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MDPCP-AHEAD HEART Payment Playbook

Performance Year 2026

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Table of Contents

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MARYLAND PRIMARY CARE PROGRAM

Glossary

ADI - Area Deprivation Index

CDC - Centers for Disease Control and Prevention

CDI - Community Deprivation Index

CMF - Care Management Fees

CMS - Centers for Medicare & Medicaid Services

CRISP - Chesapeake Regional Information System for our Patients

CTO - Care Transformation Organization

CTR - Care Transformation Requirement

DME - Durable Medical Equipment

EHR - Electronic Health Record

FAQs - Frequently Asked Questions

FFS - Fee for Service

FQHC - Federally Qualified Health Center

HCC - Hierarchical Condition Category

HRSN - Health-Related Social Needs

MDPCP-AHEAD - Maryland Primary Care Program in the Achieving Healthcare Efficiency through Accountable Design Model

NIH - National Institutes of Health

PA - Participation Agreement

PBIP - Performance Based Incentive Payment

PBPM - Per Beneficiary Per Month

PFAC - Patient and Family Advisory Council

RPM - Remote Patient Monitoring

SDOH - Social Determinants of Health

SNAP - Supplemental Nutrition Assistance Program

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About the HEART Payment Playbook

The guidance in this HEART Payment Playbook was developed by the Office of Advanced Primary Care at the State of Maryland.

The HEART Payment Playbook is intended to support the Maryland Primary Care Program in the Achieving Healthcare Efficiency through Accountable Design (MDPCP-AHEAD) participating practices, Federally Qualified Health Centers (FQHC), or Care Transformation Organizations (CTO) in:

- Understanding Community Deprivation Index (CDI) and the HEART payment;
- Determining the most effective and appropriate use of HEART funds;
- Understanding necessary tracking and reporting of HEART payment usage; and
- Providing answers to Frequently Asked Questions (FAQs).

Practices, FQHCs, or CTOs should use this guide and work with your Practice Coach to determine the most effective use of your HEART payments.

Note that the potential services that can be supported by HEART payments in this guide are not fully inclusive of allowable expenditures and are meant to represent a general guide regarding how the funds may be used. CMS will not be able to weigh in on the allowability of specific payment uses for an individual practice, FQHC, or CTO. In the event of any inconsistency between the guidance in the HEART Payment Playbook and the provisions of the Participation Agreement, the provisions of Participation Agreement shall prevail.

Please consult your MDPCP-AHEAD Participation Agreement and MDPCP-AHEAD Connect for the most accurate information.

Why HEART Payments?

The HEART payment provides additional support to MDPCP-AHEAD participants serving socioeconomically disadvantaged populations and promotes the State's and CMS' goal to empower individuals to live healthier lives.

Benefits to Patients and Communities

Beneficiaries with high clinical risk and high CDI scores have complex needs. A holistic approach and substantial investment of resources are often needed to improve clinical outcomes and sustain progress on beneficiaries' health goals. The goal of the HEART payment is to address the complex needs of these under-resourced Medicare beneficiaries, improving their social conditions in the short term and their clinical outcomes in the long term.

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High ADI and CDI are Associated with High Cost and Worse Outcomes

Health outcomes and costs are often strongly driven by social and environmental factors, beyond just medical complexity. Both CDI and ADI are measures of neighborhood-level socioeconomic disadvantage. While ADI has historically been used to identify underserved areas, CDI offers a more refined and statistically robust approach, especially in urban settings, by incorporating updated variables and improved methodology. Studies have shown that high deprivation scores, whether measured by ADI or CDI, are associated with:

- Worse diabetes control, blood pressure control, and cholesterol control in Medicare Advantage beneficiaries;[1]
- Higher readmission rates in Maryland hospitals;[2] and
- Lower rates of recommended cancer screenings.[3]

In a 2020 study of Maryland Medicare Fee-For-Service (FFS) beneficiaries specifically, beneficiaries with high ADI in combination with high Hierarchical Condition Category (HCC) risk scores were shown to have significantly greater healthcare costs.[4] Emerging analyses suggest that CDI may offer even stronger predictive power for identifying high need, high-cost populations.[5]

As such, investing in patients with high complexity and high CDI scores aims to improve health outcomes and lower costs in this targeted group of high need individuals.

ADI and CDI Background

The ADI was defined by a National Institutes of Health team and first published in 2003, with the goal of quantifying and comparing social disadvantage across geographic neighborhoods.[6] It is a composite measure, derived through a combination of 17 input variables from census data, which are now estimated annually at the "census block group" level through the US Census Bureau's American Community Survey. Census block groups typically contain 600 to 3,000 people.

