maryland health services cost review commission

Physician Engagement & Alignment Workgroup

TCOC Model Progression

Meeting #1

January 2023

Workgroup Members

Physicians:

- Dr. James Elliott – Chairman
- Dr. Farzaneh Sabi
- Dr. David Safferman
- Dr. George Bone
- Dr. Ramani Peruvemba
- Dr. Benjamin Lowentritt
- Dr. Harbhajan Ajrawat
- Dr. James York

Program Administration:

- Gene Ransom, MedChi
- Jacqueline Howard, UMMS
- Ben Steffen, MHCC
- David Sharp, MHCC
- Laura Goodman, Medicaid
- Dr. Howard Haft, MDPCP PMO
- Zach Rabovsky, CareFirst
- Laura Russell, MHA

Agenda

1. Workgroup Purpose, Goals, Timeline - Dr. Elliot
2. Background on the Maryland Model - HSCRC
3. TCOC Model Progression Overview - HSCRC
4. Episode Quality Improvement Program (EQIP) Update - HSCRC
5. Maryland Primary Care Program (MDPCP) Update - PMO
6. Comments and Next Steps - HSCRC

Workgroup Overview

Workgroup Purpose & Goals

Purpose: Generate policy recommendations to promote physician alignment and engagement under an expanded Maryland Model beyond 2026.

Goals:

1. Review existing physician alignment programs (EQIP & MDPCP).
2. Identify potential expansions & revisions to current programs.
3. Make recommendations for additional programs that will enhance physician alignment and engagement.
4. Make recommendations for incorporating Health Equity principles into physician alignment programs.

Guiding Principles

1. The Progression Plan should further the goals of the Maryland Health Model to lead the nation in health equity, quality, access, cost of care and consumer experience through aligned incentives and value-based payment methodologies across providers and payers.
2. The Progression Plan should include high-level recommendations that are feasible to implement and build upon existing initiatives and programs, where possible.
3. The Progression Plan should utilize State flexibility in order to tailor delivery system and payment reform efforts unique to Maryland.
4. The Progression Plan recommendations should adhere to the all-payer nature of the system to align quality and cost incentives across payers.
5. The Progression Plan recommendations should be established through a collaborative public process.

Timeline

Event	Topic	Sub-Topics
Meeting 1 (February 2nd)	Overview	Workgroup Agenda/Goals Health Equity Considerations
		View from MedChi
		EQIP Update
		MDPCP Update
		Other considerations – Multi-State Model, GBR 2.0, State Primary Care workgroup etc., Medicaid.
		Invite public comment on direction of model regarding physician programs and physician alignment
Meeting 2 (March 2nd)	Public Comment	Workgroup members reflect on key themes and views on priorities
	Workgroup Discussion	Identify areas of focus, common themes, etc.
Meeting 3 (March 30th)	Recap of Public Comment	
	First Draft Recommendation	HSCRC review of straw man proposal and discussion
Report Release (Late March)	First Draft Written Recommendation to Workgroup and Public	Workgroup will provide feedback and report will be refined via email etc.
Meeting 4 (Mid-May)	Review Final Draft	

The Maryland Model

Maryland's Unique Healthcare System: Overview

Maryland Health Model

CMS-MD Agreement Incentives

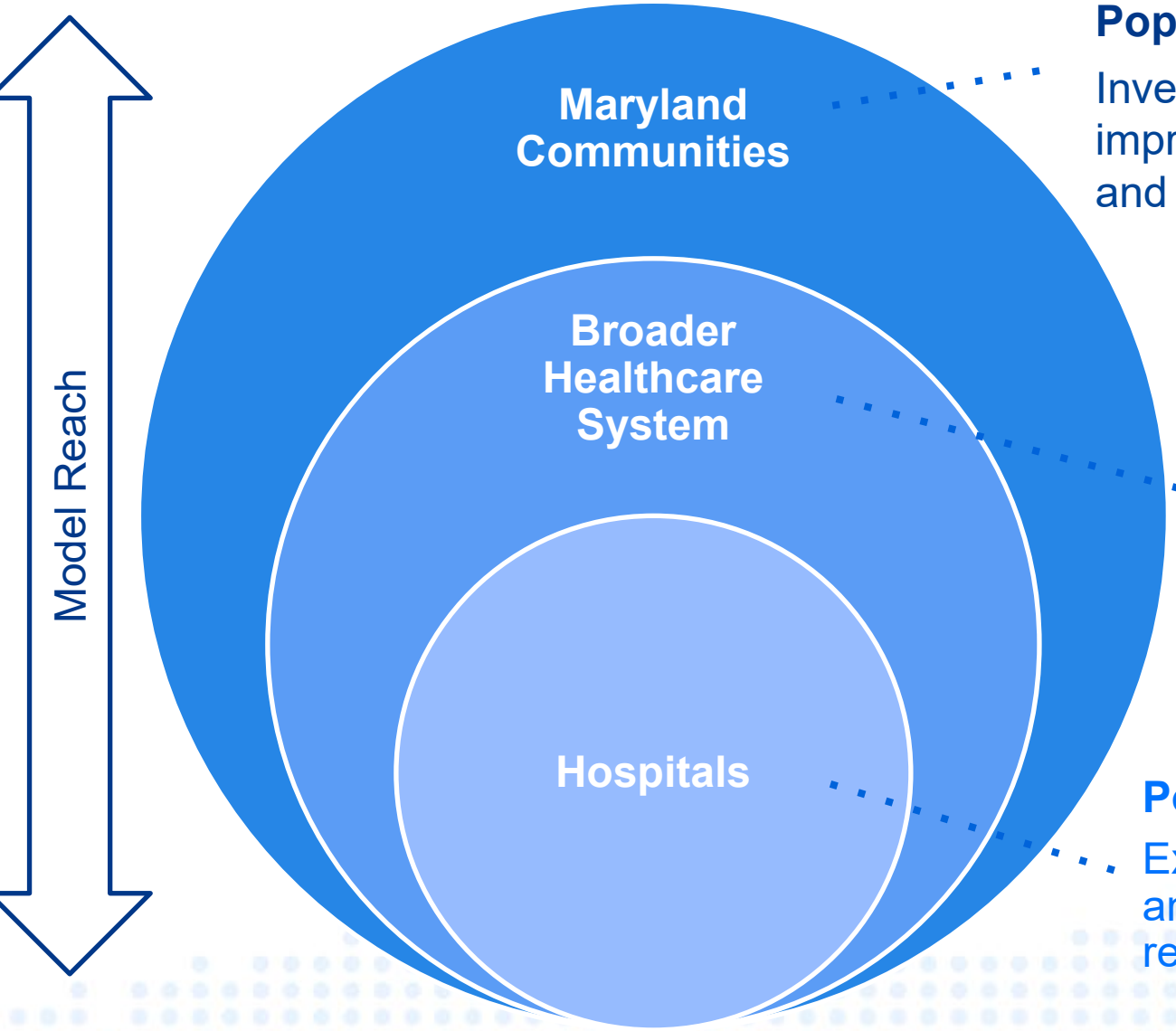
- Refers to work and programs (often led by the Commission) layered on top of the rate setting system aimed at improving performance under the State's terminable agreements
  - All-Payer Model (2014-2018)
  - Total Cost of Care Model (2019-2028)

Commission Policies

All-Payer Hospital Rate Setting System

- Refers to the hospital payment structure that has existed in various forms since the Commission was established in the 1970s
- The framework can be adjusted to support the State's work to achieve CMS agreement targets and other statewide priorities

TCOC Model Components



Population Health and Health Equity

Investment in initiatives that aim to make statewide improvements in the areas of diabetes, opioid addiction, and maternal and child health.

