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Maryland Primary Care Program (MDPCP)

MDPCP Advisory Council Meeting

Chad Perman
Executive Director, MDPCP Management Office

April 3, 2024

Agenda Item 3: MDPCP Update

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MDPCP Recent Accomplishments

- **New Participants onboarding** - Onboarded 25 new MDPCP practices and 1 CTO for 2024 program year
- **Behavioral Health Integration**-
  - Reached milestone of over 1,000,000 MDPCP beneficiaries screened for risky alcohol use and illicit substance use through SBIRT
  - 338 current MDPCP practices have implemented SBIRT
- **Health Equity** - Partnered with 211MD to update over 1,000 resources in their directory of social service resources and help 211MD establish key partnerships in Eastern and Western Maryland
- **Learning System** - Hosted the 2023 Advanced Primary Care Staff Training Academy
- **CRISP Tools and Reports**-
  - Implementation of the Prediabetes and Non-Fatal Overdose Smart Alerts
  - New reports and tools: SBIRT dashboard, Multi-payor reports platform, Medication Synchronization Opportunity Summary and High Risk Medications-Top 100 Prescribers reports, TPCC report
- **Practice Coaching** - Successful engaged all practices that needed to transition tracks to ensure a 99% pass rate

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MDPCP Annual Report - Summary of Recommendations to CMMI

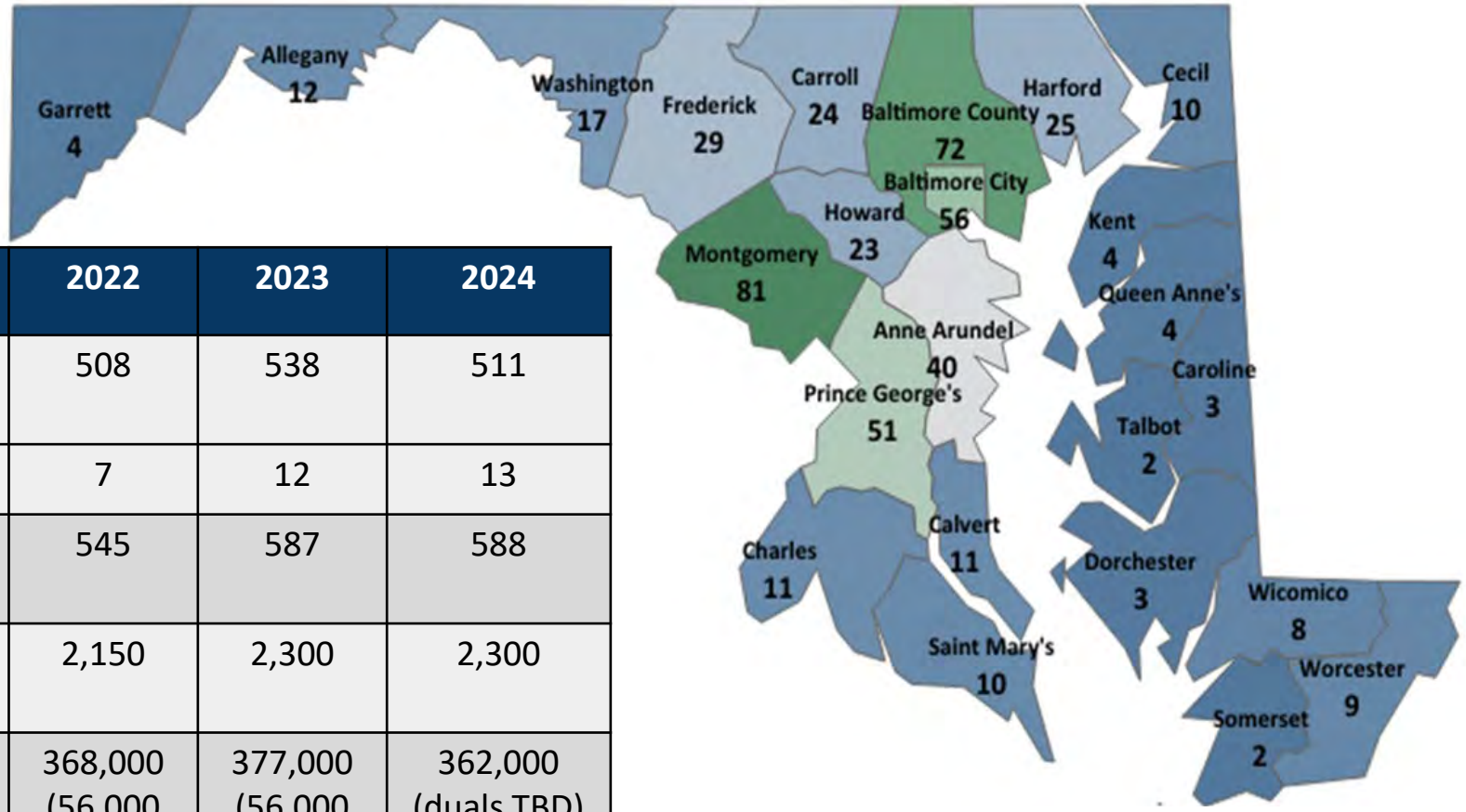
Submitted to CMMI October 2023

1. **2024 Policy and Operations**
   a. Improve resolution time and process for program payment issues **CMMI Working On**
   b. Update process and timeline for reviewing policy updates **CMMI Accepted - AC Meeting Will Be Initial test**
   c. Involve practices in the CAHPS survey administration process **CMMI Providing Additional Detail in Future Reports**
2. **2025 Policy**
   a. Continue to improve the design of the HEART payment **CMMI Working On - Discussing Today**
   b. Reconfigure Performance Based Adjustment (PBA) **Not at this time**
   c. Incorporate Performance Measurement design elements of the Making Care Primary (MCP) model **Not at this time**
   d. Assess bias in the current attribution algorithm and consider adjusting attribution to improve diversity in MDPCP beneficiary population. **Not at this time**

