Maryland
DEPARTMENT OF HEALTH

ANNUAL REPORT 2019

MARYLAND PRIMARY CARE PROGRAM

ACKNOWLEDGEMENTS

The 2019 Maryland Primary Care Program Annual Report was written as a collaborative effort between the Program Management Office at the Maryland Department of Health and many partners, including the Maryland Primary Care Program Advisory Council. Sincere gratitude is extended to all who contributed to the Annual Report, as well as the primary care practices doing the important care transformation work for patients in Maryland.

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EXECUTIVE SUMMARY

The 2019 Maryland Primary Care Program (MDPCP) Annual Report provides data and analysis on the process and outcomes of transforming the delivery of primary healthcare through 380 primary care practices across the state of Maryland. The MDPCP was created as a major element in the Total Cost of Care contract in order to support willing and eligible primary care practices to provide better care and expanded access to a wide range of services including data driven, targeted care management, behavioral health services, and attention to the social needs of patients. Participating practices are supported jointly by the Center for Medicare and Medicaid Innovation (CMMI) MDPCP team and the Maryland Department of Health Program Management Office (PMO). Unique to the MDPCP, practices also have the opportunity to partner with Care Transformation Organizations (CTOs) to assist with staffing and technical assistance needs. The State also provides practice support through a team of dedicated practice coaches, the extensive services of the state designated Health Information Exchange (CRISP), the expert analytics from The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) and contractors supporting additional needs.

MDPCP is designed to run from 2019 through 2026 with annual open enrollments for practices during the first five program years. Practices may enter the program in the advanced (Track 2) level or the basic (Track 1) level. Practices that enter in Track 1 must meet stringent care delivery, quality, and administrative requirements and advance to Track 2 by no later than the end of their third year of program participation. Track 2 provides the practices with greater financial support and requires practices to accept a partial prepayment for basic evaluation and management services. Requiring a transition to fully advanced primary care is driven by the expectation that through this program the State will have an organized, identifiable, and fully operational advanced primary care workforce functioning independently while under the guidance of MDH and CMMI and working collaboratively with MDH and CMMI. Additional details on payments and care transformation requirements are found in the body of the Annual Report.

MEETING THE MDPCP'S THREE YEAR 1 OBJECTIVES

The report that follows provides details on the rapidity of broad based healthcare delivery transformation that occurred during the first program

year of MDPCP (Program Year 1, or PY1). Notably the initial Request for Applications had 595 applicants. Of those, 380 met the initial program requirements and ultimately participated, with the majority (90%) entering as Track 1 practices. The first quarter of PY1 was consumed with onboarding and all the usual complexities associated with the start of a large, multifaceted program jointly supported by state and federal partners. By the middle of PY1, the practices began to make substantial gains and finished the year meeting the following first year objectives of the program:

- Infrastructure Development - Building a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to controlling the growth of Maryland's Medicare part A and B costs
- Care Transformation - Improving population health through continuous, relationship-based primary care that proactively addresses both medical and behavioral health needs, as well as social determinants of health and provides continuity of care
- Quality and Utilization improvement - Establishing data tools and quality improvement processes that allow practices to monitor performance

Infrastructure Development

The first program year was one of growth, innovation, and partnership development. The first six months of the program included administrative onboarding for practices and introduction to this new program. Still, in just this first year, the MDPCP has fostered a robust statewide network of dedicated primary care practices who are eager to transform care to better serve their patients. To facilitate care transformation, the MDPCP has engaged in a number of public-private partnerships in healthcare delivery. One of the keys to MDPCP's early success has been the development of a broad set of partners. These partnership activities include the following:

- CRISP - suite of beneficiary claims reports designed for MDPCP practices
- The Hilltop Institute - development of a model for predicting avoidable hospital events
- Mosaic Group - implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to address behavioral health needs
- Electronic Medical Record (EMR) optimization vendor - assisting practices with implementation, connectivity, and interoperability
- Community-based organizations - supporting social needs through electronic referrals

Care Transformation

The primary goal of the MDPCP is the sustainable transformation of the delivery of primary care across the state to include all of the elements of advanced primary care to support the health needs of Marylanders. MDPCP practices must submit quarterly reporting on questions pertaining to meeting the program's five Care Transformation Requirements (CTRs) in order to show their progress in implementing care transformation. MDPCP practices' responses to CTR questions demonstrate that their capacity to meet the program's five CTRs improved significantly over the course of PY1. Key takeaways from practices' responses to the CTR questions include the indications that over the course of 2019:

- Patient access to practices improved, with increasing percentages of practices offering same or next-day appointments (increased from 59.6% of practices to 68.6%) and telephone advice outside of regular work hours (increased from 66.5% of practices to 78.7%)
- Practices offered patients an increasingly wide range of medical treatment settings, including telehealth (the percentage of practices offering video-based teleconferencing increased from 38.6% to 47.6%, and the percentage of practices offering medical visits over an electronic exchange increased from 47.3% to 54.3%)
- Practices' use of care management increased, with the percentage of patients under longitudinal care management growing from 7.2% in the first quarter to 10.0% in the fourth quarter
- Nearly all practices (95%) integrated behavioral health into the delivery of primary care by the end of the fourth quarter, ushering in a new era of statewide behavioral health integration

Prior to the MDPCP, one of the most important issues facing high risk and rising risk Marylanders was the paucity of care management. By the end of PY1, MDPCP practices had brought 10% of Medicare fee-for-service (FFS) beneficiaries into care management using data driven strategies for risk stratification. In recognition of a shortage of behavioral health services, MDPCP practices were required to integrate behavioral health services into each and every brick and mortar office to promote a major improvement in access to this important care. By the end of PY1, over 95% of practices had begun or completed behavioral health integration. It is notable that with support from the State's contractor, 117 of the practices fully implemented an evidence-based protocol known as Screening, Brief Intervention, and Referral to Treatment (SBIRT), creating another line of defense against the opioid

crisis. To the best of our understanding, this is the largest implementation of SBIRT in primary care in the nation. The Annual Report to follow will provide much more detail on care transformation successes and remaining needs.

Quality and Utilization Improvement

In addition to the quarterly reporting on care transformation requirements, MDPCP practices were required to submit biannual rosters for Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and annually submit quality measures. Due to the quality measure submission period overlapping with the onset of the COVID-19 pandemic, practices were encouraged to focus their attention on pandemic response in priority over quality data submission. The quality data submitted therefore represents only a partial sampling of the overall program. The results of the partial sample highlight the stronger performances of the advanced Track 2 practices in the important areas of diabetes and hypertension control.

The practices were also evaluated on the hospital and emergency department utilization of their attributed Medicare beneficiaries under a HEDIS-like framework (Healthcare Effectiveness Data and Information Set) using a synthetic comparison group composed of virtual statewide practices. Of interest, the MDPCP practices were provided both technical assistance and a specific artificial intelligence data driven tool to focus their attention on ambulatory sensitive, avoidable emergency department and hospital visits. Key takeaways from practice quality and utilization results include the following:

- **Clinical Quality (compared to national MIPS reporting)**: Practices performed well on chronic disease management quality measures: 67% surpassed the 50th percentile for controlling high blood pressure and 85% surpassed the 50th percentile for diabetes A1C control. In fact, half of all MDPCP practices scored in the 80th percentile or above for A1C control.
- **Utilization (compared to all practices with Maryland FFS beneficiaries)**: On inpatient utilization, 57% of practices performed better than the 50th percentile of benchmark Maryland FFS practices. On emergency department visits, 69% of practices performed better than the benchmark.
- **Patient Satisfaction (compared to CPC+ practices)**: On the CAHPS summary score, 37% of practices beat the 50th percentile of the benchmark practices. Note that over 50 practices were exempted from CAHPS scoring in 2019 due to surveys taking places in other CMS programs.

RECOMMENDATIONS

As we move through the second year of the MDPCP amidst a pandemic, economic hardships, and social and racial justice movements, healthcare transformation takes center stage and has brought a sharp focus on the recommendations to enhance and sustain the work that is being done within MDPCP. The recommendations fall into three broad categories:

Recommendations to improve operations

First, recommendations to improve operations focus on building on the work that has already been started to reduce administrative burden and allow practices to maximize their focus on comprehensive patient care. Changes could include reducing the number of questions asked in care transformation requirements reporting, streamlining other administrative reporting requirements, broadening the use of care management fees, and providing care transformation data feedback reports to practices.

Recommendations to improve quality and utilization measurement

The second group of recommendations are focused on continuing to align the quality, utilization and consumer satisfaction measures to align with the state's population health goals. There is opportunity for better alignment between varied programs and payers by allowing the State to drive determination of the measurement framework.

Recommendations pertaining to governance, administration, and delegation to the State

The final group of recommendations seek to develop a more collaborative governance structure between MDH and CMMI in order to coordinate effective policy decisions. Specifically, MDH recommends establishing a joint and equitable structure that facilitates mutually agreeable decisions.

The Maryland Department of Health offers the following detailed report for your consideration and understanding of the work that has been done and work that remains to be done in this important program.

PROMULGATION STATEMENT

The Maryland Total Cost of Care Model contract indicates that the State may submit a yearly Annual Report on the MDPCP to CMS. It further indicates that within the Annual Report the State may:

1. Suggest ways in which CMS can improve operations under the MDPCP, such as modifications to participating practices' care transformation requirements.
2. Suggest utilization and quality measures for purposes of the 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 (CRP), and the Outcomes-Based Credits.
3. Make recommendations to CMS on components of the 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 above three stated areas.

INTRODUCTION TO MDPCP

To create statewide healthcare transformation and improve health outcomes while reducing avoidable hospital and emergency department utilization, the Maryland Department of Health (MDH), in collaboration with the Center for Medicare and Medicaid Innovation (CMMI), launched the Maryland Primary Care Program (MDPCP) in 2019. The statewide program, designed to span at least eight years, aims to make strategic investments in primary care practices and build a resilient statewide infrastructure to prevent and manage chronic disease. Specific objectives in Program Year 1 (PY1) of the MDPCP program include:

- **Infrastructure Development** - Building a strong, effective primary care delivery system to identify and respond to medical, behavioral, and social needs while contributing to controlling the growth of Maryland's Medicare part A and B costs
- **Care Transformation** - Improving population health through continuous, relationship-based primary care that proactively addresses both the medical and social determinants of health and provides continuity of care
- **Quality and Utilization improvement** - Establishing data tools and quality improvement processes that allow practices to monitor performance

The report to follow provides details on the measurable and impactful elements of primary care transformation achieved in 2019, the first program year of MDPCP.

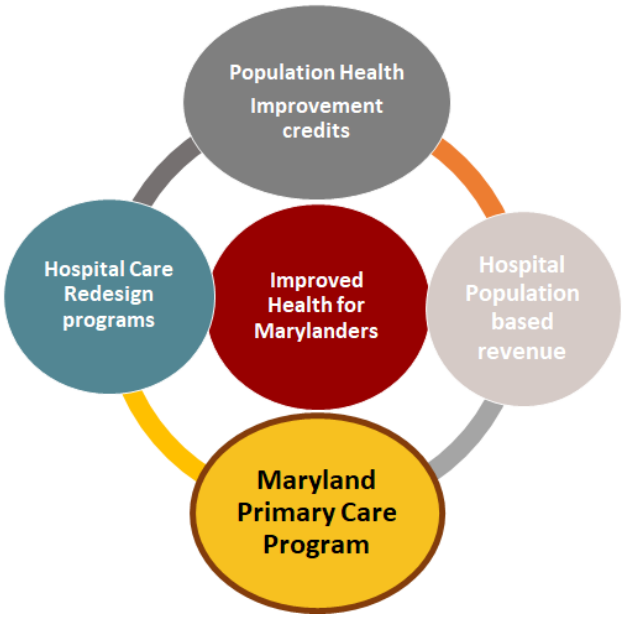
ALIGNMENT WITH THE MARYLAND TOTAL COST OF CARE MODEL

The MDPCP is part of a broader Maryland initiative to transform care and reduce costs throughout the health system. In 2014 under the All Payer Model, Maryland began this initiative at the hospital level, moving Maryland hospitals to Global Budget Revenues (GBR) and addressing key quality and utilization measures. In 2019, the State further committed to transforming its health care system beyond hospital walls through the joint State-CMMI establishment of the Maryland Total Cost of Care Model, which sets a target for total costs of care reductions for Medicare in the state. The contract specifically calls for health care delivery transformation: "Under this Model, CMS and the State will test whether **State-wide health care delivery transformation**, in conjunction with Population-Based Payments, improves population health and care

outcomes for individuals, while controlling the growth of Medicare Total Cost of Care."[1]

Moreover, the Maryland Model, as it's known, calls for improved population health outcomes supported by broad, innovative care redesign between hospital and non-hospital partners across the state. The model includes four aligned programs: the Hospital Payment Program, in which all hospitals operate within global population based budgets (PBR); the Care Redesign Program, which enables hospitals to make incentive payments to non-hospital health care providers; Population Health Improvement Outcomes-Based Credits, where the State receives credits for positive outcomes on investment in specified population health initiatives; and the MDPCP within MDH.

Figure 1. Diagram of the four programs in Maryland's Total Cost of Care model



In the Maryland Model, the State and its stakeholders are addressing the long term trend of high, rising, and unsustainable health care costs. The highest costs for health care services are predominantly found in the management of late-stage illness and hospital care. Preventive, relationship-based primary care has been shown to be effective in improving outcomes and reducing costs within these populations.[2] The MDPCP aims to contribute to Maryland's goal of controlling total costs while improving health outcomes through the implementation of advanced primary care throughout the state.

[1] Maryland Total Cost of Care Model State Agreement. https://hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf

[2] Altschuler J, Margolius D, Bodenheimer T, Grumbach K. Estimating a reasonable patient panel size for primary care physicians with team-based task delegation. Ann Fam Med. 2012;10(5):396-400. doi:10.1370/afm.1400.

MDPCP STRUCTURE AND REQUIREMENTS

The overarching themes of the MDPCP are to transform the delivery of primary care broadly across the State within the framework of Advanced Primary Care, to improve the health of the population served, and to provide the right care at the right time in the most appropriate setting. These themes align directly with the aforementioned PY1 objectives. As part of their participation in the program, primary care practices are required to provide comprehensive primary care services. The MDPCP's Care Transformation Requirements (CTRs) for practices describe the five key functions of advanced primary care:

1. Care Management
2. Access and Continuity
3. Comprehensiveness and Coordination
4. Beneficiary and Caregiver Experience, and
5. Planned Care for Health Outcomes

Within these five key functions, practices are required to provide specific services, including:

> **Advanced Primary Care services provided by MDPCP practices**: expanding patients' access to care; empaneling patients to providers; implementing data-driven, risk-stratified care management; providing transitional care management; coordinating care with specialists; hosting "Patient Family Advisory Councils"; integrating behavioral health; screening for social needs; and using health information technology tools to continuously improve quality.

Quality of care for the program is measured by practice performance on electronic Clinical Quality Measures (eCQMs).[3] In the first year of the program, practices were required to track and report on three eCQMs:

1. Diabetes HbA1c Control (NQF 0059),
2. Hypertension Control (NQF 0018), and
3. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF 0004).

[3]As defined by CMS, eCQMs "are tools that help measure and track the quality of health care services that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) provide, as generated by a provider's electronic health record (EHR)." https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures#:~:text=Electronic%20clinical%20quality%20measures%20(eCQMs,electronic%20health%20record%20(EHR).

In addition to measuring quality of care, patient satisfaction is measured by each practice's performance on the CAHPS Clinician and Group survey, which is administered by CMS to a sample of the practices' patient population. Additionally, practices are also evaluated on their performance on Healthcare Effectiveness Data and Information Set (HEDIS) measures for reducing inpatient hospital admissions and ED utilization.

MDPCP has two tracks. Track 1 is designed as a temporary track for practices that have not yet achieved all of the requirements of advanced primary care. Track 2 is reserved for practices that have met all of the requirements of advanced primary care and are willing to accept a modified payment structure. Track 1 practices report on their progress toward meeting the five CTRs to CMS on a regular basis, and are required to achieve Track 2 status by no later than the end of the third year of participation. Requiring a transition to fully advanced primary care is driven by the expectation that through this program the State will have an organized, identifiable, and fully operational advanced primary care workforce functioning independently while under the guidance and working collaboratively with MDH and CMMI.

Payment Redesign

The transformation to advanced primary care is supported by enhanced payments to participating practices. In exchange for implementing changes and services, participating practices receive prospective, non-visit-based payments per attributed Medicare patient known as Care Management Fees (CMF). Primary care practices are paid a CMF on a per beneficiary per month basis, risk stratified based on acuity using the CMS Hierarchical Condition Category (HCC) risk adjustment model. CMFs are paid prospectively (on a quarterly basis) to MDPCP practices and Care Transformation Organizations (CTOs). CMFs may only be used to directly meet the CTRs. Practices may optionally decide to partner with a CTO. CTOs are organizations that furnish an array of care management and coordination services and staffing at the request of the MDPCP practice, in order to help them meet program requirements. Practices that decide to partner with a CTO will either share 30% or 50% of their CMF with their CTO partner depending on the level of support the CTO provides.

