Maryland
DEPARTMENT OF HEALTH

2020 ANNUAL REPORT

MDPCP
MARYLAND PRIMARY CARE PROGRAM

ACKNOWLEDGMENTS

The 2020 Maryland Primary Care Program (MDPCP) Annual Report was written as a collaborative effort between the MDPCP Program Management Office at the Maryland Department of Health and many partners, including the MDPCP Advisory Council. Sincere gratitude is extended to all who contributed to the Annual Report, as well as the primary care practices doing the important care transformation work for patients in Maryland.

Authors

- Secretary Dennis Schrader
- Howard Haft, MD, MMM, CPE, FACPE
- Chad Perman, MPP
- Alice Sowinski-RIce, MPH
- Stephen Bowden, MA, MPH
- Emily Gruber, MBA, MPH
- Raghavi Anand, MPH
- Kayleigh Hope
- Jamie Roa

Reviewers

- Bob Atlas, MBA
- Michael Barr, MD, MBA, MACP, FRCP
- Robert Berenson, MD, FACP
- Scott Berkowitz, MD, MBA
- Kenneth Buczynski, MD
- Melanie Cavaliere, MS*
- Cathy Chapman, CRNP, RN
- Stacia Cohen, RN, MBA
- Willem Daniel, MA
- Allan Field, LFACHE
- Kevin Hayes, PhD
- Debora Kuchka-Craig, MS, FHFMA
- Kathleen Loughran
- Nkem Okeke, MD, MPH, MBA, MSPM
- Anene Onyeabo, MPH, PMP*
- Mai Pham, MD
- Gene Ransom III, JD
- Michael Riebman, MD
- Scott Rose, JD
- Steven Schuh, MBA, MS
- David Sharp, PhD
- Ben Steffen, MA
- Alana Sutherland, MPH*

* Staff Support

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Glossary

ACRONYM	EXPANSION
AAPM	Advanced Alternative Payment Model
ADI	Area Deprivation Index
AHU	Acute Hospital Utilization
APM	All Payer Model
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBO	Community-Based Organizations
CMF	Care Management Fee
CMMI	Center for Medicare and Medicaid Innovation
CPC+	Comprehensive Primary Care Plus
CPCP	Comprehensive Primary Care Payment
CRISP	Chesapeake Regional Information System for our Patients
CRP	Care Redesign Program (HSCRC)
CRS	CRISP Reporting Suite
CTO	Care Transformation Organization
CTR	Care Transformation Requirement
CVI	COVID-19 Vulnerability Index
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
EDU	Emergency Department Utilization
EHR	Electronic Health Record
ENS	Encounter Notification System
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FVF	Flat Visit Fee
GBR	Global Budget Revenue
HCC	Hierarchical Conditions Category
HEART	Health Equity Advancement Resource and Transformation
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
HSCRC	Health Services Cost Review Commission
IP	Inpatient
IT	Information Technology
mAb	monoclonal Antibodies
MDH	Maryland Department of Health
MDPCP	Maryland Primary Care Program
MIPS	Merit-based Incentive Payment System
MUA	Medically Underserved Areas
OB-GYN	Obstetrics and Gynecology
PBIP	Performance Based Incentive Payment
PBPM	Per Beneficiary Per Month
PFAC	Patient Family Advisory Council
PMO	Program Management Office

PPE	Personal Protective Equipment
POC	Point of Care
PQI	Prevention Quality Indicator
Pre-AH	Prevent Avoidable Hospital Events (tool)
PY1	Program Year 1
PY2	Program Year 2
QPP	Quality Payment Program
RFA	Request for Applications
SBIRT	Screening, Brief Intervention and Referral to Treatment
SIHIS	Statewide Integrated Health Improvement Strategy
TCOC	Total Cost of Care

Executive Summary

The 2020 Maryland Primary Care Program (MDPCP) Annual Report presents findings on the second program year and progress towards primary care transformation for 476 primary care practices across the state of Maryland. MDPCP supports Maryland's statewide health transformation with the goal of building a strong, effective primary care delivery system, inclusive of medical, behavioral, and social needs. The advanced primary care model in MDPCP includes targeted care management, behavioral health integration, screening and referrals for unmet social needs, and continuous, data-driven quality improvement. The Center for Medicare and Medicaid Innovation (CMMI) MDPCP team and the Maryland Department of Health Program Management Office (PMO) jointly manage MDPCP and provide support and technical assistance to practices. Practices can choose to receive additional support around staffing, technical assistance, and administration through a partnership with Care Transformation Organizations (CTOs). A team of practice coaches at the PMO work with practices and CTOs to progress through the program and implement care transformation requirements. Additional practice support includes: a comprehensive and free learning and education system; reports, dashboards, and outreach staff support from the state designated Health Information Exchange (CRISP); advanced analytics from The Hilltop Institute at the University of Maryland, Baltimore County (UMBC); implementation support for Screening, Brief Intervention, and Referral to Treatment (SBIRT) workflows for patients with behavioral health needs from Mosaic Group; and contractors supporting additional patient related needs.

As part of Maryland's Total Cost of Care (TCOC) Model, MDPCP is designed to operate from 2019 through 2026, at which point CMMI will evaluate how well the model met its goals to determine its permanence. Practices in MDPCP participate in either the basic track (Track 1) or the advanced track (Track 2). Practices in Track 2 receive additional payments through an adjusted pre-payment mechanism and are required to implement additional care transformation activities. Practices must transition from Track 1 to Track 2 no later than their third year of program participation.

Through investment in a robust, organized, and enhanced primary care system, MDPCP aims to reduce avoidable hospital and emergency department visits, lower overall health system costs, and improve quality outcomes for all Marylanders. Additionally, the integration of public health and primary care driven by MDPCP creates the infrastructure necessary for rapid coordination and response to public health emergencies, as seen through the COVID-19 pandemic. Additional details on payments and care transformation requirements are found in the body of the Annual Report.

Meeting MDPCP's Program Year 2 Objectives

The report that follows provides details on the rapidity of broad-based healthcare delivery transformation that occurred during the second program year (Program Year 2, or PY2) of MDPCP. Of the 476 practices that participated in 2020, the majority (74.4% or 354 practices) were Track 1 practices. About 41% of these Track 1 practices (147 practices) were able to

successfully transition to Track 2 for 2021. In PY2, practices made substantial gains in broad care transformation, quality, and utilization measures and finished the year meeting the second year objectives of the program:

- **Infrastructure Enhancement** - Continuing to build 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, social needs, and provides continuity of care
- **Quality and Utilization Improvement** - Establishing data tools and quality improvement processes that allow practices to monitor their performance

Additionally, the emergence of COVID-19 in Maryland in March 2020 prompted MDPCP to adopt an *ad hoc* objective for PY2: **Support practice and CTO efforts to address COVID-19, thereby mitigating the disease's impact on the state**.

Infrastructure Enhancement

During PY2, MDPCP continued to foster a robust, statewide network of dedicated primary care practices that were eager to transform care to better serve their patients. MDPCP facilitated care transformation by engaging in a number of public-private partnerships in healthcare delivery. PY2 partnership activities included the following:

- Chesapeake Regional Information System for our Patients (CRISP) - Provided a suite of beneficiary claims reports designed for MDPCP practices
- The Hilltop Institute - Continually updated an Artificial Intelligence (AI) model developed with MDH for predicting avoidable hospital events that is available to practices through their CRISP dashboard
- Mosaic Group - Practice-level implementation of the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to address behavioral health needs
- Community-based organizations - Supported patients' social needs through electronic referrals
- Socially Determined, Inc. - Provided a specific COVID-19 Vulnerability Index (CVI) to practices to allow for prioritized, equitable attention to the needs of the most vulnerable patients

Care Transformation

The primary goal of MDPCP is the sustainable transformation of the delivery of primary care across the state to include all elements of advanced primary care to support the health needs of Marylanders. MDPCP practices must submit semiannual reporting on questions pertaining to meeting the program's five Care Transformation Requirements (CTRs) to show their progress in implementing care transformation. MDPCP practices' responses to CTR questions demonstrate that their capacity to meet various program CTRs improved significantly between Q1 of PY1 and

Q3 of PY2. From January 2019 until September 2020, the key takeaways from practices' responses to the CTR questions indicate that:

- Practices offered patients greater access to medical treatment.
- Practices' use of care management expanded.
- Beneficiary follow-up rates after ED and hospital discharge continued to increase.
- The number of practices that screen their beneficiaries for unmet social needs increased.

Prior to MDPCP, an important issue facing high-risk and rising risk Marylanders was the paucity of care management. By the end of PY2, MDPCP practices had brought 17.2% of Medicare fee-for-service (FFS) beneficiaries into care management using data-driven strategies for risk stratification.

Furthermore, by the end of 2020, 157 practices, with support from the State's contractor (The Mosaic Group), had fully implemented SBIRT, creating another line of defense against the opioid crisis in the community. 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.

Quality and Utilization Improvement

In addition to the quarterly reporting on care transformation requirements, MDPCP practices were required to submit rosters for Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and annual quality measures.

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

- ***Clinical Quality*** *(compared to national CMS reporting)* - Clinical performance remained high despite the ongoing complications with the COVID-19 pandemic. The majority of practices continued to perform above the national median on both eCQMs.
- ***Patient Satisfaction*** *(compared to national Comprehensive Primary Care Plus (CPC+) practices)* - CAHPS performance decreased slightly; though due to the narrow performance margins and PBIP calculation methodology, this had a significant negative impact on PBIP retention.
- ***Utilization*** *(compared to all practices with Maryland FFS beneficiaries)* - Utilization decreased significantly when compared to historical, expected projections. Even after adjusting the benchmarks to be concurrent with 2020 Maryland utilization, MDPCP practices still performed better than the benchmark population.

- ***Cost*** *(compared to a closely-matched comparison group using a "difference-in-differences" analysis)* - MDPCP practices demonstrated reductions in utilization and cost savings even after accounting for the investment of program payments.

COVID-19

During 2020, MDPCP undertook a wide range of efforts to provide a bundle of COVID-specific support to practices and CTOs to help address pandemic-related concerns and effectively enhance the advanced primary care approach, such as:

- Initiation and execution of a webinar series to update participating primary care practices with timely information (e.g. epidemiological status of the pandemic, testing strategies, health equity data, etc.) regarding the pandemic along with resources and best practices they could use to mitigate its impact (e.g. safe office workflows, Personal Protective Equipment (PPE) use and access, etc.) during a time of misinformation and information overload
- Provision of daily clinical data to practices on hospital admissions, ED visits, workflow guidance, and data analytics tools to help anticipate avoidable complications
- Support of practice efforts to provide vulnerable patients with expanded care through telemedicine and special accommodations if they needed to be seen in person
- Enablement of practices to enroll in ImmuNet, a crucial step for receipt of the COVID-19 vaccines after the vaccines became available

As a result of these efforts, beneficiaries served by MDPCP experienced fewer cases of COVID-19, fewer hospitalizations, and fewer deaths than beneficiaries served by closely-matched practices.[11] The results were statistically significant.

Recommendations

The MDPCP PMO believes the implementation of a series of recommendations will enable MDPCP to build further on its successes at: enhancing infrastructure, transforming care, improving quality and utilization, and addressing COVID-19. The recommendations fall into four broad categories:

Recommendation 1: Concerning the Maryland State Government's Role in MDPCP

Given the significant investments that the State has made and will continue to make, the State requests a greater role to control the policies and operations of MDPCP and its interest in the creation of a sustainable, effective advanced primary care infrastructure for the health of all Marylanders.

Such an arrangement would provide for a smoother policy development process and greater buy-in from participants and state partners. Accordingly, the State and CMMI should commit to

[1] Perman C, Adashi E, Gruber E, Haft H. Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health-Supported Advanced Primary Care Paradigm. The Milbank Memorial Fund. Published September 9, 2021.

collaborative, monthly meetings with leadership on both sides to determine policy and future strategy for the program. Meetings should include a jointly developed agenda, standing items, and review of current and future challenges.

Recommendation 2: Concerning Evaluation of MDPCP

To reduce confounding variables in the Program Evaluation, every effort should be made to maintain programmatic fidelity regarding program policy throughout the evaluation period. The State recommends that policy changes made to MDPCP recently should be taken into consideration when evaluating the program.

Recommendation 3: Concerning Performance-Based Incentive Payment (PBIP) Design Improvement

The State's recommendations for improvements to PBIP design are multi-faceted:

- In the wake of challenges experienced with the CAHPS measure nationwide during 2020, the State looks forward to meeting with CMMI to discuss opportunities to improve the approach to CAHPS.
- The State recommends exploring alternative methods of evaluating patient satisfaction. The State and CMMI have already begun initial discussions regarding piloting the new Patient Centered Primary Care Measure (PCPCM) patient satisfaction measure from the American Board of Family Medicine, and the State looks forward to the opportunity to submit a more detailed pilot proposal.
- The PBIP structure and requirement to attain 50% on Quality to qualify for any PBIP retention resulted in a significant negative impact to participants' 2020 performance. While the State supports the focus on clinical quality and patient satisfaction, the quality gate used for PBIP retention should be reevaluated.
- The State recommends setting benchmarks prospectively to reward good performance. Additionally, strategies to reward improvement in addition to attainment should be considered in future performance years.

Recommendation 4: Concerning an Increase in the Program's Focus on Health Equity

To achieve the State and CMMI's shared goal of advancing health equity, the State recommends an increased focus on health equity through initiatives such as: providing HEART payment support and technical assistance, sharing analysis of HEART payment effectiveness, exploring an equity-focused performance measure, disaggregating of CAHPS data in a feedback report, and including an equity lens in core CMMI documentation for the program.

Promulgation Statement

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

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

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

Introduction to the Maryland Primary Care Program

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 program's goal is to create statewide healthcare transformation and improve health outcomes while reducing avoidable. Inpatient (IP) and Emergency Department (ED) utilization. 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 2 (PY2) of MDPCP include:

1. Strengthening primary care infrastructure
2. Broad care transformation
3. Meeting goals in clinical quality and utilization performance

Additionally, with the onset of the COVID-19 pandemic and its significant impact, a major objective that emerged during PY2 was working with MDH Public Health Services to mitigate harm to Marylanders. The report will provide details on the measurable and impactful elements of primary care transformation achieved in 2020, the second program year of MDPCP.

Alignment with Maryland Total Cost of Care Model

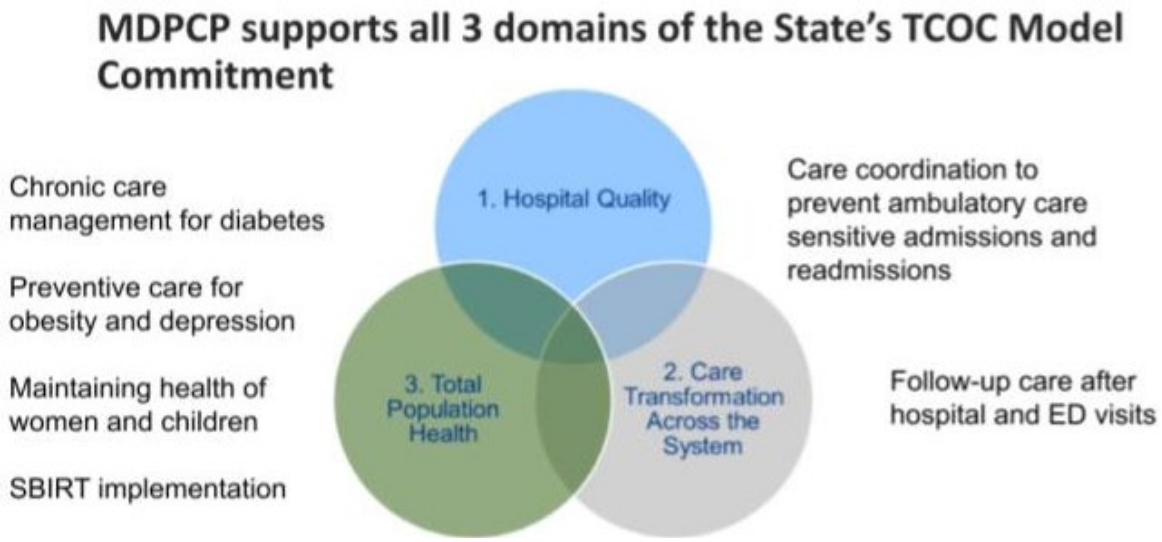
MDPCP is part of a broader state initiative to transform care and reduce costs across the Maryland health system. In 2014, under the All Payer Model (APM), Maryland began this initiative at the hospital level, moving Maryland hospitals to Global Budget Revenue (GBR) and addressing key quality and utilization measures. In 2019, the APM transitioned to the Total Cost of Care (TCOC) contract with the Centers for Medicare and Medicaid Services (CMS). Under this contract, MDPCP is called on "to provide better patient-centered care for Maryland residents."

In 2020, CMMI called upon the State to increase its focus on population health improvement codified in a Memorandum of Understanding entitled the Statewide Integrated Health Improvement Strategy (SIHIS). MDPCP plays key roles in achieving the SIHIS goals and milestones detailed below.

SIHIS Goals

MDPCP is a key player in all three SIHIS domains, as outlined in Figure 1. MDPCP Program Management Office (PMO) has developed a work plan that outlines how MDPCP supports each domain of the SIHIS, establishes the timeline, and identifies metrics of success and additional resources needed. Briefly, this section discusses MDPCP's role in each SIHIS domain.

Figure 1. MDPCP's Role in the SIHIS



SIHIS Domain 1: Hospital Quality	
SIHIS Goal	**MDPCP Role**
Reduce avoidable admissions and readmissions	MDPCP practices serve the majority of Marylanders and have demonstrated effectiveness in reducing hospital admissions through multidisciplinary care management and the use of data analytic tools. Success in this SIHIS domain relies on MDPCP's effective management of patients with chronic conditions and collaboration with hospitals and other stakeholders.

SIHIS Domain 2: Care Transformation, including Care Coordination and Care Transformation Initiatives for Medicare Beneficiaries	
SIHIS Goal	**MDPCP Role**
Increase the amount of Medicare TCOC or number of Medicare beneficiaries under Care Transformation Initiatives (CTIs), Care Redesign Program, or successor payment model	MDPCP is part of the broad care transformation across the state. Although not included in the list of hospital-sponsored care transformation initiatives, MDPCP is a vital component of successful statewide transformation.
Improve care coordination for patients with chronic conditions	MDPCP practices serve the majority of Marylanders and are responsible for the continuous care for those with chronic conditions. MDPCP has produced positive results in improving the continuity of care after discharge from hospital and/or EDs using a multidisciplinary care management approach, as demonstrated by the data in the Objective 2 section on pg.39 of this report. MDPCP is central to success in this measure.

SIHIS Domain 3: Total Population Health, including Diabetes Prevention and Management, Opioid Overdose Mortality, and Maternal and Child Health	
Goal	**MDPCP Role**
Reduce the mean Body Mass Index (BMI) for adult Maryland residents	MDPCP practices measure and respond to elevated BMIs for their patients on a regular basis. In order to provide additional incentive for success in this measure, MDPCP will be introducing a new electronic Clinical Quality Measure (eCQM) to the Performance Based Incentive Payment (PBIP) in 2021. The eCQM requires that, for patients with a BMI outside of normal parameters, there is an appropriate follow-up plan detailed in the Electronic Health Record (EHR) such as specialist or weight management referrals.

Improve overdose mortality	MDPCP has provided practices with technical assistance and contractor support to address substance use disorder at the practice level with the implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT). One of the SIHIS benchmarks is the implementation of SBIRT in 200 practices by the end of 2021. At the time of this writing, in Q4 2021, SBIRT has been implemented in over 300 practices, far exceeding the milestone.
Reduce severe maternal morbidity rate	MDPCP will collaborate with Primary Care and Obstetrics and Gynecology (OB-GYN) providers to reduce the risks for severe maternal morbidity to assure that women of child-bearing age are in good health overall.
Decrease asthma-related ED visit rates for ages 2-17	MDPCP practices, through expanded access to care, will assist with reduction of the likelihood of unnecessary asthma related visits for their pediatric patients.

MDPCP Structure and Requirements

The overarching themes of 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 PY2 objectives. As part of their comprehensive primary care services, MDPCP's Care Transformation Requirements (CTRs) for practices describe the five key functions of advanced primary care:

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

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

1. Expanding patients' access to care
2. Empaneling patients to providers or care teams
3. Implementing data-driven, risk-stratified care management
4. Providing transitional care management
5. Coordinating care with specialists

6. Hosting Patient Family Advisory Councils (PFACs)
7. Integrating behavioral health
8. Screening for social needs and linking to community services
9. Using health information technology tools to continuously improve quality of care

Quality of care for the program is measured by practice performance on electronic Clinical Quality Measures (eCQMs). In the first year of the program, practices were required to track and report on three eCQMs; in 2020, practices were only required to track and report on Diabetes HbA1c Control and Hypertension Control. See Table 1 for more detail.