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[1] Durfey SNM, Kind AJH, Buckingham WR, DuGoff EH, Trivedi AN. Neighborhood disadvantage and chronic disease management. *Health Serv Res*. 2019;54 Suppl 1(Suppl 1):206-216. doi:10.1111/1475- 6773.13092.

[2] Jencks SF, Schuster A, Dougherty GB, Gerovich S, Brock JE, Kind AJH. Safety-Net Hospitals, Neighborhood Disadvantage, and Readmissions Under Maryland's All-Payer Program: An Observational Study. *Ann Intern Med*. 2019;171(2):91-98. doi:10.7326/M16-2671.

[3] Kurani SS, McCoy RG, Lampman MA, et al. Association of Neighborhood Measures of Social Determinants of Health With Breast, Cervical, and Colorectal Cancer Screening Rates in the US Midwest. *JAMA Netw Open*. 2020;3(3):e200618. Published 2020 Mar 2. doi:10.1001/jamanetworkopen.2020.0618.

[4] Sapra KJ, Yang W, Walczak NB, Cha SS. Identifying High-Cost Medicare Beneficiaries: Impact of Neighborhood Socioeconomic Disadvantage. *Pop Health Mgmt*. 2020;23(1):12-19. https://doi.org/10.1089/pop.2019.0016.

[5] Robst J, Cogburn R, Forlines G, Frazier L, Kautter J. The development of the Community Deprivation Index and its application to accountable care organizations. Health Aff Sch. 2024 Nov 27;2(12):qxae161. doi: 10.1093/haschl/qxae161. PMID: 39664484; PMCID: PMC11629994.

[6] Singh GK. Area deprivation and widening inequalities in US mortality, 1969-1998. *Am J Public Health*. 2003;93(7):1137-1143. doi:10.2105/ajph.93.7.1137.

ADI is a relative measure, typically reported by percentile (1-100) or decile (1-10), with a higher percentile indicating greater disadvantage. While ADI can be reported for an individual, it is important to remember that an "individual's ADI" is the ADI of the census block group of their residence, and each individual faces a unique set and degree of social challenges. Since 2003, ADI has been used, studied, and validated as a measure of social disadvantage, correlating with many common healthcare outcomes, including cancer screening rates, chronic condition control, hospital readmission, and total cost of care.[7] Measures similar to ADI are used across the US and world; prominent examples include Massachusetts' Neighborhood Stress Score, New Zealand Deprivation Index, and the United Kingdom's Indices of Multiple Deprivation.

To build on the foundation laid by ADI, the CDI was developed as a more refined and statistically robust measure of neighborhood-level disadvantage. CDI incorporates updated variables from the American Community Survey, applies statistical shrinkage to reduce noise, uses population data from 2019 instead of 1990, and standardizes inputs to ensure comparability across regions. It was designed to address limitations of ADI—particularly for urban areas—and has demonstrated stronger correlations with healthcare utilization and outcomes. While ADI remains a valuable and widely recognized tool, CDI represents an evolution in how socioeconomic disadvantage is measured and applied in health policy.

HEART Payment Overview

The HEART payment is an established amount paid Per Beneficiary Per Month (PBPM) for each beneficiary attributed to an MDPCP-AHEAD Practice or FQHC who is in the 4th HCC risk score tier (75th to 89th percentile of HCC risk scores) or the complex risk tier (90th to 99th percentiles of HCC risk scores) and who falls into the highest deprivation quintile of CDI (based on Maryland's attributed Medicare population across MDPCP-AHEAD and Primary Care AHEAD). The HEART payment is $110 PBPM, paid to MDPCP-AHEAD practices on a quarterly basis.

CDI quintiles for MDPCP-AHEAD are calculated based on Maryland's attributed Medicare population in MDPCP-AHEAD and Primary Care AHEAD in the first quarter of attribution for a performance year. CDI quintiles, HCC risk score tiers, and eligibility for HEART are provided for all attributed beneficiaries in the quarterly Beneficiary Attribution Reports available in the MDPCP-AHEAD Portal. Beneficiaries' CDI scores are also reported in Chesapeake Regional Information System for our Patients (CRISP). Identification of HEART beneficiaries will occur on a quarterly basis along with quarterly attribution determination. Note that if a beneficiary qualifies for HEART one quarter, they may not necessarily qualify for the following quarter.

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[7] Kurani SS, McCoy RG, Lampman MA, et al. Association of Neighborhood Measures of Social Determinants of Health With Breast, Cervical, and Colorectal Cancer Screening Rates in the US Midwest. *JAMA Netw Open*. 2020;3(3):e200618. Published 2020 Mar 2. doi:10.1001/jamanetworkopen.2020.0618.

Payment calculations for HEART are made on an annual basis in Q1 and then divided evenly into four quarterly payments. There will be no recoupments for HEART in future quarters so that HEART is a stable quarterly payment each year. As stated above, the list of HEART-eligible beneficiaries for each quarter may still change on a quarterly basis.