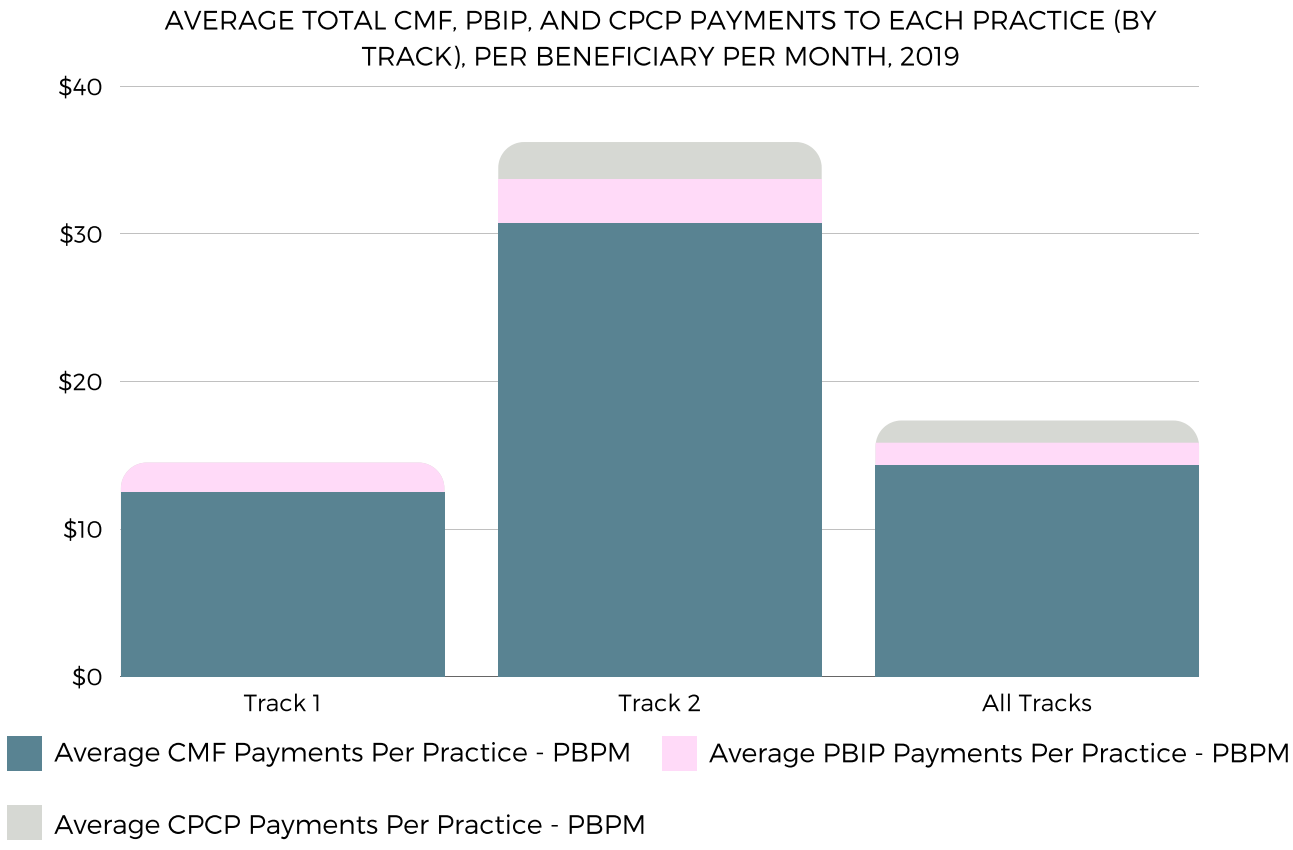
To encourage and reward accountability for beneficiary experience, clinical quality, and utilization that drive total cost of care, the MDPCP payments includes a prepaid Performance-Based Incentive Payment (PBIP). The annual PBIP is paid prospectively, but a Participant Practice may retain the PBIP (in

whole or in part) only if it meets certain annual performance thresholds. The PBIP includes two distinct components: incentives for performance on clinical quality and patient experience measures, as well as hospital and ED utilization measures.

For the advanced Track 2 practices, MDPCP payments also include a Comprehensive Primary Care Payment (CPCP). The CPCP is a partly-capitated payment in which a portion is paid quarterly upfront, and the remainder is paid when services are billed.

MDPCP payments are critical to enhancing practices' capacity to implement care transformation. In 2019, as Figure 2 displays, average per beneficiary per month CMF payments to Track 1 practices totaled $12.47, and $30.69 for Track 2 practices. Furthermore, the chart displays that the average per beneficiary per month CMF payments to all practices was $14.32. Note that these amounts do not include any CMF payments shared with CTOs. In 2019, the average combined total of the CMF and PBIP payments CTOs received monthly for each of the beneficiaries attributed to their partner practices was $11.96.

Figure 2. Average per beneficiary per month payments to MDPCP practices, by payment type



Multipayer design

The MDPCP is a multipayer program designed to include commercial payers and Medicaid on a voluntary basis. In order to participate as an "Aligned Payer", Payers are required to submit an application to CMMI and are accepted based on their willingness to align with the program on non-visit-based payments, provider financial risk strategies, and quality measurement. This multipayer alignment of payment approaches and reporting requirements is intended to reduce the administrative burden for practices. MDPCP began operations with Medicare FFS in 2019, and has since added CareFirst as an Aligned Payer in 2020. It is important to note that the care transformation that occurs within MDPCP benefits all patients independent of payer type or self-pay status.

ROLES AND OPERATIONS

Program Management Office (PMO)

MDH facilitates MDPCP operations and practice transformation through its Program Management Office (PMO) comprising both office-based and field staff. MDPCP leadership, operations, and staff are all housed operationally within the PMO, and its physician executive director reports directly to the Secretary of Health. This unique reporting arrangement allows primary care practices to identify a single source of leadership within the State that offers both clinical guidance and the authority of state government.

To provide hands-on support to practice leaders and staff, the PMO includes practice coaches who work directly and daily with practices. At the same time, the PMO offers regular webinars focused on areas of implementation such as behavioral health and other topics. Additionally, contractors offer staff training programs, webinars, and provider leadership academies in locations across the State.

Center for Medicare and Medicaid Innovation (CMMI)

The PMO works in conjunction with federal partners at CMMI to manage the MDPCP. CMMI focuses on regulatory compliance, and enforces program requirements via legal Participation Agreements. Technical processes related to program payments, attribution of beneficiaries, and collection of CTR reporting via the CMS Enterprise Portal are also led by CMMI and their contractors. A Learning System, encompassing an online portal for participant collaboration (Connect), webinars, program guides, in-person Learning Sessions and other learning events were also primarily managed by CMMI and their contractor, The Lewin Group, in the first year of the MDPCP.

Care Transformation Organizations (CTOs)

Practices have the option to receive operational and administrative support from Care Transformation Organizations (CTOs). An extension of the practices, CTOs are private entities that hire and manage the interdisciplinary care management teams that provide care coordination services at the direction of the participating practices. In particular, the CTOs may use their economies of scale to obtain staff and support that may be difficult for small and medium size practices to obtain. Practices that choose to partner with a CTO can therefore include care team members who they would otherwise have difficulty acquiring on their own such as pharmacists, licensed clinical social workers, community health workers, and care management RNs. CTOs also offer support for care transitions, standardized beneficiary screening, data tools and informatics, and practice transformation. CTOs are funded by a share of the practices' care management fees; they also receive performance bonuses based on the aggregate performance of the practices they serve.

Advisory Council

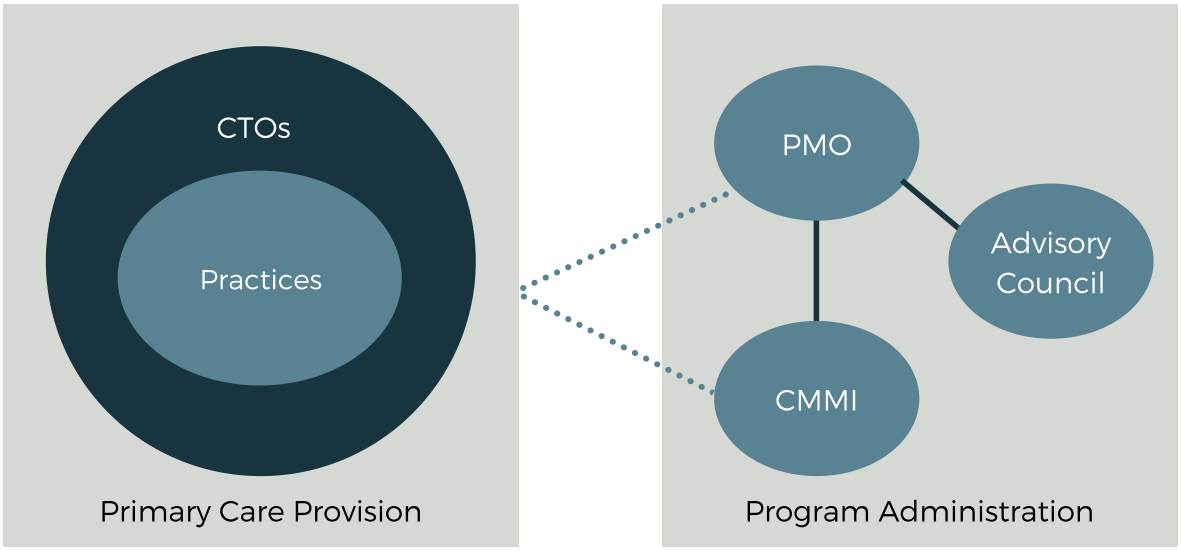
The purpose of the Advisory Council is to provide input to the Secretary of Health and the PMO on the operations of the MDPCP from a diverse group of stakeholders. The Advisory Council is convened and staffed by the Maryland Health Care Commission (MHCC), in collaboration with the PMO. Participants include representatives from practices actively participating in the program, CTOs, health systems, expertise in advanced primary care and other value-based payment models, private payers, the Maryland Hospital Association, the MedChi, The Maryland State Medical Society, the Health Services Cost Review Commission (HSCRC) and others.

A summary of the roles and responsibilities of each party involved in MDPCP is included in Table 1.

Table 1. Summary of roles and responsibilities of the main parties involved in operating the MDPCP for 2019

Group	Roles and Responsibilities
PMO	• Provide **program leadership** through designated Physician Executive Director and the PMO leadership team • Provide **technical assistance and guidance** to practice on care transformation through individual practice coaches • Provide and continually improve suite of data and analytics to practices • Work with CMMI to update **program policy and strategic planning** for future program enhancements • Organize and conduct **webinar trainings** for practices • Jointly manage practice **quality reporting processes** with CRISP (The Chesapeake Regional Information System for our Patients) • Manage **day-to-day operations** and implementation assistance with practices • Foster and maintain **external relationships with public and private stakeholders** • Publish meaningful results on MDPCP innovative activities
CMMI	• Provide **program guidance** through a dedicated team • Manage **regulatory compliance** and enforcement of program requirements • Determine and **operate technical processes** related to program payments, attribution of beneficiaries, and collection of CTR reporting • Manage the Learning System including Connect, an online learning portal for practices to collaborate and receive program updates • Coordinate with the PMO and State on **policy and strategic planning** • **Issue program documents** including the RFA, Participation Agreement, and Payment Methodologies • Manage **application processes** and determinations • Oversee the Total Cost of Care Model and its components
CTOs	• Furnish **care coordination services and staffing** • Support care transitions • Provide **data and analytics support** to practices • Assist with **practice transformation**
Advisory Council	• Provide **high-level input on MDPCP future directions**, operations, and policy • Make recommendations directly to the PMO and MDH Secretary

Figure 3. Diagram of the different parties involved in the MDPCP

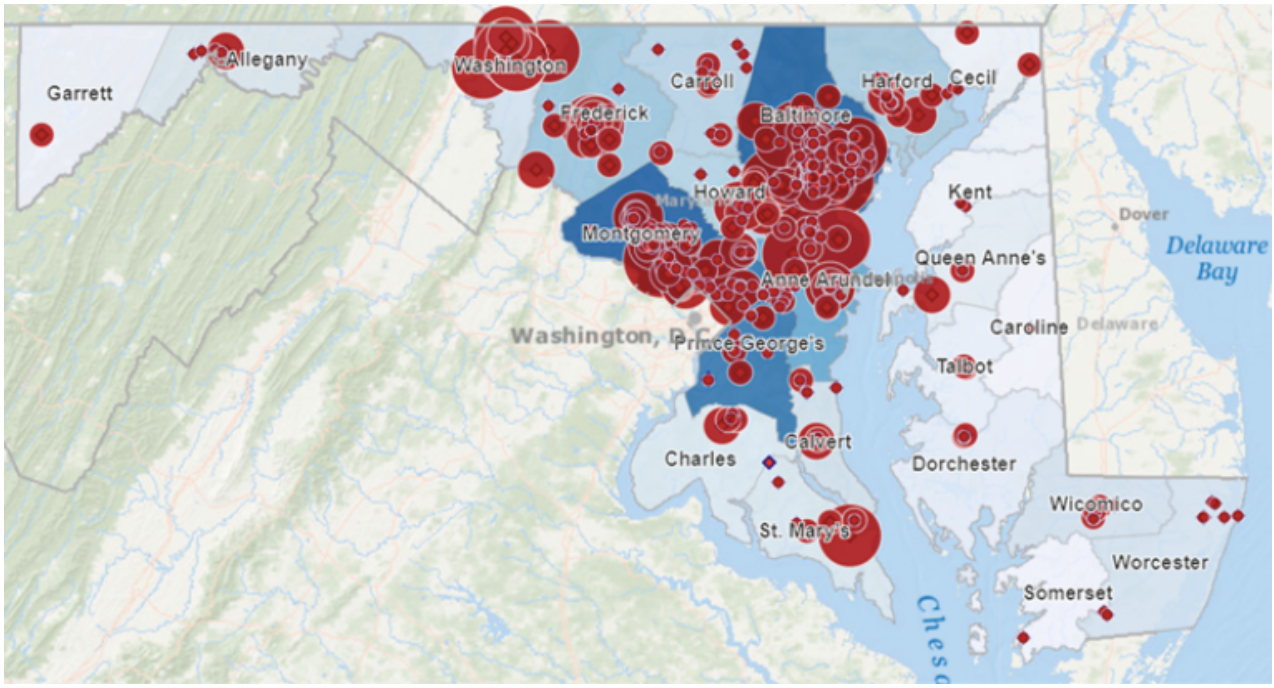


MDPCP PARTICIPANT CHARACTERISTICS

PRACTICE CHARACTERISTICS

In PY1, 380 diverse practices participated in the MDPCP across all counties in Maryland out of an estimated 780 eligible practices.[4] The majority of these (90%) entered the program as Track 1, and most chose to leverage a CTO to help them meet the program transformation requirements. Over 1,500 providers participated in the program, including not only Physicians (MD or DO), but also Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists. The map in Figure 4 displays the locations of MDPCP practices.

Figure 4. Map of practices participating in the MDPCP in 2019. Practice size based on the number of participating providers is represented by the size of the dots.



[4] 380 unique practices were participating in MDPCP as of January 1, 2019. By the end of the calendar year, 6 practices had either withdrawn from the program or merged with another location, for a total of 374. 780 eligible practice calculation is based on internal analysis and may not be exact.

Figure 5. Percentage of practices in each practice track, and percentage partnering with a CTO.

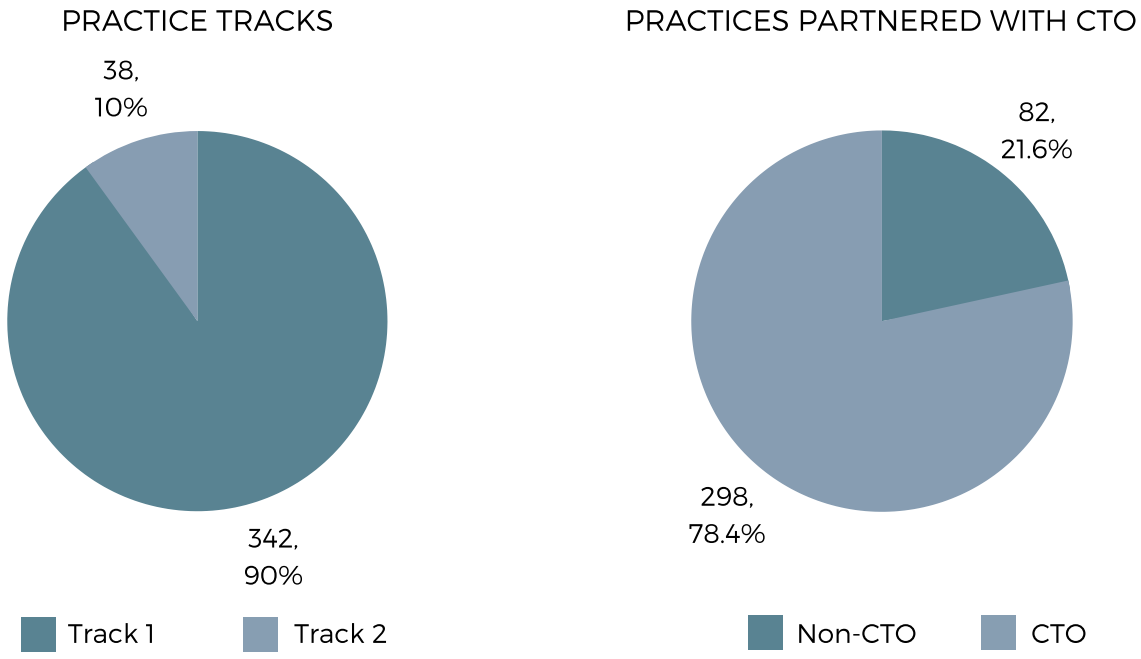


Table 2. Select MDPCP Practice Staff Information for 2019

Category	Sub-category	Provider/Staff #
Provider Types	Clinical Nurse Specialist or Nurse Practitioner	344
	Physician (MD or DO)	1,222
	Physician Assistant	150
	Total # of Providers	*1,716*
Staff Types	Behavioral Health/Social Worker	27
	Care Manager/Care Coordinator	150
	Consultant	135
	Dietitian/Nutritionist	7
	Health Educator	1
	Laboratory/Radiology Technician	12
	Licensed Practical Nurse (LPN)	41
	Medical Assistant	1,139
	Other Health Staff	401
	Pharmacist/Pharmacy Technician	7
	Physical/Respiratory Therapist	2

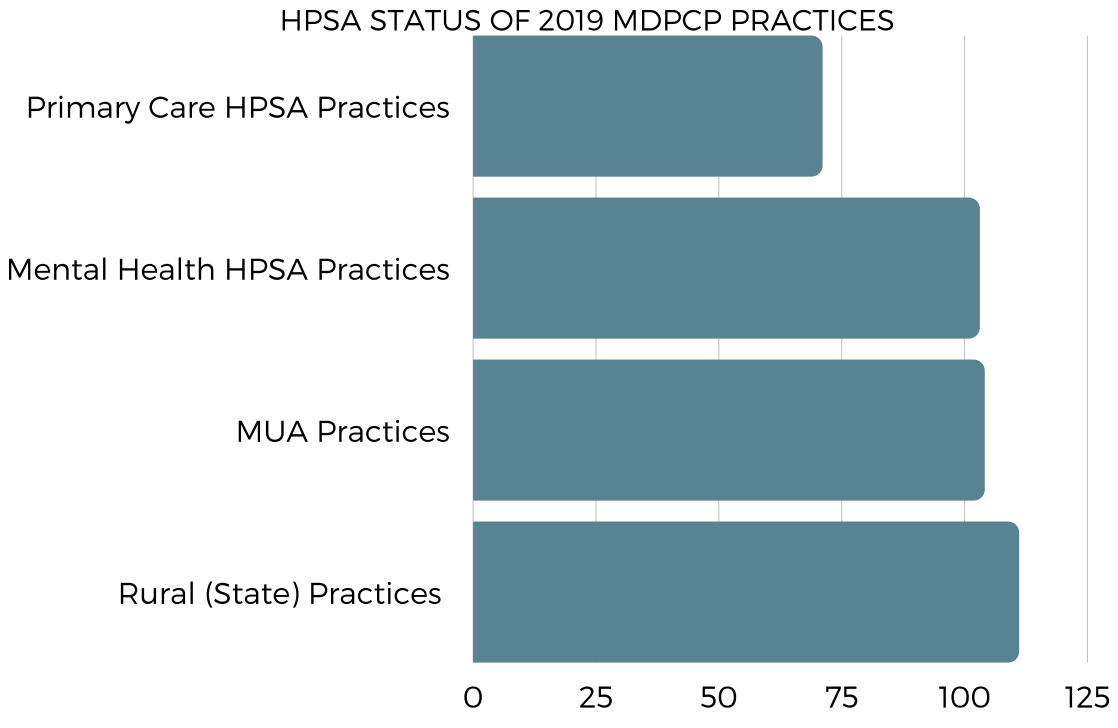
Practice Supervisor/Practice Manager	270
Quality Improvement Specialist	18
Receptionist/Appointing	1037
Registered Nurse (RN)	129
Total # of Staff	*3,376*

MDPCP practices serve a diverse population around the state. Many 2019 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 6 shows, 71 2019 MDPCP practices were located in primary care HPSAs and 103 were located in mental health HPSAs.

