Maryland
DEPARTMENT OF HEALTH

2021

ANNUAL REPORT

MDPCP
MARYLAND PRIMARY CARE PROGRAM

ACKNOWLEDGMENTS

The 2021 Maryland Primary Care Program (MDPCP) Annual Report was written as a collaborative effort between the Maryland Department of Health Program Management Office (PMO) and many partners, including the MDPCP Advisory Council.

Sincere gratitude is extended to all who contributed to the Annual Report, as well as the primary care practices and their partner Care Transformation Organizations doing the important care transformation work in Maryland.

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Glossary

ACRONYM	EXPANSION
ADI	Area Deprivation Index
AHRQ	Agency of Healthcare Research and Quality
AHU	Acute Hospital Utilization
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMF	Care Management Fee
CMMI	Center for Medicare and Medicaid Innovation
CMS	Center for Medicare Services
CPC+	Comprehensive Primary Care Plus
CPCP	Comprehensive Primary Care Payment
CQI	Continuous Quality Improvement
CRISP	Chesapeake Regional Information System for our Patients
CRP	Care Redesign Program (HSCRC)
CRS	CRISP Reporting Services
CTO	Care Transformation Organization
eCQM	electronic Clinical Quality Measure
ED	Emergency Department
EDU	Emergency Department Utilization
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FVF	Flat Visit Fee
HbA1c	Hemoglobin A1c
HCC	Hierarchical Conditions Category
HEART	Health Equity Advancement Resource and Transformation
HIE	Health Information Exchange

HIT	Health Information Technology
HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
HSCRC	Health Services Cost Review Commission
IP	Inpatient
mAb	monoclonal Antibody
MDH	Maryland Department of Health
MDPCP	Maryland Primary Care Program
MIPS	Merit-based Incentive Payment System
MOU	Memorandum of Understanding
MUA	Medically Underserved Areas
OUD	Opioid Use Disorder
PBIP	Performance Based Incentive Payment
PBPM	Per Beneficiary Per Month
PCR	Polymerase Chain Reaction
PMO	Program Management Office
POC	Point-of-Care
PQI	Prevention Quality Indicator
Pre-AH	Predicting Avoidable Hospital Events (tool)
PY[x]	Program Year [x], where x = {1, 2, 3}
QI	Quality Improvement
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SIHIS	Statewide Integrated Health Improvement Strategy
TCOC	Total Cost of Care

Executive Summary

The 2021 Maryland Primary Care Program (MDPCP) Annual Report presents findings on the third program year and progress towards primary care transformation in 525 primary care practices across Maryland. MDPCP supports Maryland's statewide health transformation with the goal of building a strong, effective primary care delivery system, inclusive of medical, behavioral, and social needs. The advanced primary care model in MDPCP includes targeted care management, behavioral health integration, screening and referrals for unmet social needs, and continuous, data-driven quality improvement. The Center for Medicare and Medicaid Innovation (CMMI) and the Maryland Department of Health Program Management Office (PMO) jointly operate MDPCP and provide support and technical assistance to practices.

As part of Maryland's Total Cost of Care (TCOC) Model, MDPCP is designed to operate from 2019 through 2026. At the end of 2023, CMMI will evaluate how well the Model met its goals of reduced Medicare costs and improved quality. MDPCP supports the overall Model goals through investment in a robust, organized, and enhanced primary care system. MDPCP aims to reduce avoidable hospital and emergency department visits, lower overall health system costs, and improve quality outcomes for all Marylanders. Additionally, the integration of public health and primary care driven by MDPCP creates the infrastructure necessary for rapid coordination and response to public health emergencies, as evidenced by response to the COVID-19 pandemic.

In 2021, COVID-19 and public health integration defined the program. MDPCP demonstrated its critical role in maintaining the health of Marylanders. MDPCP continued to expand comprehensive, advanced primary care across the state, while addressing the COVID-19 pandemic through broad implementation of telehealth, testing, therapeutics, and vaccination. Maryland was one of the first states to engage the field of primary care in fighting the pandemic. In fact, Maryland is currently home to one of the largest primary care vaccination networks in the country. The program also analyzed its impact on COVID-19, finding an 18% lower rate in COVID-19 deaths, accompanied by lower rates of cases and hospitalizations against a comparable population. Despite the many hardships placed on the Maryland community during this time, MDPCP practices and their Care Transformation Organizations (CTOs) rose to the challenge and were able to maintain access and staffing. This was in part due to the advanced payments and support provided by MDPCP. While much of the country saw primary care practices closing their doors, MDPCP practices remained open and accessible. MDPCP demonstrated to the nation both the foundational role of advanced primary care in preserving health and the importance of providing enhanced resources to a broad and well-organized network of practices.

Key program results from each section of the report are below.

Reach and Scope	• Engaged with 525 practices, approximately 67% of eligible practices • Managed the health of over 392,000 fee-for-service beneficiaries, approximately a 10% increase since 2019 (not including other beneficiaries and patients)

COVID-19	● Facilitated the delivery of 70,000 point-of-care tests to practices ● Ensured 314,090 beneficiaries completed the COVID-19 vaccine primary series ● Implemented the Triple Play Strategy framework to systematically deliver testing, therapeutics and vaccines through MDPCP practices ● Published study findings of better COVID-19 health outcomes associated with MDPCP practices
Health IT	● Increased usage of the Chesapeake Regional Information System for our Patients Reporting Services (CRS) MDPCP data reports by 74% among MDPCP practices and Care Transformation Organizations over the base year average of 2,036 report loads ● Developed two new reports, implemented two new tools, and improved existing reports in response to practice and provider feedback in CRISP
Health Equity	● Incorporated health equity as an additional program focus and as a program goal ● Received a multi-million dollar grant from the U.S. Centers for Disease Control and Prevention to expand health equity initiatives including expansion of social needs screenings and implementing data tools to assess disparities in clinical quality outcomes
Performance	● Achieved lower COVID-19-related health impacts relative to comparison group ● Achieved scores better than the national average in electronic Clinical Quality Measures for diabetes and hypertension control ● Achieved a reduction in avoidable hospital utilization (as measured by a decrease of Prevention Quality Indicator (PQI)-like events per every 1,000 MDPCP attributed beneficiaries) compared to the previous year ● Ensured 100% of MDPCP practices implemented a strategy to integrate behavioral health into practice workflows
Quality Improvement and Learning	● Renewed focus on quality improvement (QI) by fostering the “all teach, all learn” culture ● Established the Learning Advisory Council to gather feedback regarding the Learning System from key stakeholders

Per the TCOC Model contract, the PMO may provide recommendations annually to the Centers for Medicare and Medicaid Services. As such, the PMO makes seven recommendations to CMMI to improve MDPCP policy and operations in 2023 and beyond:

1. **Direct Participant Feedback:** Collaborate with the PMO to collect program feedback, including opportunities for improvement, directly from program participants.
2. **Track 2 Option Maintenance:** Maintain the Track 2 option as a sustainable payment model for practices that may be reluctant or unable to accept significant downside financial risk.
3. **Total Cost of Care (TCOC) Measure Weight Reduction:** Reduce the weight of the TCOC measure in the MDPCP performance framework to 5% as a reflection of the approximate portion of the TCOC that goes to primary care.
4. **Payer Alignment Oversight:** CMMI should set minimum standards for alignment and actively monitor implementation of the agreed-upon standards on the aligned payer Memorandum of Understanding (MOU).
5. **HEART Payment Use – Expansion of Flexibilities:** Increase the effectiveness of Health Equity Resource Advancement and Transformation (HEART) Payment funds by

enabling broader use of funds at the practice level, use of funds for medication cost-sharing, and use of funds for non-Medicare-covered equipment.

6. **Track 3 Performance-Based Adjustment:** Evaluate, monitor and restructure the budget neutrality mechanism in PBA under Track 3 with consideration to adjust payments based on fair prospective benchmarks that would allow all practices to be graded based on an external benchmark.
7. **Retroactive Change to Performance Measure Benchmarks:** Establish a regular period annually for the State PMO and CMMI to review and finalize benchmarks for the forthcoming year. Commit to making changes jointly with the PMO only when absolutely necessary and communicate these changes to participants as far in advance as possible. While this recommendation has been made in the past, retroactive changes have continued due to the public health emergency, and thus the issue is highly sensitive for participants.

Promulgation Statement

The Maryland Total Cost of Care Model contract indicates that the State may submit an Annual Report on the Maryland Primary Care Program (MDPCP) to the Center for Medicare and Medicaid Services (CMS). The contract further indicates that within the Annual Report, the State may:

1. Suggest ways in which CMS can improve operations under MDPCP, such as modifications to participating practices' care transformation requirements
2. Suggest utilization and quality measures for purposes of the Performance Based Incentive Payment (PBIP) that align with those used for purposes of the hospital quality and value-based payment program under the Hospital Payment Program, the Care Redesign Program, and the Outcomes-Based Credits
3. Make recommendations to CMS on components of MDPCP implementation that are appropriate for delegation to the State

As such, the Annual Report that follows includes program background, accomplishments, and recommendations in alignment with the aforementioned three areas.

Introduction to the Maryland Primary Care Program

A critical component of Maryland's Total Cost of Care Model (TCOC) is the Maryland Primary Care Program (MDPCP), which was created in partnership between Center for Medicare and Medicaid Services (CMMI) and the Maryland Department of Health (MDH). The goals of the program are to assist primary care practices in delivering advanced primary care and support health care transformation. MDPCP seeks to engage primary care practices in playing a larger role in: prevention, management of chronic disease, and reducing avoidable inpatient (IP) and emergency department (ED) utilization.

Collaborative partnerships are key to achieving the goals and objectives of the program. Within the report, the State refers to the State of Maryland, which is responsible for maintaining the Total Cost of Care Model contract with CMMI. MDH refers to the Maryland Department of Health, a critical partner, composed of many sub-departments that work closely with the support staff for MDPCP. Lastly, the Program Management Office (PMO) provides the MDH leadership and the support staff for the program.

2021 was framed by the continuation of the COVID-19 pandemic, which impacted the work of the practices, the program, MDH, and the State. Although the pandemic continued, the program continued to strive for the Program Year 3 (PY3) objectives and overall program goals with a measured approach. As a result of COVID-19, the program did not host a Request for Applications for new program participants to start in 2022.

This report will cover how MDPCP performed in relation to the program's goals, the specific performance year objectives in 2021 (PY3), and benchmarks. Additionally, this report will describe the reach and scope of the program, the COVID-19 response and public health integration efforts, health information technology (HIT), and work with Chesapeake Regional Information System for our Patients (CRISP), health equity workstreams, quality improvement and learning, recommendations to CMS, and a look ahead.

MDPCP Reach and Scope

MDPCP Adoption & Reach

A stated and critical goal of the TCOC contract broadly is to transform the delivery of health care across the state. The TCOC contract can only reach its full potential if the work of transforming health care is adopted by a large portion of the delivery system. In essence, the model is testing not only the movement from volume to value, but also the ability of a state to establish that movement across the delivery system. Sustainable impact and true success is measured by broad, statewide adoption of advanced primary care and continual transition to more comprehensive care. In keeping with that goal, MDPCP is focused on the recruitment and retention of as many willing and qualified primary care practices across the state of Maryland.

By PY3, MDPCP had already achieved a high level of adoption by Maryland primary care practices, with 525 practices engaged during the program year, representing approximately 67% of eligible practices.[1] These participating practices are composed of approximately 2,150 primary care providers, including 1,460 physicians (MD or DO), 450 nurse practitioners or clinical nurse specialists, and 270 physician assistants. The most common physician specialties are Internal/Adult Medicine (~850 physicians) and Family Medicine (~550 physicians).

The reach of the program is also measured by the number of Medicare fee-for-service (FFS) beneficiaries cared for by MDPCP practices. By this measure, the program has also seen a commensurate growth from PY2 (356,000 beneficiaries) to PY3 (392,000 beneficiaries), representing approximately a 10% increase.

To further explore the reach and scope of the program, a deeper examination of participating Care Transformation Organizations (CTOs), Federally Qualified Health Center (FQHCs), practices, providers, and attributed beneficiaries is described below.

CTOs

Participating practices in MDPCP have the option to partner with a CTO. In PY3, 27 organizations served as CTOs. The number of CTOs offering services in each of the 24 Maryland jurisdictions ranged from seven (in Cecil County) to fourteen (in Baltimore City, Baltimore County, Howard County, and Prince George's County). Figure 1 shows the growth in the number of CTOs offering services in each county across program years. Nearly two-thirds of participating CTOs were affiliated with a Maryland hospital or health system, whereas the remaining CTOs were independent entities. 410 of the 525 practices (78%) that participated in MDPCP in 2021 were affiliated with a CTO. Participating CTOs were paired with as few as one and as many as 53 primary care practices. In 2021, 21% CTOs partnered with five or fewer practices and in 2021 CTOs partnered with a median of 16 practices. CTOs employed a wide range of staff in PY3, including behavioral health professionals, care managers, community health workers, data analysts, licensed clinical social workers, pharmacists, and practice transformation consultants.

[1] MDH research suggests that there are approximately 780 eligible practices (some primary care practices in Maryland are ineligible to participate in MDPCP).

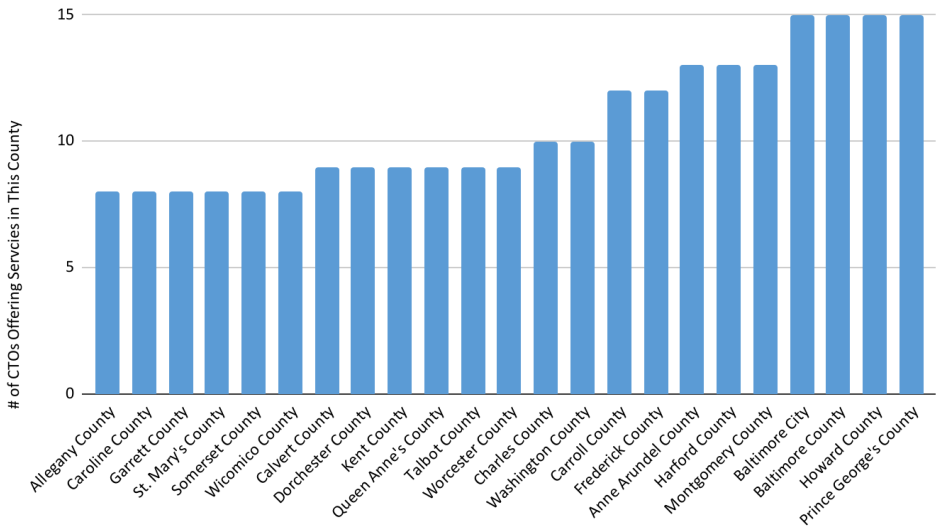

Figure 1. Number of CTOs Operating in Each Maryland County, 2021.

FQHCs

In 2021, FQHCs became eligible for participation in the MDPCP. FQHCs serve underserved areas and populations, and often have more racially diverse patient populations. Seven FQHC organizations representing 44 geographically diverse practice sites joined the program in 2021. The seven FQHC organizations– covering both rural and urban populations– had a total of 11,620 beneficiaries attributed to MDPCP in 2021, of which 58.5% were dual-eligible beneficiaries (termed “duals,” and referring to beneficiaries enrolled in both Medicare and Medicaid) .

Practice Characteristics

In PY3, 525 diverse practices participated in the MDPCP across all 24 counties in Maryland. More than half of participating practices in 2021 (51%) participated in Track 2, while over three-quarters of practices (78%) chose to leverage a CTO to help them meet the program transformation requirements (Fig. 2). Figure 3 displays the locations of MDPCP practices.

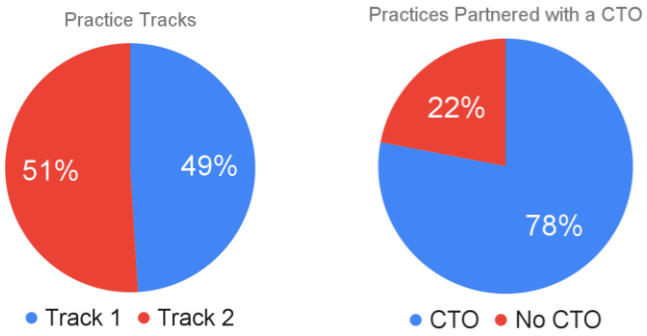

Figure 2. Percentage of Practices in Each Practice Track and Percentage Partnering with a CTO.

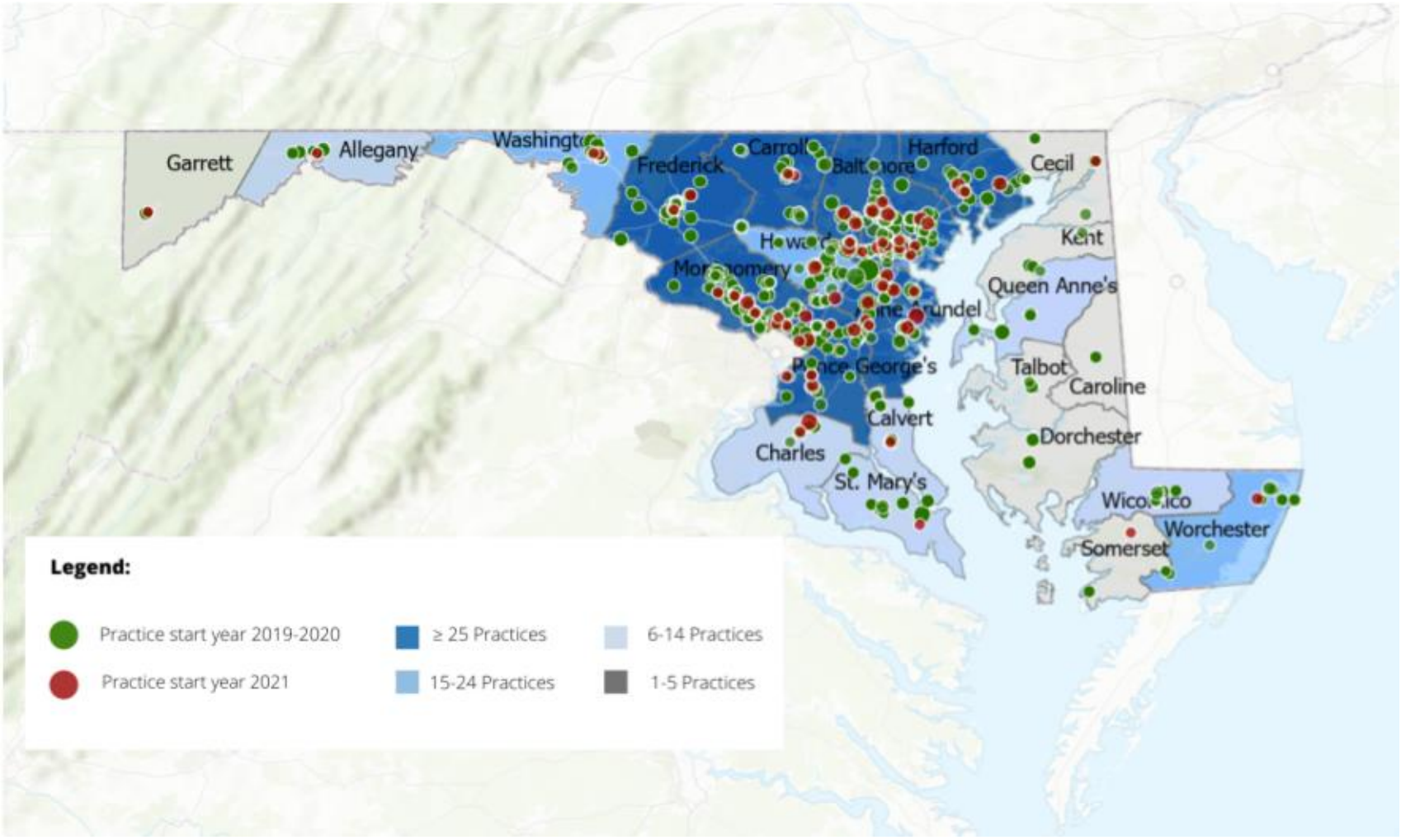

Figure 3. Map of MDPCP Participating Practices by County, 2021.

Diversity and Access

MDPCP practices serve a diverse population across the state including serving as the primary source of care to individuals in underserved areas. Many 2021 MDPCP practices fell within geographic locales that the Health Resources and Services Administration (HRSA) designates as Health Professional Shortage Areas (HPSAs). HRSA designation of an area as a "HPSA" indicates that an area does not have enough providers to meet the health needs of its population. There are three types of HPSAs: primary care, mental health, and dental. As Figure 4 shows, 109 MDPCP practices were located in primary care HPSAs and 152 were located in mental health HPSAs in 2021.

HRSA also designates geographic locales where it assesses a shortage of primary care health services as Medically Underserved Areas (MUAs). In 2021, 144 MDPCP practices were located in MUAs (Fig. 4). Furthermore, MDH designates specific counties as "rural." In 2021, there were 178 MDPCP practices that were located in counties that MDH labels as "rural" (Fig. 4).

