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Maryland Primary Care Program
MDPCP Advisory Council

September 13, 2022

MDPCP Management Office
Chad Perman, Executive Director

Agenda

- MDPCP Program Updates - 2022 Scope, Major Initiatives and Program Performance
- MDPCP Track 3 Update
- Multi-payer Data Sharing Platform and Feedback

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MDPCP Program Updates - 2022 Scope, Priorities, and Program Performance

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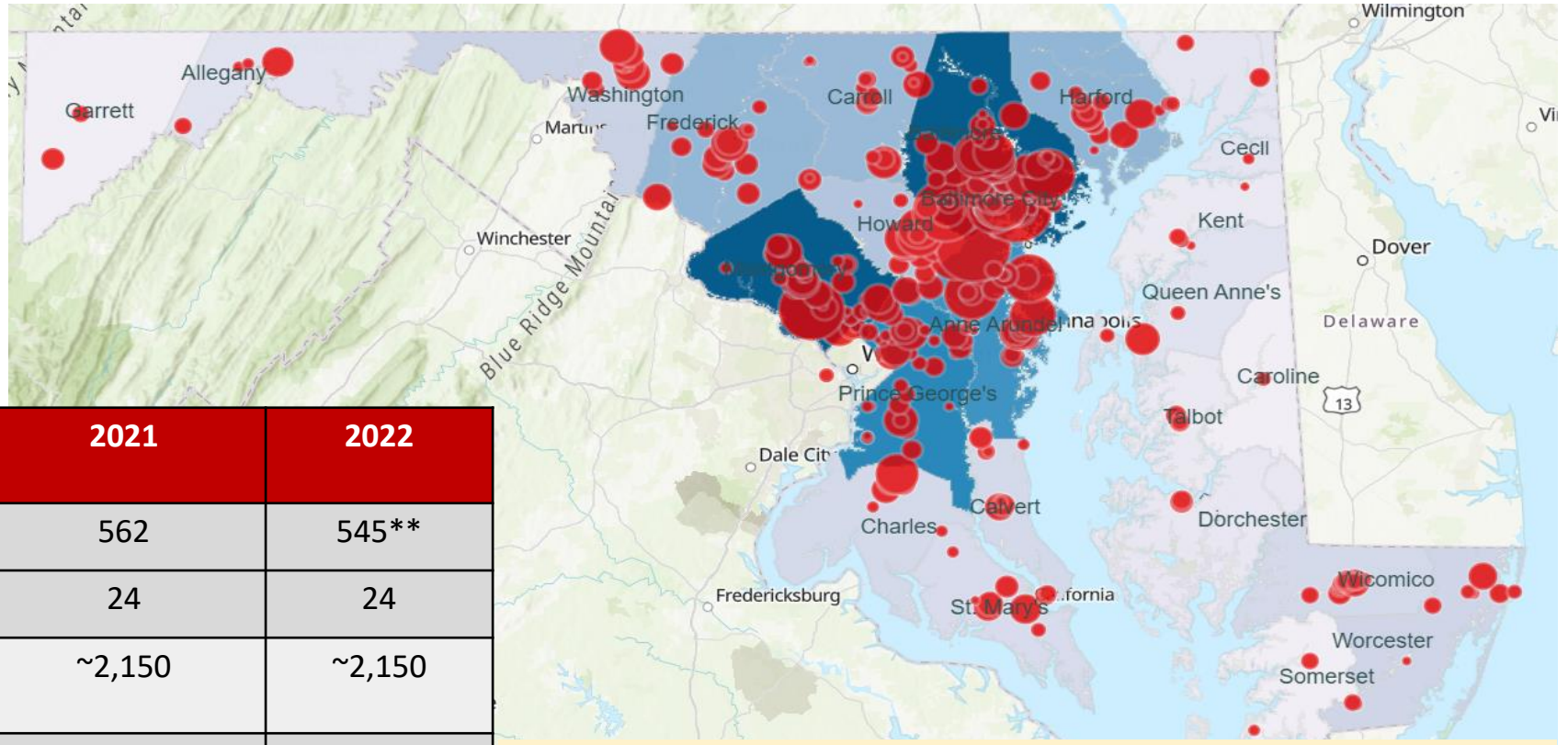
MDPCP in 2022

Support infrastructure – 24 Care Transformation Organizations

Statewide – Practices in every county



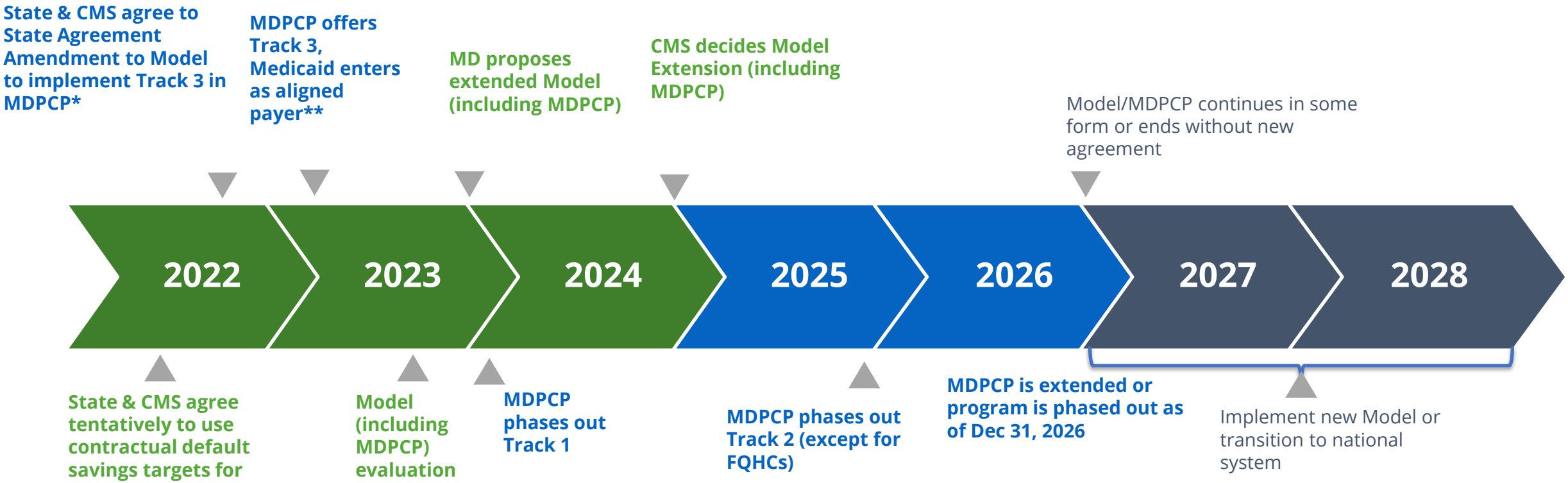
PARTICIPANTS	2019	2020	2021	2022
Practice sites	380	476	562	545**
CTOs	21	23	24	24
Providers in MDPCP	~1,500	~2,000	~2,150	~2,150
FFS beneficiaries attributed†	220,000 (28,717 duals)	356,000 (45,031 duals)	392,000 (60,000 duals)	376,000 (54,000 duals)
Marylanders served	2,000,000 – 3,000,000*	2,700,000 – 3,800,000*	over 4,000,000*	over 4,000,000*

** ***545 sites*** **– 7 FQHC organizations represent 44 site locations (508 official participants)**

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

†Data reflects highmark of each year

MDPCP and Total Cost of Care Model Timeline



*RELEASE-Maryland-and-CMS-advance-Total-Cost-of-Care-Model-and-Maryland-Primary-Care-Program-with-amendment,-MOU

** TBD

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MDPCP Priorities

Key Facts:
MDPCP is a key part of the Statewide Integrated Health Improvement Strategy (SIHIS) is designed to engage State agencies and private-sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs for Marylanders.

Incorporating health equity lens

Reducing risk-adjusted PQIs (avoidable admissions/ED visits)

Improving post-discharge follow-up

Addressing behavioral health including SUD

Reducing mean body mass (BMI) and diabetes incidence

Integrating Public Health

Renewed Focus on Health Equity

HEART Payment directs funding towards meeting patients' social needs

Summer 2022: **Social Risk Factors toolkit and technical assistance for practices to improve social needs screening** workflows and collection of patient self-reported demographic data

Stratifying data by key socio-demographic variables to understand disparities

- Maryland Health Equity & Digital Quality Measures Project for eCQMs
- CRISP Health Equity by Demographics report

Reach out to your practice coach to participate in these initiatives!

Notable COVID-19 Accomplishments

Vaccinations

- **485,652** cumulative doses administered
- **500 primary care practices (**292 MDPCP) involved in Primary Care Vaccine Program

Testing

- **Federal Test to Treat Program** now open to Primary Care and Urgent Care
- Primary care practices have continued to **test onsite** to mitigate COVID-19 spread

Equity

- Primary care sites provide better racial equity in vaccinations than other state sites
- Vaccine Tracker outreach to patients

Webinars

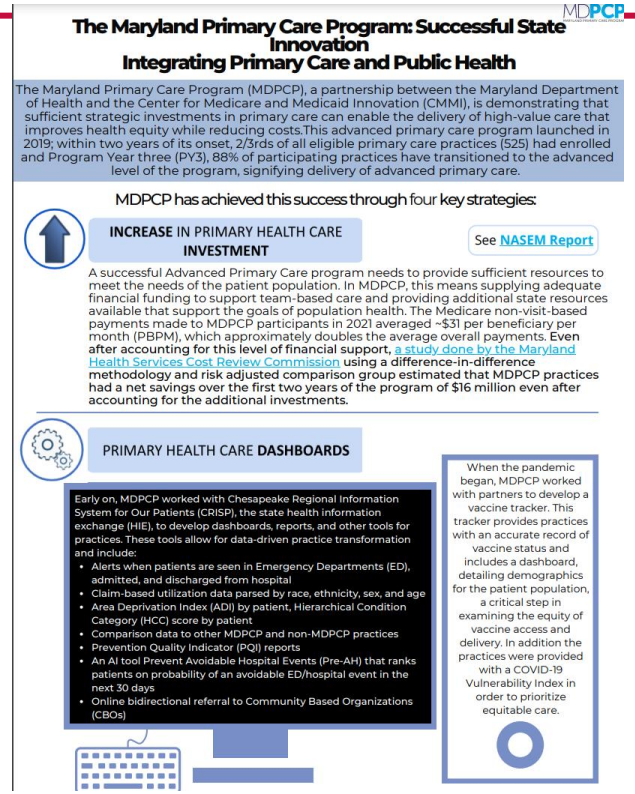
- **121** MDPCP COVID-19 Updates Webinars since March 2020 (03/2020 - 05/2022)
- **Over 20K** total attendees since the beginning of the pandemic

Therapeutics

- Eligible patients referred to **oral antivirals and monoclonals** per NIH prioritization
- Providers utilized the **Triple Play Strategy**

Notable MDPCP Presentations and Publications

- MDPCP presentation to National Academy (NASEM) for the "Strengthening Primary Care" webinar
  - One pager
  - Slide deck and recording
- JAMA Article: The Maryland Primary Care Program—A Blueprint for the Nation?
- MDH Press Release: "More than 700 primary care practices have joined the fight against COVID-19 through Maryland's Primary Care Vaccine Program"
- MDH Photo Release: "Maryland Primary Care Program Celebrates Successful COVID Booster Campaign Statewide"
- Milbank Issue Brief: "Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health–Supported Advanced Primary Care Paradigm"



PBPM, 2019 - 2021 (HCC - Risk Adjusted)

Equivalent non-participating population

A subset of the statewide non-participating population, demographically matched to the participating pop by age, sex, dual eligibility, and county of residence

Statewide non-participating population

All Medicare FFS beneficiaries who are eligible for MDPCP and not attributed to a participating provider

HCC Risk-adjustment

CMS assigns all participating beneficiaries an HCC score. The score is based on the community risk model to reflect the beneficiary's clinical profile and care needs. Risk-adjustment is based on the average HCC score of attributed beneficiaries.

Category	Base Year 2019	2020	2021	Percent Change 2019-2020	Percent Change 2020 - 2021	Percent Change 2019 - 2021
Statewide FFS population	$1,038	$1,059	$1,125	2.0%	6.2%	8.4%
Statewide Non-Participating Population	$1,001	$1,016	$1,129	1.5%	11.1%	12.8%
Equivalent Non-Participating Population	$1,017	$1,025	$1,146	0.8%	11.8%	12.6%
MDPCP Statewide	**$1,016**	**$1,018**	**$1,124**	**0.2%**	**10.4%**	**10.7%**

Monthly Maryland Primary Care Program Performance Dashboard

Inpatient Admission Utilization per K, 2019 - 2021 (HCC - Risk Adjusted)

Equivalent non-participating population

A subset of the statewide non-participating population, demographically matched to the participating pop by age, sex, dual eligibility, and county of residence

Statewide non-participating population

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Category	Base Year 2019	2020	2021	Percent Change 2019-2020	Percent Change 2020-2021	Percent Change 2019-2021
Statewide FFS population	248.9	217.3	216.8	-12.7%	-0.2%	-12.9%
Statewide Non-Participating Population	247.3	215.0	223.3	-13.1%	3.9%	-9.7%
Equivalent Non-Participating Population	248.1	214.7	223.5	-13.5%	4.1%	-9.9%
MDPCP Statewide	**244.3**	**211.1**	**214.6**	**-13.6%**	**1.7%**	**-12.2%**

ED Visit Utilization per K, 2019 - 2021 (HCC - Risk Adjusted)

Equivalent non-participating population

A subset of the statewide non-participating population, demographically matched to the participating pop by age, sex, dual eligibility, and county of residence

Statewide non-participating population

All Medicare FFS beneficiaries who are eligible for MDPCP and not attributed to a participating provider

HCC Risk-adjustment

CMS assigns all participating beneficiaries an HCC score. The score is based on the community risk model to reflect the beneficiary's clinical profile and care needs. Risk-adjustment is based on the average HCC score of attributed beneficiaries.