HEART payments are part of the CMF and will not be tied to an MDPCP-AHEAD participant's performance on quality and utilization measures. In other words, CMS will not recoup an MDPCP-AHEAD participant's HEART payment based on their performance on quality and utilization measures. The CMF Percentage Payment Option selected by each practice/FQHC and its partner CTO in their CTO Arrangement will apply to the HEART payment, meaning that CTOs will receive the specified percentage of HEART funds.

Potential Enhanced Care Transformation Services for HEART Payments

The MDPCP-AHEAD Participation Agreement describes the uses of HEART Payment funds. This section of the HEART Payment Playbook intends to reinforce and provide more context on the possible use of funds. MDPCP-AHEAD participants can leverage HEART payments to provide enhanced care transformation services for beneficiaries in the 4th HCC risk score tier or the complex risk tier and who fall within the High Deprivation CDI-quintile and other identified high need beneficiaries. The following potential enhanced care transformation services for HEART Payments are not fully inclusive and are meant to represent a general guide regarding how the payments may be used. CMS cannot provide guidance on specific payment uses for an individual practice or CTO beyond the information provided in the MDPCP-AHEAD Participation Agreements. Practices and CTOs should consult their own legal counsel if further guidance is desired.

Table 1. Potential Enhanced Care Transformation Services for HEART Payments.

Comprehensive Primary Care Functions of Advanced Primary Care	Potential Enhanced Care Transformation Services
Access and Continuity	• Identify and address barriers to care initiation, continuity, and preventative care for MDPCP-AHEAD Beneficiaries including, but not limited to, language barriers, transportation, cost, and/or health system navigation and health literacy. • Identify and address barriers to care management through the use of technology, such as telehealth and remote patient management technology.

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Comprehensive Primary Care Functions of Advanced Primary Care	Potential Enhanced Care Transformation Services
Care Management	• Provide holistic, high-intensity care management that may include coordination for essential clothing, education/employment support, and access to safe exercise facilities. • Provide a MDPCP-AHEAD Beneficiary experiencing interpersonal violence/toxic stress with services such as ongoing safety planning and management or linkages to community-based social services and mental health agencies with interpersonal violence experience. • Provide one-on-one case management or educational services to assist the MDPCP-AHEAD Beneficiary in addressing food insecurity and access to safe water. Assist the MDPCP-AHEAD Beneficiary in accessing community-based food and nutrition resources, such as food pantries, farmers market voucher programs, etc. • Provide tailored chronic disease management and prevention services.
Comprehensiveness and Coordination across the Continuum of Care	• Facilitate access to health-related legal supports. • Facilitate access to behavioral health services. • Facilitate access to food and nutrition care management services. • Facilitate access to housing navigation, support, and sustaining services, including access to essential utilities. • Connect the MDPCP-AHEAD Beneficiary to social services to help with finding housing necessary to support meeting medical care needs. • Connect the MDPCP-AHEAD Beneficiary to home remediation services that may eliminate known home-based health and safety risks (i.e., pest eradication, carpet or mold removal).

Comprehensive Primary Care Functions of Advanced Primary Care	Potential Enhanced Care Transformation Services
Beneficiary & Caregiver Experience	• Engage beneficiaries and caregivers in identifying and mitigating barriers to recommended resources (i.e. assistance with enrollment in additional eligible benefits and/or supports). • Build practice capacity to provide community-centered care and strong patient-provider partnerships through services such as access to language interpreter services, extending linguistic competency beyond the clinical encounter, and providing staff with training.
Planned Care for Health Outcomes	• Implementation and tracking of health-related social needs assessment screening, customizing electronic health records to capture social determinants and linking data through health information exchanges, and other screenings and analyses (unfilled prescriptions or under-dosing of medications due to cost, behavioral health and substance use, intimate partner violence, adverse childhood experiences, preventive health screenings, vaccinations). • Data collection and analysis, including disaggregated data on outcomes for different subpopulations and analysis on health-related social needs screening data.

Limitations on HEART Payments

The HEART payment should be used to provide additional support to improve outcomes and address the relatively high cost of care for beneficiaries in the 4th HCC risk score tier or the complex risk tier and who fall within the High Deprivation CDI-quintile or other high need beneficiaries identified by the practice.

Prohibited use of funds for these beneficiaries are specified in the MDPCP-AHEAD Participation Agreement and may include:

- To pay income tax or to make other tax payments not expressly permitted by the terms of this Agreement;
- To pay for the purchase of imaging equipment;
- To pay for the purchase of Medicare-covered durable medical equipment;

- To pay for the purchase of drugs, biologicals, or other medications;
- To pay for continuing medical education (CME) (if not directly related to the MDPCP-AHEAD);
- To pay for personnel or other costs directly related to the MDPCP-AHEAD Practice or MDPCP-AHEAD Practice Site billing or coding;
- To pay for office space, supplies, or decorations; and
- To make payments to MDPCP-AHEAD Practitioners and other MDPCP-AHEAD Practice Site staff for purposes other than supporting work directly related to enhanced care transformation services.