Payment and Delivery System Reform

Incentivization of care transformation and partnerships across settings of care by expanding opportunities for non-hospital provider participation in value-based programs

Population-Based Revenue

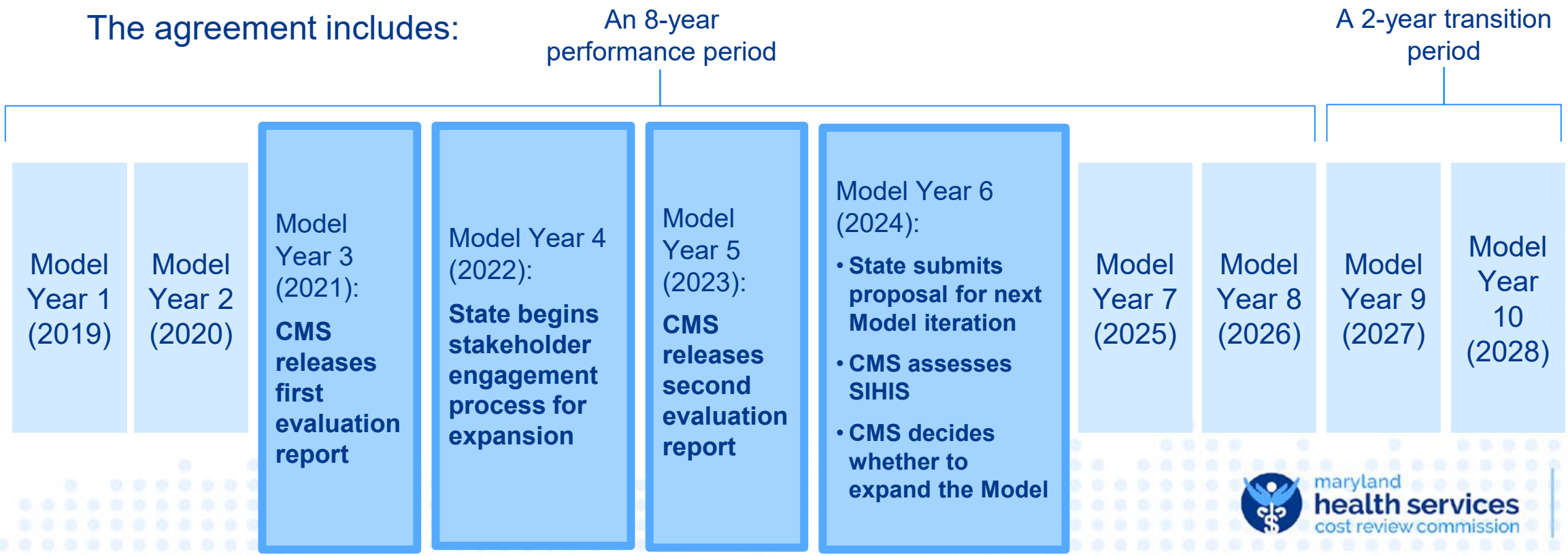
Expanded hospital quality requirements, incentives, and responsibility to control total costs through limited revenue-at-risk

TCOC Model: Moving Forward

The Maryland Total Cost of Care Model State Agreement states:

> "Under this Model, CMS and the State will test whether statewide healthcare delivery transformation, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare Total Cost of Care."

The agreement includes:



Health Equity Overview

HSCRC's Health Equity Definition:

Equity in Hospital Quality is achieved when every person has an equal opportunity to access and receive efficient, high-quality healthcare and no one is disadvantaged due to their social position or other socially determined circumstances.

HSCRC's Current Equity Work

- All HSCRC policies must include section on how policy impacts health equity.
  - Existing policies (e.g., all-payer rate setting, shared uncompensated care funding, quality programs that assess the better of attainment vs improvement, efficiency assessments that control for indigent care service delivery).
- The Commission has also improved its ability to assess potential inequities in health outcomes.
  - Tableau reports from CRISP provide the ability to stratify results by various socio-demographic factors including race.
- Readmission Disparity Gap Program
  - Rewards hospitals for reducing disparities in readmissions based on a composite measure of social risk which incorporates a patient's race, Medicaid status, and the Area Deprivation Index.

TCOC Model Progression

Progression Plan Development Timeline

Oct 2022-April 2023
- Small Workgroups begin
- Progress Updates to Secretary's Vision Group (SVG)

April 2023
- Small Workgroups Conclude
- Written workgroup recommendations finalized by HSCRC and State staff