MDPCP in 2024 - 511 Participating Practices

Support infrastructure – 26 Care Transformation Organizations

Statewide – Practices in every county



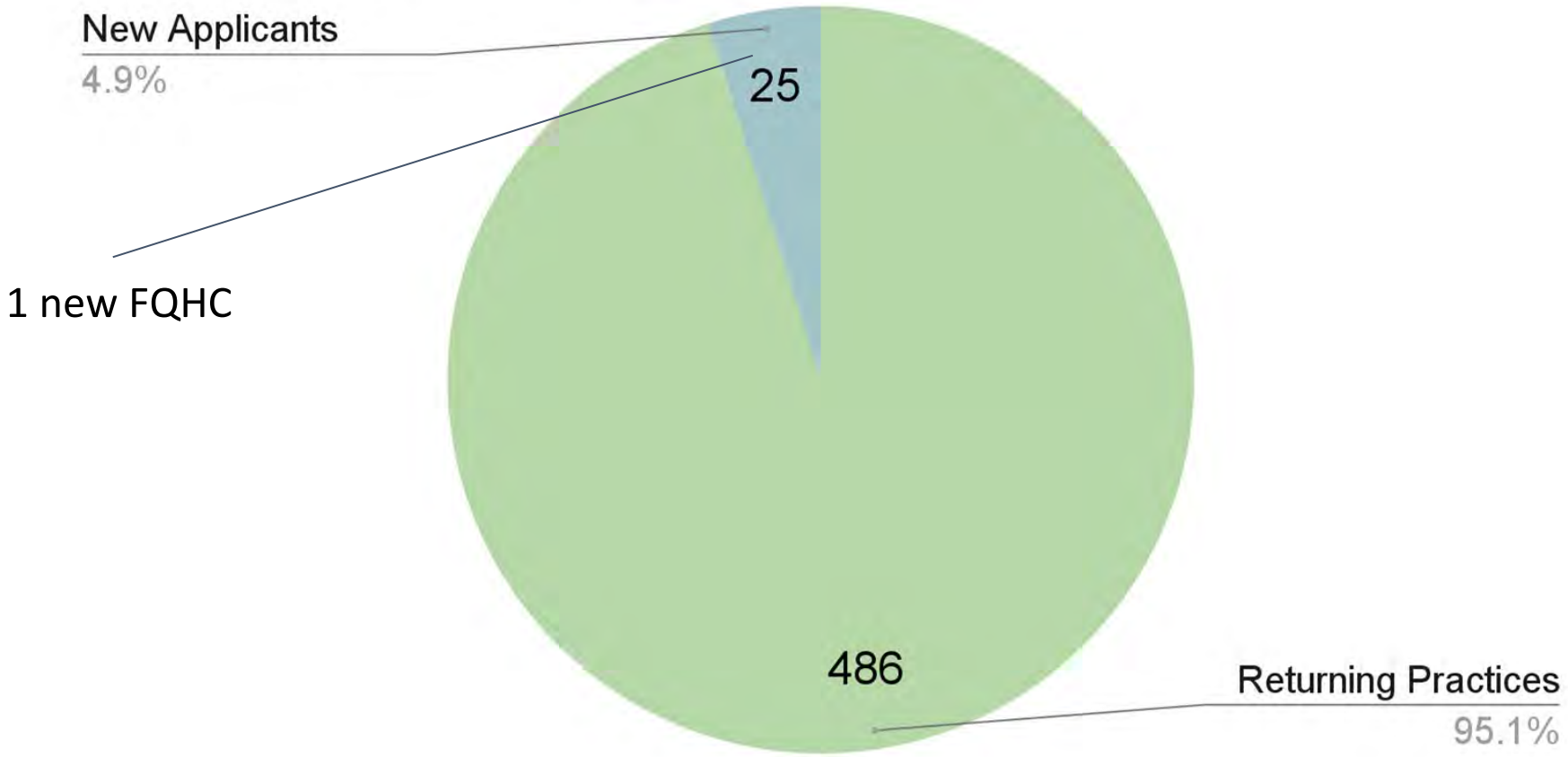
PARTICIPANTS	2019	2020	2021	2022	2023	2024
Practices	380	476	525	508	538	511
FQHCs	-	-	7	7	12	13
Total sites	380	476	562	545	587	588
Providers*	1,500	2,000	2,150	2,150	2,300	2,300
Medicare Beneficiaries attributed*	215,000 (30,000 duals)	326,000 (48,000 duals)	387,000 (58,000 duals)	368,000 (56,000 duals)	377,000 (56,000 duals)	362,000 (duals TBD)

Largest state program in the nation through 2023 - by number of practices and practices per capita (compared to CMS' national Primary Care First Model)

*Yearly totals for these metrics are approximate and based on Q1 attribution for the corresponding year.

2024 MDPCP Participants

511 total practices, including 13 FQHCs



Regional diversity:

- 8 Capital region
- 7 Central region
- 4 Southern region
- 6 Western region

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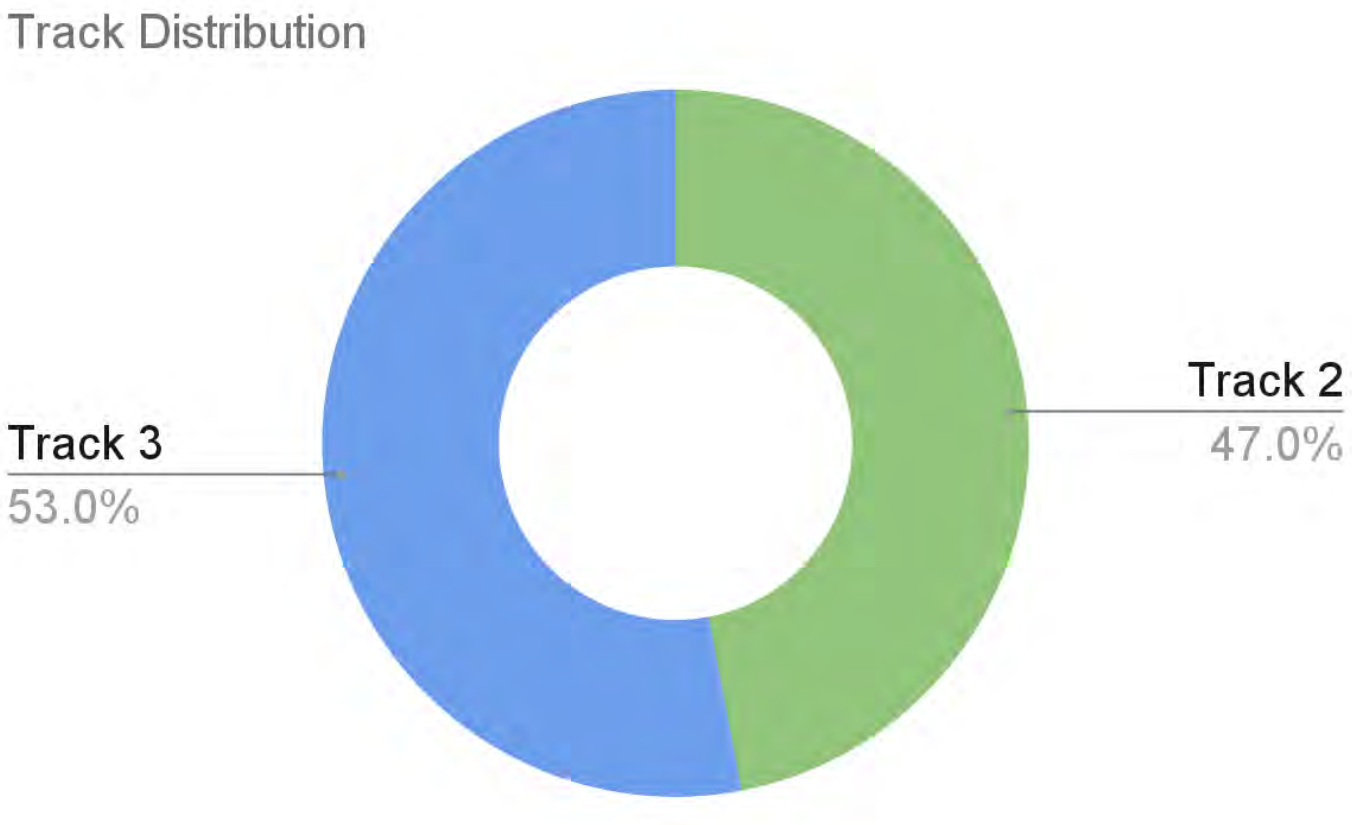
2024 MDPCP Participants by Track