Table 1. MDPCP eCQMs by Year

Measures	2019	2020
Diabetes HbA1c Control (CMS 122)	X	X
Hypertension Control (CMS 165)	X	X
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (CMS 137)	X	

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 for the fee-for-service (FFS) portion of their revenue. Track 1 practices report on their progress toward meeting the five CTRs to Centers for Medicare & Medicaid Services (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 of and collaboration with MDH and CMMI. This unique aspect of MDPCP separates it from the Comprehensive Primary Care Plus (CPC+) model since practices were not allowed to transition between tracks in CPC+, so Track 2 practices in CPC+ had consistently superior performance as compared to those in Track 1.[2] MDPCP requires practices to transition to Track 2, which results in all participants increasing the level of advanced primary care they deliver, and providing better patient-centered care for Maryland residents.

[2] Peikes D, Anglin G, Taylor EF, Dale S, O'Malley A, Ghosh A, Swankoski K, Converse L, Keith R, Finucane M, Crosson J, Mutti A, Grannemann T, Zutshi A, Brown R. Evaluation of the Comprehensive Primary Care Initiative: Third Annual Report. Mathematica Policy Research. Published December 2016.

Roles and Operations

MDH facilitates MDPCP operations and practice transformation through its PMO comprising both office-based and field staff. MDPCP leadership, operations, and staff are all housed operationally within the PMO, and its Executive Director reports directly to the Deputy Secretary for Health Care Financing. This reporting system allows primary care practices to identify a single source of leadership within the State that offers both practice transformation 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 with practices daily. At the same time, the PMO offers regular educational webinars focused on areas of implementation such as behavioral health, COVID-19, and other topics. Additionally, contractors offer training programs, webinars, and leadership academy events to staff.

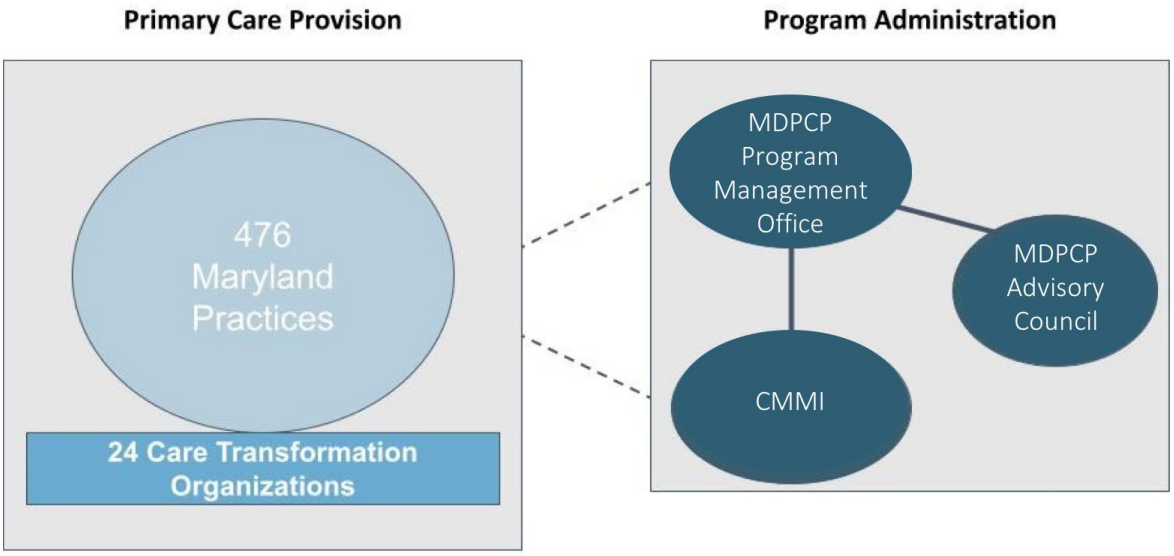
The PMO works in conjunction with federal partners at CMMI to manage MDPCP. CMMI focuses on regulatory compliance and enforces program requirements via legal Participation Agreements.

Practices have the option to receive operational and administrative support from Care Transformation Organizations (CTOs). CTOs are private entities that hire and manage interdisciplinary care management teams that provide care coordination services at the direction of the participating practices. CTOs may use their economies of scale to obtain staff and support that may be difficult for small and medium-sized practices to obtain. Practices that choose to partner with a CTO can therefore include care team members who they would have difficulty acquiring on their own such as pharmacists, clinical social workers, community health workers, and care management Registered Nurses (RNs). CTOs also offer support for care transitions, focused pharmacy reviews, standardized beneficiary screening, data tools, 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.

The Advisory Council, comprising a diverse group of stakeholders, provides input to the Secretary of Health and the PMO on the operations of MDPCP. The 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, experts in advanced primary care and other value-based payment models, private payers, the Maryland Hospital Association, MedChi (the Maryland State Medical Society), and the Health Services Cost Review Commission (HSCRC).

A description of the partners in the program can be located in Appendix A under Table A1. Figure 2 below depicts the relationship between program participants and program administration.

Figure 2. Diagram of the Different Parties Involved in MDPCP in 2020



MDPCP Reach and Scope

Reach

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

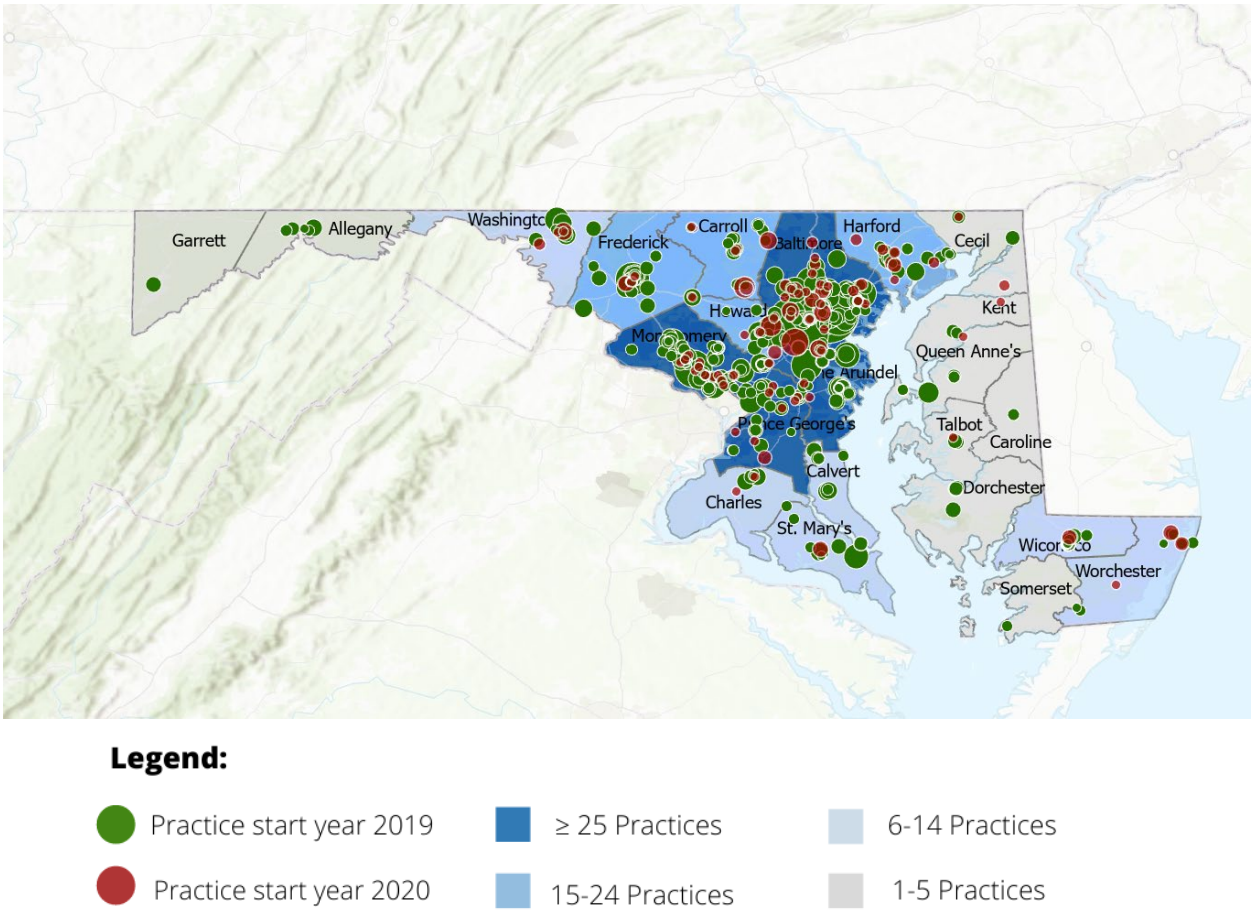
By PY2, MDPCP had already achieved a high level of adoption by Maryland primary care practices, with 476 practices engaged during the program year representing 61% of what MDH research suggests are approximately 780 eligible practices (some primary care practices in Maryland are ineligible to participate in MDPCP). These participating practices represented approximately 2,000 primary care providers in 2020.

The reach of the program is also measured by the number of Medicare FFS beneficiaries cared for by MDPCP practices. By this measure, the program has also seen a commensurate growth from PY1 (214,640 beneficiaries) to PY2 (325,770 beneficiaries).

Practice Characteristics

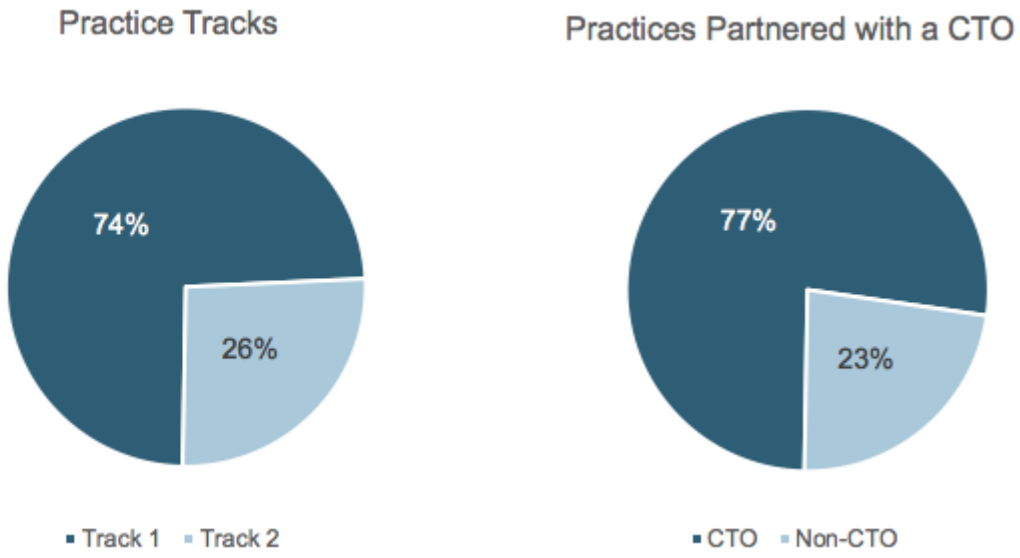
In PY2, 476 diverse practices participated in MDPCP across all counties in Maryland out of an estimated 780 eligible practices. The majority of participating practices in 2020 (75.4%) were Track 1, and most practices chose to leverage a CTO to help them meet the program transformation requirements. Approximately 2,000 providers participated in the program, including more than 1,300 physicians (MD or DO), 400 nurse practitioners/clinical nurse specialists, and more than 100 physician assistants. The map in Figure 3 displays the locations of MDPCP practices. Figure 4 shows other traits of practices that participated in MDPCP in 2020.

Figure 3. Map of Practices Participating in MDPCP in 2020*



**Practice size based on the number of participating providers is represented by the size of the dots.*

Figure 4. Percentage of Practices in Each Practice Track and Percentage Partnering with a CTO



Practice Payments

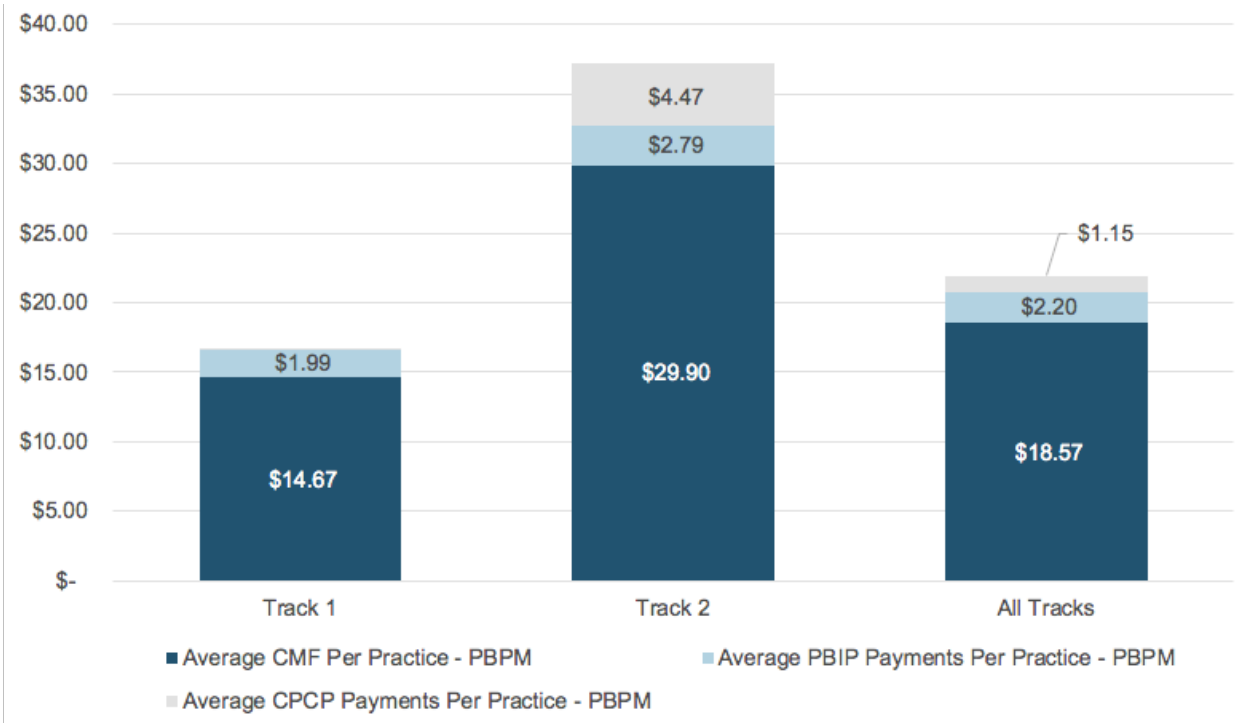
The transformation to advanced primary care is supported by enhanced payments to participating practices. In exchange for implementing changes and services, participating practices receive prospective, non-visit based Care Management Fees (CMFs) per attributed Medicare patient. Primary care practices are paid on the basis of a risk-stratified, per beneficiary per month (PBPM) CMF, 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 CTOs.

Furthermore, to encourage and reward accountability for beneficiary experience, clinical quality, and utilization that drive total cost of care, MDPCP payments include 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 the practice meets certain annual performance thresholds. The PBIP includes two distinct components: 1) incentives for performance on clinical quality and patient experience measures, and 2) hospital and ED utilization measures.

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 prospectively, and the remainder is paid when services are billed.

MDPCP payments are critical to enhancing practices' capacity to implement care transformation. In 2020, as Figure 5 displays average per beneficiary per month CMF payments to Track 1 practices totaled $14.67, and $29.90 for Track 2 practices. Furthermore, the chart displays that the average PBPM CMF payment to all practices was $18.57. Note that these amounts do not include any CMF payments to CTOs. Figure 5 contains additional information regarding the average PBPM MDPCP payments to practices in 2020.

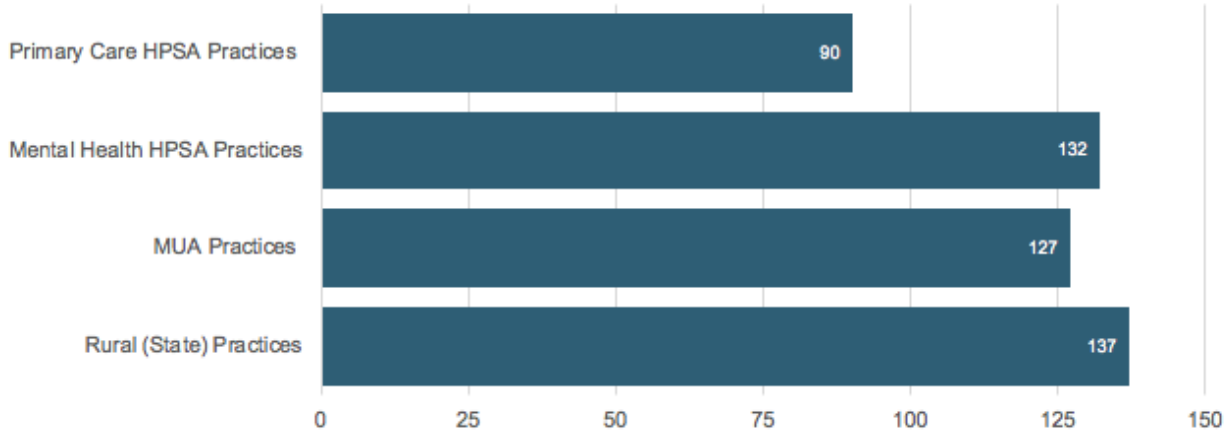
Figure 5. Average Per Beneficiary Per Month Payments to MDPCP Practices by Payment Type



MDPCP practices serve a diverse population across the state including serving as the primary source of care to vulnerable individuals in otherwise underserved areas. Many 2020 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 an "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, 90 2020 MDPCP practices were located in primary care HPSAs and 132 were located in mental health HPSAs.

HRSA also designates geographic locales where it assesses a shortage of primary care health services as Medically Underserved Areas (MUAs). Figure 6 depicts that in 2020, 127 MDPCP practices were located in MUAs. Furthermore, MDH designates specific counties as "rural." As Figure 6 shows, there were 137 MDPCP practices in 2020 that were located in counties the MDH labels as "rural."

Figure 6: Count of MDPCP Practices in Various HPSA Categories



Patient Characteristics

As of the beginning of 2020, over 325,000 Medicare FFS beneficiaries were officially attributed to MDPCP practices. However, the impact on the Maryland population is much broader, with an estimated 2.7-3.8 million total patients with other insurance types benefitting from the care being provided by these practices. The table and graphics that follow describe statistics on the MDPCP FFS beneficiary population. More specifically, Table 2 shows select MDPCP patient characteristics, Figure 7 shows the distribution of MDPCP-attributed beneficiaries by HCC risk tier, Figure 8 shows the distribution of MDPCP-attributed beneficiaries by age, and Figure 9 shows MDPCP-attributed beneficiaries by race.

From 2019, the program added 96 practice sites and gained about 500 providers. The FFS beneficiaries attributed grew by over 111,000 from 2019 to 2020 and during this same timeframe the number of dual-eligible beneficiaries (termed “duals,” and referring to beneficiaries enrolled in both Medicare and Medicaid) increased by over 18,000. The program also served an estimated 700,000 more Maryland residents in 2020 than in 2019.