HRSA uses another label, "Medically Underserved Areas," (MUAs) to designate geographic locales where it assesses there is a shortage of primary care health services. Figure 6 depicts that in 2019 104 MDPCP practices were located in MUAs.

Furthermore, the Maryland Department of Health designates specific counties as "rural." As Figure 6 shows, there were 111 2019 MDPCP practices that were located in counties the Maryland Department of Health labels as "rural."

Figure 6. Count of MDPCP Practices in Various HPSA Categories



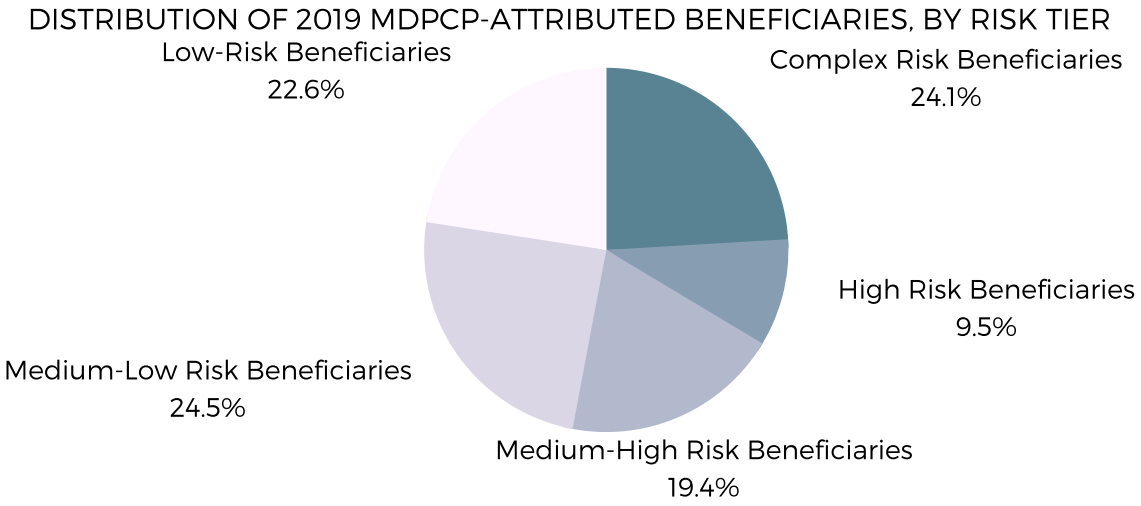
PATIENT CHARACTERISTICS

As of the program start date, over 219,000 Medicare FFS beneficiaries were officially attributed to MDPCP practices. However, the impact on the Maryland population is much broader, with an estimated 2-3 million total patients with other insurance types benefitting from the care being provided by these practices.[5] The tables and graphics that follow describe statistics on the MDPCP FFS beneficiary population.

Table 3. Select MDPCP Patient Characteristics

Category	Sub-category	Statistic
Patient Group	FFS enrollees	219,639
	Other patients	2,000,000 - 3,000,000[5]
Dual Eligible Status	Non-Dual Eligibles	86.04%
	Dual Eligibles	13.96%

Figure 7. Distribution of MDPCP Attributed Beneficiaries by HCC Risk Tier



[5] The Annals of Family Medicine, 2012, http://www.annfammed.org/content/10/5/396.full

Figure 8. Distribution of MDPCP Attributed Beneficiaries by Age Group

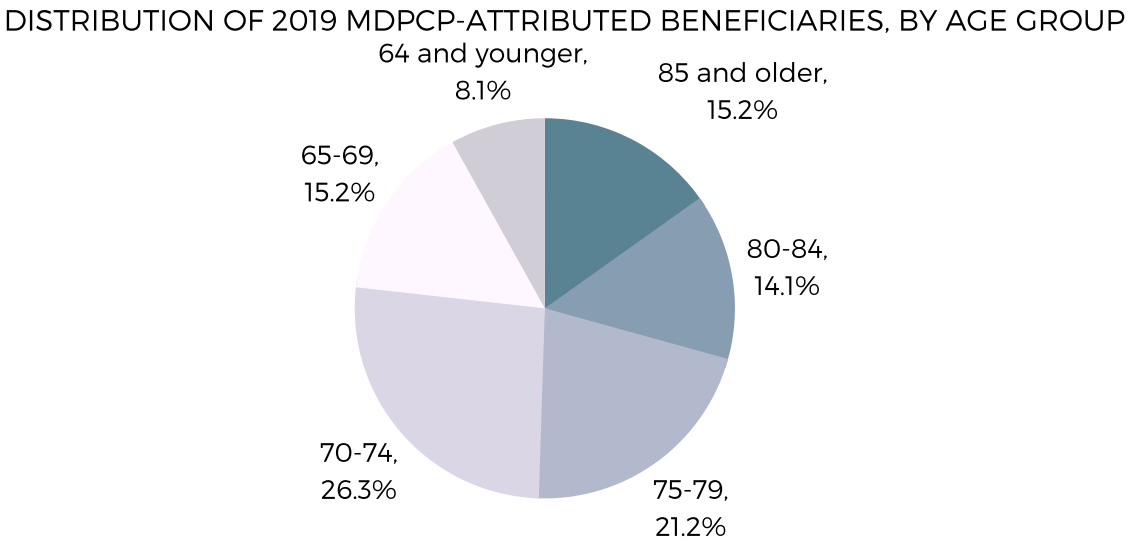
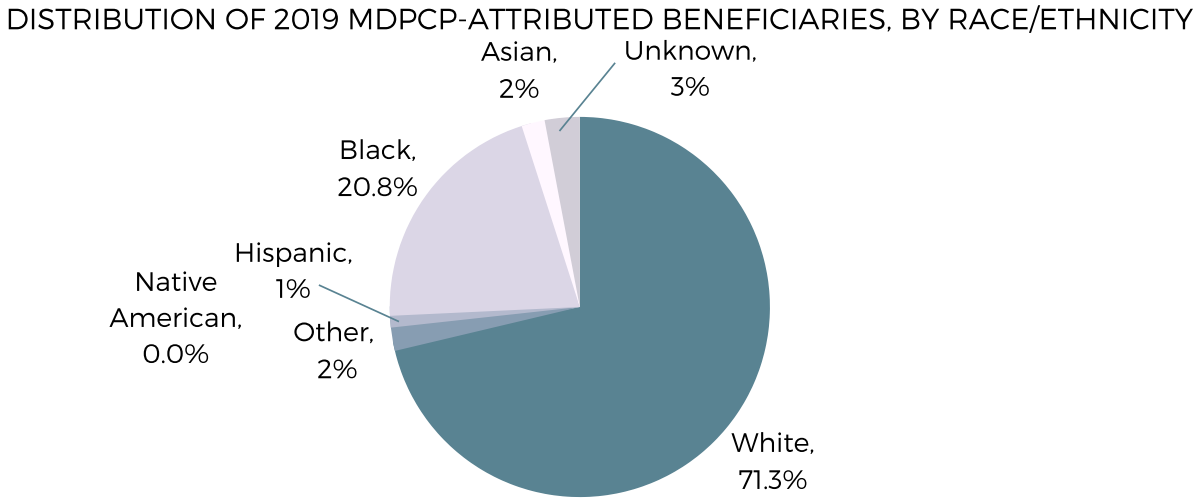


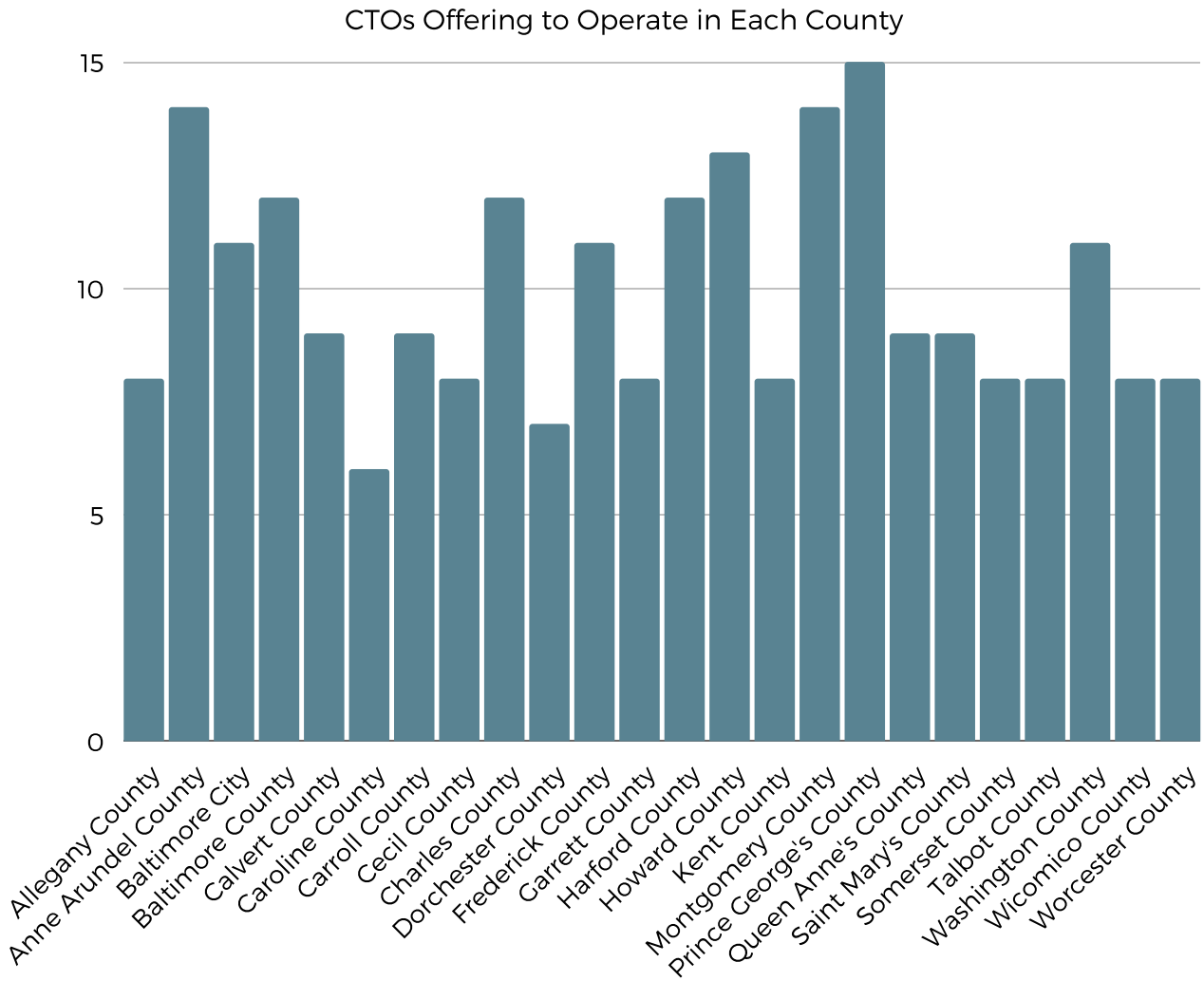
Figure 9. Distribution of MDPCP Attributed Beneficiaries by Race/Ethnicity



CTO CHARACTERISTICS

In the first year of the program, 21 organizations served as CTOs covering all 24 counties in Maryland. Two-thirds of participating CTOs were affiliated with a Maryland hospital or health system, whereas the remaining CTOs were independent entities. Of the 380 primary care practices that were selected to participate in the MDPCP in its first year, 298 chose to partner with a CTO (78%). Participating CTOs were paired with multiple primary care practices, ranging from only one paired practice, up to as many as 47 practices. One-third of 2019 CTOs partnered with five or fewer practices, and in 2019 CTOs partnered with a median of 12 practices.

Figure 10. Number of CTOs operating in each county



CTOs employed a wide range of staff types in PY1, including behavioral health professionals, care managers, community health workers, data analysts, licensed social workers, pharmacists, practice transformation consultants, and others. A complete list is provided in Table 1 in the Appendix.

Table 4. Select MDPCP CTO characteristics

Category	Sub-category	Statistic
# of CTOs	# of CTOs Owned By a Hospital	14
	# of CTOs Not Owned By a Hospital	7
Counties With CTO Presence	N/A	24 (100%)

OBJECTIVE 1: BUILDING PRIMARY CARE INFRASTRUCTURE

The process that led to the establishment of the MDPCP began in 2016 and progressed through a series of meetings with health care stakeholders, the MDH, HSCRC and CMMI, eventually resulting in the launch of the program in 2019. The first program year was one of growth, innovation, and partnership development. The first six months of the program included administrative onboarding for practices and introduction to this new program. Still, in just this first year, the MDPCP has fostered a robust statewide network of dedicated primary care practices who are eager to transform care to better serve their patients. Practices have successfully engaged in care transformation activities, such as implementing integrated behavioral health, coordinating transitions of care, and implementing data driven care management services. Best practices are being shared across the program by practices of all sizes and stripes.

To facilitate care transformation, the MDPCP has engaged in a number of **public-private partnerships** in healthcare delivery. One of the keys to MDPCP's success has been the development of a broad set of partners. These partnership activities include the following:

- **CRISP** - suite of beneficiary claims reports designed for MDPCP practices
- **The Hilltop Institute** - development of a model for predicting avoidable hospital events
- **Mosaic Group** - implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to address behavioral health needs
- **Electronic Medical Record (EMR) optimization vendor** - assisting practices with implementation, connectivity, and interoperability
- **Community-based organizations** - supporting social needs through electronic referrals

This section of the report focuses on the key broad-scale activities initiated by the State and MDPCP practices in 2019, many with the aforementioned partners, that began the shift to advanced primary care.

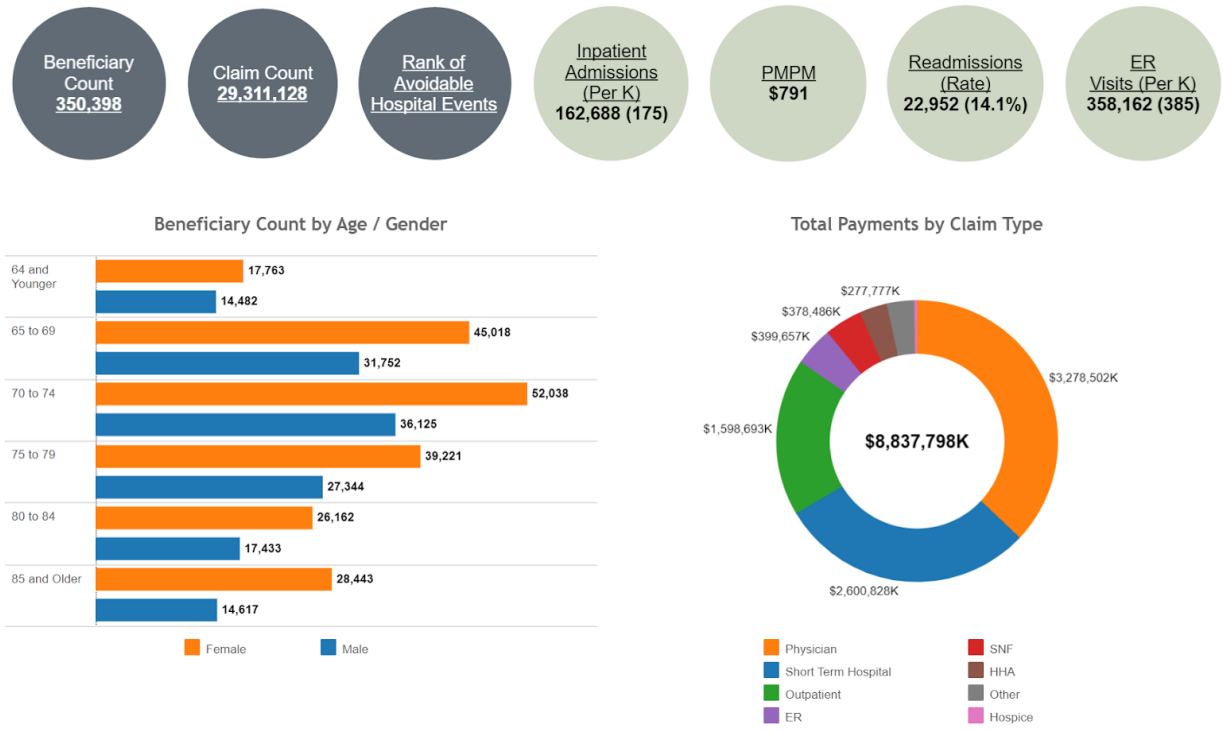
UNIFIED REPORTING SUITE THROUGH CRISP

One of MDPCP's key partners in providing data-driven care has been the state-designated health information exchange known as the Chesapeake Regional Information System for Our Patients (CRISP). CRISP provides all practices with a suite of health information technology tools, including a nearly real-time event notification system, clinical query, care alerts and patient summaries, and prescription drug monitoring program.

Practices and CTOs can also use a suite of tools that includes a quality data upload portal, utilization and cost data visualizations, predictive analytics, and a bidirectional community-based organization electronic referral system.

Claims data are refreshed monthly, allowing practices to track their hospital and emergency department utilization compared to peers and the state overall, as well as identify high-cost patients and high-volume, high-cost specialists. This data allows practices to understand the relative costs between specialists so that providers may engage specialists in conversations about coordinating care.