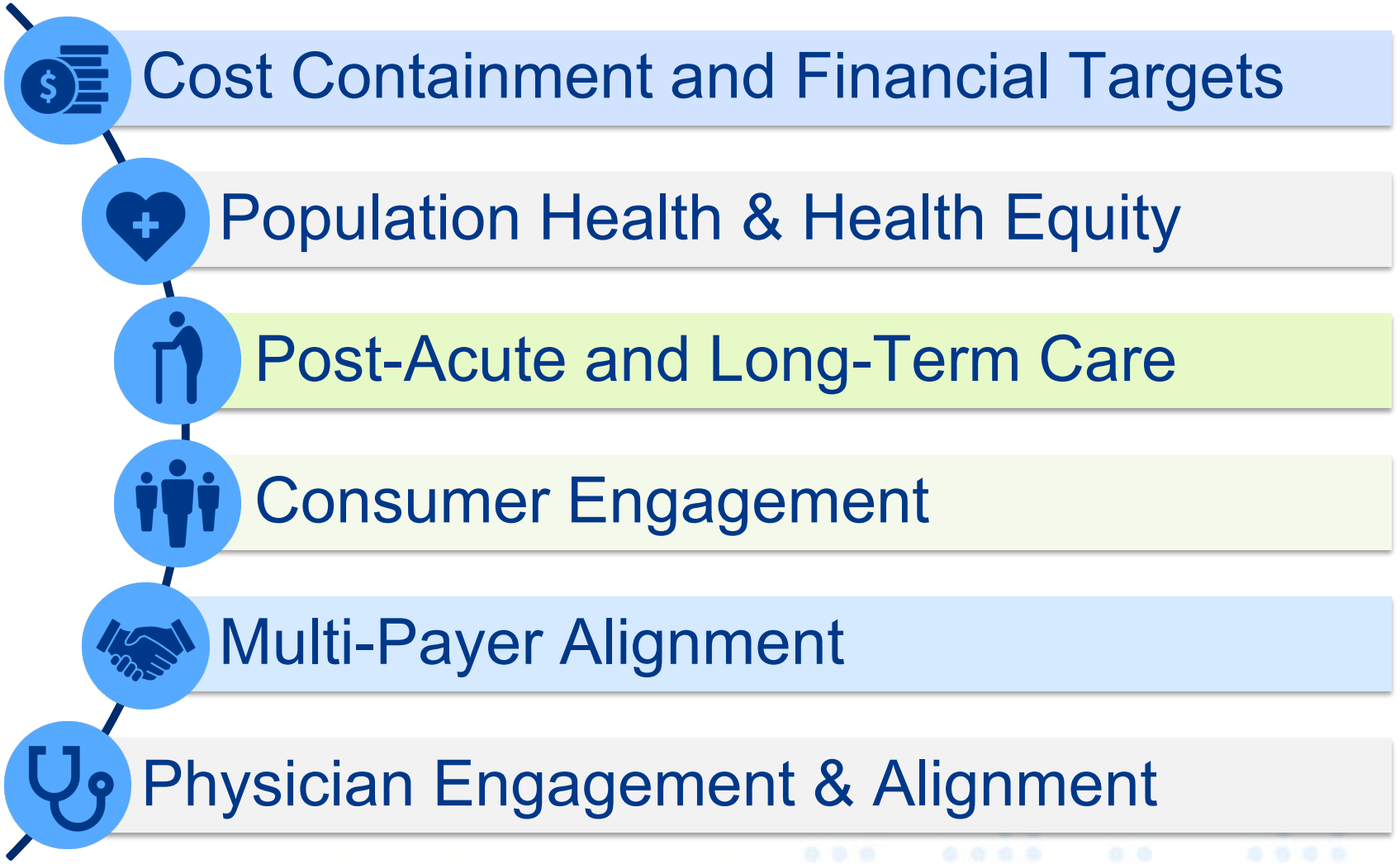
May-June 2023
- Draft Progression Plan finalized (May)
- Draft plan circulated to HSCRC Commission and SVG for initial comment (June)

June - Sept 2023
- Draft Progression Plan circulated for public comment
- Socialize with other important stakeholders (elected officials, others as needed)

Oct - Dec 2023
- Public comments reviewed and integrated into final Progression Plan

Dec 2023
- Final Progression Plan submitted to CMMI

Stakeholder Small Group Focus Areas



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Small Group Meetings

Meeting details are on the Total Cost of Care Model Progression Page

Topic	Meeting Details
Cost-Containment & Financial Targets	Total Cost of Care Workgroup hscrc.tcoc@maryland.gov
Population Health & Health Equity	Performance Measurement Workgroup hscrc.performance@maryland.gov
Consumer Engagement	In Development
Multi-Payer Alignment	In Development
Post-Acute and Long-Term Care	In Development
Physician Engagement & Alignment	In Development

Multi-State Model

States Advancing All-Payer Health Equity Approaches and Development

CMMI is planning on a new multi-state model.

CMMI leadership wants to move away from single state models (MD, PA, VT) and some other states are interested in cost-control models (OR, WA, RI).

CMMI is still building this model. No written description has been shared w/ HSCRC. This presentation is HSCRC's best current understanding of the Model.

CMMI has said model will be voluntary for States.

Multi-State Model: Model Components

GBRs for hospitals (based, in part, on MD), possibly including both facility and professional fee.

- All-payer for facility (some states may start w/ Medicare, Medicaid, and State employee plan)
- May not be all-payer for professional fee; would not change payer differentials.

- Increased focus (and more explicit targets) on health equity, primary care investment, multi payer alignment, quality, and statewide population health improvement.
- Primary care: Align Medicare with States' activities on primary care. Operational management with the State. Possible requirement for a minimum PCP spending amount.
- Significant State flexibilities, but with aligned components.
  - Flexibility on financial targets
  - Population Health Targets

Multi-State Model: Process and Timing

States Advancing All-Payer Health Equity Approaches and Development

- State staff started meeting with CMMI on this Model recently & will meet bi-weekly starting January 11.
- CMMI is planning to enter clearance in February with a concept for the Model.
- CMMI staff are hoping to have the first application period in late 2023. At least one application period will occur in a later year
- The Model will be 8-10 years in duration (needed to see outcomes in population health/ health equity)

HSCRC is going to have parallel workstreams on Maryland's future:

1) Planning for a single-state model and/or permeant extensions of elements of Maryland's Model.
2) Meeting with CMMI on the multi-state model to try to influence the model design.

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The Episode Quality Improvement Program

Value-Based Medicare Incentive Payment Opportunity for Maryland Physicians

The Episode Quality Improvement Program (EQIP)

After approval of the TCOC Model, HSCRC staff began exploring opportunities to **align with hospital efforts to control costs across the healthcare system.**

Maryland **physicians largely remain on fee-for-service** reimbursement incentives and, as a result of the TCOC Model, are left out of national, **Medicare** value-based payment programs.

Therefore, it is imperative that the State **creates new value-based reimbursement** opportunities to **ensure cost containment in non-hospital settings.**