Table 2. Select MDPCP Patient Characteristics

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

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

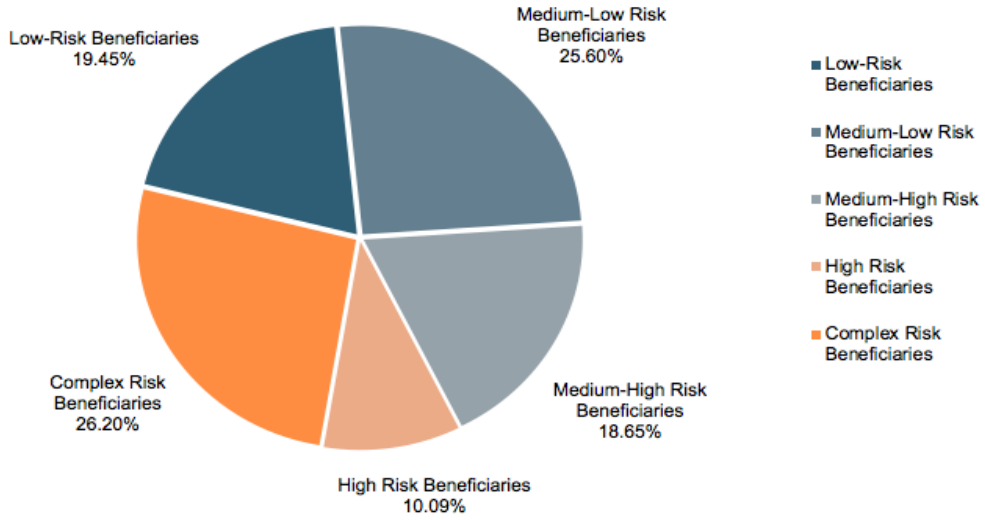


Figure 8. Distribution of MDPCP-Attributed Beneficiaries by Age Group

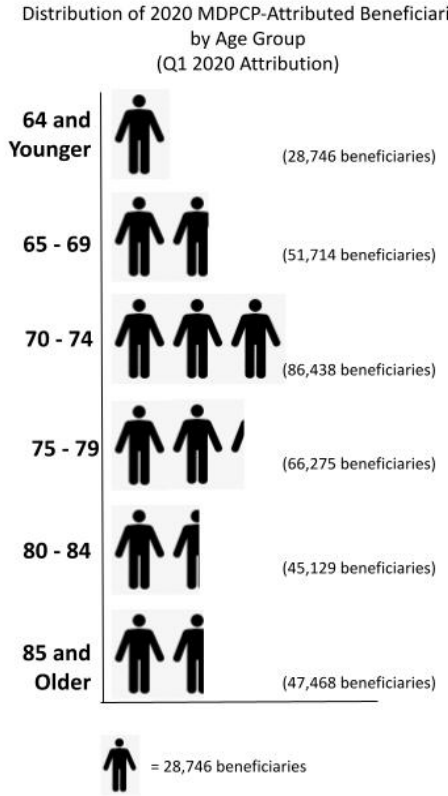
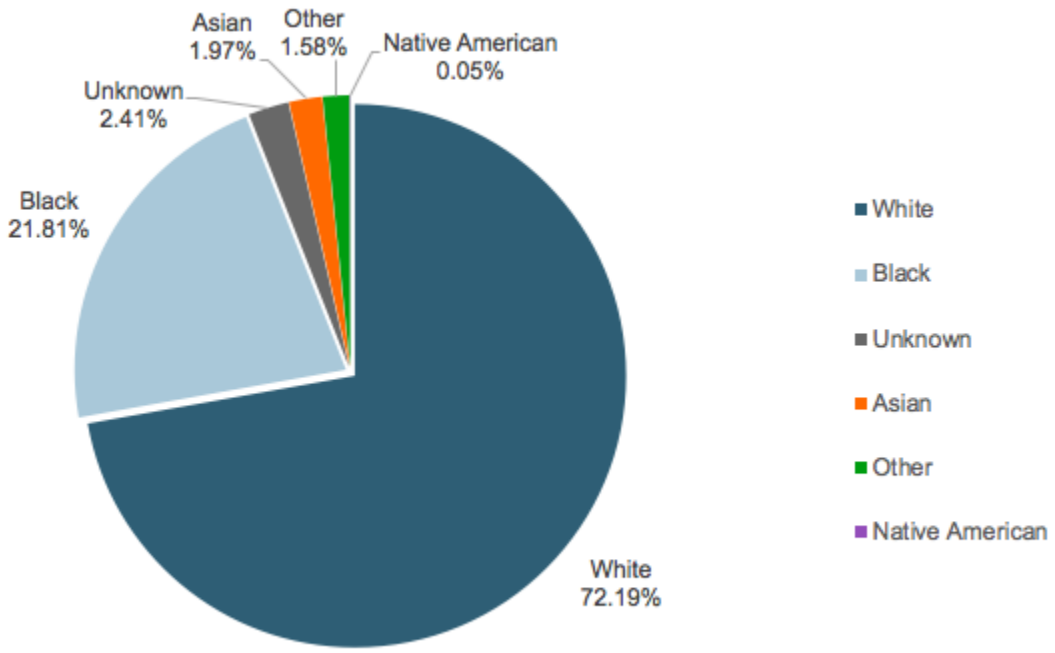


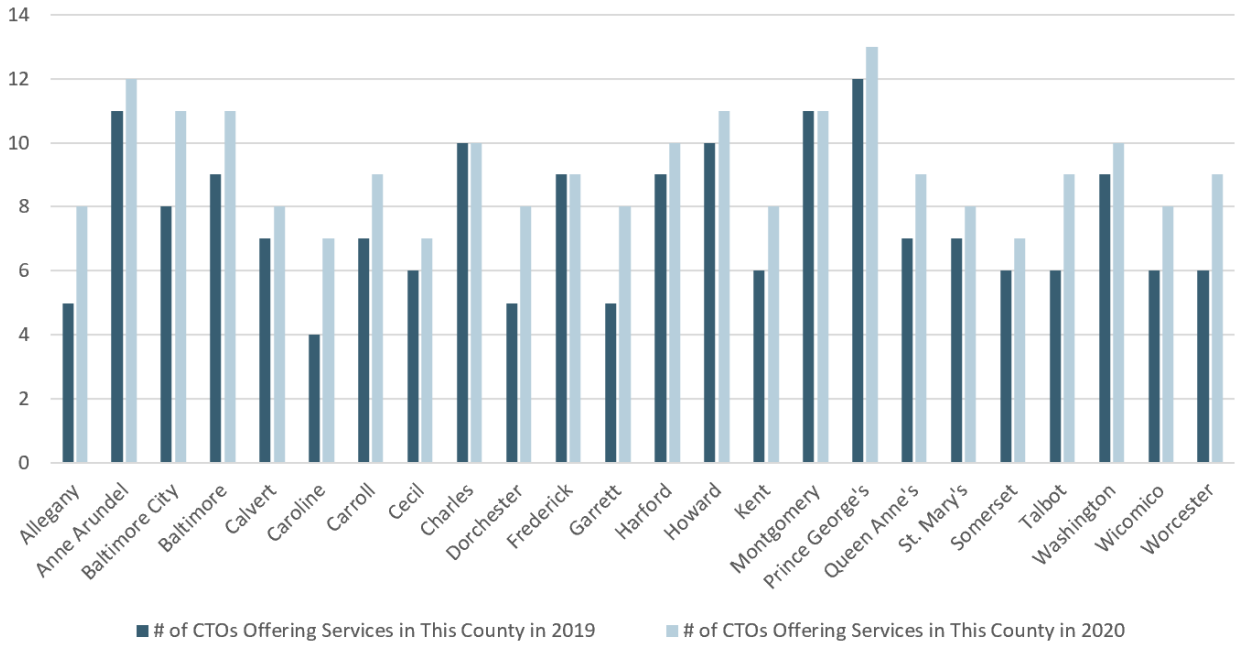
Figure 9. Distribution of 2020 MDPCP-Attributed Beneficiaries by Race



CTO Characteristics

In PY2, 24 organizations served as CTOs. The number of CTOs offering services in all 23 counties and Baltimore City ranged from seven (in Caroline County and Somerset County) to 15 (in Prince George's County). Figure 10 shows the growth in the number of CTOs offering services in each county across program years. 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 MDPCP in its first year, 298 chose to partner with a CTO (78%). 339 of the 476 practices (71%) that participated in MDPCP in 2020 were affiliated with a CTO. Participating CTOs were paired with as few as one and as many as 51 primary care practices. 21% of 2020 CTOs partnered with five or fewer practices and in 2019 CTOs partnered with a median of 15 practices. CTOs employed a wide range of staff in PY2, including behavioral health professionals, care managers, community health workers, data analysts, licensed clinical social workers, pharmacists, and practice transformation consultants.

Figure 10. Number of CTOs Operating in Each Maryland County, 2019 - 2020



Objective 1: Enhancing Primary Care Infrastructure

2020 Update on Infrastructure

To further catalyze practices' care transformation during 2020, MDPCP has engaged in several **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:

- **Chesapeake Regional Information System for our Patients (CRISP)** - The Health Information Exchange (HIE) provides a suite of beneficiary claims reports designed for MDPCP practices, including detailed reports on Prevention Quality Indicators (PQIs), specialist referrals, costs of care, and utilization compared to the state overall and closely matched non-MDPCP practices.
- **The Hilltop Institute** - The group developed an Artificial Intelligence (AI) model for predicting avoidable hospital events deployed to practices on their CRISP dashboards.
- **The Mosaic Group and other Behavioral Integration Activities** - The Mosaic Group implemented the SBIRT program to address behavioral health needs.
- **Community-based organizations** - These organizations supported social needs through electronic referrals.
- **Socially Determined, Inc.** - The group provided a specific COVID-19 Vulnerability Index (CVI) to practices to allow for prioritized equitable attention to the needs of the most vulnerable patients.

The following section of the report focuses on the key broad-scale activities initiated by the State and MDPCP practices in 2019, many in collaboration with the aforementioned partners, that began the shift to advanced primary care. In 2020, MDPCP continued to expand and improve these partnerships.

CRISP

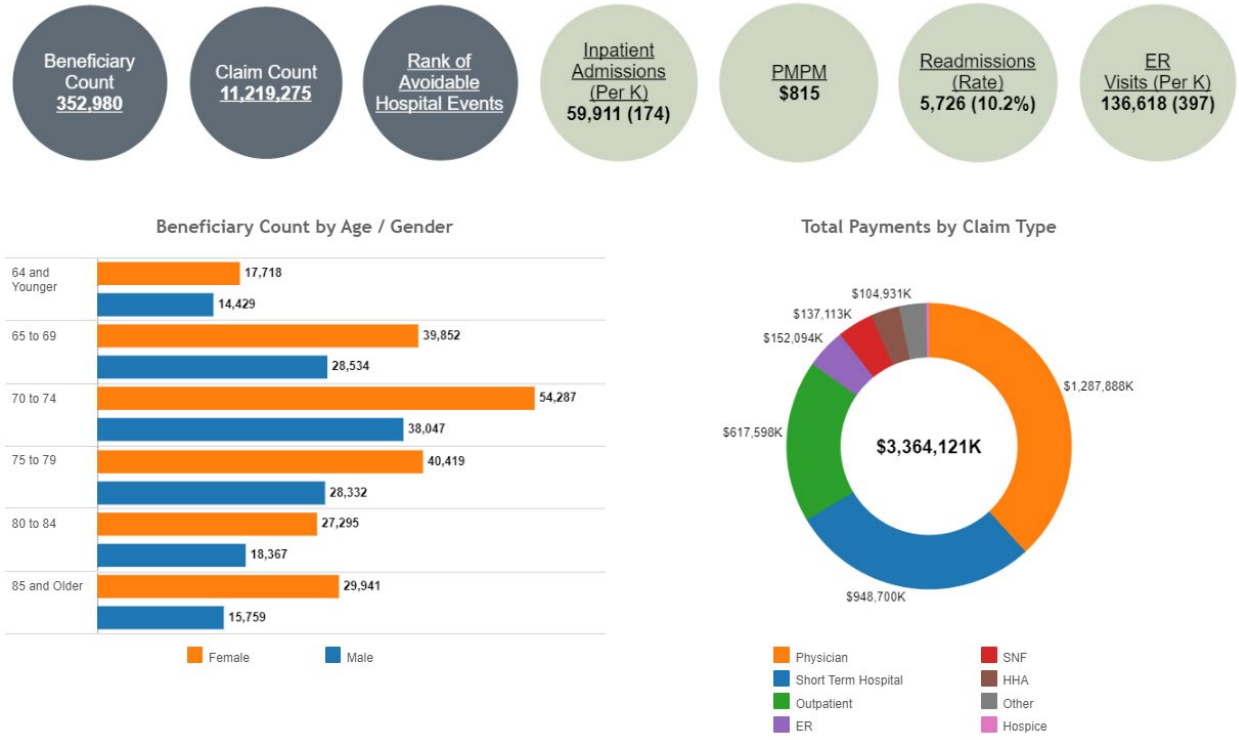
One of MDPCP's key partners in providing data-driven care has been the state designated HIE known as CRISP. CRISP provides all practices with a suite of health information technology tools, including a nearly real-time event notification system, clinical query, care alerts and patient summaries, and a prescription drug monitoring program. Figure 11 displays the default report for MDPCP CRISP reports. In 2020, MDPCP accomplished the following in partnership with CRISP:

- Added a new PQI report to allow practices to identify patients with conditions who contribute to hospital events that could have been avoided by addressing them in a primary care setting
- Worked closely with CRISP staff to resolve issues at the practice and CTO level on Encounter Notification Services (ENS) feeds and care alert updates.
- Ensured that all practices that transitioned to Track 2 used the Pre-AH Tool in 2020.

- Created brief “bite-sized” videos for every MDPCP CRISP report to train practices on how to use each report in under 15 minutes.
- Developed the capability for care teams to report and view COVID-19 test results within CRISP.
- Partnered with CRISP and Socially Determined, Inc., to develop a COVID-19 Vulnerability Index (CVI) to help practices identify the most vulnerable patients for proactive outreach and support.

CRISP provides a portal for practices to upload “Care Alerts” on their patients available across the continuum of care and Event Notifications alerting providers to their patients admitted to hospitals or EDs. In addition, CRISP also provided a referral system for practices to direct their patients to state based COVID-19 testing facilities, and an online site for COVID-19 results.

Figure 11. Example of CRISP Population Summary Report Including Multiple Drill-down Options



The Hilltop Institute at UMBC

MDPCP works closely with The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) to provide a monthly report to all MDPCP practices on their attributed beneficiaries’ risk of incurring a hospitalization or ED event that is considered preventable with ambulatory care. This report is based on a predictive model – Hilltop’s Pre-AH Model™ - and these individual-level risk scores are updated monthly and displayed in the MDPCP CRISP reports.

This model has been in production since October 2019, and several updates were made to the model and reports in 2020, including the:

- Addition of reporting drill-down screens to help care managers and providers to better understand better *which* risk factors are driving a beneficiary's likelihood of incurring an avoidable hospital event
- Webinars for program participants in partnership with Hilltop to discuss enhancements and how workflows may need to be adjusted
- Increased model retraining frequency. Hilltop shifted from a quarterly retraining schedule to a monthly cadence so that the risk scores better reflected changing healthcare utilization patterns due to COVID-19
- Inclusion of additional risk factors and other modeling changes designed to improve the predictive performance of the model
- Revision of program documentation to reflect updates to the model

The Mosaic Group and Other Behavioral Health Integration Activities

MDPCP provides 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 named Mosaic Group, a contractor experienced in integrating into primary care the evidence-based protocol for SBIRT. By the end of 2020, 157 MDPCP practices had fully implemented this process, 40 more than in 2019. The contractor has continued to work with these practices to ensure continuous improvement in the process as well as working with more practices to implement SBIRT.

Many practices have also implemented the Collaborative Care Model and the behavioral health co-location model. In the Collaborative Care Model, practices utilize proactive, relationship-based care management to establish a closed-loop referral system for patients whose behavioral health needs exceed the scope of primary care. In the behavioral health co-location model, or Primary Care Behaviorist Model, behavioral health providers are physically "co-located" in primary care practices to allow for a warm hand-off of patients with behavioral health needs. Across all MDPCP practices, 97% reported developing a strategy for integrating behavioral health into their practice workflows by the end of the Q3 via the Care Management or Collaborative Care Model, Primary Care Behaviorist Model, or other approaches for addressing behavioral health needs. Furthermore, as of the end of 2020, 69 MDPCP practices had referred patients to Mindoula, a health management company that connects patients to mental health providers who administer "Collaborative Care" treatment.

Community-Based Organizations

Acknowledging the significant impact of nonmedical factors such as housing and food insecurity on health, MDPCP practices are required to screen for and address their patients' social determinants of care. To facilitate linkages to Community-Based Organizations (CBOs) to meet social needs, the state and CRISP 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. The platform will continue to build relationships with other governmental and nongovernmental organizations to further address patients' social needs. In 2020, active partners include the following CBOs:

- Bethesda NEWtrition & Wellness Solutions
- Catholic Charities of Baltimore
- Giant Food Nutrition
- MAC Living Well
- Meals on Wheels
- NeighborRide
- PreventionLink

MDPCP anticipates more partners to be added to electronic referral (e-referral) on CRISP. In the meantime, Figure 12 shows the organizations with whom MDPCP has established relationships. Each organization highlighted in Figure 12 works with MDPCP to support practices in providing high-quality, patient-centered care for patients' medical, behavioral, and social needs.

Figure 12. MDPCP Established Relationships with Organizations

Socially Determined, Inc.

The MDPCP PMO partnered with CRISP and Socially Determined, Inc., to develop a COVID-19 Vulnerability Index (CVI). This metric represents an individual's likelihood of exposure to COVID-19 and the potential to experience severe complications requiring inpatient or critical care. The CVI is based on a multivariate model that includes the following factors:

- Demographic factors, such as advanced age
- Chronic disease burden, such as asthma, diabetes, hypertension
- Community-level SDOH risk factors, such as economic climate and resilience
- Social risk factors, such as elevated risk of food insecurity or housing instability

- Environmental factors, such as congregate sites (e.g., senior living facilities, shelters, prisons)
- Health care infrastructure, including inpatient and critical care capability

The CVI was added to the Likelihood of Avoidable Hospital Event Report within CRS so users can use both risk models together to target beneficiary outreach to those who are at high risk for avoidable hospital events (Pre-AH Tool) and are at high risk for COVID-19 (CVI). The reports also allow for tracking the status of beneficiary outreach and follow-up to enable practices to maximize the impact of their outreach and care coordination among their attributed populations.

Educational Offerings

The MDPCP PMO organized and hosted over 30 educational webinars with 1,500+ total attendees in 2020. Topics ranged from comprehensive medication management to advance care planning. Important events included:

- Staff Academy
- Provider Leadership Academy
- COVID-19 Updates Webinars
- In-person Learning Session 3 (in partnership with CMMI)
- Virtual Learning Session 4 (in partnership with CMMI)
- Affinity Groups (in partnership with CMMI)
- Webinars
- CareFirst BlueCross BlueShield Regional Collaboratives

The PMO, in conjunction with other partners, have conducted a variety of events to support the transformation process. The 2020 Learning Events Summary shows a list of events and materials available to all practices during the year. Program participants also accessed the MDPCP Connect website for the most recent program information and educational materials including chat feeds, FAQs, and workflow guides.

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. The statewide program instills a sense of belonging in participating primary care providers and the primary care community— a powerful yet intangible asset. The PMO strives to consistently articulate a clear mission and vision to the providers, leading to a synergistic effect with the tangible investments and the financial incentives.

In PY2, the PMO refined and expanded the practice supports that began in PY1. To provide hands-on support to practice leaders and staff, the PMO continued to train practice coaches who work directly and daily with practices. At the same time, the PMO offered regular webinars focused on areas of care transformation, such as behavioral health, optimal use of health Information Technology (IT), and screening for unmet social needs. The State's offerings were

directly complementary to the federal Learning System, augmenting CMMI's sophisticated distance resources in a manner customized to MDPCP. Additionally, contractors offered staff training programs, webinars, and provider leadership academies in locations across the state.

Integration with Public Health

The MDPCP PMO links the program specifically to MDH and more broadly to public health. Since the onset of the program, MDPCP has been linked through the PMO to both MDH and public health. This linkage became more apparent and grew exponentially during the COVID-19 pandemic as detailed in the COVID-19 section of this report. In times of crises that demand broad actions and mitigations at the community level, the field of public health has historically suffered from insufficient resources and limited reach. Primary care traditionally has had little access to the data, tools, and strategies needed to address population-wide impacts. Two examples of the synergy that has occurred through the integration of MDPCP and the field of public health were present in the response to the opioid epidemic and the COVID-19 pandemic. In the case of the opioid epidemic, the MDPCP PMO provided resources and technical assistance to allow practices broadly to implement SBIRT in 157 practices as of the end of 2020. In the case of the COVID-19 pandemic, the PMO held webinars several times per week. Data, technical assistance, and resources provided by MDH allowed these practices to serve as the agents of care and intervention at the community level.

Aligned Payers

Beginning in 2020, MDPCP began to accept aligned payers to further support all-payer transformation. In 2020, MDPCP welcomed CareFirst, Maryland's largest commercial payer. CareFirst has been operating a statewide Patient-Centered Medical Home (PCMH) since 2010, with over 1,200 practices in the program. In fact, 75% of MDPCP practices also participate in the CareFirst PCMH. Primary care practices in these two programs now have an aligned set of standards for Medicare and CareFirst patient care management and quality care measures. Both programs emphasize reducing unnecessary hospital utilization and management of chronic diseases. In September 2020, CareFirst and MDPCP hosted a joint webinar for practices on the alignment process and expected collaboration. Since that time, CareFirst and MDPCP have been meeting monthly to align priorities and technical assistance. The joint practice support teams of the CareFirst consultants and MDPCP coaches began consulting each other on best ways to support their shared practices on joint program priorities, including diabetes management and behavioral health integration. Starting in 2021, CareFirst and MDPCP agreed to co-host educational events including the Practice Staff Academy and Provider Leadership Academy.