Figure 11. Example of CRISP Population Summary report including multiple drill-down options



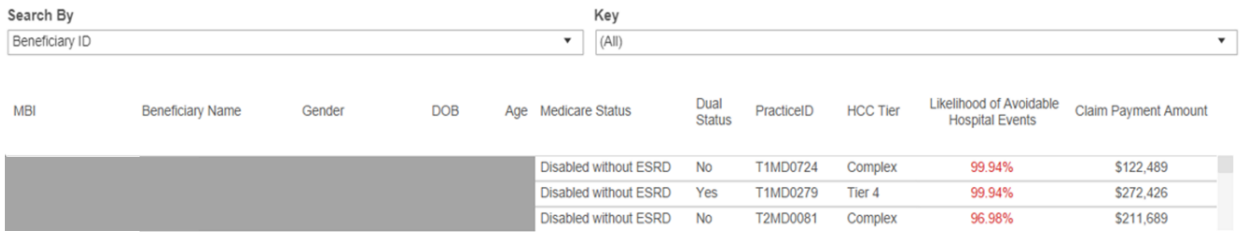
Practice Testimonial - How one practice used CRISP tools to improve transitions of care

"Our biggest friend and savior has been CRISP, which has evolved exponentially in the past few years. CRISP ENS [Event Notification Service] on a daily basis allows us to follow up with patients who have been discharged from hospitals or the ER in minutes thanks to this real time service… All of these reporting tools and filters have made it so much easier to not only track our patients and prioritize them better and create care plans, but to educate them on safe practices during these times. I feel like it has helped us do a lot more than we would have been able to do a few years ago." - Physician at an MDPCP practice

AVOIDABLE HOSPITAL EVENTS

Even with the suite of reporting tools from CRISP, the State identified an opportunity to further improve health outcomes by providing a data analytics tool to assist practices in reducing avoidable hospital and emergency department services utilization. Recognizing the challenges that prior programs have experienced in avoiding unnecessary hospital and ED utilization, Maryland contracted with The Hilltop Institute at the University of Maryland Baltimore County to create a user-friendly tool to identify patients at risk for avoidable hospitalization (AH) or ED visits. The Pre-AH Model™ tool uses artificial intelligence to analyze claims, demographics, diagnoses, and pharmacy and environmental/social data sets to predict avoidable hospital and emergency department events (tool displayed).

Figure 12. Screenshot of the Pre-AH™ Tool for three patients



Primary care providers can then target their resources to help prevent the ED visits or hospitalization. The tool is available to all practices free-of-charge on their CRISP dashboards and is updated monthly.

Practice Testimonial - How one MDPCP practice has used the Pre-AH™ tool

"I matched the 38 patients who had an Event risk of 2% or greater to those who are presently under care management in our practice. For most of the 13 patients out of that 38 who were not under care management, I found I had near identical reactions - something like 'oh yeah -- that person -- he/she has a lot of medical issues - and I haven't seen them in a while. I wonder how they are doing?' So in the search for reports and ways to use them within our present system, I think this one so far has come the closest to finding those high risk patients who are 'flying below the radar'." - Physician leader of an MDPCP practice, February 2020

ADDRESSING BEHAVIORAL HEALTH

Unmet behavioral health s can lead to significant morbidity, mortality, and avoidable hospital and ED use.[6] To address this unmet need, the MDPCP provided practices with a menu of evidence-based methods of behavioral health integration. For example, to help practices combat Maryland's statewide opioid epidemic, the state engaged a contractor experienced in integrating into primary care the evidence-based protocol for substance use known as Screening, Brief Intervention, and Referral to Treatment (SBIRT). By the end of 2019, 114 Maryland practices had fully implemented this process.

Many practices have also implemented the Collaborative Care Model and the behavioral health co-location model. The Collaborative Care Model focuses on defined patient populations tracked in a registry, measurement-based practice, and treatment to target. Primary care providers and behavioral health professionals provide evidence-based medication or psychosocial treatments supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. Across all MDPCP practices, 95% reported developing a strategy for integrating behavioral health into their practice workflows by the end of the 4th quarter via the Care Management or Collaborative Care Model, Primary Care Behaviorist Model, or other approaches for addressing behavioral health needs.

LINKAGES TO COMMUNITY-BASED ORGANIZATIONS TO TACKLE SOCIAL NEEDS

Acknowledging the significant impact of nonmedical factors such as housing

[6]Berkowitz SA, Hulberg AC, Hong C, et al. Addressing basic resource needs to improve primary care quality: a community collaboration programme. BMJ Qual Saf. 2016;25(3):164-172. doi:10.1136/bmjqs-2015-004521.

and food insecurity on health, MDPCP practices are required to screen for and address their patients' social needs. To facilitate linkages to community-based organizations to meet social needs, the state developed a bidirectional referral tool available through the CRISP platform. The referral tool provides simple, secure referrals to organizations to meet food insecurity, housing, and other needs. MDPCP has begun collaborating with Meals on Wheels Central Maryland, community self-help programs, the Maryland Department of Housing, diabetes prevention programs, Maintaining Active Citizens (MAC) Living Well Center of Excellence, Giant Food nutrition, and Catholic Charities. It plans to continue to build relationships with other government and nongovernment organizations to further address patients' social needs.

Practice Testimonial - One practice's view on the utility of the CRISP e-referral platform

"We have to go upstream to really identify the root cause of why our clients struggle to stay healthy. MDPCP recognizes the importance of focusing on the holistic patient and the CRISP referral system is very helpful." - Care coordinator at MDPCP practice

Patient Testimonial - A patient remarks on satisfaction with Meals on Wheels referral

"I live alone, so I look forward to [my care manager's] calls. She has been a lifesaver to set me up with Meals on Wheels" - Patient at an MDPCP practice

STATE LEADERSHIP AND RESOURCES

Leadership at the State level, in partnership with CMMI, is a key to the success of MDPCP practices and the program overall. In PY1, State support structures were established, including State coaches, Learning System infrastructure and content, contractor support, and more. To provide hands-on support to practice leaders and staff, the PMO began providing technical assistance and guidance with practice coaches who work directly and daily with practices. At the same time, the PMO offers regular webinars focused on areas of care transformation, such as behavioral health, optimal use of health IT, and screening for unmet social needs. The State's offerings are directly complimentary to the federal Learning System, augmenting CMMI's sophisticated distance resources in a manner customized to the MDPCP. Additionally, contractors offer staff training programs, webinars, and provider leadership academies in locations across the state. See Table 5 for a summary of state support programs for practices.

Table 5: Additional State Supports for MDPCP

CRISP	Contractors	State Coaches
• Central quality measures reporting to CMMI • Portal to access claims data reports • Provides social determinants of health referral tools and resources • Offers prescription drug monitoring programs, clinical query portal, secure messaging, Event Notification Services • Has preventable hospital and emergency department utilization tool integrated into claims reports	• Implement provider leadership academy and practice staff training academies • Provide educational materials on complex program issues • Develop and conduct behavioral health integration webinar series • Provide Screening, SBIRT implementation assistance • Help to optimize electronic medical records • Provide billing and coding guidance	• Deliver hands-on, in-person assistance and support • Offer strategies to reduce administrative burden • Provide expertise of MDPCP program requirements • Identify practice gaps and give guidance on the CTRs • Facilitate relationships between CTOs and practices • Encourage quality improvement • Assist with electronic health information exchange tool implementation

Practice Testimonial - One practice's experience with their State practice coach

"I have been with the MDPCP since the inception and I have found it to be a very rewarding program... We have learned so much from our practice coach, and she continues to be an asset to us." - Physician at an MDPCP practice

OBJECTIVE 2: CARE TRANSFORMATION

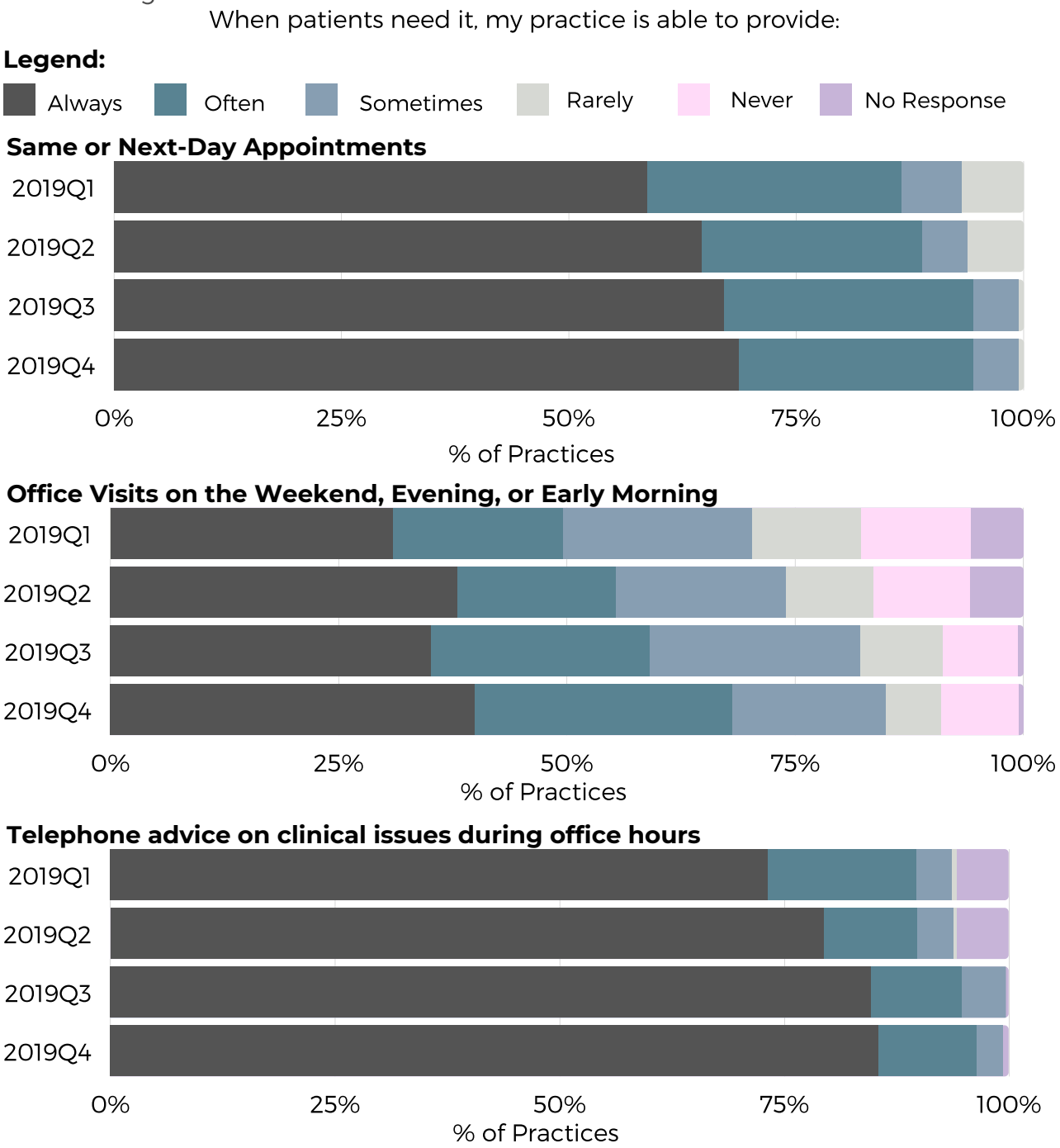
The primary goal of the MDPCP is the sustainable transformation of the delivery of primary care across the state to include all of the elements of advanced primary care to support the health needs of Marylanders. MDPCP practices must submit quarterly reporting on questions pertaining to meeting the program's five CTRs in order to show their progress in implementing care transformation. MDPCP practices' responses to CTR questions demonstrate that their capacity to meet the program's five CTRs improved significantly over the course of PY1. Key takeaways from practices' responses to the CTR questions include the indications that over the course of 2019:

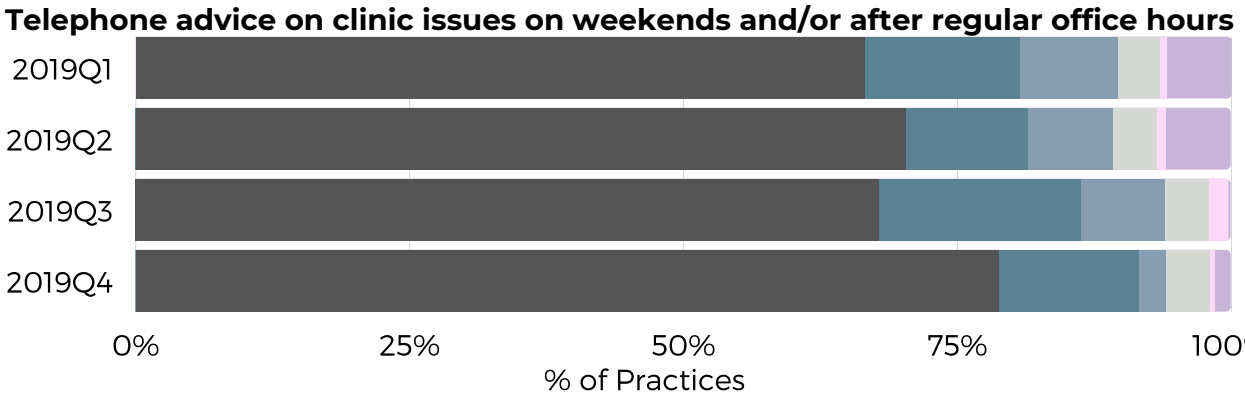
- Patient access to practices improved, with increasing percentages of practices offering same or next-day appointments (increased from 59.6% of practices to 68.6%) and telephone advice outside of regular work hours (increased from 66.5% of practices to 78.7%)
- Practices offered patients an increasingly wide range of medical treatment settings, including telehealth (the percentage of practices offering video-based teleconferencing increased from 38.6% to 47.6%, and the percentage of practices offering medical visits over an electronic exchange increased from 47.3% to 54.3%)
- Practices' use of care management increased, with the percentage of patients under longitudinal care management growing from 7.2% in the first quarter to 10.0% in the fourth quarter
- Nearly all practices (95%) integrated behavioral health into the delivery of primary care by the end of the fourth quarter, ushering in a new era of statewide behavioral health integration

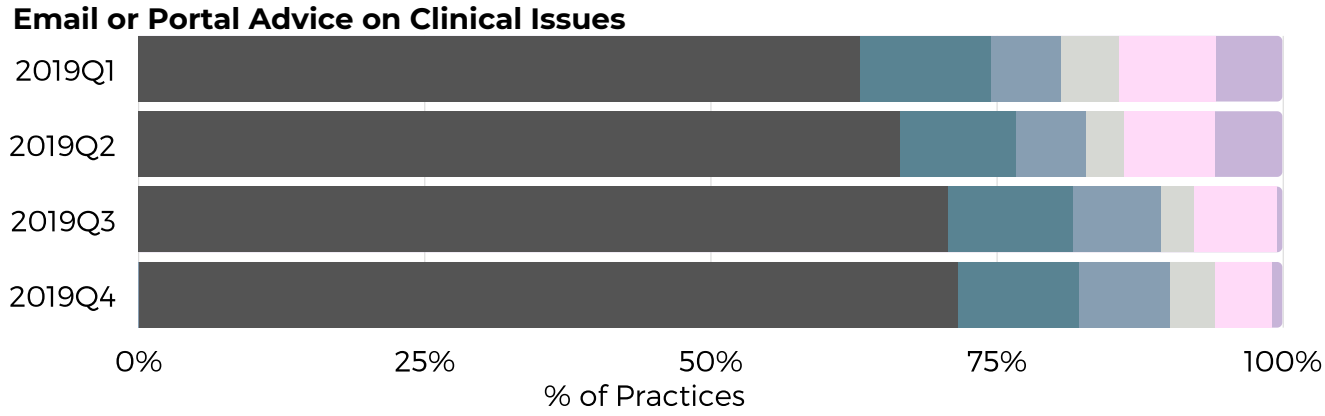
This section of the report will summarize these changes and other ways practices' efforts to transition to Advanced Primary Care were increasingly effective. For all graphs of Care Transformation Requirement questions, the total number of practices reporting is 380.

Access and Continuity

Practices' ability to offer patients accessible care gradually improved between the first and fourth quarters of 2019. In an effort to gauge practices' capacity to offer enhanced patient access, the Q1 – Q4 2019 CTR questions asked them if they could provide needy patients with (1) "Same or Next-Day Appointments," (2) "Office Visits on the Weekend, Evening, or Early Morning," (3) "Telephone advice on clinical issues during office hours," (4) "Telephone advice on clinical issues on weekends and/or after regular office hours," and (5) "Email or Portal Advice on Clinical Issues." The following charts summarize practices' responses to the prompt of "When patients need it, my practice is able to provide:" for these categories.