The Episode Quality Improvement Program – EQIP

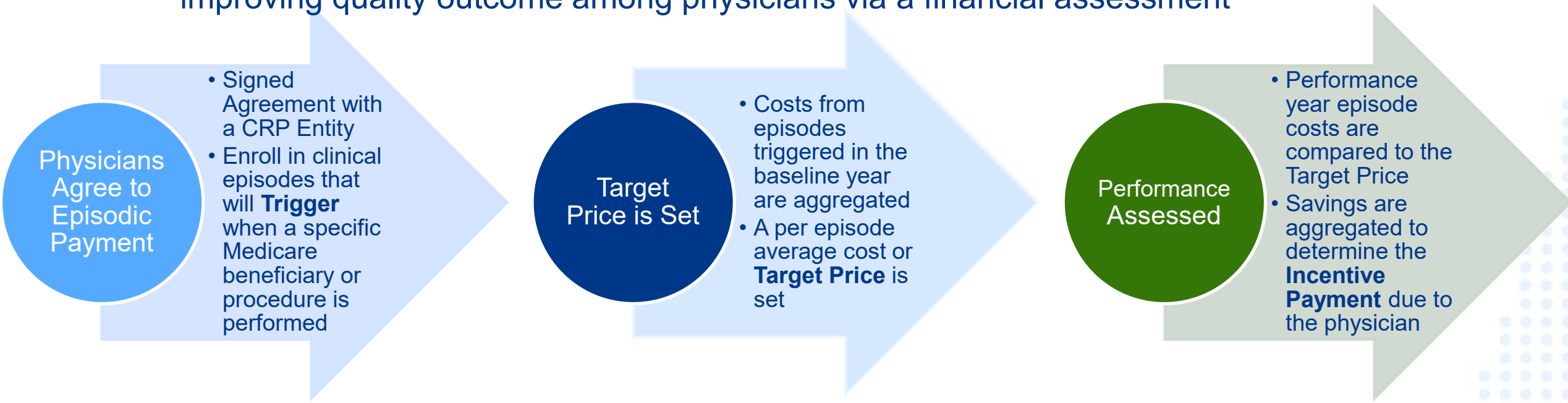
- The HSCRC created a voluntary, episodic incentive payment program for specialist physicians in Medicare, EQIP, in 2022.

Physician ownership of performance	Upside-only risk with dissavings accountability	Alignment with CareFirst's episode payment program	AAPM/value-based payment participation opportunities for MD physicians

- EQIP uses the Prometheus Episode Grouper & episodes that are created by Maryland physicians.
- This approach has allowed Maryland physicians to define their own value-based payment models.

Episodic Value-Based Payment

- Bundled-payment programs, in-particular, are effective at controlling episodic care and improving quality outcome among physicians via a financial assessment



- Analyses of CMS bundled-payment programs have shown 4-6 percent reductions in gross Medicare spending

Source: https://innovation.cms.gov/files/reports/episode-payment-models-wp.pdf

Multi-Payer Demonstration with CareFirst

- The HSCRC and CareFirst have aligned episode program definitions so that the Episodes of Care (EOC) program and EQIP can provide parallel incentives to participating physicians.
  - **Prometheus Episode Definitions** will be utilized in both programs
  - Incentive Payment and other **policy decisions will remain separate** where appropriate
  - Opportunity for **rewards across both Medicare and CareFirst** increases program outcomes
- The HSCRC will encourage other payers to start programs similar to EQIP in Maryland

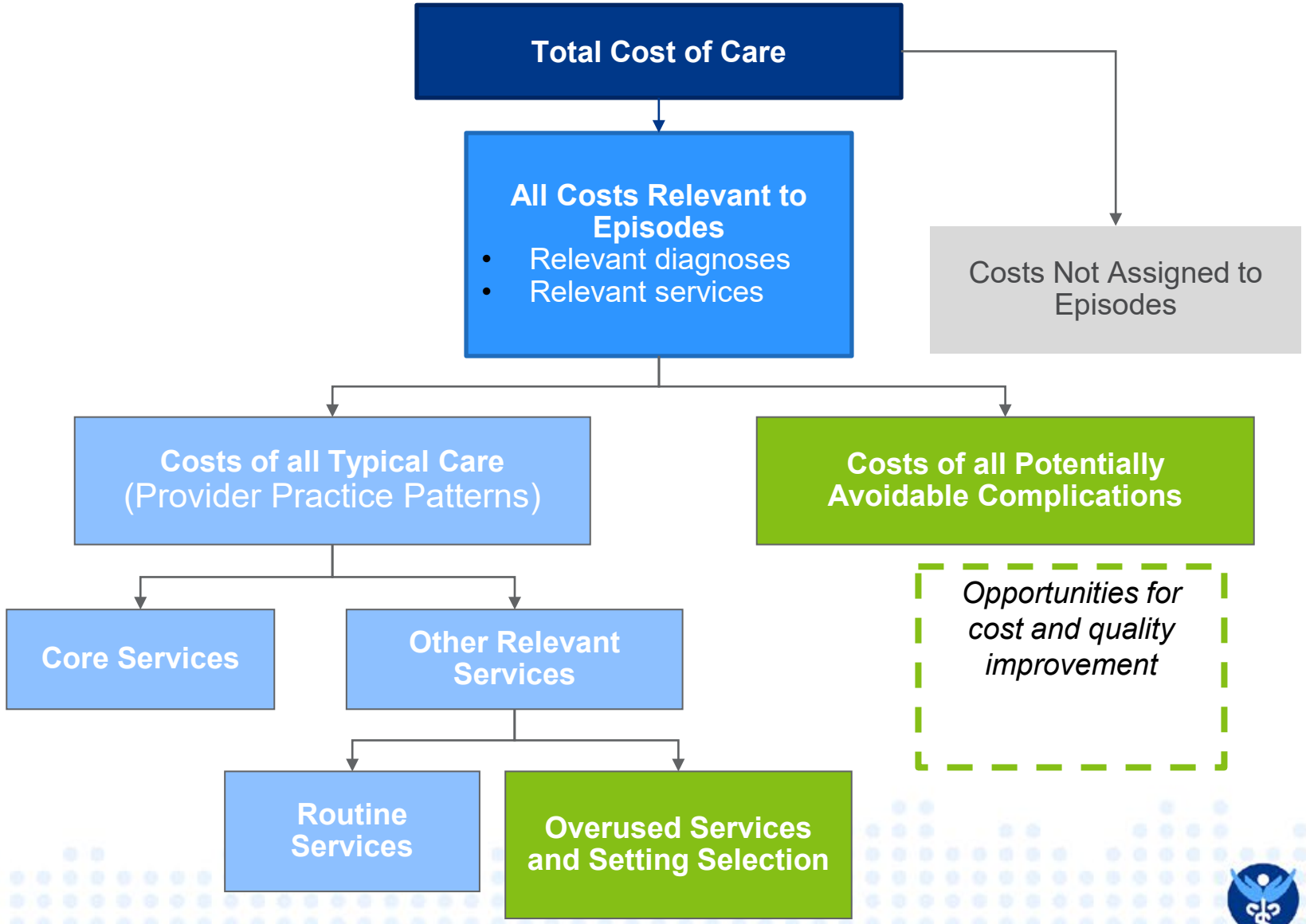


EQIP Interventions and Performance Improvement Opportunities

In addition to electing episodes, each EQIP Entity will need to indicate how they intend to produce savings in their episodes.