Objective 2: Care Transformation

The primary goal of 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. For PY 2019, MDPCP practices submitted quarterly reporting on questions pertaining to meeting the program's five CTRs in order to demonstrate their progress in implementing care transformation. Beginning with PY 2020, the requirement that practices submit responses to CTR questions transitioned to twice per year. Furthermore, due to the COVID-19 pandemic, CMS cancelled the requirement that practices answer CTR questions for Q1 2020. This section summarizes MDPCP practices' responses to CTR questions for Q1 2019 - Q4 2019 and Q3 2020. Practices' responses to CTR questions for these timeframes demonstrate their capacity to meet care transformation objectives. Other key takeaways from practices' responses to the CTR questions include the indications that between Q1 2019 and Q3 2020:

- Practices offered patients greater access to primary care services
- Practices' use of care management expanded
- Beneficiary follow-up rates after ED and hospital discharge continued to increase
- The number of practices that screen their beneficiaries for unmet social needs increased

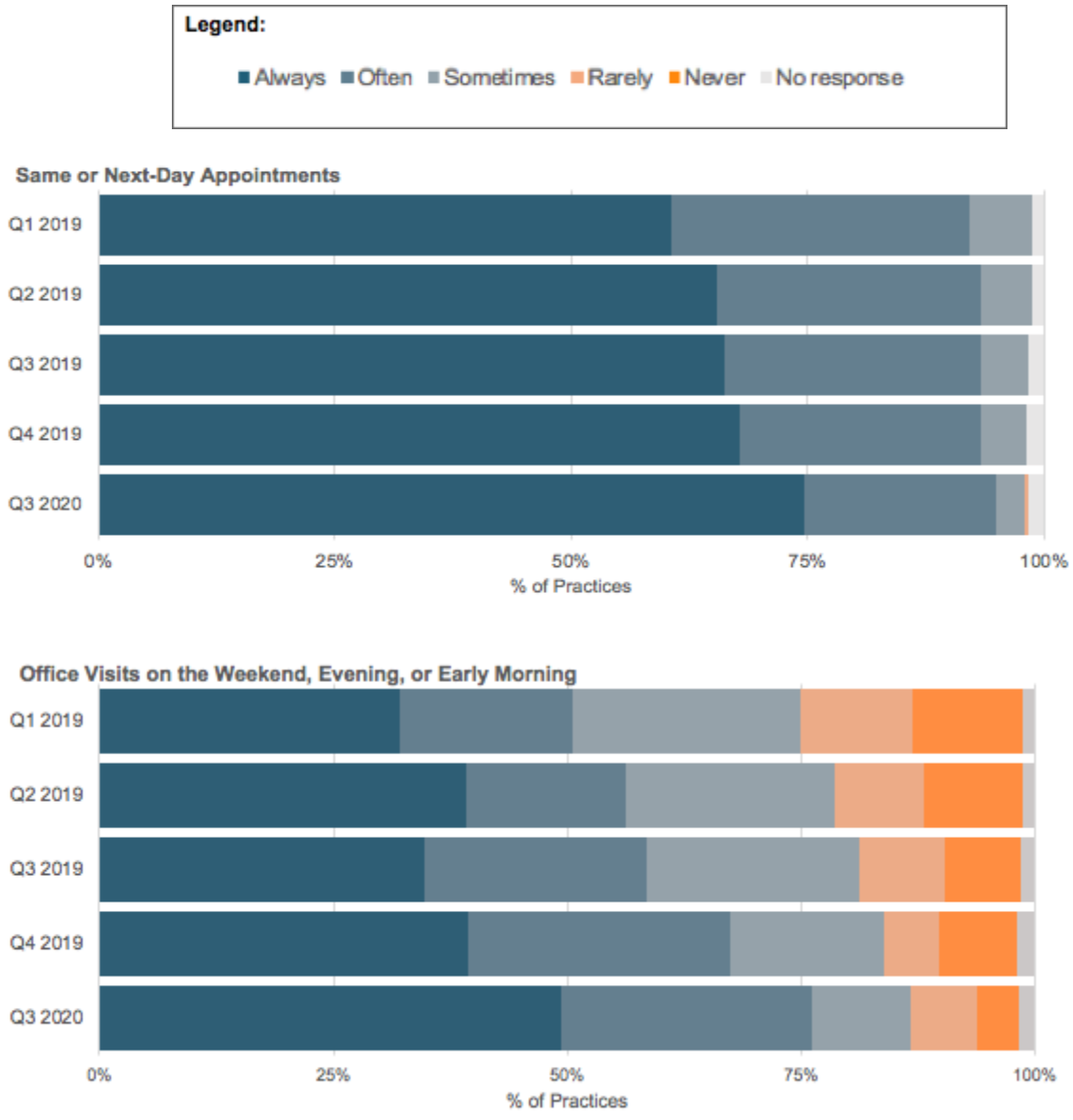
The following section of the report will describe how through these efforts, the ability of practices to meet CTRs, improved from the beginning of 2019 to Q3 2020.

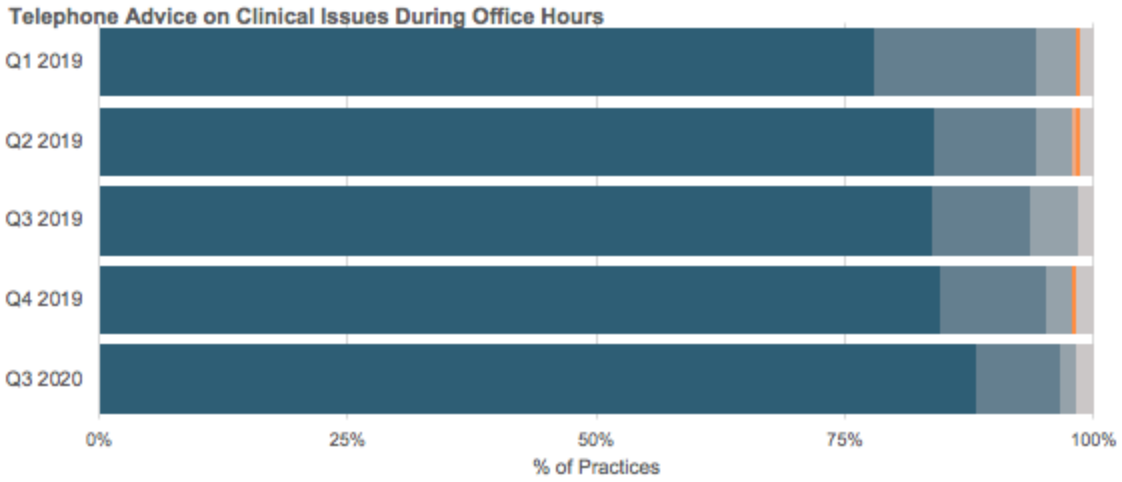
Access and Continuity

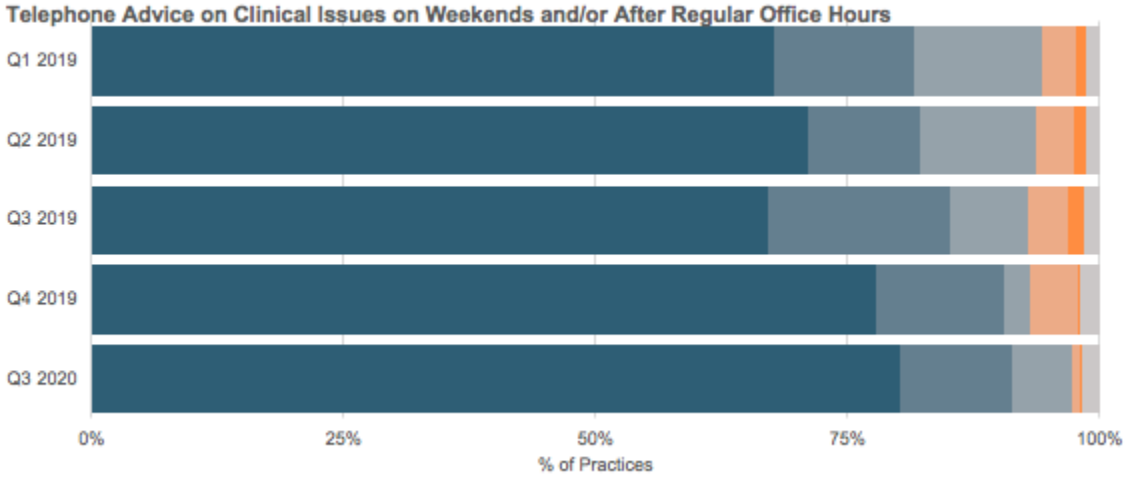
The access to medical treatment and continuity of care that practices offered to their MDPCP-attributed beneficiaries improved throughout 2019 and into Q3 2020. In an effort to gauge practices' capacity to offer enhanced patient access, the Q1 2019 - Q4 2019 and Q3 2020 CTR questions asked practices if they could provide their 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 During 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.

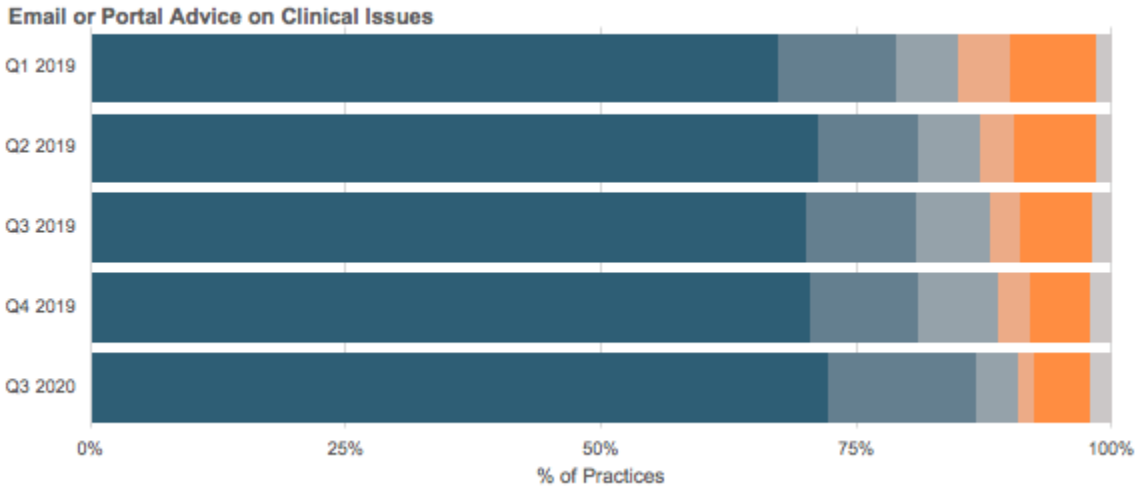
Figure 13. Expanded Access, 2020

When my patients need it, my practice is able to provide:









Key Summary**:** These charts show many ways in which practices made progress in care transformation between January 2019 and September 2020: practices' ability to offer same day

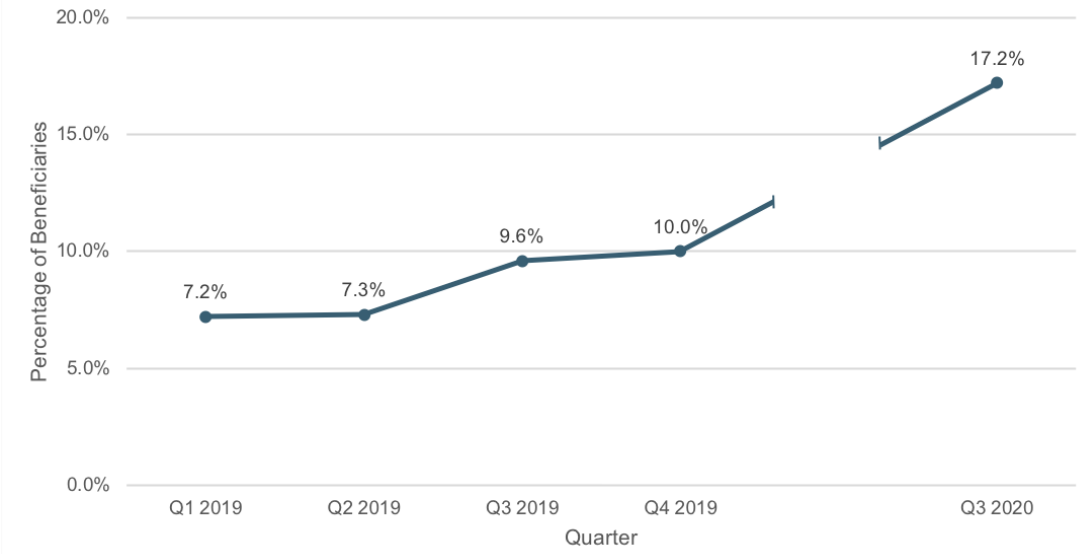
or next day appointments, office visits outside of regular business hours, telephone advice on clinical issues during office hours, telephone advice on clinical issues outside of regular office hours, and advice on clinical issues via e-mails or an online portal increased.

Care Management

Identifying Patients for Care Management

Practices collectively attested that the percentage of treated patients who were under care management increased from negligible levels before the onset of MDPCP to gains from 7.2% for Q1 2019 to 17.2% for Q3 2020. Care management is one of the foundational pieces of MDPCP, and the PMO believes practices' increasing use of care management from Q1 of 2019 to Q3 2020, as depicted by Figure 14, helped improve the coordination of patients' care, which in turn had a positive impact on their patient outcomes. In addition, this is a key element in the SIHIS and MDPCP's participation is critical to the State successfully meeting the SIHIS goals.

Figure 14. Percentage of MDPCP-Attributed Beneficiaries Under CTO of Total Empaneled



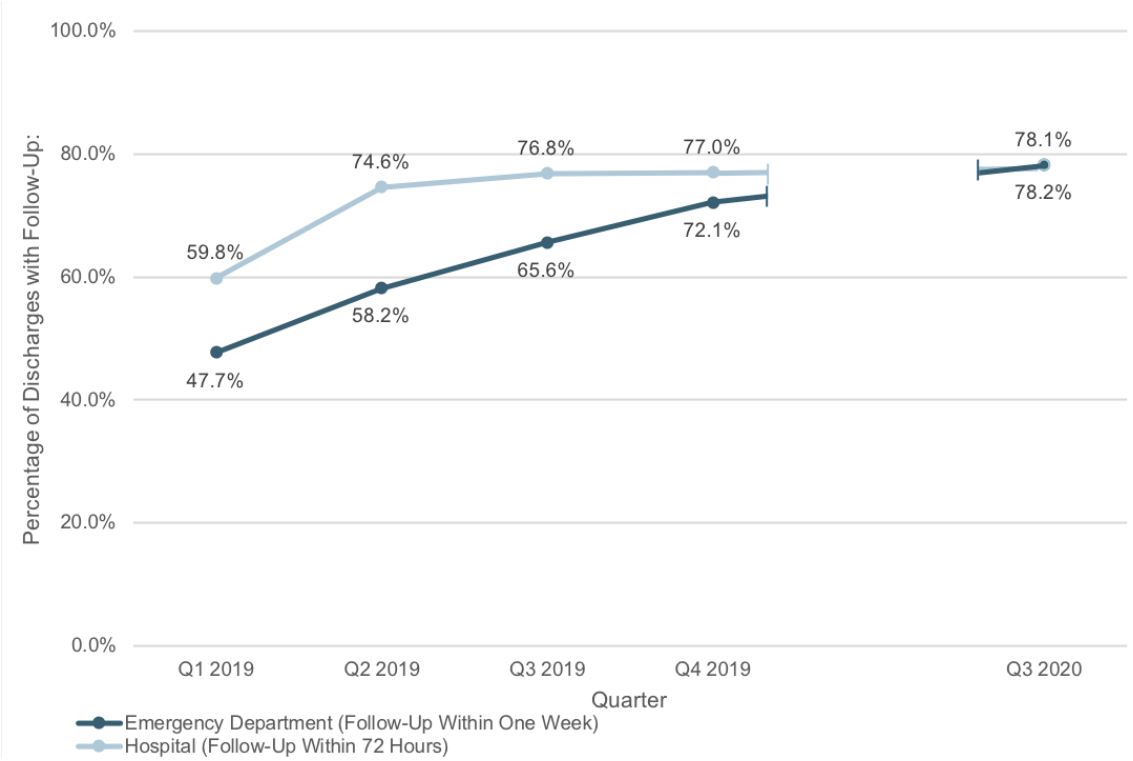
*Note: Break in data collection is due to COVID-19 disruptions causing CTR reporting to only occur in Q3 2020.

Beneficiary Follow-up- Hospital and ED Discharge

CTR responses also indicate that from the beginning of 2019 to Q3 2020 practices increasingly followed up with patients after their discharge from the hospital and the emergency department. Figure 15 shows how the frequency of practice follow-up post-hospital and post-ED discharge grew. Between Q1 2019 and Q3 2020, the percentage of patients who received practice follow-up within 72 hours or two business days after being released from the hospital increased 18.3%, and during this same timeframe, the percentage of patients who received practice follow-up

within a week after being released from the ED grew 30.5%. This is also a key element of the SIHIS.

Figure 15. Beneficiary Follow-Up- Hospital and ED Discharge



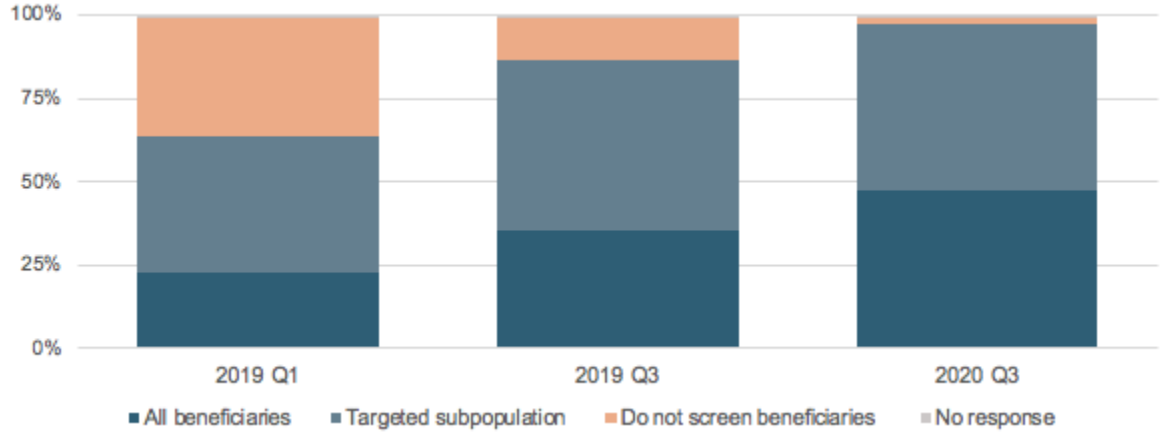
*Note: Break in data collection is due to COVID-19 disruptions causing CTR reporting to only occur in Q3 2020.

Key Summary: With the advent of MDPCP, practices' ability to conduct post-discharge follow-up with patients improved between Q1 2019 and Q3 2020. The PMO views this progress as beneficial to patients because it is well established that continuity of care is critical to address the problems that led to their hospitalizations or admissions to an ED and assure that post-release care plans are fully understood and carried out.

Linkages with Social Services

Practices were also more likely to indicate they routinely screened beneficiaries for unmet social needs during Q3 2020 than during Q1 2019. By the end of Q3 2020, 96.6% of practices were screening at least some of their patients for social needs (up from 63.4% for Q1 2019). 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.

Figure 16. Percentage of Practices that Routinely Screen Their Beneficiaries' Unmet Needs



Key Summary**:** Practice determinations that patients have unmet social needs can lead to interventions to positively address social determinants of health issues that have an adverse impact on health outcomes. The PMO therefore believes the significant growth in the share of practices that screen for unmet social needs that occurred between Q1 2019 and Q3 2020 is highly beneficial and is a strong beginning to addressing those needs through referral to community-based organizations. This element is one of the features woven into the fabric of the MDPCP that will progressively address health equity and shine a light on the Social Determinants of Health in a data-driven, objective, and effective manner.

