MDPCP

MARYLAND PRIMARY CARE PROGRAM

2020 Performance Measures Guide

February 2021
Version #2

Version History

Version	Date	Revision/Change Description	Affected Area
2	February 2021	eCQM version guidance	Introduction; eCQM Reporting

Table of Contents

Introduction

The Maryland Primary Care Program (MDPCP) 2020 Performance Measures Guide covers the quality measurement and reporting requirements for the Measurement Period of January 1, 2020–December 31, 2020. In this guide, you will find the definitions and specifications for the program's electronic Clinical Quality Measures (eCQMs), and information on the utilization measures and patient experience of care survey. The guide also addresses overlaps with reporting requirements for the Quality Payment Program (QPP) and the Medicare Shared Savings Program.

The success of MDPCP depends, in part, on how well practices advance and maintain improvements in primary care throughout and across Performance Years. One addition to this year's guide is the concept of engaging your patient in their own care, a transformative shift from the historic approach of physicians "directing" patients about their health. Research and clinical success stories indicate that engaging the patient in *self-care* improves clinical outcomes.

One tool that can assist in development of this "bi-directional" partnership is the *Health Confidence Tool*, which is provided as a Resource link later in this document. By asking just a few questions, the clinician can quickly assess a patient's level of confidence in managing their condition, understanding information, or identifying changes in their condition. This is critically valuable when managing chronic illness and addressing factors that influence their care. The *Health Confidence Tool* is efficient, effective, enables the clinician to observe patient trends, and jumpstarts important conversations to manage care.

Your practice is highly encouraged to monitor its progression toward advanced primary care through increased achievement on the Care Transformation Requirements, and performance on selected eCQMs, utilization measures, and patient experience of care surveys. Developing strong provider-patient partnerships will help your practice meet program goals of reducing utilization and enhancing the quality of care and health outcomes of patients in Maryland. ***Exhibit 1*** summarizes the performance measures required for MDPCP practices in 2020.

Exhibit 1: MDPCP 2020 Quality and Utilization Measures

	Measure Name	Measure Steward	Benchmark	Benchmark Data	Reporting Method	Measurement Period	Reporting Period
eCQMs*	Controlling High Blood Pressure (CMS165)	National Committee for Quality Assurance (NCQA)	National, All Payer	2018 MIPS Performance Data	CRISP	January 1, 2020 – December 31, 2020	January 1, 2021 – March 31, 2021
	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (CMS122)	NCQA	National, All Payer	2018 MIPS Performance Data	CRISP	January 1, 2020 – December 31, 2020	January 1, 2021 – March 31, 2021
Patient Experience of Care	CG-CAHPS® Patient Experience Survey	Agency for Healthcare Research and Quality (AHRQ)	National, All Payer	2018 CPC+ CAHPS Data	MDPCP Portal	July 1, 2020 – December 31, 2020	January 2021**

	Measure Name	Measure Steward	Benchmark	Benchmark Data	Reporting Method	Measurement Period	Reporting Period
Utilization	Inpatient Hospitalization Utilization	NCQA HEDIS	Maryland, Medicare Only	2019 Performance of Maryland Practices	No Reporting Required	January 1, 2020 – December 31, 2020	N/A
	Emergency Department Utilization	NCQA HEDIS	Maryland, Medicare Only	2019 Performance of Maryland Practices	No Reporting Required	January 1, 2020 – December 31, 2020	N/A

*Practices must report, at a minimum, data on all patients (regardless of payer) who were seen at the MDPCP Practice Site during the Measurement Period of January 1, 2020 – December 31, 2020, and who met the inclusion criteria for the eCQMs. The eCQM version listed in the Participation Agreement (PA) is the oldest version acceptable for reporting. Practices are encouraged to report using the most recent eCQM version to allow automated reporting in CRISP via QRDA III file. Practices that opt to report on the older version listed in the PA must report manually. See eCQM Reporting section of this guide for more details.
**Practices will submit patient rosters in the MDPCP Portal once per year for all patients who visited the practice during the prior 6 months.

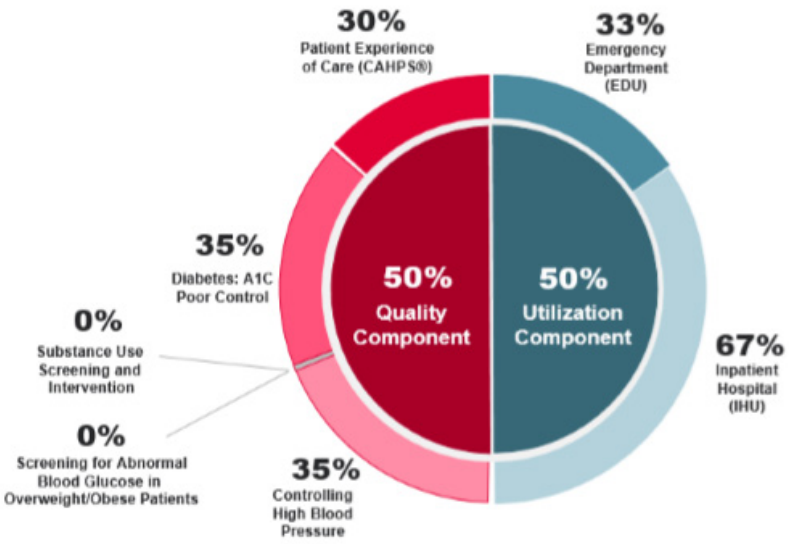
To further incentivize and reward practices that demonstrate the provision of high quality care, the Centers for Medicare & Medicaid Services (CMS) provides a Performance Based Incentive Payment (PBIP). ***Exhibit 2*** presents the components of the PBIP calculation.