Category	Base Year 2019	2021	Percent Change 2019- 2021
Statewide FFS population	457	372	-18.7%
Statewide Non-Participating Population	476	393	-17.5%
Equivalent Non-Participating Population	457	374	-18.2%
MDPCP Statewide	441	364	-17.4%

Awaiting 2020 data figures

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PQI-Like Events per K, 2019 - 2021 (HCC - Risk Adjusted)

Equivalent non-participating population

A subset of the statewide non-participating population, demographically matched to the participating pop by age, sex, dual eligibility, and county of residence

Statewide non-participating population

All Medicare FFS beneficiaries who are eligible for MDPCP and not attributed to a participating provider

HCC Risk-adjustment

CMS assigns all participating beneficiaries an HCC score. The score is based on the community risk model to reflect the beneficiary's clinical profile and care needs. Risk-adjustment is based on the average HCC score of attributed beneficiaries.

Category	Base Year 2019	2020	2021	Percent Change 2019-2020	Percent Change 2020-2021	Percent Change 2019-2021
Statewide FFS population	87.6	66.0	63.6	-24.8%	-3.5%	-27.5%
Statewide Non-Participating Population	90.0	68.2	67.0	-24.2%	-1.8%	-25.6%
Equivalent Non-Participating Population	86.1	65.0	64.8	-24.6%	-0.2%	-24.8%
MDPCP Statewide	**87.0**	**65.5**	**64.1**	**-24.7%**	**-2.1%**	**-26.3%**

Chart displays utilization for IP admissions or ED visits that fall into one of 10 AHRQ Prevention Quality Indicator (PQI) categories using the 2021 AHRQ specification.

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MDPCP Track 3 Updates

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Policy Updates

Request for Applications (RFA) for PY 2023

Opportunity for new applicants to apply to join the program beginning January 1, 2023 closed in July 2022

- Practices are eligible to start in Track 1, 2, or 3
- FQHCs are eligible to start in Track 1 or 2

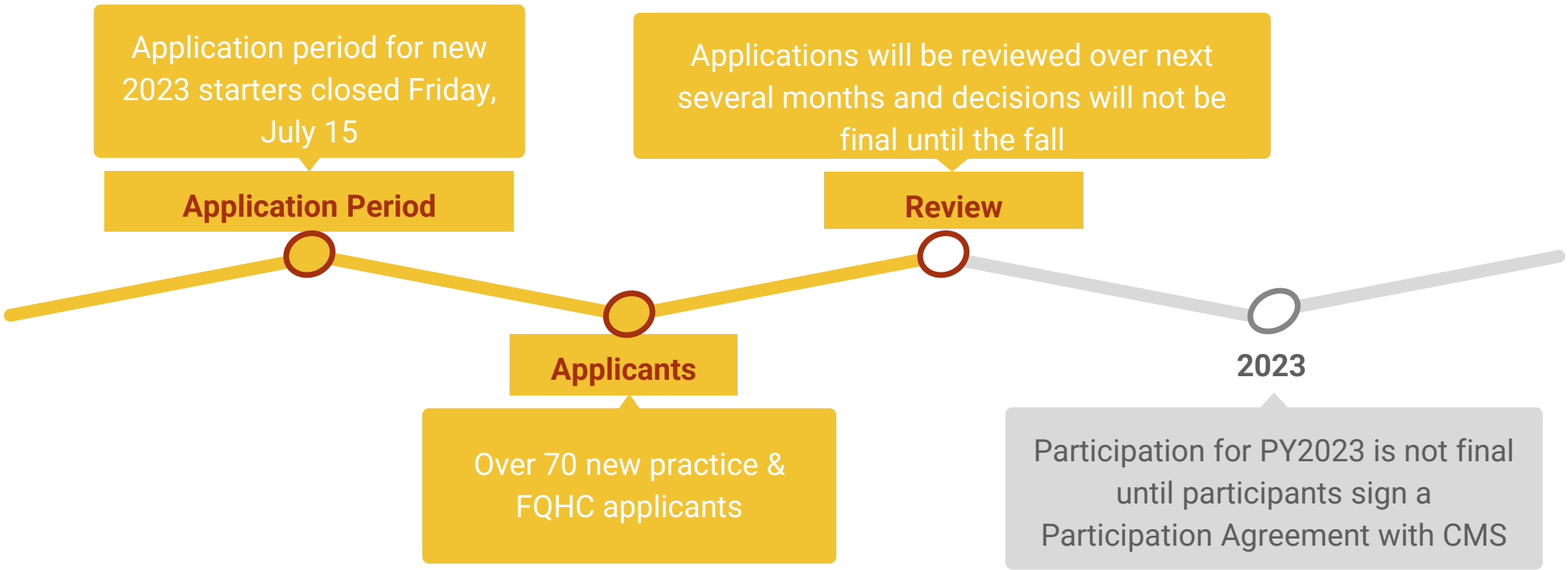
Track 3 resources are in development (e.g., Payment scenarios, FAQs, webinars)

Track 3 Transition Requirements

All Track 1 & 2 requirements, plus:

- Identifying beneficiaries for self-management support
- Comprehensive Medication Management (CMM)
- Advance care planning
- Prioritizing health-related social needs
- Collecting patient demographics
- Integrating PFAC recommendations into care & QI activities

New Participants: 2023 Request for Applications (RFA)



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Current Participants: Track Transitions for Track 2 and 3 - Fall 2022

Required Transitions

- Track 1 practices in their third year of MDPCP MUST transition to Track 2 or Track 3 in order to continue participating - **20 practices**
- Practices that participated in MDPCP as Track 2 practices in 2019 and 2020 will be required to move to Track 3 for PY 2023 - **117 practices**

Track Eligibility

- Track 1 practices may request to transition to Track 2 or directly into Track 3.
- FQHCs are eligible to participate in Tracks 1 and 2 in 2023; FQHCs are not eligible to transition to Track 3 at this time.

Timeline

- Requests completed by October during Q3 Reporting
- Decisions from CMMI completed by early December

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Multi-payer Data Sharing Platform and Feedback

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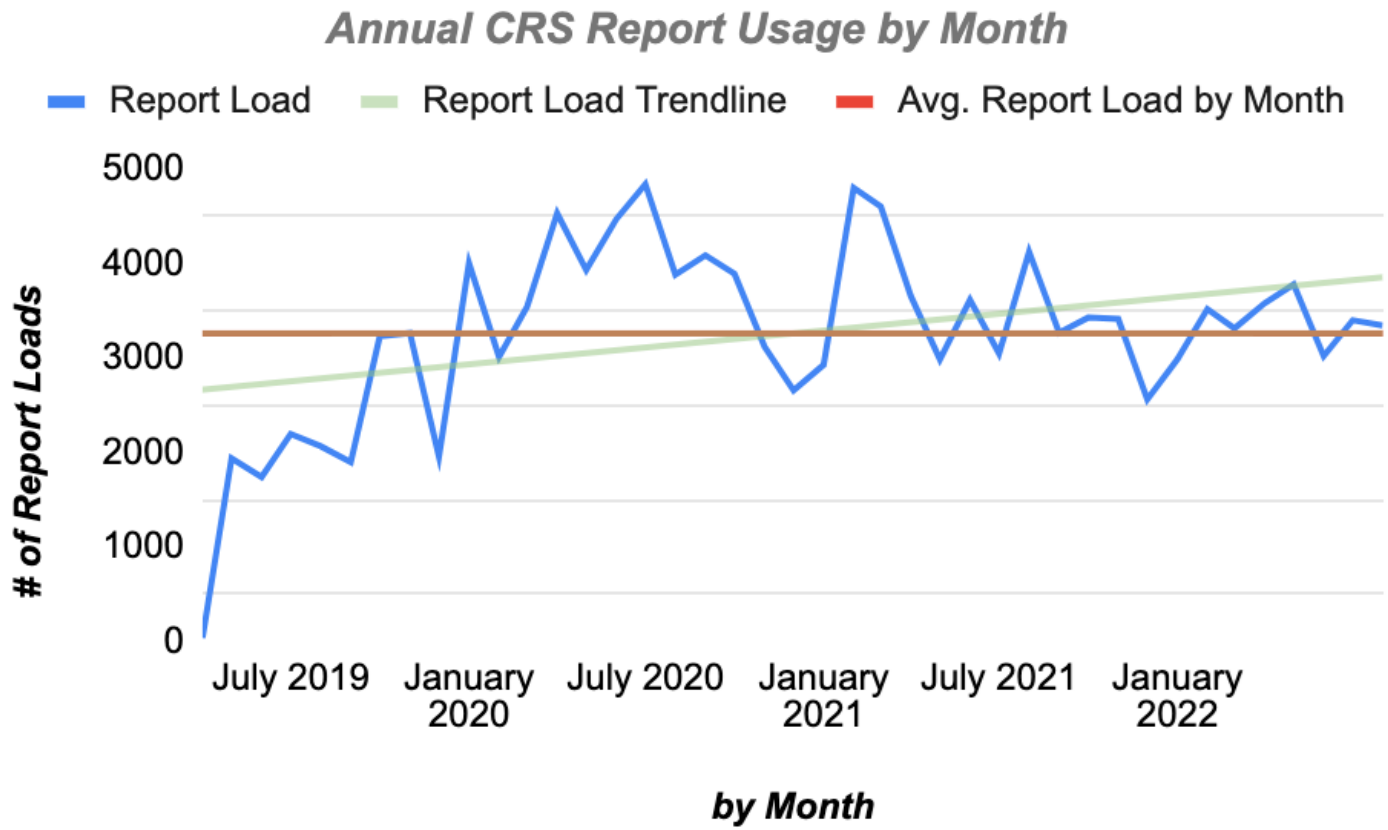
MDPCP Reports Usage Statistics - Monthly

CRISP Reporting Services MDPCP report access by month.



Source: 2022 MDPCP Reporting Suite.

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Multi-payer Data Platform Planning

- Key recommendation from stakeholders leading up to the launch of MDPCP
- Description:
  - Multi-payer primary care performance data transparency and intelligence to MDPCP practices
  - Aggregate the data from multiple payers on a central platform for ease of use by the practice in their efforts to improve cost and quality.
- Objectives:
  - Align with MDPCP goals to reduce complexity and administrative burden for practice clinicians and staff
  - Allow practices to focus on areas of greatest need across entire patient population.
  - Streamline practice initiatives and workflows for all patients

Potential Use Cases - Primary

Primary Use Cases

Practices/CTOs

1. **Population Health data reviews/multi-payer transformation** (claims data) - Provide practice providers and staff with a single view of cost and utilization data at the practice level across all participating payers.
2. **Care transitions** (Combined clinical and claims data) - ED, SNF and hospital transitions focused data on causes, trends, disparities to assist care management
3. **Risk/Event Prediction algorithms**(claims data) - Pre-AH event prediction for avoidable hospital use across all payers
4. **Gaps in care** (Combined clinical and claims data) - Identify all payer gaps in care for claims identifiable items such as A1C, cancer screening, etc.
5. **Aligned clinical quality metrics** (clinical or claims data) - Scores on important metrics like diabetes and hypertension for entire population to drive QI

State

1. **Statewide Population Health Data** - Provide State population level data to identify programming/interventions to address public health needs and program improvements.