Objective 3: Quality and Utilization Performance

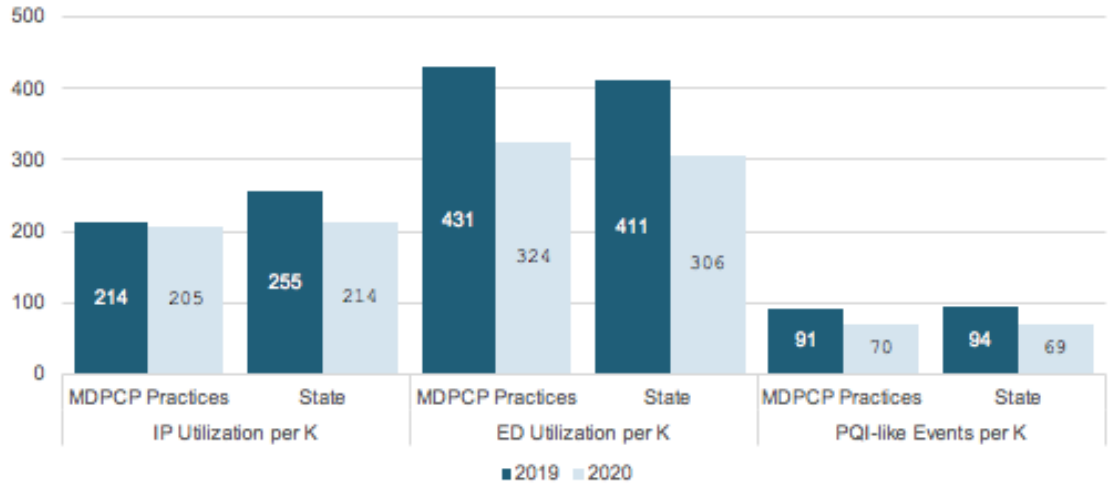
MDPCP's work in PY2 continued to focus on the core program goals of reducing utilization and improving quality. The successful results of these efforts are reflected in a decrease in both IP and ED utilization, and continued high performance on clinical quality, all despite the COVID-19 public health emergency. A detailed review of performance results is provided below. Note that all data analyses use Q1 2020 attribution unless stated otherwise.

Utilization Trends: Non-Risk-Adjusted

An important goal of Advanced Primary Care programs is the reduction of avoidable hospital utilization. The goal is to identify and care for patients in a timely manner in the most effective and efficient setting. The MDPCP provides data tools, incentives, and technical assistance to help practices achieve this goal.

The results from 2020, based on Q1 2020 attribution, show that compared to the state overall, MDPCP practices had a lower number of IP admissions per 1,000 beneficiaries: 205 compared to 214 for the state overall. There were 70 PQI-like events[3] [3]per 1,000 beneficiaries attributed to MDPCP practices, and 69 PQI-like events per 1,000 beneficiaries statewide. During 2020, there were also 324 ED visits per 1,000 beneficiaries attributed to MDPCP practices and 306 ED visits per 1,000 beneficiaries statewide.

Figure 17. Inpatient and Emergency Department Utilization Levels and Trends over 2019-2020 for MDPCP-attributed Beneficiaries versus a Statewide Comparison Group (Q1 2020 Attribution)



It is important to note that 2020 was a year in which the COVID-19 pandemic caused significant disruption to the usual patterns of care, increasing demand at times and restricting access at other times. In 2020, MDPCP launched an aggressive approach to reducing avoidable hospital

[3] PQI-like events are defined using both inpatient (IP) and Emergency Department (ED) admissions, differing from the standard AHRQ PQI definition.

utilization with an enhanced PQI data tool in the MDPCP CRISP reports and a strong emphasis on the use of the Pre-AH tool. PQIs are identified using hospital discharge data, which can be reduced through access to high-quality outpatient care.

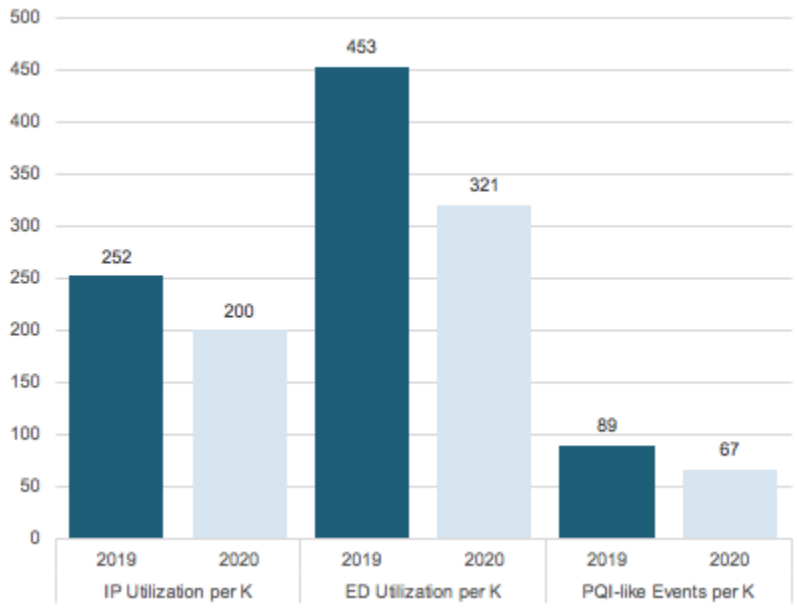
Utilization Trends: Risk Adjusted

Under the HCC risk adjustment model, CMS assigns an HCC Score and an HCC Tier to all beneficiaries in MDPCP. The HCC Score is based on the HCC community risk model to reflect the beneficiary's clinical profile and care needs. The HCC Tier is assigned to each beneficiary based on the distribution of HCC Scores across the state reference population.

The chart below shows 2019-2020 MDPCP utilization metrics that are risk-adjusted for beneficiary HCC scores. It depicts that when adjusting for beneficiary HCC Scores, during 2019 there were 252 instances of IP utilization per every 1,000 MDPCP-attributed beneficiaries, 453 instances of ED utilization per every 1,000 MDPCP-attributed beneficiaries, and 89 PQI-like events per every 1,000 MDPCP-attributed beneficiaries.

In comparison, during 2020 there were 200 instances of IP utilization per every 1,000 MDPCP-attributed beneficiaries, 321 instances of ED utilization per every 1,000 MDPCP-attributed beneficiaries, and 67 PQI-like events per every 1,000 MDPCP-attributed beneficiaries. While MDPCP practices saw reduction in all three metrics, these are risk adjusted on a population of beneficiaries attributed to the practice at any time during the year, so the results are not directly comparable to the non-risk adjusted population.

Figure 18. MDPCP HCC Risk-Adjusted Performance, 2019-2020



Quality and Utilization Performance Measure Scoring

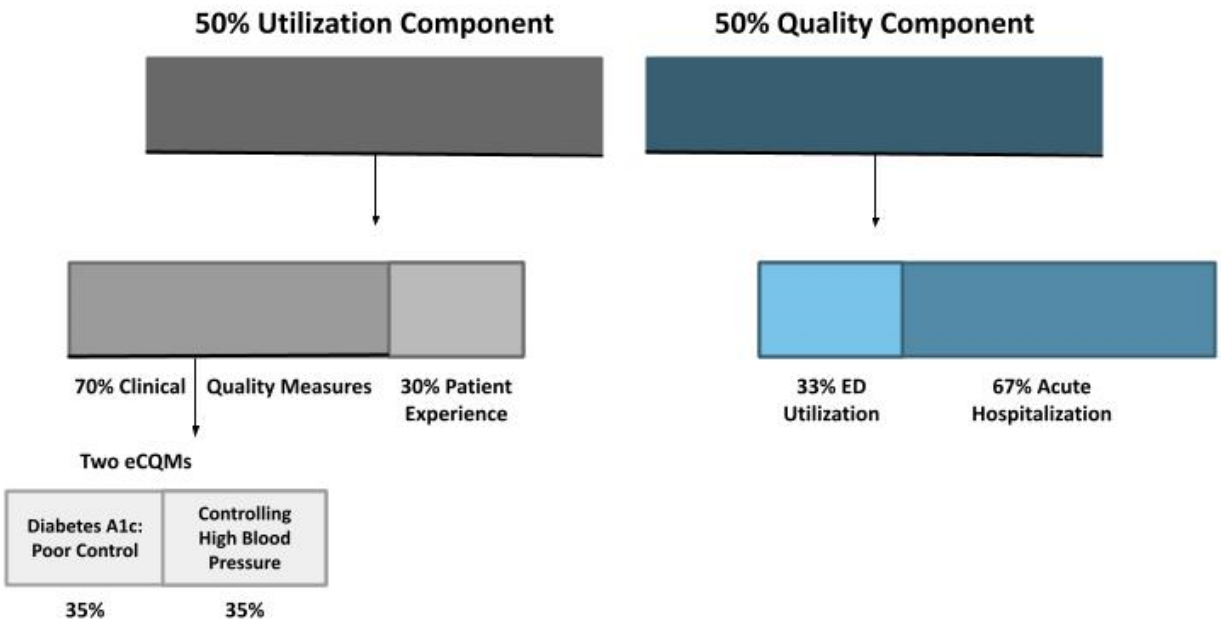
In addition to raw utilization trends, practices' quality and utilization over PY2 was measured through five official program metrics, including two risk-adjusted utilization measures, two clinical quality measures, and one measure related to patient satisfaction survey scores.

These quality and utilization results from MDPCP participants in 2020 provide a partial view into PY2 program performance as compared to PY1 performance. This is due to discrepancies in reporting across program years and changes to PBIP policy that were made because of the COVID-19 pandemic. A more detailed discussion of the impact of the pandemic on program performance is provided at the end of this section.

Quality results are based on reporting for all patients in the practice, independent of payer type. Utilization results are based only on the 2020 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, 70% is based on clinical quality measure reporting (two measures) and 30% is based on patient satisfaction survey results. Within the utilization component, IP utilization accounts for 67% and ED utilization accounts for 33% of the total. A detailed depiction of the PBIP is outlined in Figure 19.

Figure 19. Breakdown of Components of the PBIP



The two clinical quality measures are hypertension and diabetes control. In regards to measuring patient satisfaction, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is the standard for patient engagement assessments. Utilization is also a standard measure of practice performance. With that in mind, PY2 results are reported in the following areas:

- Median scores
- Performance against benchmarks
- PBIP retention

Median Quality and Utilization Scores

Median (or 50th percentile) scores for MDPCP practices for each quality or utilization measure are reported in Table 3. IP and ED utilization scores represent an observed to expected ratio, where a measure score of 1.0 indicates that utilization among a practice's attributed beneficiaries was the same as expected by the risk and size of their Medicare FFS population. Lower scores for both utilization measures represent better performance.

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. The Diabetes: Hemoglobin HbA1C Poor Control (CMS 122) measure, is an inverse measure which means that a lower score indicates higher performance. For the Controlling High Blood Pressure (CMS 165) measure, a higher score indicates higher performance.

Table 3. Median Score for MDPCP Practices on Each Measure

Measure	50th Percentile		Percent Change
	2019	2020	
Inpatient Utilization (AHU)*	1.2753	1.1149	-12.58%
ED Utilization (EDU)*	0.8199	0.6171	-24.74%
ED Utilization (EDU)* for ADI Tier 1	-	0.5624	-
ED Utilization (EDU)* for ADI Tier 2	-	0.5638	-
ED Utilization (EDU)* for ADI Tier 3	-	0.6032	-
ED Utilization (EDU)* for ADI Tier 4	-	0.6694	-
ED Utilization (EDU)* for ADI Tier 5	-	0.7391	-
CAHPS Summary Score**	80.62%	79.80%	-1.02%
CAHPS 1: Getting Timely Appointments, Care, and Information	88.79%	88.50%	-0.3%
CAHPS 2: How Well Providers Communicate With Patients	95.51%	95.27%	-0.25%
CAHPS 3: Attention to Care From Other Providers	85.23%	84.27%	-1.1%
CAHPS 4: Shared Decision Making	86.50%	85.46%	-1.2%
CAHPS 5: Providers Support Patient in Taking Care of Own Health	49.97%	48.28%	-3.4%
CAHPS 6: Patient Rating of Provider and Care	83.57%	83.84%	+.3%
Controlling High Blood Pressure (CMS165v6)	69.78%	68.67%	-1.59%
HbA1C Poor Control (CMS122v6)*	21.79%	24.22%	+11.15%

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

MDPCP Performance Compared to Benchmarks

Overall performance is summarized in Figure 20, showing MDPCP practice measure outcomes compared to benchmark breakpoints. The benchmark groups vary by category as defined by Figure 21. In 2020, benchmark breakpoints were adjusted to account for the ongoing COVID-19

pandemic. The following is a summary of overall performance on each of the three categories.

Clinical Quality (compared to national MIPS reporting)
Performance for the majority of practices on both eCQMs remained above the national median, as compared to performance on the national benchmarks from the Merit-based Incentive Program (MIPS). 63% of practices surpassed the 50th percentile for controlling high blood pressure and 80% surpassed the 50th percentile for A1C control in 2020. These percentages are slightly lower than those of 2019, where 67% of practices surpassed the 50th percentile for controlling high blood pressure and 85% surpassed the 50th percentile for A1c control. This is likely attributable to the numerous complexities surrounding health care access caused by the COVID-19 pandemic. In addition, not all practices were required to report in 2019. Therefore, higher 2019 performance may have been indicative of self-selection bias.

Figure 20. Percent of MDPCP Practices above the National Median in Controlling Diabetes

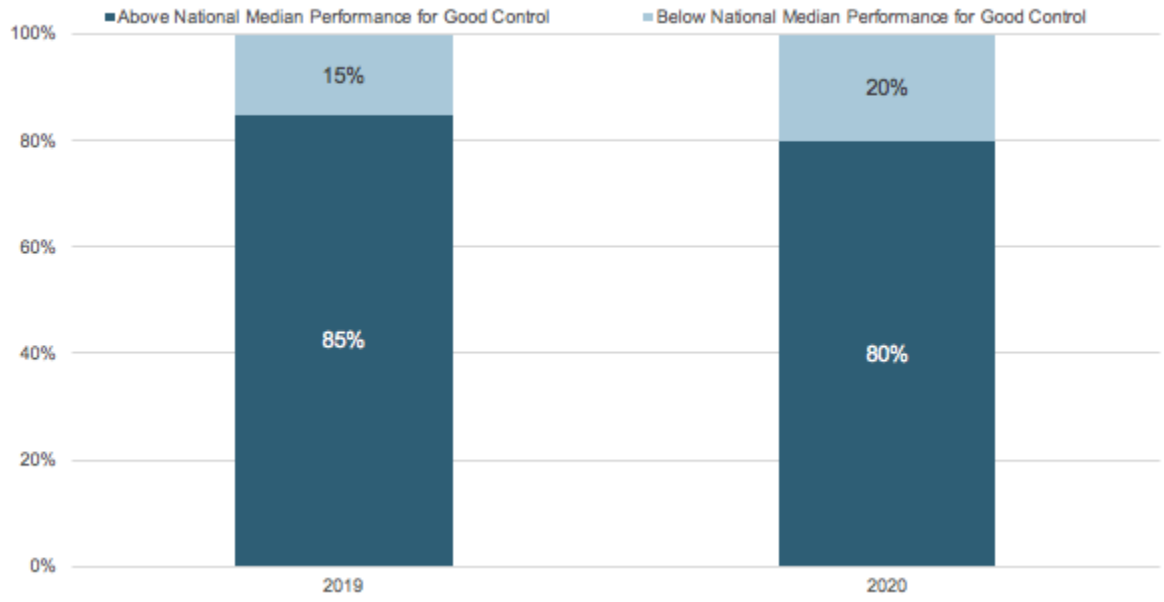
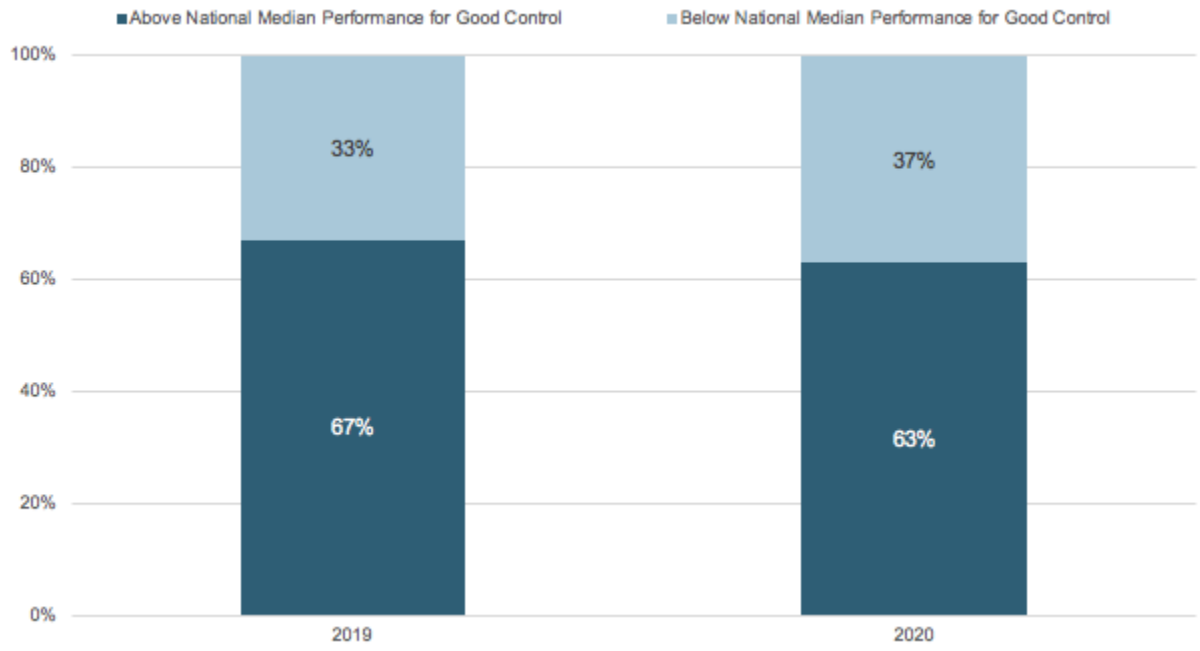


Figure 21. Percent of MDPCP Practices above the National Median in Managing Hypertension



Utilization (compared to all practices with Maryland FFS beneficiaries)
On IP utilization, 59% of practices performed better than the 50th percentile of benchmark Maryland FFS practices. With respect to ED utilization, 70% of practices performed better than the benchmark. In comparison, 57% of practices performed better than the 50th percentile for IP utilization, and 69% of practices performed better on ED utilization during PY1. Overall, despite the ongoing pandemic, PY2 utilization performance was slightly better than PY1 utilization performance when compared to a concurrent benchmark population of Maryland practices.

Patient Satisfaction (compared to 2018 CPC+ practices, nationally)
On the CAHPS summary score, 35% of practices beat the 50th percentile of the benchmark breakpoints in 2020. As shown in Figure 22, this is a slight decline from 2019, where 37% of practices beat the 50th percentile of benchmark breakpoints for the CAHPS summary score. Given that CAHPS surveys took place in the latter half of 2020, PY2 scores may have been lower due to factors interrelated to the pandemic. A few of these factors may include changing patient-provider communication norms, differing expectations of virtual vs. in-person care, and restricted appointment availability. It is also worth noting that the decrease in raw CAHPS performance was very slight, but due to the tight performance benchmarks, a 1.02% decrease in the total CAHPS scores had a significant impact on PBIP retention.

