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September 29, 2021

The Honorable Guy Guzzone
Chair, Senate Budget & Taxation Committee
3 West, Miller Senate Office Building
Annapolis, Maryland 21401

The Honorable Maggie McIntosh
Chair, House Appropriations Committee
House Office Building Room 121
Annapolis, Maryland 21401

Re: 2021 Joint Chairmen's Report - M00R01.02 (Page 119) - Health Services Cost Review Commission Evaluation of the Maryland Primary Care Program (MDPCP).

Dear Chair Guzzone and Chair McIntosh:

The 2021 Joint Chairmen's Report requested that the Health Services Cost Review Commission (HSCRC) conduct an evaluation of the Maryland Primary Care Program (MDPCP) focusing on cost-savings from the MDPCP, reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives, and a consideration of racial equity within MDPCP. The document enclosed is submitted in compliance with that request.

If you have any questions or if we may provide you with any further information, please do not hesitate to contact me at 443-621-2244 or katie.wunderlich@maryland.gov or contact Megan Renfrew, Associate Director of External Affairs, at 410-382-3855 or megan.renfrew1@maryland.gov.

Sincerely,

Katie Wunderlich
Executive Director

cc:
Jake Whitaker, Deputy Legislative Officer, Office of the Governor
Gabriella Wagner, Policy Advisor, Office of the Governor
Katherine Gibson, Operating Budget Analyst, Department of Budget and Management
Sarah Albert, Department of Legislative Services (5 copies)
Heather M. Shek, Director, Office of Governmental Affairs, Maryland Department of Health
Chad Perman, Acting Executive Director, Program Management Office for Maryland Primary Care Program

Evaluation of the Maryland Primary Care Program

Joint Chairmen's Report

October 2021

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Executive Summary

The 2021 Joint Chairmen's Report (JCR) directed the Health Services Cost Review Commission (HSCRC) to analyze the effectiveness of the Maryland Primary Care Program (MDPCP) with a comparison between cost savings and reduced utilization and the additional payments provided to primary care practices, in addition to focusing on racial equity within the Program. Specifically, the JCR included the following language:

> Given the role of the MDPCP in transforming care in the State under the total cost of care model and the prior findings that the MDPCP has yet to produce cost savings, the budget committees request information on the effectiveness of the program. In particular, this evaluation should focus on cost-savings from the MDPCP, reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives, and a consideration of racial equity within MDPCP, including racially diverse participation by providers and patients.

During the first two years of the Program (calendar years 2019 and 2020), MDPCP focused on transforming and improving care for Marylanders and reducing avoidable hospitalizations and emergency department visits, while also addressing the COVID-19 pandemic in 2020. The MDPCP did so through the integration of behavioral health, data-driven care management, identification and attention to patients' social determinants of health needs, expanded access to primary care services, and improved transitions of care.

To address the "relative" effectiveness of MDPCP practices compared to other Maryland practices, the HSCRC compared practices participating in the MDPCP to practices not participating in MDPCP and found that the growth rate of costs in MDPCP between 2019 and 2020 has grown more slowly than the comparison group. The HSCRC concludes that there has been a small savings impact from the MDPCP in the first two years of the program, even after including the additional MDPCP investments. MDPCP has made progress towards the goals of integrating primary care with the larger health care delivery system to coordinate care, provide advanced care, and lower unnecessary utilization and cost. However, there has been substantial volatility in the growth rate over the first two years, especially when considering abnormal health care patterns resulting from the COVID-19 pandemic. As stated in the report, using a Difference-in-Differences methodology in comparing the MDPCP to non-MDPCP is intended to control for this effect. More data will be necessary to determine whether the MDPCP has had a meaningful impact on the total cost of care.

The HSCRC also analyzed the racial diversity of patients in MDPCP. The MDPCP patient population is slightly less racially diverse than the overall Medicare population. There is a larger proportion of white Medicare beneficiaries and a smaller proportion of other racial groups in MDPCP. The HSCRC attempted to analyze the racial diversity of providers who participated in the MDPCP program but was unable to acquire accurate data because this data is not currently collected. Because of this, no assessment of the racial diversity of providers could be included in this report.