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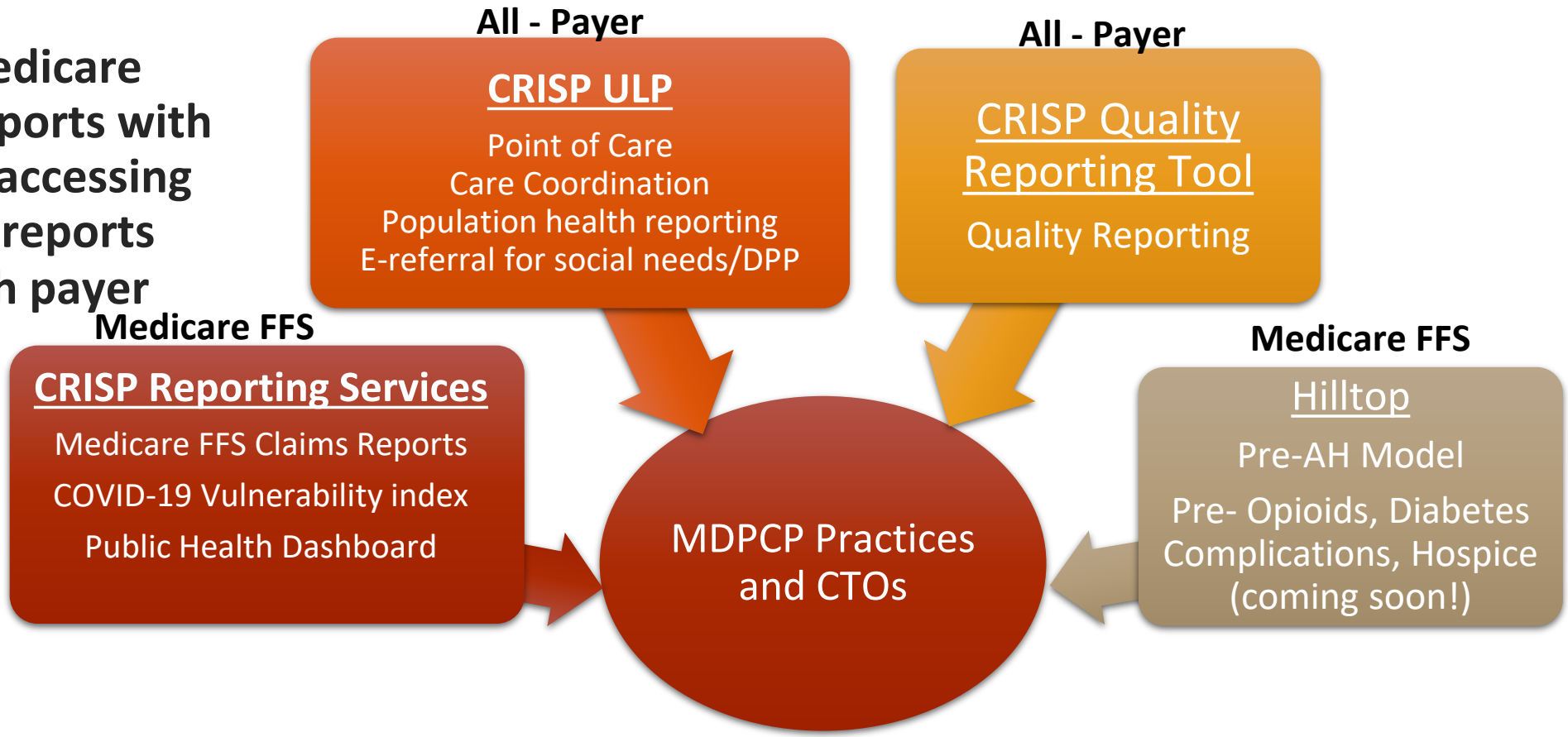
Potential Use Cases - Secondary

Secondary Use Cases for Others

1. **Aligned Payer Population Health Data** - Provide aligned payers with an opportunity to see how different payer populations and market products compare at a practice and population level.
2. **Primary Care Investment Workgroup (SB734)** – The Workgroup may need all-payer data to measure current primary care investment in Maryland.
3. **Streamlined Technical Assistance to practices** - Drive shared/aligned quality improvement support provided by State/Aligned Payer practice coaches and outreach staff

CRISP Suite of Tools for MDPCP - Today

Today - Medicare focused reports with burden of accessing additional reports across each payer



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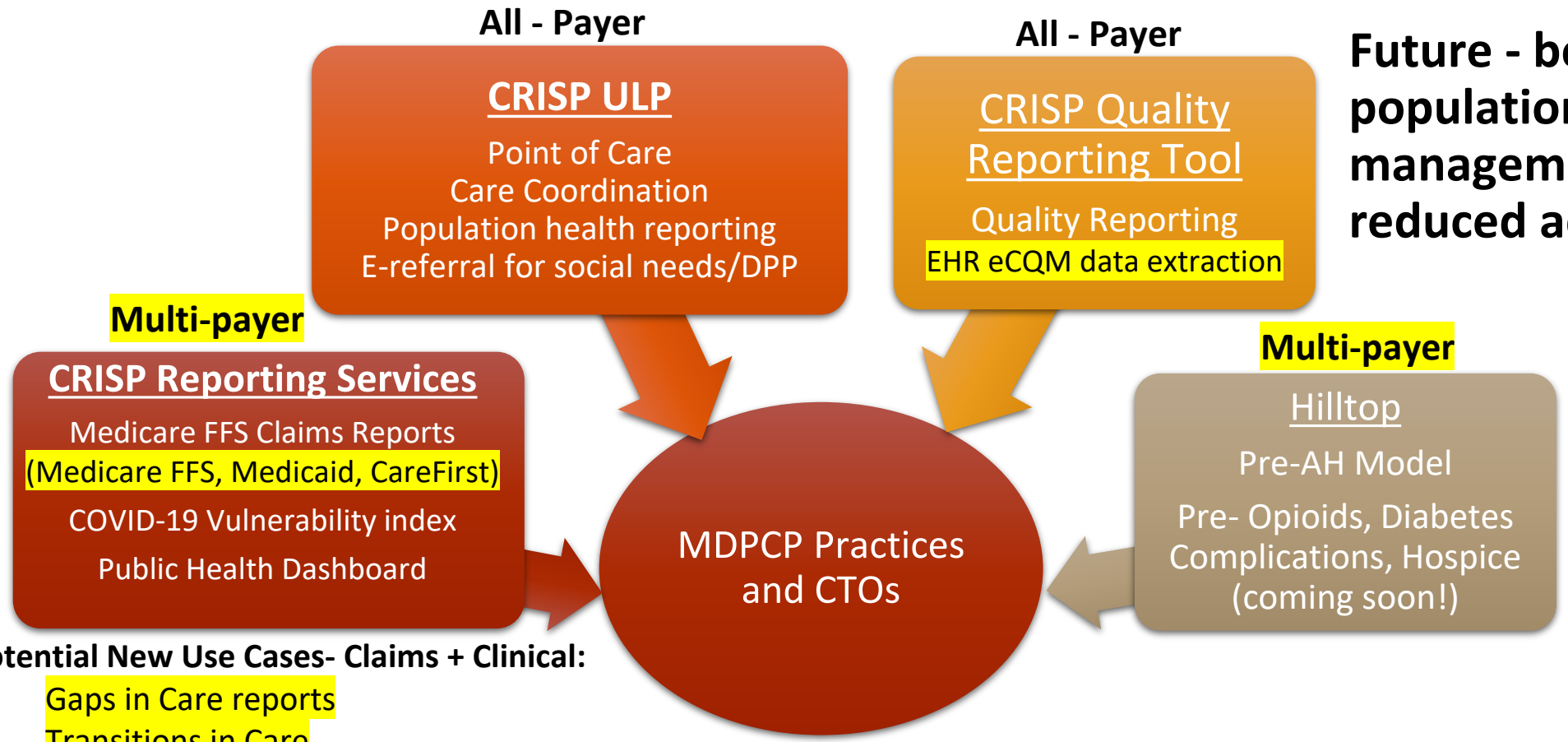
CRISP Suite of Tools for MDPCP - Future



Potential New Use Cases- Claims + Clinical:

- Gaps in Care reports
- Transitions in Care
- Multi-payer population health reports
- Breakouts by payer and market
- Health equity breakouts

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Feedback on Multi-payer Data Sharing Platform

- How would a multi-payer primary care platform improve advanced primary care in Maryland?
- Use Cases
  - What are the key use cases?
  - How would a multi-payer data sharing platform with claims and clinical quality performance across payers be used by practices, CTOs, payers, and the State?
- Other thoughts?

Future Topics for Council Feedback

- 2021 Annual Report - will be shared with Council in October; due to CMMI by end of CY 2022
- 2023 and Beyond
  - Integrating Medicaid MCOs and Practices
  - Revamping Performance Measurement Methodology
  - Further payer alignment (MA, etc)
  - Continuing to operationalize alignment with SIHIS
  - Evolution of payment models
  - Reporting on MDPCP - Public Health integration results

Thank You!

Check out the MDPCP website for updates and more information

Email mdh.pcmodel@maryland.gov with any questions or concerns

Any questions?

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Appendix

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Performance

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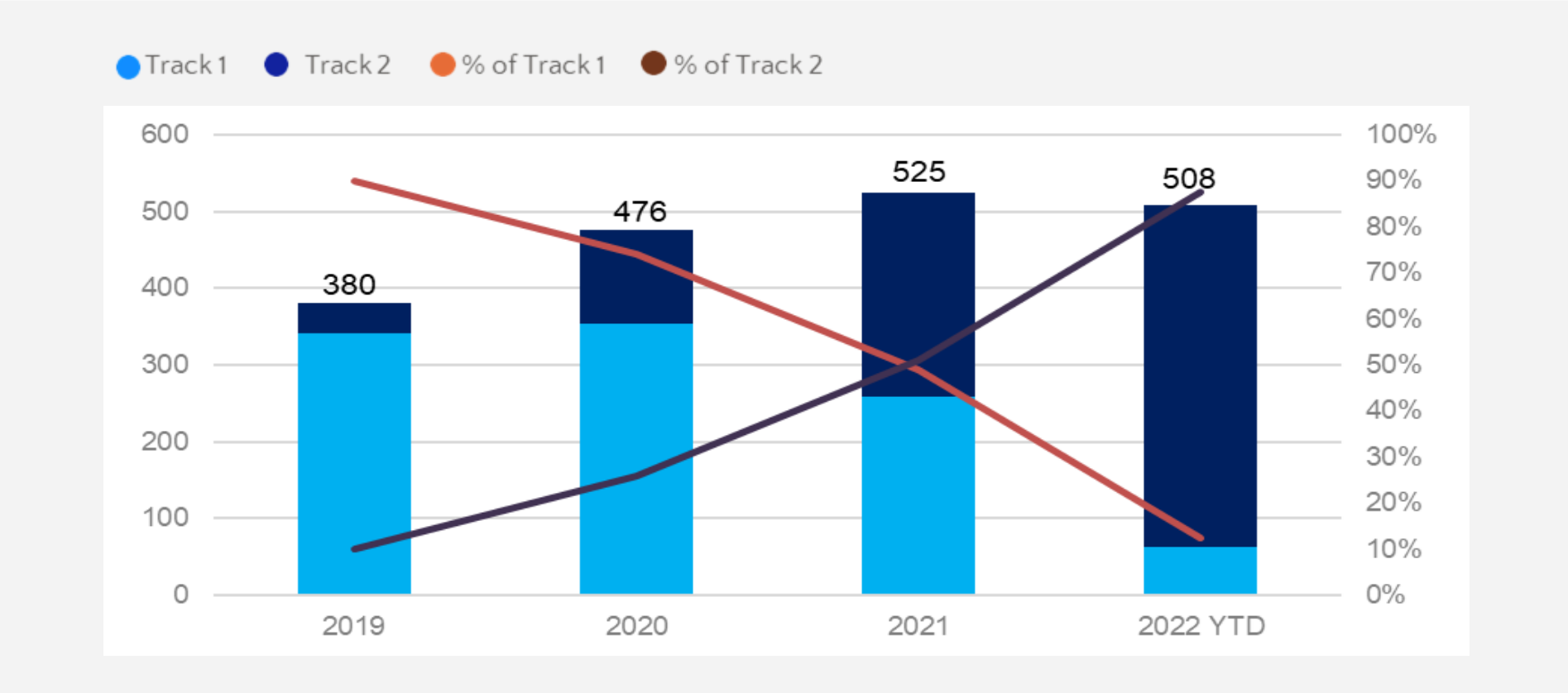
Number of MDPCP Practices by Track



[Monthly Maryland Primary Care Program Performance Dashboard]

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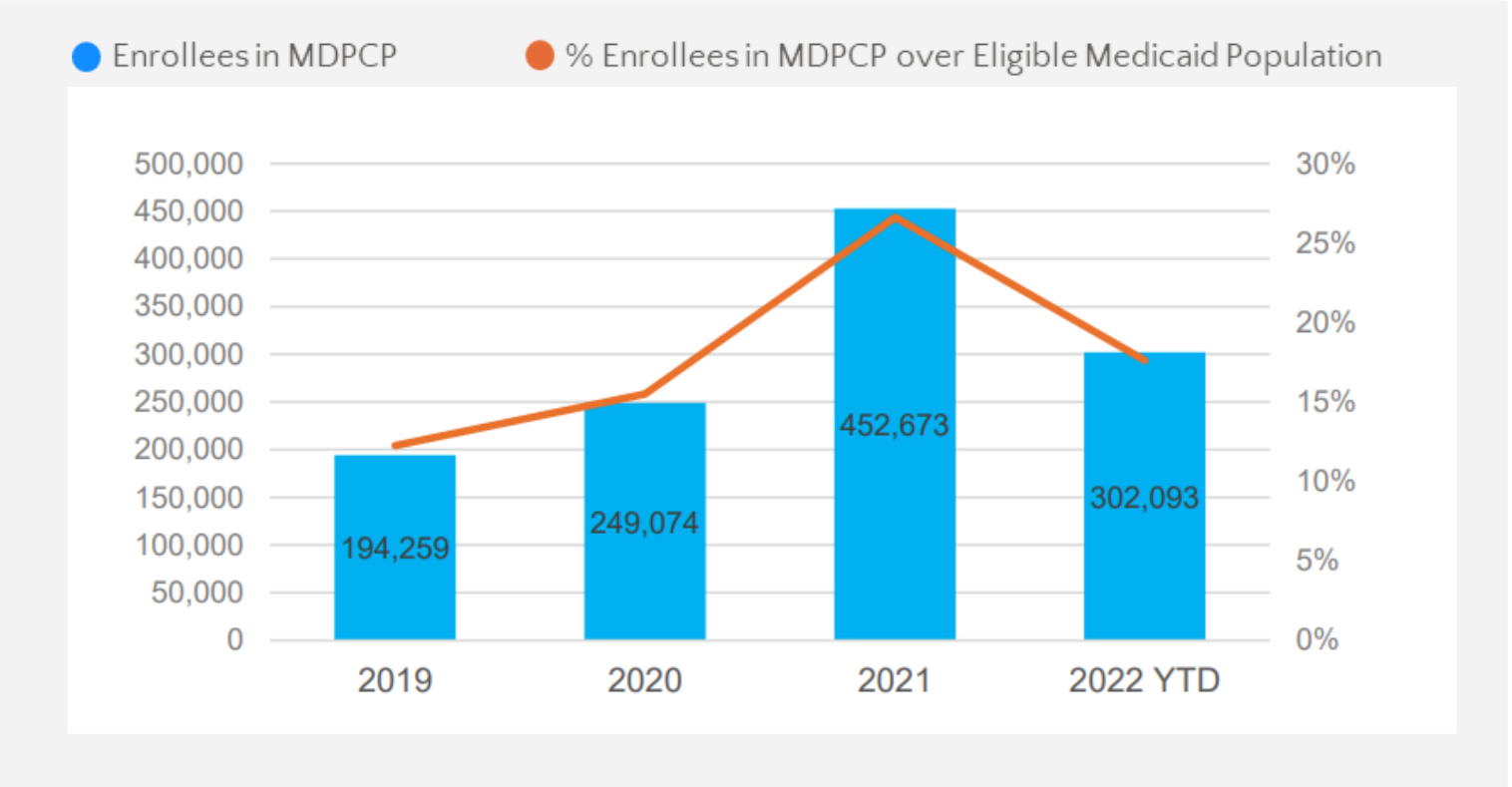
Medicaid Enrollees in MDPCP Practices as % of Eligible Medicaid Population*



