficiaries attributed*	215,000 (30,000 duals)	326,000 (48,000 duals)	387,000 (58,000 duals)	368,000 (56,000 duals)	377,000 (56,000 duals)	362,000 (duals TBD)

Largest state program in the nation through 2023 - by number of practices and practices per capita (compared to CMS' national Primary Care First Model)

*Yearly totals for these metrics are approximate and based on Q1 attribution for the corresponding year.

Overview of Practice Participation Options

Payments

TRACK 1

Standard

SUNSETTED IN 2023

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

- Care Management Fee (CMF)
- Performance-Based Incentive Payment (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)

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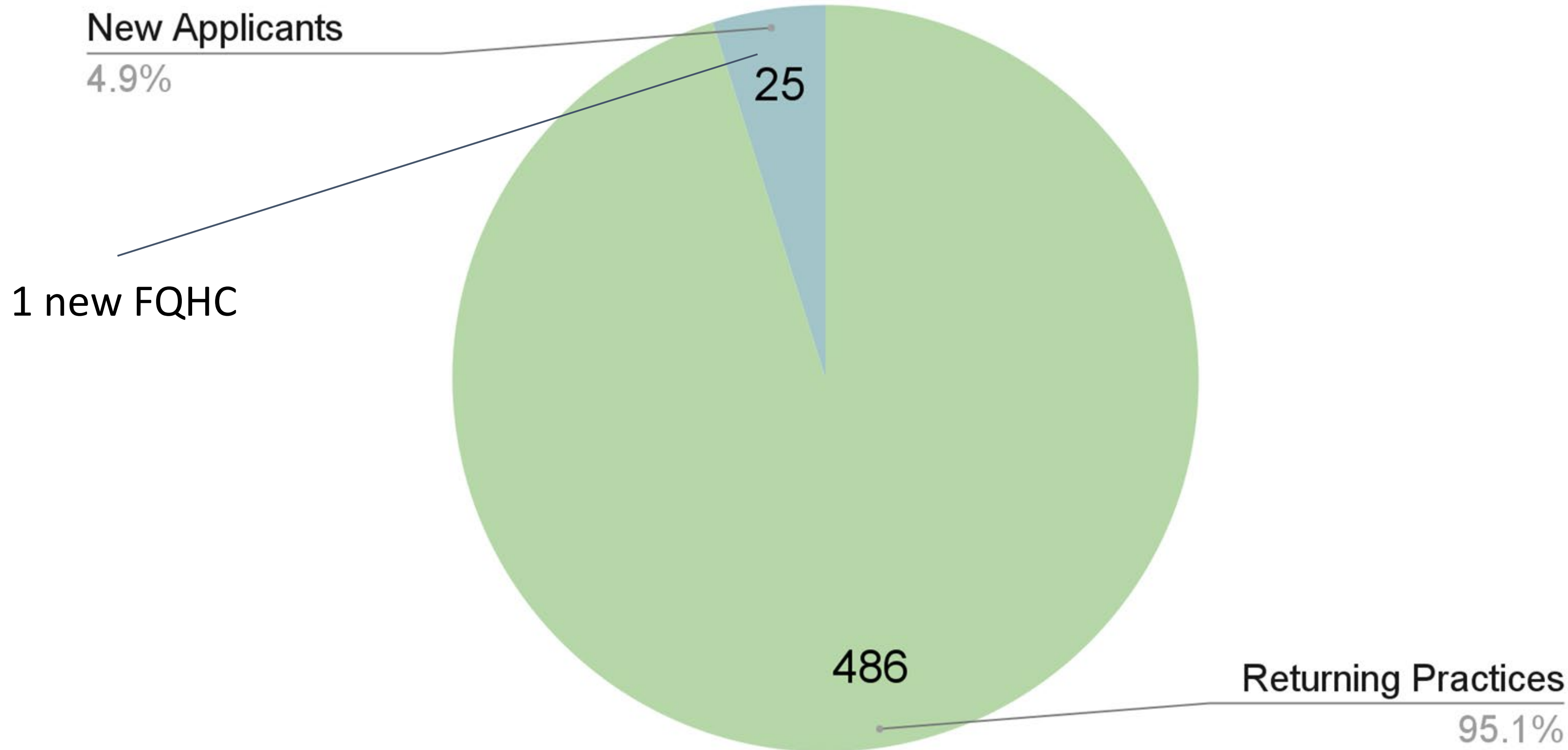
Regional Diversity of 2024 Starters

511 total practices, including 13 FQHCs



Regional diversity:

- 8 Capital region
- 7 Central region
- 4 Southern region
- 6 Western region

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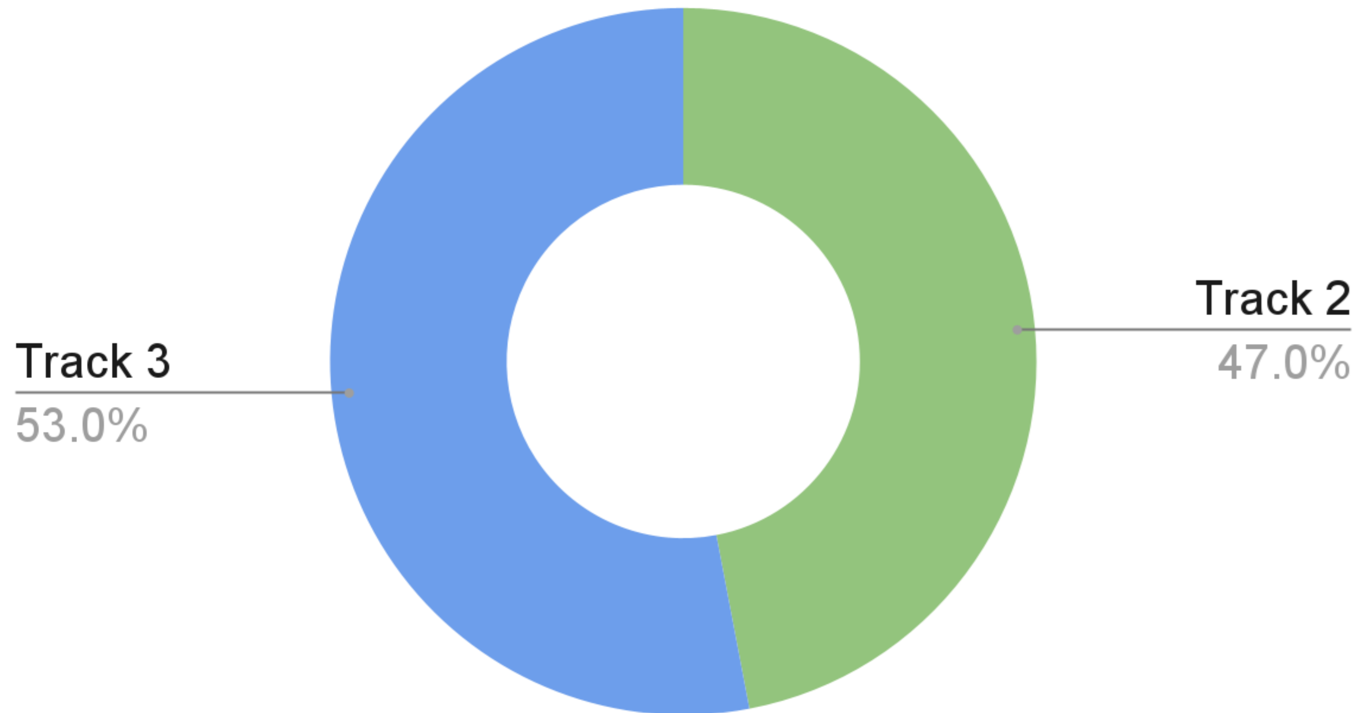
2024 MDPCP Participants by Track



Track 1
0 Practices
⬇57 from prior year

Track 2
239 Practices
⬇ 82 from prior year

Track 3
272 Practices
⬆121 from prior year

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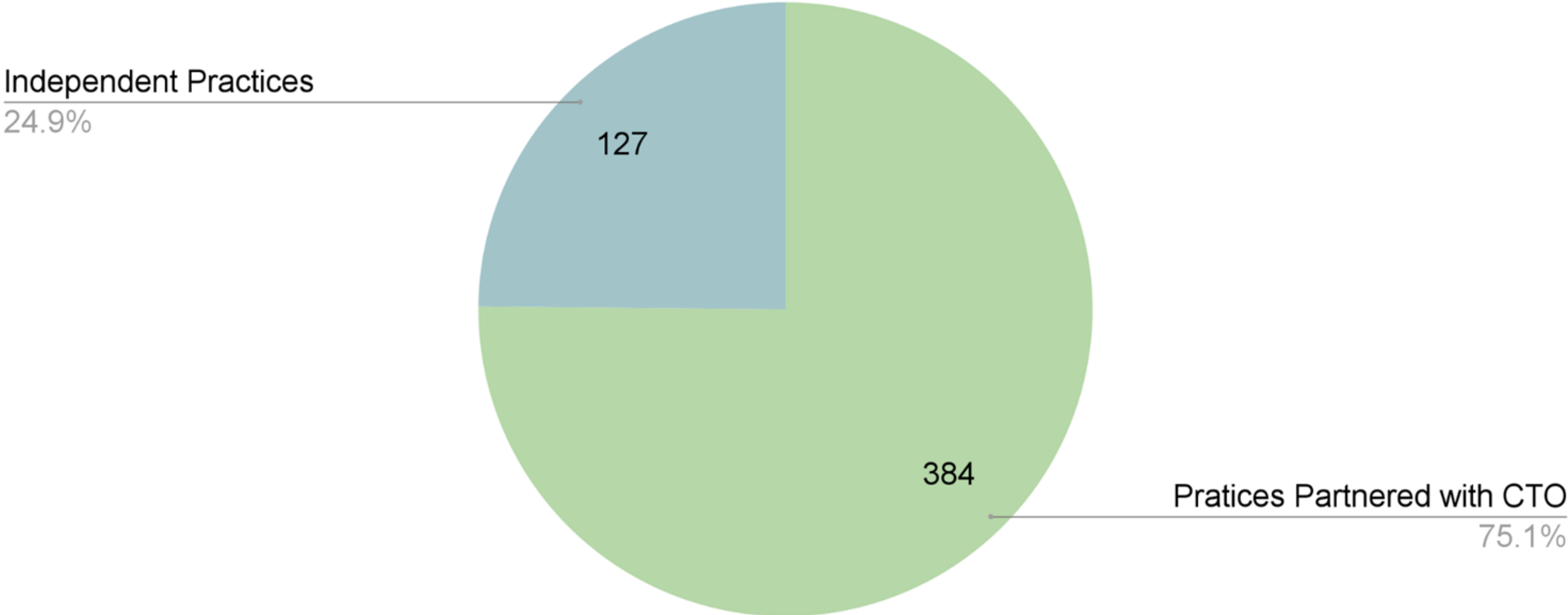
2024 CTO Partnership