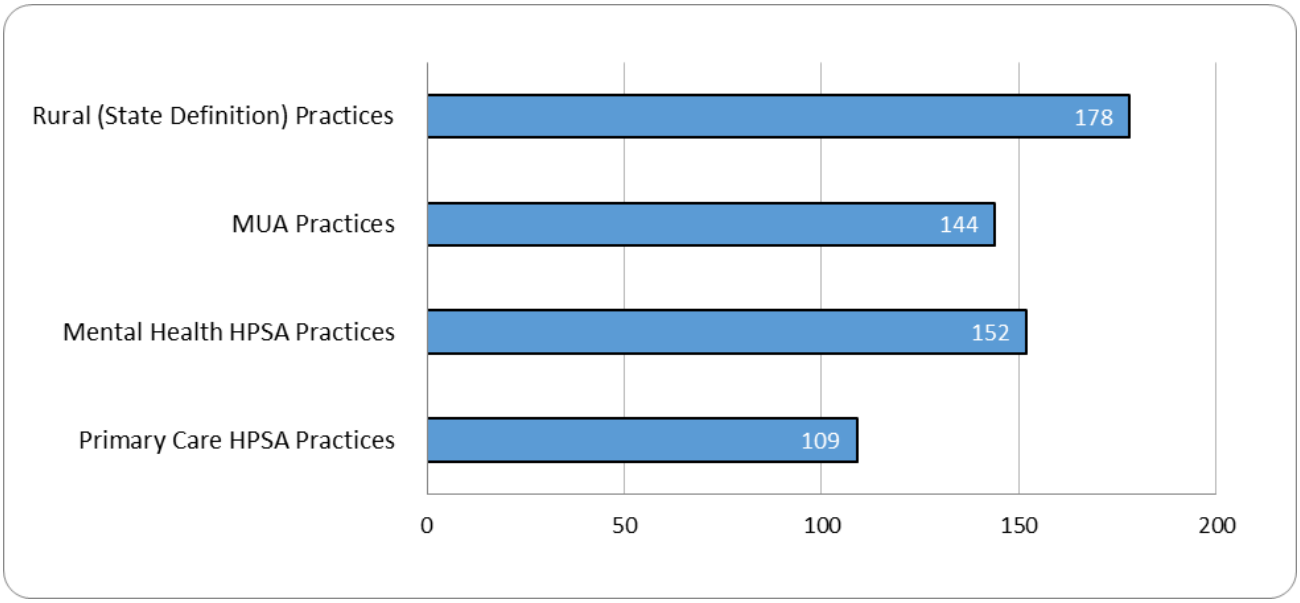

Figure 4. Count of 2021 MDPCP Practices by Underserved Category.

Provider Diversity

MDPCP started collecting data on racial and ethnic diversity of providers participating in the program through practice reporting in 2021. This reporting question was optional for practices to disclose, and therefore may not be fully representative. A breakdown of MDPCP providers by race (Table 1) and by ethnicity (Table 2) reported during Q1 2022, for those that opted in to reporting, is shown below. Note that while 183 practices opted into reporting for both the race and ethnicity questions, a different set of practices made up the 183 total for each question, leading to differential totals. Data on provider diversity in Maryland are not available for

comparison, however MDPCP compares favorably to national data that demonstrate only 5% of physicians identifying as Black or African American.

Table 1. MDPCP Provider Breakdown by Race, Q1 2022.

Provider Breakdown by Race (183 Reporting Practices)		
American Indian or Alaska Native	6	0.8%
Asian	147	20.3%
Black or African American	107	14.7%
Native Hawaiian or Other Pacific Islander	1	0.1%
White	422	58.1%
Other	43	5.9%
Total	***726***	***100.0%***

Table 2. MDPCP Provider Breakdown by Ethnicity, Q1 2022.

Provider Breakdown by Ethnicity (183 Reporting Practices)		
Hispanic or Latino	24	3.5%
Not Hispanic of Latino	669	96.5%
Total	***693***	***100.0%***

Beneficiary Characteristics

At the beginning of 2021, over 392,000 Medicare FFS beneficiaries were officially attributed to MDPCP practices. However, the impact on the Maryland population is much broader; an estimated total of 4 million patients across several insurance types benefited from the care provided by these practices. Figure 5 shows the distribution of MDPCP-attributed beneficiaries by age.

The FFS-attributed beneficiaries grew by over 51,015 from 2020 to 2021. During this same timeframe, the number of dual-eligible beneficiaries increased by over 16,000.

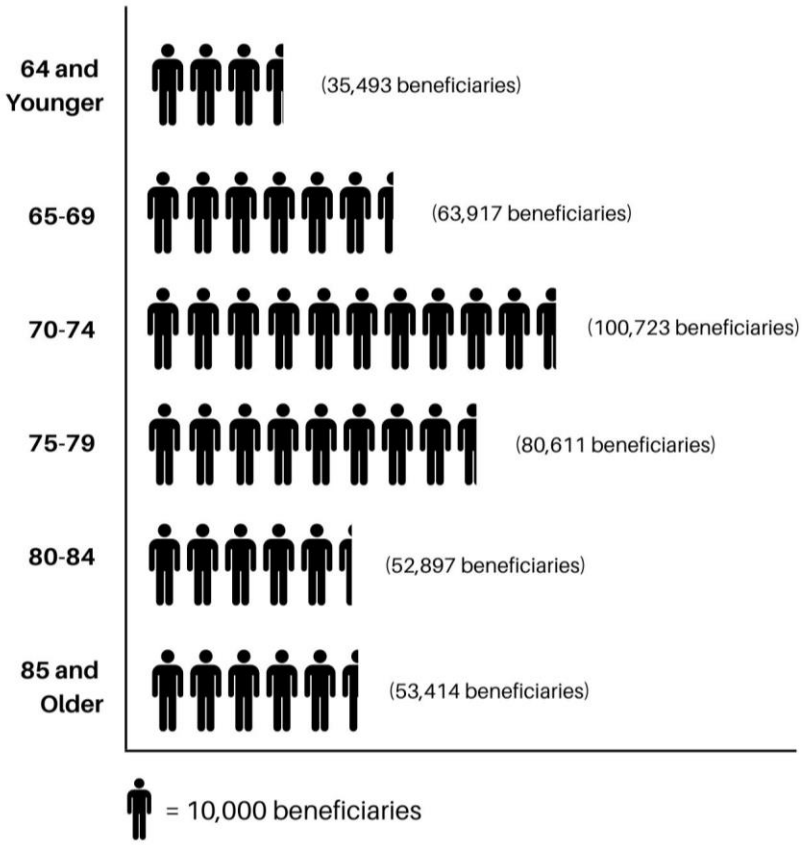

Figure 5. Distribution of MDPCP-Attributed Beneficiaries by Age Group, Q1 2021 Attribution.

Beneficiary Diversity

Table 3 below shows the demographics of the MDPCP Medicare beneficiary population compared with the demographics of the statewide Medicare beneficiary population. MDPCP is slightly less racially diverse than the overall Maryland Medicare FFS population. There is a larger proportion of white beneficiaries and smaller proportion of Asian, Black, and Hispanic beneficiaries in MDPCP.

Table 3. Demographics of the MDPCP Medicare Population Compared to the Statewide Medicare Beneficiary Population, Q4 2021 Attribution.

	MDPCP		Statewide	
Asian	7,843	2.1%	21,880	2.9%
Black	78,806	21.1%	176,547	23.4%
Hispanic	4,108	1.1%	9,808	1.3%
White	266,671	71.4%	509,271	67.5%
Other	5,602	1.5%	13,581	1.8%
Unknown	10,458	2.8%	23,389	3.1%
Total	**373,488**	**100%**	**754,476**	**100%**

The structure of the program is designed to intentionally expand the reach and scope of primary care in order to achieve care transformation. Table 4 shows MDPCP summary statistics indicating the reach of the program in PY3.

Table 4. MDPCP Summary Statistics.

Participants	2019	2020	2021
Practice Sites	380	476	525
Providers in MDPCP	~1,500	~2,000	~2,150
FFS Medicare Beneficiaries Attributed	214,640 (30,199 duals)	325,770 (48,484 duals)	376,785 (65,212 duals)
Marylanders Served	2,000,000-3,000,000	2,700,000-3,800,000	~4,000,000

Payments

In the program, the transformation to advanced primary care is supported by enhanced Medicare payments to participating practices. In exchange for implementing changes and services, participating practices receive quarterly, prospective, non-visit-based Care Management Fees (CMFs) per attributed Medicare patient. CMFs are risk-adjusted, per beneficiary per month (PBPM) fees that are based on disease burden using the Hierarchical Conditions Category (HCC) risk adjustment model.

To encourage and reward accountability for beneficiary experience, clinical quality, and utilization, program payments include a Performance-Based Incentive Payment (PBIP). The annual PBIP is paid prospectively, but a participant practice may retain the PBIP (in whole or in part) if the practice meets certain annual performance thresholds. The PBIP includes two distinct components: 1) incentives for performance on clinical quality and patient experience measures, and 2) hospital and ED utilization measures (Fig. 6).

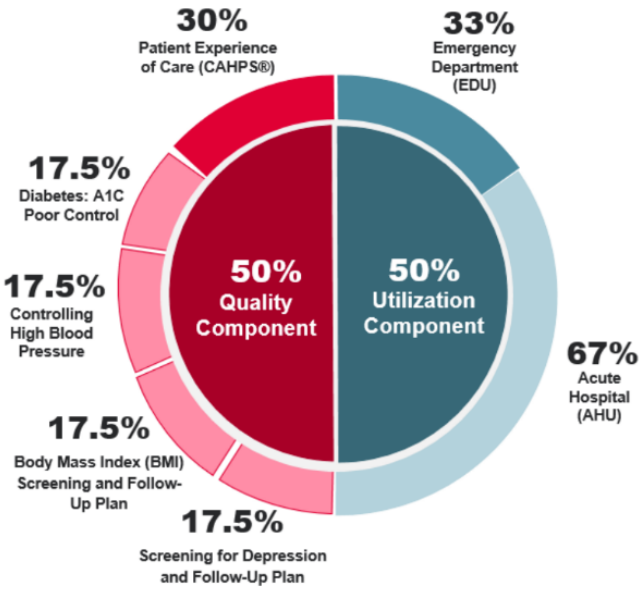

Figure 6. Breakdown Components of the PBIP.
Source: *MDPCP Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance- Based Incentive Payment, and Comprehensive Primary Care Payment. Model Year 2022. Centers for Medicare & Medicaid Services.*

For the advanced Track 2 practices, MDPCP payments also include a Comprehensive Primary Care Payment (CPCP). The CPCP is a partially capitated payment in which a portion is prospectively paid each quarter, and the remainder is paid when services are billed. Figure 7 provides a detailed depiction of MDPCP payment components, all of which are prospective payments, but do not include any Medicare FFS payments billed by the practice. It should be noted that FQHCs in Track 2 also receive the CPCP, which funds services not covered under the Medicare FQHC Prospective Payment System.

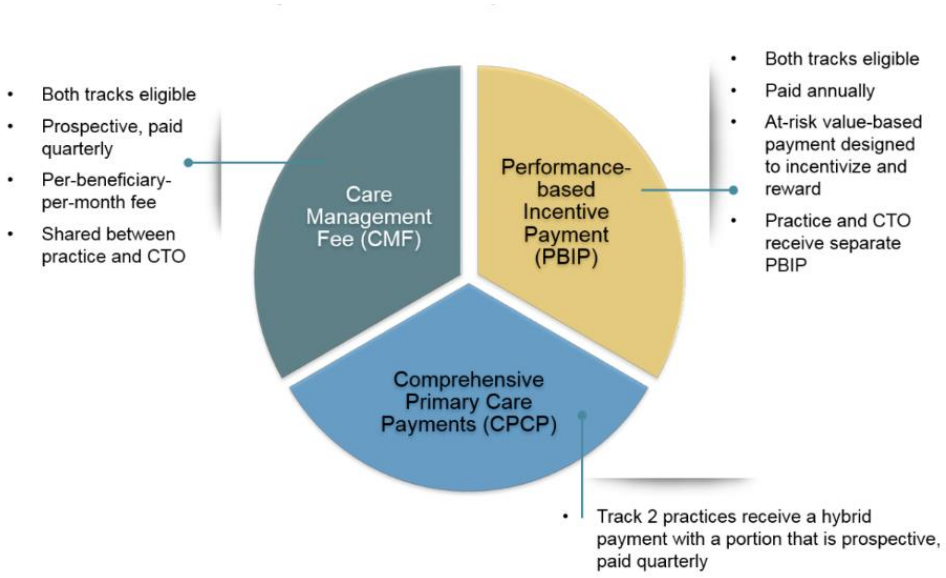

Figure 7. MDPCP Payment Components.

Disclaimer*: Please note that the above figure is not a summation chart and does not represent the proportional contribution of each element.*

Source: *MDPCP Payment Methodologies: Beneficiary Attribution, Care Management Fee, Performance- Based Incentive Payment, and Comprehensive Primary Care Payment.* Model Year 2022. Centers for Medicare & Medicaid Services

MDPCP payments are critical to enhancing practices' capacity to implement care transformation. All numbers below represent MDPCP prospective payments and not any claims billed on a FFS basis. As Table 5 displays, total MDPCP payments have increased 184% since 2019.

Table 5. Total MDPCP Payments to Practices by Year.

Component	2019 Total Payments	2020 Total Payments	2021 Total Payments	Percent Change (2019 to 2021)
CPCP Payments	$704,983	$4,673,400	$15,026,680	+2032%
PBIP Payments	$8,580,067	$18,563,695	$25,598,238	+198%
CMF Payments	$53,003,874	$102,611,859	$136,461,427	+158%
Total	**$62,288,924**	**$125,848,954**	**$177,086,345**	**+184%**

In 2021, total CPCP payments totaled $15,026,680. Total PBIP payments totaled $13,562,718 for practices and $12,035,520 for CTOs. Lastly, total CMF payments to practices totaled $91,932,313 for practices, and $44,529,115 for CTOs. Table 6 contains additional information regarding the MDPCP payments to practices in 2021, broken out by practice track. The increases in payments are driven by two factors: 1) More practices have enrolled each year which means more attributed beneficiaries; 2) Practices have increased their comprehensiveness of care by moving from Track 1 to Track 2. As practices move to Track 2, the PBPM payment levels increase. The sharp increase in CPCP is driven by the number of

practices moving from Track 1 that does not have a CPCP component to Track 2 which includes a CPCP component and pays higher rates for CMF payments for higher levels of advanced primary care. This increase is also emphasized by the requirement for Track 2 practices to increase their CPCP prepayment percentages each year.

Table 6. Total Payments to MDPCP Practices and CTOs by Payment Type.

Component	Track	Practice Payments	CTO Payments
CPCP Payments	Track 1	$0	-
	Track 2	$15,026,680	-
	Both Tracks Combined	$15,026,680	$0
PBIP Payments	Track 1	$4,124,190	-
	Track 2	$9,438,528	-
	Both Tracks Combined	$13,562,718	$12,035,520
CMF Payments	Track 1	$25,239,374	-
	Track 2	$66,692,938	-
	Both Tracks Combined	$91,932,312	$44,529,115
Total Payments	**Track 1**	$29,363,564	-
	Track 2	$91,158,146	-
	Both Tracks Combined	$120,521,710	$56,564,635
	$177,086,345		

COVID-19 and Public Health Integration

COVID-19 Response and Renewed Mitigation Strategy

2021 demonstrated the enormous power of a trained, assembled, and coordinated statewide primary care program working closely with state public health in combating the health care crisis of our generation. With the majority of Maryland primary care practices already in direct collaboration with the State, this advanced primary care workforce was poised to react quickly and effectively to the COVID-19 public health emergency. Within days of the declaration in 2020, practices pivoted to providing telehealth care. The real power of this program became evident in 2021 as practices engaged in the equitable administration of vaccines, the broad-based use of point-of-care (POC) testing, and the use of COVID-19 therapeutics to treat patients. The MDPCP infrastructure was particularly important in the COVID-19 response. The financial flexibility of the MDPCP payment model allowed practices to continue to operate and serve patients, even when the number of patient visits declined. This was essential in 2020 and continued to be key in 2021. This is a story unique to Maryland and was made a reality because of the support and partnership of MDH Public Health Services, the State, and the dedication of the many thousands of MDPCP providers and staff to “find and fight the virus.”

Throughout 2021, participating MDPCP practices spent time, energy, and resources actively responding to the COVID-19 pandemic. MDPCP practices continued to care for patients affected by COVID-19 in their offices and directed many patients to necessary therapeutic resources. The PMO worked closely with MDH leadership to ensure primary care practices were supplied with personal protective equipment, POC tests, vaccines to provide in office, and access to therapeutics either in office or via referral. This allowed practices to use best practices for infection control, and to connect COVID-19 positive patients to resources to decrease their risk of hospitalization and death, all while continuing to provide non-COVID-19 care.

The year was marked with many advancements in how the health care system responded to COVID-19. The release of COVID-19 vaccines was a major achievement and MDPCP primary care practices were a critical component in Maryland’s early rollout, as well as ensuring patients remained up to date with COVID-19 vaccines and boosters as supply became more plentiful. Beyond vaccines, new COVID-19 therapeutics were authorized and recommended for many patients with a COVID-19 infection. With these new advancements, the PMO developed the “Triple Play Strategy” (Fig. 8) for primary care providers to use to address COVID-19. This strategy includes three action items for primary care providers in the COVID-19 response:

1. **Vaccines**: Providing vaccines in-clinic or facilitating patients scheduling appointments for initial vaccines and booster doses
2. **Testing**: Administering POC tests or polymerase chain reaction (PCR) testing to patients with symptoms
3. **Therapeutics**: Referring COVID-19 positive patients to therapeutics including oral antivirals

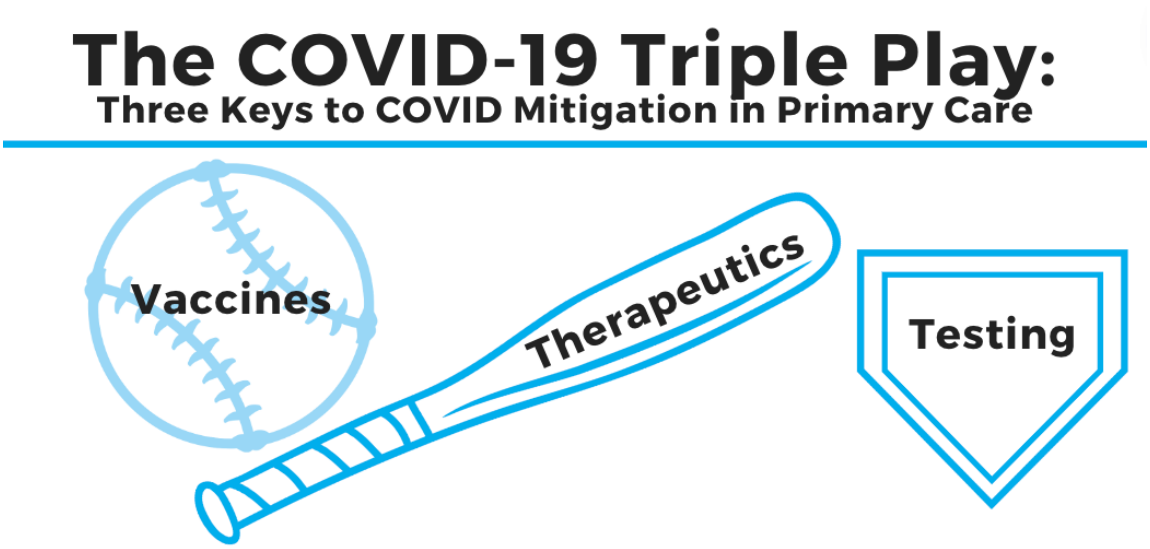

Figure 8. Triple Play Strategy.

Many of the communication strategies that proved effective in 2020 were continued throughout 2021. The PMO continued to send weekly COVID-19 emails that first focused on vaccine information and were shared with practices that were offering COVID-19 vaccines in their clinical settings. Provider feedback led the PMO to broaden the audience and content of these emails to include not only all aspects of the Triple Play Strategy, but also additional primary care practices that were engaging in other areas of the Triple Play beyond vaccines. In addition to the weekly COVID-19 emails, the PMO continued the COVID-19 webinars. In 2021, the PMO hosted 38 webinars that included updated information on surge data, vaccines, testing, therapeutics, masking, quarantine guidelines, and other related COVID-19 topics. Positive feedback for these COVID-19 webinars is displayed in Figure 9. Beyond these regular communications, the PMO also created specific guides and resources for MDPCP participants to better assist them in their efforts to mitigate COVID-19 (Fig. 10).

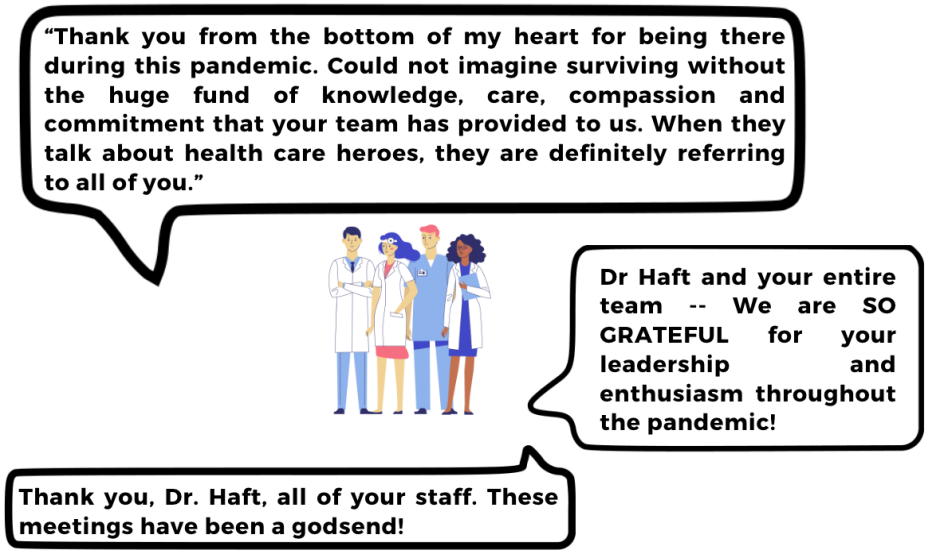

Figure 9. COVID-19 Webinar Participant Feedback.