Track 1

0 Practices

⬇57 from prior year

Track 2

239 Practices

⬇ 82 from prior year

Track 3

272 Practices

⬆121 from prior year

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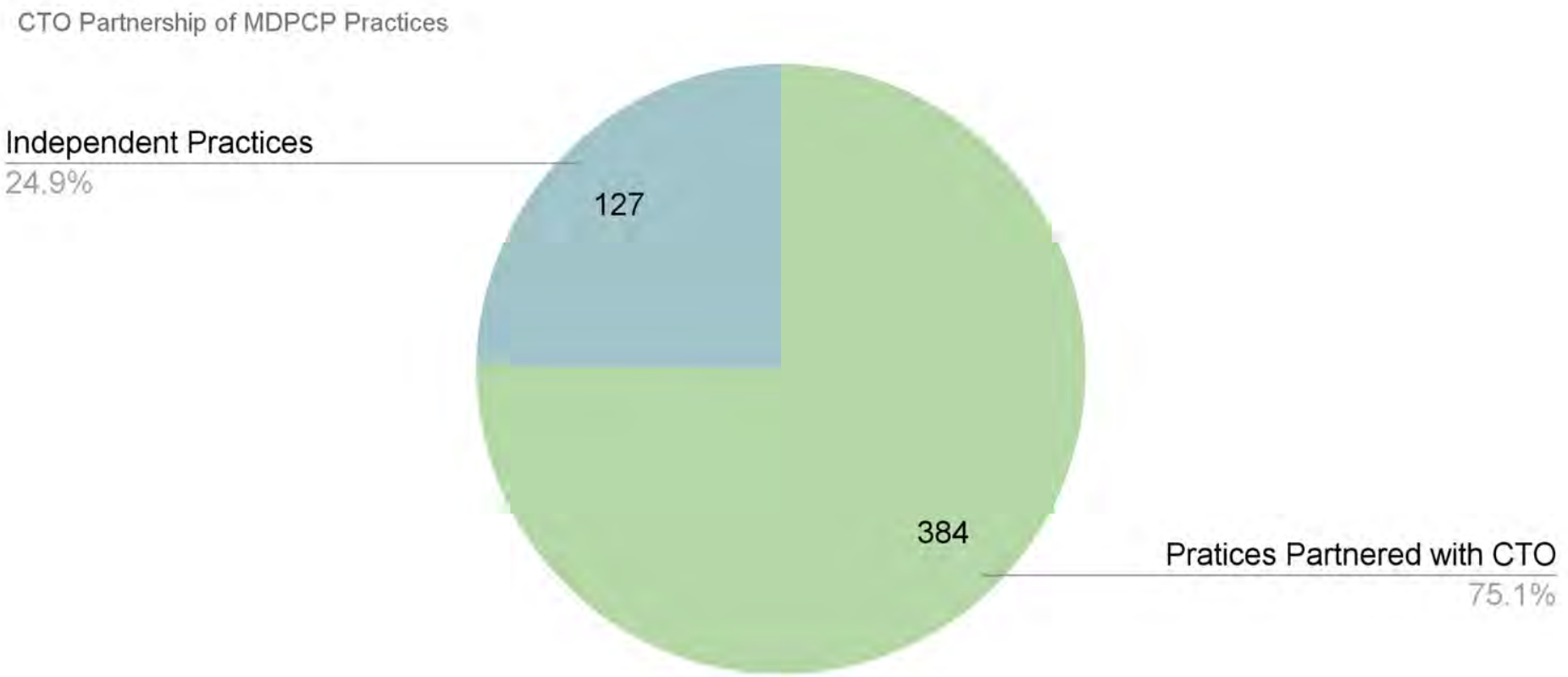
2024 CTO Partnership



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MDPCP Impacts on Utilization and Costs

- **Reduced acute utilization** per 1,000 beneficiaries, 2019-2022:*
  - Reduced Avoidable hospital utilization (PQIs) by 28%.
    - MDPCP cumulative change in PQI-like events is 1.25% lower than the equivalent non-participating population
  - Reduced Emergency Department (ED) utilization by 18%.
    - MDPCP cumulative change in ED utilization is 1.25% lower than the equivalent non-participating population
  - Reduced Inpatient Hospitalization (IP) utilization by 15%.
    - MDPCP cumulative change in IP utilization is 5.5% lower than the equivalent non-participating population
- **Lower growth in Costs** Per Beneficiary Per Month, 2019-2022:*
  - Lower average annual cost growth rate compared to equivalent non-participating population. (2.76% vs. 3.00%)

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

Note: Data through June 2023 is available in the Appendix

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MDPCP Future Update - AHEAD Model

- **Nov 2023 - CMMI Releases RFA for States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model; Press Release**
- **January/February 2024 - MDH/HSCRC conducted stakeholder input meetings to guide proposal development**
- **March 2024 - MDH/HSCRC submitted AHEAD Model application to CMMI.**
  - Application outlines the State's desire to continue MDPCP under AHEAD with an aligned Medicaid advanced primary care program and commitment to meet Model goals including increasing primary care investment and health equity focus
  - Press Release
  - Application and Summary
- **Early summer - decision expected**
- **Key Takeaway**
  - MDPCP continues through 2026
  - AHEAD may allow us to continue for another 10 years

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Agenda Item 4: 2025 Performance Measure Change

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Questions to Consider

- How relevant are these measures for practices' multi-payer focus and alignment?
- Do EHRs support these measures?
- How clinically relevant are these measures?
- What concerns would you have about these measures?
- If MDPCP were to implement one additional measure in 2025, which of the 3 would you select and why?

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BMI Measure Status

Update

- **Measure no longer supported in EHRs**- due to changes in how the BMI measure (CMS69) can be reported in MIPS, some EHR vendors have stopped supporting the measure for PY 2024, making it challenging for some MDPCP practices to report the measure.

- **2024 Measure Policy - MDPCP will suppress CMS69, BMI Screening and Follow-up Plan**
  - The weight of a suppressed measure will be reduced by half.
  - Practices will receive full credit for the half weight measure
  - Remaining weight will be redistributed among the non-suppressed measures.

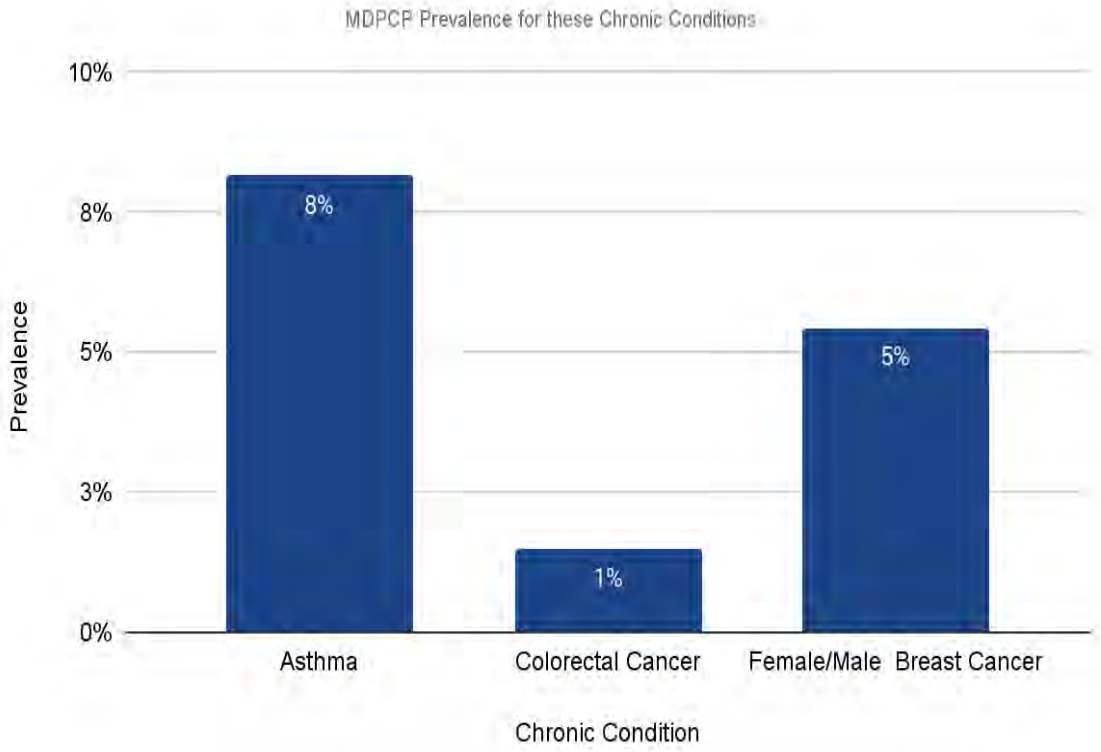
2025 - MDPCP intends to replace CMS69 with a new measure