CMS calculates this payment using data from two distinct components of performance:

1. Quality (comprised of eCQMs and patient experience of care), and
2. Utilization (comprised of EDU and AHU).

Both components make up equal parts of the prospective PBIP payment. However, a practice must obtain a minimum score of 50% on the quality component in order to retain any portion of the PBIP.

Exhibit 2: PBIP Components



Performance scores for all four eCQMs represent 70% of the quality component of PBIP retained by the practice—the remaining 30% is derived from the CG-CAHPS® survey. The *2020 Practice Participation Agreement* identifies the following four eCQMs for use in calculation of the Quality Component of the PBIP and/or monitoring, oversight, and evaluation purposes for each MDPCP Practice Site:

1. CMS165v6: Controlling High Blood Pressure (Effective Clinical Care)
2. CMS122v6: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (Effective Clinical Care)

3. CMS ID # not applicable: Screening for Abnormal Blood Glucose in Overweight/Obese Patients (Population Health)
4. CMS ID # not applicable: Substance Use Screening and Intervention Composite (Population Health)

However, because eCQM measure specifications are not yet available for the Population Health measures (#3 and #4 above), **CMS will not require practices to report on them for Performance Year (PY) 2020**. Practices will only be required to report on ***CMS165 Controlling High Blood Pressure and CMS122 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)*** for PY2020.

CMS anticipates incorporating measures focused on prediabetes and substance use disorder in future Performance Years. Practices should begin to evaluate their abilities to address these two areas and develop clinical processes to prepare to collect data for reporting.

You can find more information on the PBIP, including 50th and 80th percentile benchmarks, in the MDPCP Payment Methodologies (available on Connect).

CMS has determined that the PBIP and some Shared Savings payments made under the Shared Savings Program (Enhanced Track ACOs) are duplicative. As a result, practices concurrently participating in these programs will not receive a PBIP and their partner Care Transformation Organizations (CTOs) are not eligible for PBIP for the practice's attributed beneficiaries. Despite not receiving a PBIP, practices participating in both programs must submit a patient roster to MDPCP for the patient experience of care survey and report on eCQM measures for MDPCP program monitoring and evaluation purposes, as defined in Articles XI and XII of the Practice Participation Agreement.

Certified EHR Technology Requirements

In accordance with the MDPCP Practice Participation Agreement (Article VIII), practices must use certified EHR technology (CEHRT) that meets 2015 Edition certification criteria. These 2015 Edition (or better) CEHRT capabilities will support the MDPCP requirement for real time point of care and remote access for the practice's care team members to attributed beneficiaries' health records. For practices partnering with a CTO, the practice must ensure that the CTO's interdisciplinary team has real time access to the practice's EHR.

EHR Version Verification

To verify the CEHRT version of your EHR system, use the lookup tool on the **Certified Health IT Product webpage.**

Practices should use their health IT system to collect and report on quality data. It is important to review the reports regularly to help you understand your practice's performance and ensure that your health IT system is reporting the quality measures correctly.

2015 Edition CEHRT Compliance Guidance

All MDPCP Practices were required to have 2015 Edition CEHRT as of the start of participation in MDPCP. Practices should confirm that their Health Information Technology details in the MDPCP Portal's *My Practice Info* tab is up to date and reflects this requirement.
Practices that do not currently meet the 2015 edition CEHRT requirement should report this to the MarylandModel@cms.hhs.gov help desk immediately.

eCQM Reporting

In addition to generating eCQM reports for regular review by the practice care team, eCQM data must be submitted annually through CRISP's quality measure reporting tool[1] for each MDPCP practice. The data submitted through CRISP's quality measurement tool will be used by CMMI to calculate the amount of the quality component of the PBIP that is retained by a Participant Practice, and to carry out program monitoring and evaluation activities. Details on the process for data submission are currently being updated and will be provided to participants in a supplemental document in Fall 2020.

Pursuant to the MDPCP Practice Participation Agreement, practices must report, at a minimum, data on all patients who were seen at the MDPCP

What does your practice need to do for 2020 eCQMs?

- ☑ Report all eCQMs for the 2020 Measurement Period, which is January 1, 2020 through December 31, 2020.
- ☑ Report eCQMs during the reporting period of January 1, 2021 – March 31, 2021.
- ☑ Monitor your eCQM performance regularly (recommended).

[1] CRISP will be releasing a guide and hosting a webinar in Fall 2020 to help practices understand how to use the quality measurement tool.

Practice Site during the Measurement Period[2,3] and who met the inclusion criteria for the eCQMs (explained in more detail in later sections of this guide). A practice may, however, report eCQM data for their entire MDPCP Practice.

MDPCP eCQM scoring for PBIP calculations will be at the practice level. The CRISP quality measure tool will accommodate for practices to submit data by provider or the entire practice site. The tool will continue to allow for manual entry and automated file uploads.

Practices are responsible for the performance of all patients seen in their practice, as outlined in the measure specifications. A brief summary of which data should be reported and how it flows is below:

1. Practices report eCQM data to CRISP at the practice or NPI level.
    a. Data should be reported on all patients who meet inclusion criteria who were seen at the MDPCP Practice Site by any provider listed on the MDPCP Practitioner Roster during the Measurement Period.
    b. For providers that join or leave the practice during the PY, the practice should report on patients seen by that provider while at the practice and listed on the MDPCP Practitioner Roster.
    c. Patients seen by non-physician providers (e.g. PAs) who appear on the MDPCP Practitioner Roster should be included in data reported. If submitting by NPI, practice should report data under the NPI that billed.
2. CRISP then reports eCQM data to CMS at the practice level.