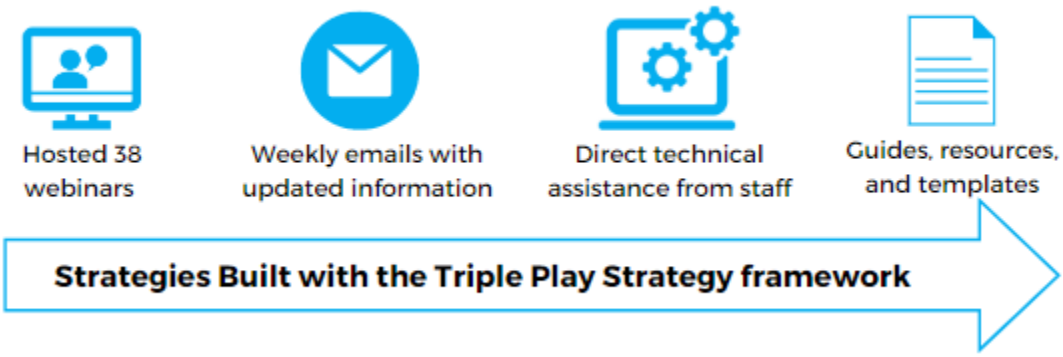

Figure 10. Strategies Built with the Triple Play Strategy Framework.

Vaccines

A major component of the primary care response to COVID-19 in 2021 was the provision and facilitation of COVID-19 vaccines. During 2021, 285 MDPCP practices joined the Maryland Primary Care Vaccine Program and provided these essential vaccines in their clinical practices. The Maryland Primary Care Vaccine Program is open to all primary care practices in the state, however MDPCP practices comprise the majority of the practices in the program. Early on in the vaccine rollout when vaccine supply was scarce, the PMO advocated for the rollout of COVID-19 vaccines to primary care practices so primary care providers could reach their most vulnerable patients. The PMO conducted this advocacy because primary care has numerous advantages as vaccination sites:

- In numerous national and local surveys, patients indicate that they prefer to get vaccinated at their doctor's office
- Through trusted relationships with patients, providers can reduce vaccine hesitancy and get more people vaccinated

- By utilizing existing staff and infrastructure, primary care practices can stand up vaccination clinic days or vaccination appointments into regular clinical days
- Primary care practices are dispersed throughout the state in both urban and rural settings, making them more accessible to patients and community members compared to mass vaccination sites
- Access to data allows primary care practices to outreach directly to their most vulnerable patients to recommend vaccination

As a result of this advocacy, Maryland became one of the first states to distribute COVID-19 vaccine to primary care practices. In early March 2021, MDH rolled out COVID-19 vaccines to 17 MDPCP practices located in strategic areas of the state to reach underserved populations.

After this initial rollout, Governor Hogan announced an expansion of COVID-19 vaccine efforts that would incorporate additional primary care practices, with priority toward practices serving largely African American or Black and Hispanic communities to ensure an equitable approach to vaccine distribution. As weeks passed, additional practices signed on, expanding to 37 practices in week 2, 89 practices in week 3, all supported by a distribution system managed by the PMO, in direct collaboration with MDH. MDH was able to capitalize on the existing infrastructure of MDPCP to rapidly communicate with practices and quickly expand the rollout.

Many of these selected practices have been serving their patients for a decade or more and have thus built strong trusting relationships with their patients. Because of these relationships, these practices found great success in outreaching to patients, answering any concerns, and providing COVID-19 vaccines to their patients.

Spotlight: Menocal Family Practice

Menocal Family Practice is an MDPCP practice serving patients in both Frederick and Baltimore. In March 2021, Menocal Family Practice stepped up as part of the first group of primary care practices in Maryland to receive COVID-19 vaccines, and quickly became a guiding voice to expand vaccination to more primary care practices.

Menocal Family Practice found great success in addressing hesitancies, concerns, and other barriers to patients receiving COVID-19 vaccines. Over the past decade, Dr. Menocal has led the practice to provide over 110,000 free vaccines to community members, and has established the practice as a trusted and known source of accurate clinical information and resources.

In particular, the practice serves many LatinX community members, a community that has experienced proportionately lower COVID-19 vaccination rates over the course of the pandemic, especially during the early rollout. The team at Menocal Family Practice not only provided the COVID-19 vaccine in office, but also staged vaccination events at numerous community events and gathering spaces for the LatinX communities in Frederick and Baltimore, reaching people outside of traditional

medical spaces and into communities. Beyond vaccination, the practice stayed open throughout the entire pandemic to continue to care for patients and provide a COVID-19 response in their communities. From March 2021 through the end of 2021, Menocal Family Practice administered 7,195 COVID-19 vaccine doses to Marylanders, about half of which went to LatinX individuals.

White House COVID Response Team Visits to MDPCP Practices

In May 2021, Dr. Bechara Choucair, the White House COVID Vaccinations Coordinator at the time, and other members of the White House COVID Response Team, visited two MDPCP practices to see firsthand the critical role that primary care practices played in Maryland's COVID-19 vaccination campaign. MedPeds and Comprehensive Women's Health, two of the earliest practices to join the vaccine initiative, each received a visit by the White House team. The White House team was able to see how these practices used MDPCP data tools in CRISP to drive a data-driven and equity-forward vaccine outreach strategy, reaching vulnerable patients who otherwise would not have been able to receive the vaccine so early. The White House COVID Response Team chose to visit participating practices because at the time, Maryland was one of few states distributing vaccines to primary care offices, which was only possible due to the foundational relationship between MDH and primary care through MDPCP.

The summer months of 2021 were known for the rise of the Delta variant of COVID-19. During this time, the PMO launched a COVID-19 Vaccine Outreach Initiative. At that time, over 80% of all MDPCP beneficiaries were up to date with their COVID-19 vaccines. However, with the Delta variant causing cases to rise, intentional outreach to the unvaccinated population was critical. The PMO targeted a group of practices that had the highest number or highest percent of unvaccinated patients and supplied them with data, resources, and a call to action to outreach to these patients. After the initial launch of this initiative, the PMO led a kickoff call and supplied practices with the MDPCP Vaccine Outreach Guide (which included information on how to work with the MDH Call Center), the MDPCP Vaccine Hesitancy Guide, a Call Script for contacting unvaccinated patients, and a ImmuTrack Guide, so practices could quickly identify through CRISP patients needing active outreach. As the initiative began, the team received feedback regarding a need for additional resources and subsequently released sample text messages, a personal provider letter template, and a "Call for Volunteers" template intended to help practices ask for volunteers to assist with registration and other vaccine administration logistics. The initiative lasted one month and among the fifty targeted practices, 8.9% of the unvaccinated MDPCP beneficiaries in the fifty targeted practices obtained their full primary series of the COVID-19 vaccine.

Through December 2021, primary care practices in Maryland administered over 302,000 cumulative COVID-19 vaccine doses at over 470 participating primary care sites, including both MDPCP and non-MDPCP practices. Towards the end of 2021, COVID-19 boosters were authorized and recommended particularly for individuals 65 years and older. These recommendations directly apply to MDPCP beneficiaries, and in turn MDPCP practices quickly outreached and recommended these booster doses to their patients.

Throughout the year, MDH called on all MDPCP practices to participate in facilitating vaccine appointments for beneficiaries, regardless of whether they were providing vaccines within their clinical space. The PMO ensured that the MDH Coronavirus webpage routinely updated the vaccine locator tool with sites willing to be publicly listed for COVID-19 vaccines. MDPCP practices that were not offering vaccines on site could easily utilize this page to assist patients with making COVID-19 vaccine appointments elsewhere.

To further assist practices with outreaching to their patients, the PMO created a number of guides, resources, and toolkits including:

- Preparing for the COVID-19 Vaccine in Primary Care Guide
- MDPCP Vaccine Outreach Guide
- MDPCP Vaccine Hesitancy Guide
- MDPCP Call Script
- MDPCP Immunocompromised Guide
- MDPCP Booster Guide
- MDPCP Triple Play Strategy Guide

These resources were periodically updated to include new and emerging clinical information, relevant conversation tips, and additional Frequently Asked Questions. Practices used these resources to guide their conversations with patients, answer any vaccine related questions, and ultimately help patients obtain these critical vaccines.

Spotlight: Dr. Casas

Despite the challenges of COVID-19, Dr. Luis A. Casas' practice was able to leverage resources and capitalize on their passion as health care providers to continue to serve patients with regard to their routine care and provide COVID-19 services.

The practice provides primary care services to patients in Prince George's County and neighboring areas. Dr. Casas and his team routinely requested POC tests from the State in order to quickly test symptomatic patients. Additionally, they offered COVID-19 vaccines in their office which made these vaccines accessible to their patients. The practice continued to see patients throughout the entire pandemic and adapted to fit the needs of their patient population. Throughout 2021, when the State would call upon primary care practices to engage in different areas of the pandemic response, Dr. Casas and his team would quickly create an internal plan.

As a small practice that has served the same patients for many years, the team has developed strong, long-lasting relationships with their patients built on a strong foundation of trust. These relationships with patients have allowed the practice to effectively provide COVID-19-related care to their patients and see a tremendous level of success with testing and vaccinations. By the end of 2021, the team successfully vaccinated 95.77% of their MDPCP beneficiaries.

The vaccine response in Maryland leveraged primary care practices in a unique way that most other states did not. From the beginning of the vaccine supply rollout, the PMO was able to ensure that the state prioritized primary care as a vital source to distribute vaccine supplies. The PMO worked with groups and individually with practices to ensure they had all of the technical assistance they needed to provide COVID-19 vaccines in their practice. MDH continued to keep primary care providers as a top priority for COVID-19 vaccines, especially when it became apparent early on, that these providers were some of the most influential sources of information, particularly for vaccines. MDPCP practices in particular were successful as a result of this prioritization. The established relationships created as a result of the program allowed for practices to obtain information and resources quickly.

ImmuTrack

A key element to the primary care response to the pandemic was the use of clinical data. In partnership with CRISP, the PMO assisted with developing ImmuTrack, a COVID-19 vaccine tracking tool. With a few clicks on their practice dashboard, practices could access their patient panels and quickly identify who had obtained a partial or the full primary series of the COVID-19 vaccine, parsed by age, race, ethnicity and underlying conditions including the vaccine type and dates of their vaccine. Providers could not only access this information, but also download and use it for outreach purposes. The PMO provided guides and training to practices on how to use ImmuTrack and how this data could improve their pandemic response.

Feedback from providers also led to the creation of some filters within the ImmuTrack including a filter for unvaccinated or partially vaccinated patients that are 75 years and older, unvaccinated or partially vaccinated and 65 years and older, and other age groups. These filters allowed practices to quickly identify specific groups of patients that they wanted to outreach to for COVID-19 vaccines. Practices could then download these patient lists, create an outreach plan, and begin calling patients. Practices accessed ImmuTrack an average of 174 times throughout the year, indicating that practices typically utilized this tool three times a week on average.

Eligible for Booster Filter

In addition to the population-based filters, the PMO worked with CRISP to develop a booster filter (Fig. 11). This tool filters the practice patient list to patients that fall into a booster eligibility category and the appropriate time has passed from their primary series. When boosters were initially authorized and recommended, the PMO encouraged practices to: 1) identify eligible patients, 2) outreach to those patients and communicate that they are now due for a recommended booster dose, and 3) offer a booster vaccine appointment or connect them with a pharmacy to schedule a booster vaccine appointment.

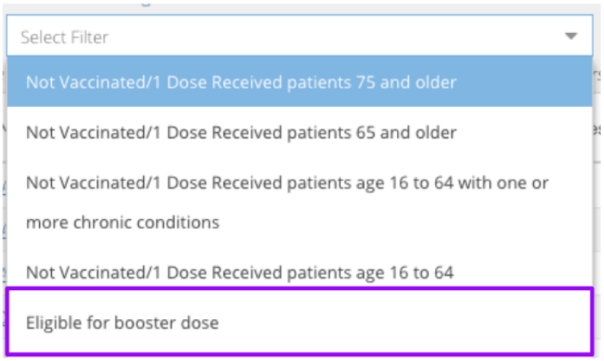

Figure 11. Snapshot of ImmuTrack Filter.

Testing

Another key component of the coordinated response in 2021 was testing. At the beginning of the pandemic, it quickly became apparent that primary care practices would benefit greatly from being able to provide testing within their clinical spaces, rather than refer patients out and potentially miss the opportunity to follow up with a positive case. When it comes to COVID-19, slower testing could be the difference between a patient remaining eligible for life-saving therapeutic measures, and missing out altogether.

Prior to 2021, the PMO partnered with the larger MDH testing efforts to start the Testing Adoption Project. In partnership with other agencies at MDH, this project intended to inform primary care providers about the importance of utilizing polymerase chain reaction tests within their practice to diagnose COVID-19 cases. The PMO assisted with creating a toolkit for PCR testing which included key guides, checklists, and other essential components for practices integrating these tests into their clinical workflows. As COVID-19 testing evolved nationally, POC testing was integrated for swift diagnosis of COVID-19 cases. The PMO assisted by informing practices of clinical workflows and state regulations for conducting POC testing within a practice setting.

Beginning in January 2021, the PMO began facilitating a process for primary care practices to obtain free POC tests from a state stockpile of resources. Practices were asked to fill out an online form indicating their clinical ability to perform these tests in their practices, and then they subsequently received these essential diagnostic supplies within a few weeks. The PMO also created useful training guides, coding information, and other relevant testing material to facilitate practices' utilization of these POC tests. Throughout 2021, the PMO facilitated the delivery of approximately 70,000 tests to practices. Figure 12 illustrates the 2021 MDPCP testing and vaccinating sites.

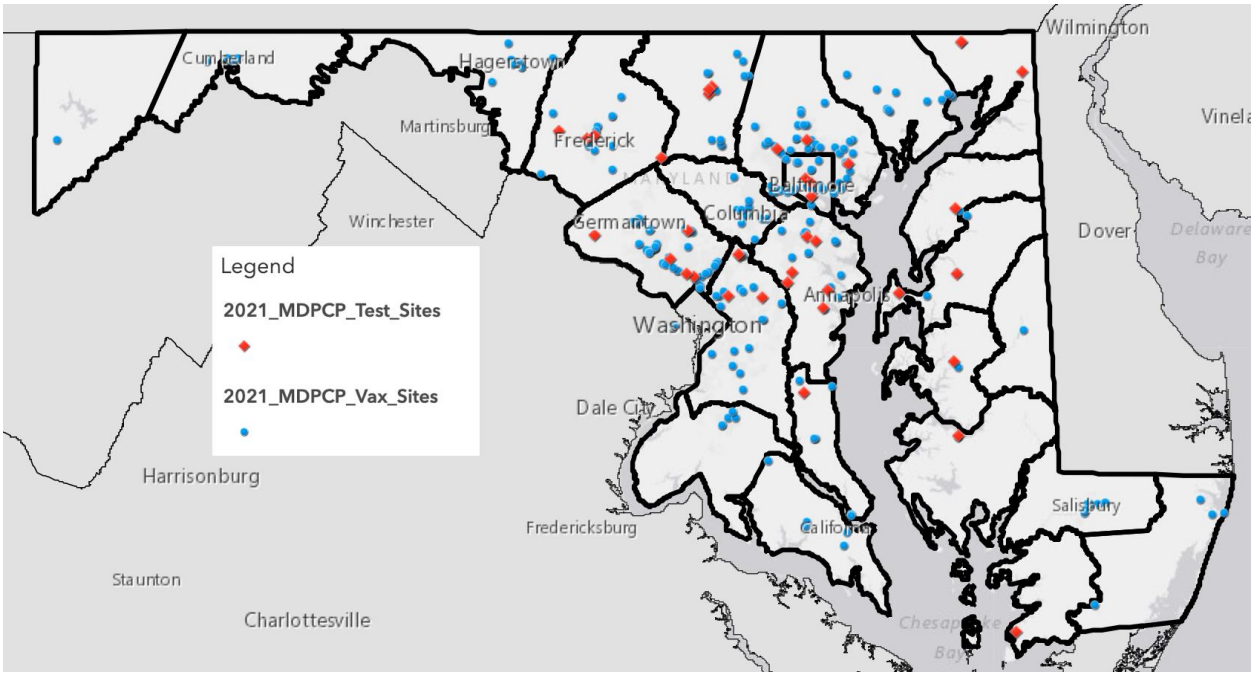

Figure 12. MDPCP Testing and Vaccinating Sites in 2021.

Therapeutics

The Testing Adoption Project was also intended to improve the efficiency of primary care providers referring eligible patients for monoclonal antibody (mAb) treatment. Access to POC tests through the Testing Adoption Project allowed providers to test patients rapidly and refer patients with COVID-19 to mAb treatment within the short treatment eligibility window. This was especially important at a time when PCR test results were slow and POC tests were not widely available. With some mAb treatments only available for patients within 5 days of a positive test, POC tests provided by MDH allowed providers to meet this window and refer more eligible patients for critical treatments.

In early 2021, mAb treatment was predominately offered at regional sites. The PMO communicated regularly with primary care practices: 1) where these treatments were; 2) how to refer patients to these sites; and 3) any additional considerations needed for these therapeutics. The PMO, through webinars, email, and other means, served as an essential communication channel for primary care providers aiming to refer patients for mAb treatment.

As the year progressed, the FDA authorized additional COVID-19 therapeutics,including oral antivirals and additional mAb treatments. As these additional treatment methods became recommended for larger patient populations, the PMO continued to actively communicate these updates to practices and encourage providers to recommend, prescribe, and refer for these lifesaving therapeutics.

As the Omicron variant began to increase in prevalence, the PMO quickly worked to communicate updates on therapeutics, efficacy information, and the NIH prioritization of COVID-

19 therapeutics. The team provided these updates at weekly COVID-19 Update Webinars and weekly emails, and partnered with the MDH Therapeutics Team on weekly clinician letters.

Public Health Integration

In September 2021, the PMO published an issue brief titled, "Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health-Supported Advanced Primary Care Paradigm," on the Milbank Memorial Fund website. This paper highlights how the relationship between the State and MDPCP practices facilitated a robust COVID-19 response, and the COVID-19 outcomes associated with MDPCP participation during 2020. In a review of 2020 claims data, participation in MDPCP was statistically significantly associated with a 7% lower incidence of COVID-19, a 10% lower inpatient admissions attributed to COVID-19, and an 18% lower death rate attributed to COVID-19, compared to a matched Maryland Medicare beneficiary cohort. This research with a large claims sample size shows that Medicare MDPCP beneficiaries experienced better COVID-19 health outcomes in 2020 than a comparable cohort. This suggests that participation in MDPCP allows advanced primary care practices to produce better COVID-19 outcomes and that integrating public health and primary care can maximize advanced primary care and improve health outcomes. This research has since been extended to review 2021 data and has indicated the same relationship between participation in MDPCP and better COVID-19 related health outcomes.

Throughout 2021, the PMO served as the information and resource hub for primary care providers on the COVID-19 response. The PMO regularly communicated information, updates, and key resources to practices in a timely and efficient manner, allowing practices to provide optimal care for their patient population. The PMO was prime to serve as this vessel given its position in MDH and the trusted relationships that have been established with practices over the years through participation in MDPCP. The integration of primary health care delivery into the public health department in Maryland was essential to creating a coordinated response. Figure 13 presents the highlights of this coordinated response. This relationship allowed dissemination of essential resources from the state health department to primary care practices on a regular basis.

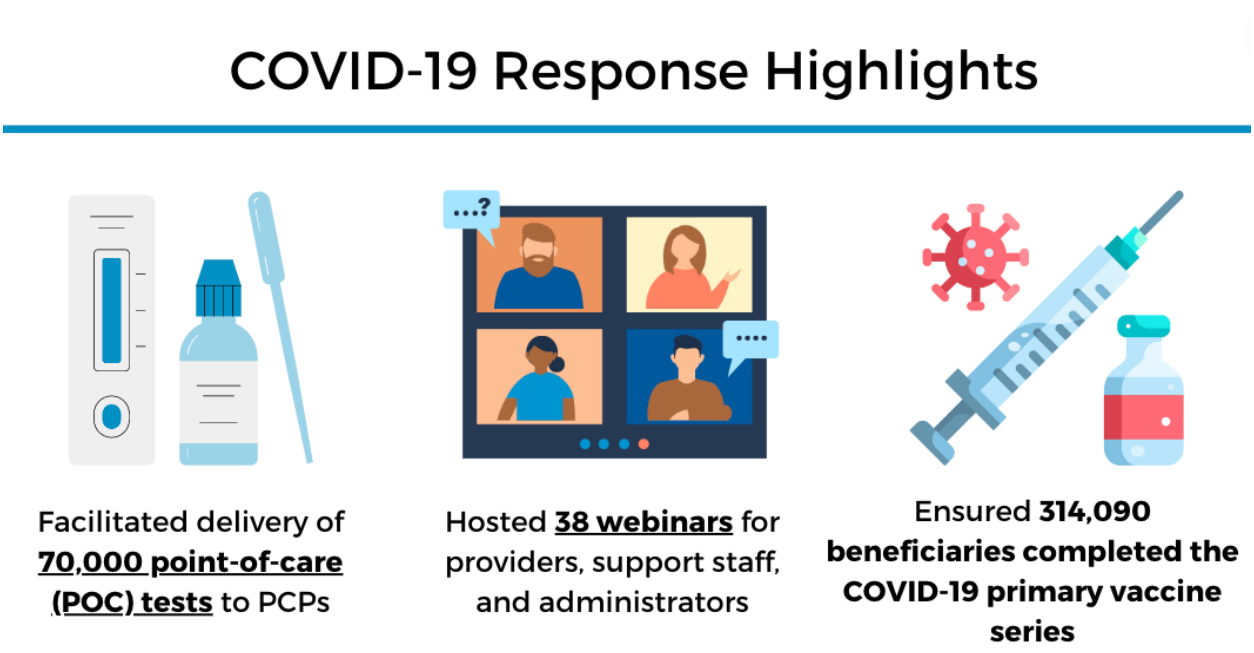

Figure 13. COVID-19 Response Highlights.