Building Practice Infrastructure

Although HEART payments are intended to support high need beneficiaries, they could also be used to support practice-wide initiatives that allow an individual practice to build the infrastructure needed to most effectively address the needs of these beneficiaries. A primary example of this is the implementation of health-related social needs screenings, and data collection and analysis related to social determinants of health, which will inform and direct choices on where and how to target the most prevalent unmet social needs for the patient population.

Suggested uses of funds to build practice infrastructure are:

- **Health-Related Social Needs (HRSN) Screening Implementation**: Implementation and tracking of health-related social needs assessment screening; customizing electronic health records to capture social needs information and linking data through health information exchanges; screening for unfilled prescriptions or underdosing of medications due to cost; behavioral health and substance use screening; intimate partner violence screening; adverse childhood experiences scoring; and/or determining rates of preventive health screenings, vaccinations, and/or management of chronic diseases in order to optimize care of underserved populations and improve MDPCP-AHEAD practice performance on quality, patient experience, and utilization measures.
    - Note: The HEART payment may be used only to fund the modification to an electronic health records system to capture the social determinants of health data specified above. The HEART payment *may not* be used to pay for a broader EHR system upgrade that also includes the HRSN screening modification. Other EHR upgrades may only be paid with PBIP or other non-MDPCP-AHEAD revenues.
- **SDOH Data Collection and Analysis**: Data collection and analysis, including disaggregated data on subpopulations, and analysis of SDOH and HRSN screening data.

- **Build Capacity for Community-Centered Care**: Build practice capacity to provide competent care and strong patient-provider partnerships through services such as access to language interpreter services, extending linguistic competency beyond the clinical encounter, providing staff with training on community-centered care or other related knowledge and skills.

Staffing

An individual practice or CTO may consider using HEART funds for staffing purposes, such as hiring a Community Health Worker to work with high need beneficiaries

Contracting with Community-Based Organizations

An individual practice or CTO may consider contracting with a community-based organization that addresses unmet social needs for the patient population, such as a food pantry or an organization providing employment support. You may use HEART funds to establish a relationship with such a community-based organization, and then to refer high need beneficiaries.

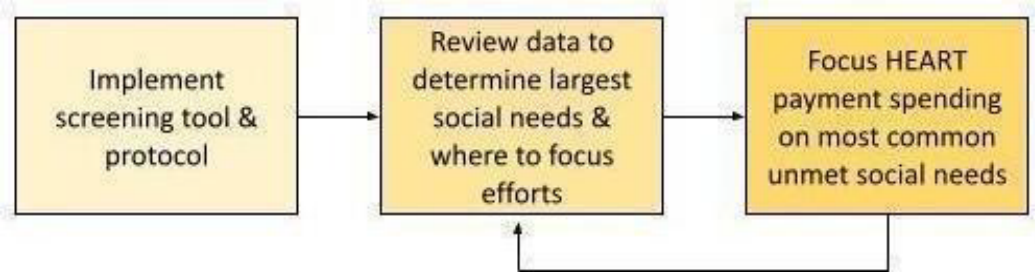
Identifying a Practice's Most Prevalent Social Needs

One of the suggested uses of the HEART payment is the collection and/or analysis of health-related social needs screening data that will inform and direct choices about services that address the needs of practices' underserved beneficiaries.

When considering how to most effectively use a practice's allocated HEART payments, data from health-related social needs screenings can be used to determine the most prevalent unmet social needs in the practice's beneficiary population. The screening data can then guide your practice to uses of the HEART payments that will best benefit the practice's specific patient population as depicted in Figure 1.

Screening for Unmet Social Needs

Figure 1. Sample Workflow for Integrating Screening for Unmet Social Needs



There are a number of common social needs screening tools of varying lengths and depths and many EHR systems have social risk screening questions built into the patient chart. If a practice does not already screen patients for unmet social needs and document the result of screening in your EHR, the HEART payment can be used to implement an appropriate workflow for your practice. MDPCP-AHEAD providers can also evaluate the effectiveness of

their practice's workforce models for screening and responding to unmet needs. The most common workforce models for social needs screening are self-administered (front desk staff or social worker staff ask patients to fill out a paper form or tablet to complete screening questions) and clinician-administered (medical providers or medical residents verbally ask patients questions).[8] To optimize the screening workflow, providers can consider delegating navigation services, reevaluating the workforce model used for social needs screening, and/or repurposing staff into a different role.