Please work with your health IT vendor or IT staff to ensure that you have the technical capabilities to record all the required measures for the MDPCP eCQMs. Practices may also seek assistance from the Maryland Program Management Office and CTOs.

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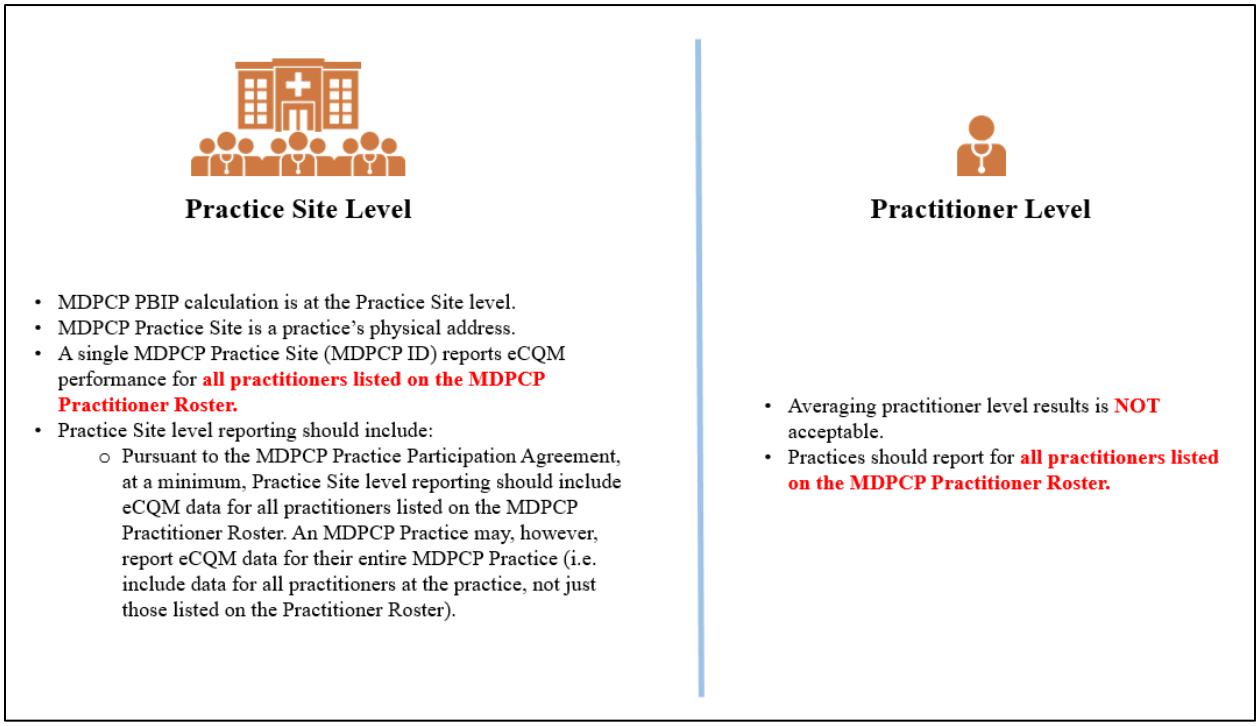
[2] Article 7.1(a) of the MDPCP Participant Agreement states the following:
7.1 Electronic Clinical Quality Measures ("eCQMs")
(a) Following each Measurement Period, the MDPCP Practice shall report to CMS a performance rate and the values used to calculate the performance rate for each eCQM in the set of MDPCP eCQM measures listed in Appendix B ("MDPCP eCQM Set") using data from all months of the Measurement Period and from only the MDPCP Practice Site as further described in the MDPCP Payment Methodologies Paper defined in Article 9.1(e).