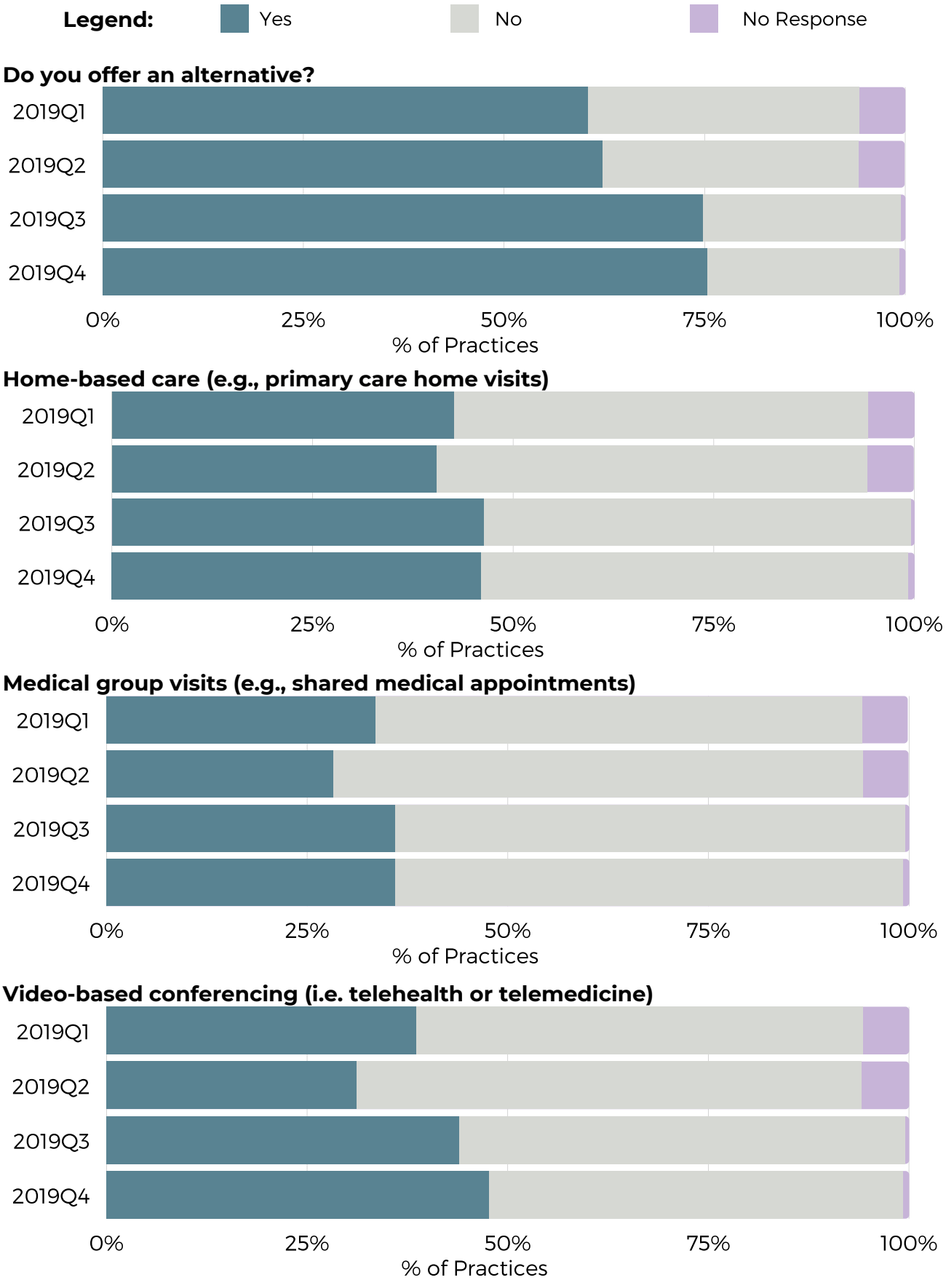




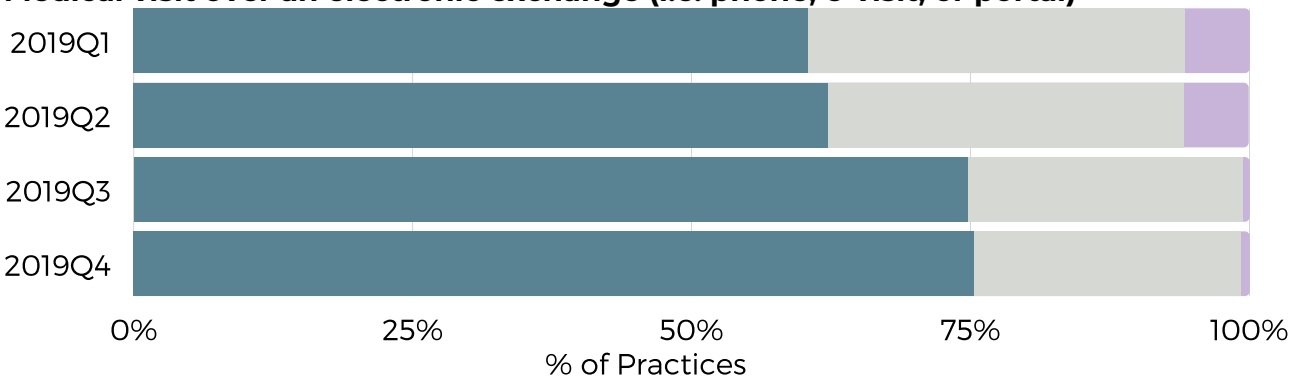
The charts show many ways practices made progress in care transformation between January and December 2019: during this timeframe their ability to offer same day or next day appointments, office visits outside of regular business hours, telephone advice on clinical issues during office hours, telephone advice on clinical issues outside of regular office hours, and advice on clinical issues via e-mails or an online portal increased.

Practices also reported how they provided alternatives to office-based care for patients through their answers to the question “In the last quarter, in which of the following ways did your practice provide alternative approaches to care other than traditional office-based visits?” From Q1 to Q4, the percentage of practices providing care in an alternative venue increased from 60.4% to 75.3%, suggesting that their ability to provide better access and continuity improved throughout the year. The following charts summarize practices’ response to this question and its related questions.

In the last quarter, in which of the following ways did your practice provide alternative approaches to care other than traditional office-based visits?



Medical visit over an electronic exchange (i.e. phone, e-visit, or portal)

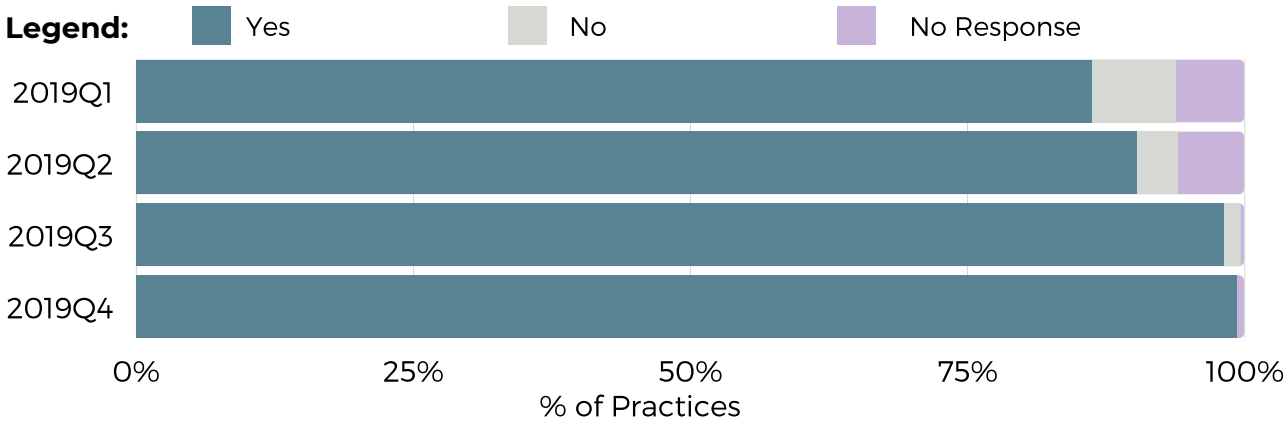


Key Takeaways: Practices' increased use of alternative approaches is important because it demonstrates their willingness and ability to conform to the needs and conveniences of their patients. Practices' greater use of alternative approaches to care is also significant because it suggests their patients' ability to get timely and accessible care from their PCPs improved over the course of 2019. The MDPCP program helped enable these enhancements by providing CMF funds practices used to make significant and steady upgrades to their telehealth capabilities.

Care Management

Practices' reporting on care management suggests that their effectiveness at providing care management also improved over the course of the year. The chart below shows that 86.2% of practices claimed they identified patients for episodic care management during Q1, and by the end of the year nearly all practices indicated they were identifying patients for episodic care management.

Do you identify beneficiaries for episodic care management?

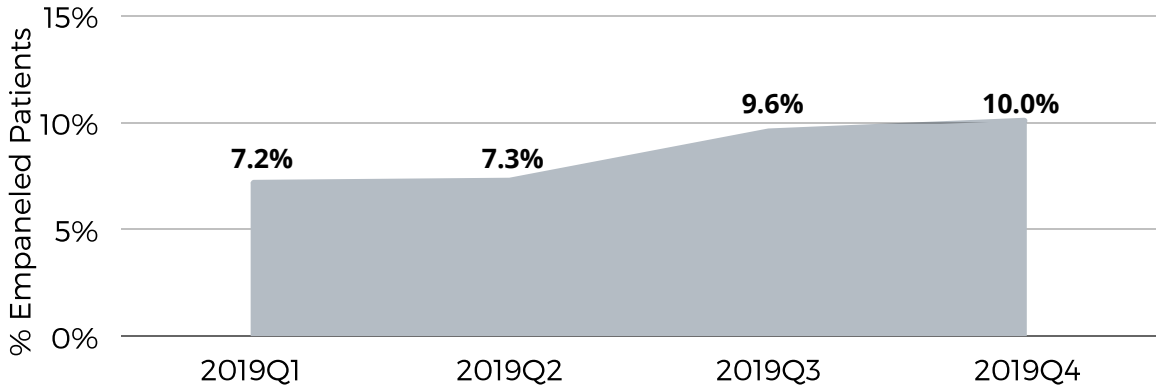


Furthermore, as the following chart shows, practices collectively attested that the percentage of patients they treated who were under longitudinal care management increased from zero before the onset of MDPCP to gains between Q1 2019 and Q4 2019 from 7.2% to 10.0%. The established target of 5% of patients in longitudinal care management was quickly and significantly

passed. Care management is one of the strong foundational pieces of MDPCP, and the PMO believes practices' increased use of care management during 2019 helped improve the coordination of patients' care, which in turn had a positive impact on their patient outcomes.

Identifying Patients for Care Management

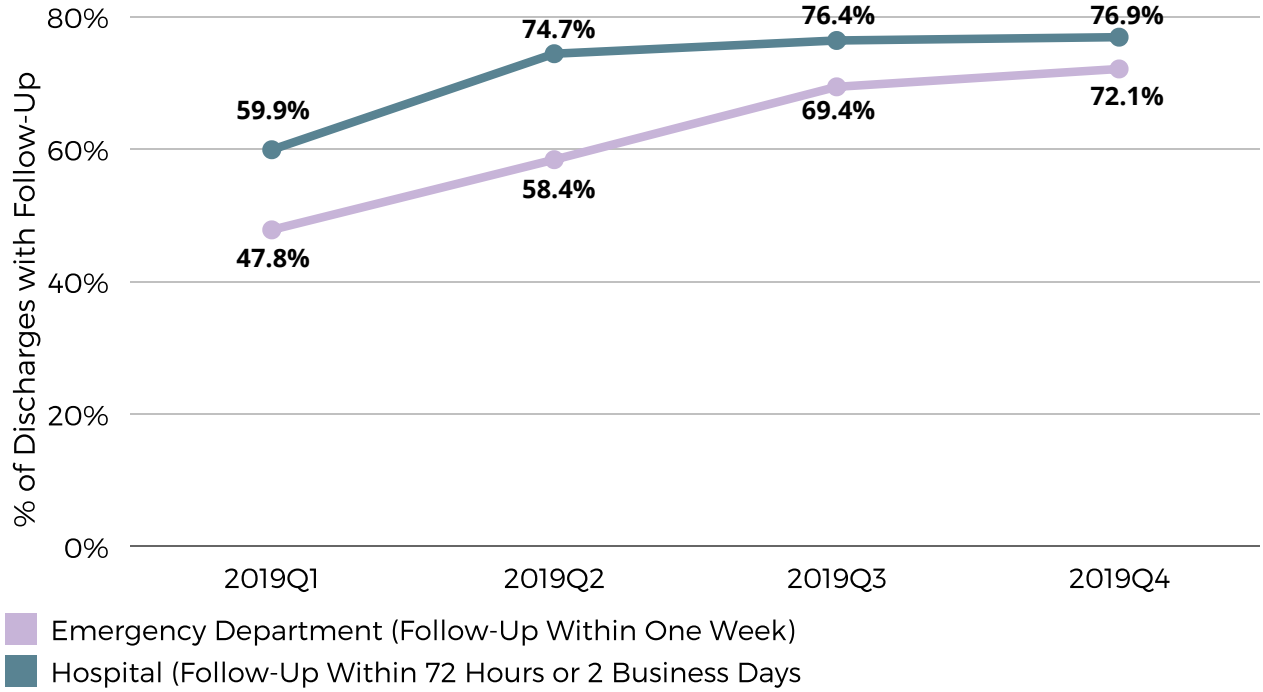
% of Empaneled Patients under Longitudinal Care Management out of Total Empaneled



Information practices gave while filling out CTR questions also indicates that over the course of 2019 they increasingly followed up with patients after their discharge from the hospital and the emergency department. This chart shows how the frequency of practice follow-up post-hospital and post-ED discharge grew: between Q1 and Q4, the percentage of patients that received practice follow-up within 72 hours or two business days after being released from the hospital increased 17.0%, and during this same timeframe the percentage of patients that received practice follow-up within a week after being released from the ED grew 24.3%.

Beneficiary Follow-Up - Hospital and ED Discharge

Follow-Up Rate by Setting



Key Takeaways: Transitional care management was a weak area in the provision of care in Maryland prior to the establishment of the MDPCP program. With the advent of MDPCP, practices' ability to conduct post-discharge follow-up with patients improved during the first quarter and steadily got better during the year. The PMO views this progress as beneficial to patients because the practices that quickly follow-up with patients after discharge can expeditiously work with those patients to address the problems that led to their hospitalizations or admissions to an ED.

Practice Testimonial - One practice's view on how care coordination has improved patient care

"The MDPCP program has benefited our patients by providing an extra level of care coordination and another person to reach out to. Care coordinating nurses and social workers work to teach patients about outside benefits/support that we wouldn't necessarily have access to. Patients have expressed that they feel more supported by our practice with this program."

Comprehensiveness and Coordination

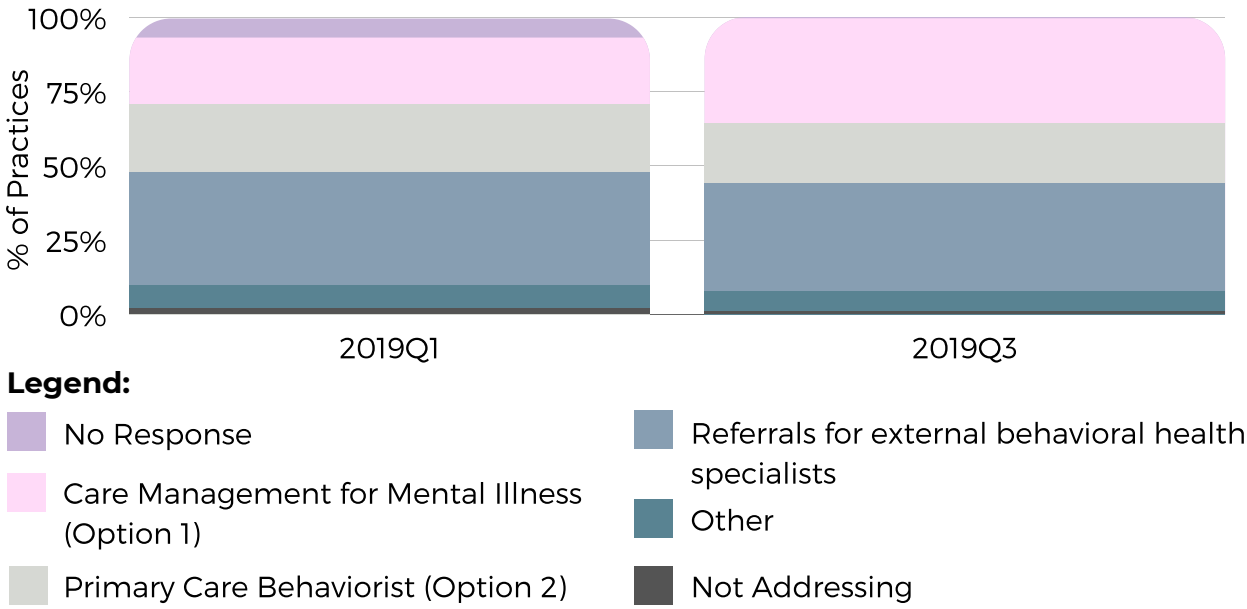
Practices' reporting indicates that the comprehensiveness of the care they offered and their coordination with non-primary care providers improved appreciably over the course of 2019.

Key takeaways: The PMO believes these trends toward better coordination, integration with behavioral health, and screening for unmet social needs improved the quality of medical treatment patients received and had a positive impact on patient care.

As shown by the following chart, which summarizes answers to a CTR question about practices' efforts to address behavioral health needs, the percentage of practices that identified steps needed to improve patients' behavioral health fell between Q1 2019 and Q3 2019. By as early as the third quarter virtually all practices were engaged in planning and implementation of BHI.

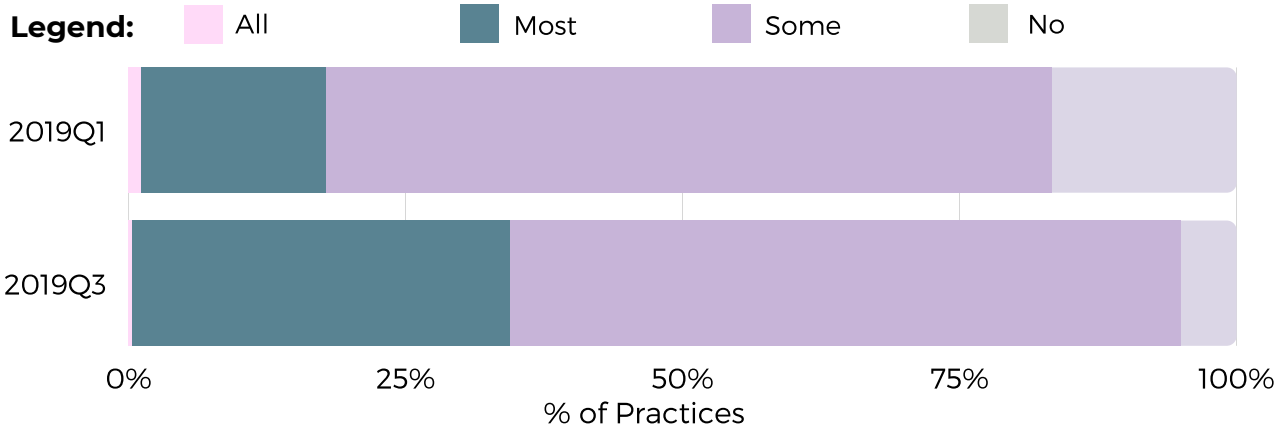
Behavioral Health Integration

What is your practice's primary strategy for addressing behavioral health needs? If you are planning to integrate one of the behavioral health models listed below, please select that option.



Similarly, the following chart, which summarizes practices' responses to a CTR inquiry about their provision of behavioral health care management in Q1 2019 and Q3 2019, shows that they implemented behavioral health care management with patients with behavioral health needs to a greater extent during the July – September timeframe than during the January – March timeframe. By the end of the third quarter 95% of the practices had integrated and were providing behavioral health services to their patients.

In the last two quarters, of your beneficiaries with identified behavioral health needs, estimate how many received behavioral health care management at your practice.