*Including dually eligible beneficiaries in MDPCP

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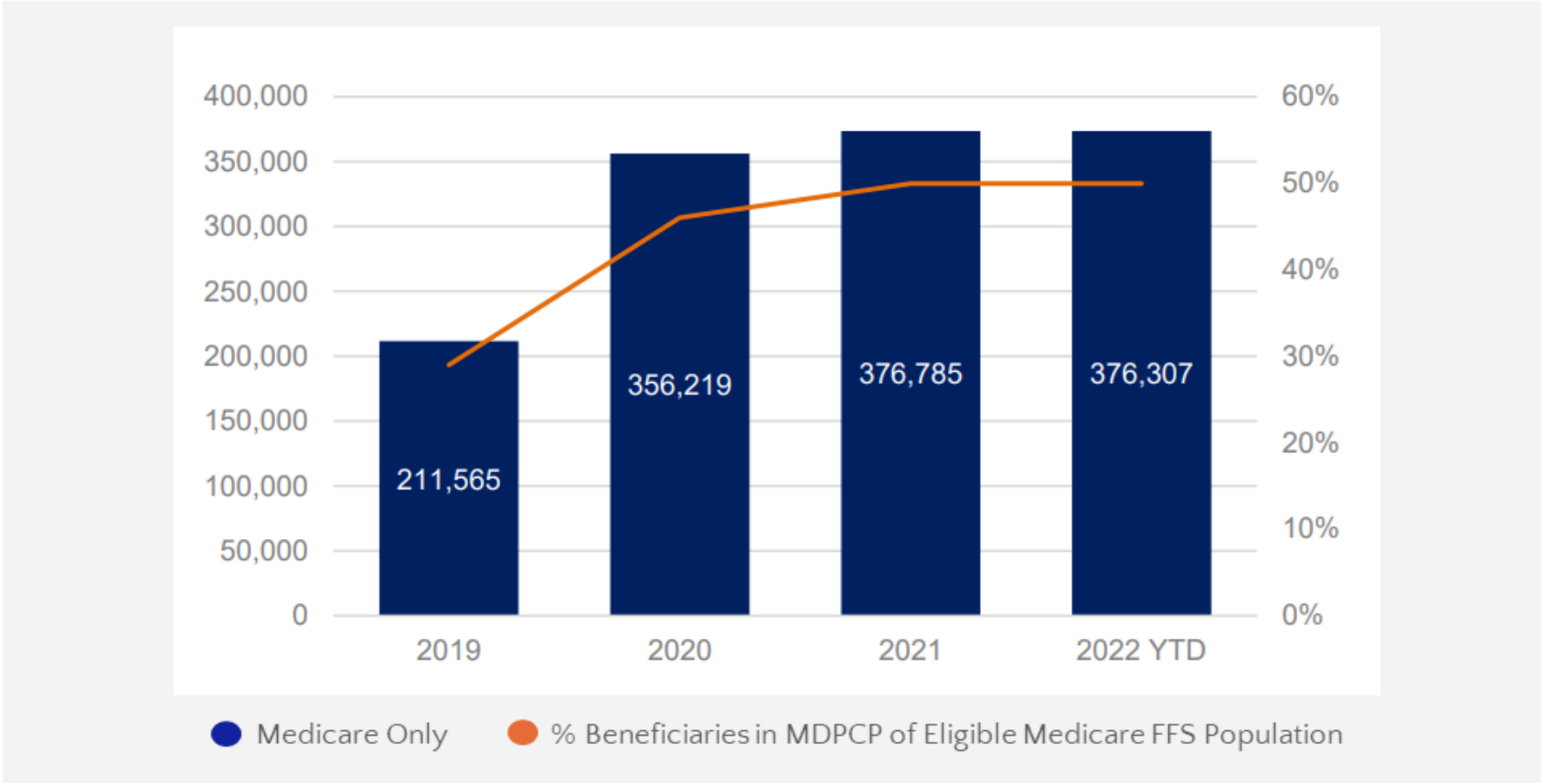
Medicare Fee-for-Service Beneficiaries in MDPCP as a Percent of Eligible Statewide Medicare Fee-for-Service Population*



*Data reflects Q4 attribution of each year

[July 2022 - MDPCP Performance Dashboard Update]

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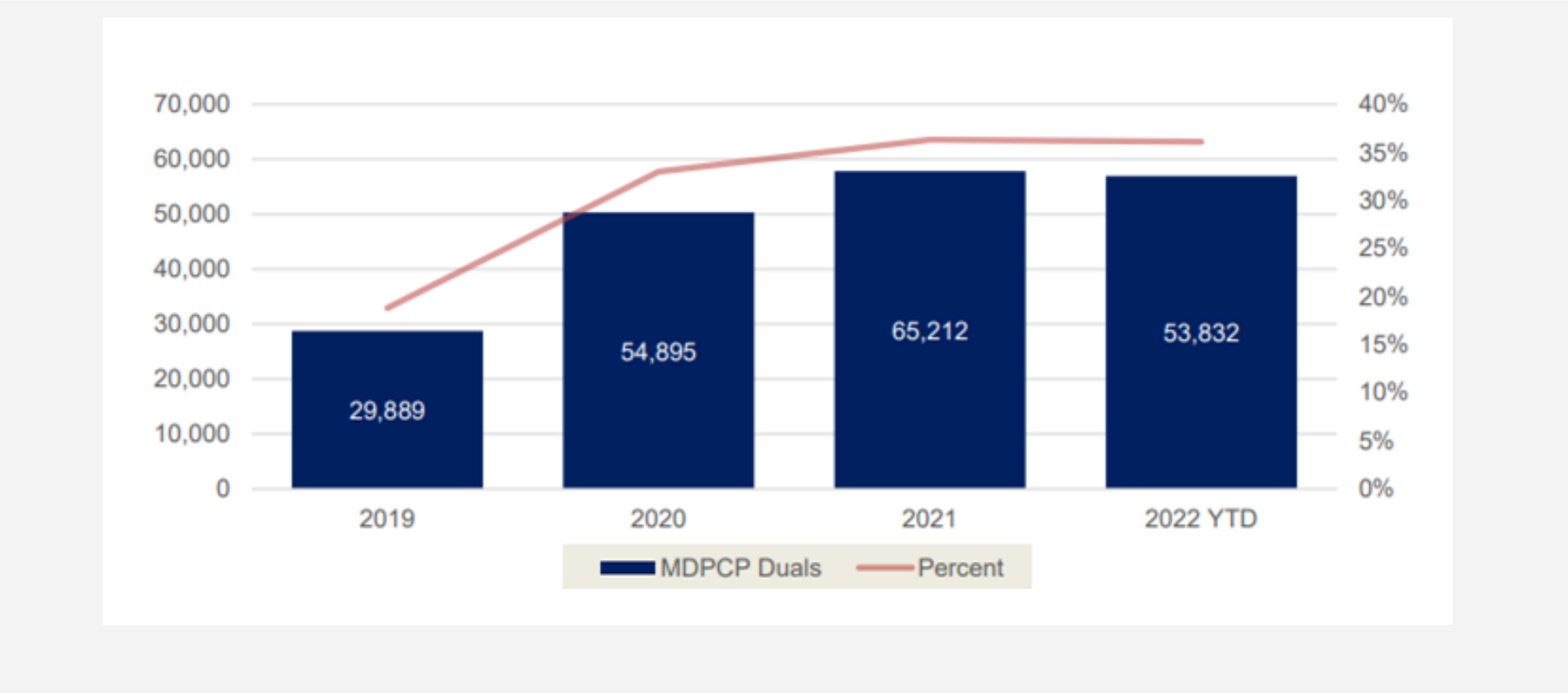
MDPCP-Enrolled Dual Eligibles as % of Total Dual Eligibles*



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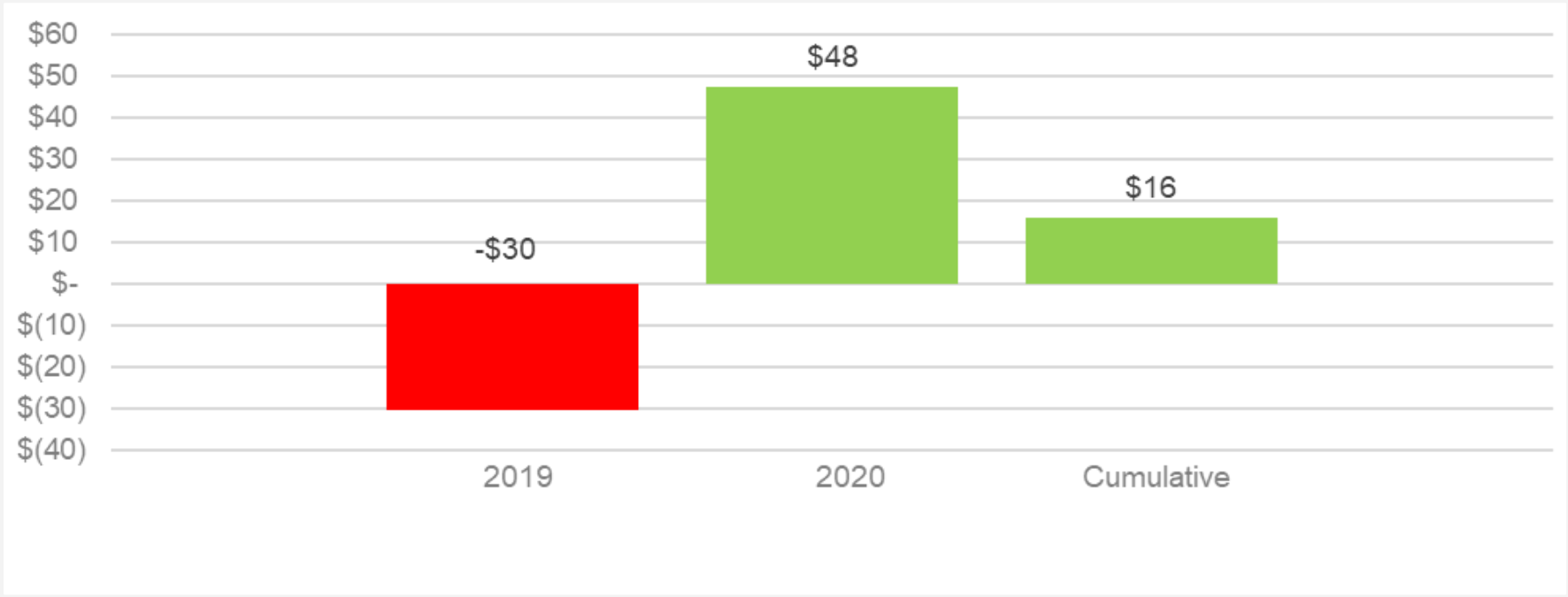
HSCRC Difference-of-Differences In Costs (Cost Savings in Millions)*



*These data represent cost savings calculated by HSCRC (after care management fees) that can be attributed directly to MDPCP.
*Cumulative savings reflect the effects of compounding.

