CONCEPT
Guiding Principles

- Broad-based provider participation design - Patient Designated Provider
- Enhanced population health management functions
- All-payer, incrementally in alignment with Phase 2 of waiver
- Care Management as a necessary element, embedded where able
- Regional Care Coordination Resources
- All Payer Model/TCOC alignment including Duals
- Person and Family Centered base of care
- Aligned and consistent set of quality/outcome metrics
- Efficient data exchange and robust, connected tools for providers
- Financial and non-financial incentives to encourage practice transformation
- Quality and cost transparency for providers and patients
Maryland Primary Care Model

Population Health Mgmt/HIT

PATIENT (PT)

Care Management Resources & Infrastructure
Administrator (State Level)
CRISP
Resource Manager (Regional)

PDP embeds or requests unembedded CM resources based on PT need

xx% CM Funds

Medicare + Medicaid + Commercial
Care Coordination Payments

xx% CM Funds

Quality Payments at Risk (MACRA qualifying)

Visit/Non-Visit-based Payments

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

Traditional PCPs

Specialists
Behavioral Health Providers
SNF Providers
Ambulatory Care Providers
LTSS Providers
Chronic HH Providers

Person-Centered Home (PCH)

Patient-Designated Provider (PDP)
Key Elements of the Model

• **Primary Care Home/ Patient-designated Provider** –
  – the most appropriate provider to manage the care of each patient, provides preventive services, coordinates care across the care continuum, and 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
  – Practice – means an individual provider or group of providers that deliver care as a team to a panel of patients. Practices may span multiple physical sites in the community

• **Care Coordination/Management Infrastructure** – a multi-level structure that coordinates care management for patients and ensures appropriate deployment of resources

• **Incenting Value-based Care**
  – Payers
    • CM Funding
    • Quality Funding
    • Upfront non-Visit based payments- facilitates alternative care delivery
  – Hospitals - chronic Care bonus pool alignment with community

• **Population Health Management/HIT** – key data exchanged to all care participants through CRISP, using tools and analytics for risk stratification, improved care, and efficient connection to other services
PRACTICE TRANSFORMATION
Driving Practice Transformation

Regional Care Management Organization

Care Managers
Practice Transformers/Transformation Programs
Performance Data

Person-Centered Home/Practice
Practice Transformation Design

- Care Management Infrastructure
- Care Management Resources, infrastructure, & Agents
- Practice Transformation Resources & Agents
- Core Practice Functions
- Performance Data
- Core Quality Metrics
- Aligned Financial Incentives

Customized CPC+ like design

- eCQM tool, State agency metrics

Risk Structures
- Health Plans
- Hospitals
- ACOs

Care Coordination Payments
Quality Payments
Non-Visit-based Payments

CRISP HIE, CRISP ICN Services
What/Who is Transforming the Practice?

Entities

- **Coordinating Entity (CE)** – serves as the financial and data management center for all Regional Care Management entities including
  - Administers payments from payers to regional entity and person-centered homes
  - Runs program analytics including risk identification and stratification
  - Connects with various programs/model

- **Regional entity** (e.g. an ACO, RP, or CIN)
  - Organizes, contracts, and deploys CM resources
  - Serves as transformation resource and Learning Network outlet
  - Provides access to medical and non-medical resources
  - Ensures continuity across providers and single CM for ease of experience for patient, utilizing CRISP and CE tools

- **CRISP** – state designated HIE that provides essential point of service information for care decisions, care coordination data, population health management data, and other key information and connections

Agents

- **Care Managers** - An individual with knowledge of community resources to address non-medical needs, whose efforts are integrated with pharmacists, therapists, specialists and primary care; a trusted advocate who shares important data via CRISP in order to keep patients safe as they navigate across settings of care and different health systems

- **Transformation agents and programs** - the individual and entity (contracted) that takes the lead on standard elements of transformation for practices, has staff and programs housed within the regional care management entities, and provides on-site technical assistance to practices
CARE MANAGEMENT INFRASTRUCTURE
Regional Care Management Organization provides the following services:

1. Resource Deployment and Contracting
   a) Coordination of primary CM resources – embedded and non-embedded (RN, MA, etc)
   b) Second level of CM resources – non traditional care management resources (PharmD, CHW, etc) based on demand by primary care managers through a referral process

2. Practice transformation training and network

3. Direct delivery of services in the community, e.g., non-office based primary care for high utilizers using CRISP hot-spotting tools?
   a) Align with HSCRC Care Coordination Infrastructure funding for Regional Partnerships and health systems to provide community based care coordination and population health

4. Real-time portal for provider of resource offerings

5. Interface with CRISP and Coordination Entity for timely data
Funding the Primary Care Model

- Care Redesign
  - Care Management Funding
    - Quality Payments Upfront - at risk
    - Visit-based Payments
      Advance non visit and discounted FFS
    - MACRA/Quality Payment Program – AAPM Bonus
      At risk