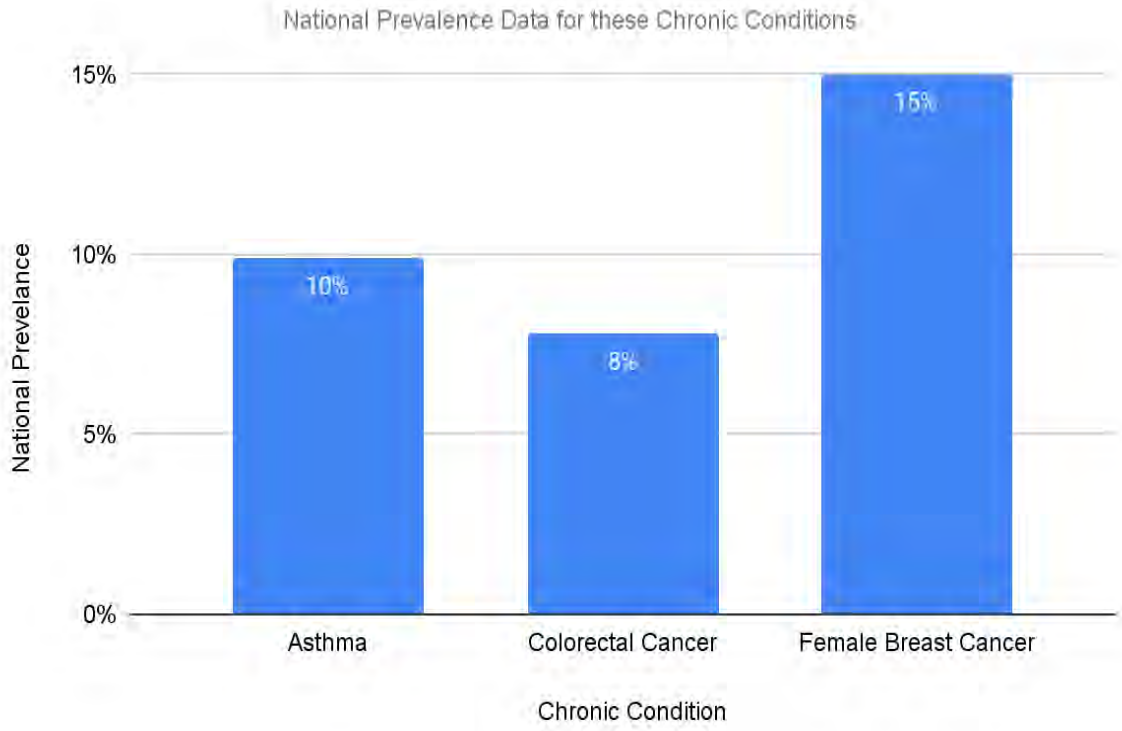
Clinical Quality Measures

Measure #	Measure	Measure Type	MDPCP	Medicaid PCP	Use in Other Programs
NQF 167, CMS 165	Controlling High Blood Pressure	eCQM	Yes	Yes*	AHEAD, Adult Core Set, Medicare, Marketplace, Commercial, MCP, PCF, CPC+, CPC, UDS, CMS Universal Foundation
NQF 204, CMS 122	HbA1c Poor Control	eCQM	Yes	Yes*	AHEAD, Adult Core Set. Medicare, Marketplace, MCP, PCF, CPC+, CPC, UDS, CMS Universal Foundation
NQF 672, CMS 2	Depression Screening and Follow-Up Plan	eCQM	Yes	Yes*	AHEAD, Adult Core Set, Commercial, MCP, CPC, UDS
NQF 421, CMS 69	BMI Screening and Follow-up-Plan	eCQM	To Be Removed	No	
NQF 139, CMS 130	Colorectal Cancer Screening	eCQM	Proposed New	Yes*	AHEAD, Adult Core Set, Commercial, MCP, PCF, CPC+, CPC, UDS, CMS Universal Foundation
NQF 93, CMS 125	Breast Cancer Screening	eCQM	Proposed New	Yes*	AHEAD, Adult Core Set, Medicare, Marketplace, Commercial, CPC+, CPC, UDS, CMS Universal Foundation
CMIT 80	Asthma Medication Ratio	HEDIS	Proposed New	Yes*	Adult Core Set, PHIP (HealthChoice)

*Proposed

Condition Prevalence - MDPCP Beneficiaries vs National





MDPCP data represents Q1-2024 attributed beneficiaries with a CCW flag for the chronic condition in January - October **2023**.
National Prevalence Asthma data was retrieved from Behavioral Risk Factor Surveillance System (BRFSS) and is 2022 Age-Adjusted Prevalence.
National Prevalence Female Breast Cancer and Colorectal Cancer data was retrieved from Surveillance, Epidemiology and End Results Program (Seer) and is the percent of estimated new cases in 2023.