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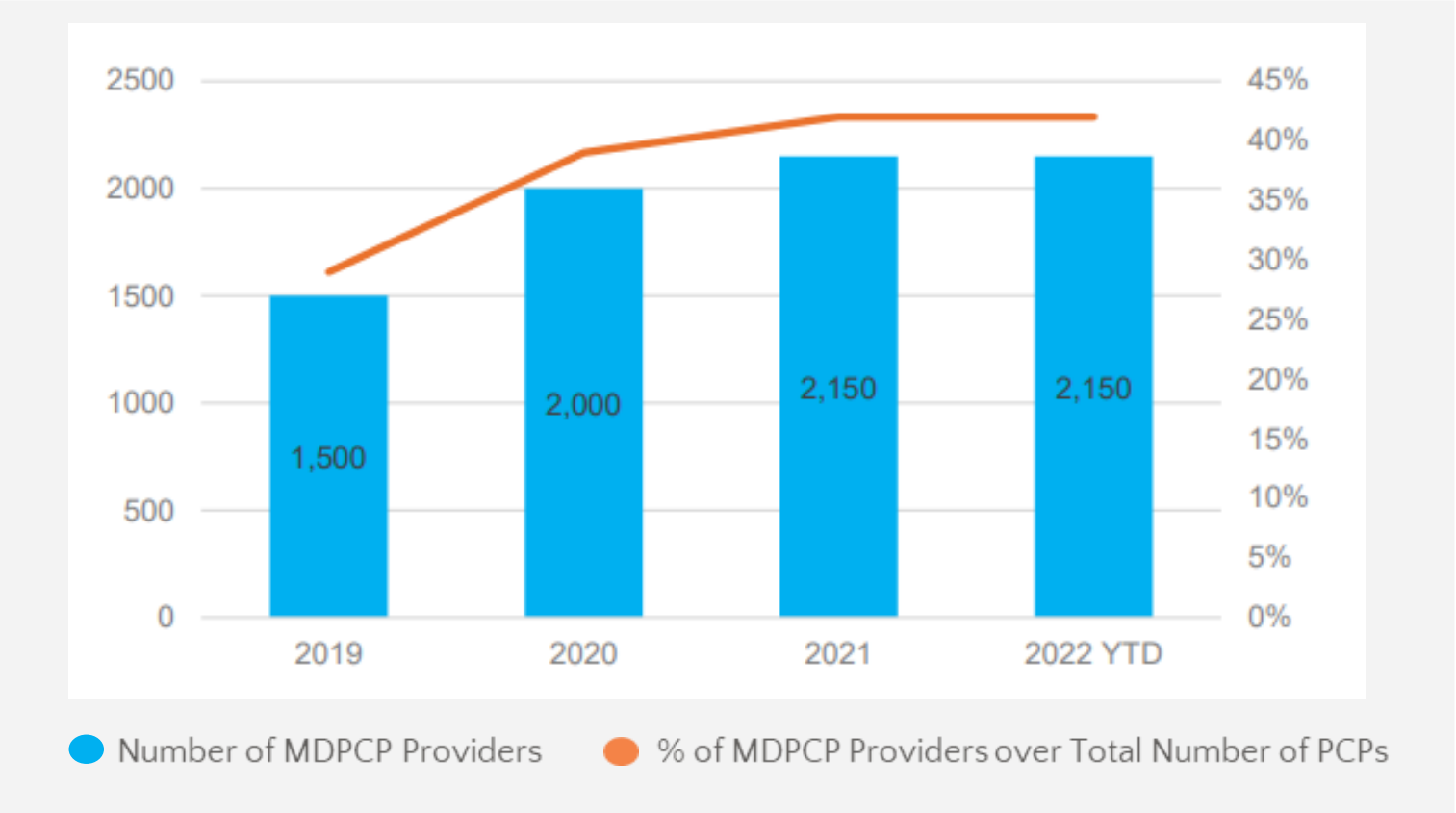
MDPCP Providers as a % of Total Number of Primary Care Providers in Maryland*



*Including all active, board-certified Internal Medicine, Family Medicine, and General Practice physicians in Maryland

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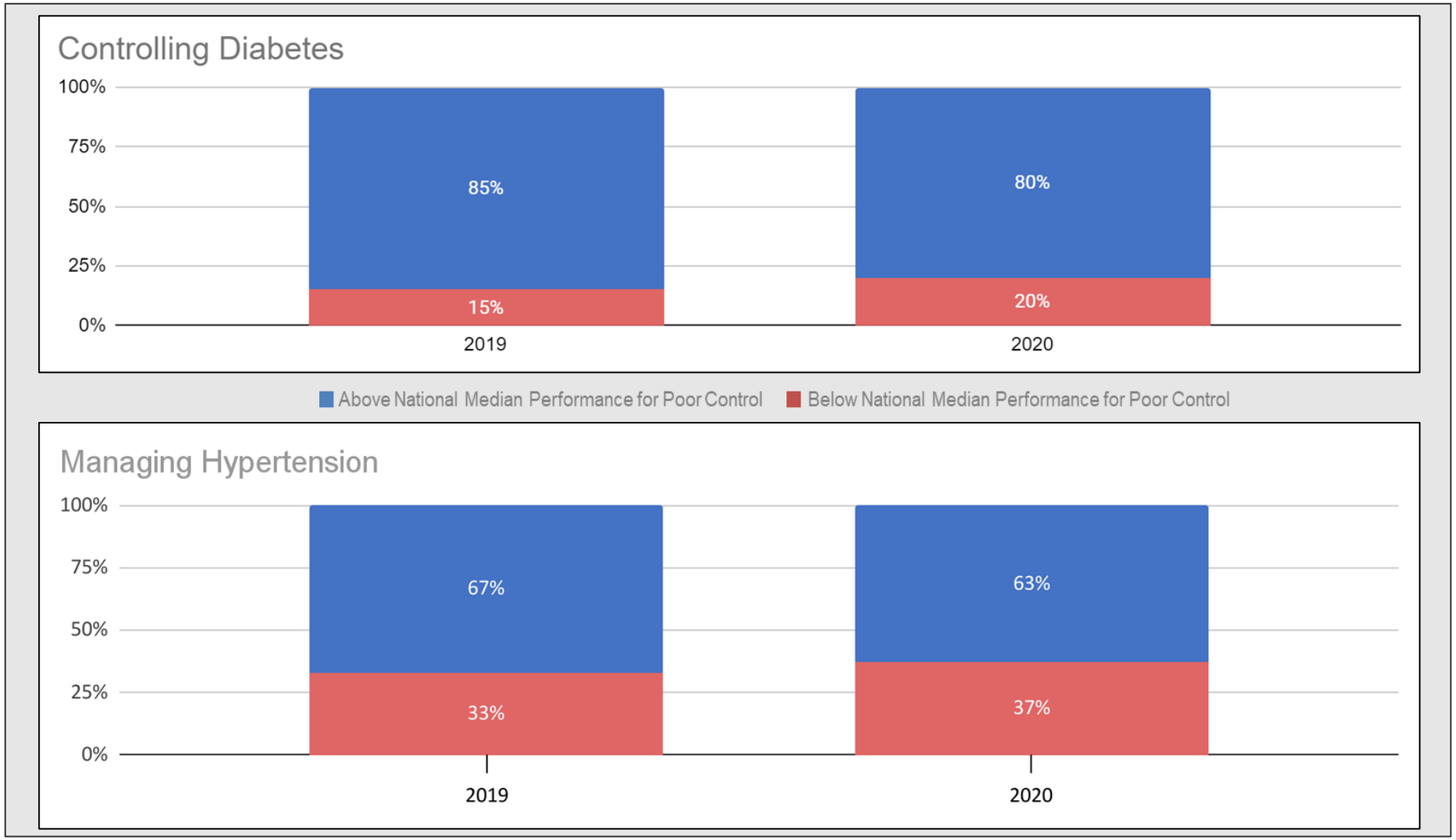
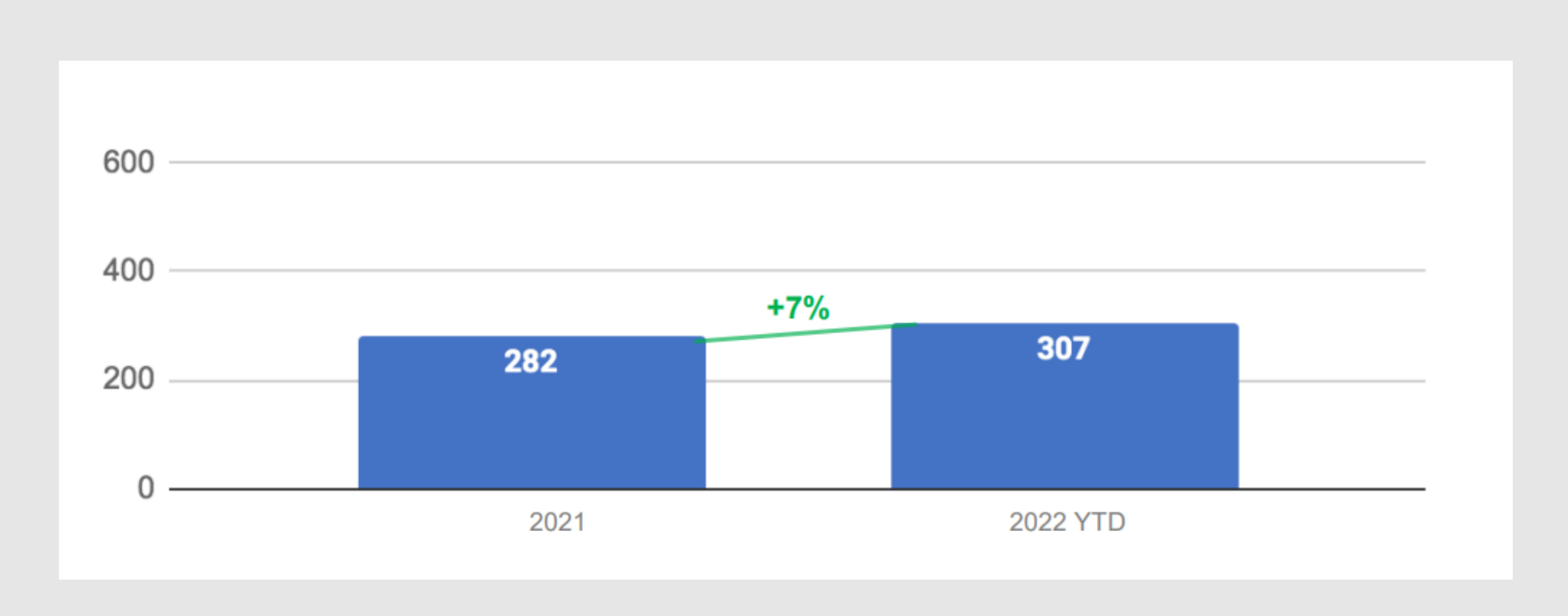
Percent of MDPCP Practices above the National Median in Controlling Diabetes and Managing Hypertension*



*Based on MIPS (Merit-Based Incentive Payment System) reporting. A1C control is a method for treating and controlling blood sugar level for diabetes patients. Data are from 2020

MDPCP Practices' Participating in the Primary Care Vaccination Program



Data are through July 29, 2022

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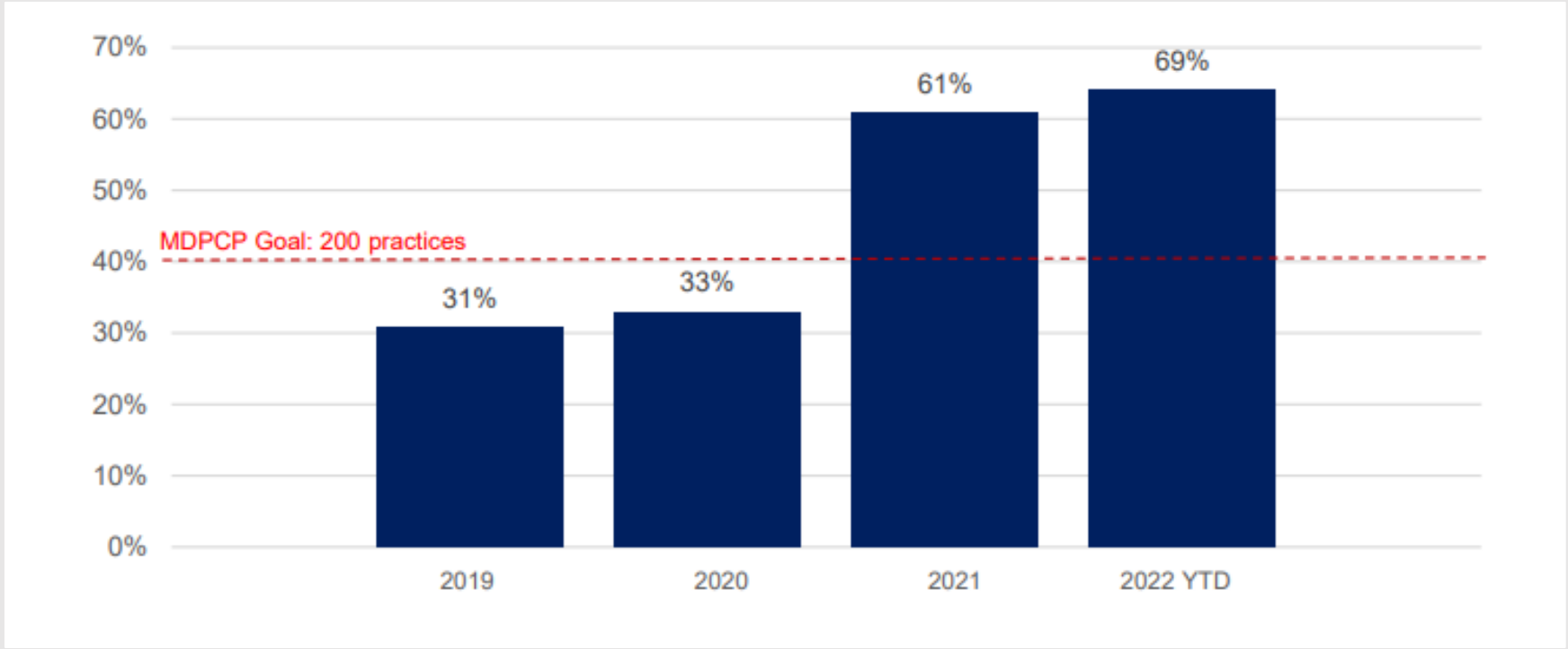
Percent of MDPCP Practices that have Implemented SBIRT*



*SBIRT (Screening, Brief Intervention, and Referral to Treatment) is a best practice used to identify and refer to treatment people suffering from substance use disorder (SUD).