Intervention Category	Example Intervention
Clinical Care Redesign and Quality Improvement	Standardized, evidence-based protocols are implemented, for example for discharge planning and follow-up care.
	Performance of medication reconciliation.
	Elimination of duplicative, potentially avoidable complications or low value services
Beneficiary/Caregiver Engagement	Patient education/shared decision making is provided pre-admission and addresses post-discharge options.
	Implementation of "health literacy" practices for patient/family education
Care Coordination and Care Transitions	Assignment of a care manager and enhanced coordination to follow patient across care settings
	Interdisciplinary team meetings address patients' needs and progress.
	Selection of most cost efficient, high-quality settings of care

PROMETHEUS Relevant Cost Analysis



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Target Price Methodology

- 2019 will serve as a **Baseline** for the first three performance years for EQIP Entities joining in Y1
  - Each EQIP Entity will have their own **unique Target Price** per episode
  - The baseline will be trended forward in order to compare to current performance costs
  - Target Prices are not final until the end of the Performance Year as final inflation will need to be applied
  - The baseline for entities that join in subsequent performance years will be the year prior to them joining
- Each episode will have a **singular Target Price**, regardless of the setting of care (Hospital, Outpatient Facility, ASC)
  - The price gap between ASC and Hospital is significantly larger under the Medicare fee schedule than under commercial, particularly in Maryland where hospital rates are regulated.
  - This will **create incentive to shift lower acuity procedures** to lower cost settings, aligning with GBR incentives.

Incentive Payment Methodology

***Incentive Payments** will be direct checks made from the CRP Entity to the EQIP Entity for aggregate positive performance after a minimum savings threshold, shared savings split, and quality adjustment are applied.*

1. Performance Period Results

- The Performance Period Episode costs are less than the Target Price in the aggregate across all episodes in which the EQIP Entity participates.
- At least three percent of savings are achieved (stat. significant)
- Dissavings from prior year (if any) are offset

2. Shared Savings

- Each Care Partner's Target Price** will be compared to the statewide experience and annually ranked based on relative efficiency. Lower cost providers will be in a higher tier and vice versa.
- The Shared Savings split with Medicare will be based on the Care Partner's Target Price rank

Target Price Rank	% of Savings to due Care Partner
Up to 33rd percentile	50 percent
34th – 66th percentile	65 percent
66th + percentile	80 percent

3. Clinical Quality Score

- 5% of the incentive payment achieved will be withheld for quality assessment
- The EQIP Entity's quality performance will indicate the portion of this withholding that is 'earned back'

4. Incentive Payment Cap

- The result is no more than 25 percent of the EQIP Participant's prior year Part B payments

5. Final Incentive Payment

- Paid directly to the payment remission source indicated by the EQIP Entity*
- Paid in full, following calendar year after the end of the performance year
- In addition to incentive payments, if QPP thresholds are met, Medicare will pay a bonus to physicians and increase rate updates in future years.

**The EQIP entity can direct the payment remission source to distribute payments to individual Care Partners however it desires.*
*** In Year 1 the Target Price will be used to determine the tercile, in subsequent years, prior year performance will be used.*

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Episodes for PY1, Episode Type, Length

Cardiology	Gastroenterology and General Surgery	Orthopedics and Neurosurgery
Pacemaker / Defibrillator – Procedure, 30	Colonoscopy – Procedure, 14	Hip Replacement & Hip Revision – Procedure, 90
Acute Myocardial Infarction – Acute, 30	Colorectal Resection – Procedure, 90	Hip/Pelvic Fracture – Acute, 30
CABG &/or Valve Procedures – Procedure, 90	Gall Bladder Surgery – Procedure, 90	Knee Arthroscopy – Procedure, 90
Coronary Angioplasty – Procedure, 90	Upper GI Endoscopy – Procedure, 14	Knee Replacement & Knee Revision – Procedure, 90
		Lumbar Laminectomy – Procedure, 90
		Lumbar Spine Fusion – Procedure, 180
		Shoulder Replacement – Procedure, 90

Prometheus Episodes – PY 2

Specialty	Episode Name	Episode Type
Allergist	Allergic Rhinitis/Chronic Sinusitis	Chronic
	Asthma	Chronic
Dermatologist	Cellulitis, Skin Infection	Complications
	Dermatitis, Urticaria	Complications
	Decubitus Ulcer	Complications
Ophthalmologist	Cataract Surgery, 14	Procedural
	Glaucoma	Chronic
Orthopedist/Orthopedic Surgeon	Low Back Pain	Chronic
	Osteoarthritis	Chronic
	Accidental Falls	Complications
Urologist	Catheter Associated UTIs	Complications
	Urinary Tract Infection	Complications
	Transurethral resection prostate	Complications
	Prostatectomy, 90	Procedural

ED Episodes

ED Episodes	
Chest Pain	Pneumonia
Hypertension	Asthma/COPD
Atrial Fibrillation	Skin & Soft Tissue Infection
Deep Vein Thrombosis	Syncope
Abdominal Pain & Gastrointestinal Symptoms	Fever, Fatigue or Weakness
Diverticulitis	Shortness of Breath
Hyperglycemia with Diabetes Mullitus	Hyperglycemia
Dehydration & Electrolyte Derangements	Skin and soft tissue infections
Urinary Tract Infection	Deep vein thrombosis
Nephrolithiasis	

Enrollment Summary

EQIP entities enrolled:	62
Total Care Partners:	2,787
Specialties represented:	43
Participation in all 45 available EQIP Episodes	
Smallest Entity:	1 CP
Largest Entity:	994 CPs
Entities participating in more than 2 episodes:	36

Clinical Episode Categories	Number of EQIP Entities	Number of Care Partners
Allergy	14	1461
Cardiology	24	1570
Dermatology	5	1201
Emergency Care	11	1703
Gastroenterology	21	1545
Ophthalmology	7	1171
Orthopedics	33	2097
Urology	6	238

Chronic Kidney Disease (CKD) – Episode Specs and Development

Inclusion

- Maryland Medicare FFS beneficiaries

Episode Trigger

- Stage IV CKD (N18.4)

Episode Length/End Date

- The Episode will last until 90 days after the beneficiary progresses to ESRD.

Additional Specifications

- Unlike a fixed episode legnth, a variable length episode will require an alterantive target pricing methodology.
  - Panel based target pricing
  - PBPM target pricing
- Exclusions

Musculoskeletal (MSK) – Episode Specs and Development

Inclusion

- Maryland Medicare FFS beneficiaries

Exclusion

- MSK Surgery within 6 months
- Active Oncology
- ESRD
- Long term opiates
- Substance Abuse
- Trauma
- Neuro

Episode Trigger

- PT Evaluation (CPT: '97161, 97162, 97163') *with*
- MSK Diagnosis (ICD10: M00-M27, M30-M36, M40-M54, M60-M96.89, M97-M97XXS, M99-M99.9, S00-S99)

Additional Specifications

- Episode Length
- Provider Attribution

Behavioral Health – Episode Specs and Development

Beneficiary Inclusion

- Maryland Medicare FFS beneficiaries
- Severe Mental Illness within the past 2 years. SMI includes:
  - Bipolar Disorder
  - Schizoaffective Disorder
  - Major Depressive Disorder
  - And others

Elligible Participants

- Psychiatrists (e.g., MD, DO) and Psychiatric Mental Health Nurse Practitioners (PMHNP)
- Includes therapists like LCSW, LCPC, LMHC, etc.