Aggregating & Analyzing Data on Social Needs Screenings

After implementing a social needs screening tool and protocol at the practice, aggregating screening data across the patient population can help you determine where to focus efforts with usage of the HEART payments. When aggregating data from health-related social needs screenings, consider grouping needs into common domains, such as transportation, food, housing, safety, and social isolation. When aggregating data, consider data for the patient population as a whole and for just those beneficiaries who are deemed high need or meet HEART payment qualification. The needs for these populations may be different. A practice can determine effective HEART payment use based on social needs screening data, combined with care team clinical judgement and existing initiatives at the practice.

Consider also using clinical data along with social needs screening data to determine ideal payment usage. For example, if many of your HEART-payment-qualifying or other high need beneficiaries experience food insecurity and are diagnosed with diabetes, the practice could implement group diabetes care classes for these beneficiaries and give out a box of healthy food at each class with easy at-home recipes.

Finally, use qualitative data as well by having conversations with the care team on what they see as the highest priority social needs to tackle, based on their everyday experience with patients.

Implementing a Plan for Continued Assessment

Every quarter, attributed HEART beneficiaries or high need beneficiaries may change. A plan should be created to reassess and track the largest social needs of a practice's patient population. Continued assessment and monitoring will inform the practice on where to focus social needs prioritization efforts.

Implementation of this plan should consider two key factors: who and when. More specifically, practices should determine which individual or group of individuals at the practice are dedicated to reassessing and tracking the social needs of the practice's patient population as well as decide on a recurring time at the beginning of each quarter to conduct this assessment activity.

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[8] Sandhu S, Xu J, Eisenson H,, Bettger JP. Workforce Models to Screen for and Address Patients' Unmet Social Needs in the Clinic Setting: A Scoping Review. Journals of Primary Care & Community Health. 2021;12:1 -12. https://doi.org/10.1177/21501327211021021

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Approaches to Use of HEART Payments

There is flexibility regarding how practices choose to use the HEART payments, but practices should ensure these payments directly support efforts to address the health and health-related social needs of beneficiaries identified as HEART-eligible or high need. MDPCP-AHEAD practices and CTOs should tailor interventions to practice settings and needs, and your HEART-eligible or high need beneficiaries.

Link Beneficiaries to Existing Services and Benefits

When implementing new programs and structures using HEART payments, practices are encouraged to link beneficiaries with existing services and benefits whenever possible, so that the funds are not used to duplicate programs and services that are already available.

Care Management Example: Daisy

> Daisy is a high need beneficiary. In Daisy's last meeting with her Care Manager, her Care Manager mentioned that Daisy has been unreachable over the phone for recent check-ins. Daisy let her Care Manager know that she often cannot pay for phone service for a full month.
>
> Daisy's practice uses the HEART payment to help Daisy enroll in the government sponsored Lifeline Program to get phone service. This HEART payment usage meets Daisy's need while taking advantage of an already existing program, rather than creating a duplicative program.

Access and Continuity Example: Freddy

> Freddy is a HEART beneficiary. In his last social needs screen, he indicated that he is sometimes worried that his food would run out before he had money to buy more.
>
> In addition to connecting Freddy to an existing local food pantry, Freddy's practice also uses HEART funds to support Freddy in applying for Supplemental Nutrition Assistance Program (SNAP), so he has an ongoing source of food assistance. In the short term, Freddy's practice also provides direct food assistance with home-delivered produce through a partnership with a local farm.

Identifying Most Effective Use of Payment through Community Engagement

> Funds may also be used to determine the greatest needs that a practice's beneficiaries identify to inform a practice's priorities for the use of HEART payments.

Comprehensiveness and Coordination across Continuum of Care Example: MDPCP-AHEAD Practice

> A MDPCP-AHEAD practice determines three potential effective uses for their HEART payments and wants to pitch the three uses to their PFAC to determine which payment use will be most beneficial for their population.
>
> 1. The practice recognizes that their PFAC does not represent the

characteristics of their patient population and acknowledges that currently, their PFAC only includes patients that have free time to participate in volunteer activities.

2. The practice decides to pay PFAC participants for their time at meetings, allowing people with barriers, such as those needing to pay for care of family members during the PFAC meeting, to have a voice on the PFAC.
3. After forming a more representative PFAC, the practice receives better quality feedback on which potential HEART payment usage will best support their patient population.

Provide Services to Beneficiaries to Meet their Particular Health-Related Social Needs

HEART payments can be used to provide services to beneficiaries to address health-related social needs.

Access and Continuity Example: Carmen

Carmen is a high need beneficiary, and she has not been taking her medications regularly. At her last visit, Carmen let her provider know that she gets home late from work and does not have transportation to get to the pharmacy to pick up her medications when the pharmacy is open.