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MDPCP Impacts on Utilization and Costs

- **Reduced acute utilization** per 1,000 beneficiaries, 2019-2022:*
  - Reduced Avoidable hospital utilization (PQIs) by **28%.**
    - MDPCP cumulative change in PQI-like events is 1.25% lower than the equivalent non-participating population
  - Reduced Emergency Department (ED) utilization by **18%**.
    - MDPCP cumulative change in ED utilization is 1.25% lower than the equivalent non-participating population
  - Reduced Inpatient Hospitalization (IP) utilization by **15%.**
    - MDPCP cumulative change in IP utilization is 5.5% lower than the equivalent non-participating population
- **Lower growth in Costs** Per Beneficiary Per Month, 2019-2022:*
  - Lower average annual cost growth rate compared to equivalent non-participating population. (2.76% vs. 3.00%)

*Rates are risk-adjusted, which accounts for differences in patient population illness acuity, to allow for direct comparison

Note: Data through June 2023 is available in the Appendix

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Accomplishments

National Recognition

- MDPCP presentation to **National Academy (NASEM)** for the "Strengthening Primary Care" webinar
  - One pager
  - Slide deck and recording
- **JAMA Article**: *The Maryland Primary Care Program—A Blueprint for the Nation?*
- **HEART** payment presentation at **2022 American Academy of Family Physicians** Family Medicine Experience Conference
- **Milbank Issue Brief**: *Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health–Supported Advanced Primary Care Paradigm*
- ***JAMA Article***: *MDPCP Beneficiary COVID Outcomes*
  - *27% lower death rate*
  - *12% lower admission rate*

MDPCP

The Maryland Primary Care Program: Successful State Innovation
Integrating Primary Care and Public Health

The Maryland Primary Care Program (MDPCP), a partnership between the Maryland Department of Health and the Center for Medicare and Medicaid Innovation (CMMI), is demonstrating that sufficient strategic investments in primary care can enable the delivery of high-value care that improves health equity while reducing costs.This advanced primary care program launched in 2019; within two years of its onset, 2/3rds of all eligible primary care practices (525) had enrolled and Program Year three (PY3), 88% of participating practices have transitioned to the advanced level of the program, signifying delivery of advanced primary care.

MDPCP has achieved this success through four key strategies:

INCREASE IN PRIMARY HEALTH CARE **INVESTMENT**

See NASEM Report

A successful Advanced Primary Care program needs to provide sufficient resources to meet the needs of the patient population. In MDPCP, this means supplying adequate financial funding to support team-based care and providing additional state resources available that support the goals of population health. The Medicare non-visit-based payments made to MDPCP participants in 2021 averaged ~$31 per beneficiary per month (PBPM), which approximately doubles the average overall payments. **Even after accounting for this level of financial support, a study done by the Maryland Health Services Cost Review Commission using a difference-in-difference methodology and risk adjusted comparison group estimated that MDPCP practices had a net savings over the first two years of the program of $16 million even after accounting for the additional investments.**

PRIMARY HEALTH CARE **DASHBOARDS**

Early on, MDPCP worked with Chesapeake Regional Information System for Our Patients (CRISP), the state health information exchange (HIE), to develop dashboards, reports, and other tools for practices. These tools allow for data-driven practice transformation and include:

- Alerts when patients are seen in Emergency Departments (ED), admitted, and discharged from hospital
- Claim-based utilization data parsed by race, ethnicity, sex, and age
- Area Deprivation Index (ADI) by patient, Hierarchical Condition Category (HCC) score by patient
- Comparison data to other MDPCP and non-MDPCP practices
- Prevention Quality Indicator (PQI) reports
- An AI tool Prevent Avoidable Hospital Events (Pre-AH) that ranks patients on probability of an avoidable ED/hospital event in the next 30 days
- Online bidirectional referral to Community Based Organizations (CBOs)

When the pandemic began, MDPCP worked with partners to develop a vaccine tracker. This tracker provides practices with an accurate record of vaccine status and includes a dashboard, detailing demographics for the patient population, a critical step in examining the equity of vaccine access and delivery. In addition the practices were provided with a COVID-19 Vulnerability Index in order to prioritize equitable care.

The Maryland State Medical Society

CRISP Summit Understanding the Episode Quality Improvement Program (EQIP)

Gene M. Ransom, III
Chief Executive Officer
MedChi, The Maryland State Medical Society

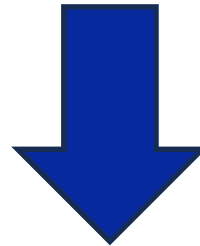
Incentive Payment Opportunity for Maryland PhysiciansValue-Based Medicare

Understanding the Opportunity

Maryland physicians largely remain on fee-for-service reimbursement incentives.

As a result of the Total Cost of Care Model, Maryland physicians are left out of national, Medicare value-based payment programs.

There is a need for new value-based reimbursement opportunities to ensure cost containment in non-hospital settings.



The HSCRC, CRISP, and MedChi created a voluntary, episodic incentive payment program for physicians in Medicare, EQIP, in 2022.

What is the Episode Quality Improvement Program?

EQIP is a voluntary program that engages non-hospital Medicare practitioners and suppliers in care transformation and value-based payment through an episode-based approach.

EQIP will provide incentive payments to physicians who improve the quality of care and reduce the cost of care they provide to Maryland Medicare patients.

Benefits include:

- Avoid MIPS participation and qualify as an AAPM.
- No downside risk for the practice and an outside chance at shared savings rewards.

EQIP will utilize the Prometheus Episode Grouper to define a clinical ‘episode’.

Goals of EQIP

- Increase physicians' accountability for improving quality of care and reducing healthcare spending related to episodes of care.
- Support and encourage physicians interested in continuously transforming care to align with value-based payment policies and Maryland hospital Global Budget Revenues (GBR).
- Reduce episode costs by eliminating unnecessary or low-value care, shifting care to lower-cost settings where clinically appropriate, increasing care coordination, and fostering quality improvement.
- Shift towards physician-focused, value-based care reimbursement to create environments that stimulate rapid development and deployment of new evidence-based knowledge.
- Increase the likelihood of better health at lower cost through patient education and ongoing communication throughout the clinical episode.

Episodic Value-Based Payment

- EQIP works directly with physicians and allows them to earn a portion of the savings they create through better care management.
- EQIP helps to align physicians with the hospitals and the TCOC Model. By succeeding in EQIP, physicians will help the state meet its savings target and reduce potentially avoidable hospitalizations.

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

EQIP Methodology

Each episode has a Target Price that is based on the EQIP Entities costs in 2019.

- The baseline period costs are trended forward based on inflation.
- The Target Price is set regardless of the setting of care (Hospital, Outpatient Facility, ASC) where the episode is initiated. This creates an incentive for participants to move episodes to the most cost-efficient setting of care.

EQIP Entities earn savings based on whether the actual performance period costs are less than or equal to the Target Price.

- Each Care Partner's Target will be compared to the statewide experience and annually ranked based on relative efficiency. Lower cost providers will be in a higher tier and vice versa.
- This ensures that expensive entities are brought down to their peers while efficient entities still have an incentive to participate.

Target Price Rank	% of Savings due to Care Partner
Up to 33rd percentile	50 percent
34th – 66th percentile	65 percent
66th + percentile	80 percent

EQIP Interventions and Performance Improvement Opportunities

In addition to electing episodes, each EQIP Entity will need to indicate how they intend to produce savings in their episodes.

Intervention Category	Example Intervention
Clinical Care Redesign and Quality Improvement	Standardized, evidence-based protocols are implemented, for example for discharge planning and follow-up care.
	Performance of medication reconciliation.
	Elimination of duplicative, potentially avoidable complications or low value services
Beneficiary/Caregiver Engagement	Patient education/shared decision making is provided pre-admission and addresses post-discharge options.
	Implementation of "health literacy" practices for patient/family education
Care Coordination and Care Transitions	Assignment of a care manager and enhanced coordination to follow patient across care settings
	Interdisciplinary team meetings address patients' needs and progress.
	Selection of most cost efficient, high-quality settings of care

Participation Requirements

1. You must qualify as a Care Partner with CMS

- Must be licensed and enrolled in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).
- Must use CEHRT and CRISP, Maryland's health information exchange.