Figure 22. 50th Percentile of MDPCP Practices' CAHPS Scores, 2019-2020

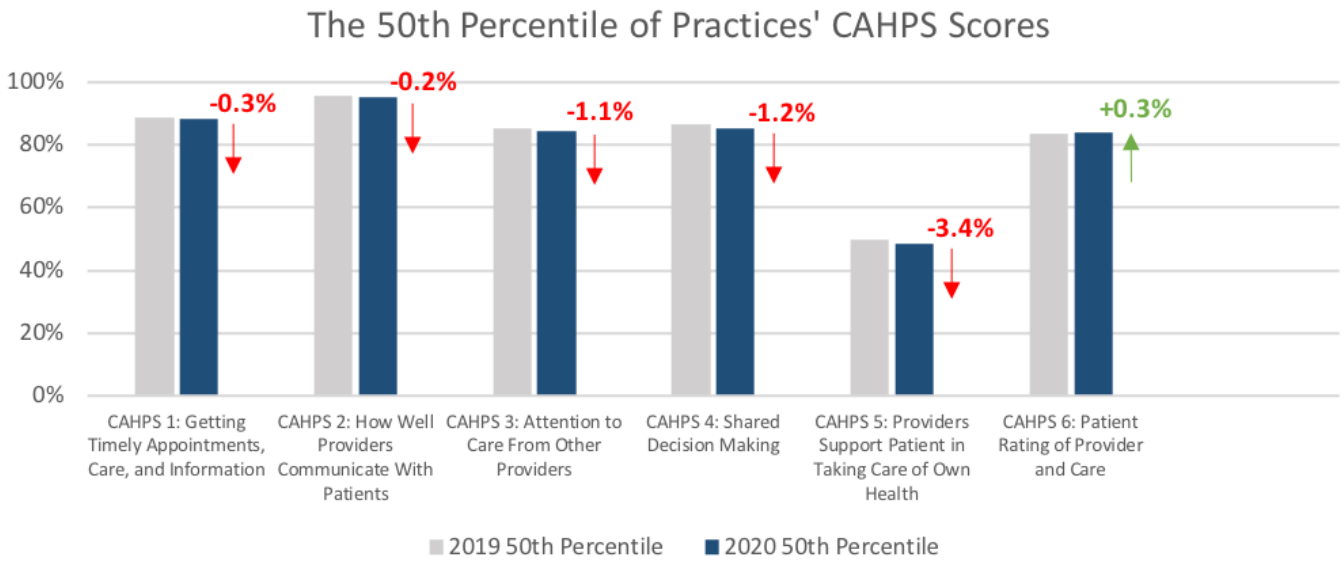


Figure 23. MDPCP Practices' Performance Against Benchmark Breakpoints, 2019-2020

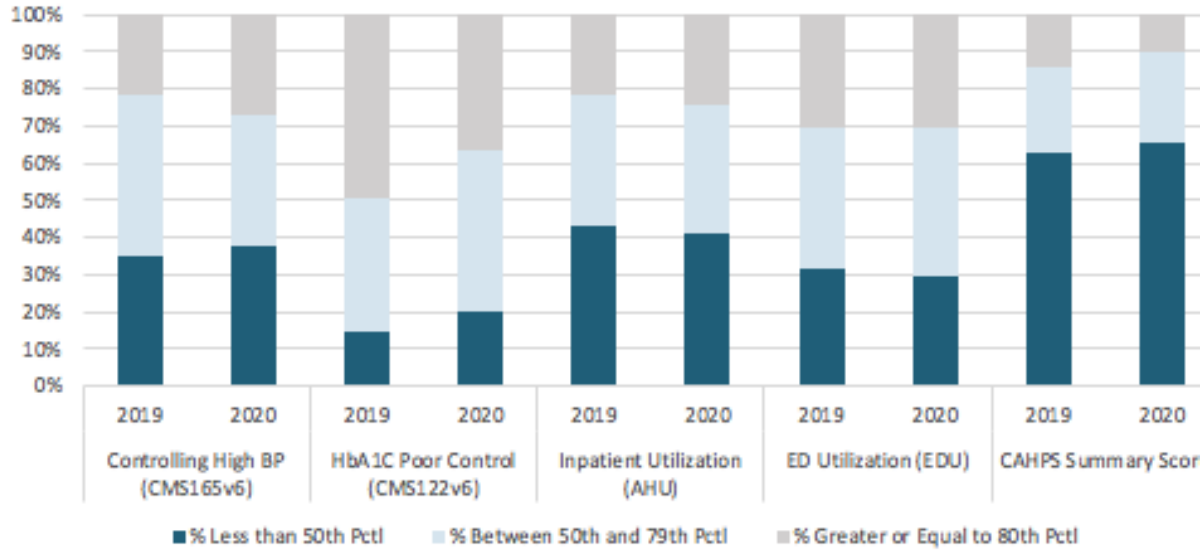


Table 4. Benchmark Populations for Each Measure

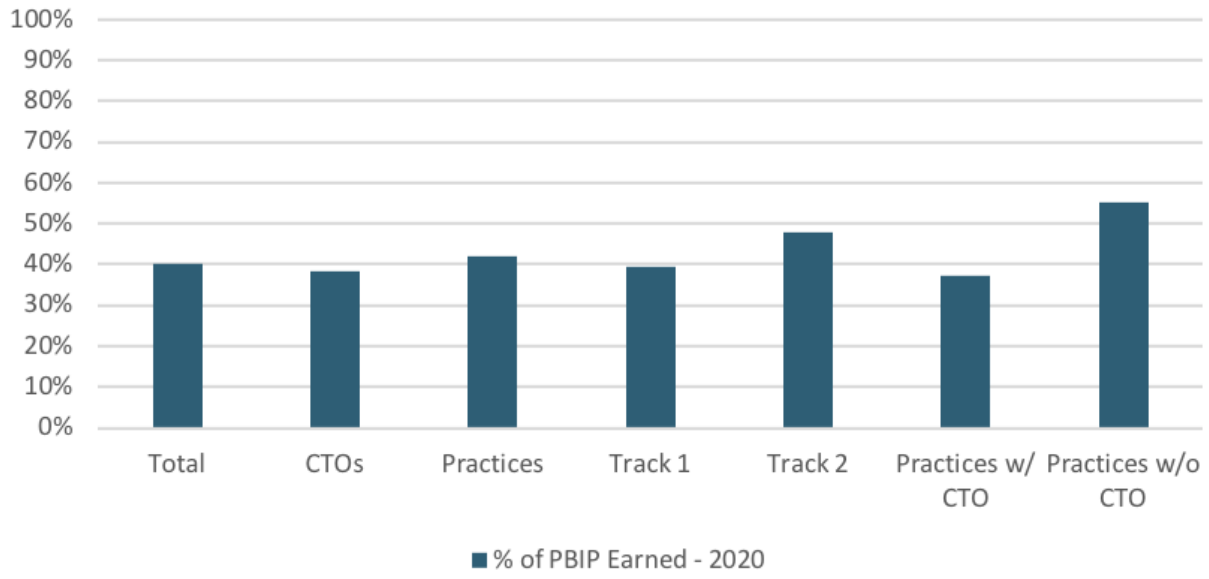
Measure	Benchmark Population	Year of Benchmark Data
CG-CAHPS	CPC+	2018 CPC+ CAHPS
eCQMs	National, all payer	MIPS 2018 Performance
Utilization	Maryland, Medicare only	2020 Maryland Utilization

Measure Performance Impact on PBIP

In 2020, 40.1% of practice and CTO PBIP was retained based on PY2 performance. To mitigate the impacts of the COVID-19 pandemic on quality and utilization measure performance in PY2, the "better of" methodology was used. All MDPCP practices received the better of either their own practice Earned Score or the MDPCP median practice Earned Score on each measure. For AHU specifically, practices received the better of the Earned Score or the ADI-adjusted Earned Score. There was variation in how much PBIP was retained among groups, organized by track and CTO affiliation. Additional detail is available in Figure 24. Detailed breakdowns on individual measures by CTO are provided in Appendix B. Key results are:

- Track 2 practices outperformed Track 1 practices, as expected.
- Non-CTO affiliated practices retained more PBIP than practices with CTOs. This may be explained by the fact that a large portion of non-CTO practices were supported by CTO-like groups, such as Privia, an independent practice management group. Practices that are already high performing may not require the help of a CTO and therefore participate independently.

Figure 24. Percentage of PBIP Earned, 2020



COVID-19 Impact on Performance

The COVID-19 pandemic posed numerous difficulties, several of which were new and foreign to practices; they can be categorized into the following three areas:

1. Operations - Practices had to adapt quickly and efficiently their daily operations and workflows as a result of emergency COVID-19 protocols, taking into account patient and provider safety, staff capability, and illness severity.
2. Patient Visits - Considering the method of transmission for COVID-19, office visits for patients could not resume per the usual cadence and format. Alternate patient visit formats resulted in difficulties in obtaining patient vitals, such as blood pressure, and presented challenges for the clinical quality measures.
3. Technology - Practices swiftly had to integrate telehealth services as the primary patient visit modality and implement critical remote patient monitoring technology. Providers needed to identify and resolve IT issues and engage patients through unfamiliar techniques.

Additionally, performance comparisons between 2019 and 2020 are made more difficult by multiple factors, many of which stem from discrepancies in reporting across program years. As a consequence of the COVID-19 pandemic, practices were not required to submit quality data for PY1, therefore 2020 marked the first year that all actively participating MDPCP practices submitted quality data. Although many practices did submit quality data in 2019, 157 practices (41% of 2019 participants) did not. This may be reflective of a self-selection bias in which higher-performing practices submitted data and poorer performers did not, resulting in a skewed picture of eCQM performance.

The COVID-19 public health emergency necessitated changes to the PBIP calculation policies for 2020. Practices received the better of their own practice Earned Score or the MDPCP median practice Earned Score on each measure. While this was beneficial to practices who scored below the median on eCQMs, the program's median performance on CAHPS was only in the 31st percentile, which required practices to score above the 50th percentile in order to earn any PBIP for the CAHPS component. It is very likely that the pandemic contributed to the slight decrease in performance due to factors such as changing patient-provider communication norms and differing expectations of virtual vs. in-person care, as well as factors outside of the practices' control, such as delays in USPS mail delivery. Lower CAHPS performance overall, in conjunction with a policy requiring practices to earn at least 50% of the quality component in order to be eligible to retain any PBIP at all, contributed to many practices and CTOs losing some or all of their PBIP for 2020.

Due to the COVID-19 pandemic, IP utilization and ED utilization decreased statewide. The raw decrease was significant as compared to 2019: -12.58% for AHU and -24.74% for ED Utilization. However, due to changes in benchmarking policy and the shift to concurrent 2020 benchmarks for utilization measures, the magnitude of this impact is not reflected in performance against benchmarks or PBIP retention. Despite this policy change, MDPCP

practices still performed slightly better than the concurrent Maryland benchmarks on both IP utilization and ED utilization.

Cost

The Health Services Cost Review Commission (HSCRC) conducted an analysis to evaluate program performance while controlling for the pandemic. The analysis used a difference-in-differences approach to ensure that the impact of MDPCP was isolated from any exogenous factors, such as the COVID-19 pandemic, which caused decreases in utilization and costs for the entire Maryland population. The difference-in-differences analysis shows the impact of MDPCP after the impact of the pandemic and other exogenous factors are controlled for.

The HSCRC concluded that, "The program has demonstrated a clear and growing reduction in hospital utilization. The cost savings generated from reduced hospital utilization by MDPCP have been partially offset by the care management fees paid to the primary care physicians; the savings have been sufficient to cover this additional investment in primary care."

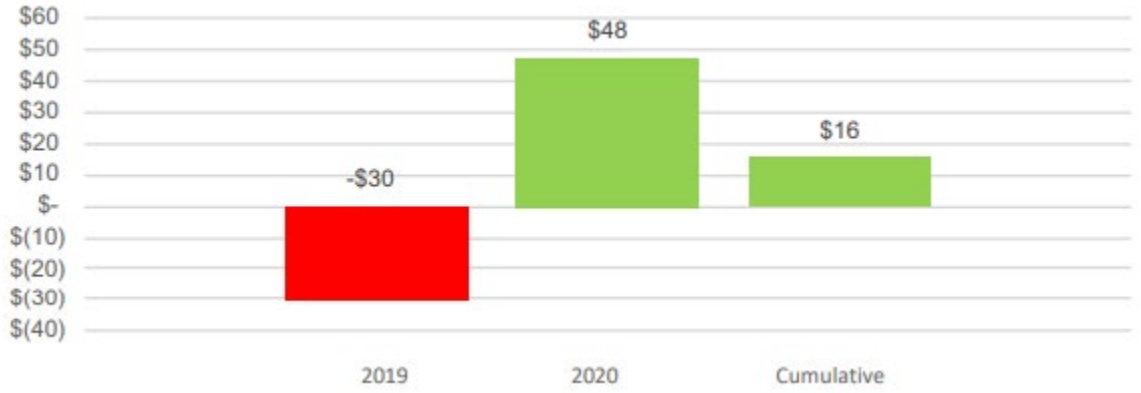
Table 5. MDPCP Evaluation Results, 2019-2020

	Total Cost of Care			Inpatient Utilization		
	2019 Trend	**2020 Trend**	**Cumulative Trend**	**2019**	**2020**	**Cumulative Trend**
MDPCP	3.36%	-4.41%	-1.19%	-4.90%	-17.08%	-20.87%
Comparison Group	2.39%	-3.03%	-0.72%	-4.07%	-15.48%	-18.92%
Difference-in-Differences	0.97%	-1.37%	-0.48%	-0.83%	-1.60%	-1.96%

Source: Joint Chairmen's Report,October 2021, Evaluation of the Maryland Primary Care Program

MDPCP practices demonstrated reductions in utilization and cost savings even after accounting for the investment of program payments. This stands as a remarkable finding in just the second year of the program..

Figure 25. HSCRC Difference-in-Differences in Net Costs (Cost Savings in Millions)



*The cumulative savings are less than the difference between 2019 and 2020 due to compounding.

Source: Joint Chairmen's Report, October 2021, Evaluation of the Maryland Primary Care Program

Key Takeaways: Overall, PY 2020 of MDPCP found decreases in both IP and ED utilization, and continued high performance on clinical quality, all notwithstanding the COVID-19 public health emergency. More specifically:

- Clinical performance remained high despite the ongoing complications with the COVID-19 pandemic. The majority of practices continued to perform above the national median on both eCQMs
- CAHPS performance decreased slightly, though due to the narrow performance margins and PBIP calculation methodology, this had a significant negative impact on PBIP retention
- Utilization decreased significantly when compared to historical expected projections. Even after adjusting the benchmarks to be concurrent with 2020 Maryland utilization, MDPCP practices still performed better than the benchmark population
- MDPCP practices demonstrated reductions in utilization and cost savings even after accounting for the investment of program payments

COVID-19 Response

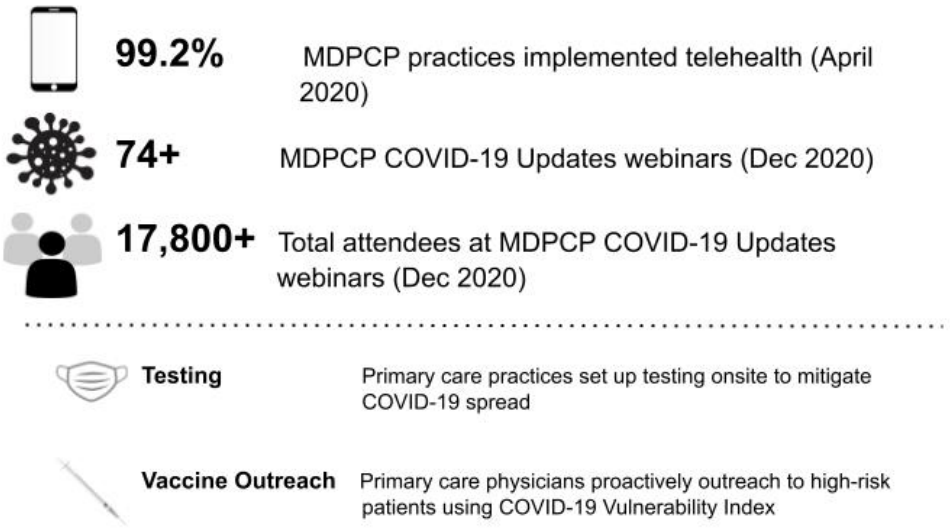
In March 2020, the primary care practices of MDPCP, with the support of MDH, began a powerful and coordinated response to COVID-19. The MDPCP PMO initiated a series of webinars to update participating MDPCP primary care practices on the pandemic's status, COVID-19 testing, access to Personal Protective Equipment (PPE), and modified workflows. Figure 26 shows the impact of the MDPCP COVID-19 Updates webinars. During a time of widespread misinformation, the webinars offered the practices trustworthy and up to date information and communicated complex information in a digestible format.

Top Five Things MDPCP Practices Did in 2020 in Response to the COVID-19 Pandemic

1. Using the COVID-19 Vulnerability Index (CVI) in CRISP, the PMO helped practices to identify high-risk patients and assist with outreach and communication.
2. Practices, with the help of the PMO, were able to provide vulnerable patients with expanded care through telemedicine and special accommodations if patients needed to be seen in person.
3. Practices were able to offer COVID-19 testing for every patient that visited their practice
4. Practices stayed up to date with current information provided by the CDC and were able to track case rates in the area. Practices were able to visit the MDH and MDPCP websites for additional information regarding case rates and current guidelines.
5. Practices were able to address vaccine hesitancy with their patients as well as enroll in ImmuNet to track patients who did and did not receive the COVID-19 vaccine.

Outdoor Testing Site Established and Utilized by MDPCP Practice Stone Run Family Medicine

Figure 26. Primary Care Responds to COVID-19



Leadership and Guidance

MDPCP created a platform upon which state public health leaders offered immediate guidance to primary care clinicians and shared best practices. Through this platform, the MDPCP leadership team hosted webinars multiple times a week and achieved the following three key objectives:

1. Communicate timely, relevant information - The webinars focused on topics such as how to apply for a small business loan, how to pivot to telehealth, and how to understand the implications of new state and federal waivers on reimbursement for virtual care and other services.
2. Provide up to date information on the state of the pandemic in Maryland - The webinars informed clinicians of how to use data to identify and reach out to vulnerable patients. In the early webinars, the MDPCP leadership team focused on how the state had adapted the dashboards of CRISP to track COVID-19 cases and streamline the testing process. Providers were able to use the system to help identify who should be tested, order tests, and track results. The state had asked primary care providers to follow up on positive and negative lab tests ordered by contact tracers for their patients, accept unassigned patients who have tested positive, and identify patients for testing.
3. Inform practices about the COVID-19 Vulnerability Index (CVI) - The index was created by data from Socially Determined, Inc. in partnership with CRISP and CareFirst. The CVI combines social, demographic, and claims data from Medicaid and commercial payers to produce risk scores on a person's age, medical conditions, place of residence, and more. Combining these data points assists practices in identifying patients who may be at higher risk for complications and assists the practices in reaching out to those individuals.

Public Health Data Sharing

Through CRISP, the practices accessed specialized reports, which were designed to identify specific patients at high risk for contracting COVID-19 and who could benefit from proactive outreach. Along with these reports, the CVI was incorporated into MDPCP primary care practices' CRISP dashboards, which also allowed primary care providers to identify high-risk patients. From April 2020 to December 2020, 99.8% of MDPCP practices accessed the CVI tool in CRISP.

MDH provided MDPCP primary care practices with daily clinical data on hospital admissions, ED visits, workflow guidance, and data analytics tools (such as the Pre-AH Model report) to help anticipate avoidable complications. During the early days of the pandemic, practices offered COVID-19 testing until Maryland was able to establish a statewide system of outdoor and drive-through testing sites. When Maryland's statewide stay-at-home order was issued, MDH provided the practices with technical assistance, coaching, and support towards the establishment of telehealth services. MDH also partnered with the state medical society and CareFirst to implement telehealth platforms in the participating practices.

Testing, Monoclonal Antibody (mAb) Referrals, and Sustained Care

The PMO facilitated the provision of a telehealth platform at no cost to practices, technical assistance for rapidly and effectively implementing telehealth, and remote patient monitoring. By April 2020, a survey of 474 MDPCP practices demonstrated that 99.2% (470 practices) of MDPCP practices had successfully implemented telehealth as a form of care.

To prop up COVID-19 testing standards and workflows, MDH provided technical assistance on safe workflows for testing, supplied testing materials, and shared test result turnaround times through various laboratories in an effort to promote data visibility. The PMO established a Testing Adoption Team that conducted focused outreach to practices to implement on-premises testing, provided free point of care testing materials, and facilitated systems for results reporting to the MDH through CRISP. The outreach focused on having equitable access to COVID-19 testing. These activities were also coordinated with the MDH Testing Taskforce. Practices also took advantage of an online patient referral system through CRISP, which allowed providers to refer beneficiaries for testing and enabled beneficiaries to schedule their own testing appointments and referrals to monoclonal antibody (mAb) infusion sites.

All the combined aforementioned activities produced a synergistic, public health-primary care response to the COVID-19 pandemic. The goal of these comprehensive, coordinated activities and partnerships was to mitigate the impact of COVID-19 and this goal was indeed achieved. A recent study published in the Milbank Fund (Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health–Supported Advanced Primary Care Paradigm) corroborated this goal. More specifically, Perman et al. compared rates of COVID-19 diagnosis, COVID-related

hospitalization, and COVID-related death in an MDPCP beneficiary cohort to a matched non-MDPCP cohort.