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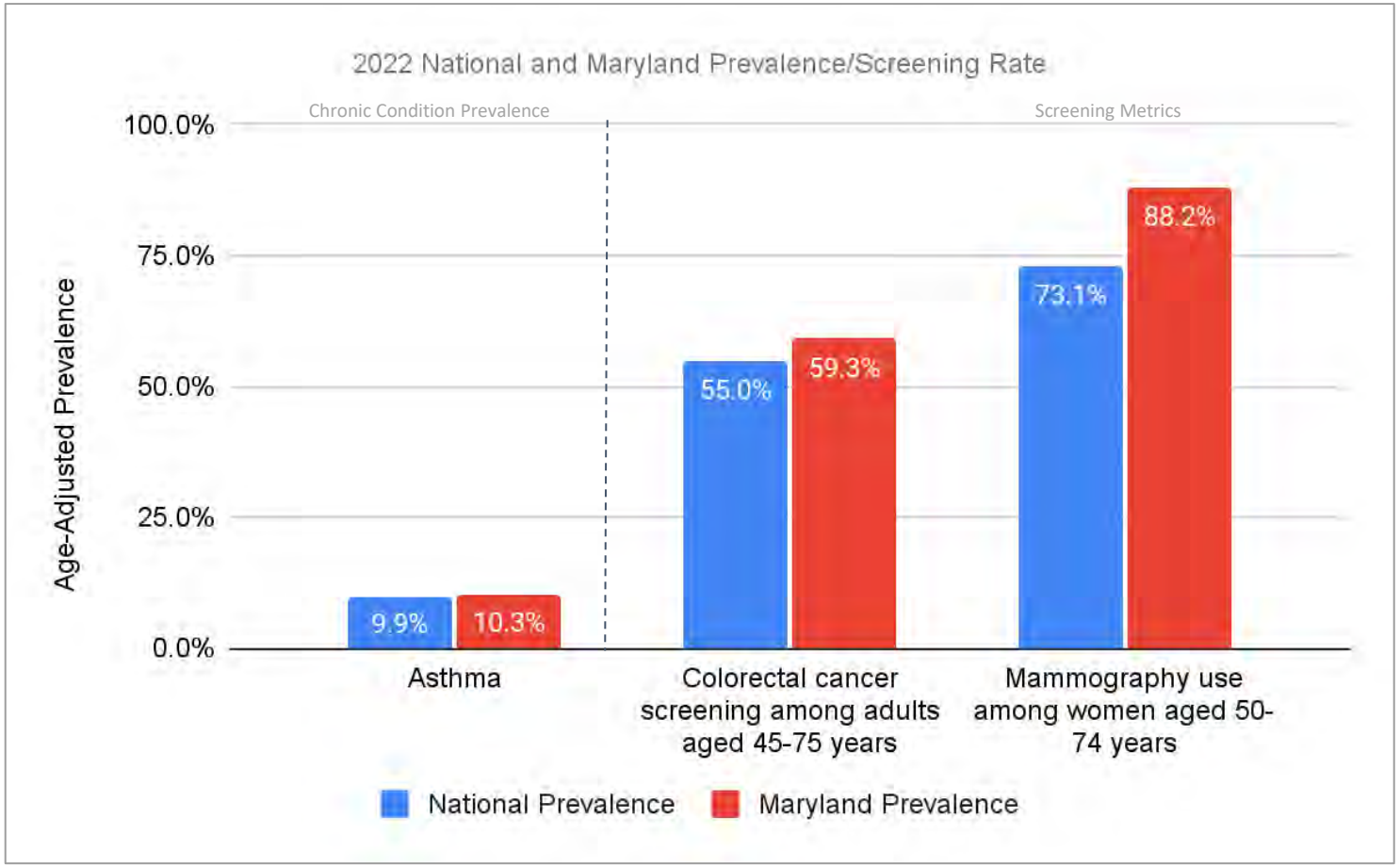
National and Maryland Prevalence and Screening Rates*



*Data was retrieved from Behavioral Risk Factor Surveillance System (BRFSS) and is 2022 data

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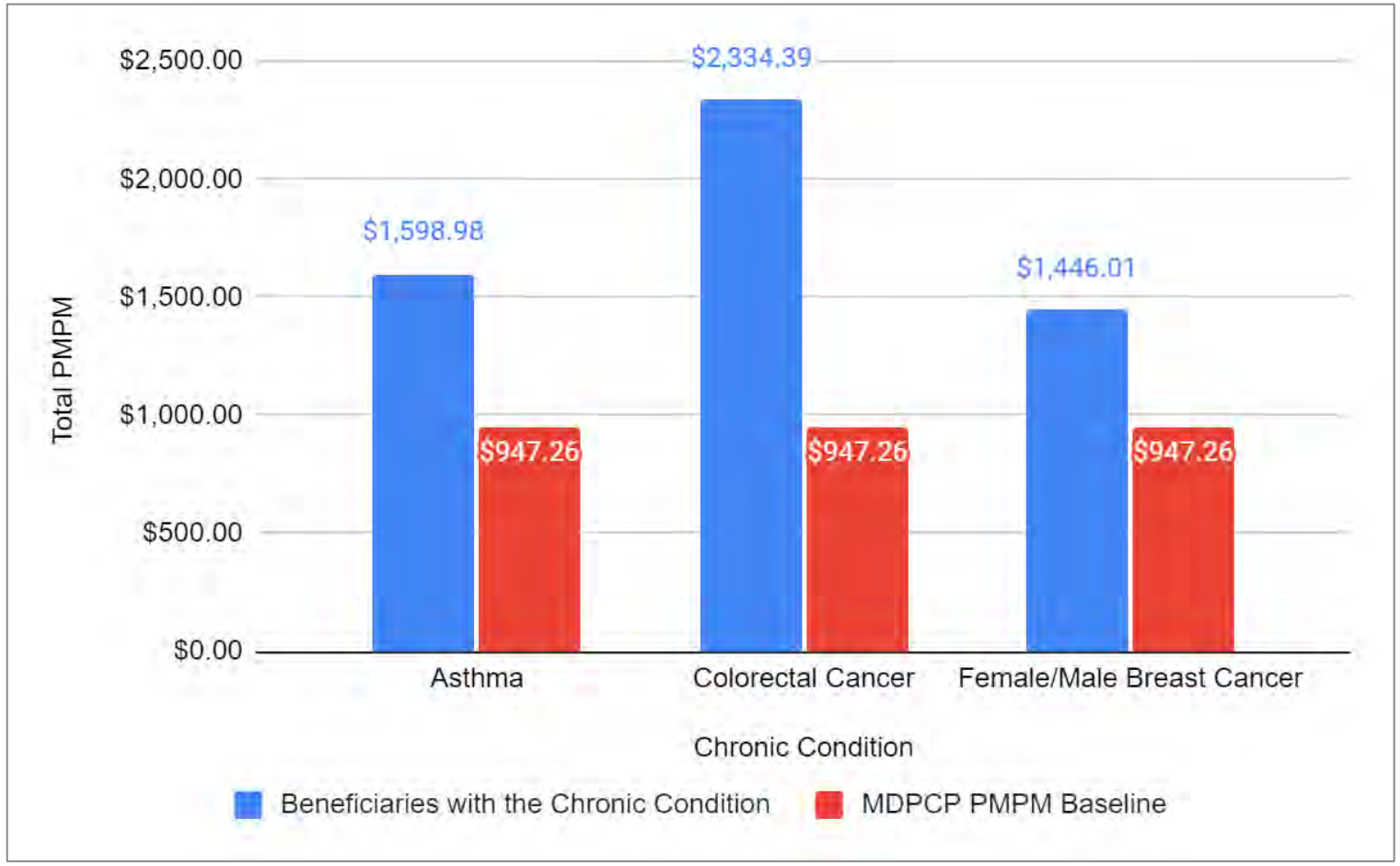
Economic Burden - MDPCP Beneficiaries' PBPM



Data represents the total PMPM for 1/2023 - 10/2023 (Q1 2024 attribution).