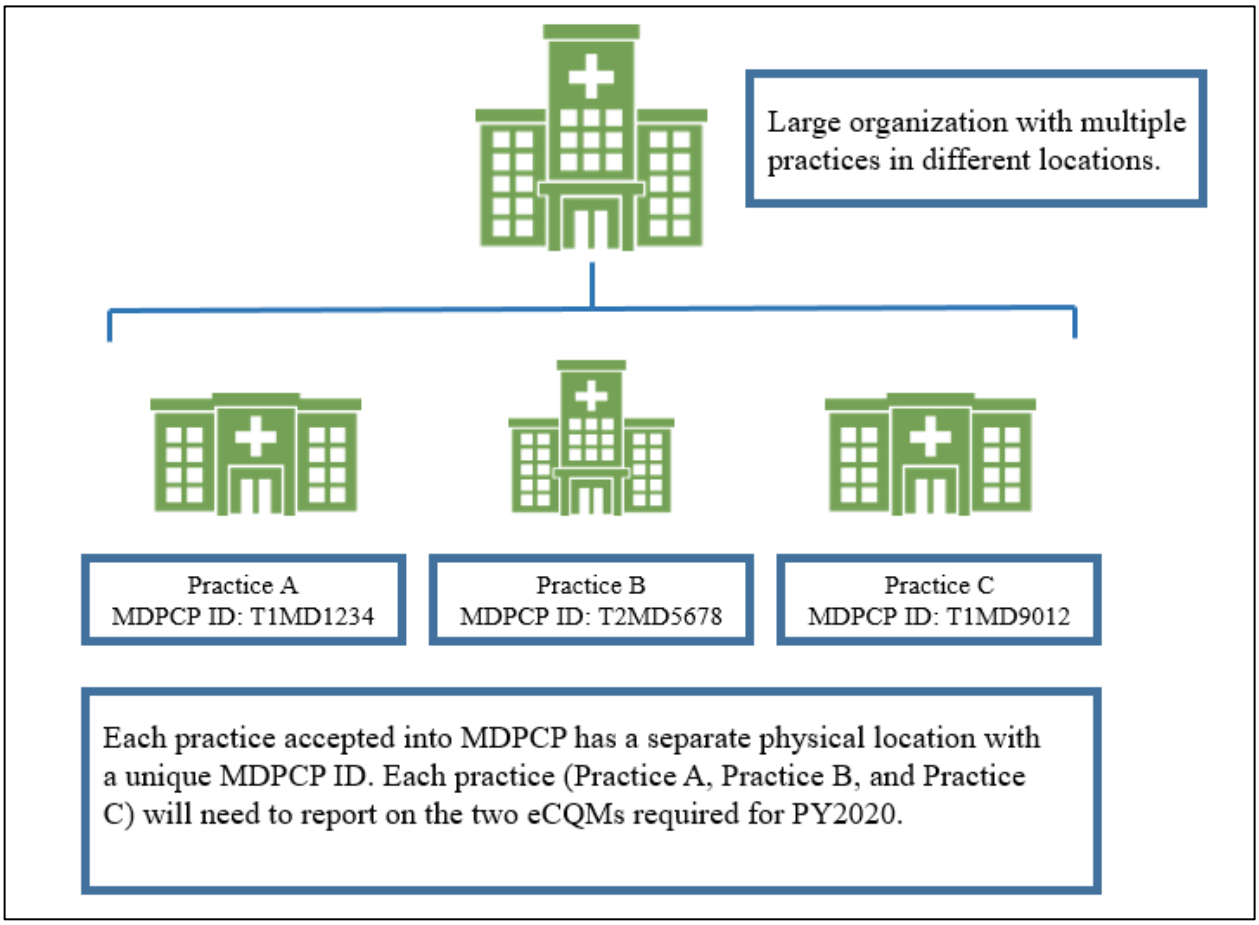
[3] "MDPCP Practice Site" means a group of one or more physicians, or physicians and non-physician practitioners, each of whom is listed on the Practitioner Roster, that bills for Primary Care Services furnished at a single physical location identified by a single street address located in the state of Maryland under a single Medicare-enrolled TIN belonging to the MDPCP Practice

Exhibit 3: MDPCP Practice Site Level vs. Practitioner Level eCQM Reporting



Larger organizations with multiple practice sites and locations should report under **their unique MDPCP ID**, unless instructed otherwise by CMS due to a practice structure or ownership change. Each practice site is responsible for reporting on all eCQMs. Therefore, monitoring of performance should be done at the practice site level. **Exhibit 4** presents an additional example of practice site level reporting.

Exhibit 4: Practice Site Level eCQM Reporting



The eCQM version listed in the Participation Agreement is the oldest version acceptable for reporting. We encourage practices to report using the most recent version, as listed for the applicable Performance Year in the eCQI Resource Center, to allow automated reporting via QRDA III file. Practices that opt to report on the older version listed in the Participation Agreement must report manually. Please see the table below (Exhibit 5) for a complete guide of acceptable measure versions and reporting methods.

Exhibit 5: Acceptable Measure Versions & Reporting Methods

CMS ID#	Measure Title	Manual	QRDA III
CMS165	Controlling High Blood Pressure	Version 6 to 8	Version 8
CMS122	Diabetes: HbA1c Poor Control (>9%)	Version 6 to 8	Version 8

eCQM Measure Details and Improving Your Performance Rate

All MDPCP practices must report on two eCQMs for the 2020 Measurement Period.[4] The eCQM measure specifications **are not yet available** for the population health measures listed in **Exhibit 6**, and practices will not be required to report on them for PY2020. Practices should begin to evaluate their abilities to address these two areas and develop clinical processes to prepare to collect data for reporting.

For the two effective clinical care measures, practices must report, at a minimum, data on all patients who were seen at the MDPCP Practice Site during the Measurement Period and who met the inclusion criteria for the eCQMs. A practice may, however, report eCQM data for their entire MDPCP Practice. **Exhibit 6** summarizes additional information about the MDPCP eCQMs.

Exhibit 6: MDPCP Quality Measure Set[5]

CMS ID#	Measure Title	Measure Type	Benchmark Population	Domain
CMS165	Controlling High Blood Pressure	Outcome	National, All Payer	Effective Clinical Care
CMS122	Diabetes: HbA1c Poor Control (>9%)	Outcome	National, All Payer	Effective Clinical Care
N/A	Screening for Abnormal Blood Glucose in Overweight/ Obese Patients	Process	N/A	Population Health
N/A	Substance Use Screening and Intervention Composite	Process	N/A	Population Health

These eCQMs fall into one of two categories: outcome and process measures. The *Controlling High Blood Pressure* and *Diabetes: HbA1c Poor Control* eCQMs are intermediate outcome measures, and both fall into the CMS quality domain of "Effective Clinical Care". These eCQMs all align with the Merit-based Incentive Payment System (MIPS) of the QPP and with the Core Quality Measure Collaborative measure list for ACOs, Patient-Centered Medical Homes (PCMHs), and primary care, so some practices may have prior experience with these measures.