Health IT

The enhancement of primary care infrastructure continues to be the key focus including broad-scale activities initiated by the PMO and MDPCP practices. The effective and efficient use of health information technology is one of the cornerstones of advanced primary care. The PMO has collaborated with public and private industry partners to develop a suite of health IT tools deployed consistently over the state Health Information Exchange (HIE) platform and these tools are continuously enhanced and regularly updated. MDPCP providers and staff provide input to the development of the tools and are trained and supported by the PMO staff in applying the tools.

To further support practices' care transformation during PY3, the PMO has continued partnering with several public and private health care entities. In maintaining successful long-term relationships with several partners, MDPCP accomplishments include the:

- Development of two new reports to support practices in identifying vulnerable populations needing care management
- Implementation of two new CRISP tools to aid practices in achieving population health goals
- Improvement of existing reports in response to CRISP Reporting Services (CRS) user feedback, focusing on better operationalization of reports
- Increased usage of CRS MDPCP reports in 2021 by 74% among MDPCP practices and CTOs by developing new reports that provide data analytics and trends to show improvement of health outcomes
- Enhancement of the Predicting Avoidable Hospital Events (Pre-AH) model performance to predict patient risk scores more accurately and consistently
- Improved practice reporting in the CRISP Unified Landing Page to ensure they met performance targets related to Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Partnerships with CRISP and The Hilltop Institute

One of MDPCP's most critical partners in providing data-driven care is the state-designated HIE, CRISP. CRISP continues to design beneficiary claims reports tailored to MDPCP practices, known as the MDPCP Reports. Some of the detailed claim reports focus on Prevention Quality Indicator (PQI) measures, specialist referrals, costs of care, and hospital utilization. CRISP also hosts a suite of health information technology tools, which includes a near real-time event notification system, clinical query functionality, care alerts, patient health records, and a prescription drug monitoring program platform. In collaboration with CRISP, the following reports and tools were developed and enhanced in 2021.

- **SBIRT Reporting Tool**: Developed a tracking system for practices to record SBIRT accomplishments. SBIRT is a clinical module used in primary care to identify patients facing challenges with substance use and, if appropriate, refer them to treatment programs. Select MDPCP practices participate in reporting SBIRT and inputting the

number of patients they have worked with each month into the CRISP Unified Landing Page (ULP). CRISP sends this information to the PMO monthly.

- **eCQM Reporting Tool**: Designed and successfully implemented a manual reporting tool for electronic Clinical Quality Measure (eCQM) data collection to replace CRISP's existing CAliPR QRDA tool.
- **COVID-19 Tracker**: Implemented the ImmuTrack application for practices to track COVID-19 vaccine uptake. This application allowed users to view their attributed patients, view their COVID-19 vaccination status, and track outreach efforts to ensure their attributed patients receive vaccinations. The PMO worked closely with CRISP to enhance ImmuTrack when clinical guidance changed. The PMO worked closely with the practices to help with the rollout and training for this tool, including the development of guides and technical assistance.

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is another valued MDPCP partner. In partnership with the PMO, Hilltop has developed an Artificial Intelligence (AI) model that predicts avoidable hospital events. Hilltop provides an up-to-date monthly report to all MDPCP practices referencing their attributed beneficiaries' risk of incurring a preventable inpatient admission or ED event. This report contains predictions of the patient's risk scores and reasons for risk (Hilltop's Pre-AH Model™), displayed in the MDPCP CRS Suite. This model has been in production since October 2019. In PY3, Hilltop:

- Continued Pre-AH model operation, including periodic retraining throughout the year to incorporate COVID-19 impact, monthly score refreshing, and ongoing model monitoring
- Updated Pre-AH model functionality
- Redefined the avoidable hospital events outcome variable to reflect updated logic from the Agency of Healthcare Research and Quality (AHRQ) PQI definition
- Refreshed the timeframe of the environmental risk factor data to reflect more recent data and geocoding beneficiary addresses to increase the granularity of the environmental risk factors

MDPCP Reports Development & Enhancements

In response to MDPCP report users and practice coach feedback, the PMO implemented the following enhancements to MDPCP reports, which are monthly reports designed for use by practices and CTOs to manage their MDPCP populations, reflecting quarterly changes in attribution.

- **Health Equity by Demographics Report**: This allows users to track utilization trends by beneficiary demographic category to help identify vulnerable populations and their need for care management.
- **Population Comparison Group**: Added a new population comparison group and an equivalent non-participating population for all trend reports. This subset of the non-participating population is matched to the participating population on demographic factors for more meaningful comparisons.
- **Specialist and Ancillary Services Report (enhancement and rebranding)**: The previously titled, “Professional Services Report (BETOS/Place of Service)” was improved using the Restructured BETOS Classification System (RBCS) taxonomy, an

enhancement from the Berenson Eggers Type of Service (BETOS) taxonomy. The restructured report created a streamlined approach to identifying Part B services by provider specialties. Report enhancements also included procedure code drill-throughs to better understand the cost drivers among specialties.

- **PQI-Like Events:** A beneficiary level drill-through was added to show diagnosis codes related to PQI-Like Events (i.e., IP and ED claims of interest) to allow practices further insight into their clinical needs and history of their patient population.

MDPCP Reports Usage Statistics

The figures below (Figures 14 - 16) present usage statistics that identify which reports are the most highly used and the frequency of reports viewed by the MDPCP practices. The practices generally view these reports to identify areas of improvement to better serve their MDPCP beneficiaries. With annual report enhancements and developments, these statistics show that the data provided to the practices are a valuable resource for achieving better health care outcomes.

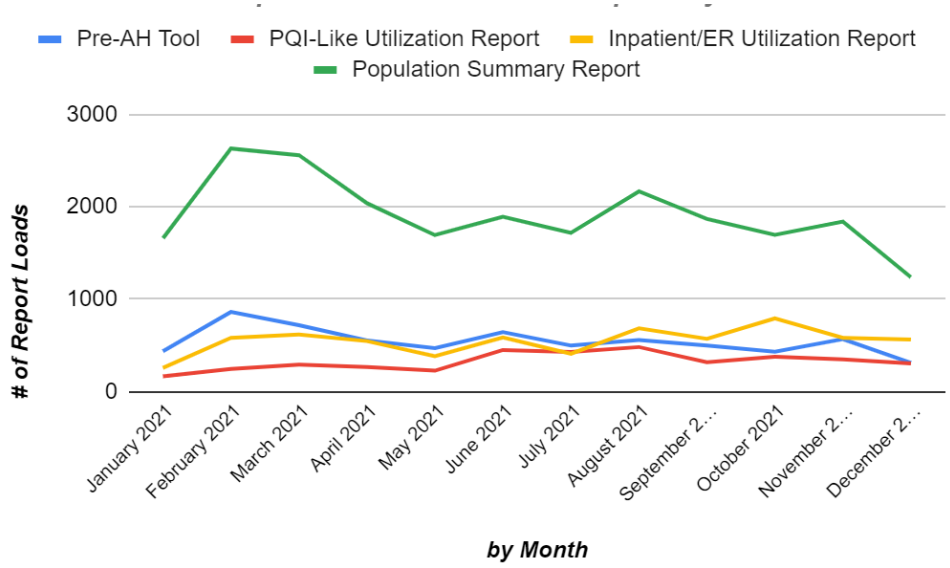

Figure 14. 2021 Top Four CRS Report Usage by Month.
Source: *2022 MDPCP Reporting Suite.*

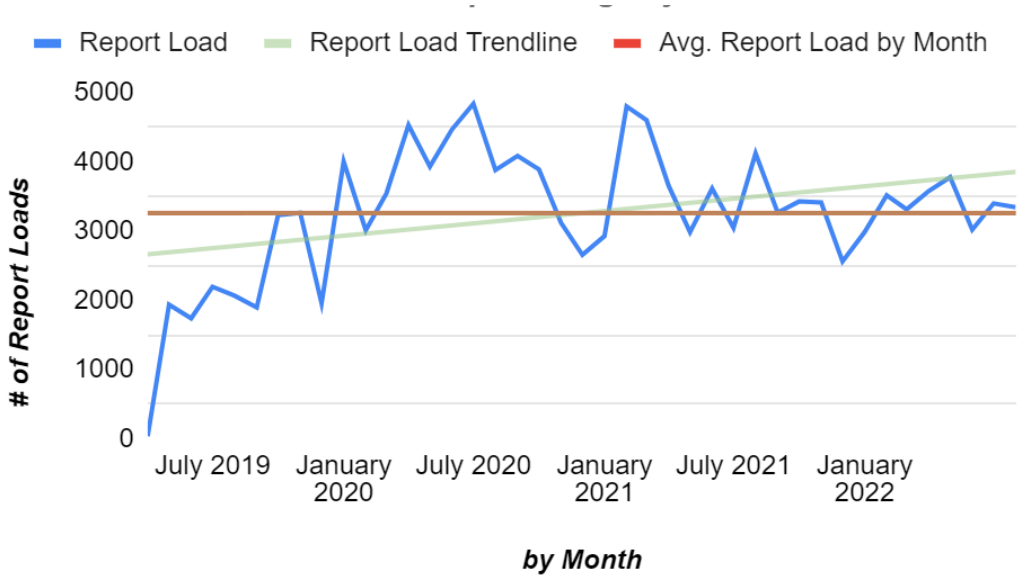

Figure 15. Monthly CRS Report Usage from July 2019-January 2022.
Source: *2022 MDPCP Reporting Suite*.

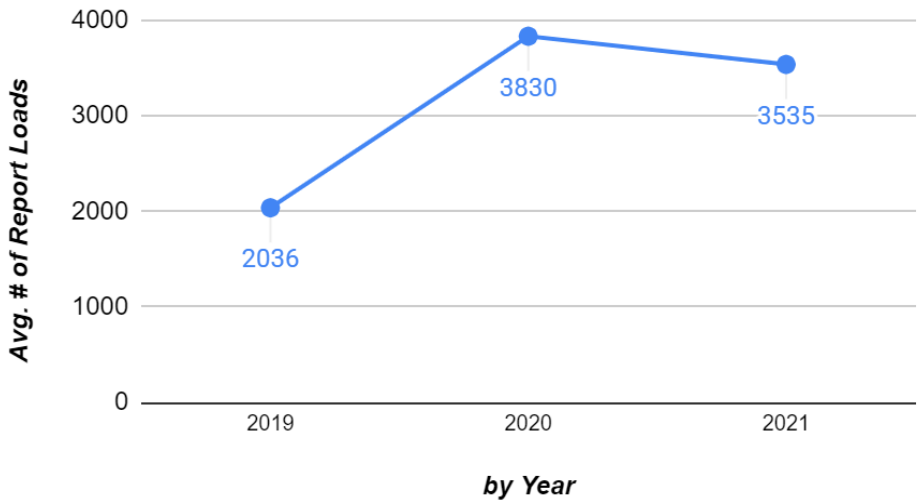

Figure 16. CRS Report Monthly Average Usage by Year.
Source*: 2022 MDPCP Reporting Suite.*

Spotlight: Maryland Primary Care Physicians

Maryland Primary Care Physicians is the largest physician-owned primary care group in Central Maryland, with nine physician offices located in Anne Arundel, Howard, Prince George's, and Queen Anne's counties. The Maryland Primary Care Physicians are high utilizers of the CRS reports averaging 3,027 report loads per year which reflects their success in the MDPCP program. The most frequently used reports by this group of practices are the:

- Population Summary report
- PQI-Like Utilization report
- Pre-AH Tool
- Inpatient/ER Utilization report

The Maryland Primary Care Physicians utilizes these reports to maximize quality of care by way of clinical pathway processes to reduce the number of Emergency Room and Inpatient Admissions. The use of these reports has also realized several needs within the organization such as the need to acquire an Informatics Nurse to operationalize data and provide the practices shared access to innovative technology. The Informatics Nurse plays a major role in identifying areas of improvement for each practice as well as educating both clinical and administrative staff on how to become forward-thinking while using an investigative approach to better manage chronic health illnesses. The implementation of a shared database platform using CRS reports data provides comprehensive actionable lists of quarterly beneficiary attribution for empanelment and chronic care management efforts. The Maryland Primary Care Physicians has proven that incorporating the CRS reports into their daily workflow increases value for their beneficiaries, improves practice performance, and contributes to the overarching goal of lowering health care costs.

Health Equity

In 2021, the PMO added an additional focus for the program on health equity and developed a comprehensive health equity strategy for advancing equitable access to care, quality of care, and health outcomes in MDPCP practices. This move towards incorporating goals and projects around health equity for MDPCP practices emerged for a number of reasons, including:

1. Growing awareness of disparities and the urgency of providing equitable care raised by the COVID-19 pandemic;
2. Alignment with the refocused CMS effort around health equity; and
3. As the program entered its third year, MDPCP had successfully implemented core program infrastructure and the time was ripe to expand beyond initial program outline and goals.

Key health equity accomplishments for the PMO in 2021 include:

- Added additional program focus on goals centered around advancing health equity and reducing disparities in primary care-centric outcome measures.
- Received multi-million dollar grant through June 2023 under the CDC grant "National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities" for expanding practice capacity to screen and refer for social needs, and use data tools to understand disparities in clinical quality outcomes.

While much of the progress around health equity for MDPCP occurred in 2022, including the rollout of the Health Equity Resource Advancement and Transformation (HEART) Payment, 2021 served as the beginning of focused effort in this area.

Disparities in Primary Care-Related Outcomes in MDPCP

In order to work towards achieving health equity in MDPCP practices, it is important to understand disparities related to primary care-centric outcomes in MDPCP. A key MDPCP outcome metric with a significant racial disparity is the rate of PQI-like events in different populations. As seen below in Figure 17, there is a persistent disparity in the rate of PQI-like events by racial and ethnic populations, with Black or African American MDPCP beneficiaries having the highest rate of PQI-like events, followed by Hispanic, White, and Asian beneficiaries. This shows a serious inequity, with Black or African American beneficiaries having consistently higher rates of avoidable hospital events than other racial and ethnic populations of MDPCP beneficiaries.

As such, reducing the racial disparity in PQI-like events was established as a primary goal for MDPCP in the coming years. MDPCP aims to reduce this disparity by providing data tools to practices to help them understand disparities in their particular patient populations and design interventions; providing support and technical assistance to practices to improve quality of care for under-resourced populations; and ensuring a workplace culture of equity both at MDPCP practices and within internal PMO team operations.

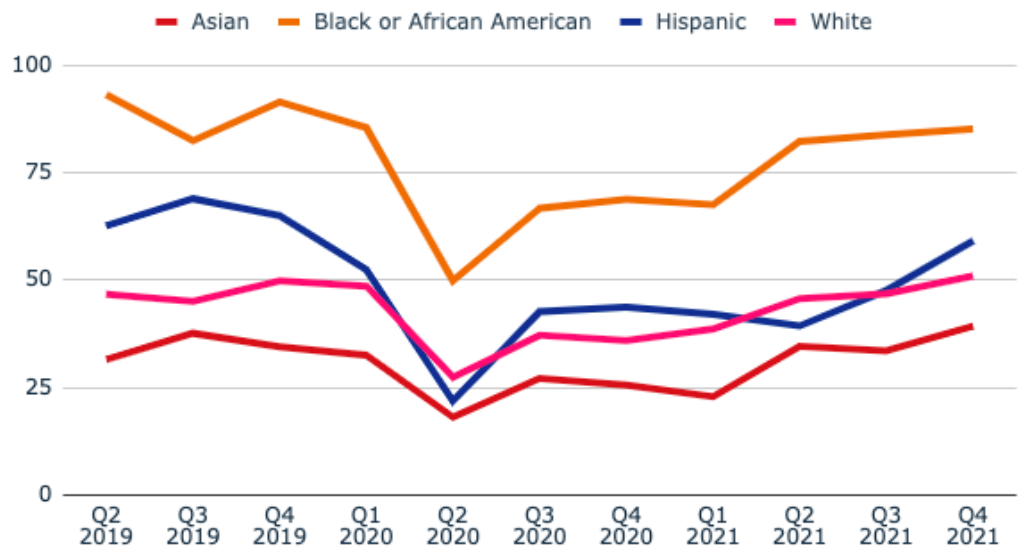

Figure 17. Rate of PQI-like Events for MDPCP Beneficiaries, Stratified by Race/Ethnicity.
Source: MDPCP Dashboard, Q2 2022 Attribution.

Spotlight: HCDI and Gerald Family Care's Clinical Food Pantry

In 2021, Gerald Family Care and their CTO partner HealthCare Dynamics International (HCDI) created a clinical food pantry, where beneficiaries experiencing food insecurity could come pick up bags of canned groceries and fresh food every other week directly at the practice. This work was driven by multiple integrated factors: Gerald Family Care saw high prevalence of diabetes and hypertension in its MDPCP beneficiaries; many patients reside in food desert areas; and the practice found food insecurity was a primary challenge for patients in their Social Determinants of Health screenings. In response, their Clinical Food Pantry was created to provide patients with both food to help them feed their family for two weeks, and education on reading nutrition labels. In 2021, the Gerald Family Care/HCDI Clinical Food Pantry delivered 220 bags of food for a total of 4,146 pounds of food in service to their community. For more information on these efforts, please visit Gerald Family Care and HCDI: Together Addressing the Social and Medical Needs of the Community.

Practice Data Tools to Understand Disparities

The PMO has stood up a robust data platform with abundant data on equity so that practices can understand disparities in access to care, quality of care, outcomes, and costs in their particular patient populations. In 2021, the PMO added a new report to the CRS suite titled "Health Equity by Demographics." With this report, practices can view trends over time in utilization and cost outcomes, stratified by various demographic factors. This report allows practices to understand where disparities exist for their particular patient panel, in order to design interventions to reduce these disparities. If disparities are identified, practices can drill down to the patient-level to understand levers for intervention.

The example output in Figure 18 displays a disparity in ED admissions per 1,000 beneficiaries between Medicare-Medicaid dual eligible and non-dual-eligible beneficiaries.

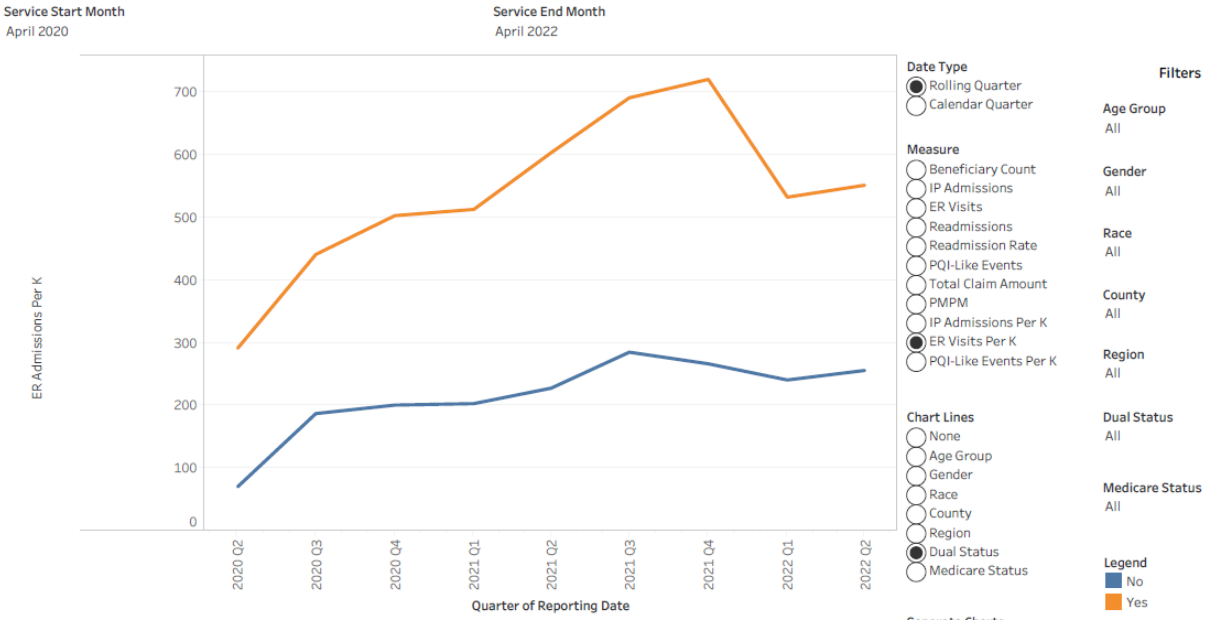

Figure 18. Example Output from Health Equity by Demographics Report.

The MDPCP CRS suite also includes a number of risk indicator variables that factor in social risk factors for practices to take social risk into account when risk stratifying beneficiaries. These variables include Area Deprivation Index (ADI) and COVID-19 Vulnerability Index, a measure of susceptibility to severe COVID-19 developed in partnership with Socially Determined Inc. that considers medical conditions, demographics, environmental, and social factors. These data reports and systems provide MDPCP practices with an understanding of where disparities exist in utilization, cost, clinical quality outcomes, and access to care for their patient populations. With measurement and understanding of disparities, practices are able to design targeted interventions to reduce disparities and improve patient care for their populations.

MDPCP Grant Funding from CDC for Health Equity-Focused Projects

In summer 2021, the PMO was awarded a multi-million dollar grant under the larger CDC grant "National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities." The MDPCP projects under this grant (Fig. 19) include:

1. **MDPCP Health Equity & Digital Quality Measures Project**: Initiative creating a platform for extracting and reporting on digital quality measure data with a health equity focus. This platform extracts quality measure data (such as diabetes control and hypertension control) and stratifies this data by key socio-demographic factors to understand disparities in clinical quality outcomes.
2. **Social Risk Factors Technical Assistance**: Providing a toolkit and individualized technical assistance to practices around social needs screening and collecting patient self-reporting demographic data.