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Health Equity considerations

- **Breast cancer screening** rates differ by **insurance status, race/ethnicity, income level, and education level.**[1,2]
  - Black women have the highest rates of screening mammography, yet the breast cancer mortality rate is higher in Black women than others.[1]
- **Colorectal cancer** screening (CCS) also indicates disparities based on **race/ethnicity and insurance status.**[3,4]
  - In Maryland, only 55% of insurance individuals are up to date with CCS vs 77% of insured individuals.[4]
  - Hispanic and Latino individuals had the lowest percentage of individuals up to date with CCS at 68% in Maryland.[3,4]
- **Asthma rates** indicate disparities based on **race/ethnicity and socioeconomic status.**[5,6,7]
  - In 2020, non-Hispanic Black children had a 7.6 times higher death rate associated with asthma than non-Hispanic white children.[7]
  - Prevalence of asthma is higher among individuals with low socioeconomic status when compared to those from high socioeconomic status.[6]

1. Susan G. Komen. How Do Breast Cancer Screening Rates Compare Among Different Groups in the U.S.? Published January 23, 2024. https://www.komen.org/breast-cancer/screening/screening-disparities/
2. National Cancer Institute. *Breast Cancer Screening*. National Cancer Institute; 2023. https://progressreport.cancer.gov/detection/breast_cancer
3. Joseph DA, King JB, Dowling NF, Thomas CC, Richardson LC. Vital Signs: Colorectal Cancer Screening Test Use — United States, 2018. *MMWR Morb Mortal Wkly Rep*. 2020;69(10):253-259. doi:10.15585/mmwr.mm6910a1
4. Division of Cancer Prevention and Control. *Use of Colorectal Cancer Screening Tests*. Centers for Disease Control and Prevention; 2023. https://www.cdc.gov/cancer/colorectal/statistics/use-screening-tests-BRFSS.htm
5. Kim Y, Parrish KM, Pirritano M, Moonie S. A higher Asthma Medication Ratio (AMR) predicts a decrease in ED visits among African American and Hispanic children. *Journal of Asthma*. 2023;60(7):1428-1437. doi:10.1080/02770903.2022.2155183
6. Perez MF, Coutinho MT. An Overview of Health Disparities in Asthma. *Yale J Biol Med*. 2021;94(3):497-507.
7. U.S. Department of Health and Human Services Office of Minority Health. Asthma and African Americans. minorityhealth.hhs.gov. Published November 29, 2022. https://minorityhealth.hhs.gov/asthma-and-african-americans#:~:text=In%202020%2C%20non%2DHispanic%20blacks,of%20non%2DHispanic%20white%20children

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Measure Definitions and Key Risk Factors

Measure	Definition	Key Risk Factors
Breast Cancer Screening	% of women ages 50-74 years old who had a mammogram for breast cancer during 27 months before the end of the measurement period.[1]	• Individuals most at risk include women that are 50 years or older.[2] • Other risk factors include substance abuse, reproductive history, and family history.[3]
Colorectal Cancer Screening	% of patients ages 45-75 years old who were appropriately screened for colorectal cancer during the measurement period.[4]	• Individuals most at risk include those who are 50 years or older or individuals with family history of colon or rectal cancer.[5]
Asthma Medication Ratio	% of individuals ages 5-64 years old identified with persistent asthma and a ratio of controller medication to total asthma medication of 0.5+ during the measurement period.[6]	• All individuals can be at risk, but asthma is one of the most common long-term diseases for children.[7] • Risk factors can include environmental exposures and genetics.[7]

1. American Medical Association. *Quality ID #112 (NQF 2372): Breast Cancer Screening*. Centers for Medicare & Medicaid Services; 2022. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2023_Measure_112_MedicarePartBClaims.pdf
2. Cancer Research UK. Breast screening. cancareresearchuk.org. Published May 26, 2023. https://www.cancerresearchuk.org/about-cancer/breast-cancer/getting-diagnosed/screening-breast#:~:text=To%20have%20screening%20you%20have,trans%20or%20non%2Dbinary%20people
3. World Health Organization. Breast cancer. who.int. Published March 13, 2024. https://www.who.int/news-room/fact-sheets/detail/breast-cancer#:~:text=Key%20facts%201%20Breast%20cancer%20caused%20670%20000,Approximately%200.5%E2%80%931%25%20of%20breast%20cancers%20occur%20in%20men
4. American Medical Association. Quality ID #113 (NQF 0034): Colorectal Cancer Screening. Centers for Medicare & Medicaid Services; 2022. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_113_MIPSCQM.pdf
5. Cancer.Net. Colorectal Cancer: Risk Factors and Prevention. cancer.net. Published September 2023. https://www.cancer.net/cancer-types/colorectal-cancer/risk-factors-and-prevention#:~:text=Age
6. Partnership Healthplan of California. Quality Measure Highlight Asthma Medication Ratio (AMR). Partnership Healthplan of California; 2019. https://www.partnershiphp.org/Providers/Quality/Documents/Performance%20Improvement%202019/AMR%202019%20Highlight_Provider_03_22_19_FINAL.pdf
7. Centers for Disease Control and Prevention. Asthma. cdc.gov. Published October 21, 2020. https://www.cdc.gov/nceh/tracking/topics/asthma.htm#:~:text=Asthma%20affects%20all%20races%2C%20ages,been%20linked%20to%20developing%20asthma

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Discussion

- How relevant are these measures for practices' multi-payer focus and alignment?
- Do EHRs support these measures?
- How clinically relevant are these measures?
- What concerns would you have about these measures?
- If MDPCP were to implement one additional measure in 2025, which of the 3 would you select and why?

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Agenda Item 5: HEART Payment Flexibility

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Questions to Consider

- Would these policy changes affect your implementation of HEART?
- Would this policy change be beneficial? Or do you see drawbacks?
- Are there any implementation challenges you envision with these changes?
- Are there tweaks you'd recommend considering?
- Any additional feedback?

Status and Challenges with HEART Payment

Background: HEART introduced in 2022, provides additional PBPM funding for practices serving beneficiaries with a combination of high HCC score (representing medical complexity) and high ADI score (social risk).

Status: Many practices and CTOs have found success with HEART, implementing innovative supports in particular for patients' unmet social needs. However, practices have shared *key policy design challenges* with HEART, namely:

1. HEART methodology does not always identify the "right" patients with the most need
2. HEART eligibility changes per quarter affect continuity of care

Proposed Policy Change

Policy option 1: Enable HEART to be spent on any MDPCP beneficiary (preferred) PMO Preference

- Practices could determine which beneficiaries are most in need and could benefit from the additional services that HEART provides
- Encourages practices to screen *all* MDPCP beneficiaries for unmet social needs
- Removes the challenge of quarterly fluctuations

Policy option 2: Enable HEART to be spent on an expanded group of MDPCP beneficiaries (e.g. dual eligibles, high utilizers) Backup option

- Increase likelihood that HEART identifies beneficiaries who could benefit from HEART services

Note: these policy options will need to go through CMMI approval processes and thus may not be implemented in 2025

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Discussion

- Would these policy changes affect your implementation of HEART?
- Would this policy change be beneficial? Or do you see drawbacks?
- Are there any implementation challenges you envision with these changes?
- Are there tweaks you'd recommend considering?
- Any additional feedback?

Agenda Item 6: EQIP-PC Design and MDPCP Transition

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Questions to Consider

- How many years do new practices need in order to be ready to transition to MDPCP?
- What are the key factors to ensure readiness?
- Should it be an explicit requirement that practices transition to MDPCP? Or are there some types of practices that should be exempted from transition?
- Should dual participation be allowed? Or does that threaten MDPCP sustainability?
- What implementation challenges might arise?