In the MDPCP, CMS calculates eCQMs as a performance rate, as shown in **Exhibit 7**. Each performance rate is specific to one eCQM in a Measurement Period. The components of the performance rate are defined by NCQA, the measure steward for the eCQMs. NCQA defines the measure and outlines the patients to be included in the numerator and the denominator for the rate. CMS then measures the performance rate against the applicable national, all payer benchmark. Additional details about each eCQM's numerator and denominator inclusions and exclusions are included in the sections that follow.

Practices should submit data to MDPCP regardless of their number of cases. Practices must ensure that their denominator population sample captures at least 60% of the true eligible

[4] Note: For Performance Year 2020, MDPCP will accept the most current eCQM version as of the beginning of the Performance Year. We encourage practices incorporate updates as new versions become available throughout the year.

[5] The CMS measures are adapted from the NQF measures. See measure specifications in the links for each measure for more details.

population (i.e., all eligible patients in the practice's all payer population). This is also a QPP requirement.

For more general guidance on eCQMs, please refer to CMS' Electronic Clinical Quality Measure Logic and Implementation Guidance Version 4.0.

Exhibit 7: Performance Rate Formula

$$\text{Performance Rate} = \frac{\text{Numerator} - \text{Numerator Exclusions}}{\text{Denominator} - \text{Denominator Exclusions} - \text{Denominator Exceptions}}$$

Capturing CMS165 Data in Your Practice

What is the CMS165 – Controlling High Blood Pressure Measure?

The CMS165v8 measure is defined as the percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the Measurement Period and whose blood pressure was adequately controlled (<140/90mmHg) during the Measurement Period.

Measure Details and Definitions

Measurement Period:

January 1, 2020 – December 31, 2020

Reporting Period for MDPCP:

January 1, 2021 – March 31, 2021

Numerator:[6]

Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the Measurement Period.

Numerator Exclusions:

Not Applicable

Why was this measure selected?

Also known as the "silent killer", high blood pressure can be a significant contributing factor to a higher risk of heart disease, stroke, kidney disease, and other health issues. Controlling high blood pressure is an important step in preventing and reducing heart disease (leading cause of death in the United States) and stroke. Practices should have a treatment plan in place and resources readily available for their patients with high blood pressure to avoid long-term costs from unmanaged care. Treatment plans can include appropriate pharmacological and non-pharmacological interventions.

[6] Only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. Do not include BP readings taken during an acute inpatient stay or an ED visit, taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests, or reported by or taken by the member. If no blood pressure is recorded during the Measurement Period, the patient's blood pressure is assumed "not controlled". If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.

Denominator:[7]

Patients 18-85 years of age who had a visit and diagnosis of essential hypertension overlapping the Measurement Period.

Denominator Exclusions:

Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the Measurement Period. Also, exclude patients with a diagnosis of pregnancy during the Measurement Period.

Exclude patients whose hospice care overlaps the Measurement Period.

Exclude patients 66 and older who are living long term in an institution for more than 90 days during the Measurement Period.

Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.

Practices must report, **at a minimum**, data on all patients who were seen at the **MDPCP Practice Site** during the **Measurement Period** and who met the inclusion criteria for the eCQMs. A practice may, however, report eCQM data for their **entire MDPCP Practice**.

How to Improve Your Performance Rate

Best Practices:

A *higher* performance rate on this measure indicates better quality. Thus, the more patients with a hypertension diagnosis that you are able to show have adequately controlled blood pressure, the better the practice will perform on the measure. Here are useful tips to improve your performance on this measure:

- Make your performance on this measure a practice priority. Ensure that the Care Team understands that controlling blood pressure requires a provider-patient partnership. Include the patient in developing an approach to manage blood pressure.
- Set a practice goal for this measure and use your EHR reporting capabilities to understand your current practice performance. Encourage your staff to contribute ideas about how to reach that goal and ask each team member how they will engage their patients in managing their own care.
- Run test scenarios to see how data is captured in your EHR and create workflows for the practitioner/care team.
- Provide regular reports to each practitioner/care team on their performance on the measure—be transparent with the results from these reports. Regularly review staff competencies in assessing patients' understanding and management of their blood pressure.
- Publicize your efforts to improve care and your practice-level results with your patients. Engage your patients in this effort – this is about them. Consider highlighting the

[7] For 2020, the Controlling High Blood Pressure denominator includes telehealth encounters.

successes of patients who achieve blood pressure control and encouraging them to act as a peer support to others who would benefit. Arrange for a Patient and Family Advisory Council (PFAC) that builds on these success stories.

- Document and date when your patient was diagnosed with hypertension in your practice's EHR[8].
- Set a personalized goal with your patient for blood pressure. Develop a bi-directional *Patient Self-Care Plan* that includes specific changes to lifestyle and other factors that contribute to high blood pressure. Discuss relaxation techniques and other non-pharmacological interventions to reduce stress.
- Establish a process to pull reports from your EHR on patients with qualifying hypertension diagnoses on at least a monthly basis. Use your EHR to flag patients who are not at their personalized goal so that it can be addressed by the care team.
- Use the full array of capabilities you are building in your practice through MDPCP to help you improve your performance on this measure and reach your practice's goal—include each member of your care team in this process.
- Adhere to evidence-based guidelines for the treatment of hypertension.

Resources

Advancing Primary Care in the MDPCP

Utilize this document to help you identify new tactics/strategies and discover new tools to address high blood pressure at your practice.

Million Hearts®

Explore the Million Hearts® website to learn more about hypertension control.

Health Confidence and the What Matters Index - 2018

Health Confidence is a tool for patient engagement, activation, and self-management. Utilize this document to learn more about the tool and the benefits of patient engagement. The document also provides multiple engagement templates that you can adopt for your practice.