**Data are through July 29, 2022

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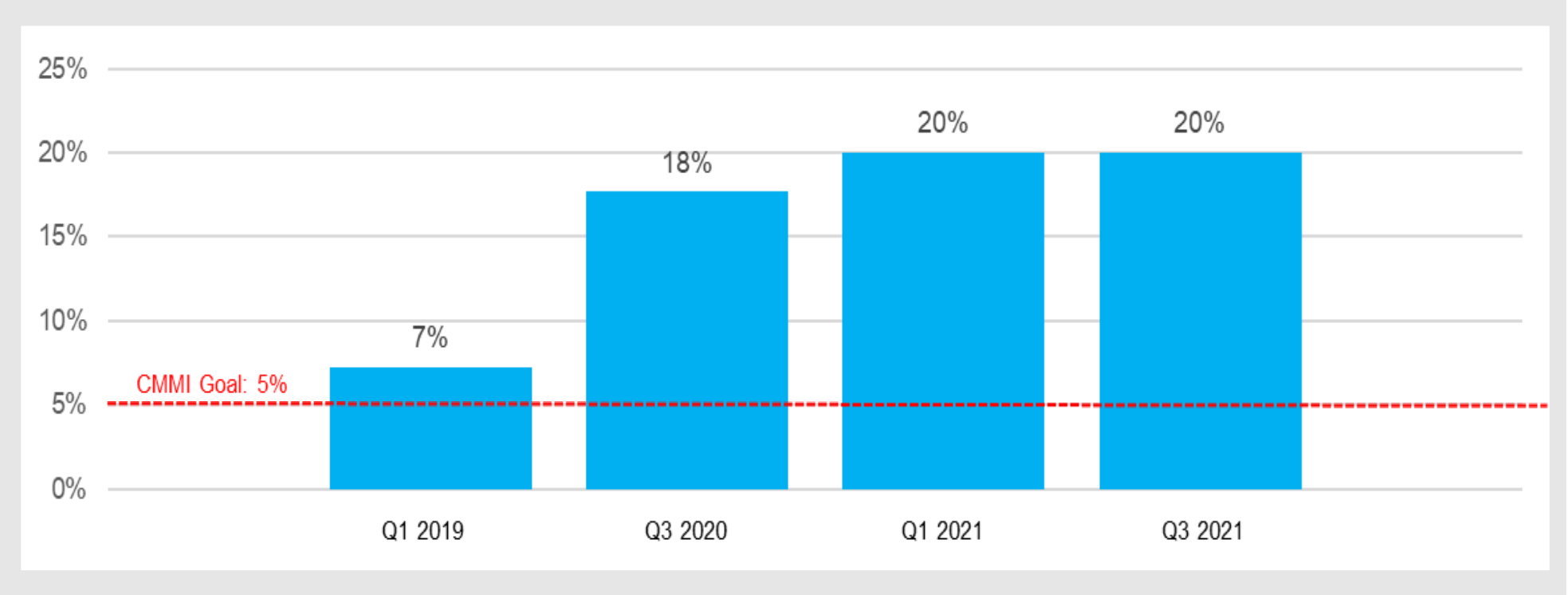
Percent of Beneficiaries under Longitudinal Care Management*



*CMMI (Centers for Medicare & Medicaid Services Innovation Center) develops and tests new healthcare payment and service delivery models to improve patient care and reduce costs.

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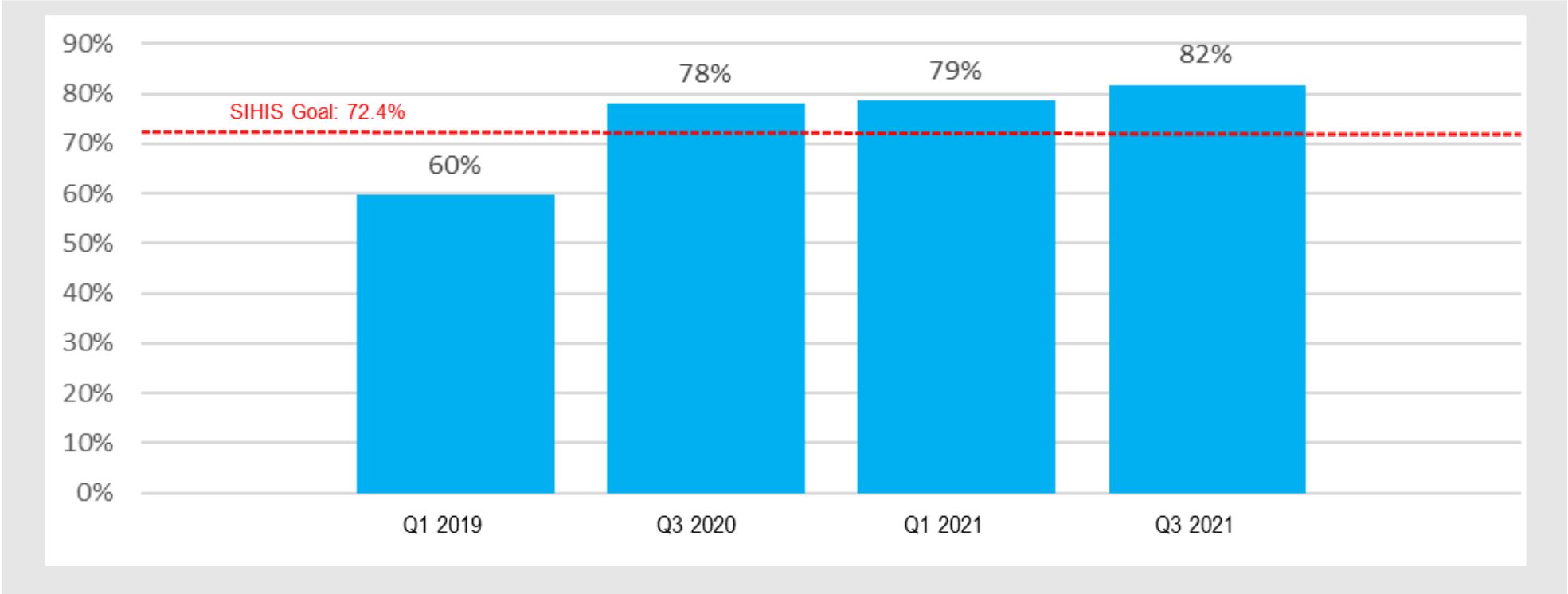
Percent of Beneficiaries with Follow-up after Hospital Admissions within Two Business Days



*SIHIS (Statewide Integrated Health Improvement Strategy) is designed to engage state agencies and private-sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs

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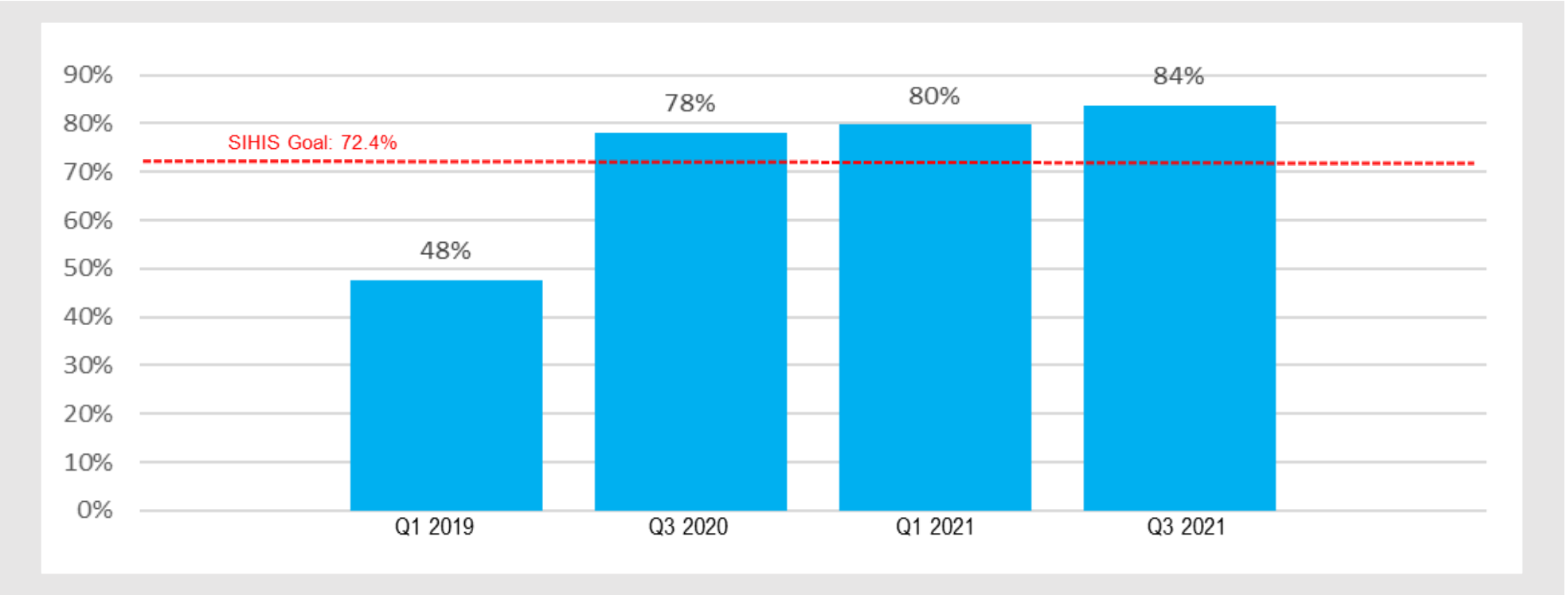
Percent of Beneficiaries with Follow-up after Emergency Department Visits within One Week



*SIHIS (Statewide Integrated Health Improvement Strategy) is designed to engage state agencies and private-sector partners to collaborate and invest in improving health, addressing disparities, and reducing costs

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SBIRT Summary

Monthly Summary Statistics

350
Total Practices Implementing SBIRT

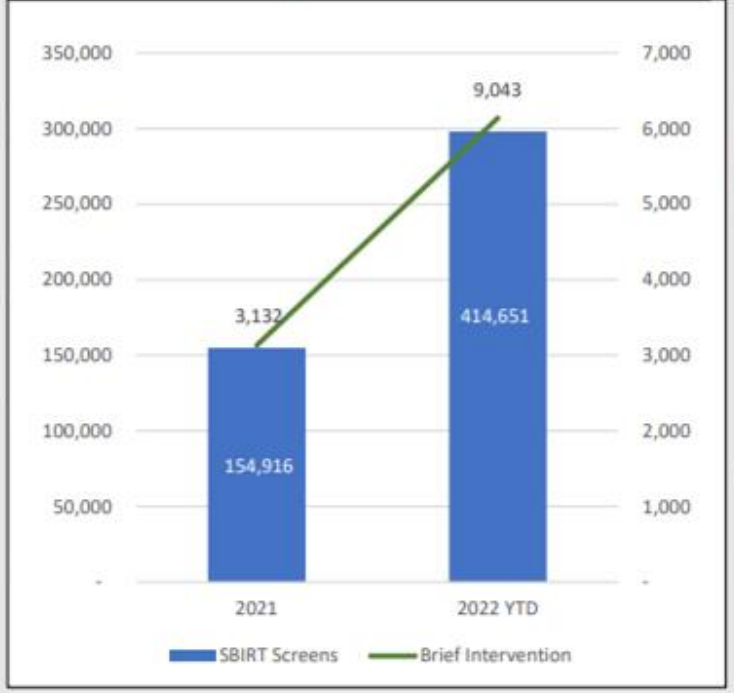
213
Practices Reporting

414,651
SBIRT Screenings

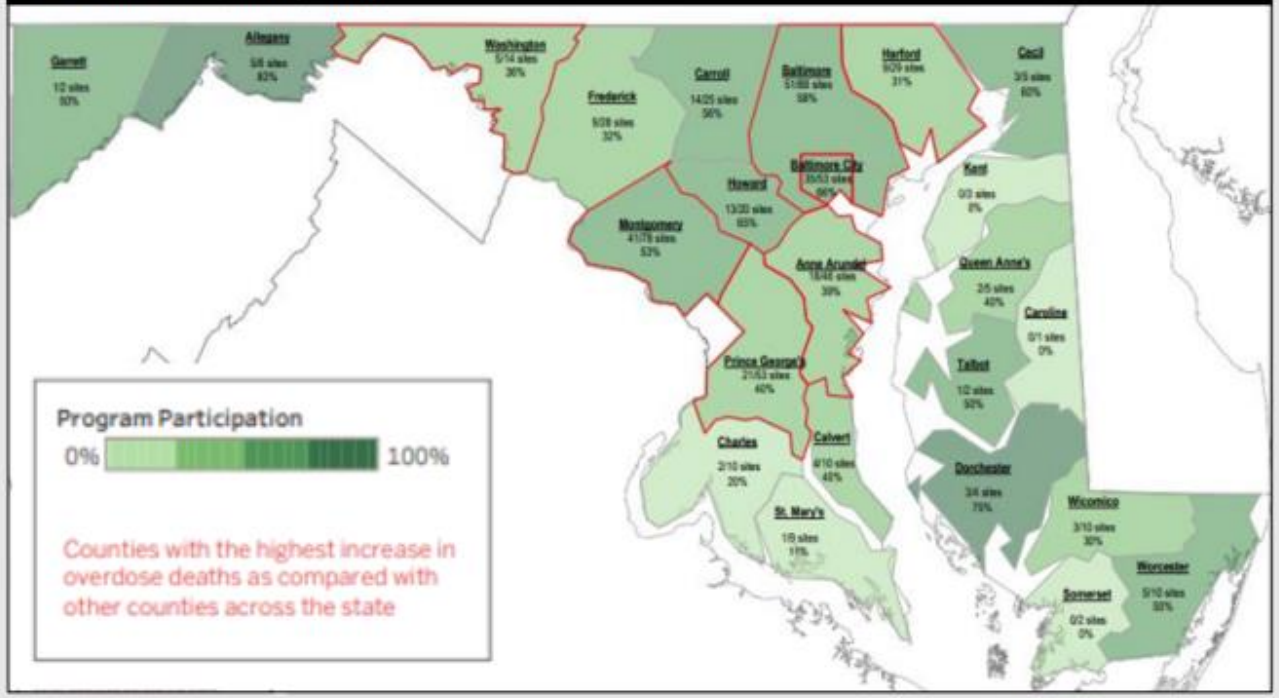
29,060
Positive SBIRT Screenings

9,043
Brief Interventions (BI)