EQIP-PC and MDPCP

- HSCRC is developing a new program to expand/create new primary care availability in underserved areas of the state
- Designed to complement MDPCP
- $19 million - funded by one-time MPA Savings under TCOC Model
- Target start date of Jan 1, 2025 (subject to CMS approval)
- Payments- 1)upfront infrastructure funding; 2)Medicare PBPM for 3-5 years; 3)shared savings opportunity in years 4-5
- Potential opportunities for AAPM status and PC bundles
- Transition to MDPCP may be required

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Additional details on EQIP PC: https://www.crisphealth.org/learning-system/eqip-pc/

MDPCP-like Elements

Elements that would prepare practices for MDPCP:

- Model of care
  - Care Management
  - Integrated Care (e.g. specialty coordination)
  - Community Linkages
- Quality Measures - aligned with MDPCP
- Attribution (no minimum)

Discussion

- How many years do new practices need in order to be ready to transition to MDPCP?
- What are the key factors to ensure readiness?
- Should it be an explicit requirement that practices transition to MDPCP? Or are there some types of practices that should be exempted from transition?
- Should dual participation be allowed? Or does that threaten MDPCP sustainability?
- What implementation challenges might arise?

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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2024 Priorities

Improve patient engagement with a focus on relationship building, processes, and health equity

Create and implement a culture of **data-driven care delivery and care management practices**

Implement comprehensive, holistic care inclusive of **behavioral health and social needs**

Demonstrate program **ROI and quality improvement**

Note: Data is HCC risk-adjusted

Lower Inpatient and Avoidable Hospital Utilization, 2019 - 2022

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

Category		Base Year 2019	2020	2021	2022	Total Percent Change
Inpatient Hospital Utilization (IP) per 1,000 beneficiaries						
Statewide Non-Participating Population		246.6	215.0	219.2	215.6	-12.5%
	% Change from Prior Year	N/A	-12.8%	2.0%	-1.7%	
Equivalent Non-Participating Population		248.3	214.7	218.8	213.4	-14.1%
	% Change from Prior Year	N/A	-13.6%	2.0%	-2.5%	
MDPCP		244.0	211.1	212.4	207.8	**-15.0%**
	% Change from Prior Year	N/A	-13.5%	0.7%	-2.2%	
Avoidable Hospital Events (IP and ED)* per 1,000 beneficiaries						
Statewide Non-Participating Population		89.3	68.2	66.6	65.2	-28.0%
	% Change from Prior Year	N/A	-23.5%	-2.4%	-2.1%	
Equivalent Non-Participating Population		87.3	65.0	64.1	63.6	-27.7%
	% Change from Prior Year	N/A	-25.7%	-1.2%	-0.8%	
MDPCP		87.0	65.5	64.4	63.1	**-28.4%**
	% Change from Prior Year	N/A	-24.8%	-1.7%	-1.9%	

*Uses the AHRQ specifications for avoidable inpatient admissions + ED visits

PBPM, 2019 vs 2023 YTD (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	2022	2023 YTD	Cumulative Percent Change
Statewide Non-Participating Population		$1,002.87	$1,016.02	$1,108.73	$1,136.65	$1,187.97	17.47%
	% Change from Prior Year	N/A	**1.31%**	**9.12%**	**2.52%**	**4.52%**	
Equivalent Non-Participating Population		$1,015.91	$1,024.95	$1,123.87	$1,143.57	$1,210.75	18.16%
	% Change from Prior Year	N/A	**0.89%**	**9.65%**	**1.75%**	**5.87%**	
MDPCP		$1,015.29	$1,018.02	$1,105.55	$1,131.99	$1,172.45	14.83%
	% Change from Prior Year	N/A	**0.27%**	**8.60%**	**2.39%**	**3.57%**	

YTD - June 2023

IP Utilization per K, 2019 vs 2023 YTD
(HCC Risk-Adjusted)

Category		Base Year 2019	2020	2021	2022	2023 YTD	Cumulative Percent Change
Statewide Non-Participating Population		244.67	213.95	217.68	213.67	227.21	-6.33%
	% Change from Prior Year	N/A	**-12.56%**	**1.74%**	**-1.84%**	**6.33%**	
Equivalent Non-Participating Population		248.05	212.08	216.50	215.99	223.88	-9.00%
	% Change from Prior Year	N/A	**-14.50%**	**2.08%**	**-0.23%**	**3.65%**	
MDPCP		242.10	210.08	212.01	207.61	214.29	-11.16%
	% Change from Prior Year	N/A	**-13.22%**	**0.92%**	**-2.08%**	**3.22%**	

YTD - June 2023

ED Utilization per K, 2019 vs 2023 YTD
(HCC Risk-Adjusted)

Category		Base Year 2019	2020	2021	2022	2023 YTD	Cumulative Percent Change
Statewide Non-Participating Population		466.74	363.34	389.11	384.55	390.34	-14.72%
	% Change from Prior Year	N/A	**-22.15%**	**7.09%**	**-1.17%**	**1.51%**	
Equivalent Non-Participating Population		457.53	350.87	373.74	375.38	385.55	-13.64%
	% Change from Prior Year	N/A	**-23.31%**	**6.52%**	**0.44%**	**2.71%**	
MDPCP		448.03	345.14	371.08	366.52	371.36	-15.36%
	% Change from Prior Year	N/A	**-22.97%**	**7.52%**	**-1.23%**	**1.32%**	

YTD - June 2023

PQI-Like Events Per K, 2019 vs 2023 YTD
(HCC Risk Adjusted)

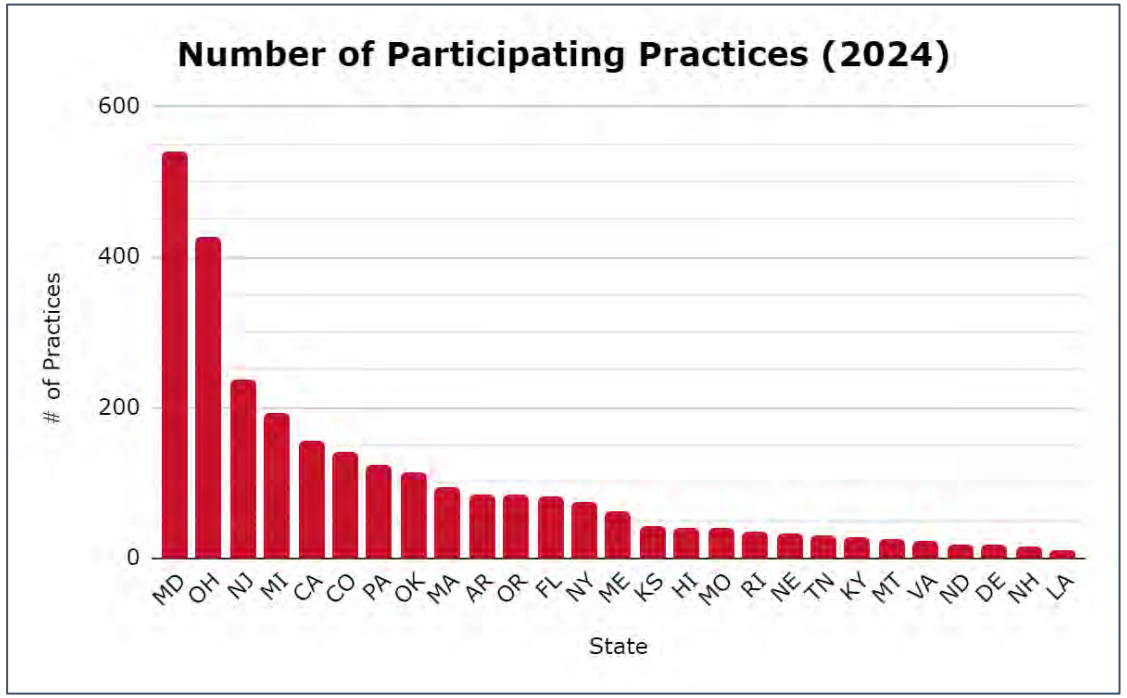
Category		Base Year 2019	2020	2021	2022	2023 YTD	Cumulative Percent Change
Statewide Non-Participating Population		88.15	67.30	65.44	63.92	69.79	-19.57%
	% Change from Prior Year	N/A	**-23.66%**	**-2.77%**	**-2.32%**	**9.18%**	
Equivalent Non-Participating Population		87.33	66.18	63.58	62.59	66.35	-23.70%
	% Change from Prior Year	N/A	**-24.22%**	**-3.92%**	**-1.56%**	**6.00%**	
MDPCP		87.23	65.48	64.41	63.73	67.96	-20.99%
	% Change from Prior Year	N/A	**-24.93%**	**-1.65%**	**-1.04%**	**6.63%**	