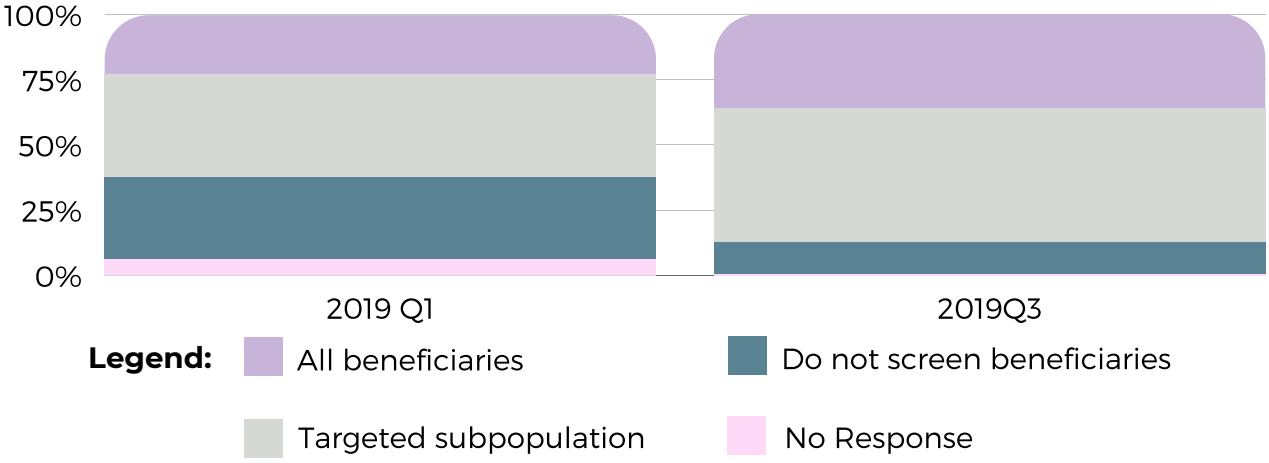


Practices were also more likely to respond affirmatively to the question "Do you routinely screen your beneficiaries for unmet social needs?" in Q3 2019 reporting than Q1 2019 reporting. By the end of the 3rd quarter, 88% of

practices were screening their patients for social needs. Screening tools that practices have used to evaluate patients' social needs include the Accountable Health Communities tool, other standardized screening tools (such as the HealthLeads screening tools), and screening tools that the practices created themselves.

Linkages with Social Services

Do you routinely screen your beneficiaries for unmet social needs?



Practices' responses to the Q1 2019 and Q3 2019 CTR question "What are the health-related social needs your practice has prioritized to address in your beneficiary population?" also indicate that they were better able to address patients' social determinants of health during the July – September timeframe than during the January – March timeframe: for the period of Q1, 85.0% of practices replied to this question by noting "We have not prioritized any social needs to address in our beneficiary population," but only 27.1% of practices responded the same way for the period of Q3.

	2019 Q1	2019 Q3
We have not prioritized any social needs to address in our beneficiary population.	85.0%	27.1%

Practices most frequently reported that in Q3 they had prioritized beneficiaries' social needs regarding food insecurity, housing instability, transportation, safety, and financial resources. Many practices also indicated that they had taken steps to try to address patients' social needs related to employment and utilities.

Practice Testimonial - How patient care has become more comprehensive for patients at one practice

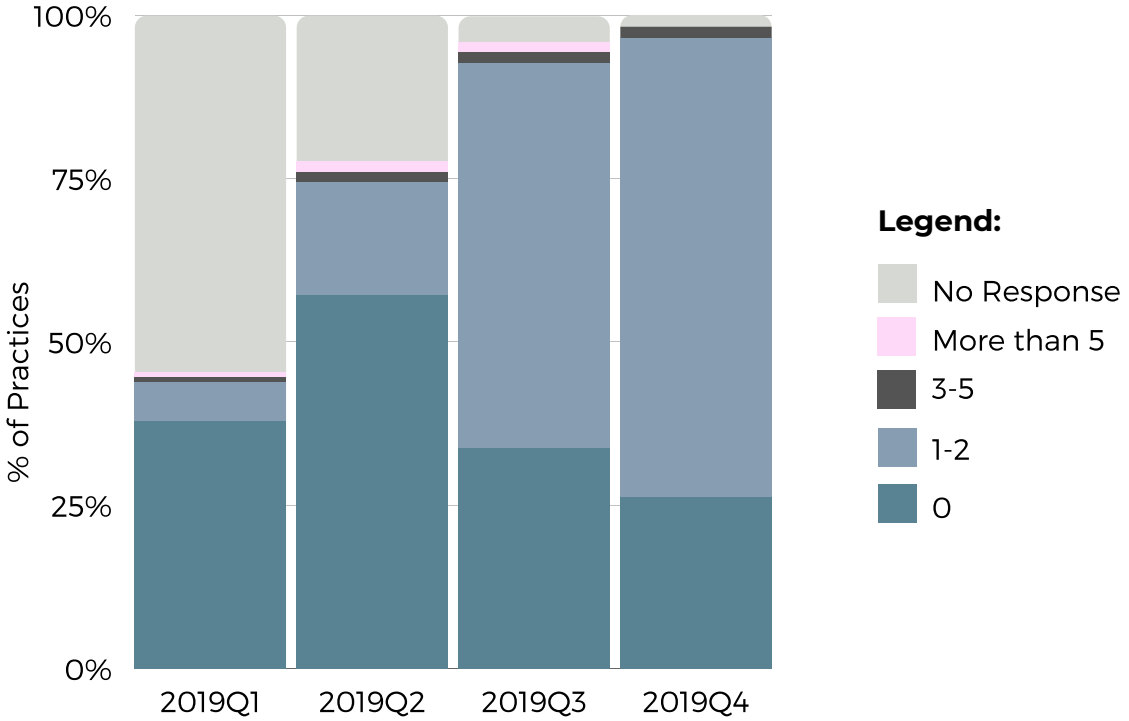
"Through our affiliation with MDPCP our staff and providers are a much better trained team, well informed and more knowledgeable in their ability to manage the care of our patients collectively. Our patients and their families now realize that they have vast access to an array of comprehensive care and services (such as a collaborative mental and behavioral health, comprehensive medication review, ride sharing options, remote patient monitoring and telehealth services to name a few) initiated and managed right at their primary care providers office with one goal in mind, and that is to provide them with the much needed care management, access and continuity of care while creating a unique patient experience for them in a most cost effective manner." - Physician at an MDPCP practice

Beneficiary and Caregiver Engagement

Practices' answers to CTR questions also show that in general they increasingly engaged with patients and caregivers as 2019 went on. The chart below, which summarizes practices' replies to a CTR inquiry about the number of Patient and Family Advisory Council (PFAC) meetings convened each quarter, suggests that their PFACs were more likely to meet during Q3 2019 and Q4 2019 than during Q1 2019. Practices have reported a variety of positive changes to practice operations from PFAC feedback, including adding WiFi to a practice for patients in the waiting room and creating a more handicap-accessible office entrance.

Engaging Beneficiaries and Caregivers in Your Practice

Identify the number of meetings held by your practice PFAC in the last quarter



Practice Testimonial - One practice's view on improved patient experience in MDPCP

"Patients have expressed their gratitude for the MDPCP/CTO program in their community and oftentimes ask me if this program exists in their family and friends' Primary Care facilities. Patients appreciate the resources and being able to directly speak with someone on their behalf with concerns at home that affect their health care. I have noticed with resources, patients are participating more with follow up appointments and completing preventive measurements. I look forward to continuing to assist our patients with receiving quality healthcare. " - Patient Liaison Referral Navigator at an MDPCP practice

Patient Testimonial - Patient at an MDPCP practice describes their positive experiences

"Why did this program not exist much sooner? It gives me peace of mind that someone cares enough to proactively call me to see how I am doing. My care manager is always patient and nice. I really appreciate that." – Patient at one MDPCP practice

Use of Planned Care for Health Outcomes

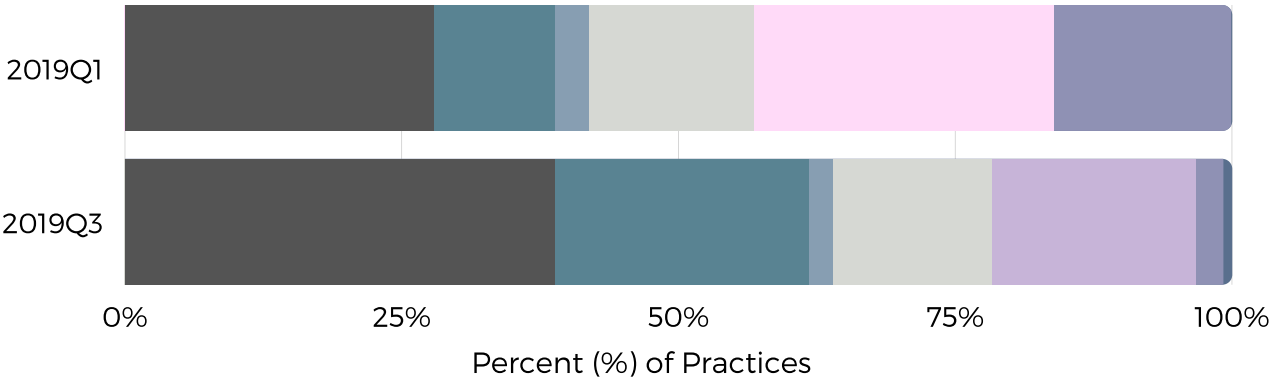
The extent to which practices convened to plan care for health outcomes increased from Q1 2019 to Q3 2019. Indeed, the three charts below, which summarize practices' replies to Q1 and Q3 CTR questions about the frequency with which they met to discuss beneficiary care and quality improvement data, suggest that practices deliberated more to discuss patients' treatment between July and September than between January and March (in the case of all three questions, practices only had the option of responding "Ad Hoc" for Q1 and "Only as needed or ad hoc" for Q3).

Key takeaways: Increased use of meetings to plan care benefits patient health outcomes because these meetings provide clinicians with opportunities to coordinate care for their patients, carefully think through how to best treat them, and exchange best practices regarding patient care.

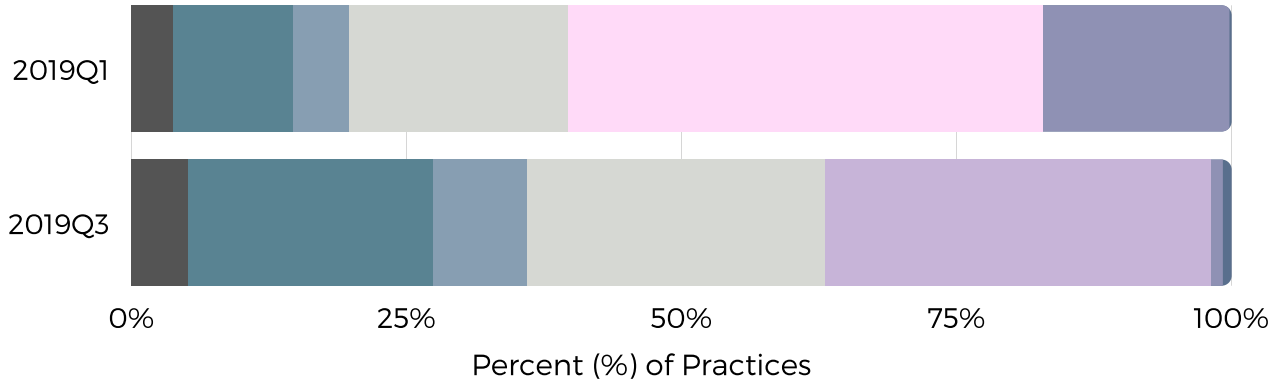
Legend:

- At least daily
- At least weekly
- At least every 2 weeks
- At least monthly
- Ad hoc
- Only as needed or ad hoc
- Never
- No Response

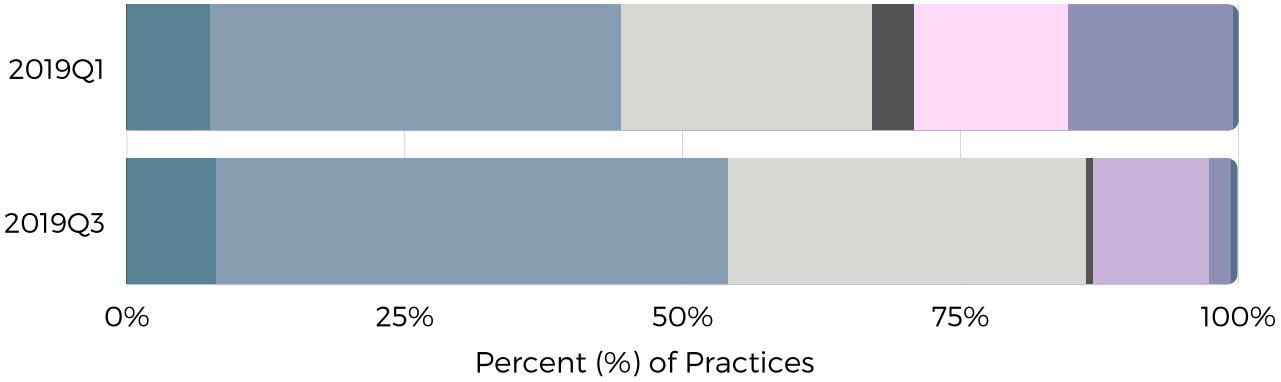
How often do care teams at your practice have structured huddles focused on beneficiary care?



How often do care teams at your practice have scheduled care team meetings to discuss high-risk beneficiaries and planned care?



How often do care teams at your practice meet and review quality improvement data (e.g., data on quality, cost, utilization, and beneficiary experience of care)?



OBJECTIVE 3: QUALITY AND UTILIZATION PERFORMANCE

Much of the MDPCP's PY1 work focused on building supportive infrastructure across the State and assisting practices with the implementation of new care delivery processes. The early part of PY1 also required the PMO to provide information to practices and onboard them to the program. Additionally, it took CTOs and practices several months to recruit, hire, and train staff. Actionable data was not available for practices until several months into the program. Finally, raw CCLF data was not made available to CTOs during the first program year. MDPCP-driven care transformation would naturally precede the impact the program will have on beneficiary utilization and quality measures. As a result of these factors, the MDPCP PMO did not anticipate there to be major changes in MDPCP practices' rates of inpatient hospitalization and emergency room visits over the course of 2019. Nevertheless, the rate of inpatient hospitalizations and emergency room visits by beneficiaries attributed to MDPCP for Q1 2019 align well with a statewide, non-risk adjusted comparison group. Utilization management will remain a key area for the program in future years.

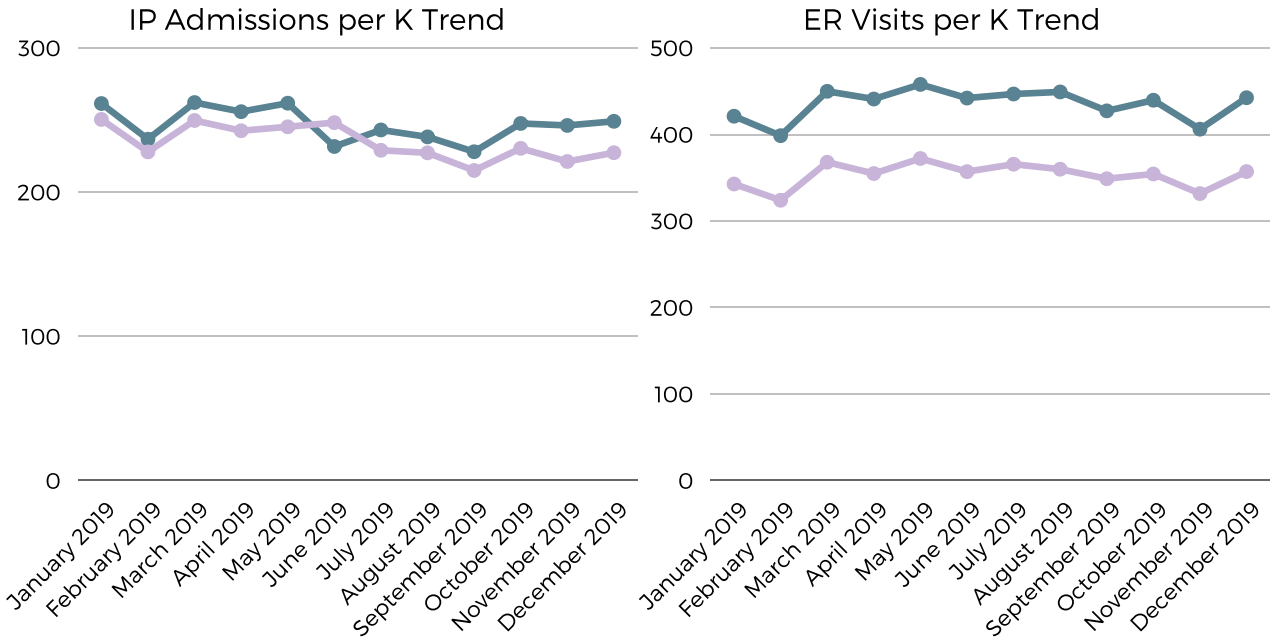
UTILIZATION TRENDS: NON RISK-ADJUSTED

There were 247 inpatient admissions per 1,000 Q1 2019 MDPCP-attributed beneficiaries over the course of 2019, and during this same timeframe there were 235 inpatient admissions per 1,000 beneficiaries in the state-wide comparison group. Furthermore, whereas in 2019 there were 435 ER visits per 1,000 beneficiaries attributed to MDPCP during Q1 2019, over the course of the year there were 353 ER visits for every 1,000 beneficiaries in the state-wide comparison group. The following charts show that the month-over-month "IP Admissions per K" and "ER Visits per K" trends for Q1 2019 MDPCP-attributed beneficiaries followed a similar pattern to the month-over-month trends for the "IP Admissions per K" and "ER Visits per K" for the statewide comparison group.

Figure 13. Inpatient and Emergency Department Utilization levels and trends over 2019 for MDPCP-attributed beneficiaries versus a statewide comparison group

IP Admissions Per K	
Practice	247
State	234

ER Visits per K	
Practice	435
State	353



MDPCP intends to further adjust the utilization measures with a focus on specifically reducing avoidable utilization for ambulatory sensitive conditions (PQIs). In order to meet this objective, the MDPCP is working to develop clear representations of the hospital and emergency department PQIs that MDPCP-attributed beneficiaries experience and are aligned with the TCOC. In Q4 2019, MDPCP launched a tool that it uses to gauge the frequency with which the beneficiaries attributed to MDPCP practices experience PQI-like events, but the MDPCP does not believe that in 2019 this tool had a significant impact on how often PQI events occur for MDPCP-attributed beneficiaries.

QUALITY AND UTILIZATION PERFORMANCE MEASURE REPORTING

In addition to raw utilization trends, practices' quality and utilization over PY1 was measured through six reported metrics, including two risk-adjusted utilization measures, three clinical quality measures, and one measure related to patient satisfaction survey scores.