Episode Attribution

- If a member has a diagnosed Severe Mental Illness (SMI) and has been seen by at least 1 BH provider in the last **year**, they are attributed to the BH Co-Op of their BH provider.
- Beneficiaries are assigned to the BH providers for the entire year.

Additional Episode Development

- We welcome ideas from other stakeholders. In order to develop an episode, stakeholders will need to identify:
  - A list of triggering procedures or diagnosis
  - Included and excluded costs for the episode

- The HSCRC is committed to working with all interested stakeholders, but we have limited bandwidth.
  - We anticipate adding 1-2 new episodes per year
  - We will prioritize based on the number of interested physicians

Episode Development Process

Fall/Winter

- Stakeholder Input into Episodes of Interest
- Analytic Plan development

Winter

- Episode Policy Design
- CMMI Approval of new Episodes

Spring

- Recruitment and Episode Education

July

- Enrollment Opens for new Care Partners and EQIP Entities

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Maryland Primary Care Program (MDPCP)

MDPCP Update for the HSCRC Physician Stakeholder Workgroup

Chad Perman
Executive Director, MDPCP Management Office

Feb 2, 2023

Agenda

- Recap of program today and status
- Current focus areas for development/modification/expansion
- Future potential areas of focus

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Program Status and Update

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Key Facts

- MDPCP is the largest Medicare advanced primary care program in the nation.
- MDPCP is in its 5th year of operation and covers every Maryland county and serves approximately 4 million Marylanders.
- Approximately $200M annually in Federal dollars is sent directly to primary care practices for patient care.
- Approximately $5.6M in FY23 Federal grants to fund MDH operations - support practices in addressing health equity, behavioral health, COVID-19 and data-driven patient care.

MDPCP Impacts on Utilization and Costs

- **Reduced acute utilization** per 1,000 beneficiaries, 2019-2021:*
  - Reduced Avoidable hospital utilization (PQIs) by 26% over base year 2019.
  - Reduced Emergency Department (ED) utilization by 17.4%.
  - Reduced Inpatient Hospitalization (IP) utilization by 12.2%.
- **Lower growth in Costs** Per Beneficiary Per Month, 2019-2021:*
  - 17% lower increase of costs compared to equivalent non-participating population.

6% greater reduction when compared to the Equivalent Non-Participating Population

21% greater reduction when compared to the Equivalent Non-Participating Population

*Rates are risk-adjusted, which accounts for differences in patient population illness acuity, to allow for direct comparison

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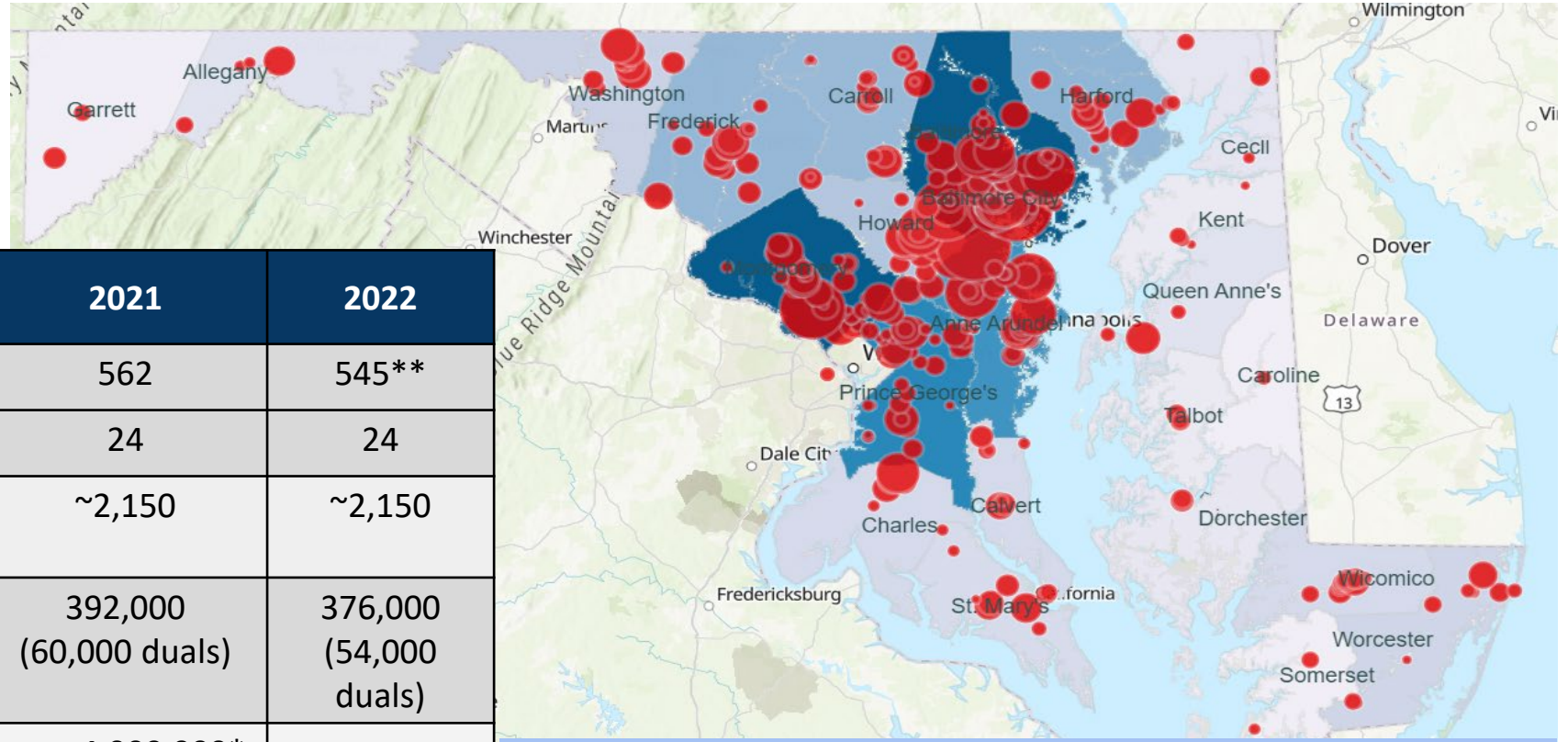
MDPCP Recent Accomplishments

- **Health Equity** - Rolled out nation's first direct payment to practices to better address patient's social needs.
- **Education and Support** - Transitioned MDPCP Learning and Quality Improvement program from federal government to MDH.
- **Governor - CMS Agreement** - Executed Amendment to TCOC Model to establish Track 3 (including release of a new Request for Applications).
- **Opioids/Substance Use Disorder** - Implemented Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol into over 350 practices or 69% of MDPCP practices.