Using Health Confidence to Improve Patient Outcomes

This study observed 287 patients, including 32 "at risk" patients and recorded their health confidence scores. The goal of the study was to increase a patient's confidence in personal health care management, leading to improved health outcomes and less use of hospital care.

[8] The final blood pressure reading of the measurement year cannot be taken on the same day that hypertension was first diagnosed; it must be a later encounter.

Capturing CMS122 Data in Your Practice

What is the CMS122 – Diabetes: HbA1c Poor Control (>9%) Measure?

The CMS122v8 measure is defined as the percentage of patients 18-75 years of age with diabetes who had HbA1c > 9.0% during the Measurement Period.

Measure Details and Definitions

Measurement Period:

January 1, 2020 – December 31, 2020

Reporting Period for MDPCP:

January 1, 2021 – March 31, 2021

Numerator:[9]

Patients whose most recent HbA1c level (performed during the Measurement Period) is >9.0%.

Why was this measure selected?

According to the Centers for Disease Control and Prevention (CDC), there are more than 100 million U.S. adults that are now living with diabetes or pre-diabetes. The total direct costs of diabetes in 2017 was $237 billion, which accounts for approximately 1 in 4 total health care dollars spent in the United States. People with diabetes are at risk of developing other health problems such as heart disease, stroke, kidney disease, eye problems, dental disease, nerve damage, and foot problems. These conditions and potential long-term costs can be improved by having proper screenings and exams, and developing bi-directional patient Self-Care treatment plans. Engaging patients in self-care is transformational.

[9] Patient is numerator compliant if most recent HbA1c level >9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the measurement period. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.

Numerator Exclusions:

Not Applicable

Denominator:[10]

Patients 18-75 years of age with diabetes with a visit during the Measurement Period.

Denominator Exclusions:

Exclude patients whose hospice care overlaps the measurement period.

Exclude patients 66 and older who are living long term in an institution for more than 90 days during the measurement period.

Practices must report, **at a minimum**, data on all patients who were seen at the **MDPCP Practice Site** during the **Measurement Period** and who met the inclusion criteria for the eCQMs. A practice may, however, report eCQM data for their **entire MDPCP Practice**.

Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.

How to Improve Your Performance Rate

Best Practices:

A *lower* performance rate on this measure indicates better quality. Thus, the fewer patients with an HbA1c level that is >9.0%, the better the practice will perform on the measure. Here are a few useful tips to improve your performance on this measure:

- Make your performance on this measure a practice priority. Ensure that the Care Team understands that managing diabetes effectively requires a provider-patient partnership. Include the patient in developing an approach to managing diabetes.
- Set a practice goal for this measure and use your EHR reporting capabilities to understand your current practice performance. Encourage your staff to contribute ideas about how to reach that goal and ask each team member how they will engage their patients in managing their own care.
- Run test scenarios to see how data is captured in your EHR and create workflows for the practitioner/care team.
- Provide regular reports to each practitioner/care team on their performance on the measure—be transparent with the results from these reports. Regularly review staff competencies in assessing patients' diabetes understanding and management.
- Publicize your efforts to improve care and your practice-level results with your patients. Engage your patients in this effort – this is about them. Consider highlighting the successes of patients who achieve diabetes control and encouraging them to act as a peer support to others who would benefit. Arrange for a PFAC that builds on these success stories.

[10] Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.

- Document and date when your patient was diagnosed with diabetes in your practice's EHR.
- Set personalized goals with your patient for managing diabetes. Develop a bi-directional *Patient Self-Care Plan* that includes specific changes to lifestyle and other factors that contribute to uncontrolled diabetes or development of Type 2 diabetes. Establish a process to pull reports from your EHR on patients with a qualifying diabetes diagnoses on at least a monthly basis. Use your EHR to flag patients who are not meeting their personalized goals so that the care team can follow up.
- Use the full array of capabilities you are building in your practice through MDPCP to help you increase your performance on this measure and reach your practice's goal—include each member of your care team for this process.
- Use standing orders to ensure that each patient has a relevant HbA1c in their chart.
- Identify resources and facilitate referrals for more intensive diabetes and nutrition education and self-management support, either in the practice or in the community.
- Adhere to evidence-based guidance for the treatment of diabetes.

Resources

Advancing Primary Care in the MDPCP

Utilize this document to help you identify new tactics/strategies and discover new tools to address high blood pressure at your practice.

Managing Diabetes (CDC)

Develop a process to empower patients through diabetes self-management education (DSME) and provide ongoing support.

Health Confidence and the What Matters Index - 2018

Health Confidence is a tool for patient engagement, activation, and self-management. Utilize this document to learn more about the tool and the benefits of patient engagement. The document also provides multiple engagement templates that you can adopt for your practice.

Using Health Confidence to Improve Patient Outcomes

This study observed 287 patients, including 32 "at risk" patients and recorded their health confidence scores. The goal of the study was to increase a patient's confidence in personal health care management, leading to improved health outcomes and less use of hospital care.

Patient Experience of Care (CG-CAHPS®)

Improved experience of care is an explicit aim of MDPCP. Patients with positive experiences in primary care are often more engaged in their care and more likely to adhere to medication and other care regimens.[11,12] Patients who rate their experience of care highly are also less likely to utilize inpatient and emergency department (ED) services.[12,13] Additionally, studies have shown that there is a correlation between the strength of a clinic's process of care to prevent or manage disease and a patient's experience receiving the care. For these reasons, positive reports of patient experience may reflect high quality care.[11,14] Finally, improving patient experience positively correlates with patient loyalty and retention, reduces medical malpractice risk, and increases employee satisfaction.[11]

CMS will conduct the CG-CAHPS® patient experience of care survey for MDPCP practices. As noted in Article 7.2 of the Participation Agreement[15], practices should include on their Patient Survey Roster eligible patients seen by eligible providers who are MDPCP Practitioners listed on the Practitioner Roster during the Measurement Period.[16] The results of these surveys will serve as the basis of your practice's patient experience of care survey portion of the PBIP (assessed annually).