3. **Social Needs Referral Data and Technology Support**: Improving a state-supported online directory of social support resources.

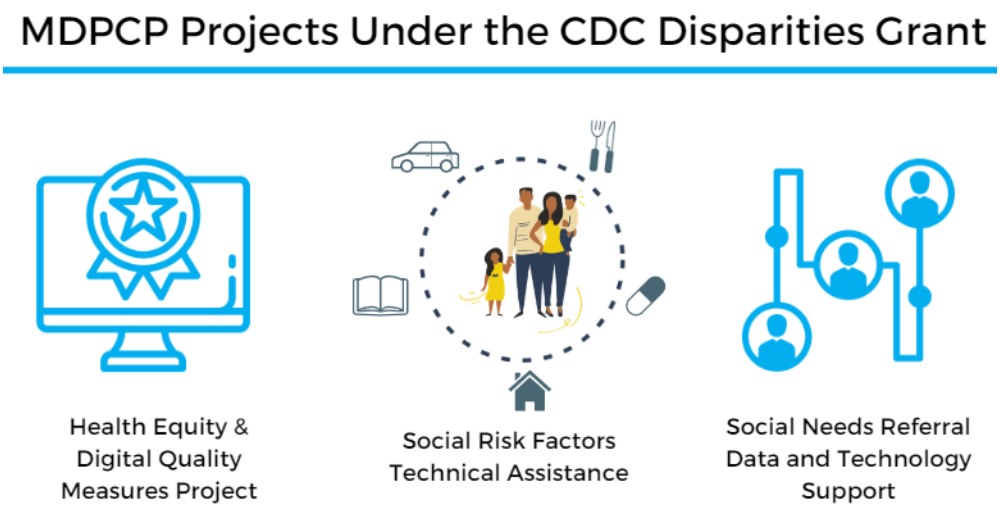

Figure 19. MDPCP Projects under The CDC Grant, "National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved. This includes racial and ethnic minority populations and rural communities.

While MDPCP was awarded these funds in 2021, many of the activities within these projects kicked off in 2022. Results will be shared as these projects progress.

Performance

MDPCP's work in PY3 continued to focus on reducing unnecessary hospital utilization and improving quality. The successful results of these efforts are reflected in a decrease in COVID-19 related health impacts, as well as reductions in avoidable hospital utilization and better than the national average in eCQM measures for diabetes and hypertension control, despite the ongoing COVID-19 public health emergency. A detailed review on performance results is provided below. Note that all data analyses use dynamic attribution, which accounts for all beneficiaries that have been attributed during any point in the year.

COVID-19's Impact on Performance

The State suggests caution while interpreting year-over-year changes in hospital and Emergency Department utilization and costs in 2020 and 2021 due to wide, pandemic-induced fluctuations. Over the course of the pandemic, COVID-19 infections can be described as following the pattern of a wave and the corresponding health resource utilization and outcomes mirrored these patterns. When infections peaked, hospitalizations rose sharply and would wane as infections declined. These peaks also had a mixed impact on ED utilization.The risk of exposure to the virus caused some patients to be more discerning in seeking care, particularly during infection peaks, which led to spikes in demand for care when cases were lower. US health care expenditures, driven by the pandemic, rose 9.7% from 2019 to 2020 despite a high rate of infection and a decreased level of ED utilization. In 2021, the overall spending growth slowed considerably to 4.2% with hospital spending growth still high at 5.7%.

Under Maryland's global hospital budgeting payment system, there is also a confounding effect where declines in hospital utilization are addressed by increasing the payment for unit services, furthermore disconnecting reductions in utilization from cost reductions. To further understand this payment nuance each hospital is provided with a fixed all-payer annual, budgeted dollar amount by the state hospital payment regulating body: Health Services Cost Review Commission (HSCRC). Hospitals estimate the volume of services they will provide during the budget period and set prices accordingly. If volumes drop below the expected target the hospital will increase the unit pricing to offset the decrease in volume sufficient to utilize the entire budgeted amount. The increases typically occur at the end of a budget cycle so prices for the same service at the same hospital may vary depending on the time of the year. Conversely, if volumes exceed the estimated amount the hospitals would not receive additional funding and experience a budget shortfall.

Utilization

An important goal of an advanced primary care program is the reduction of avoidable hospital utilization. To achieve this goal, primary care practices must identify and care for patients in a timely manner, and in the most effective and efficient setting. The PMO assists practices in achieving this goal through the provision of data tools, monetary incentives, and technical assistance. MDPCP's impact is accurately assessed with the use of enhanced analytics, including measurement tools that utilize comparison groups and risk adjustments.

Risk Adjustment

Under the HCC risk adjustment model, CMS assigns an HCC score and a HCC tier to all beneficiaries in the MDPCP. The HCC score is based on the HCC community risk model to reflect each beneficiary's clinical profile and care needs. The HCC tier is assigned to each beneficiary based on the distribution of HCC scores across the state reference population. Figure 20 displays the distribution MDPCP beneficiaries by HCC risk tier. The data below reflects utilization metrics that are risk-adjusted for beneficiary HCC scores.

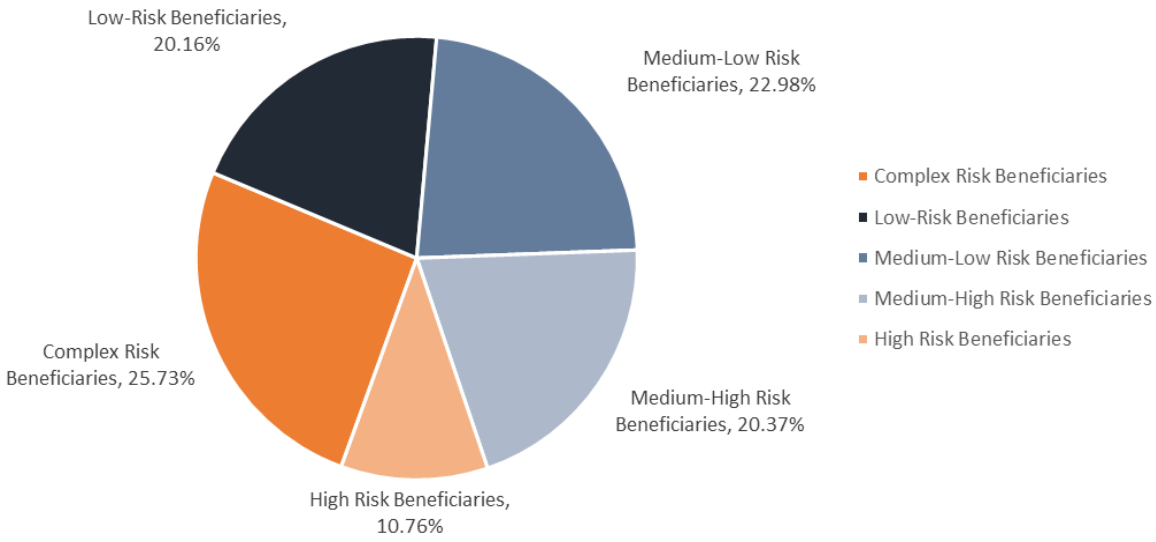

Figure 20. Distribution of MDPCP-Attributed Beneficiaries by HCC Risk Tier, 2021.

Comparison Groups

Utilization trends for beneficiaries attributed to MDPCP practices were evaluated against several comparison groups that had different characteristics (see Table 7).

Table 7. Comparison Group Characteristics, 2021.

Population	Beneficiary Count	Description
MDPCP	335,779	Represents all beneficiaries attributed to MDPCP participating practices.
Statewide FFS (Fee for Service) Population	751,590	Represents the entire State's Medicare fee-for-service beneficiary population with both Part A and B coverage. This is comprised of three distinct sub-groups: 1) beneficiaries participating in MDPCP, 2) beneficiaries eligible for MDPCP and attributed to a provider, but not participating in the program, and 3) beneficiaries who are either not eligible for the program or are not able to be attributed to a provider due to the lack of a) available claims or b) a treatment relationship with a provider.
Statewide Non-Participating Population	252,287	Represents all Medicare FFS beneficiaries who are eligible for MDPCP, but are not attributed to a primary care provider participating in MDPCP.
Equivalent Non-Participating Population	93,214	Represents a subset of a non-participating MDPCP population that meet the eligibility criteria to participate in MDPCP but are attributed to providers not participating in MDPCP. This Statewide Non-Participating Population is demographically matched to the participating MDPCP population in a selected attribution quarter on the distribution of age band, race, sex, dual eligibility, and county of residence.

Utilization Trends

The charts below show 2019 to 2021 MDPCP utilization metrics. Overall, there was a slight increase in hospital utilization in 2021. Both IP visits (Fig. 21) and ED visits (Fig. 22) increased from the prior year.

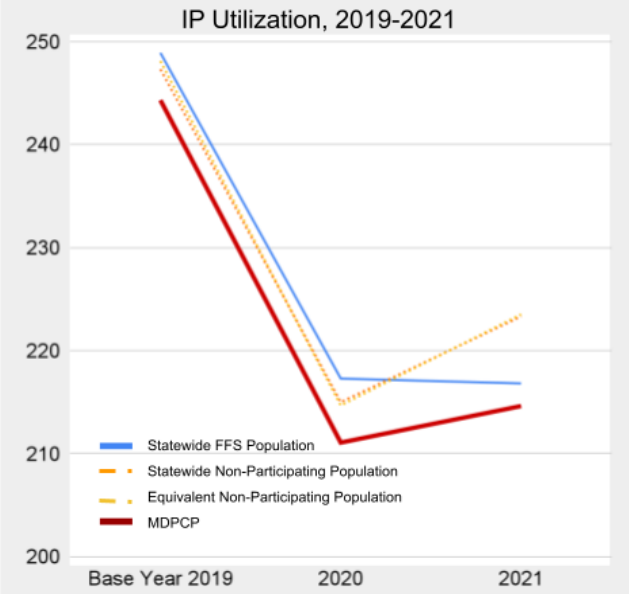

Figure 21. IP Utilization Performance.

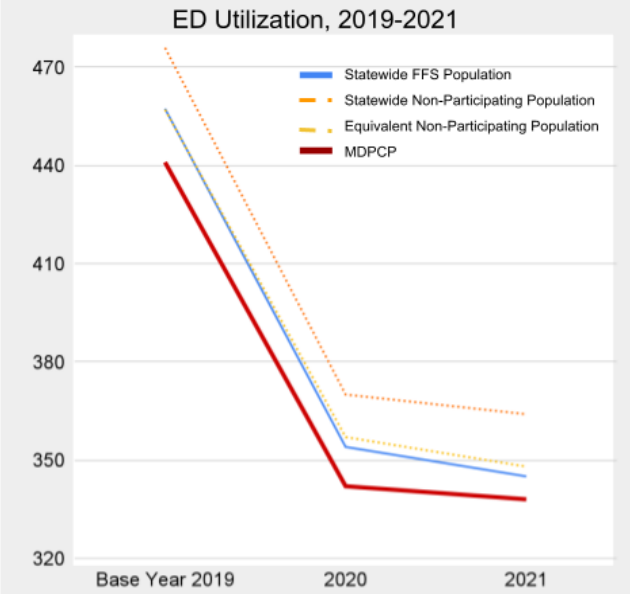

Figure 22. ED Utilization Performance.

In PY3, IP utilization, as measured by IP visits per every 1,000 MDPCP-attributed beneficiaries, was 212, an increase of 1.7%compared to the prior year (Table 8). ED utilization, as measured by ED visits per every 1,000 MDPCP-attributed beneficiaries, was 364, an 8.7% increase compared to the prior year (Table 9). This is a reversal from the prior two years, in which hospital utilization fell during the COVID-19 pandemic and reflects pent-up demand.

Table 8. IP Utilization Performance.

IP Utilization, 2019-2021					
Population		**Base Year 2019**	**2020**	**2021**	**Total Percentage Change**
Statewide FFS		249	217	217	-12.9%
	% Change from PY	N/A	-13%	0%	
Statewide Non-Participating		247	215	223	-9.7%
	% Change from PY	N/A	-13%	4%	
Equivalent Non-Participating		248	215	224	-9.9%
	% Change from PY	N/A	-13%	4%	
MDPCP		244	211	215	-12.2%
	% Change from PY	N/A	-14%	2%	

Table 9. ED Utilization Performance.

ED Utilization, 2019-2021					
Population		**Base Year 2019**	**2020**	**2021**	**Total Percentage Change**
Statewide FFS		457	354	372	-18.7%
	% Change from PY	N/A	-23%	5%	
Statewide Non-Participating		476	370	392	-17.5%
	% Change from PY	N/A	-22%	6%	
Equivalent Non-Participating		457	357	374	-18.2%
	% Change from PY	N/A	-22%	5%	
MDPCP		441	342	364	-17.4%
	% Change from PY	N/A	-22%	6%	

In contrast, there was a decrease in PQI-like events (Fig. 23). PQIs are potentially preventable complications which can be reduced through access to high-quality outpatient care. PQIs are identified using hospital discharge data, and PQI-like utilization reflects IP admissions or ED visits that fall into one of the eleven PQI classifications based on the AHRQ specification.

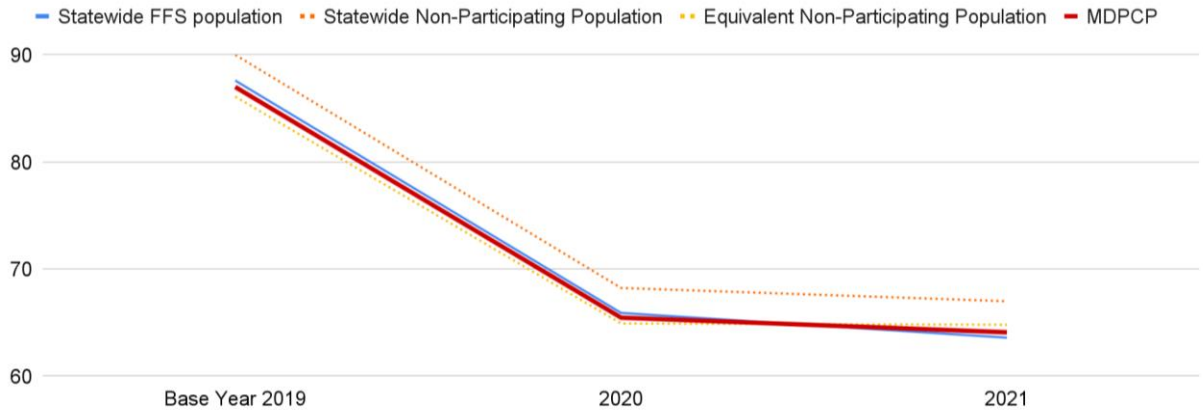

Figure 23. PQI-like Events Performance.

In 2021, there were 64 PQI-like events per every 1,000 MDPCP-attributed beneficiaries, a decrease of 2.1% compared to the previous year (Table 10). This trend follows the prior two years in which PQI-like events decreased. However, unlike prior years, there was greater variation in performance in this metric amongst the aforementioned comparison groups. There was a 2.1% decrease in PQI-like events for MDPCP-attributed beneficiaries, while there was a 0.2% decrease for the equivalent non-participating population.

Table 10. PQI-Like Events Performance.

PQI-Like Events, 2019-2021					
Population		**Base Year 2019**	**2020**	**2021**	**Total Percentage Change**
Statewide FFS		88	66	64	-27.4%
	% Change from Prior Year	N/A	-25%	-4%	
Statewide Non-Participating		90	68	67	-25.6%
	% Change from Prior Year	N/A	-24%	-2%	
Equivalent Non-Participating		86	65	65	-24.7%
	% Change from Prior Year	N/A	-25%	0%	
MDPCP		87	65	64	-26.3%
	% Change from Prior Year	N/A	-25%	-2%	

Per Beneficiary Per Month (PBPM) Payments

Figure 24 below displays year-over-year change in PBPM payments to practices by comparison group. In 2021, MDPCP practices had an average PBPM payment of $1,124. As shown by Table 11, this represents a 10.6% increase in average PBPM payment since 2019.

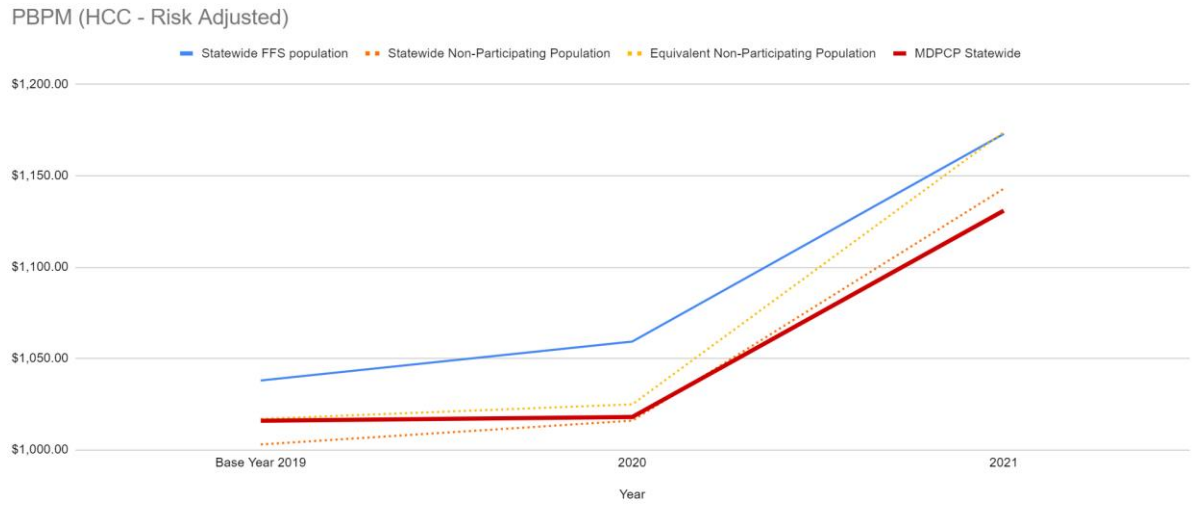

Figure 24. PBPM Performance, 2019-2021.

Table 11. PBPM Performance,* 2019-2021.

Per Beneficiary Per Month Payments, 2019-2021					
Population		**Base Year 2019**	**2020**	**2021**	**Total Percentage Change**
Statewide FFS		$1,038	$1,059	$1,125	8.4%
	% Change from Prior Year	N/A	2%	6%	
Statewide Non-Participating		$1,001	$1,016	$1,129	12.8%
	% Change from Prior Year	N/A	2%	11%	
Equivalent Non-Participating		$1,017	$1,024	$1,146	12.7%
	% Change from Prior Year	N/A	1%	12%	
MDPCP		$1,016	$1,018	$1,124	10.6%

	% Change from Prior Year	N/A	0%	10%	

*****PBPM performance is based on claims and does not reflect payments to MDPCP practices.

Median Quality and Utilization Scores

Median (or 50th percentile) scores for MDPCP practices for each quality or utilization measure are reported in Table 12.

Clinical quality measures use CMS technical specifications for each measure. The “Diabetes HbA1c Poor Control” (CMS122) measure is an inverse measure, which means that a lower score indicates higher performance. For the “Controlling High Blood Pressure” (CMS165), “Body Mass Index (BMI) Screening and Follow-up Plan” (CMS69), and “Depression Screening and Follow-up Plan” (CMS2) measures, a higher score indicates better performance.

IP or Acute Hospital Utilization (AHU) and ED utilization scores represent an observed-to-expected ratio, where a measure score of 1.0 indicates that utilization among a practice’s attributed beneficiaries was the same as expected by the risk and size of their Medicare FFS population. Lower scores for both utilization measures represent better performance.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores reflect the patient satisfaction survey scores for six domains and an aggregate score.

The following section covers overall performance in each of these three areas in greater detail.

ED Utilization (EDU)*	0.82	0.62	0.67	-18.19%
ED Utilization (EDU)* for ADI Tier 1	N/A	0.56	0.63	-
ED Utilization (EDU)* for ADI Tier 2	N/A	0.56	0.61	-
ED Utilization (EDU)* for ADI Tier 3	N/A	0.60	0.68	-
CAHPS Summary Score**	80.62%	79.80%	79.83%	-0.79%
CAHPS 1: Getting Timely Appointments, Care, and Information	88.79%	88.50%	87.51%	-1.28%
CAHPS 2: How Well Providers Communicate With Patients	95.51%	95.27%	94.96%	-0.55%

CAHPS 3: Attention to Care From Other Providers	85.23%	84.27%	84.35%	0.88%
CAHPS 4: Shared Decision Making	86.50%	85.46%	85.69%	0.81%
Screening for Depression and Follow-Up Plan (CMS2)	N/A	N/A	61.96%	N/A

*Inverse measure. Lower score indicates higher performance.
**The CAHPS summary score is used for the PBIP. The breakdown of each CAHPS category is included here as informational but not used for PBIP scoring.

MDPCP Performance Compared to Benchmarks

Overall performance is summarized in Figures 25-31, showing MDPCP practice measure outcomes compared to benchmark breakpoints. The benchmark groups vary by category as defined by Table 13. The following is a summary of overall performance on each of the three categories.

Clinical Quality (compared to national MIPS reporting)

Performance for the majority of practices on all four eCQMs remained above the national median, as compared to performance on the national benchmarks from the Merit-based Incentive Program (MIPS). 70% of practices surpassed the 50th percentile for controlling high blood pressure and 81% surpassed the 50th percentile for A1c control in 2021. These percentages are slightly higher than those in 2020, where 63% of practices surpassed the 50th percentile for controlling high blood pressure. Meanwhile, percentages for A1c control remained about the same, with 20% of practices surpassing the 50th percentile for A1c control in 2020.