2. You must enroll in EQIP

- Establish EQIP Entity with multiple Care Partners
- Select Episodes and Interventions and agree to quality metrics
- Each Care Partner Signs a Care Partner Arrangement
- Determine Payment Remission Recipient

3. You must meet episode thresholds

- Provide care in Maryland
- For a single episode, threshold = 11 episodes in the baseline
- Across all episodes of participation, threshold = 50 episodes in the baseline

EQIP Year 1 Results

- EQIP saved $20 million in total cost of care in 2021.
- Overall, EQIP episodes accounted for ~$400 million in costs so the savings rate was approximately 5%.
  - Savings were only counted if the entity exceeded a 3% minimum savings rate, which was created to ensure that savings and payouts from EQIP would be statistically significant.
  - 19 EQIP entities earned savings out of a total of 50. However, many of the smaller practices had difficulty earning savings.
- Based on the savings, we expect to pay out $13 million in incentive payments to physicians (i.e., 60% of the total earned savings).

Support for Smaller Practices

In PY3 MedChi assisted smaller practices in grouping together into single entities.

In PY4+, we are considering providing practices with some practice transformation supports.

Learning More About EQIP

Please reach out if you would like to schedule a meeting about EQIP with your organization. Staff will be available to:

- Walk through opportunity analysis, specific to your organization
- Discuss any episode definitions
- Answer specific questions

EQIP Subgroup Bi-Monthly Meeting Schedule

- The third Friday of every other month, 9-11am
- To be added to distribution list, email: osimon@medchi.org

If you have additional questions, please reach out to osimon@medchi.org or gransom@medchi.org.

AHEAD Update

Christa Speicher, Deputy Director, Payment Reform
Maryland Health Services Cost Review Commission

AHEAD Overview

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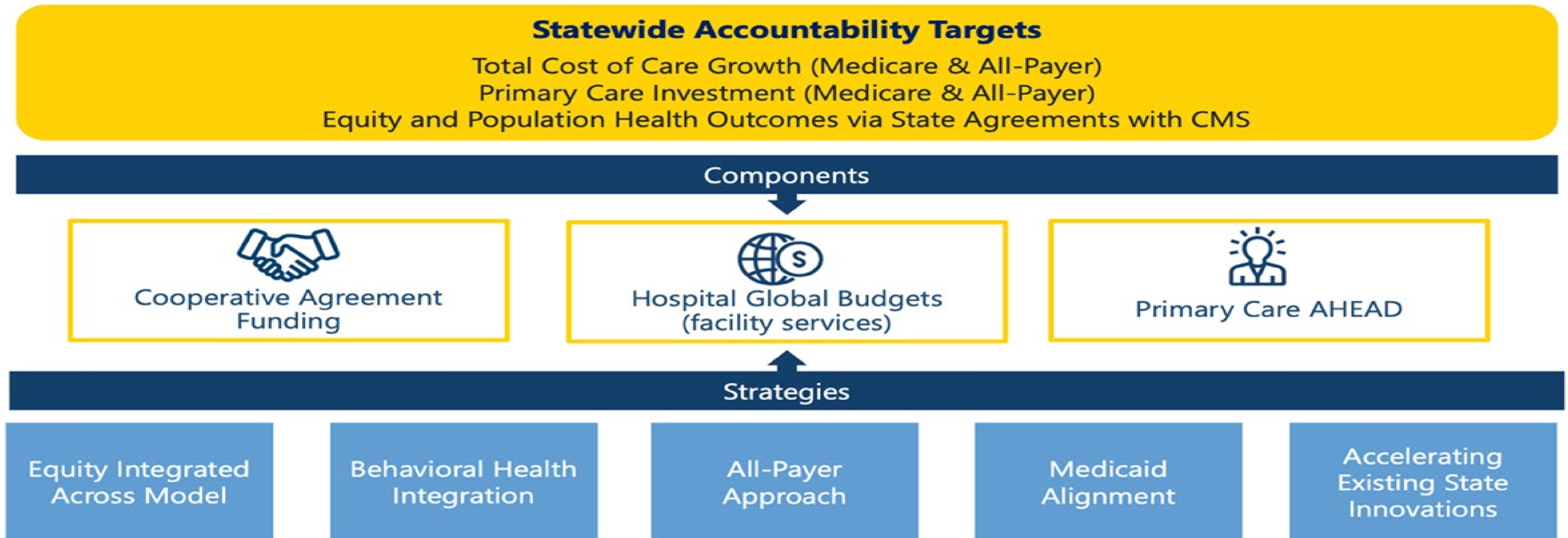
States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model



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The Maryland Health Model is important to our State

The Maryland Health Model improves the quality of life of Marylanders by:

- Controlling hospital cost growth while enhancing quality (care is provided in the right setting at the right time).
- Guaranteeing equitable funding of uncompensated care
- Stabilizing hospitals in order to ensure access to care in all parts of the state (ex. COVID-19)
- Equalizing hospital charges for all payers (including the uninsured), benefiting consumers, and employers
- Supporting population health and health equity initiatives

Losing the Model would deprive **Maryland communities of these benefits**.