Introduction

The 2021 Joint Chairmen's Report (JCR) directed the Health Services Cost Review Commission (HSCRC) to analyze the effectiveness of the Maryland Primary Care Program (MDPCP) with a comparison between cost savings and reduced utilization and the additional payments provided to primary care providers, in addition to focusing on racial equity within the Program. Specifically, the JCR included the following language:

> Given the role of the MDPCP in transforming care in the State under the total cost of care model and the prior findings that the MDPCP has yet to produce cost savings, the budget committees request information on the effectiveness of the program. In particular, this evaluation should focus on cost-savings from the MDPCP, reducing unnecessary utilization or hospitalization for patients participating in the MDPCP over the increased expenditures from provider incentives, and a consideration of racial equity within MDPCP, including racially diverse participation by providers and patients.

The HSCRC completed a similar evaluation in 2020.[1] The 2020 evaluation found that the cost trends for practices participating in the MDPCP and practices that did not participate in MDPCP were very similar from calendar year 2018 to 2019. In 2020, the HSCRC concluded there was little cost-savings impact from the MDPCP in the first year of the program. When including the impact of the care management fees paid to MDPCP practices and Care Transformation Organizations (CTOs), the MDPCP participating practices had higher per beneficiary/per month (PBPM) compared to the similar practices not participating in MDPCP using a difference-in-difference analysis.

This 2021 report contains background information on the Maryland Total Cost of Care Model and the MDPCP, a description of HSCRC's approach to evaluating the MDPCP, the results of the evaluation of expenditures, and information on the racial diversity of patients served by the MDPCP program.

Background

The MDPCP supports primary care practices by providing funding and support for the delivery of "advanced primary care" services to their patients. The MDPCP is a program run by the Centers for Medicare and Medicaid Services (CMS) with technical support for practices provided by the Program Management Office in the Maryland Department of Health (MDH). The MDPCP is a component of the Total Cost of Care (TCOC) Model agreement between Maryland and the Center for Medicare and Medicaid Innovation (CMMI), a Center within CMS. This section describes the TCOC Model and Maryland's unique rate setting system for hospitals and provides background on the MDPCP, including program goals and payment and management structure.

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[1] Health Services Cost Review Commission, "Evaluation of the Maryland Primary Care Program : Joint Chairmen's report", October 2020, available at http://dlslibrary.state.md.us/publications/JCR/2020/2020_122.pdf

Maryland Hospital Rate Setting and the Total Cost of Care Model

The State of Maryland entered into an agreement with the Centers for Medicare and Medicaid Services (CMS) to run a demonstration program called the TCOC Model. The TCOC Model began in 2019 and is expected to run through 2028. The TCOC Model aims to coordinate care, implement broad healthcare delivery reform, and improve quality and reduce costs across both hospital and non-hospital settings. The TCOC Model includes financial and quality targets that the State must meet to continue the Model agreement with CMMI.

The Model allows the State to set hospital payments for Medicare. Under the Total Cost of Care Model agreement, hospitals are subject to global budgets on revenue (GBRs), which set an annual payment limit for hospitals regardless of the hospital utilization rate. Global budgets, which have been in place for all general acute hospitals since 2014, have fundamentally changed hospitals' incentives from increasing fee-for-service volume to improving population health and driving toward value-based outcomes.

A key element of the TCOC Model is the Maryland Primary Care Program (MDPCP), a voluntary program that provides funding and support for the delivery of advanced primary care in Maryland. The MDPCP supports the goals of the TCOC Model by providing key tools to primary care practices to aid in prevention and management of chronic disease, address behavioral health and social needs, provide targeted care management, care through transitions of care and to prevent unnecessary hospital utilization. A strong primary care system will be necessary to support the State's continued efforts to improve health outcomes and reduce unnecessary hospitalizations to meet these targets.

Maryland Primary Care Program

The Maryland Primary Care Program (MDPCP) supports primary care practices by providing funding and support for the delivery of "advanced primary care" services to their patients. This advanced model of care is intended to provide comprehensive and holistic primary care services to optimize individual and population health outcomes. A core feature of the MDPCP is the attribution of Medicare beneficiaries to primary care practices. Attribution means that primary care practices are assigned a panel of Medicare beneficiaries and are tasked with providing advanced primary care to their attributed beneficiaries. Unlike some commercial patient-centered medical home models, Medicare beneficiaries are not limited to seeing a certain primary care physician. Rather, Medicare beneficiaries are free to see any Medicare provider and MDPCP assigns Medicare beneficiaries to the primary care practice that provides the plurality of that beneficiary's primary care services.