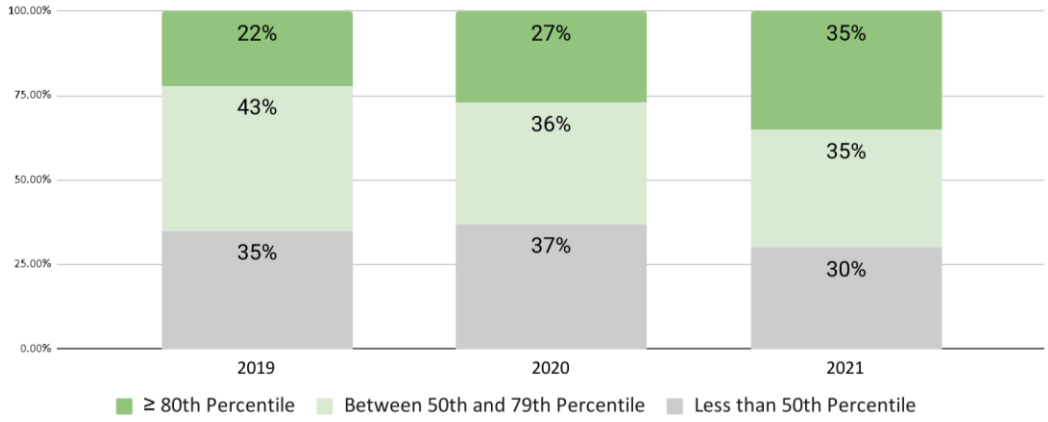

Figure 25. Percentage of MDPCP Practices above the National Median in Controlling High Blood Pressure (CMS165).

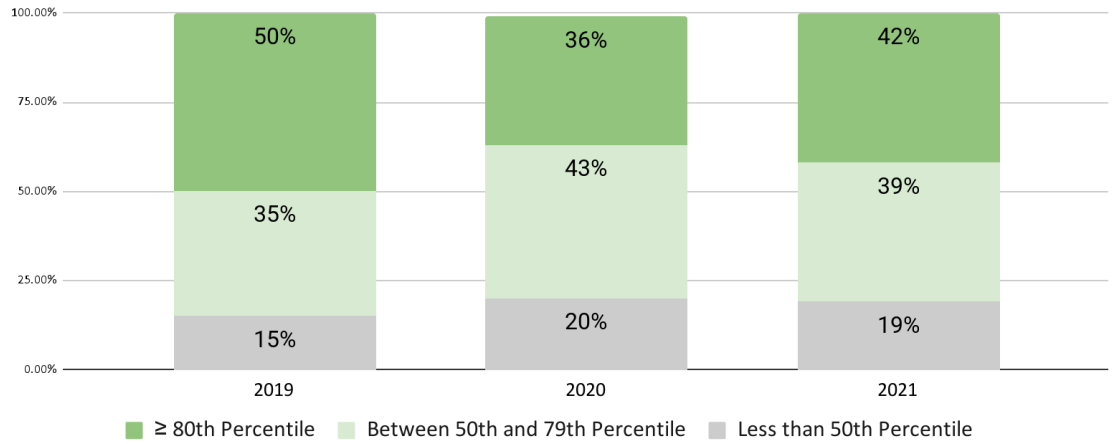

Figure 26. Percentage of MDPCP Practices above the National Median in HbA1c Control (CMS122).

In addition to controlling high blood pressure and hemoglobin A1c (HbA1c), there were two new clinical quality measures in 2021. These were the “Screening for Depression (CMS2) and Follow-up Plan” measure and the “BMI Screening and Follow-up Plan” (CMS69) measure. MDPCP performance against the benchmark is depicted by Figure 27 and Figure 28 below.

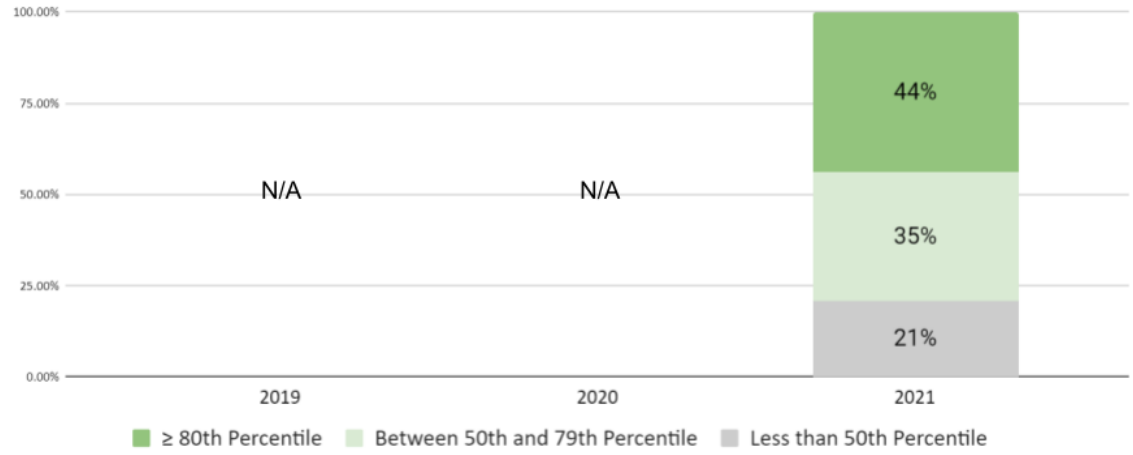

Figure 27. MDPCP Practices’ Performance Against Benchmark Screening for Depression and Follow-Up Plan.

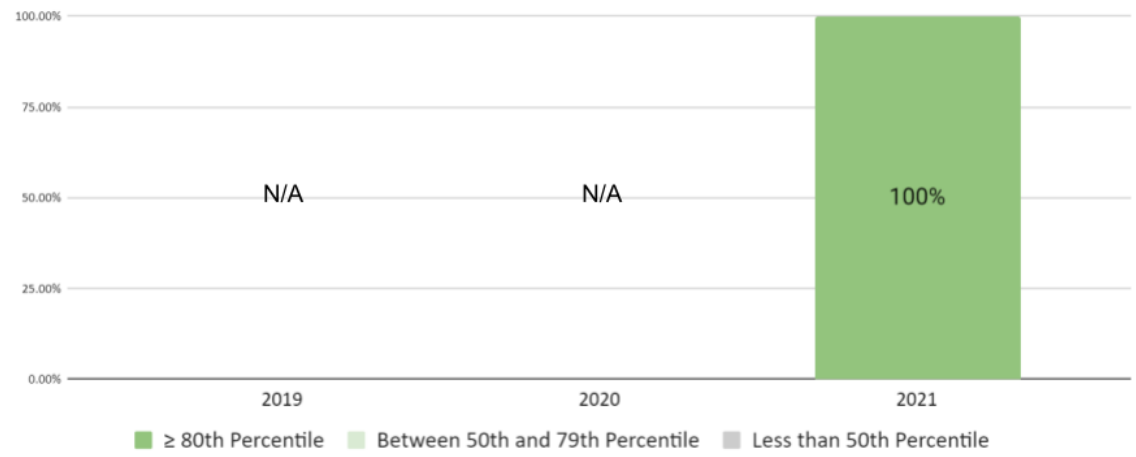

Figure 28. MDPCP Practices' Performance Against Benchmark BMI Screening and Follow-Up Plan*.

*Note that this measure was nationally suppressed for 2021. All practices received full credit.

Utilization (compared to all practices with Maryland FFS beneficiaries)

With regard to IP utilization, 85% of practices performed better than the 50th percentile of Maryland FFS practices. With respect to ED utilization, 88% of practices performed better than the 50th percentile benchmark. These results represent significant improvement compared to prior years, as shown by Figure 29 and Figure 30 below.

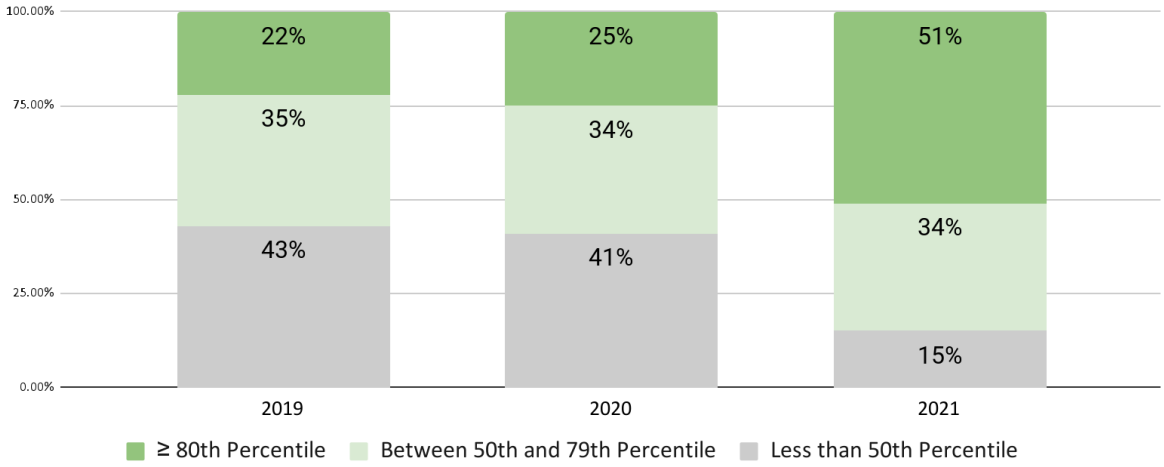

Figure 29. MDPCP Practices' Performance Against Benchmark, IP Utilization (AHU).

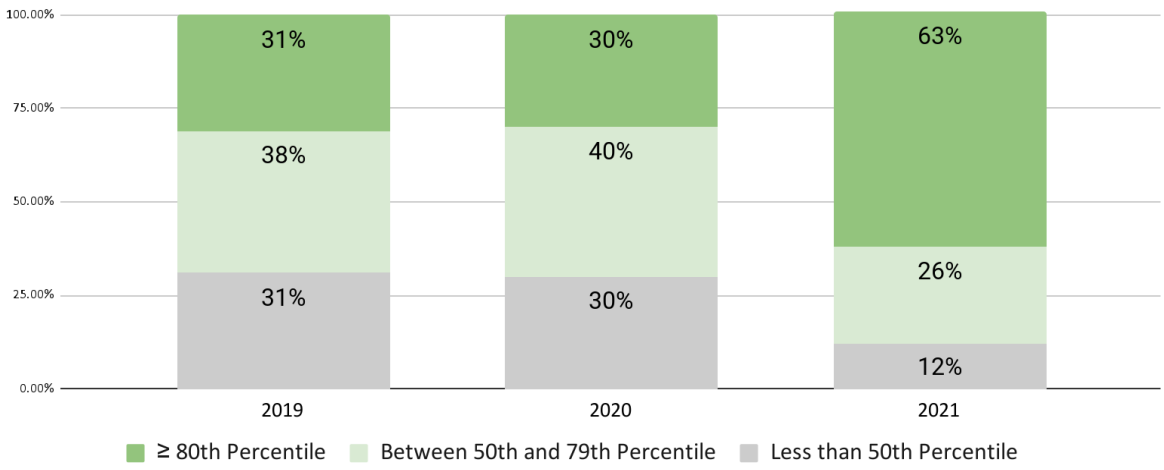

Figure 30. MDPCP Practices' Performance Against Benchmark, ED Utilization (EDU).

Patient Satisfaction (compared to 2019 CPC+ practices, nationally)

As seen by the CAHPS summary score, 50% of practices exceeded the 50th percentile of the benchmark breakpoints in 2021, compared to 2019 practices in the Comprehensive Primary Care Plus (CPC+) program. As shown in Figure 31, this is an increase from 2020, where 35% of practices beat the 50th percentile of benchmark breakpoints for the CAHPS summary score.

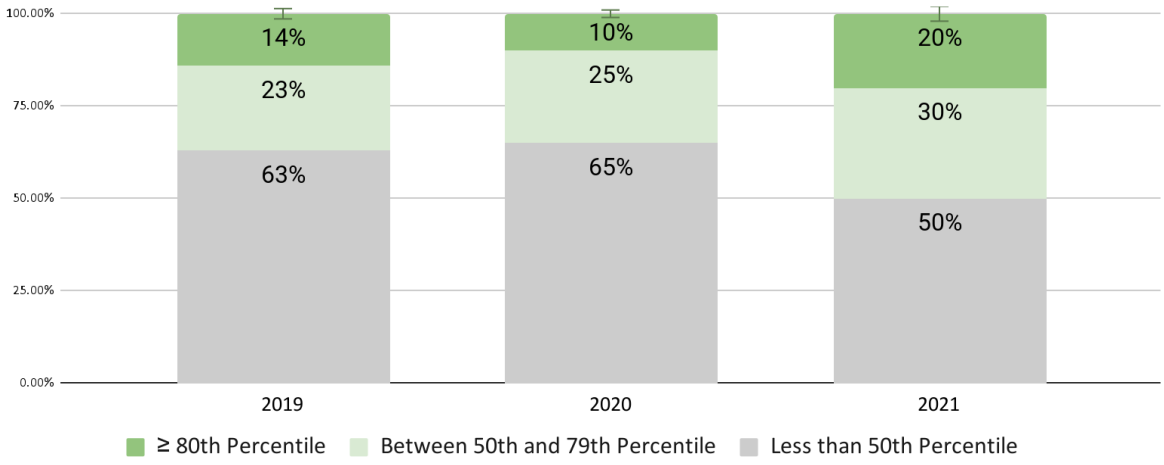

Figure 31. MDPCP Practices' Performance Against Benchmark, CAHPS Scores.

Table 13. Benchmark Populations for Each Measure.

Measure	Benchmark Population	Year of Benchmark Data
CG-CAHPS	MDPCP	2021 MDPCP CAHPS
eCQMs	National, all payer	2019 MIPS Performance
Utilization	Maryland, Medicare only	2019 Maryland Utilization

Measure Performance Impact on PBIP

In 2021, 61.7% of practice PBIP was retained based on PY3 performance, reflecting a 19.5% increase in PBIP retention from the prior year (Figure 32). There was variation in how much PBIP was retained among groups, organized by track and CTO affiliation. Additional details are available in Figure 33. The key results are:

- Track 2 practices outperformed Track 1 practices, as expected
- CTO affiliated practices retained more PBIP than non-CTO affiliated practices, as expected

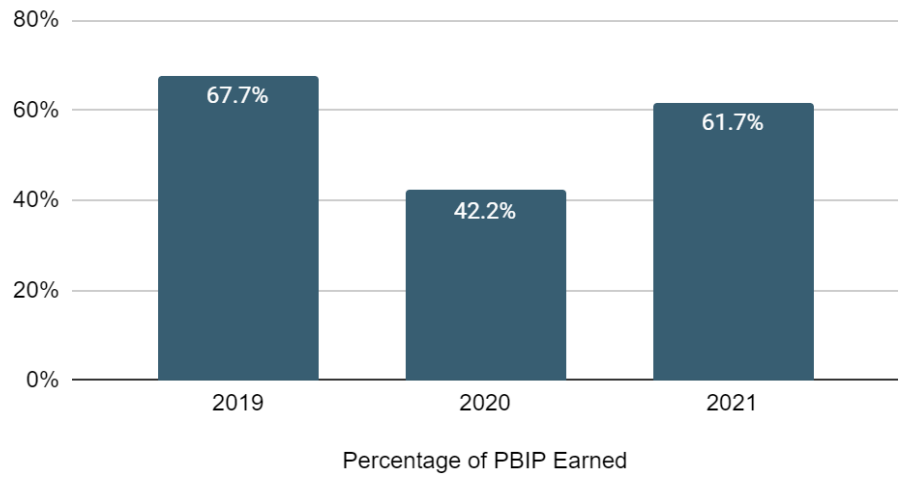

Figure 32. Percentage of PBIP Earned by MDPCP Practices, 2019-2021.

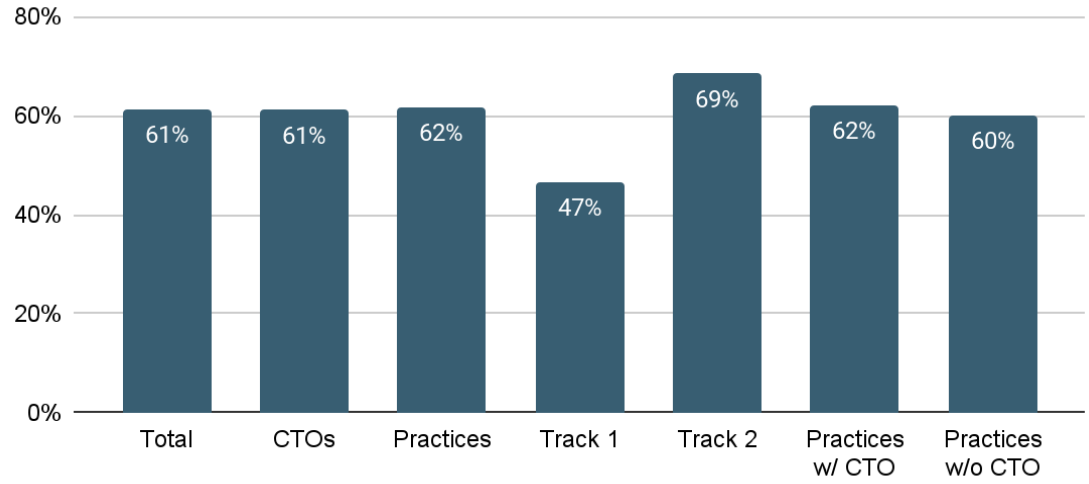

Figure 33. Percentage of PBIP Earned by Group, 2021.

SIHIS Alignment

The SIHIS seeks to convene efforts across the state in three interrelated domains in an effort to improve the health of all Marylanders. The three interrelated SIHIS domains are hospital quality, care transformation across the system, and total population health. The PMO works to support all three of these domains through the MDPCP care transformation requirements including avoiding hospitalizations and readmissions, improving care coordination for beneficiaries with chronic diseases, improving overdose mortality, and other related efforts.

Behavioral Health Integration

The PMO has been working to promote behavioral health integration into primary care since 2019. In fact, MDPCP provides practices with a menu of evidence-based methods to include behavioral health integration in their delivery of health care. As of Q3 2021, 100% of MDPCP practices reported implementing a strategy to integrate behavioral health into their practice workflows. Behavioral health integration is a component of the larger Statewide Integrated Health Improvement Strategy (SIHIS), which focuses on substance use disorder. The SIHIS implementation goal for the evidence-based protocol SBIRT among MDPCP practices in 2021 was 200 practices. As of December 2021, 319 MDPCP practice sites (including 7 FQHC sites) had implemented SBIRT to identify and appropriately refer patients with substance use disorders to services and treatment.

The Mosaic Group and Implementation of SBIRT

MDPCP supports the State's efforts to address substance use in the community, with a focus on opioids. One of the core features of the advanced primary care model within MDPCP is integration of behavioral health services within the primary care setting to respond proactively to patients' behavioral health needs. To help primary care practices combat Maryland's statewide opioid epidemic, the PMO engages a contractor, Mosaic Group (referenced as "Mosaic"), which is experienced in integrating SBIRT into primary care.

The PMO, in partnership with Mosaic, has continued to work with these practices to ensure continuous improvement in the process as well as continue to work with more practices to implement SBIRT. Since 2021, the PMO, supported by the Behavioral Health Administration (BHA), has established a three-fold strategy to use SBIRT to drive reductions in opioid use disorder (OUD). The following elements are components of this strategy:

- **SBIRT implementation in hot spot OUD areas:** The PMO prioritizes the implementation of SBIRT in opioid use disorder hot spots including these counties: Anne Arundel, Baltimore, Montgomery, Prince George's, Washington and Harford, and in Baltimore City. The State is focused on increasing the number of practices using SBIRT statewide, but focuses particularly on recruiting practices to use this strategy in these hot spots. Concentration of practices in hot spot counties is included in Figure 34 below.
- **Practice improvement**: The PMO, through a contractor, actively reviews data reported by MDPCP practices to ensure the practices are meeting performance targets related to the use of SBIRT. Practices that have implemented SBIRT are provided with a report on the assessment of their data and actions that the practice could take to improve their use of SBIRT. As of December 2021, over 40 practices were working with the contractor to

review SBIRT-related data, assess their current workflows, and identify the action steps to improve the use of SBIRT within the practice.

- **SBIRT data in CRISP**: As of December 2021, 199 practices had uploaded SBIRT data into a CRISP tool built to capture each practice's progress. Table 14 displays the number of SBIRT screenings, positive screens, and brief interventions for the August to December 2021 time period. The PMO is working with additional practices to increase the number of practices reporting SBIRT data through CRISP. Since SBIRT reporting is voluntary, practices' support of this work has been critical. Accordingly, the State does not anticipate all practices that have implemented SBIRT will report in any given month.

Table 14. Number of SBIRT Screenings, Positive Screens, and Brief Interventions for MDPCP Practices, August 2021 - December 2021.

SBIRT Screenings	Positive Screens	Brief Interventions
154,916	9,295	3,132

Note: Practices have been voluntarily reporting data related to SBIRT to MDH since August 2021.