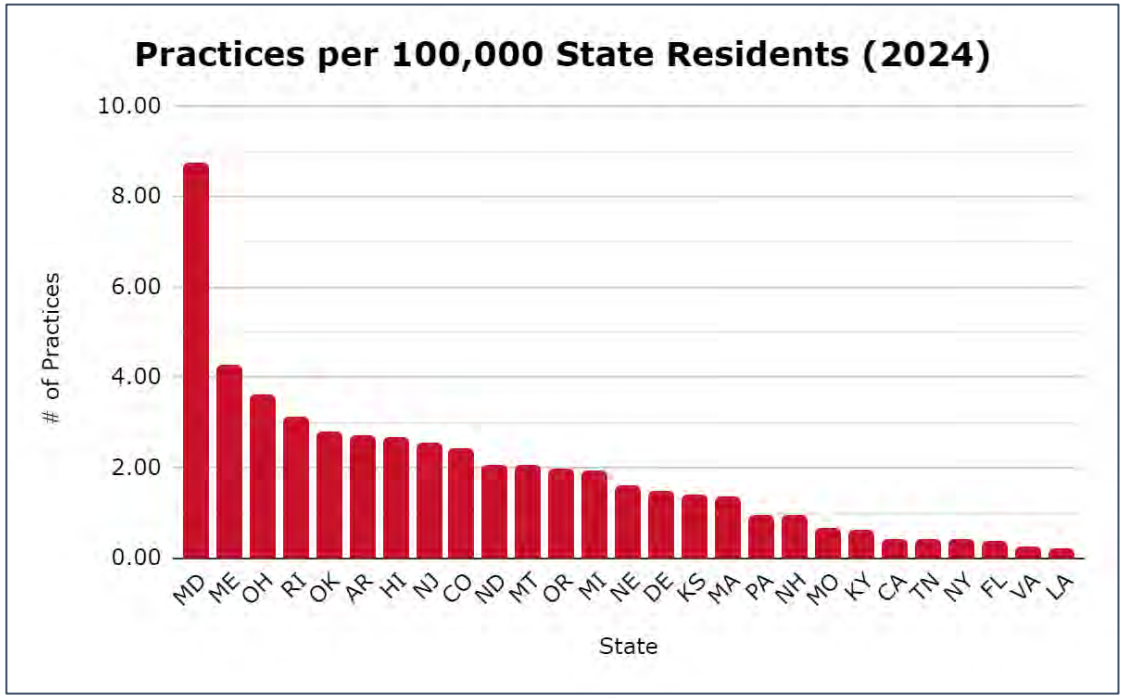
YTD - June 2023

Chart displays utilization for IP admissions or ED visits that fall into one of 10 PQI categories using 2022 AHRQ specification

2024 Update - Still the Largest Medicare FFS Advanced Primary Care Program in the Nation

When compared to the national Primary Care First model, MDPCP is the nation's largest advanced primary care program by state based on number of practices and practices per 100k residents.





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Importance of Potential Measure Additions

240,000

women are diagnosed with breast cancer each year.[1]

In Maryland, the incidence rate for breast cancer is 133.2 cases per 100,000 women compared to the 127 cases per 100,000 women in the U.S.[2]

147,950

new cases of colorectal cancer were identified in 2020 alone.[3]

Between 2016 to 2020, Maryland had an average of 2,518 annual cases of colorectal cancer compared to the 138, 021 average annual U.S. cases.[4]

25 mil.

are impacted by asthma within the United States.[5]

59.8% of individuals with asthma experience persistent severity in Maryland.[6]

1. Division of Cancer Prevention and Control, Centers for Disease Control and Prevention. Basic Information About Breast Cancer. Published July 25, 2023. https://www.cdc.gov/cancer/breast/basic_info/index.htm#:~:text=Each%20year%20in%20the%20United,cancer%20than%20all%20other%20women.
2. State Cancer Profiles. State Cancer Profiles: Incidence Rate Tables - Breast (Female). National Cancer Institute; 2024. https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=24&areatype=county&cancer=055&race=00&age=001&stage=999&type=incd&sortVariableName=rate&sortOrder=default&output=0#results
3. American Medical Association. Quality ID #113 (NQF 0034): Colorectal Cancer Screening. Centers for Medicare & Medicaid Services; 2022. https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2023_Measure_113_MIPSCQM.pdf
4. State Cancer Profiles. State Cancer Profiles: Incidence Rate Tables - Colon & Rectum. National Cancer Institute; 2024. https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=24&areatype=county&cancer=020&race=00&sex=0&age=001&stage=999&type=incd&sortVariableName=rate&sortOrder=default&output=0#results
5. United States Environmental Protection Agency. What is Asthma? Published November 28, 2023. https://www.epa.gov/asthma/what-asthma#:~:text=Asthma%20is%20a%20serious%2C%20sometimes,an%20estimated%204%20million%20children.
6. National Center for Environmental Health. Asthma Severity among Adults with Current Asthma. National Center for Environmental Health; 2015. https://www.cdc.gov/asthma/asthma_stats/severity_adult.htm

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Recent MDPCP Recognition

- Journal of American Medical Association Article: ***Association of Participation in the Maryland Primary Care Program With COVID-19 Outcomes Among Medicare Beneficiaries***
- MDPCP presentation to **NACCHO Public Health Preparedness Summit**
  - "Leveraging Primary Care to Robustly Respond to Public Health Emergencies"
- MDPCP presentation at the **CRISP Annual Summit**
  - "MDPCP Alignment with State Population Health Strategy: CRISP Tools and Supports"
- MDPCP presentation at the **2nd National Primary Care Transformation Summit**
  - "Transforming Primary Care Through an Integrated Relationship"

MDPCP's Health Equity Approach

MDPCP is committed to achieving **equitable quality of care, access to care, and outcomes at the primary care level**. Four core priority areas around health equity are: data, social needs screening and referral, payment, and QI to reduce disparities.

Data

Enable all MDPCP practices and CTOs to have the foundational data capacity to understand disparities in clinical quality, utilization, and cost

Social Needs Screening and Referral

Ensure all MDPCP practices and CTOs effectively screen patients for social needs and refer patients to community resources to address those needs

Payment

Give practices the financial resources to address social needs, specifically the HEART Payment, which directs funding to target beneficiaries' social needs

Quality Improvement to Reduce Disparities

Build QI capabilities and infrastructure within practices to reduce disparities in measures such as PQI-like events, ED events, and hospital follow up rates