Significant improvements in COVID-19 impacts were seen for MDPCP-attributed beneficiaries as compared to a closely-matched cohort of patients in non-MDPCP practices. In fact, MDPCP participation was associated with a lower incidence rate of COVID-19 diagnosis (4.3% of beneficiaries vs. 4.6%, P<.001), a lower proportion of total beneficiaries who were admitted to the hospital for COVID-19 (1.29% of beneficiaries vs. 1.43%, P=.0027), and a lower proportion of total beneficiaries who died of COVID-19 (0.41% vs. 0.5%, P=.0022).[1]

Vaccines

From the onset of the pandemic, the PMO presented frequent updates to practices via webinars, coach outreach, toolkits, and direct mailings regarding all aspects of their response to threats posed by COVID-19. The PMO provided the practices with: 1) scientific information regarding the vaccine as soon as it became available, and 2) the processes and support to register on the state's Immunet system for ordering, receiving, and utilizing vaccines. Practices were well-prepared to receive vaccines as they became available to primary care practices in 2021; practices were armed with detailed scientific information regarding each of the proposed and authorized vaccines which they used to combat vaccine hesitancy.

Telehealth and Remote Patient Monitoring

In an effort to increase practices' use of telehealth (and subsequently reduce the spread of COVID-19 that occurred as a result of in-person medical treatment), the PMO worked with the Maryland State Medical Society to issue over 200 HIPAA-compliant telehealth licenses to MDPCP practices. The pandemic also pushed practices and CTOs to adapt and offer new, innovative solutions for patient care with the support of the PMO. For example, one CTO established a program that provided nutritional guidance and more than 2,000 pounds of healthy food to patients experiencing food insecurity. Some MDPCP practices set up outdoor COVID-19 testing facilities before they were established by the State. A Baltimore area practice implemented a wide range of changes in response to COVID-19, among them being proactively reaching out to patients to check on their health and well-being and establishing separate and distinct areas where patients were tested and treated for COVID-19 from areas where patients were treated for other ailments (see call-out box below for more information).

How one practice has made innovative use of telehealth and remote monitoring
Mace Medical, a Baltimore area MDPCP practice, made many changes to their workflows and treatment methods following the COVID-19 outbreak. Mace Medical staff members, whose workloads fell significantly because of the pandemic, reached out to patients to see how they were doing. Referring to the impact of this new workflow, the Mace Medical Chief Operating Officer has said, "You'd be surprised by how many people said, 'Thank you for calling. I've

been having chest pains.'"

Mace Medical also sequestered areas where its providers treated patients for issues that were possibly related to COVID-19 and for those issues that were not possibly related to COVID-19. The location where Mace Medical administered COVID-19 tests was also separated from where the organization treated patients who suffered from non-COVID-19 medical problems.

When Mace Medical determined that patients were COVID-19-positive but well enough to be discharged, the practice would give them remote patient monitoring equipment and send them to their homes to isolate. Care managers would then follow-up with these patients to determine their temperature and oxygen levels.

Additionally, Mace Medical has worked with Mindoula to refer patients who could benefit from behavioral health providers for mental health treatment.

Furthermore, after the onset of the pandemic, the PMO organized webinars that featured guidance to practices about how to implement effectively remote patient monitoring. Commenting about remote patient monitoring, one practice representative said:

> [Telehealth] has helped us expand to things like more patient monitoring, you know....we have started to implement remote patient monitoring, and really were it not for the pandemic and our relative ease of transition to telehealth, we probably wouldn't be doing remote patient monitoring.

An MDPCP physician from another practice mentioned:

> Medicare especially has been very proactive and innovative about trying to roll out new payment models to meet that need. So when I say virtual ... I look at it globally, not just that virtual face to face telehealth visit, similar to what we're doing now, but remote patient monitoring, or emails or phone calls, anything that meets the patient's needs.

Recommendations to CMS

The following section represents a series of recommendations from the State to CMMI intended to use the experience and learning from 2019 and 2020 to enhance subsequent program years. Many of the following recommendations have already begun to be discussed with CMMI as of late 2021, and the State looks forward to continuing collaboration on these initiatives into future years.

State's Role in MDPCP Policy

The State recognizes that CMMI is testing a model under its statutory authority and is pleased to be able to have MDPCP included as a key component of the model. The combination of the many years of model testing experience and expertise in CMMI, together with the practical Maryland specific knowledge and resources provided by MDH, is a winning combination. The State once again requests a greater role in determining MDPCP policy.

The State has made and will continue to make significant investments in this program. The State has a great interest in the creation of a sustainable, effective advanced primary care infrastructure for the health of all Marylanders. Moreover, the State is held accountable for the results produced by MDPCP. For these reasons, the State would like to ensure that policy changes take into consideration maintaining the broad reach of the program, the engagement of providers, and the ability to meet SIHIS goals. The Model Contract states 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."

As such, the State requests the ability, guided by stakeholder input, to control jointly the policies and operations of MDPCP and take responsibility for the program. Such an arrangement would provide for a smoother policy development process and greater buy-in from participants and state partners. Accordingly, the State and CMMI should establish monthly meetings with leadership on both sides to determine policy and future strategy for the program. The collaborative, regular meeting process should include a jointly developed agenda and standing items and review of current and future challenges.

Recommendation: Commit to collaborative, monthly policy meetings with leadership on both sides. Establish shared principles for decision-making and schedule for addressing recurring policy items.

Evaluation of MDPCP

To reduce confounding variables in the Program Evaluation, every effort should be made to maintain programmatic fidelity regarding program policy throughout the evaluation period. The State recommends that changes made to MDPCP recently should be taken into consideration when evaluating the program. A non-exhaustive list of those changes is documented below:

- The elimination of the 2021 open enrollment period should be taken into consideration in the evaluation of the reach of the MDPCP.
- The first three years before significant changes were made provide for a steady period with consistent programmatic policies. Future years may be harder to interpret and disentangle effects with the multiple policy changes.
- Significant changes made in payment methodology or other incentives should be taken into account.
- The novel introduction of Area Deprivation Index (ADI) to adjust care management fees will have significant impacts on the revenue base of practices and may produce unpredictable results in MDPCP.
- The loss of the CMF complex category inclusions of Substance Use Disorder and Mental Health Disorders may have significant impacts on practice level CMFs and reduce funding for treating behavioral health conditions.

Recommendation: Consider changes in MDPCP policy when conducting program evaluation of MDPCP.

Performance Based Incentive Payment (PBIP) Design Improvement

CAHPS Performance

2020 was an unusual and difficult year for everyone around the country. In Maryland, the challenges made measurement of performance all the more difficult. In an effort to avoid future issues, CMMI has graciously offered to meet with the State to discuss potential resolutions which may include:

- More appropriate benchmarking for 2021 to account for the public health emergency
- Understanding external factors resulting in poor CAHPS performance that may have been beyond the practices' control, such as USPS issues with delivering mail
- Ensuring that the program uses the newest survey version 3.1 or 4.0, which includes questions about telehealth
- Providing greater transparency on results and additional detail to practices regarding their CAHPS scores, such as survey response rates and performance on individual questions to assist practices in future quality improvement efforts

Recommendation: CMMI and MDH meet to discuss opportunities to improve CAHPS approach.

Piloting Other Patient Satisfaction Measures

Due to the challenges experienced with CAHPS nationwide during 2020, the State recommends exploring alternative methods of evaluating patient satisfaction. The State and CMMI have already begun initial discussions regarding piloting the new Patient Centered Primary Care Measure (PCPCM) patient satisfaction measure from the American Board of Family Medicine. The State is planning to submit a more detailed proposal for a pilot in PY 2022,and looks forward to further collaboration with CMMI on ways to potentially incorporate such a measure more formally in future program years.

Recommendation: MDH to submit a proposal to CMMI on a new patient satisfaction measure pilot.

PBIP Quality Threshold
Separately, PBIP design should be reevaluated. The PBIP structure and requirement to attain 50% on Quality to qualify for any PBIP retention resulted in a significant negative impact to participants' 2020 performance. Many practices and CTOs did not perform well on patient satisfaction and thus lost all or some of their PBIP. Since learning of their 2020 PBIP performance, practices and CTOs have provided feedback that the PBIP recoupment calculations and process creates a disincentive for performance improvement. Although most participants implemented significant changes to their workflows in order to meet eCQM and utilization thresholds, they still ended up losing some or all of their PBIP due to lower performance on the CAHPS measure. While the State supports the focus on patient satisfaction, the State recommends reconsidering the threshold level or removing the threshold requirement entirely for future program years.

Recommendation: Reevaluate quality gate used for PBIP retention.

Future Benchmarking
Lastly, the State recommends continuing the use of historical, prospective benchmarks for quality and utilization measures. Practices need objective targets to guide their improvement. Moreover, where possible, the State recommends using comparisons against national benchmarks to allow for practices to understand and aim for known targets and be rewarded or penalized according to their performance against that benchmark. At the same time, the State recommends against using a program-level goal of budget neutrality for the performance assessments.

Recommendation: The State recommends setting benchmarks prospectively to reward good performance. Additionally, strategies to reward improvement in addition to attainment should be considered in future performance years.

Program Focus on Health Equity

CMMI's recent Strategy Refresh identifies advancing health equity as a core objective, and specifically aims to embed health equity into every aspect of CMMI models. Similarly, a core goal for the State is to achieve equitable quality of care, access to services, and health outcomes in MDPCP practices. To achieve these aligned objectives, the State recommends an increased focus on health equity through initiatives such as:

- **HEART payment support and technical assistance** - The new Health Equity Advancement Resource and Transformation (HEART) payment, which will be implemented for the first time in PY 2022, is specifically designed to address beneficiaries' social needs. In order to maximize the effectiveness of these payments, the State recommends that CMMI provides specific technical assistance to practices on allowable and suggested use of funds, and technical assistance on suggested tracking

and reporting of HEART payment funding. CMMI and the PMO have already begun jointly working toward this goal.

- **Shared analysis of HEART payment effectiveness** - The State recommends performing research and analysis to determine which uses of HEART payments have beneficial effects on reducing cost and utilization. CMMI and the State should be jointly engaged in this research, and findings should be used to direct effective usage of future practice HEART payments. To make this research timely, CMMI and the State should agree to a timetable early on so that research can be used to inform practice as early as the second half of 2022 and by the start of 2023.
- **Equity-focused performance measure** - CMMI should work with the State to explore the potential future use of an equity-based PBIP measure for the program, to financially incentivize practices to improve the health of under-resourced populations.
- **Disaggregation of CAHPS data feedback report** - The State recommends disaggregating CAHPS data by various demographic factors (race/ethnicity, gender, language, etc.) and providing that data to practices, in order for practices to understand any disparities in patient experience and to focus on improvements.
- **Include an equity lens in core CMMI documentation for the program** - The State recommends including a focus on health equity in core program documentation, such as the Advancing Primary Care Guide. This will show practices that health equity is a priority for the program and will guide practices toward incorporating equity into their practice culture and operations.

Recommendation: Increase the Program's focus on health equity by: providing HEART payment support and technical assistance, shared analysis of HEART payment effectiveness, exploring an equity-focused performance measure, disaggregation of CAHPS data in a feedback report, and including an equity lens in core CMMI documentation for the program.

Looking Ahead

Throughout the first two years of the program, the State and CMMI have worked jointly on several initiatives to expand and improve MDPCP. This collaboration has continued through 2021, and the State looks forward to further enhancements in the following areas:

Open Enrollment

MDPCP is looking forward to the open enrollment periods in 2022 and 2023 to continue to expand the reach of the program. The State is particularly looking forward to adding additional Federally Qualified Health Centers (FQHCs) in these years to continue to address the health needs of Maryland's most vulnerable populations.

Track 3

In an effort to align further with national trends in primary care and other CMS value-based payment models, the State has begun working collaboratively with CMMI to develop a Track 3 for the program. The State looks forward to implementing the next iteration of the program to further the State's and CMMI's shared goal of improving the health of Marylanders.

Medicaid Alignment

With CMMI's encouragement, the State, led by MDH, has committed to bringing Medicaid on as an aligned payer. This work has already begun and when completed will provide Medicaid recipients with the benefit of advanced primary care and allow participating practices to benefit from coordinated and focused operations, data feeds, payments, quality reporting, and incentives.

Expanded Public Health Integration

Among the most exciting and beneficial changes that are in the near future of MDPCP have to do with the further integration with public health. Historically, the field of public health and primary care have been siloed. Beginning in 2021, the MDPCP PMO will be engaged in several key initiatives in conjunction with MDH Public Health Services:

1. Extraction and reporting of practices' clinical quality data and other relevant data with a focus on health equity
2. Expansion of Point of Care (POC) testing capabilities to MDPCP practices across the state to provide expanded disease surveillance information for public health officials and more efficient care at the practice level
3. Expansion of social needs screening and referral to CBOs
4. Further growth and contribution to public health vaccination programs for COVID-19 and other emerging diseases

5. Continued analysis of the rich data sets that are generated within MDPCP to guide practice level program implementation and to inform state program leaders and policy makers in areas of health improvements and equity.
6. Continued review and external reporting to stakeholders on the impacts of the program related to utilization, healthcare costs, quality and consumer satisfaction
7. Implementation and validation of new and improved methods for surveying patients on their perception of the care provided by MDPCP practices

Alignment with Hospital Models and SIHIS Goals

MDPCP is a part of a broader Maryland initiative to transform care and reduce costs throughout the health system. The Total Cost of Care contract with the CMS is expected to generate Medicare savings, transform care delivery, and improve the health of Marylanders. The State committed to quality improvement, care transformation, and population goals under the SIHIS. MDPCP has a vital role in meeting many of those goals, especially related to avoidable hospital utilization, follow-up after discharge, and population health goals related to diabetes, child asthma control, severe maternal morbidity, and opioid mortality. MDPCP's performance goals are aligned with the SIHIS goals and the State plans to continue to build on that alignment as it works closely with MDH, HSCRC, and CMMI colleagues.

Expanded and Redesigned Learning Offerings

In 2021 and beyond, the State will be taking increased responsibility for the technical assistance and education infrastructure of the program. The State has received feedback from participants that direct connections with fellow practices is crucial to implementing new workflows and understanding the many challenges in managing change. Beginning in 2021 and continuing into future program years, the State will offer numerous webinars on key MDPCP concepts, but will also focus on offering more peer-to-peer opportunities, such as networking events for providers and their staff, as well as a Staff Academy featuring breakout rooms for practice staff to share unique experiences and learn from one another. The Affinity Group structure, for topics such as Care Management, will also remain available as a venue for program participants with similar roles and interests to share their experiences and learn from their peers.

The State also intends to implement Plan-Do-Study-Act (PDSA) cycles with select groups of MDPCP practices (specifically, those who need increased support as justified by quantitative data and qualitative input from practice coaches) to support them in driving quality improvement at their practice through the development of sustainable workflows, staff empowerment, and education around quality indicators and reporting. The State also intends to continue to collaborate with CMMI on shared events and communications, such as a monthly newsletter, quarterly Office Hours presentations, and program guides and resources. Finally, the State intends to establish a Learning Advisory Council composed of program participants and other stakeholders to obtain direct input for shaping and creating future learning offerings.

Appendix A: Roles & Responsibilities

Table A1. Summary of the Roles and Responsibilities of the Main Groups Involved in Operating the MDPCP for 2020

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 • 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 Request for Applications (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

Appendix B: CTO Performance Details

Distribution of CTO Performance

Among all three utilization measures, there were large gaps in performance among practices by CTO affiliation*. ED utilization per thousand (K) for the worst-performing group of practices (by CTO) for 2020 was 402.52, whereas the ED utilization per k of the best-performing group of practices (by CTO) was 228.33. There was also a large gap, 44%, in the PQI-like events per k for 2020 by groups of practices that were partnered with each CTO.

Overall, the range in utilization per K outlines patterns among which CTOs may have been more effective in aiding their practices. Despite differences in utilization rates among CTOs, a trend that remained consistent among all CTOs across program years is the decline in per K rates. This decline is likely attributed to the dramatic decline in utilization in non-COVID medical care caused by the pandemic, rather than being indicative of program performance alone. The tables below are arranged in order of highest to lowest utilization rates per K in 2020.

Key Takeaways: The range in utilization rates per K by CTO, displayed in Figures B1,B2, and B3 below, illustrate that:

1. There was variation in practice performance during 2020
2. Some CTOs may have been more effective than others at aiding their practices' efforts to maximize quality and minimize utilization
3. The complications due to the pandemic led to overall trends in decreased utilization across all practices

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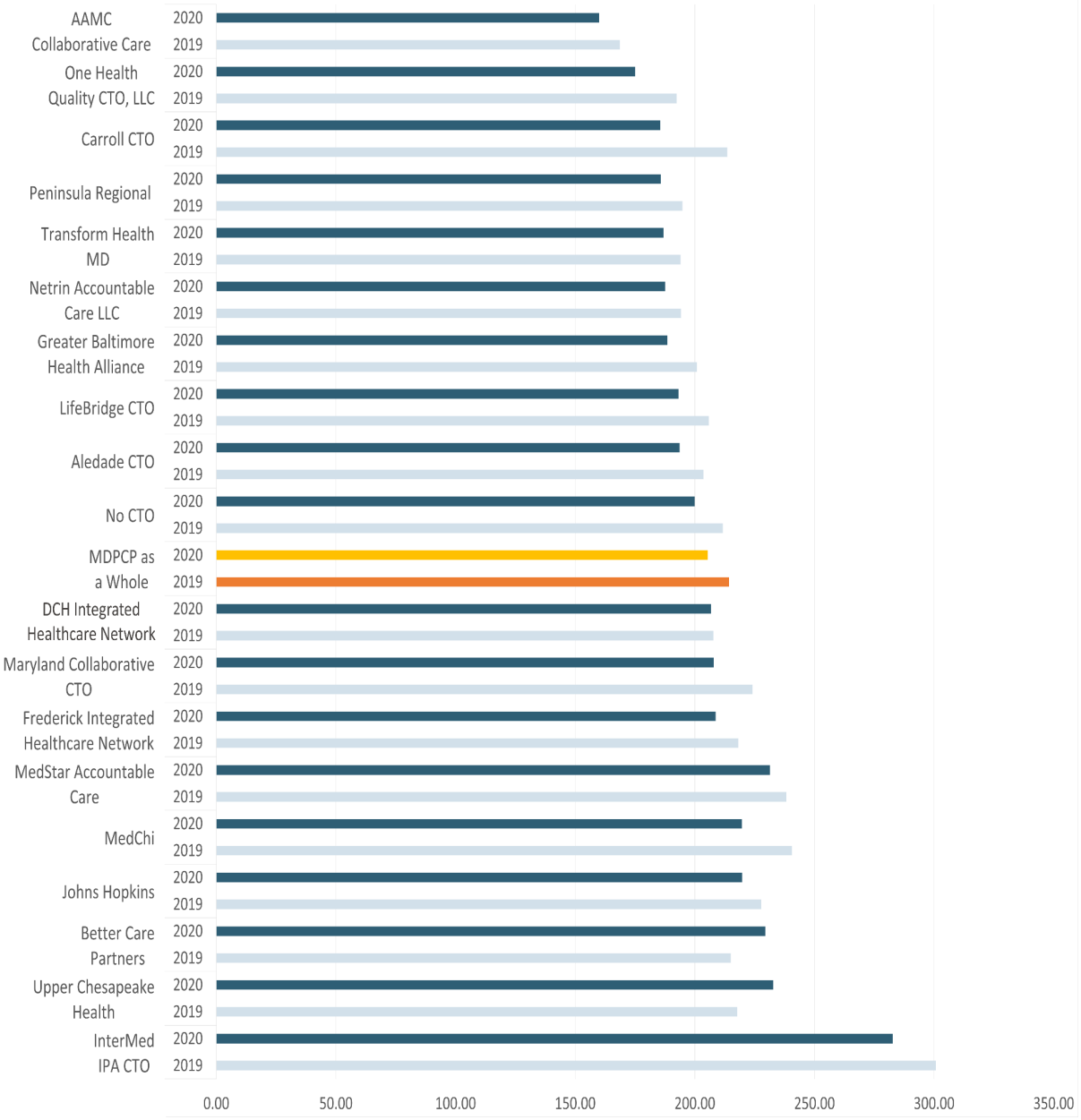
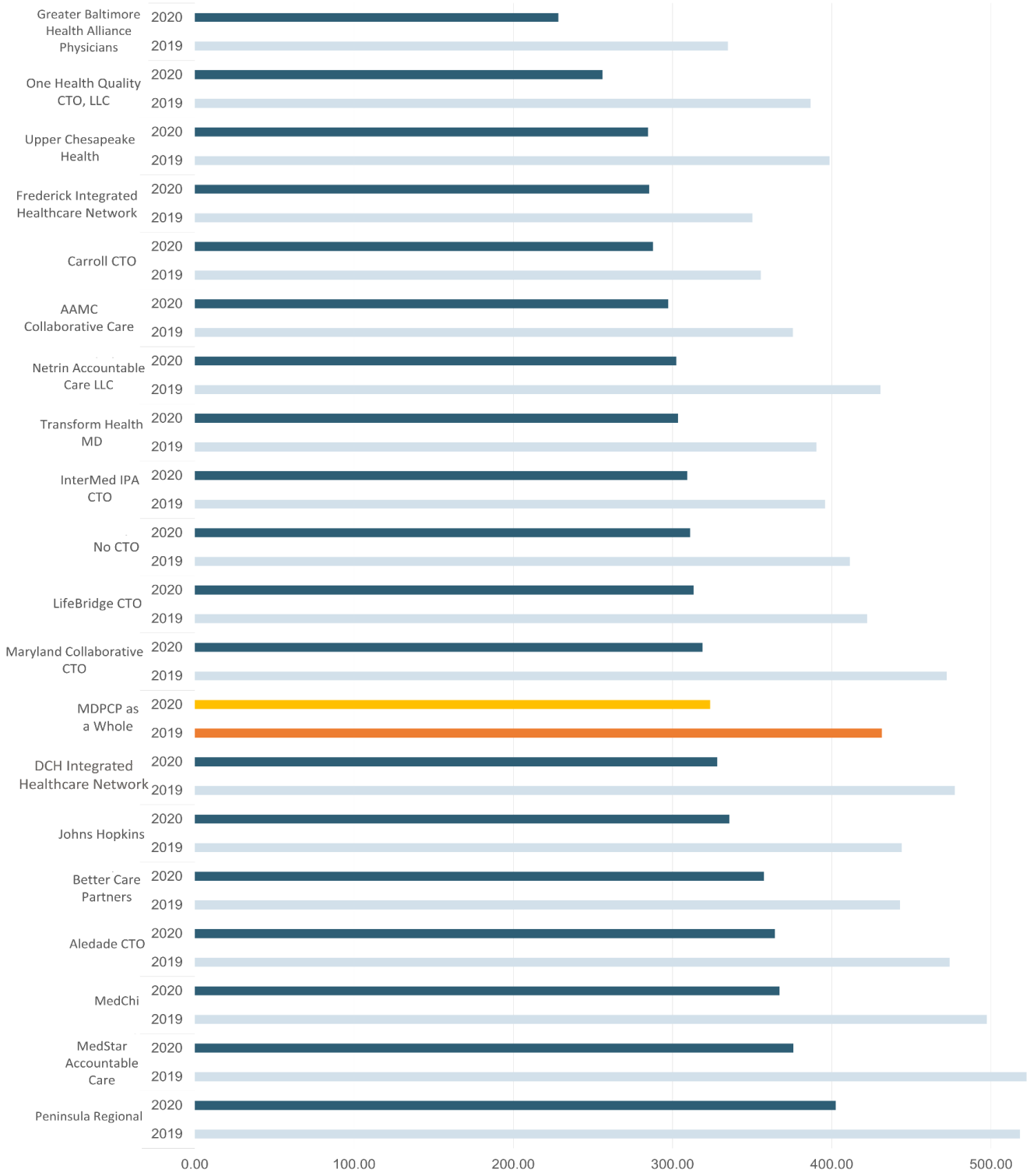
*To protect practice and patient privacy, utilization metrics are not available for CTOs with fewer than 5 partner practices. These CTOs include HCD International, Holy Cross, Western Maryland Physician Network, and PHS Doctors CTOs.