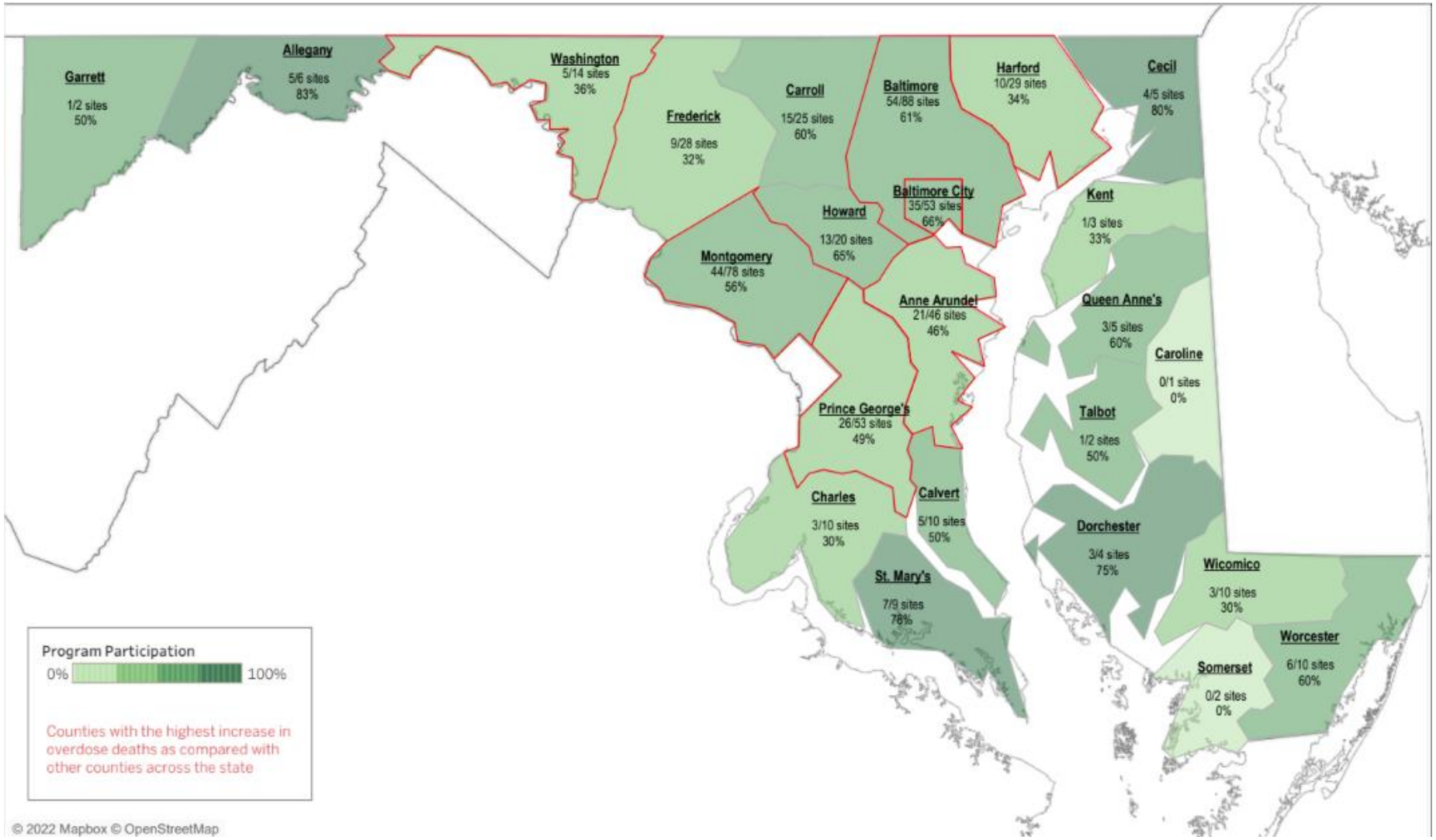

Figure 34. MDPCP Practices that use SBIRT compared to total MDPCP Practices by County.

Diabetes Prevention and Management

MDPCP has also aligned with SIHIS on reducing BMI and diabetes incidence. On diabetes, all MDPCP practices tracked electronic clinical quality measures (eCQM) related to Body Mass Index (BMI) screening and follow-up plan (CMS69) and diabetes control (CMS122) in 2021. Figure 26 shows HbA1c control, which is a way to measure diabetes control, for MDPCP practices for 2019-2021 compared to the national median of reporting providers.[2] Practices are focused on managing patient weight and providing patients with support to reduce the risk of developing diabetes through strategies such as referrals to Diabetes Prevention Programs (DPP).[3] Many MDPCP practices have partnered with hospitals that are funded through HSCRC's Regional Partnership Catalyst Program.[4] The purpose of the Diabetes Regional Partnerships is to increase referrals and enrollment in DPPs and diabetes-management programs. Additionally, the PMO has been working closely with CareFirst to plan a coordinated strategy to address diabetes in practices participating in both MDPCP and the CareFirst Patient Centered Medical Home (PCMH) programs.

Moreover, the PMO has established partnerships with entities across the state that are working to address weight and to implement lifestyle change programs. The PMO actively reached out to community-based organizations with the capability and capacity to accept additional referrals from MDPCP practices and established a pilot referral process via CRISP. The PMO organized meetings to introduce these partners to MDPCP practices in their service regions. These partners include Giant Food nutrition, MAC Living Well Center of Excellence, Bethesda Newtrition and Wellness Services, and Meals on Wheels of Central Maryland. The PMO also worked collaboratively with the PreventionLink program in Southern Maryland, the Maryland Department of Aging and its Area Agencies on Aging, and the MDH Center for Chronic Disease Prevention and Control to develop education and best practices communications for participating practices.

[2] Due to national issues with the measure specifications, CMS suppressed the BMI measure for performance year 2021, resulting in no scoring on this measure in this year.
[3] These referrals occur electronically through CRISP, the State-Designated Health Information Exchange.
[4] Through the Regional Partnership Catalyst program, HSCRC expects to provide $86.3 million dollars to hospitals over five years (starting in 2021) to increase use of DPP and diabetes management programs. This funding was awarded to hospitals in six regions in the State who must work with community partners, including local health departments, non-profits, local businesses, faith-based organizations, community health care providers, academic institutions, and others.

Quality Improvement and Learning

2021 Learning Offerings

Live Events & Programming

In 2021, the PMO offered numerous webinars centered around not only education, but also around *application* of key MDPCP concepts. In addition to synchronous virtual education, the State offered additional peer-to-peer opportunities, such as a networking event co-hosted with CareFirst and a roundtable focused on hospice education. All MDPCP learning events are free for MDPCP participants.

Spotlight: Hospice Roundtable

In November 2021, the PMO was joined by a total of thirteen hospice organizations across the state of Maryland to educate MDPCP participants on the basics and benefits of hospice care, including when it can be the right choice for patients and the importance of end-of-life care planning. Numerous representatives from each organization joined, all of whom had various job roles, responsibilities, and subject matter expertise. A total of 88 individuals registered for the event!

Participants had the opportunity to hear lightning talks from four knowledgeable guest speakers and were able to get a comprehensive lesson on hospice from different perspectives: Dr. Howard Haft, Dr. Dan Morhaim, Dr. Mary Alfano-Torres, and Dr. Mary Lynn McPherson. Each speaker's talk answered an important question.

- Dr. Howard Haft: What is the direct connection between MDPCP and hospice?
- Dr. Dan Morhaim: What are common misconceptions about palliative care?
- Dr. Mary Alfano-Torres: What is end-of-life care and why are these conversations important?
- Dr. Mary-Lynn McPherson: How do pharmacists fit into the hospice/palliative care equation?

Five breakout rooms were set up and organized by region with a practice coach serving as a facilitator in each one. Participants were sorted into the breakout room that they indicated they were interested in joining during the time of registration. Each hospice organization presented to practice staff (practice administrators, care managers, etc.) and CTO staff in their breakout room and provided a brief overview of their organization and what services they provided. Individuals were encouraged to engage with the hospice organization and with one another.

Registrants then received a summary email (meeting recording and slide deck) along with a resource sheet highlighting each organization (service regions, contact information, services offered). The Hospice Roundtable allowed practice and CTO staff to engage directly with hospice staff to bring focus to the importance of end-of-life care and learn about the hospice services offered by each organization in their region.

Table 15 depicts the event type and frequency of events offered throughout 2021, as detailed in the MDPCP 2021 Learning Live Calendar.

Table 15. 2021 Learning Event Summary. The table below shows the total number and type of events, organized by quarter.

Quarter	Event Type	Number of Events Offered
Q1	Webinar	16
	Affinity Group	4
	Networking	1
	Office Hour	3
Q2	Webinar	1
	Affinity Group	1
	Office Hour	2
	Meeting	1
	Training	3
Q3	Webinar	4
	Affinity Group	2
	Office Hour	1
	Networking	1
Q4	Webinar	1
	Affinity Group	1
	Office Hour	2
	Meeting	1
	Roundtable	1
	Total	**46**

The events offered in 2021 covered a variety of topics, ranging from Hepatitis C virus testing to skills for working with older adults, in addition to the “COVID-19 Provider Updates” webinar series hosted by Dr. Haft (see the COVID-19 section of this report for more information).

Resources

The PMO provided primary care providers with several resource guides throughout the year to support practices in MDPCP practice transformation. Three such sets of guides warrant attention due to their utility of practices, focusing on: eCQMs, PQIs, and staffing.

eCQM Resource Guides

The PMO provided four eCQM guides to assist practices with quality reporting:

1. CMS122v8 Resource Guide - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
2. CMS165v8 Resource Guide - Controlling High Blood Pressure
3. CMS2v9 Resource Guide - Preventive Care and Screening: Screening for Depression and Follow-up Plan
4. CMS69v8 Resource Guide - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan

Each guide included a description of the measure, numerator and denominator details, benchmark percentiles, a flowchart depicting how to interpret scores, as well as recommendations and resources on how to improve measure scores. The recommendations and resources spanned provider support resources, patient education materials, practice education initiatives, and helplines.

These four resource guides were accompanied by a best practice guide entitled, “How to Approach a Continuous Quality Improvement (CQI) Project” intended for use by the practice to embark on a CQI journey to determine how to improve performance on any (or all) of the eCQMs. The best practice guide includes an evidence-based flowchart strategy, a project checklist, and quality improvement (QI) tools.

PQI Resource Guides

Ten PQI guides were developed for the AHRQ PQIs, a set of measures that identify unnecessary hospitalizations that can be avoided with appropriate outpatient care. PQIs are a SIHIS priority, as one primary goal is to reduce avoidable admissions.

1. PQI 1 Guide - Diabetes, Short-Term Complications Admission Rate
2. PQI 3 Guide - Diabetes, Long-Term Complications Admission Rate
3. PQI 5 Guide - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate
4. PQI 7 Guide - Hypertension Admission Rate
5. PQI 8 Guide - Heart Failure Admission Rate
6. PQI 11 Guide - Community-Acquired Pneumonia Admission Rate
7. PQI 12 Guide - Urinary Tract Infection Admission Rate
8. PQI 14 Guide - Uncontrolled Diabetes Admission Rate

9. PQI 15 Guide - Asthma in Younger Adults Admission Rate
10. PQI 16 Guide - Lower Extremity Amputation Among Patients with Diabetes Rate

Each guide provided an overview of the PQI description, numerator and denominator inclusions and exclusions, along with resources for reducing PQI events (e.g., clinical resources for providers and patient support resources).

These ten guides were accompanied by a "Comprehensive PQI Guide," which describes the five Ws (what, who, where, when, and why) of PQIs. It also details which PQIs are relevant to MDPCP and walks through how to launch, navigate, adjust, and export reports through CRISP. Lastly, the guide provides a broad overview of evidence-based strategies for overall improvement in reducing avoidable hospitalization and improvement for each specific PQI category.

Staffing Guide

Considering the staff shortages that occurred as a result of the COVID-19 pandemic, MDPCP staff members compiled a guide to assist with providing staffing resources for MDPCP primary care practices. The list of resources included a description and contact information for organizations representing health care practitioners and training programs. Additionally, the guide had resources for practices located in designated Health Professional Shortage Areas (HPSAs), as these practices are eligible for state and/or federal programs.

MDPCP Learning Design & Development

In addition to diversifying the topic and format of learning offerings, a greater emphasis was placed on learning design and development by way of the MDPCP Learning Advisory Council. The MDPCP Learning Advisory Council was assembled for the purpose of advising on matters that directly concern the learning system's initiatives, events, and efforts. The Council comprised a cross-section of MDPCP primary care practices, CTOs, and the primary care learning community, adding up to a total of twelve members.

The MDPCP Learning Advisory Council members convened four times in 2021 and provided valuable feedback to assist the PMO in organizing the 2022 Learning Live calendar. The MDPCP Learning Advisory Council will continue to meet into 2022.

A Renewed Focus on Quality Improvement

Beginning in 2021, the State placed an intentional emphasis on quality improvement (QI) to foster a robust culture of "all teach, all learn" both internally at the PMO, and externally at the program level. The fulcrum of the "all teach, all learn" environment is strong peer engagement and shared learning for the purpose of actuating positive change in MDPCP and the rest of the state.

For the PMO to be appropriately positioned to examine situations with a QI lens, it was important to build capacity. The approach to capacity-building was two-fold: 1) developing foundational knowledge, and 2) applying this knowledge at the practice level.

Developing Foundational Knowledge

The PMO team completed a series of trainings focused on CQI through the Institute for Healthcare Improvement Open School. The training was supplemented by a "CQI Office Hour" guided by the Quality and Learning Lead; there, PMO team members convened to ask questions as well as discuss the coursework and application of concepts.

Plan-Do-Study-Act (PDSA) Cycles

The second part of capacity-building was engaging PMO team members - namely practice coaches - in applying the learned knowledge to a practice. The primary activity that concretized key QI concepts and brought QI to the forefront of MDPCP was Plan-Do-Study-Act (PDSA) cycles. A PDSA cycle (see Fig. 35) is an action-oriented, scientific method to test and measure a change.

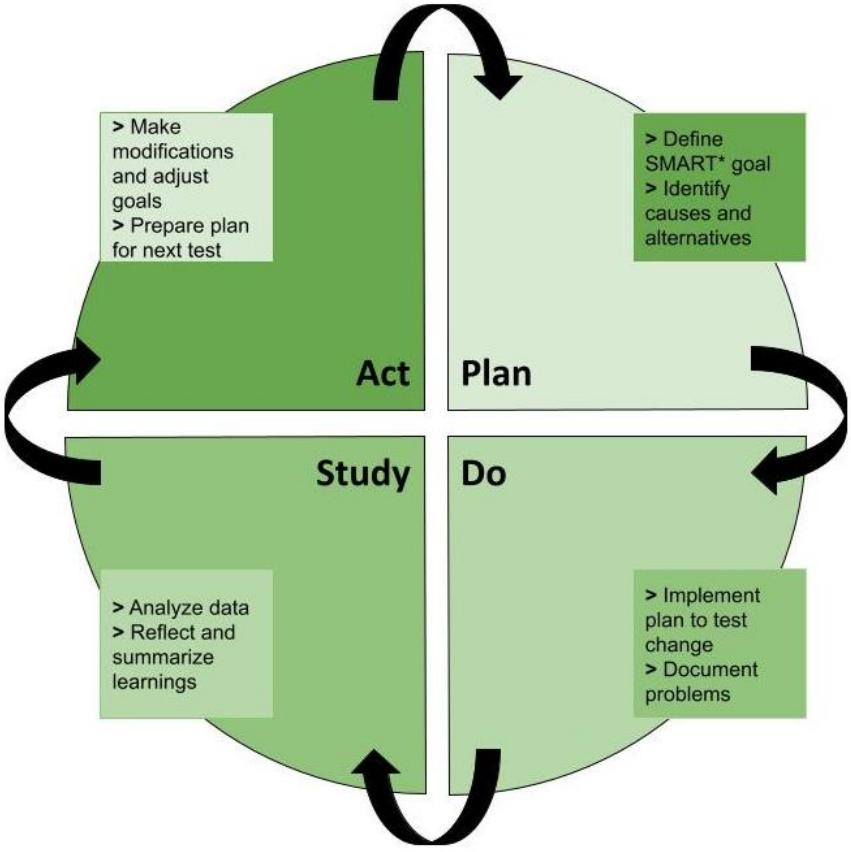

Figure 35. PDSA Cycle. The graphic explains how the PDSA cycle pertains to the practices engaging in the pilots.

*SMART - Specific, Measurable, Actionable, Relevant, Timely

The PMO began conducting two PDSA pilots in 2021, both of which will extend into early 2022: the BMI eCQM Rapid-Cycle PDSA Pilot and the Diabetes PQIs PDSA Pilot.

BMI eCQM Rapid-Cycle PDSA Pilot

The rapid-cycle model was chosen for this pilot, as change was expected in a brief period of time, and improvement would occur quickly.

One practice participated in this pilot and this practice was recruited by word-of-mouth.

The summary graphic below (Fig. 36) provides a synopsis of this pilot by depicting the Five Ws (Who, What, When, Where, Why).

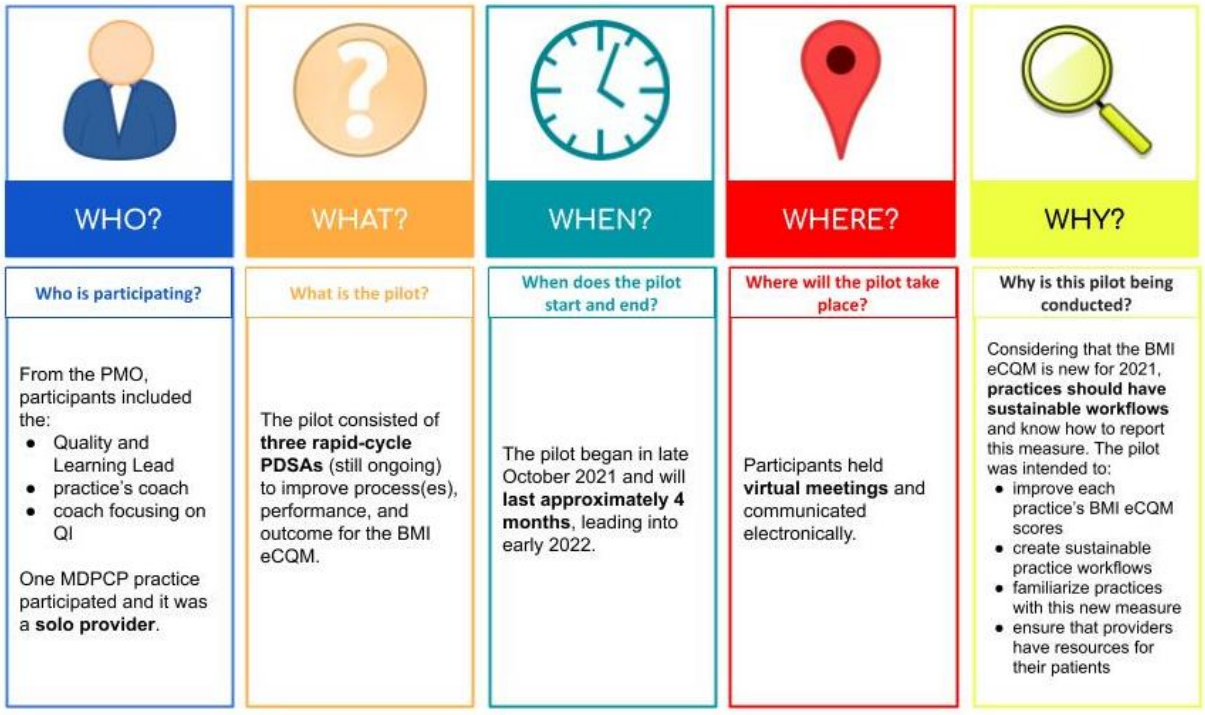

Figure 36. Five Ws - BMI eCQM PDSA Pilot.

Diabetes PQIs PDSA Pilot

With funding support from the Prevention and Health Promotion Administration, the PMO was able to offer monetary incentives for MDPCP practices to participate in this pilot.

The top 10% of practices with diabetes PQI-like events were targeted for recruitment.

Due to competing priorities and inadequate staff support, many practices expressed interest, but declined participation. Ultimately, two practices successfully signed up and actively participated in this pilot. The summary graphic below (Fig. 37) illustrates additional details by addressing the Five Ws, as it relates to the Diabetes PQIs PDSA Pilot.

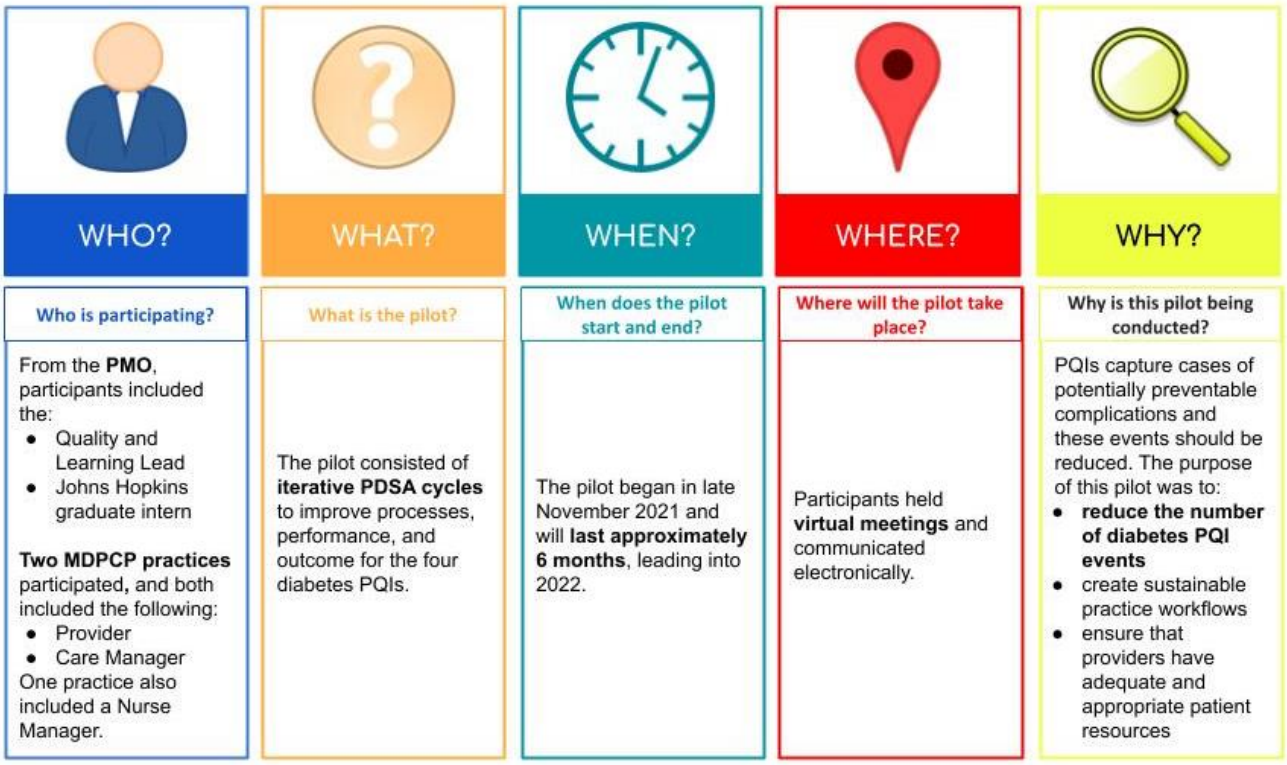

Figure 37. Five Ws - Diabetes PQIs PDSA Pilot.