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Why AHEAD

The Total Cost of Care TCOC Model agreement, which is key to Maryland's all-payer rate setting authority, is authorized through December 2026.

CMMI developed AHEAD as the federal policy approach for state implementation of population-based payment models.

AHEAD is the pathway to secure continuation of the Maryland Model.

The AHEAD Model enables Maryland to **continue and expand on its long-term commitment** to statewide improvements in healthcare quality while controlling costs.

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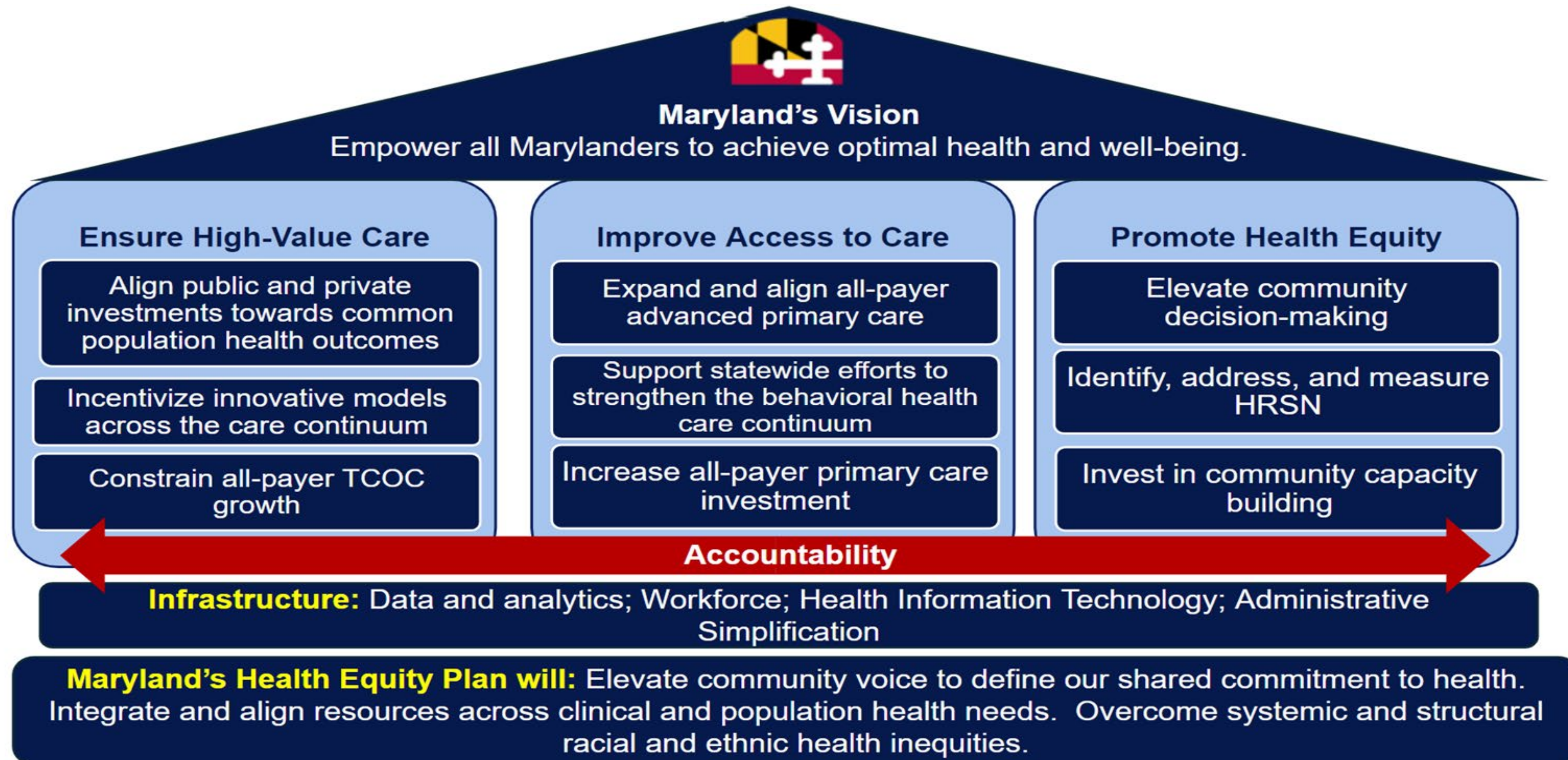
States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model