AHRQ first used the CG-CAHPS® survey in 1995. Since then, it has been widely used by a variety of organizations, including CMS, ACOs, health plans, Robert Wood Johnson Foundation, the American Board of Medical Specialties, and multi-stakeholder organizations.

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[11] Browne, K., et al. (2010). Measuring patient experience as a strategy for improving primary care. *Health Affairs.* Retrieved from http://content.healthaffairs.org/content/29/5/921.full.pdf.

[12] Saultz, J.W. (2003, September-October). Defining and Measuring Interpersonal Continuity of Care. Retrieved from http://www.hpm.org/Downloads/Bellagio/Articles/Evaluation_and_measurement/Saultz_2003_Defining_Measuring.pdf.

[13] Anhang Price, R., et al. (2014, October 1) Examining the role of patient experience surveys in measuring health care quality. Retrieved from http://escholarship.org/uc/item/8746s9d2

[14] Cook, N., et al. (2015, December). Patient Experience in Health Center Medical Homes. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/26026275

[15] ***7.2 CG-CAHPS***
For monitoring and assessment purposes, CMS will administer a Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey ("CG-CAHPS") to a sample of the MDPCP Practice Site's entire patient population, using a mode and methodology determined by CMS. The MDPCP Practice shall ensure that the MDPCP Practice Site supplies CMS with any information CMS deems necessary for purposes of administering the survey (e.g., a roster of all active patients who receive care through the MDPCP Practice Site and the contact information for such patients). CMS will share the results of the CG-CAHPS survey with the MDPCP Practice Site via the MDPCP Portal.

[16] Pursuant to the MDPCP Practice Participation Agreement, at a minimum, MDPCP Practices must provide CAHPS patient roster data for all MDPCP Practitioners. An MDPCP Practice may, however, provide CMS with CAHPS patient roster data for their entire MDPCP Practice.

The survey offers insight into important features of care delivery, such as whether patients readily understand the information that your practice provides, a patient's ease of obtaining after-hours medical advice, and their ability to see practitioners at the appointed time for an office visit.[17] Feedback about the patient experience can also help practices set priorities for patient-centered quality improvement initiatives. Regular monitoring through patient surveys provide the practice with an important view into the impact of practice changes to improve quality and reduce cost on the patient's experience of care.

What does your practice need to do for the patient experience of care survey?

- ☑ Beginning in PY2020, CMS will ask your practice to provide a roster once per year of all eligible patients seen by eligible MDPCP Practitioners during the last six months of the Performance Year. CMS will pay for the fielding of this survey.
- ☑ Your practice should review the results of the survey with staff and patient advisors and engage them in efforts to improve the patient experience of care in each area.

While participants in the Shared Savings Program have patient experience survey requirements in their respective programs, they are aggregated at the ACO level and do not reflect individual MDPCP practice performance. The CG-CAHPS® survey will provide your practice and CMS with important information about the patient experience of care in your practice.

All MDPCP practices are required to submit a patient roster of all eligible patients seen by eligible MDPCP Practitioners during the second half of the Performance Year via the MDPCP Portal for purposes of the patient experience survey. CMS will use the patient roster to select a random sample of your MDPCP Practice Site's patient population to receive the survey. More information about the patient roster submission process, guidelines, and associated frequently asked questions (FAQs) can be found on MDPCP Connect.

To help practices improve care by addressing patients' feedback, CMS will provide a summary to each practice of their results of the patient experience surveys in the MDPCP Portal. The summaries will be provided annually in the summer for the previous Performance Year. For additional information related to how the results of the CG-CAHPS® survey impacts the PBIP, see the 2020 MDPCP Payment Methodologies document on Connect.

[17] Anhang Price, R., et al. (2015). Should health care providers be accountable for patients' care experiences? Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/25416601

Utilization Measures

CMS assesses practice performance on utilization measures using claims data. For the 2020 Measurement Period, we will focus on the following two utilization measures from the Healthcare Effectiveness Data and Information Set (HEDIS®):[18]

- Acute hospitalization utilization per 1,000 attributed beneficiaries
- ED utilization per 1,000 attributed beneficiaries

Your practice will not need to report data for these two measures. CMS will evaluate your practice's Medicare claims after each Performance Year to determine your ED and inpatient hospital utilization. Additional information on how the results of the utilization measures are calculated and impact the PBIP are described in the 2020 MDPCP Payment Methodologies document on Connect.

Why is Reducing Inpatient Hospitalization and ED Utilization Important to Maryland and the MDPCP?

A significant percentage of total cost of care is incurred through avoidable hospitalizations and ED use. For this reason, these important utilization measures can serve as surrogates for total cost of care in MDPCP. Because utilization can be monitored at the practice level, practices have visibility into their performance and can test changes in the delivery of care that can have an impact on performance. The comprehensive primary care delivered through MDPCP is designed to reduce avoidable hospitalization and ED use through improved access and continuity of care, targeted care management, delivery of more comprehensive and coordinated care, strategies of planned care and population health, and engagement of patients and families.