Practices may partner with a Care Transformation Organization (CTO). CTOs are "private entities that hire and manage the interdisciplinary care management teams that provide care coordination services at the direction of the participating practices. CTOs also offer support for care transitions, standardized beneficiary

screening, data tools and informatics, and practice transformation."[2] CTOs provide resources that practices may not be able to support on their own, such as pharmacist services, health and nutrition counseling, behavioral health specialists, social services support, and health educators and community health workers. For practices that align with a CTO, CMS pays a percent of the care management fees (described below) for that practice to the CTO. CTOs also receive a performance-based incentive payment from CMS.

Participation in the MDPCP is voluntary for practices. As of the 2021 program year (program year 3), 562 practice sites were enrolled in the program, serving nearly 400,000 Medicare FFS beneficiaries. Approximately 53% of the Medicare beneficiaries in the State have been attributed to a participating MDPCP practice. Starting in 2021, Federally Qualified Health Centers (FQHCs) became eligible to participate in MDPCP; 7 FQHCs representing 44 sites currently participate.

Once a Medicare beneficiary has been attributed to a participating primary care practice, that practice is expected to provide their attributed beneficiaries with "advanced primary care." This concept is based on the patient-centered medical home model[3] where primary care physicians act as the quarterback of a patient's care. It is important to note that the care transformation that occurs within the practices is for all patients, agnostic of the payer type. Practices are evaluated by CMMI based on their performance for all patients regarding quality and patient satisfaction. CMMI also evaluates practices on hospital and ED utilization for attributed Medicare beneficiaries. For the purposes of the MDPCP, advanced primary care is defined as providing the following five primary care functions:

- **Care Management:** Practices are required to provide care management for high-risk, high-need, and rising-risk Medicare beneficiaries by integrating a care manager into practice operations. Practices must risk stratify all attributed beneficiaries to determine each beneficiaries' care management needs. Practices are required to provide long-term care management to beneficiaries with chronic conditions and episodic care management to beneficiaries with acute needs.
- **Access and Continuity:** Participating MDPCP practices are required to expand access to care through expansion of hours and telehealth. Practices in MDPCP are also required to empanel each Medicare beneficiary attributed to their practice to a provider or care team.
- **Planned Care for Health Outcomes:** Practices develop interventions that engage high-risk beneficiaries before they require hospitalization through health coaches and educators (including community health workers) and partnerships with the non-clinical community. All practices are required to utilize evidence-based protocols for screening, diagnosis, and treatment of patients.

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[2] Perman, C., Patterson, R., & Haft, H. (2020, June 25). Maryland's Innovative Primary Care Program: Building a Foundation for Health and Well-Being. Milbank Memorial Fund. https://www.milbank.org/publications/marylands-innovative-primary-care-program-building-a-foundation-for-health-and-well-being/

[3] More information about the patient-centered medical home model is available from NCQA. https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/.

- **Beneficiary and Caregiver Experience**: Practices must improve care processes using a Patient-Family/Caregiver Advisory Council to involve beneficiaries and their families in developing the practice's care redesign plans.
- **Comprehensiveness and Coordination Across the Continuum of Care:** MDPCP practices integrate behavioral health services into their practices, work with patients to identify and address social needs of their patients and provide advanced medication management. Practices receive care notifications from Maryland's State-designated health information exchange when attributed patients visit an ED or are admitted or discharged from the hospital. Practices are expected to identify high-volume/high-cost specialists serving their beneficiaries and strengthen their referral and/or co-management relationships with specialists and community and social services.

To facilitate advanced primary care in participating practices, the MDPCP significantly revises the payment system for primary care practices. The MDPCP involves three different payment streams:

1. **Care Management Fees**. An additional per beneficiary per month payment directly to participating practices from CMS intended to cover care management services and expanded team-based care;
2. **Performance-Based Incentive Payments**. Payments that reward practices that are successful at reducing hospital utilization, improving patients' experience of care, and improving the quality of patient care; and
3. **Comprehensive Primary Care Payments**. Payments to practices that transition to a more stable funding stream than the current fee-for-service (FFS) system (Track 2 practices).

Combined, these payment streams incentivize primary care practices to transform primary care delivery by investing in necessary care management and care coordination resources.

A substantial number of practices have enrolled in the MDPCP since the beginning of the program in 2019. Approximately 53% of the Medicare beneficiaries in the State have been attributed to a participating MDPCP practice.