MDPCP in 2023 - 537 Participating Practices

Support infrastructure – 25 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)
Estimated Marylanders served	2,000,000 – 3,000,000*	2,700,000 – 3,800,000*	over 4,000,000*	over 4,000,000*

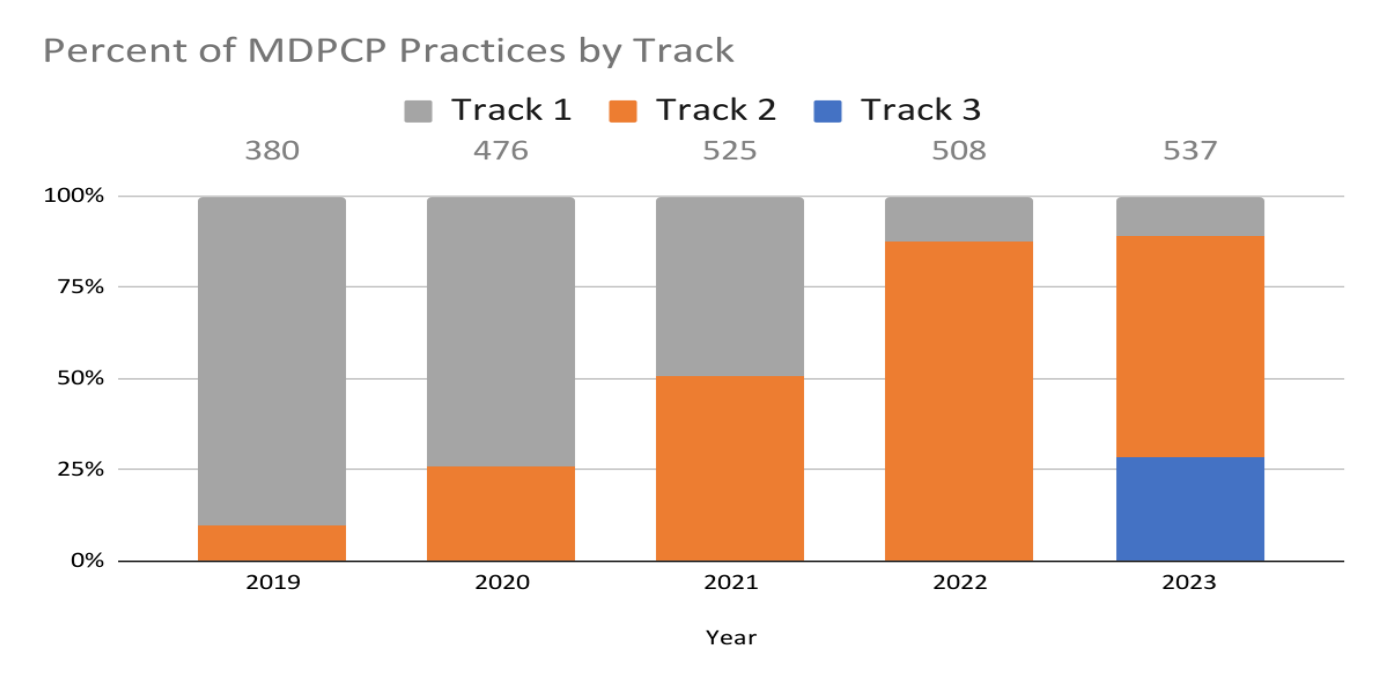
** ***545 sites*** **across 508 official participants in 2022**

Largest state program in the nation - by number of practices and practices per capita (compared to CMS' national Primary Care First Model)

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

†Data reflects highmark of each year

Year 5 by Track



Track 1

57 Practices

6 from prior year

Track 2

326 Practices

119 from prior year

Track 3

154 Practices

154 from prior year

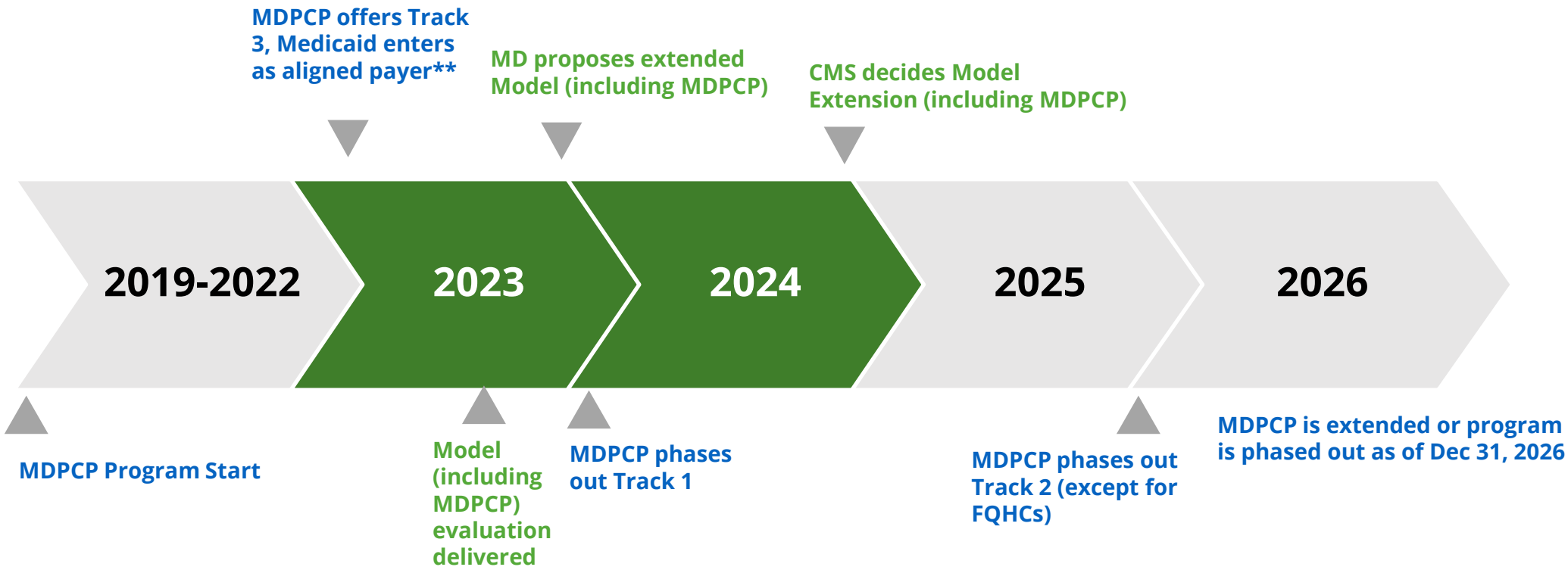
1 new CTO

5 new FQHCs

537 total practices

[Maryland Primary Care Program Performance Dashboard]
(to be updated quarterly starting in 2023)

Critical Time for MDPCP and Model



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

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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 Management Fee (CMF)
- Performance-Based Incentive Payment (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)

NEW!