Cumulative SBIRT Screenings and Brief Interventions



MDPCP SBIRT Participation by County

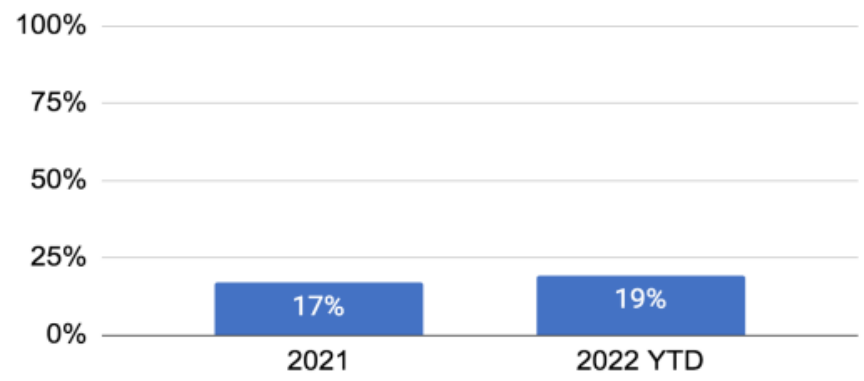


Monthly and Cumulative Statistics

	August – 21	September – 21	October – 21	November – 21	December – 21	January – 22	February – 22	March – 22	April – 22	May –22	June – 22	July-22	Total
% SBIRT Screens out of Total Eligible Patients	63%	66%	65%	66%	51%	61%	67%	62%	75%	70%	69%	71%	**65%**
% Positives out of Total SBIRT Screens	9%	8%	9%	8%	6%	5%	5%	7%	7%	7%	7%	7%	**7%**
% BI out of Total Positives	37%	29%	23%	20%	23%	26%	29%	36%	34%	36%	46%	42%	**31%**
Practices Reporting Per Month	112	123	147	154	153	175	200	213	190	222	208	213	-

MDPCP Practices Implementing Collaborative Care Model (CoCM) for Mental Health

Status of 2022 MDPCP Practices' Participation in Collaborative Care Model (CoCM)

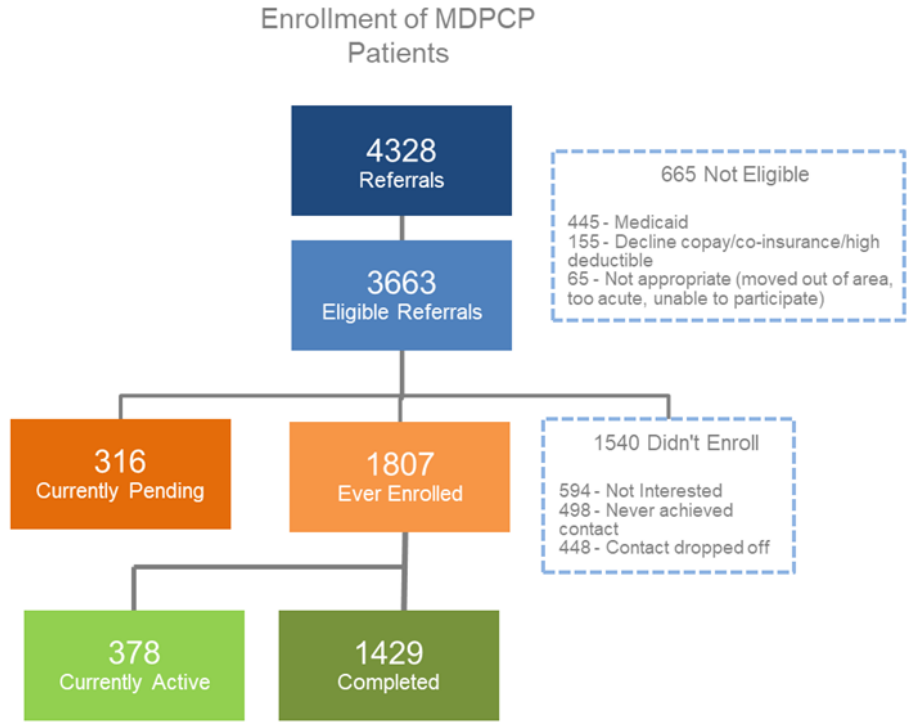


MDPCP Patients – Clinical Improvement under Collaborative Care Model (CoCM)

Days in CCP	30	60	90	120	180
% Patients with PHQ-9 CMR[2]	18%	54%	66%	72%	77%

77% of assessed patients have achieved a Clinically Meaningful Reduction (CMR) in PHQ-9 Score within 6 months in CCP and with 54% achieving CMR within just 2 months

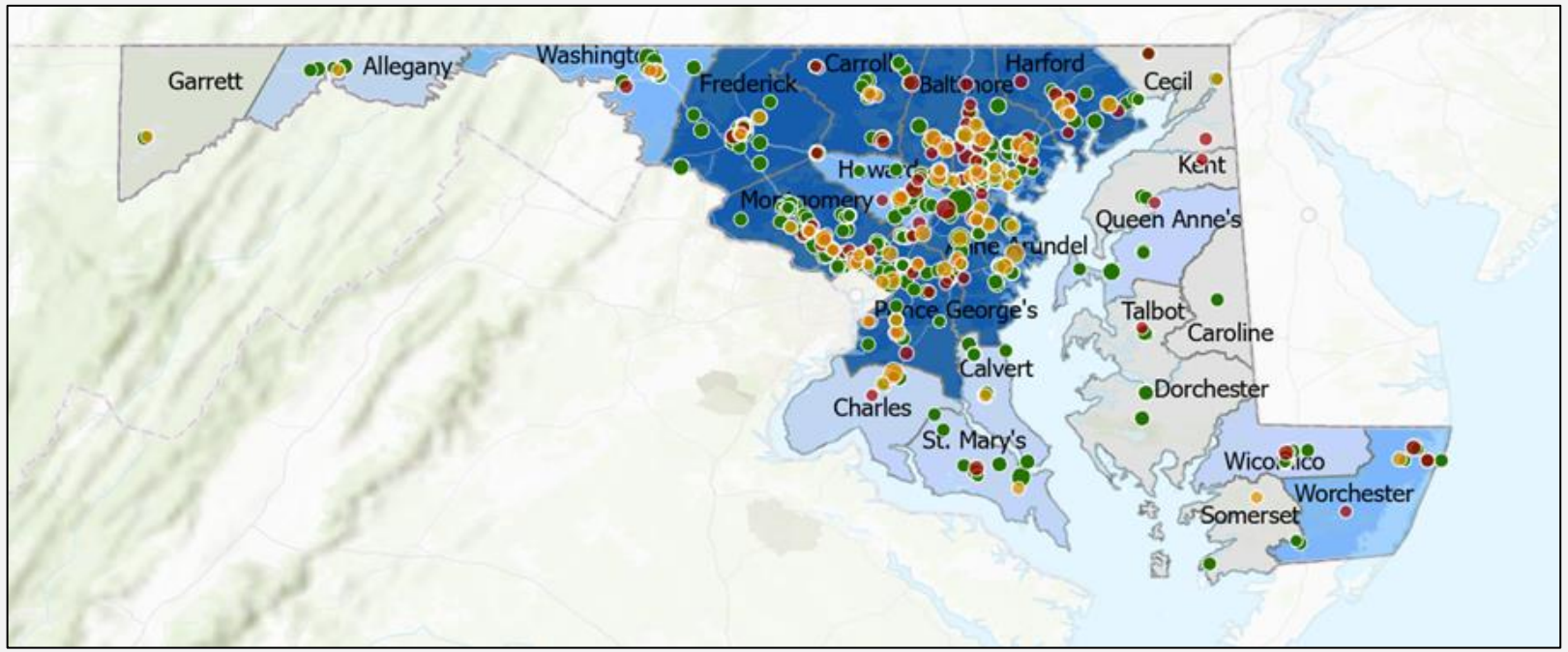
Enrollment and Engagement



4328 referrals have been received from MDPCP practices. Of referrals received, 10% were ineligible due to having Maryland Medicaid

*Data Jan 2019- April 2022 for any patient enrolled in CoCM

MDPCP Practice Locations by County



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Track 3

Maryland
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Overview of Tracks

Payments

TRACK 1

Standard

Implementation of advanced primary care functions including expanded hours, risk stratification, care management and behavioral health integration

- Care Mgmt Fee (CMF)
- Performance Incentive (PBIP)
- Standard FFS billing
- Health Equity Advancement Resource and Transformation (HEART) (if applicable)

TRACK 2

Advanced

Track 1 requirements + addition of offering of alternative care (e.g., telehealth) social needs screening and linkages, comprehensive medication management, and advance care planning

- CMF
- PBIP
- CPCP + FFS billing
- HEART (if applicable)

TRACK 3

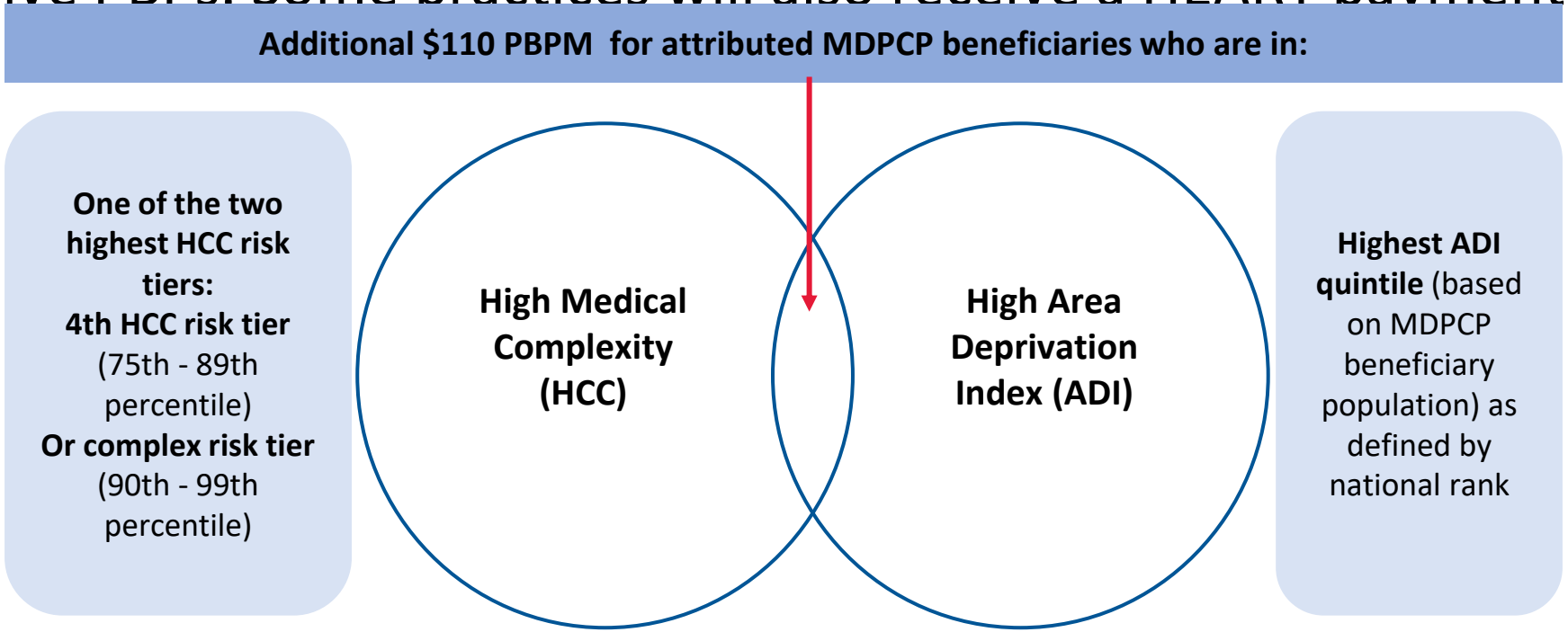
Advanced with Upside & Downside Risk

Track 2 requirements + collection of demographics data, prioritizing health related social needs, & expanded alternative care requirements

- PBP (subject to PBA)
- Flat visit fee (subject to PBA)
- Performance-Based Adjustment (PBA)
- HEART (if applicable)

HEART Payments

The Health Equity Advancement Resource and Transformation Payment (HEART) payment will be an additional payment from the PBP. All practices will receive PBPs. Some practices will also receive a HEART payment.