Figure B1. 2019 - 2020 IP Utilization Per K of CTOs with >5 Practices in 2020*

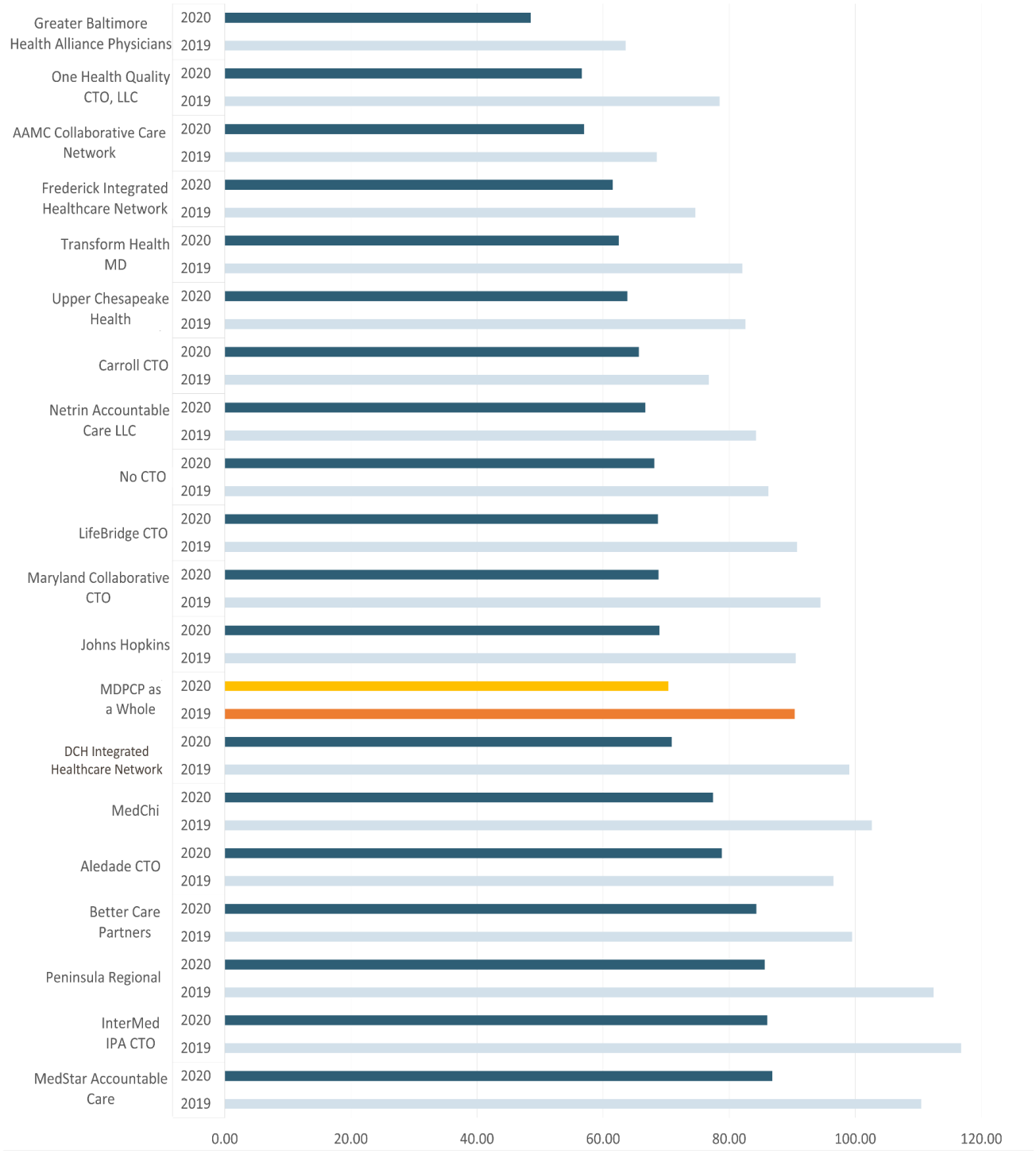


*CTOs with ≤5 practices omitted to protect patient and practice privacy

Figure B2. 2019 - 2020 ED Utilization Per K of CTOs with >5 Practices in 2020*

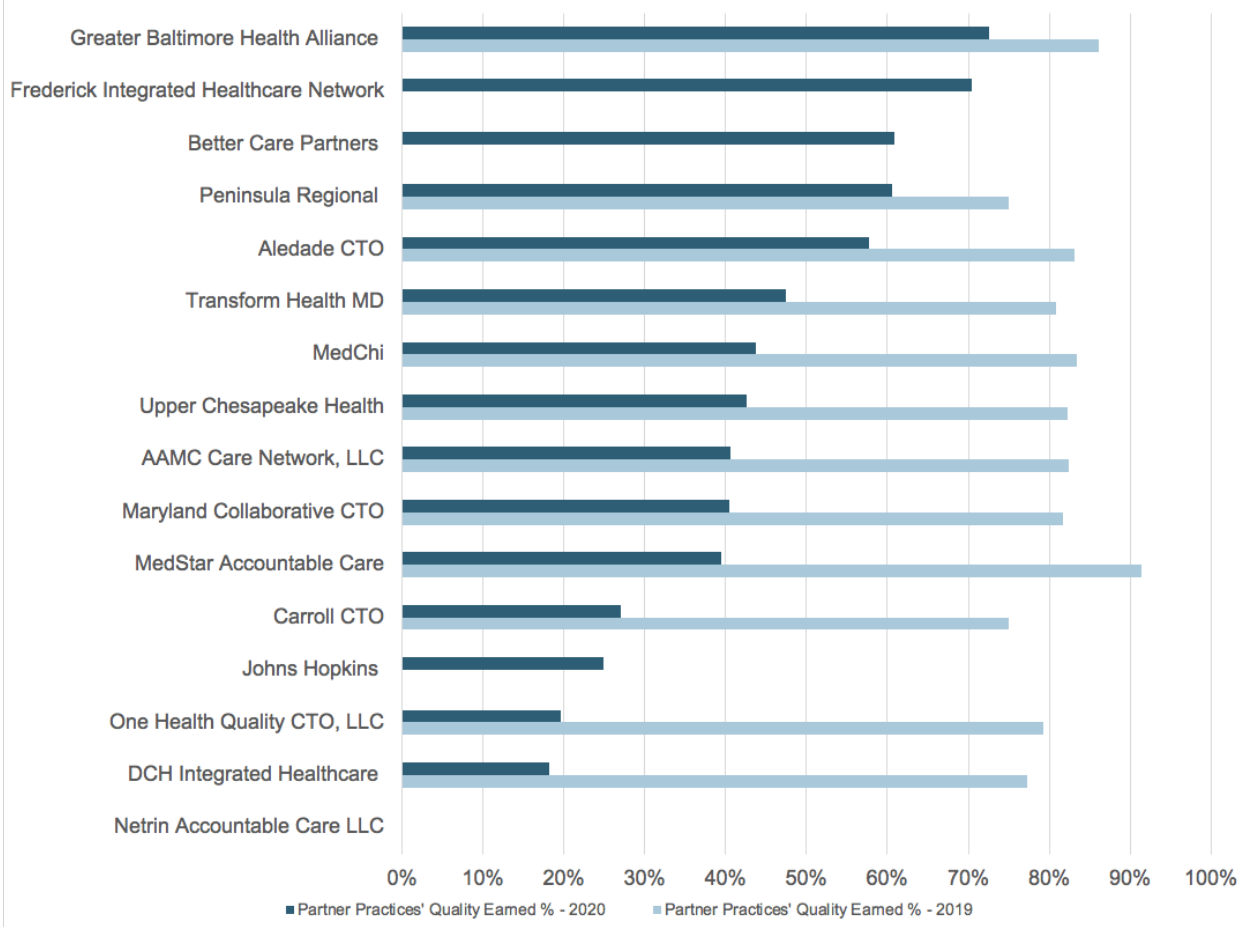


*CTOs with ≤5 practices omitted to protect patient and practice privacy



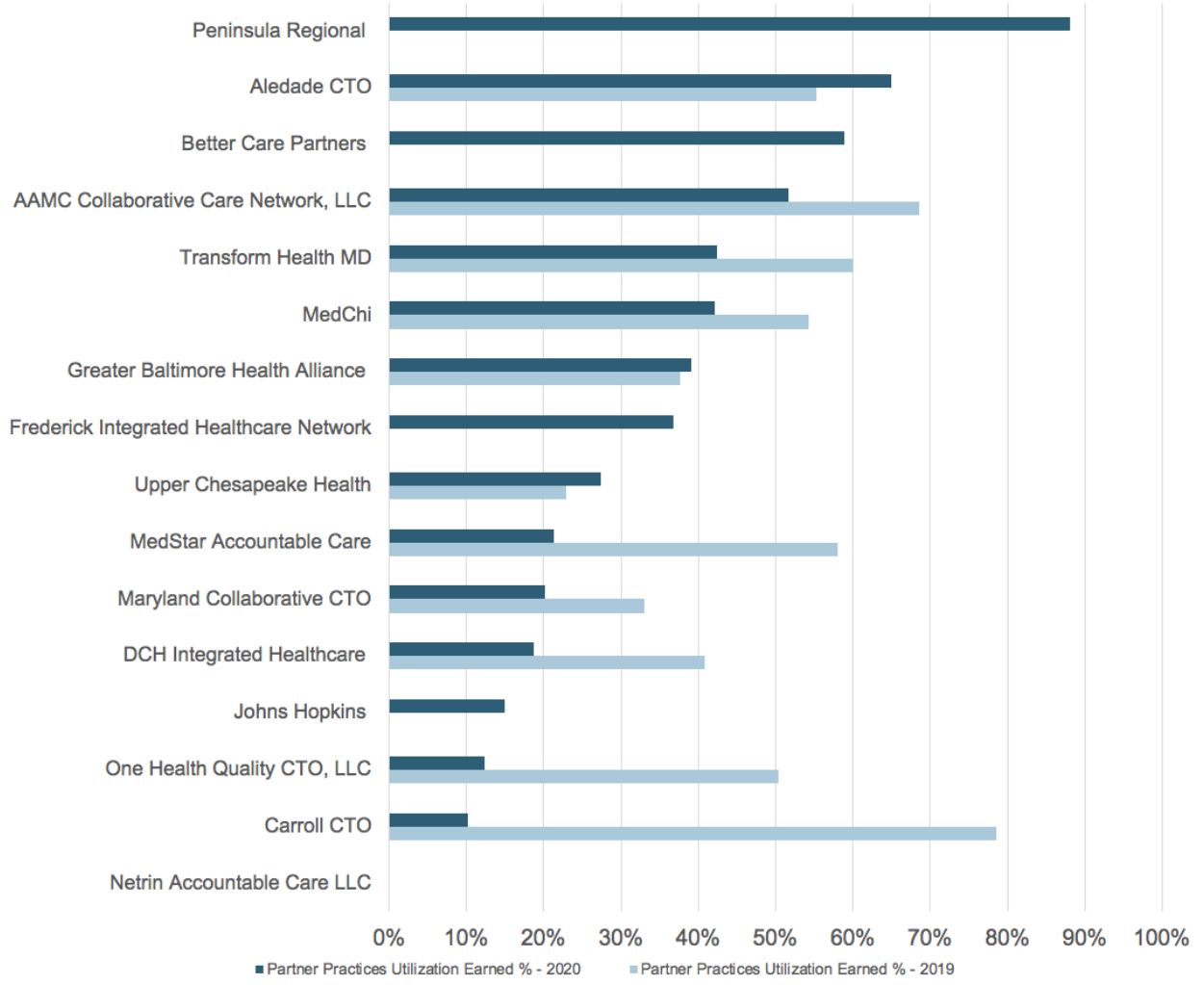
*CTOs with ≤5 practices omitted to protect patient and practice privacy

Figure B4. Practices' Quality Earned PBIP % by CTO, 2019-2020



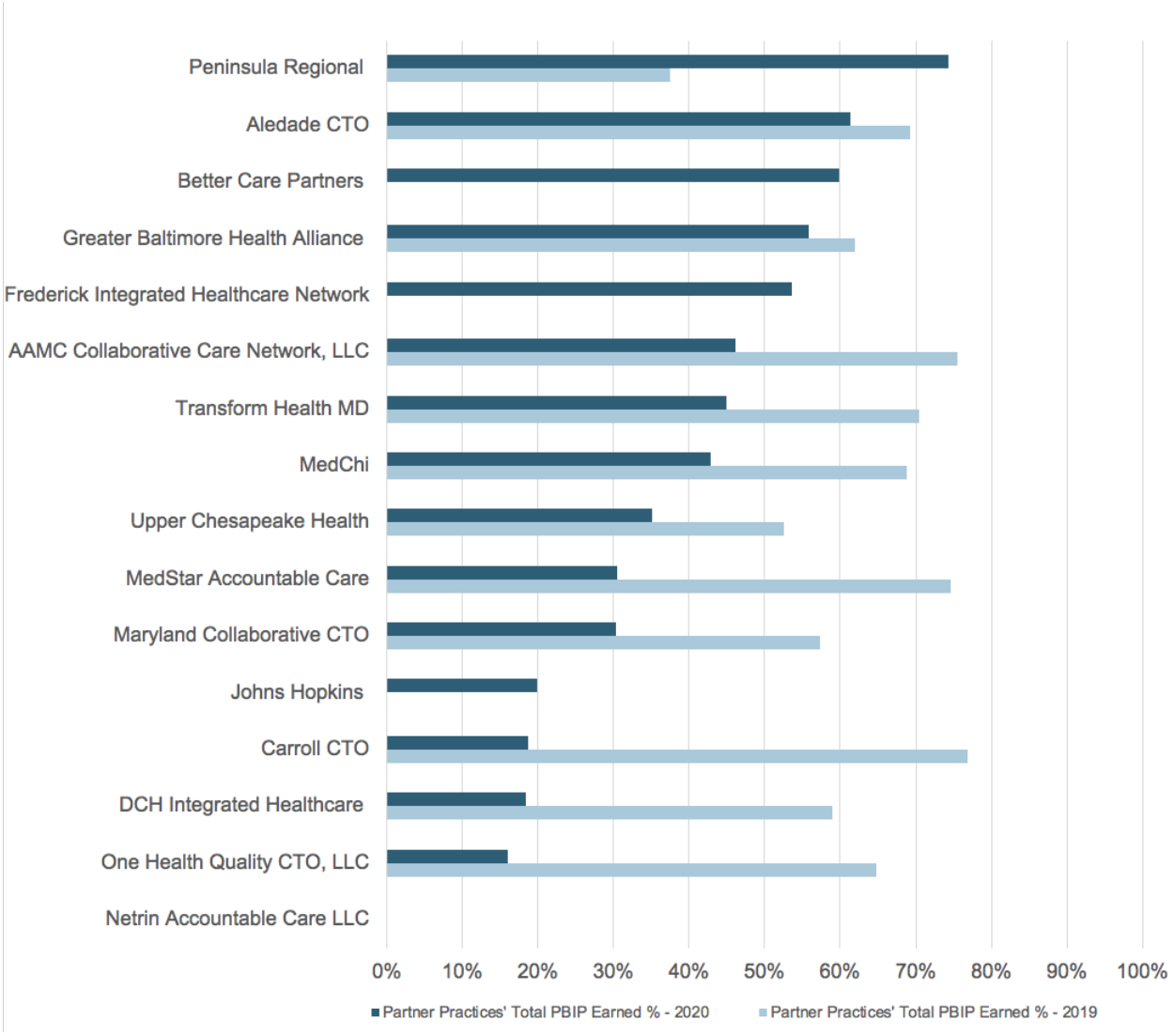
*CTOs earning no PBIP in any year were part of ACOs and therefore excluded from receiving PBIP payments

Figure B5. Practices' Total Utilization Earned PBIP % by CTO, 2019-2020



*CTOs earning no PBIP in any year were part of ACOs and therefore excluded from receiving PBIP payments

Figure B6. Practices' Total Earned PBIP % by CTO, 2019-2020



*CTOs earning no PBIP in any year were part of ACOs and therefore excluded from receiving PBIP payments

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"These succinct [COVID-19] update webinars for physicians have been extremely helpful. In particular, the updates on testing priorities, expectations of the ambulatory care providers, availability of PPE with use priorities, and future strategies for re-entry into society. Thank you!"
-- Physician

"The MDPCP program has benefited our patients by providing an extra level of care coordination and another person to reach out to. "
-- Practice Manager

"We are currently in our second year of the MDPCP program. I can say without reservation that this is a visionary program. By supporting our practices financially along with providing clear benchmarks, it has allowed us to re-envision primary care as it was meant to be."
-- Physician

"I cannot thank our MDPCP team enough for all they do for our patients and to help us here in the office. Our patients have given wonderful feedback and we are so happy to see our at-risk population be given the extra support they need, especially during these uncertain times."
-- RN Site Clinical Coordinator & Case Manager

MDPCP
MARYLAND PRIMARY CARE PROGRAM

Maryland
DEPARTMENT OF HEALTH

2020 ANNUAL REPORT

The State of Maryland has entered into a Total Cost of Care All-Payer Model contr act with the Federal Government that is designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes, and constrain the growth of health care costs in Maryland. A key element of the model is the development of the Maryland Primary Care Program (MDPCP). MDPCP is a voluntary program open to all qualifying Maryland primary care providers that provides funding and support for the delivery of advanced primary care throughout the state. The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.

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