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)

MDPCP Payer Alignment

Alignment in 5 areas:

1. Financial Incentives/ Non-visit based payments
2. Care Management
3. Quality Measures
4. Data Sharing
5. Practice Learning

2019 — **Medicare** (Center for Medicare & Medicaid INNOVATION)

2020 — CareFirst

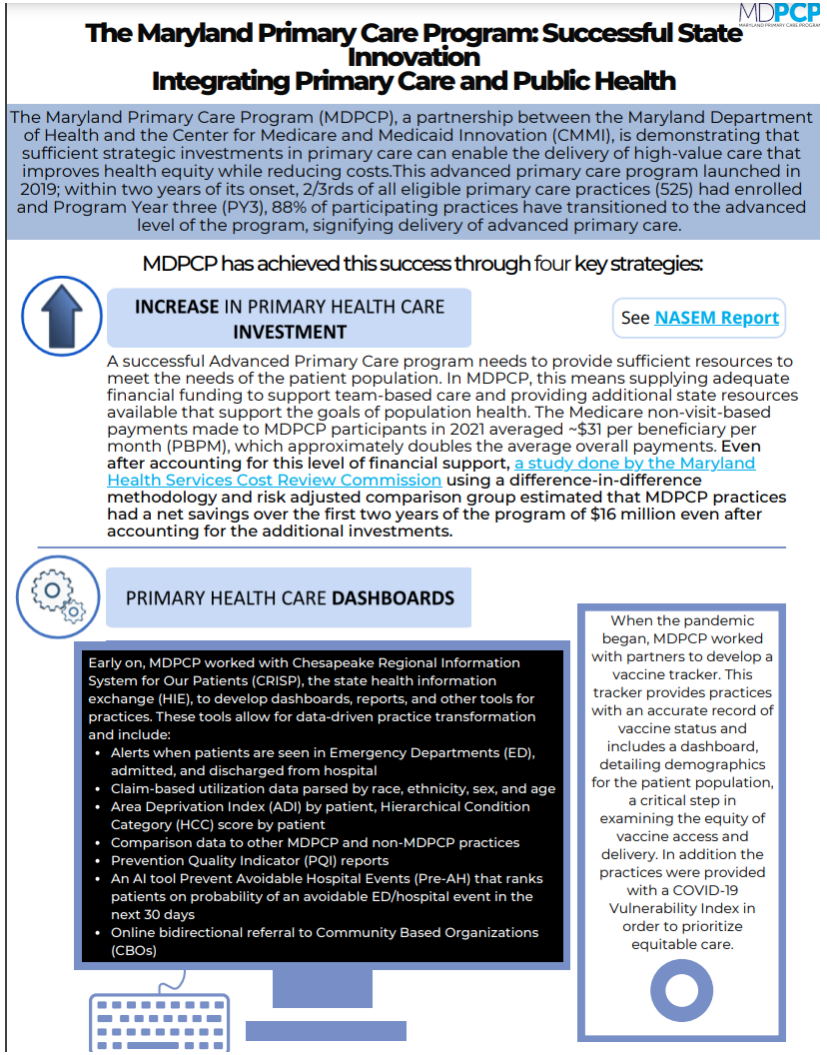
2023* — **Medicaid**
(*IN DEVELOPMENT)

MDPCP - Solicitation for Payer Partners (PDF)

Accomplishments

National Recognition

- 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?*
- **HEART** payment presentation at **2022 American Academy of Family Physicians** Family Medicine Experience Conference
- **Milbank Issue Brief**: *Improving COVID-19 Outcomes for Medicare Beneficiaries: A Public Health–Supported Advanced Primary Care Paradigm*



MDPCP

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

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

MDPCP has achieved this success through four key strategies:

INCREASE IN PRIMARY HEALTH CARE **INVESTMENT**

See NASEM Report

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

PRIMARY HEALTH CARE **DASHBOARDS**

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

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

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

Just Released: JAMA Publication

Association of Participation in the Maryland Primary Care Program With COVID-19 Outcomes Among Medicare Beneficiaries

Statistically significant results from this study include:

Higher COVID-19 vaccination rates in all study months (Dec 2020 - March 2022)

12.4% higher rate of COVID-19 vaccine boosters

7.6% lower rate of overall COVID-19 cases

27% lower death rate attributed to COVID-19

12% lower inpatient admission rate attributed to COVID-19

Published January 6, 2023

Focus Areas

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Current Focus Areas

- **Improve access to high value care**
  - expand program with greater inclusion of minority providers and providers in high needs areas
  - add meaningfully aligned payers including Medicaid
- **Improve Outcomes**
  - focus on equity and reducing disparities
  - identifying and addressing social needs
- **BHI -** screening and measurement based treatment for MH and SUD
- **Data Driven care** - enhancing CRISP tools to support utilization reduction and equity

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Future Focus Areas

- Additional payers (e.g. MA and other commercial)
- Multi-payer data platform
- Enhanced primary care investment to support all patients
- Maintain Track 2 option
- Specialist Co-management of patients
- Health equity quality measurement
- Enhanced care transitions between hospitals and primary care
- Cost sharing waivers for medications

Annual Report Snapshot, Year 3 - 2021

Year 3	Year 2	Year 1
Find below the links to the report, including: • MDPCP 2021 Annual Report • MDPCP 2021 Executive Summary • MDPCP 2021 Annual Report Snapshot	Find below the links to the report, including: • MDPCP 2020 Annual Report • MDPCP 2020 Executive Summary • MDPCP 2020 Annual Report Snapshot	Find below the links to the report, including: • MDPCP Year 1 Annual Report • MDPCP Year 1 Executive Summary • MDPCP Year 1 Visual Summary

More information about MDPCP can be found on our website.

You can reach us with any questions at mdh.pcmodel@maryland.gov.

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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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Public Comment

Request for Public Comment

1. How well are existing physician alignment programs (EQIP & MDPCP) operating?
2. What are potential expansions & revisions to these current programs?
3. What are recommendations for additional programs that will enhance physician alignment and engagement?
   - Recommendations should be:
     - Feasible to implement but can consider new Maryland and CMS flexibilities.
     - Can be implemented within 2 to 5-year time frame.
4. Recommendations for incorporating Health Equity principles into physician alignment programs?

Written comments should be submitted to the Lynne Diven at the HSCRC (lynne.diven@maryland.gov) by February 23rd

If you wish to present your comments to the Workgroup at the next meeting, please indicate that in your submission emails. You may only present if you have submitted written comments.