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The MDPCP Practice and Care Transformation Organization (CTO) **will not be at risk for the HEART payment**. More information is available here.

Participation Options & Timeline

Request for Applications (RFA):

- 2023 RFA - Spring of 2022 for January 1, 2023 start - Tracks 1, 2 & 3 available
- 2024 RFA - Spring of 2023 for January 1, 2024 start - Tracks 2 & 3 available

Transition Timelines:

- 2023 is the final year of operation for Track 1
- 2025 is the final year of operation for Track 2

Year that a Practice Began Participation in Track 2*	T3 Start Deadline	Min Time in T3 (thru 2026)
2019 starters	1/1/2023	4 years (max of 4 years in T2)
2020 starters	1/1/2023	4 years (max of 3 years in T2)
2021 starters	1/1/2024	3 years (max of 3 years in T2)
2022 starters	1/1/2025	2 years (max of 3 years in T2)
2023 starters	1/1/2026	1 year (max of 3 years in T2)
2024 starters	1/1/2026	1 year (max of 2 years in T2)

117 practices

**2025 - Track 2 participants may remain from previous years and would be required to transition to Track 3 by January 2026.*

FQHCs will not be eligible to participate in Track 3 in 2023. CMMI and MDH will revisit for possible future start. FQHCs will be eligible to remain in T2 until further notice.

Summary of Track 2 Payments

Care Management Fee (CMF)

Health Equity Advancement Resource and Transformation (HEART) Payment

Performance Based Incentive Payment (PBIP)

+

CPCP (Comprehensive Primary Care Payment)

***subject to recoupment*

=

Total MDPCP Revenue to Track 2 Practices

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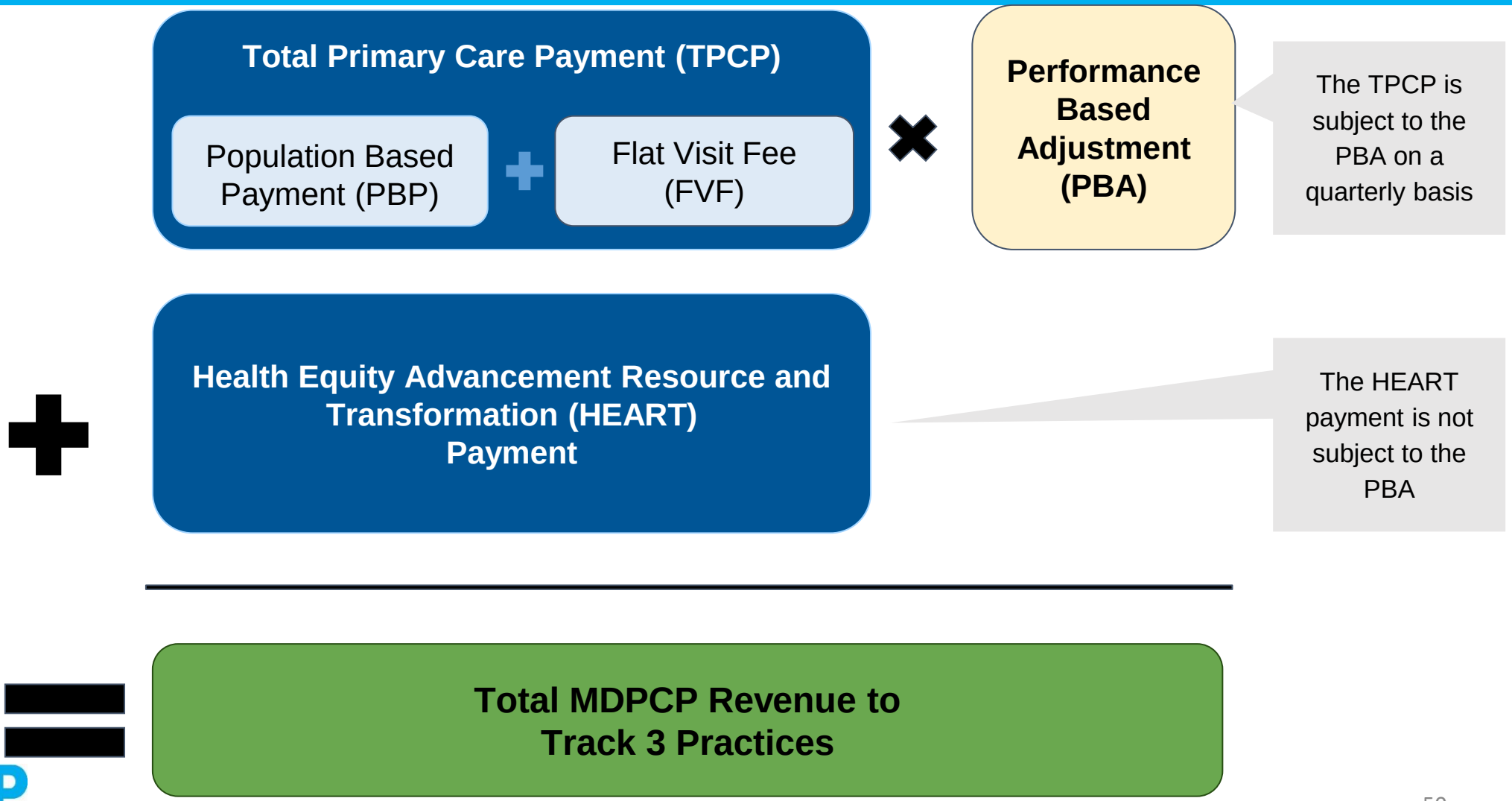
Summary of Track 3 Payments



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PBA Measures

Single-step PBA with measures consistent with Tracks 1 & 2:

QUALITY - 50% of Total PBA
National Benchmark

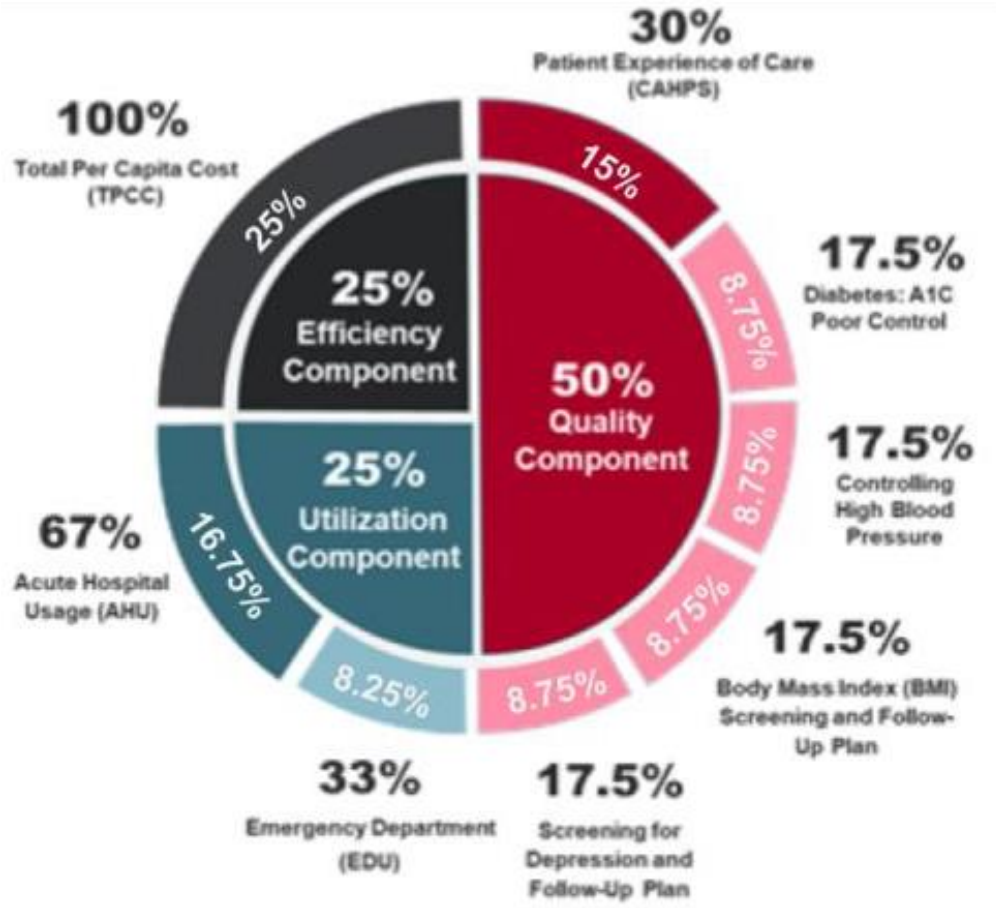
- Diabetes Control (CMS 122)
- Diabetes Prevention (e.g., BMI) (CMS 69)
- Hypertension Control (CMS 165)
- Opioid/SUD/or Depression (CMS 2)
- **Patient Experience**

UTILIZATION - 25% of Total PBA
MD Benchmarks

- **Acute Hospital Utilization**
- **Emergency Department Utilization**

COST – 25% of Total PBA
MD Benchmark

- **Total Cost of Care, TPCC**



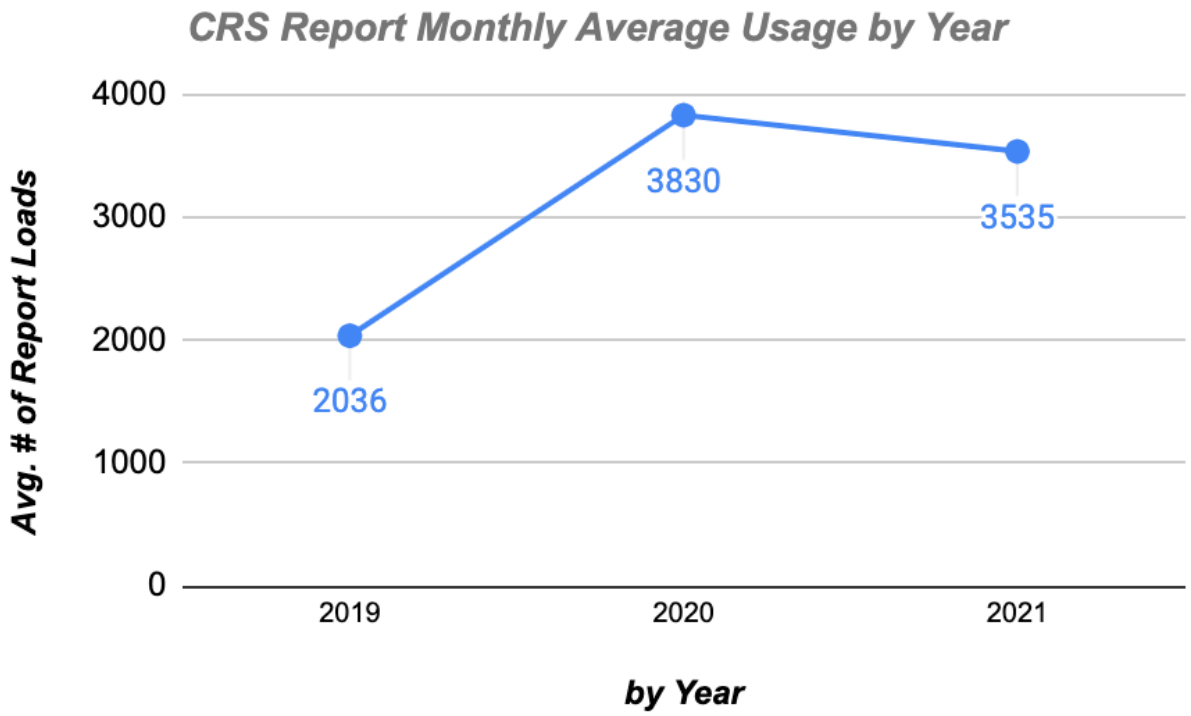
Note that the percentages in the inner circle depict percent of total and the percentages in the outer circle depict percent of the corresponding component

Glossary

CPCP	Comprehensive Primary Care Payment
FVF	Flat Visit Fee
HCC	Hierarchical Condition Category
HEART	Health Equity Advancement Resource & Transformation
MSSP ACO	Medicare Shared Savings Program Accountable Care Organization
PBA	Performance Based Adjustment
PBIP	Performance Based Incentive Payment
PBP	Performance Based Payment
PBPM	Per Beneficiary, Per Month
PFS	Physician Fee Schedule (Medicare)
TPCP	Total Primary Care Payment

MDPCP Reports Usage Statistics - Annually

CRISP Reporting Services MDPCP report average access by year.



Source: 2022 MDPCP Reporting Suite.

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