Carmen's practice uses the HEART payment to help Carmen set up mail delivery for her medications and provides public transportation and rideshare vouchers for Carmen to use to get to the pharmacy and back if needed. On top of that, Carmen's practice also helps Carmen enroll in medication discount programs.

Community Health Workers

Community Health Workers (CHWs) are healthcare team members who help bridge the gap between healthcare and communities, through experience as members of the communities which they serve, plus professional training. CHW integration and workflows are varied and customized to practice and beneficiary needs. A practice or CTO may consider employing a CHW directly or contracting with an organization that employs CHWs. Helpful resources for CHW implementation include:

- The CDC Resources for Community Health Workers; and
- MDH Community Health Worker Integration Resource Guide

Successful HEART Use Cases for MDPCP-AHEAD Practices and CTOs

The following use cases have been shared as effective uses of HEART funds in supporting HEART-qualifying or other high need beneficiaries for other MDPCP-AHEAD practices and CTOs.

Effective Practice-Level Use Cases

- Hiring, in particular: social workers, Community Health Workers, or peer support specialists to work with HEART or high need beneficiaries (see Staffing section for more information on use of HEART for staffing).
- Contracting with a community-based organization to address beneficiaries' social needs. Example effective contracts include payment on a per-referral basis or pre-payment for a particular number of referrals.
    - Examples of successful relationships with community-based organizations include partnering with:
        - a safe ride service that invoices for transportation services;
        - an organization that provides home visits to address social isolation or;
        - a food or grocery-delivery organization to address food access.
- Staff training on communication with patients on social needs, motivational interviewing, etc.

Effective Beneficiary-Level Use Cases

Note that the beneficiary-level HEART use cases below are provided for HEART- qualifying or other high need beneficiaries.

Table 2. HEART Domain and Effective Use Cases

Domain	Effective Use Cases
Food assistance services	Home-delivered meals; home-delivered groceries; connection with a local food pantry; connection with a local farm; grocery store gift cards or vouchers; assistance with enrollment into SNAP
Housing support	Home remediation services; pest eradication; ensuring adequate heating/cooling; lead inspection and abatement; assistance in accessing housing benefits
Transportation	Providing transportation to healthcare visits
Transitions of care support	Home visits post-discharge; assistance with grocery shopping or meal preparation for a certain window of time after hospital discharge
Utility support	Assistance with utility and water bill payments; assistance in enrolling and accessing utility benefits
Social isolation support	Providing home visiting services for beneficiaries with social isolation
Medication affordability services	Offering no-cost medication delivery services; assistance in accessing medication discount programs *Note: paying for medications is a PROHIBITED use case*
Financial support	Covering co-pays for medical visits for beneficiaries with financial barriers; clothing such as compression socks and diabetic shoes *Note: covering co-pays for medications is a PROHIBITED use case*
Chronic disease management education and support	Enrolling beneficiaries into classes or directly providing classes or education on topics such as chronic disease self-management, falls prevention, and senior fitness programs; providing care kits with supplies for patients with a particular chronic disease

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Tips from Fellow MDPCP-AHEAD Practices and CTOs

See the below tips that MDPCP-AHEAD practices and CTOs have shared about developing their HEART payment programs:

- **Where to start? Screen and use data!** If a practice is unsure of where to start, using data is often a good starting point. Screening your practice's HEART and high need beneficiaries for social needs and compiling that data practice-wide will show the practice which social needs are most common among its beneficiary population. Then the practice can strategize on the best way to address the most prevalent needs in the population. Other practices have found that the most prevalent needs were not necessarily what they were expecting.
- **Use existing resources and consider expanding existing programs.** The intention of HEART is not that every practice independently creates a food pantry. Rather, understand and leverage existing community-based organizations, state, and federal programs. In addition, if a CTO or practice already has successful programs or initiatives to address medical or social needs, they do not necessarily need to create new programs with HEART. Consider expanding the existing programs to HEART or high need beneficiaries, or offering additional services to these beneficiaries.
- **Designate a HEART lead or team and ensure all staff at the practice understands HEART.** Having a lead for your practice's HEART program can be useful to drive the HEART program forward. In addition, educating all practice staff on HEART can have many benefits! Say a beneficiary is offered services through HEART and they ask questions to the front desk staff - the front desk staff could provide answers or share how the beneficiary can get more information. Or, if all providers in the practice know about HEART they can share information with the appropriate beneficiaries during visits. Not all staff members need to know every detail, but the practice can use the HEART Payment Primer to educate staff on HEART at a high-level.
- **Enroll HEART and high need beneficiaries in care management.** HEART or high need beneficiaries with ongoing needs will benefit from a longitudinal relationship with a care manager, who can assess the impact of provided resources and interventions, and continually assess needs and opportunities for HEART.
- **HEART can often be used to cover an immediate need, while developing a long- term, sustainable solution.** For example, providing food or grocery vouchers to a beneficiary while helping them apply for SNAP; or helping with a beneficiary's utility payments while helping them enroll in Office of Home Energy Program benefits.
- **Developing the infrastructure for a practice's HEART program takes time, in particular developing partnerships with community-based organizations.** Know that this work takes time to set up and that is okay! Other MDPCP-AHEAD practices and CTOs have done this work and can be a good resource. If your practice feels stuck or behind, you can always reach out to your Practice Coach.