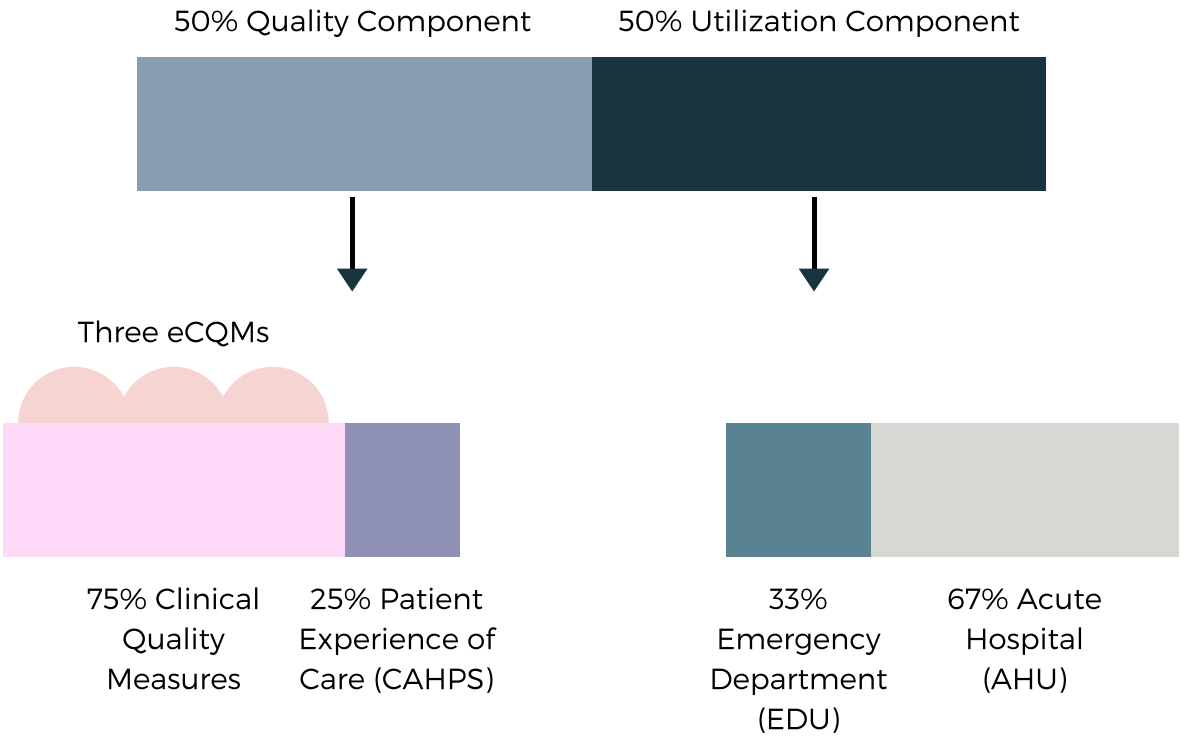
These quality and utilization results for MDPCP participants in 2019 provide a partial view into PY1 performance. As a consequence of the COVID-19 pandemic, practices were not required to submit quality data and were instead encouraged to focus their efforts on the provision of care during the pandemic. Many practices had already submitted data prior to the onset of the pandemic and others still chose to submit. Overall, 223 practices submitted quality data for PY1.[7]

[7] According to CMS, 223 practices submitted one or more sets of data sets regarding CMS137v6 (AOD), CMS165v6 (HBP), and/or CMS122v62 (A1C).

Quality results are based on reporting for all patients independent of payer type. Utilization results are based only on the 2019 Medicare FFS claims of attributed beneficiaries regarding acute hospital and emergency department visits. All results are calculated at the practice and CTO levels.

Quality and utilization each count for 50% of the total PBIP. Within the quality component, 75% is based on clinical quality measure reporting (three measures) and 25% is based on patient satisfaction survey results. Within the utilization component, acute hospital utilization accounts for 67% and Emergency Department utilization accounts for 33% of the total.

Figure 14. Breakdown of components of the PBIP



The three clinical quality measures include measures for hypertension and diabetes control, which are well-known to practices, and a substance use disorder measure (NQF0004), which was new to most practices. Regarding patient satisfaction, practices have been measured in a variety of ways over the years - the CAHPS survey is the standard for patient engagement assessments. Utilization is also a standard measure of practice performance. However, the methodology used in MDPCP is a HEDIS-like risk-adjusted measure using a synthetic statewide control group that is unique to MDPCP. With that in mind, PY1 results are reported in the following areas:

- Median scores
- Performance against benchmarks
- PBIP retention
- CTO performance impact

Median Quality and Utilization Scores

Median (or 50th percentile) scores for MDPCP practices for each quality or utilization measure are reported in Table 6. Inpatient 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 as determined by the risk and size of their Medicare FFS population. Lower scores for both utilization measures represent better performance.

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

Clinical Quality measures use CMS technical specifications for each measure. For the Diabetes: Hemoglobin HbA1C Poor Control measure, a lower score indicates higher performance. For the Controlling High Blood Pressure and Init. & Eng. of AOD Treatment measures, a higher score indicates higher performance.

Table 6. Median Score for MDPCP Practices on each measure

Measure	50th percentile
Inpatient Utilization (AHU)*	1.2753
ED Utilization (EDU)*	0.8199
CAHPS Summary Score**	80.62%
CAHPS 1: Getting Timely Appointments, Care, and Information	88.79%
CAHPS 2: How Well Providers Communicate With Patients	95.51%
CAHPS 3: Attention to Care From Other Providers	85.23%
CAHPS 4: Shared Decision Making	86.50%
CAHPS 5: Providers Support Patient in Taking Care of Own Health	49.97%
CAHPS 6: Patient Rating of Provider and Care	83.57%
Init. & Eng. of AOD Treatment (CMS137v6)	--***
Controlling High Blood Pressure (CMS165v6)	69.78%
HbA1C Poor Control (CMS122v6)*	21.79%

*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.
***The 50th percentile benchmark for this measure is 0.00% and the 80th percentile benchmark for this measure is 1.47%. Refer to Table 7 for a distribution of MDPCP practice comparisons.

MDPCP Performance Compared to Benchmarks

Overall performance is summarized in Table 7, showing MDPCP practice measure outcomes compared to a benchmark group. The benchmark groups vary by category as defined by Table 8. The following is a summary of overall performance:

- **Clinical Quality (compared to national MIPS reporting):** Practices performed significantly better on clinical quality than utilization and patient satisfaction. On the substance use measure (AOD treatment), 100% of practices beat the 50th percentile (however, the 50th percentile was 0.00%), including 39% exceeding the 80th percentile of national MIPS reporting (80th percentile was 1.47%). Practices also performed well on chronic disease management: 67% surpassed the 50th percentile for controlling high blood pressure and 85% surpassed the 50th percentile for A1C control. In fact, half of all MDPCP practices scored in the 80th percentile or above for A1C control. Correspondingly, aggregate scores for CTOs (based on their practices) performed better on quality than utilization.
- **Utilization (compared to all practices with Maryland FFS beneficiaries):** On inpatient utilization, 57% of practices performed better on hospitalizations than the 50th percentile of benchmark Maryland FFS practices. On emergency department visits, 69% of practices performed better than the benchmark. Additional detail on the unique control group used for comparison in setting the Maryland benchmark is available below.
- **Patient Satisfaction (compared to CPC+ practices):** On the CAHPS summary score, 37% of practices beat the 50th percentile of the benchmark practices. Note that over 50 practices were exempted from CAHPS scoring in 2019 due to surveys taking places in other CMS programs.

Table 7: Performance Against Benchmark Breakpoints (All Practices)

Measure	Count of Practices with a Result	% < than 50th Pctl	% >= 50th and <= 79th Pctl	% >= Equal to 80th Pctl
Init. & Eng. of AOD Treatment (CMS137v6)	168	0%	61%	39%
Controlling High BP (CMS165v6)	221	35%	43%	22%
HbA1C Poor Control (CMS122v6)	220	15%	35%	50%
Inpatient Utilization (AHU)	375	43%	35%	22%
ED Utilization (EDU)	375	31%	38%	31%
CAHPS Summary Score	321	63%	23%	14%

* Note: some practices received exemption from reporting due to participating in an MSSP ACO or due to the COVID-19 pandemic. Practices reporting are out of a total 375 practices.

Table 8. Benchmark populations for each measure

Measure	Benchmark Population	Year of Benchmark Data
CG-CAHPS	CPC+	2018 CPC+ CAHPS
eCQMs	National, all payer	MIPS 2018 Performance
Utilization	Maryland, Medicare only	2019 Maryland Utilization

The utilization benchmarks are based on a national HEDIS methodology that has been adapted to Maryland.[8]

[8] Using primary and specialty care services claims data for the entire state of Maryland, CMMI created a virtual panel of 3,237 artificially constructed benchmark practices that represent the distribution of performance from the 1st-99th percentile as if they were actual practices using actual beneficiaries. The panel of 3,237 benchmark practices was created from a combination of MDPCP and non-MDPCP providers. CMMI compared actual MDPCP practices' performance to these benchmark practices' ED and Acute Hospital Utilization performance. Specifically, CMMI identified which MDPCP practices performed below the 50th percentile, between the 50th and 80th percentile, and above the 80th percentile for purposes of PBIP retention compared to all MDPCP practices and the virtual practices. This information is used to determine each practice's retention of PBIP for the utilization measure.

Measure Performance Impact on PBIP

Quality and utilization performance is incented with the PBIP. In PY1 on request from the State, CMS did not recoup these payments due to the COVID-19 pandemic's impact on practice reporting and to support practice financial sustainability.

Nonetheless, impact on PBIP was scored for informational purposes and is outlined in the following table. In total, 66.6% of practice and CTO PBIP would have been retained based on 2019 performance. Notable results include that Track 2 practices performed 14.1 percentage points better than Track 1 practices (78.6% compared to 64.5%). Also, practices without CTOs, approximately 25% of the program's practices, performed slightly better than those with CTOs (70.2% compared to 66%). A large portion of the non CTO practices were supported by an independent practice management group (Privia) and may account for this difference.

Table 9: Summary of PBIP % Earned (if recouped)

Category	% of PBIP Earned
Total	66.6%
CTOs	65.9%
Practices	67.4%
Track 1	64.5%
Track 2	78.6%
Practices w/ CTO	66.0%
Practices w/o CTO	70.2%

Detailed breakdowns on individual measures is provided in the Appendix. Initial impressions and key results include:

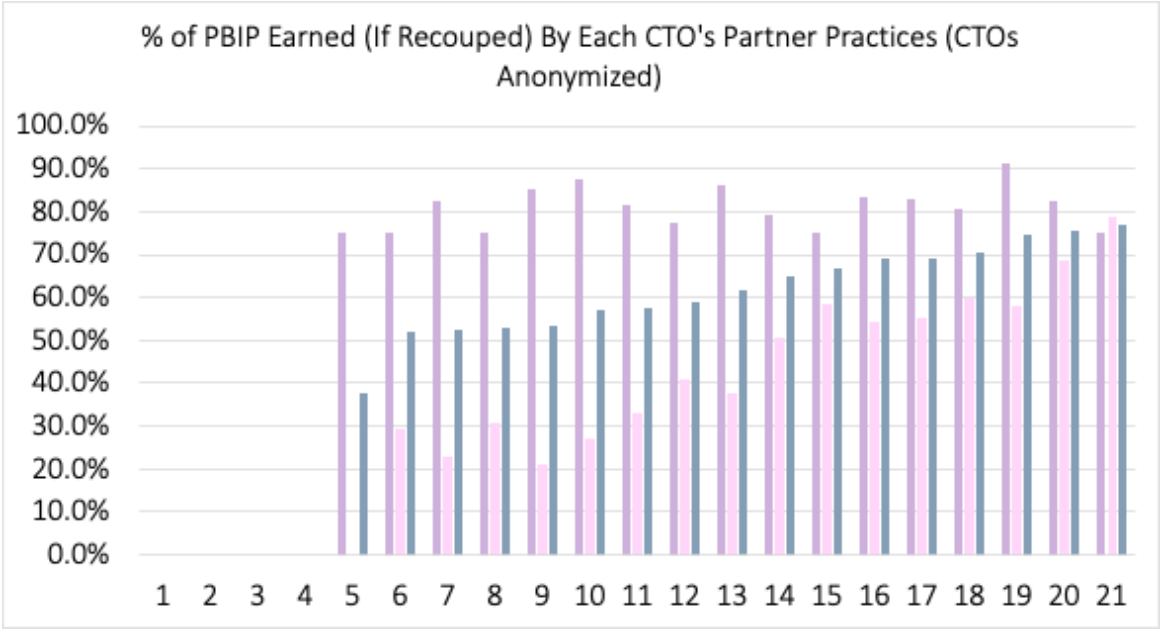
- Track 2 practices performed better than Track 1 practices on 5 of 6 reported measures
- There is no association between performance and either practice size or CTO affiliation
- MSSP practices generally performed worse than non-MSSP practices

Distribution of CTO Performance

Additionally, the range of the aggregate quality PBIP scores, utilization PBIP scores, and total PBIP scores for each CTO's practices further indicates there was variation in practice performance during 2019, and these trends also suggest that some CTOs may have been more effective than others at aiding their practices' efforts to maximize quality and minimize utilization. As Table 8 displays, among the CTOs which partnered with practices, one CTO's practices had an overall earned quality PBIP percentage of 75.0%, but another CTO's practices scored an aggregate quality PBIP percentage of 91.4%.

Figure 15 shows an even greater disparity in the utilization performance of the practices affiliated with each of the 21 CTOs: the utilization PBIP score of the worst-performing group of practices (by CTO) was 21.2%, whereas the utilization PBIP of the best-performing group of practices (by CTO) was 78.6%. There was also a large gap, 39.3%, in the total PBIP percentage earned by the groups of practices that were partnered with each CTO. Indeed, Figure 15 displays that the lowest total PBIP percentage earned by a group of practices affiliated with a CTO was 37.5%, and the highest total PBIP percentage earned by a group of practices working with a CTO was 76.8%. PBIP scoring is not available for the practices that are partnered with four CTOs that received exemptions from reporting for 2019, a fact that Figure 15 also reflects.

Figure 15: Percent of PBIP Earned (if recouped) by each CTO's Partner Practices (note: four CTOs received exemption from reporting)



COVID-19

While COVID-19 activities occurred in 2020 after PY1, they are included as an important update to highlight given the urgency of the pandemic.

The primary care workforce, coordinated and supported by MDH through the PMO, has become a critical part of Maryland's public health response to the COVID-19 pandemic. The MDPCP providers have mounted a coordinated telemedicine response, shared best practices, and conducted outreach to at-risk patients, keeping this vulnerable population out of harm's way.

Since March, the vast majority of practices in Maryland have implemented or expanded their telemedicine offerings. Based on a recent survey of practices, 472 practices indicated they are offering virtual care, while others have stayed open using telephone and limited in-person visits to care for their patients.[9]

Focused on supporting the primary care community during the pandemic, the PMO held its first COVID-19 informational webinar for practices on March 12, when Maryland had only 12 virus-infected individuals. Since then, MDPCP has hosted COVID update webinars three to five times a week led by the PMO executive director and attended by more than 2,000 unique primary care practice providers and staff. These webinars had an average attendance of 207 attendees as of 6/25/20. The COVID-19 webinars cover topics such as provider staff and patient safety, testing, personal protective equipment, behavioral health needs during a pandemic, minority health and health disparities, identifying high-risk patients, and communicating with patients. The webinars have allowed providers the opportunity to speak to their peers and share their experiences. Approaches on issues such as how best to triage patients in parking lots and outdoor environments have been honed by the practices during these virtual events.

More recently the PMO has developed technical manuals to guide practices in transitioning back to in-office visits in a graduated fashion. The PMO held a three-hour training webinar on reopening and preparing for the long term. The PMO is also working with the State's emergency management and public health agencies to deliver PPE and testing materials to several hundred

[9]As of January 1, 2020, 476 practices are participating in the MDPCP.

MDPCP practices. The coordination is buttressed by testing guidance for the primary care setting including detailed workflows.

The primary care workforce, coordinated and supported by MDH through the PMO, has become a critical part of Maryland's public health response to the COVID-19 pandemic. The MDPCP providers have mounted a coordinated telemedicine response, shared best practices, and conducted outreach to at-risk patients, keeping this vulnerable population out of harm's way.

Practice Testimonials - two practices' views on the key informational role of MDPCP during COVID-19

"I appreciate the work done by Dr. Haft and his team in presenting such useful COVID-19 update webinars over the past many weeks. I have watched each one, and typically copy pertinent slides and share information with my entire office staff and colleagues the next day. This is a great service to the Maryland community. Thank you very much." - Physician at an MDPCP practice

"I think the program has been a great help guiding all of us through the COVID-19 crisis. I especially feel that the seminars that were provided to us at the beginning of the crisis were the most helpful. They helped my staff and I understand how to glide through this whole process, making this challenging time a lot smoother for everyone." - Physician at an MDPCP practice

RECOMMENDATIONS TO CMS

The following section represents a series of recommendations from the State to CMMI intended to use the experience and learning from Program Year 1 to enhance subsequent program years while making every effort to maintain the program overall design in order to allow a fair and balanced program evaluation. The MDPCP was created as part of the overall structure of the TCOC model to promote broad based healthcare transformation at the primary care level within a voluntary program. The MDPCP achieved that goal to a significant effect even within the first program year.

Anticipating the need to refine various MDPCP elements based on an understanding of the importance of stakeholder involvement, the State established an MDPCP Advisory Council. The recommendations that follow are supported by the Advisory Council.

RECOMMENDATIONS TO IMPROVE OPERATIONS

1. **Reduce the frequency of reporting and simplify the Care Transformation Requirement questionnaire**

   During Program Year 1, based on direct feedback from practices and CTOs, it was apparent that the practice reporting requirements were numerous, time consuming, and in some instances a legacy from prior programs without relevance to the MDPCP. The State MDPCP PMO worked collaboratively with the CMMI MDPCP team during PY1 to address many of the excessive and non-contributory reporting requirements. The State appreciates the commitment made by CMS to be intentional to reduce administrative burdens, hold patients over paperwork, and allow providers to focus on patient care. The following recommendations are made in the same spirit and intend to further focus attention on the provision of high value healthcare rather than administrative reporting.

   a. **Reduce Frequency of Reporting -** During the COVID-19 pandemic the reporting of Care Transformation Requirements (CTRs) was reduced from quarterly to semi-annual in order to allow focus on the pandemic needs of patients. This reduction did not result in any meaningful loss of program analytic information but did result in hundreds of hours of time freed up to devote to patient care rather than data entry. This action is emblematic of the type of reduced reporting burden that needs to be promoted through the life of the MDPCP.