Table 1: MDPCP Care Management Fees by Year

	Number of Physicians	Number of Attributed Beneficiaries	Care Management Fees
2019	1,569	206,000	$53 million
2020	1,886	309,000	$104 million
2021	2,150	396,000 (Q1)	$148 million (projected)

Other primary care-based programs created by the federal Centers for Medicare and Medicaid Services (CMS) have strong multi-payer alignment, meaning that private payers and Medicaid use a similar payment structure to encourage practices to provide patient centered medical care to non-Medicare beneficiaries. By employing a similar payment strategy across other payers, CMS hopes that practices will transform their entire practice's operations, rather than just a portion. In Maryland, the advanced primary care program run by CareFirst BlueCross BlueShield, the largest private health insurer in Maryland, is recognized as an MDPCP aligned program by CMS, advancing multi-payer alignment under MDPCP in the State.[4] The changes in primary care practices required by MDPCP and the CareFirst program benefit all patients. Maryland Medicaid program is also exploring ways to align with the MDPCP to further expand multi-payer alignment with the MDPCP.

CMS evaluates MDPCP practices on quality of care and patient satisfaction of all patients, regardless of payer type, and on the practice's success at reducing hospital and ED utilization for attributed Medicare beneficiaries.[5]

Payment Reform in MDPCP

Advanced primary care involves a substantial expenditure of time on services that are traditionally not covered as a billable service by Medicare, such as non-visit-based care or enhanced behavioral health services. Additionally, the billable services that are covered by Medicare tend to reward the provision of high-volume services rather than services that have the biggest impact on reducing unnecessary utilization or improving the quality of care. Therefore, MDPCP transitions primary care payments towards reimbursement that is based on the number of attributed patients and not on the number of services provided.

1. Care Management Fees

CMS provides participating MDPCP practices a monthly care management fee for each beneficiary attributed to a participating practice. The amount of the care management fees depends on two factors: 1) the track that the practice participates in; and 2) the "risk" level of the attributed beneficiary.

Participating practices are divided into two tracks. Track 1 practices are required to meet a minimum standard of advanced primary care and are expected to progressively increase their level of sophistication within the advanced primary care functional areas, eventually transitioning to another track. Track 1 practices are allowed up to three years in the program to meet the advanced care requirements and transition to Track 2. Track 1 practices that do not make this transition in three years are eliminated from

[4] CMS recognized CareFirst as an alignment payer beginning in January 2020. https://innovation.cms.gov/innovation-models/md-tccm
[5] Quality measures focus on diabetes control, hypertension control, BMI assessment and follow-up, and depression assessment and follow-up.

MDPCP. Track 2 practices provide a higher level advanced primary care. Due to the higher level of services provided by the Track 2 practices, they receive a higher care management fee amount.

The amount of the care management fees also increases based on the “risk” of the beneficiary. Risk is measured by the CMS hierarchical clinical conditions (HCC) algorithm, which assigns a risk score based on the age of the beneficiary and on the number of chronic conditions that beneficiary has. The risk score measures both the expected cost of the beneficiary over the course of a year and the complexity of managing that beneficiary’s care. Beneficiaries with more chronic conditions receive a higher care management fee, based on the assumption that they require more care management services.

Table 2 below shows the amount of the monthly care management fees paid to the practices for each attributed beneficiary, according to the beneficiaries’ risk tier.

Table 2: Care Management Fees by Beneficiary Risk Tier

Risk Tier	Criteria	Track 1	Track 2
Tier 1	01-24% HCC	$6	$9
Tier 2	25-49% HCC	$8	$11
Tier 3	50-74% HCC	$16	$19
Tier 4	75-89% HCC	$30	$33
Complex	90+% HCC or persistent and severe mental illness, substance use disorder or dementia	$50	$100

2. Performance-Based Incentive Payments

MDPCP also includes a Performance-Based Incentive Payment (PBIP) that is designed to encourage and reward accountability for beneficiary experience, clinical quality, and utilization measures that drive total cost of care. The maximum PBIP is $2.50 per beneficiary per month for a Track 1 practice and $4.00 per beneficiary per month for a Track 2 practice.

The PBIP is prepaid, meaning that CMS pays the full amount at the beginning of the annual performance period. Participating practices that meet annual performance thresholds retain all of the PBIP. The program recoups some or all of the PBIPs from practices that do not meet all annual performance thresholds. CMS believes that the potential loss of repaying the PBIP is a greater motivator than the possibility of earning an incentive payment.

