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

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

MDPCP has achieved this success through four key strategies:

INCREASE IN PRIMARY HEALTH CARE INVESTMENT

See NASEM Report

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

PRIMARY HEALTH CARE DASHBOARDS

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

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

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

RISK ADJUSTMENT AND EQUITY

Equity is a major focus of MDPCP's mission. The state provides data tools and educational resources to assist practices in stratifying data to understand disparities, identify beneficiaries with the highest level of unmet needs, and refer patients for social needs. Key examples of MDPCP's health equity focus are below.

Pioneering payment stream that directs funding to target social needs: Beginning in 2022, MDPCP practices receive the Health Equity Advancement Resource and Transformation (HEART) payment to provide additional resources to support social needs of high-need patients. The payment provides $110 PBPM for Medicare beneficiaries who are considered high-risk clinically and who have high neighborhood-level socioeconomic disadvantage (measured through Area Deprivation Index). This payment directs more resources to the highest need patients, and it is pioneering as a payment to primary care based on beneficiary social risk level.

Emphasis on social needs screening and referrals: Primary care practices in the advanced MDPDP track are required to screen patients for unmet social needs and refer to community-based resources. MDPCP and CRISP are supporting this work through:

- A bidirectional referral tool within CRISP to refer to community-based resources
- Providing technical assistance on best practices for screening for social needs and incorporating screenings into EHRs and workflows

PUBLIC HEALTH INTEGRATION

Primary care plays a prominent role in addressing the COVID-19 pandemic. MDPCP, along with State public health partners, led a unified response to COVID-19 that included pandemic data, clinical guidance, and resources to strategically respond to patient needs.

MDPCP's well established communication system, direct relationship with practices, and integration with public health infrastructure served as essential building blocks in the overall success in pandemic response. With these resources, practices were able to provide vaccines, test patients, and refer for therapeutics in a coordinated, statewide approach throughout the pandemic. **As noted in a 2021 Milbank study comparing MDPCP participation status and COVID-19 outcomes, MDPCP participation was significantly associated with fewer COVID-19 cases, hospitalizations, and deaths.**

GLOSSARY

- **ADI** - Area Deprivation Index
- **CBOs** - Community-Based Organizations
- **CMMI** - Center for Medicare and Medicaid Innovation
- **CRISP** - Chesapeake Regional Information System for Our Patients
- **FFS** - Fee-for-Service
- **HCC** - Hierarchical Condition Category
- **HEART** - Health Equity Advancement Resource and Transformation
- **HIE** - Health Information Exchange
- **MDPCP** - Maryland Primary Care Program
- **PBPM** - Per Beneficiary Per Month
- **PY3** - Program Year Three