[18] Disclaimer: The "Acute Hospitalization Utilization" and "Emergency Department Utilization" measures and specifications were developed by NCQA under the Performance Measurements contract (HHSM-500-2006-00060C) with CMS and are included in HEDIS with permission of CMS. HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. NCQA also makes no representations, warranties or endorsements about the quality of any organization or clinician who uses or reports performance measures. NCQA has no liability to anyone who relies on HEDIS measures and specifications or data reflective of performance under such measures and specifications. Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications. The American Medical Association (AMA) holds a copyright to the CPT® codes contained in the measures' specifications.

What does your practice need to do for utilization measures?

- ☑ Your practice does not need to report anything for these measures. CMS calculates these measures at the end of each program year using claims data.
- ☑ Your practice should engage in the primary care functions that can improve the quality of care reflected in these measures (e.g. risk stratification, medication management, empanelment, care management, and care coordination), as described in *Advancing Primary Care in the MDPCP*.
- ☑ Your practice should also utilize data from CRISP and clinical data to track and monitor hospital, ED, and specialty care utilization.

Below is a list of practice-shared resources from the Comprehensive Primary Care Plus (CPC+) Program. These practices have implemented processes that contributed to lowering hospital and ED utilization. Your practice should consider the needs of your patient population as you make decisions on how to implement care delivery, health IT, data analysis, and collaboration strategies to lower rates of utilization.

Practice Resource

Amherst Medical Associates (Amherst, NY)
Creating a New Visit Model to Ensure Patients' Timely Access

Cascades East Family Medicine Center (Region, OR)
Improving ED Utilization Rates with Triage Nurses and Proactive Outreach

Warren Clinic (Tulsa, OK)
Increasing Access by Solving the Transportation Problem

Family Practice Associates (Broomfield, CO)
Using Data to Reduce Emergency Department Visits

MDPCP and Other CMS Quality Program Reporting

Quality Payment Program and MDPCP

The QPP, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a quality payment incentive program for physicians and other eligible clinicians that is designed to reward high value care with positive outcomes over the high volume promoted by the traditional fee-for-service model.

> QPP requirements may change each Performance Year due to policy changes. The most current information on the QPP can be found at https://qpp.cms.gov/.

Providers can participate in two ways: through the MIPS, which provides performance-based payment adjustments, or through an Advanced Alternative Payment Model (APM). Medicare-enrolled clinicians are required to participate in MIPS unless they meet exemption criteria or achieve Qualifying Alternative Payment Model Participant (QP) status due to sufficient participation in an Advanced APM.

The MDPCP is an Advanced APM under the Medical Home Model standard; however, not all practices will meet the Medical Home Model standard, and their participating providers will be required to report to MIPS. In addition, participating providers listed on the roster of a practice that does meet the Medical Home Model standard may not meet the QP (qualifying APM participant) threshold. These providers also will be required to report to MIPS. The MDPCP is also a MIPS APM, which provides credit in certain MIPS categories. We encourage all providers and practices to use the QPP Participation Status lookup tool at https://qpp.cms.gov/participation-lookup to check their QP status and MIPS eligibility. (QP status is determined at the NPI level. This tool allows for lookups of individual NPIs. To check the status of all NPIs assigned to a particular TIN, you must first sign into your QPP account; from there, you can download a list of all NPIs associated with a TIN and their status.)

CMS will make QP determinations using each Advanced APM entity's Participation List at three points in time: March 31st, June 30th, and August 31st. Providers must only achieve QP status at one of the three dates to be considered a QP for the Performance Year.

For additional information on the process and methodology that CMS will use to make QP determinations, thresholds, and snapshot dates, please review the Qualifying Alternative Payment Model Participants (QPs) Methodology Fact Sheet.

Medicare Shared Savings Program and MDPCP

Primary care practices that are part of Shared Savings Program ACOs may also participate in the MDPCP. MDPCP practices participating in both programs (i.e., dual participants) must meet all MDPCP quality reporting requirements for the full 2020 Measurement Period. On the Shared Savings Program side, the practice's ACO must also meet all quality reporting requirements of the Shared Savings Program.

Additionally, for dual participants in MDPCP and Advanced APM tracks of MSSP, CMS will evaluate the QP status for the *individual* provider based on their cumulative participation in MDPCP and MSSP. Any providers that are eligible for MIPS will be scored based on the MSSP entity's MIPS score (under the MIPS APM scoring standard), rather than the MDPCP practice score.

Dual participants will participate in completion of CG-CAHPS® surveys for both MDPCP and the Shared Savings Program. ACOs meet the Shared Savings Program requirements to measure patient experience of care by participating in completion of the CG-CAHPS survey. Additionally, all patients, not only a practice's Medicare fee-for-service patients, will be included in patient rosters subject to use for the CG-CAHPS® survey.

Questions?

Additional questions/comments regarding the overlap between QPP and MDPCP should be sent to either the QPP Help Desk (QPP@cms.hhs.gov or 1-866-288-8292) or MDPCP Team at CMS (MarylandModel@cms.hhs.gov or 1-844-711-2664, Option 7).

Additional information is available in the 2020 MDPCP Payment Methodologies document on Connect.

Contact Us with Questions

For questions, please contact MarylandModel@cms.hhs.gov or 1-844-711-2664. Please have your MDPCP ID ready if you call or include it in the subject line of emails. (For practices, your MDPCP ID is T#MD####, where T# denotes whether you are Track 1 or Track 2, and the last four digits are from your application number. For CTOs, your ID is CTO0####, where the last four digits are from your application number.) For all MDPCP Help Desk options, review the Help Desk Guidance Document.