- **Flagging HEART or high need beneficiaries in the practice EHR can be useful.** If the practice has an EHR that enables it to denote a flag for HEART or high need beneficiaries, this can enable providers in the room with a beneficiary to know the person is a high need beneficiary and offer services as needed. Note that because HEART attribution changes over time, if a practice pursues this route they will need to create a process with their IT staff to update the HEART flag.
- **Continually assess the beneficiary-specific impact of resources provided through HEART.** Providing a resource or intervention is not the end of the road, and it is important to also follow up with beneficiaries and assess the impact of those resources and their continued needs. Enrolling beneficiaries in care management is a great way to facilitate this follow-up, through the use of a care plan.

Consider the Total Payment Size in Determining Use of Funds

For practices with fewer beneficiaries eligible for HEART funds, it will be important to effectively maximize the funds received. For practices receiving fewer total HEART payments, prioritizing the identification of beneficiaries' social needs and linking beneficiaries to existing services to address those needs, may allow practices to more effectively meet the needs of a greater number of beneficiaries.

Practices with more beneficiaries eligible for HEART payments will have greater flexibility on their use of available funds and may have more opportunities to provide a mix of referred and direct services to their beneficiaries. It is also important to note that practices have the flexibility to change how they use their HEART payments at any point, as long as changes to the use of HEART payments are intended to holistically improve health for a practice's eligible beneficiaries.

Share Successes with Other MDPCP-AHEAD Practices!

As your practice moves forward and uses the HEART payments, share the strategies, structures, and programs that successfully address beneficiaries' social needs. Practices are also encouraged to share challenges encountered and lessons learned to create opportunities for discussion and collaboration with other practices.

Practices can always share with other practices and CTOs on Connect! In addition, the Office of Advanced Primary Care holds quarterly HEART Payment User Groups. Reach out to your Practice Coach if you would like to highlight the practice's success on a webinar.

Frameworks for Developing and Implementing Interventions

Many approaches and frameworks exist to guide healthcare entities in addressing social needs and can guide a practice or CTO as they consider how to spend HEART payments.
Such resources include:

- The National Academies of Science, Engineering, and Medicine's 2019 report Integrating Social Care into the Delivery of Health Care; and

- The Patient-Centered Outcomes Research Institute's Evidence Map of social needs interventions.

Guidance on Tracking and Reporting Usage of HEART Payment

Financial Reporting

Participants must record and track HEART payment expenditures separately from all other practice and MDPCP-AHEAD revenues per Payment Policies requirements in the MDPCP-AHEAD Participation Agreements.

Participants are required to report on use of HEART payments as part of annual Financial Reporting in the MDPCP Portal. Financial reporting for HEART funds is similar to reporting on use of CMF in terms of structure and level of detail: HEART expenditures are reported across a number of categories but reported expenditures do not need to be tied to specific beneficiaries for purposes of annual financial reporting in the MDPCP Portal. However, practices should maintain detailed records of beneficiary- and practice-level spending for internal clinical purposes (such as tracking beneficiary outcomes and success of interventions) and audits.

Participants should track total HEART payment funds spent by service and on staffing for HEART. In tracking, participants should delineate between payments spent at the beneficiary level, payments spent at the broader practice level, and funds spent on staffing for HEART, without linking dollar amounts to specific beneficiaries for purposes of reporting. In other words, if a practice receives $1,100 in HEART payments, the practice should be able to delineate that, for example, $600 went to beneficiary-level interventions (and what services those were; spending per service), and $500 that went to practice-level HEART services (and what those services were; spending per service), but payments do not need to be tied to specific beneficiaries in the financial reporting. However, participants should create and maintain records that substantiate financial reporting, as with all CMF payments, in case of selection for audit. In other words, if asked to verify spending on a small sample of HEART or high need beneficiaries or on practice-level investments, practices must be prepared to share with auditors the internal records linking the interventions/spending to a sample of specific beneficiaries or practice-level services.

Questions in MDPCP-AHEAD Annual Reporting

As part of annual reporting, participants will be required to respond to multiple choice questions that aim to gather insight into whether practices identified priorities for utilizing HEART payments, how those priorities were chosen, any barriers to selecting priorities, and whether practices began implementing services using HEART payments.