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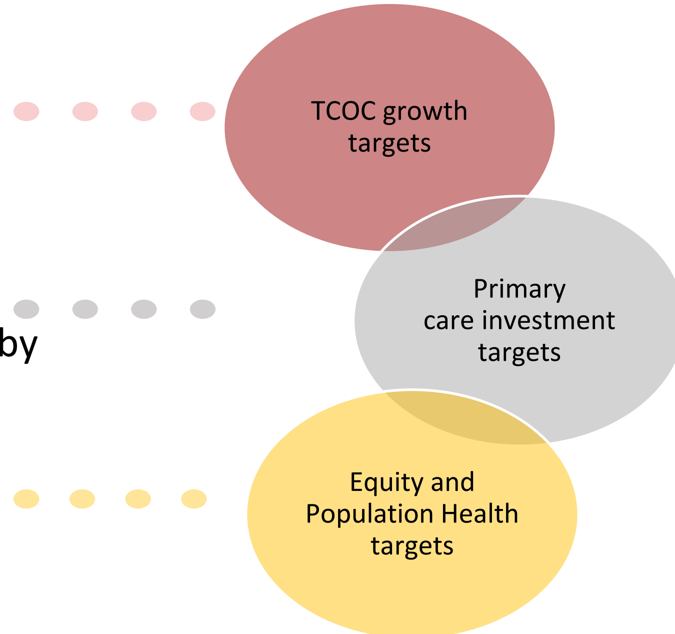
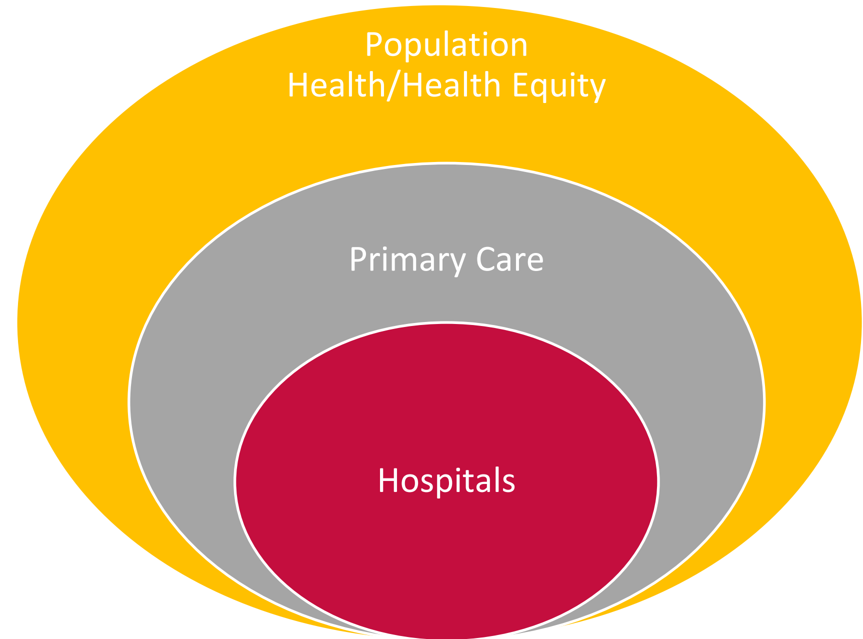
AHEAD Builds on the TCOC Model

The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model is a state total cost of care (TCOC) model designed to:

- curb growth in healthcare cost spending;
- improve population health; and
- advance health equity by reducing disparities in health outcomes.



Similar to the Maryland Total Cost of Care (TCOC) Model, AHEAD focuses on three overlapping domains to achieve its goals.



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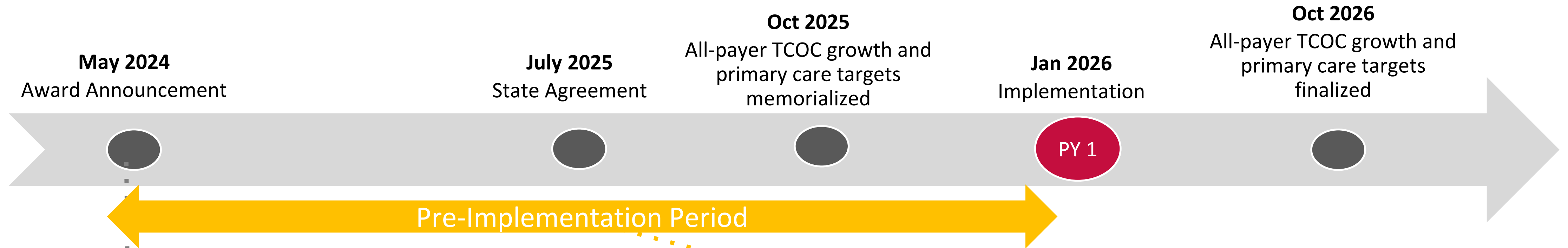
TCOC Model and AHEAD