We acknowledge the action taken by CMMI for PY2 related to COVID-19. We propose that the CTR reporting be maintained at the twice yearly frequency going forward.

b. **Simplify and target Care Transformation Requirement reporting questions -** The CTR reporting questions were originally taken as a legacy from the CPC+ program. The stated goal of the CTRs from CPC+ was to inform program leadership on individual practice and overall program progress in key areas and inform the ongoing Learning System activities to support areas of need. During PY1 it was evident that many of the CTR reporting requirements were not relevant to MDPCP and that many relevant areas were not captured in the CTRs. For example, with the State's focus on addressing substance use disorders in the State Integrated Health Improvement Strategy, it would be informative to focus a CTR question specifically on whether practices have implemented SBIRT. Moreover, it was noted by the CMMI Learning Team that the CTRs were not going to be used for individual practice evaluations nor to inform changes and adaptations in the Learning System moving forward. Also, the CTR reporting as currently configured is 42 pages of questions. Many of the questions are redundant and some have little relevance to the MDPCP. For example, practices are asked whether they have received assistance from a CTO or practice coach 20 times each, when this could be consolidated into a single question.

The MDPCP maintains many of the Advanced Primary Care elements of CPC+ but differs from CPC+ in many ways. Importantly, based on conversations with CMMI, the purpose of CTR reporting in MDPCP is different from CPC+ and should be reevaluated in that light. The main purpose of CTR reporting in MDPCP is to serve the unique purpose of acting as a gating criteria to determine when practices are capable of moving from Track 1 to Track 2. Within the design of MDPCP this is a critical function since practices must achieve Track 2 status by the end of their 3rd year of participation or leave the program.

In regard to the unique needs of the MDPCP, we recommend amending and reducing the CTR reporting questions to focus on specific MDPCP requirements. An example of the types of amendments to be submitted include the elimination of repetition of the question on State coach and PMO assistance with each CTR and consolidation of these questions in one area. In terms of simplification

and alignment, the questions related to Behavioral Health Integration could focus on the strategies used in the MDPCP: Collaborative Care, SBIRT and Co-Location. We recommend working with the PMO to revise the CTR reporting questions in advance of the first quarter of 2021.

2. **Broaden use of Care Management Fees to maximize care transformation**

The Care Management Fees (CMF) provided to practices have been the most critical part of the overall payment redesign in support of statewide care transformation. Non-visit-based, population-based, risk-adjusted payments are the centerpiece of many of the current and future modifications in payments intended to create a more equitable and resilient healthcare delivery system. The validation of this concept was evident during the COVID-19 pandemic as the CMFs became essential for practices to sustain their care activities.

The Practice and CTO Participation Agreements specify the excluded uses of these funds but fall short of clearly defining permitted uses of the CMFs. During PY1 many practices and CTOs requested clarification on permitted uses of the funds and were advised by CMS to "consult with their attorneys" and that no further clarification would be provided. As a result, program participants have been forced to narrowly interpret permitted uses.

As a key component of the TCOC Model, the State believes the intention of the CMFs is to be used broadly for the support of care transformation activities at the practice level and activities to support the practice transformation at the CTO level, all directed at support of patients cared for by the practices. There has been confusion among practices and CTOs as to whether activities that bring broad based transformation and care improvements that are not limited to Medicare FFS beneficiaries attributed to practices under the MDPCP are permitted.

We recommend offering official guidance via FAQs and Office Hours to clearly communicate that any activity not listed on the prohibited activity list is permitted and specifically that activities that broadly affect the health of all patients are also permitted.

3. **Reduce practice administrative burden**

CMS has stated willingness and intention to reduce administrative burdens to providers and practices. CMS Administrator Seema Verma recently

announced the formation of a new commission to make recommendations for reduction of burden (Office of Burden Reduction and Health Informatics). The State is in full agreement with this intention and thereby makes the following recommendations to reduce administrative burden in the MDPCP without detracting from the purpose of transforming healthcare or reducing the ability to evaluate program efficacy.

a) Establish a single help desk for the program
b) Establish a single communication channel accessible to all practices
c) Create a central program portal for both program application and administration
d) Reduce need for annual Participation Agreements, instead using amendments as necessary
e) Reduce user verifications, staff roster uploads, and other administrative requirements to once per year
f) Simplify guidance and requirements for quality reporting

We recommend the above delineation of areas to reduce administrative burden in the MDPCP without compromising care transformation at practices or evaluation of program goals and efficiency.

4. **Send Care Transformation Requirement progress feedback data to participants**

Per the RFA, the State recommends that CMMI provide an annual report to each practice that provides clear data on the practice's performance. Performance will include quality and utilization measured against the previously communicated benchmarks and its peers in MDPCP.

In addition to future inclusion of benchmark data, we recommend including practices' current progress on the CTRs with a comparison against its peers in MDPCP.

RECOMMENDATIONS TO UPDATE UTILIZATION, QUALITY, AND PATIENT EXPERIENCE MEASURES

1. **Revise process for choosing utilization and quality measures, comparison groups, and benchmarks**

   The intent of the TCOC model contract is to test the effectiveness of a statewide program of payment and delivery reform in improving health and lowering costs of care. The State has been afforded the flexibility to select the population health measures under the agreement. In order to further the broad collaboration with providers participating in the MDPCP, the PMO has participated in discussions on the measure selection and benchmarking for MDPCP, with the final decisions resting with CMMI.

   In PY1 there were several unanticipated challenges in capturing the measure related to substance abuse (NQF0004) that led to the abandonment of this measure in the calculation of the PBIP. The challenges associated with capturing this measure and the attendant uncertainty related to the PBIP impact distracted and caused unnecessary work for many MDPCP participants. Additionally, benchmarks and comparison groups for PY1 were not revealed to participants until well into PY2, raising unanswered questions by participants.

   Quality and utilization measures, benchmarks, and comparison groups for PY2 were also delayed well into the actual program year. During PY2, the Advisory Council took an interest in the development and alignment of measures, benchmarks, and comparison groups. The Advisory Council represents a broad group of stakeholders, including representation from MedChi, The Maryland State Medical Society, payers, HSCRC, consumers, the Maryland Hospital Association, and experts in quality measurement. This group together with technical support from the PMO is best positioned to align the quality and utilization measures with the broad interests of the state in a more efficient and easily incorporated manner than the current process.

   The State proposes that beginning for PY4 measure setting, the quality measure development, benchmarks, and comparison group selection be made by the State in alignment with the State's overall Population Health Improvement Plan and hospital quality improvement goals. Measures would be delivered to CMMI in advance of each program year for inclusion in the PBIP adjudication process.

2. **Pilot new consumer satisfaction survey for 2021**

The PMO recommends piloting the American Academy of Family Physicians (AAFP) Person-Centered Primary Care Measure in 2021 to better assess consumer experience. In the future, this consumer experience survey may become the standard for primary care practices. Sponsored and studied by the Robert Graham Center in conjunction with the AAFP, the module has been developed to enhance accuracy and administration of patient experience measurement. Moreover, it would reduce the administrative burden of uploading rosters and completing the CAHPS process.

The Person-Centered Primary Care Measure uses an 11-item patient survey to assess patient experience, and combines responses into a single measure to assess the breadth of patient experience in primary care. The 11-item Person-Centered Primary Care Measure is available from QPP at https://qpp.cms.gov/mips/explore-measures/quality-measures.

The Person-Centered Primary Care Measure uses a single measurement to assess diverse primary care mechanisms hypothesized to be associated with better personal and population health, equity, quality, and sustainable health care expenditure, including:

- accessibility,
- a comprehensive, whole person focus,
- integrating care across acute and chronic illness, prevention, mental health, and life events,
- coordinating care in a fragmented system,
- knowing the patient as a person,
- developing a relationship through key life events,
- advocacy,
- providing care in a family context,
- providing care in a community context,
- goal-oriented care, and
- disease, illness, and prevention management.

Source: https://www.annfammed.org/content/17/3/221.full

We recommend piloting use of the Person-Centered Primary Care Measure to measure patient experience as a substitute for the CAHPS survey in PY3. This measure is comprehensive in assessing the patient

experience in primary care, is less burdensome for the patient to complete, and is simpler to evaluate the results.

RECOMMENDATIONS PERTAINING TO GOVERNANCE, ADMINISTRATION, AND DELEGATION TO THE STATE

1. **Learning System cooperative management and leadership**

   The State recommends that portions of the Learning System, exclusive of Connect and annual CMMI guides, be delegated to the State. The State believes it is in position to offer technical assistance and guidance in the following areas:

   - high-level planning for the Learning System (jointly with CMMI and Lewin)
   - webinars
   - affinity groups
   - in-person events
   - practice spotlights

   Importantly, the Learning System requires shared leadership and decision making. We propose developing a shared purpose for the Learning System and a corresponding shared leadership. Shared leadership for the Learning System would include:

   - CMMI MDPCP director/lead
   - CMMI Learning lead
   - CMMI contractor lead
   - PMO executive director
   - PMO learning lead

   We recommend delegation of the above listed portions of the Learning System to the State, with an appointed joint CMMI-State leadership and decision making body.

2. **Establish joint and equitable governance structure for the PMO (State) and CMMI on MDPCP policy issues**

   Clearly defined governance is a critical feature for any successful enterprise. The TCOC contract indicates that "the MDH will assist CMS in the implementation of the Maryland Primary Care Program ('MDPCP') to provide better patient-centered care for Maryland residents", without further defining the scope of assistance provided by MDH or the roles and responsibilities variously of the State and CMS in implementing MDPCP.

MDH established the Program Management Office (PMO) under the Secretary to serve as a management vehicle for MDH. Together with the Secretary and the Maryland Healthcare Commission, the PMO established the MDPCP Advisory Council. The PMO also conceived the CTO concept and provides strategic leadership to CTOs, jointly delivers with CMMI (Lewin) the Learning System, manages a variety of operational and program development processes, works with community partners, recruits practices, and serves as the State leadership source for the MDPCP.

As a key component of the TCOC Model and its success in Maryland, it is imperative that the State have an equitable role in governance of MDPCP. The State and its stakeholders have taken full financial risk for the Model including the MDPCP. Despite that, the State holds little control over how MDPCP is managed or altered over time to meet the Model's goals.

In particular, CMMI has taken the role of unilateral decision making for all policy and major programmatic issues. The State, through the PMO, has had a voice in the decision making process but falls short of having a vote. The State believes that the overall program would be best served through the establishment of a clearly defined governance structure that provides balanced input and decision making between the State and CMMI. The unique relationship between CMMI and the State with the MDPCP does not exist in any other CMMI-State programs. The State suggests the governance structure will facilitate the policy decision making process and allow Maryland stakeholders to have a greater sense of inclusion and ownership of the MDPCP.

The State recommends the establishment of a shared governance structure for the management of MDPCP effective starting PY3. Governance would include a regular meeting schedule, joint sign-off on policy decisions and major program documents, and a plan for dispute resolution. The State suggests that the governance structure should include the lead member of the CMMI MDPCP team, the Executive Director of the MDPCP, the Secretary of MDH (or designee), Director of CMMI (or designee), and the State Employed Co-Chair of the MDPCP Advisory Council. This team should meet on a regular basis to determine vision and major program decisions.

LOOKING AHEAD

In 2019, the State and CMMI worked collaboratively on several innovation and expansion projects for future program years, and has continued to innovate and expand for PY2. In the first year of the program, Medicare was the only participating payer. After extensive discussions over 2019, CareFirst BlueCross BlueShield, the state's largest commercial payer, was approved as an aligned payer in 2020. As of 2018, CareFirst enrollment in the Maryland large group market was over 560,000 (55% market share), in the Maryland small group market was over 186,000 (70% market share), and in the Maryland individual market was over 165,000 (69% market share). Since 2011, CareFirst has had its own Patient-Centered Medical Home (PCMH) program with 4,400 physicians and nurse practitioners (as of 2018).[10] Importantly, 438 out of 476 MDPCP practices also participate in the CareFirst PCMH program. This alignment for primary care practices is critical to reducing administrative burden and streamlining practices' workflows.

In an effort to extend the program to more practices serving vulnerable populations, the State and CMMI have added Maryland's Federally Qualified Health Centers (FQHCs) as eligible participants beginning in January 2021. Moving forward, the program anticipates Medicaid and additional commercial payers will join over time. In an effort to further drive MDPCP to align with national trends in primary care and towards population-based payments, the State will be working collaboratively with CMMI to develop a Track 3 for the program.

MDPCP will continue to innovate to provide the best care at the right time in the best setting for Marylanders. We look to the near future to:

- Continue to address the urgent COVID-19 crisis and ensure primary care practices are resilient to the pandemic threat.
- Innovate and expand telehealth and remote patient monitoring.
- Pilot advanced machine learning algorithms turning data into actionable intelligence at the point of care.
- Identify and address the social needs of patients within a coordinated system of care built on the state HIE.
- Add meaningful measures of effectiveness of care through enhanced patient surveys.
- Adjust the primary care payment system to be resilient and sufficient to meet the needs of practices in support of those they serve.

[10] https://member.carefirst.com/members/news/media-news/2018/carefirst-patient-centered-medical-home-program-nets-billion-in-savings-since-2011.page

APPENDIX

Table 1. Select MDPCP Practice Information

Category	Sub-category	Total #
CTO Affiliation	Practices Affiliated with a CTO	298
	Practices Not Affiliated with a CTO	82
	Total # of Practices	*380*
Track	Track 1	342
	Track 2	38
Provider Types	Clinical Nurse Specialist or Nurse Practitioner	344
	Physician (MD or DO)	1,222
	Physician Assistant	150
	Total # of Providers	*1,716*
Staff Types (2019)	Behavioral Health/Social Worker	27
	Care Manager/Care Coordinator	150
	Consultant	135
	Dietitian/Nutritionist	7
	Health Educator	1
	Laboratory/Radiology Technician	12
	Licensed Practical Nurse (LPN)	41
	Medical Assistant	1,139
	Other Health Staff	401
	Pharmacist/Pharmacy Technician	7
	Physical/Respiratory Therapist	2
	Practice Supervisor/Practice Manager	270
	Quality Improvement Specialist	18
	Receptionist/Appointing	1037
	Registered Nurse (RN)	129
	Total # of Staff	*3,376*

Table 2. Select MDPCP FFS Beneficiaries' characteristics for 2019

Sub-Category 1	Sub-category 2	Total
Age Group Distribution	64 and Younger	8%
	65 to 69	15%
	70 to 74	15%
	75 to 79	21%
	80 to 84	14%
	85 and Older	15%
Beneficiaries By HCC Risk Tier	Low-Risk Beneficiaries	49,560
	Medium-Low Risk Beneficiaries	53,738
	Medium-High Risk Beneficiaries	42,559
	High Risk Beneficiaries	20,933
	Complex Risk Beneficiaries	52,849
Chronic Conditions	Alzheimer's Disease	8,036
	Alzheimers Disease and Related Disorders or Senile Dementia	25,615
	Acquired Hypothyroidism	34,447
	Asthma	11,300
	Atrial Fibrillation	25,088
	Benign Prostatic Hyperplasia	17,011
	Chronic Kidney Disease	60,804
	Chronic Obstructive Pulmonary Disease and Bronchiectasis	21,194
	Diabetes	66,660
	Hyperlipidemia	120,903
	Hypertension	138,877
	Osteoporosis	15,984
	Stroke	9,474
	Female/Male Breast Cancer	8,472
	Colorectal Cancer	2,659
	Prostate Cancer	8,456
	Lung Cancer	2,693
	Endometrial Cancer	955
	Acute Myocardial Infarction	2,010

Anemia	47,846
Hip/Pelvic Fracture	1,246
Cataract	34,564
Glaucoma	27,029
Depression	37,843
Heart Failure	37,843
Ischemic Heart Disease	61,998
Rheumatoid Arthritis/Osteoarthritis	84,275

Table 3. MDPCP CTO Staff Levels for 2019

Sub-category 2	Total
Care Manager - Medical Assistant	17
Care Manager - Other	36
Care Manager - RN	97
Community Health Worker	27
Data Analyst	16
Health IT Support	10
Licensed Social Worker	21
Nutritionist	2
Other	135
Pharmacist	16
Practice Transformation Consultant	14
Psychiatrist	13

Table 4. Breakdown of quality and utilization measure scores by different practice types

Measure	Category	Practices	Mean	P-Value
HbA1C Poor Control (CMS122v6)*	Total	220	26.11%	
	Track 1	216	26.27%	0.3534
	Track 2	4	17.52%	
	CTO-No	29	28.42%	0.4849
	CTO-Yes	191	25.77%	
	Practice Size - 1-3	123	26.80%	0.5237
	Practice Size - 4+	97	25.24%	
	MSSP-No	175	26.95%	0.0287
	MSSP-Yes	45	22.90%	
Init. & Eng. of AOD Treatment (CMS137v6)	Total	168	14.21%	
	Track 1	164	14.52%	<.0001
	Track 2	4	1.51%	
	CTO-No	19	33.56%	0.0122
	CTO-Yes	149	11.58%	
	Practice Size - 1-3	86	18.35%	0.0423
	Practice Size - 4+	82	9.81%	
	MSSP-No	124	18.14%	<.0001
	MSSP-Yes	44	3.21%	
Controlling High BP (CMS165v6)	Total	221	67.92%	
	Track 1	217	67.81%	0.3995
	Track 2	4	73.46%	
	CTO-No	29	64.82%	0.1856
	CTO-Yes	192	68.37%	
	Practice Size - 1-3	123	67.47%	0.5713
	Practice Size - 4+	98	68.46%	
	MSSP-No	175	67.76%	0.0244
	MSSP-Yes	46	64.74%	
	Total	375	1.2674	
	Track 1	337	1.2853	<.0001
	Track 2	38	1.1084	

Inpatient Utilization (AHU)*	CTO-No	82	1.2073	0.0009
	CTO-Yes	293	1.2842	
	Practice Size - 1-3	206	1.2456	0.0102
	Practice Size - 4+	169	1.2939	
	MSSP-No	252	1.2504	0.0125
	MSSP-Yes	123	1.3016	
ED Utilization (EDU)*	Total	375	0.8431	
	Track 1	337	0.8600	<.0001
	Track 2	38	0.6935	
	CTO-No	82	0.8198	0.2806
	CTO-Yes	293	0.8497	
	Practice Size - 1-3	206	0.8517	0.4098
	Practice Size - 4+	169	0.8327	
	MSSP-No	124	0.8391	0.6350
	MSSP-Yes	44	0.8507	
CAHPS Summary Score	Total	320	80.23%	
	Track 1	284	80.05%	0.0144
	Track 2	36	81.69%	
	CTO-No	76	80.90 %	0.0803
	CTO-Yes	244	80.02%	
	Practice Size - 1-3	179	80.70%	0.0135
	Practice Size - 4+	141	79.64%	
	CAHPS Response Rate - (0% - 28%)	164	79.07%	<.0001
	CAHPS Response Rate - 28%+	156	81.46%	
	MSSP-No	252	80.51%	0.0131
	MSSP-Yes	68	79.22%	

*Inverse measure. Lower score indicates higher performance.

Red highlighting indicates that a difference in means is statistically significant at the .05 level.