CTOs will be asked to report on whether and how they supported partner practices in HEART payment-related services.

MDPCP
MARYLAND PRIMARY CARE PROGRAM

HEART Payment FAQs

Q1: How will an individual practice know which beneficiaries qualify for HEART payments?

> **A1:** Beneficiary-level information related to HEART payments and eligibility will be provided for all attributed beneficiaries in the quarterly Beneficiary Attribution Reports available in the MDPCP-AHEAD Portal on an ongoing basis. To access this data, download the report posted on the Payment & Attribution page in the MDPCP-AHEAD Portal for the applicable quarter.
>
> The payment summary tab displays the number of attributed beneficiaries within each CDI quintile, the number of HEART-eligible beneficiaries, and total practice-level quarterly HEART payment. The Attributed Beneficiary tab includes each attributed beneficiary's HCC risk score, CDI quintiles, and HEART eligibility indicator (HEART-eligible – Yes/No).

Q2: Will CTO HEART payments have the same split as CMF payments? Will CTOs need to spend HEART payments on HEART-eligible beneficiaries as well?

> **A2:** Yes. HEART payments are part of the CMF and are subject to the CMF split selected by each practice and CTO. CTOs are expected to adhere to the same requirements as practices for appropriate use of the HEART payments.

Q3. How did you arrive at the specific CDI and HCC thresholds?

> **A3:** The HCC risk tiers are defined in the MDPCP-AHEAD Participation Agreements and are based on percentile distributions. CDI quintiles used for the HEART payment are based on Maryland's attributed Medicare population across MDPCP and Primary Care AHEAD, divided evenly into five groups.

Q4: What will practices need to report on for their use of HEART payment? Will they need to track and report every dollar linked to particular patients? What is the level of granularity for reporting?

> **A4:** Practices are required to report on certain categories of HEART spending at the practice level and beneficiary level as part of annual financial reporting. While financial reporting will not require substantiation of spending, practices should maintain accounting records to support the reporting per your MDPCP-AHEAD Participation Agreements. **CMS will request records to substantiate the reporting if a practice is selected for audit.**

Q5: How is the top quintile of CDI defined? What is the CDI score cutoff?

> **A5:** CDI quintiles for MDPCP-AHEAD will be based on the Maryland's attributed Medicare population across MDPCP and Primary Care AHEAD, divided into five groups of equal size. Therefore, there is no established CDI score that places a beneficiary in the top tier, as the quintiles may change with quarterly attribution.

Q6: How can practices/CTOs evaluate whether their use of HEART payments has been effective?

> **A6:** Regular review of HEART payment beneficiary outcomes (utilization), beneficiary feedback on services, PFAC feedback, and other meaningful information and data sources more specific to selected HEART payment interventions and services can inform whether the use of payments was effective. Practices should identify appropriate data points and establish a regular schedule for review.

Q7: Will participants need to complete financial reporting on which HEART beneficiaries received services funded with HEART payments?

> **A7:** Financial reporting on use of HEART funds will be similar to reporting on use of CMF in terms of structure and level of detail: HEART expenditures will be reported at the beneficiary and practice level (or CTO level), then broken down across a number of categories. During annual financial reporting, reported expenditures do not need to be tied to specific beneficiaries. However, practices should maintain detailed records of beneficiary- and practice-level spending for internal purposes (such as tracking beneficiary outcomes and success of interventions) and audits.

Q8: Do participants need to use exactly $110 per month (or the appropriate per member per month based on CTO split) for each HEART beneficiary or can participants distribute HEART funds as needed among the group of HEART-qualifying and high need beneficiaries?

> **A8**: Participants can distribute HEART funds as needed among the group of HEART-qualifying and high need beneficiaries. Likely there will be more than $110 per month spent on some beneficiaries and less than $110 per month spent on other beneficiaries.

Q9: Can we use HEART funds to build our HEART payment program? For example, can we use our HEART funds to pay for our staff's time in planning the HEART program, reviewing and analyzing data on social needs of HEART or high need beneficiaries, and building relationships with community organizations?

> **A9**: Yes, using HEART funds to build the infrastructure for your HEART payment program is a valid practice-level use of HEART funds.

Q10: HEART-qualifying beneficiaries are determined on a quarterly basis, and practices/CTOs receive each quarter's HEART beneficiary list at the end of the first month of the quarter (e.g. the last week of January for Q1). Can you clarify what is considered the appropriate quarter practices and CTOs can spend HEART at the beneficiary level for the list of beneficiaries?

> **A10**: Practices and CTOs should use the most recent HEART beneficiary list available when spending HEART funds at the beneficiary level. In other words, practices can use the Q1 list into the beginning of Q2 until the Q2 list comes out about a month into Q2. Practices can also use HEART funds on beneficiaries who are determined as high need, even if they are not HEART-qualifying.