Feature	MD TCOC Model	AHEAD
Hospital Global Budgets	Maryland has a well developed all payer hospital global budget model.	Maryland can use the same methodology under AHEAD, subject to CMS approval.
Cost Growth Targets	Total cost of care Medicare savings target and all payer hospital spending target.	Total cost of care Medicare savings target, primary care investment targets, and all payer total cost of care spending targets (including Medicaid, MA, and commercial insurance)
Primary Care Program	Maryland has a well-developed Medicare primary care program.	A primary care program that is aligned between Medicare and Medicaid is required.
Quality	Maryland has a robust hospital quality program, including a measure on disparities. The MDPCP Program also has a quality program.	Similar hospital quality targets. For other providers/programs, Maryland will select quality measures from a list of measures provided by CMS.
Population Health & Equity	Maryland set population health targets related to diabetes, opioids, maternal morbidity, and childhood asthma.	States will select a set of population health measures from a menu of options provided by CMS. State must develop a health equity plan and equity targets.

Looking AHEAD



Maryland's NOFO response will seek to **leverage new federal resources** to plan for the future of the Maryland Health Model.

Applying in Cohort 1 will secure **Maryland's role as a leader** in competing for federal funding while providing it **time to negotiate** new model terms prior to 2026 implementation.

The State envisions that **policy development and decision-making** will begin in July 2024 (the beginning of the Pre-Implementation Period) and continue through the July 2025 execution of the State Agreement. There will be **opportunity for community input** throughout this time frame.

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Primary Care AHEAD Requirements

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AHEAD Requirements for Primary Care

	Requirement	Status
✓	Medicaid primary care alternative payment model	• Developed and initial vetting of Medicaid concept
✓	Recruitment	• MDPCP has over 500 practices • Medicaid could have approximately 500 practices depending on attribution method
✓	Care transformation	• Integrating behavioral health care as a function of primary care, enhanced care management and specialty coordination, and addressing health-related social needs of beneficiaries
✓	Commercial alignment (encouraged)	• Maryland's largest commercial payer CareFirst BlueCross BlueShield has been an aligned MDPCP payer
✓	Accountability	• Maryland has rich data to develop targets and measure progress

Primary Care AHEAD
Application Requirements At-A-Glance

Transformation	Targets	Recruitment
- Current and planned Medicaid initiatives in primary care	- Strategy to measure primary care investment across payers over time	- Recruitment plan during pre-implementation period
- Tools for increasing access to primary care	- Measure primary care spending	- Types of practices participating in Medicaid primary care APM
- Align Primary Care AHEAD with existing efforts	- Establish a specific goal of increasing statewide primary care investment in proportion to the total cost of care	- Gaps in current participation and plans to address gaps under Primary Care AHEAD

Key Components of Primary Care AHEAD

- **A Medicare Enhanced Primary Care Payment (EPCP)** to fund advanced care management and behavioral health integration activities for Participant Primary Care Practices' attributed Medicare FFS beneficiaries. The EPCP will be adjusted for social and medical risk.
- **Care transformation requirements**:
  - Integrate behavioral health care as a function of primary care
  - Enhanced care management and speciality coordination
  - Address health-related social needs of beneficiaries
- **Medicaid Alignment:**
  - Care transformation requirements
  - Aligned quality measures between Medicaid and Medicare advanced primary care programs

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Key Goals of Primary Care AHEAD

- **Increase investment** in primary care as a proportion of TCOC for Medicare FFS and across all-payers.
- **Align Medicare's primary care strategy with efforts already underway in state Medicaid programs**, including enhanced care management, behavioral health integration, and referrals for health-related social needs.
- **Target populations most in need of improved access to high-quality primary care by ensuring that FQHCs** and RHCs can receive enhanced primary care payments and **adjusting payments for medical and social risk given the particular needs of the patients they serve**.
- **Encourage more providers to build increased capacity to deliver advanced primary care**.

Primary Care Definition

Primary Care AHEAD working definition for investment measurement for Medicare FFS includes:

- General practice
- Family practice
- Internal medicine
- OBGYN
- Hospice and palliative care
- Psychiatry
- Geriatric psychiatry
- Pediatric medicine
- Physician assistant
- Geriatric medicine
- Certified nurse midwife
- Nurse practitioner
- Addiction medicine
- Preventive medicine
- Neuropsychiatry
- Certified clinical nurse specialist

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Source: CMS AHEAD Primary Care Investment Methodology

Questions and Answers

Additional comments may be sent to: mdh.maryland-model@maryland.gov

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