The scalability of this work will be considered as both pilots near completion, taking into account meaningfulness, burden, and value for both the practices and PMO staff.

Looking Toward 2022 and Beyond

Looking at the future of MDPCP, the PMO expects even greater opportunities and larger impacts from this program.

Addressing Social Needs and Health Equity

The PMO has established a broad portfolio of active health equity projects to enhance the capacity of MDPCP practices to provide more effective care for patients of all backgrounds and will be expanding support to practices for screening and addressing the social needs of patients. In 2022, MDPCP will establish the new HEART payment which is provided to practices to address the needs of vulnerable, medically complex patients who reside in areas of high social deprivation. Of note, the HEART payment is the first known payment adjusted for social risk factors used in a CMMI program. MDPCP will be the incubator to the next generation of value-based payment to drive improvements in health equity.

Other work will include a visual, claims-based measures report broken down by key health equity characteristics including race, age, and sex. New projects for 2022 include training on cultural competency and health literacy, implementation of an automated clinical quality measures platform integrated with a practice's Electronic Health Record, and a partnership with MD 211 to enhance its resource directory for social needs.

Addressing Behavioral Health Needs

The PMO will continue the work of addressing Maryland's opioid crisis by expanding the evidence-based approach of SBIRT in communities across the state. Currently (as of December 2021), 319 MDPCP practices have implemented this important tool for addressing substance use disorders. The PMO also intends to broaden primary care access to Medication for Opioid Use Disorders to enhance MDPCP's role in fighting the ongoing opioid epidemic. Moreover, the PMO will continue to support practices implementing the Collaborative Care Model to address mental health issues.

Expanding Actionable Data

The PMO will continue its strong partnership with CRISP to provide comprehensive data reports to improve population health management outcomes. Recent additions to the MDPCP reporting suite include the Health Equity by Demographics report, a revised and expanded Specialist and Ancillary Services report, a new Total Per Capita Cost measure report, and the Chronic Condition Warehouse indicators with updated diagnosis definitions and new diagnosis code additions: Urologic Cancer, Parkinson's Disease, and Pneumonia. The most recent addition to the reporting suite is the prediction tools which include the existing Avoidable Hospitalizations (Pre-AH) model and two new prediction models: Severe Diabetes Complications (Pre-DC) and Hospice/End of Life (Pre-HE).

Adding Support and Reducing Administrative Burden

The PMO will continue to augment the financial support from CMS with on-the-ground technical assistance from practice coaches and a robust education system of remote learning and

practical guidance. Key topics for learning and guidance will focus on unnecessary hospital utilization and best practices for prevention and management of diabetes and hypertension.

Increasing Participation in MDPCP

For the open enrollment period in 2022, MDPCP anticipates adding more primary care practices and CTOs across the state. Consequently, In 2023, MDPCP will see an increase in the scope and impact of the program. MDPCP is already the first CMS advanced primary care program to include both FQHCs and practices in the same program. MDPCP anticipates adding additional health centers during the open enrollment periods for 2023 and 2024 program start years. MDPCP is also one of the largest advanced primary care programs in the nation. When compared to CMMI's national model, Primary Care First, MDPCP has the most practices of any state in the nation. On a per capita basis, MDPCP is also the most robust. Maryland has 8.24 MDPCP practices per 100,000 residents. The next closest state is Maine (4.45), nearly half of MDPCP's rate.

Working on Payer Expansion

MDPCP added CareFirst in 2020 as the initial aligned commercial payer and is actively exploring the addition of Medicaid as an aligned payer in 2023. Key action steps will be taken in 2022 to actualize this goal.

Implementing and Exploring New Payment Strategies

In 2022, in partnership with CMS, MDPCP is continuing to develop payment strategies that move primary care payments toward non-visit based payments to support team-based advanced primary care delivery with the launch of a novel Track 3 in 2023.

Considering More Stakeholder Input

As Maryland continues to transform the delivery of health care for the better and more equitable health of all Marylanders, the PMO will continue to listen to stakeholders and take their feedback into consideration. MDPCP can succeed only by meeting the needs of providers and patients alike.

Recommendations to CMS

The PMO makes seven recommendations to improve MDPCP policy and operations in 2023 and beyond. The seven recommendations cover the following areas:

1. Direct Participant Feedback
2. Track 2 Option Maintenance
3. Total Cost of Care (TCOC) Measure Weight Reduction
4. Payer Alignment Oversight
5. HEART Payment Use - Expansion of Flexibilities
6. Track 3 Performance-Based Adjustment
7. Retroactive Change to Performance Measure Benchmarks

Recommendation 1: Direct Participant Feedback

Recommendation: CMMI should collaborate with the PMO to collect feedback directly from program participants.

We recommend that CMMI work with the PMO to actively solicit feedback directly from program participants in 2023, especially practices and their providers. CMMI and MDH are testing out a Listening Session with a small group in December 2022, which could serve as the model for future feedback sessions. The purpose of the meeting series would be to allow participants to communicate directly to CMMI both their concerns and opportunities for improvement. To date, CMMI has had little opportunity to hear from those on the ground, the providers and their staff who are trying to implement the program's requirements on a daily basis. Feedback sessions have the promise of rebuilding practices' enthusiasm about MDPCP while identifying improvements that are mutually beneficial for all parties.

Recommendation 2: Track 2 Option Maintenance

Recommendation: Maintain Track 2 option as a sustainable payment model for practices that may be reluctant or unable to accept significant downside financial risk. Substantial financial risk could threaten the ability to provide care or drive practices out of MDPCP. It's important to note that the PMO expressed this concern during Track 3 development and are now reiterating it due to ongoing concern voiced by MDPCP participants about the complex financial methodology in Track 3 and the widespread adoption of the Track 2 financial model.

We recommend that CMMI preserve the Track 2 option for practices that may be reluctant or unable to accept significant downside financial risk. We base this on the advice of the recent landmark National Academies of Sciences, Engineering, and Medicine (NASEM) Implementing High Quality Primary Care report that recommends incorporating hybrid payment models for primary care that "pay for primary care teams to care for people, not doctors to deliver services."

The recommended NASEM payment model is a hybrid model including both fee-for-service and population-based payments, notably without mention of the need for significant downside financial risk. Under the PBA, the potential for 10% downside risk in Track 3 on the majority of Medicare payments to a primary care practice (including all of a practice's Evaluation and Management billing) can be unsustainable for those practices reluctant or unable to accept

significant downside financial risk, many of which operate on a slim margin. These practices may need to cut back staff and services in order to accept substantial downside risk, leading to a disruption in care. Furthermore, the sheer complexity of risk-adjustment calculations in Track 3 creates discomfort from a lack of understanding and control of future payments, potentially disincentivizing participation.

The fee-for-service elements of NASEM-recommended primary care payment models should be based on a neutral incentive that neither encourages unnecessary volume nor discourages appropriate levels of provider-patient interactions. The fee-for-service payments in Track 3 are significantly below the level of neutral incentive and barely cover the costs associated with claims submission alone. Although the fee-for-service payments in Track 3, or flat visit fee (FVF), are designed to account for only 60% of payments to practices and the remaining 40% would be paid to practices via a population-based payment, practices rely on the cash flows of the FVF to cover their operational costs. Falling below a neutral fee-for-service payment for face-to-face visits discourages the personal interaction between patients and providers and erodes the trust that is needed for a high level of patient engagement.

The viability of Track 3 is uncertain and may pose an existential threat to MDPCP's long term role as a foundation for Maryland's health care transformation. Under the current pace of change in the program, practices may reject Track 3 and withdraw from MDPCP: it is unlikely that they will be willing or able to rejoin the program. The national model of Primary Care First, of which Track 3 is based, has yet to demonstrate its long-term viability. Therefore, in MDPCP, some practices may move to Track 3 based on the mandatory transition rule, only to find that they face significant financial stress from the model and choose to leave after the first year. Once a practice leaves MDPCP, there will be a reduction of Medicare beneficiaries who have access to comprehensive, advanced primary care. Other practices may decide to go other routes, such as concierge medicine, which reduces access for Medicare FFS beneficiaries at large. In either case, the loss of the organized, and effective primary care workforce in Maryland is at substantial risk.

Moreover, the combination of practice mergers and acquisitions and the significant increase in financial risk mandated by Track 3 has the potential of driving down MDPCP participation. The financial risk and administrative burden associated with MDPCP may also be accelerating mergers and acquisitions by larger groups, which does not align with MDPCP's goal to support comprehensive primary care, no matter the size and location of a practice.

Thus, maintaining Track 2 as an option for practices and making Track 3 optional should be reconsidered. In order to effectively manage care across the state, MDPCP must maintain its broad provider and practice enrollment. A smaller program would fall short of having a major impact on overall costs and quality for the state. Track 2 provides a measure of accountability to efficient care using TCOC in the PBIP without posing a threat to core practice funding by resting significant portions of financial risk on TCOC calculations. For all of these reasons, we recommend maintaining Track 2 beyond 2025.

Recommendation 3: Total Cost of Care (TCOC) Measure Weight Reduction

Recommendation: Reduce the weight of the TCOC measure (the Total Per Capita Cost measure) in the MDPCP performance framework to 5% as a reflection of the approximate portion of the TCOC paid to primary care.

In Maryland's all-payer hospital global budget environment, reductions in Medicare specific utilization may not be fully reflected in savings to Medicare due to methodological complexities. Moreover, while primary care can influence avoidable hospital utilization, it has less impact on specialty and other costs. Even more significantly, the increases in health care spending are largely predicated on increasing prices for goods and services. Primary care has no control over price increases outside of primary care. The State does not disagree with introducing appropriately balanced total cost of care responsibility to primary care practices as a matter of creating accountability. However, the State is concerned that the influence of the TCOC does not approach the current 25% share of the PBIP or PBA. On balance, additional weight can be given to the hospital and emergency department utilization measures, to maintain alignment with hospitals under the TCOC Model's goals of reducing hospital utilization.
In addition, performance-based adjustments should take into account the work that can reasonably be accomplished by primary care. Primary care consumes approximately 5% of the total cost of care TCOC – even less in Medicare -- and has limited ability to control the remaining 95%.

Recommendation 4: HEART Payment Use - Expansion of Flexibilities

Recommendation: Increase the effectiveness of HEART Payment funds by enabling broader use of funds at the practice level, use of funds for medication cost-sharing, and use of funds for non-Medicare-covered equipment.

The HEART Payment rollout has been a successful collaboration between CMMI and the State, due in part to the regular cadence of HEART Payment workgroup meetings that have allowed the State and CMMI to share innovative ideas, develop joint payment guidance, and strategically plan improvements to HEART payment implementation. The payment itself has gained national attention as a pioneering allocation of financial resources to primary care practices to address beneficiaries' social needs. The HEART Payment is also a key part of CMMI and the State's health equity focus in the program. In the first year of the rollout of the HEART Payment, the State has gathered feedback from practices on payment structure, and accordingly recommends options to broaden the use of the HEART Payment to maximize effectiveness.

With the restructuring of references to the HEART Payment in the 2023 program Participation Agreements, CMMI has already maintained language that allows for a broad spectrum of potential activities using HEART Payment funds. The PMO recommends that CMMI builds on this initiative by considering the following expansion of HEART Payment structure:

- **Enable use of the HEART Payment to cover medication cost-sharing** as practices consistently share with the PMO that medication affordability is one of the most prevalent unmet needs in their beneficiary population. Comprehensive medication

management and pharmacy integration are a core focus of the MDPCP, however this work cannot be effective if beneficiaries cannot afford regular prescriptions. The HEART Payment is intended to facilitate resource allocation to under-resourced beneficiaries to improve their health. As such, the State recommends that CMMI pursue a waiver to allow HEART Payment to be used to help beneficiaries cover cost-sharing for essential medications.

- **Enable use of the HEART Payment for non-Medicare-covered equipment** as practices cannot use the HEART Payment to purchase durable medical equipment (DME), however an exact definition of DME remains unclear for practices. This has created a gray area where practices are uncertain whether they can use the HEART Payment to pay for certain equipment for HEART beneficiaries. The State recommends that CMMI clarify HEART Payment usage to allow for using funds to purchase patient equipment not covered by Medicare. The potential benefits of this change are wide-reaching, including uses such as purchase of home blood pressure monitors to better manage hypertension and purchase of hearing aids to assist beneficiaries with hearing loss and who otherwise would not have access to this equipment.
- **Consider broadening the scope of payment usage beyond designated HEART beneficiaries** as consistent feedback from practices in the current rollout of the HEART Payment is that the identified HEART beneficiaries are inclusive of many but not all of the MDPCP beneficiaries who could most benefit from additional services. Because HEART Payment eligibility uses an area-based measure rather than a beneficiary-specific measure, beneficiaries identified to receive the payment do not necessarily need additional investment, and at the same time beneficiaries not identified may benefit from additional services. To account for this mismatch, the State recommends that CMMI consider allowing practices to spend HEART Payment funds on the individual MDPCP beneficiaries that the practice determines are most in need of services. Importantly, this change also has the potential to reduce practices' administrative burden of recording and documenting HEART payment usage.

Beyond broadening uses of the HEART Payment, the State also recommends that CMMI and the PMO collaborate on quantitative and qualitative evaluations of the HEART Payment to understand the strengths and opportunities of the program, and to continue to improve the effectiveness of the payment in future program years.

Recommendation 5: Track 3 Performance-Based Adjustment

Recommendation: Evaluate, monitor and restructure the budget neutrality mechanism in PBA under Track 3 with consideration to adjust payments based on fair prospective benchmarks that would allow all practices to be graded based on an external benchmark. It's important to note that the PMO expressed this concern during Track 3 development and are now reiterating it due to ample pushback from MDPCP participants.

We recommend evaluating, monitoring, and potentially restructuring the budget neutrality mechanism in PBA under Track 3 with consideration to adjust payments based on prospective benchmarks that would allow all practices to be graded based on an external benchmark. An

ideal PBA framework would allow for all high performing practices to be rewarded and all low-performing practices to receive penalties, thus fairly aligning payment to performance. If all practices perform well, it would require more dollars to compensate practices, but Medicare would be seeing enhanced value for that performance. Any such increase in funding would be minimal due to the size of the PBA in relation to overall program payments, and would be accounted for by the nature of the State's overall TCOC savings targets. Accordingly, for practices that perform poorly and fall below benchmarks, practices still would be subject to penalties and be required to repay monies to Medicare. It is likely that performance will be normally distributed and thus more directly align good performance with rewards and poor performance with penalties. While this recommendation has been made in the past, MDPCP participants have continued to indicate concerns about the program.

The current PBA policy creates winners and losers, even if performance exceeds benchmarks. The budget neutral basis for the Track 3 PBA creates a situation where practices compete with one another for a ranking on the scale of winners (up to 25% increase in TPCP) to losers (10% loss of TPCP). The consequence of this design is that potentially practices can do very well, meeting or exceeding expectations, but not as well as other practices and still stand to lose 10% of their TPCP. This design feature will have a chilling effect on those who might suffer significant financial loss, essentially being punished for good behavior. Conversely, this within-program ranking may result in a scenario where the majority of practices do not meet expectations, but are nonetheless rewarded for comparative performance.

Recommendation 6: Retroactive Change to Performance Measure Benchmarks

Recommendation: Establish a regular period annually for the State PMO and CMMI to review and finalize benchmarks for the forthcoming year. Commit to making changes jointly with the State PMO only when absolutely necessary and communicate these changes to participants as far in advance as possible. (Note: while this recommendation has been made in the past, retroactive changes have continued due to the public health emergency, and thus participants have continued to indicate concerns about the program.)

CMMI and the PMO have partnered over the past four years to develop the performance methodology of MDPCP. One key tenet has been the need to provide prospective benchmarks to practices so they have clear direction at the beginning of the year. The clear direction is key in communicating the program's performance priorities and ensuring practices and CTOs alike have concrete, measurable targets to shoot for. MDPCP participants have consistently cited the need for prospective benchmarks as a way to incentivize high performance among their staff and a fair way to measure performance. The State admits that the last 2.5 years have been abnormal due to the Public Health Emergency, and thus retroactive adjustments to benchmarks have been necessary to ensure an accurate and fair way of evaluating performance. At the same time, it is important that retroactive changes to benchmarks be limited in nature and frequency so as not to sow confusion and distrust among the practices. Clear, prospective benchmarks with minimal retroactive changes will help promote positive behavior change in the pursuit of better patient health.

Recommendation 7: Payer Alignment Oversight

Recommendation: CMMI should actively monitor and collaborate with payers on alignment in partnership with MDH.

The alignment for all payers should ensure full alignment with MDPCP on data sharing, quality measurement, non-visit-based payments and site-based care management. A few principles for consideration under enhancing alignment are as follows:

1. Payment Models and Financial Risk - public and private payers should make every effort to offer payment models that are responsive to the risk attraction and risk-averse segments of the primary care community. The aforementioned NASEM Report should be used as a guide, including the model of hybrid payments.
2. Data Sharing - payers should make every effort to make claims data important to population health management available on a shared multi-payer platform so practices can access a single site for all of their patients' claims data. This would reduce practices' administrative burden of having to access a different site for each payer and streamline the number of reports for primary care practices with limited staffing, which ultimately allows for more dedicated time to clinical care and population health management. Effective multi-payer alignment requires multi-payer data being shared with the practices to create real-time insights on their patient population; practices can better manage care and produce outcomes beneficial to program policy such as reduced avoidable utilization and closing gaps in care.
3. Quality Measurement - payers should align with key MDPCP measures which have already been aligned with the State's population health goals under the SIHIS, creating efficiencies and incentives for population health management across all populations.
4. Care Management - payers should provide supplemental funding or other resources to practices to enable embedded care management across all patient populations. Today, Medicare is funding 100% of site-based care management staffing and activities. While plan-based care management is appropriate, practices can enhance care management at the site level to improve patient uptake and reduce plans' remote care management costs. Site based care management is generally more accepted by patients, more accessible, and more cognizant of patient needs.
5. Learning System - payers should look to create shared resources and education for practices, ideally providing streamlined resources to reduce burden on practices and improve adoption.

TESTIMONIALS

"We at [practice name redacted] have been very pleased to work with the MDPCP program through our CTO at [CTO name redacted]. **We have found that the pharmacy and social work consults made available to us have been particularly valuable in providing the best possible care to patients.** In addition, our two CTO reps, [names redacted] have been a pleasure to work with and provide us with timely information that makes our job in Population Health much easier to do than [other value-based programs]."

– Provider

"2020, the first year of my participation with the MDPCP and the now-infamous year of the COVID-19 pandemic brought a level of challenge to my career that was beyond imaginable and is one that I am still struggling to overcome both financially and organizationally...while I am grateful for all of the assistance received from the other federal programs, **I must make special mention of the MDPCP funding in providing the financial support to hire needed personnel to keep the doors of [practice name redacted] open. I am a very proud participant of this program and continue to learn a great deal about the health informatics behind the work I am so dedicated to doing.** It is my fervent hope that I will continue to be able to take part in the care model that is MDPCP."

– Provider

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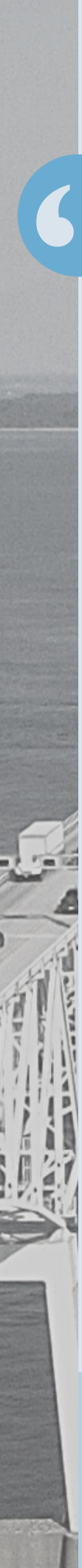

TESTIMONIALS

"The [CTO name redacted] lost both its Chief Operating Officer and its IT and Network directly within 8 weeks of each other this summer. Although I was supportive of the moves of both these individuals, it certainly left me (with less than a year's tenure) strapped for expertise. **I just want to commend [Lead Coach] for her support of us during this period of transition.** We have since replaced one of the two positions, but in the interim (and still now) we have had huge gaps in expertise that had to be filled so that we could move forward. [CTO name redacted] supports a significant number of primary care practices both employed and in [county name redacted] and we did not want to have these staffing changes affect our track record of success.

I can assure you that we would not have been successful to date without [Lead Coach's] support. She has been responsive, patient, knowledgeable and above all, supportive as my new staff and I have had to get into the weeds of the MDPCP program and learn quickly.

I think it is so important to recognize staff when they go "above and beyond" and add such value to their roles and employers. Congratulations for having [Lead Coach] on your team."

-CTO Executive

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2021 ANNUAL REPORT

The State of Maryland has entered into 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 providers 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.

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