3. Comprehensive Primary Care Payments for Track 2 Practices

MDPCP also includes a substantial transformation in the way that CMS pays primary care physicians. Practices in Track 2 receive a substantial portion (up to 60%) of their Medicare payments as a non-visit

based per beneficiary per month payment. CMS pays participating practices in a hybrid fashion: part of the payment is an upfront per-beneficiary per-month amount (PBPM) that is paid quarterly (the Comprehensive Primary Care Payment or CPCP), and part is a reduced fee-for-service (FFS) amount that is paid based on claims submission. This payment approach moves a portion of the primary care practices' revenue into value-based reimbursement in the form of a capitated payment. This allows practices to focus on providing the right care to their attributed beneficiaries rather than providing high volumes of services to obtain higher reimbursement. Track 1 practices receive regular Medicare fee-for-service payments and do not receive comprehensive primary care payments.

Management of the Maryland Primary Care Program

The Maryland Primary Care Program is run by CMS as part of the Total Cost of Care Model. To participate in the program, practices and CTOs must sign an MDPCP Participation Agreement with CMS. CMS attributes beneficiaries to MDPCP practices and monitors practice performance. CMS pays care management fees, Performance Based Incentive Payments, and comprehensive primary care payments. CMS also sets the metrics that determine program success and evaluate the program. If CMS determines that MDPCP is not achieving savings or improving health care quality, CMS has the authority to end the program.

The State, represented by the MDPCP Program Management Office (PMO), provides technical assistance to practices participating in MDPCP and represents the practices in discussions with CMS regarding the program. The PMO within the Maryland Department of Health (MDH) provides education and support to practices, including regular webinars focused on topics that are core to the MDPCP, staff training programs, and provider leadership academies in locations across the state. The PMO provides additional contractual support to practices including implementation of SBIRT to address the opioid epidemic, COVID-19 education, chronic disease technical assistance, and linkages to community partners. The PMO also provides data analysis tools for cost and utilization, Prevention Quality Indicator (PQI) data, and the Pre-AH Avoidable Hospitalizations tool that assists practices in identifying beneficiaries at high risk for hospitalization. Additionally, the PMO provided primary care providers with tools to response to the COVID-19 public health emergency, including the COVID Vulnerability Index (CVI), Point-of-Care tests, an online referral system for testing and monoclonal antibody referrals, guidance on COVID-19-related workflows, a series of 100 webinars, and vaccine preparation and ordering assistance.

The Maryland Health Care Commission (MHCC) convenes and staffs the Maryland Primary Care Program (MDPCP) Advisory Council, which provides recommendations to CMS regarding the structure and design of the Maryland Primary Care Program in the State's annual report to the Centers for Medicare and Medicaid Services on MDPCP.

The Maryland Health Services Cost Review Commission (HSCRC) is an independent state agency responsible for regulating the quality and cost of hospital services. The HSCRC administers the State's

TCOC Model and ensures that the State has met its financial obligations to the Medicare program, inclusive of both hospital and MDPCP costs.

For MDPCP to be successful, CMS, the MDH PMO, MHCC and HSCRC must work collaboratively to set policy, engage practices, and monitor results that have an impact on the State's overall TCOC Model performance.

HSCRC's Evaluation Approach

MDPCP is an important part of Maryland's efforts to transform its statewide healthcare delivery system. The program is also critically important to the success of the Total Cost of Care Model. As directed by the Committees, the HSCRC analyzed the impact of the MDPCP on both the Medicare total cost of care and inpatient utilization. To perform the analysis, HSCRC attributed Medicare beneficiaries to primary care practices in the State. The HSCRC then risk adjusted the population to ensure group of beneficiaries are comparable and used a difference-in-difference analysis to estimate the impact of the MDPCP. This approach is consistent with CMS's approach to evaluating the MDPCP as CMS also uses a difference-in-difference analysis.

Attribution

In the MDPCP program, CMS attributes beneficiaries to the primary care practices that are participating in the program. Beneficiaries were attributed to the primary care practice that provided the plurality of their primary care services. CMS does not release their attribution algorithms, so the HSCRC recreated the algorithm based on extensive technical documentation released by CMS. The HSCRC attributed beneficiaries to all primary care providers in the State. The HSCRC then divided the primary care providers into the MDPCP providers and a comparison group made up of all eligible providers who did not participate in MDPCP.

Risk-Adjustment

It is possible that differences in outcomes may be due to changes in the risk profile of the attributed beneficiaries. For example, if the rates of high-cost chronic conditions increase from one year to the next, then costs are also likely to grow substantially. Therefore, it is crucial to risk adjust the two populations. CMS' Hierarchical Condition Category (HCC) scores were developed to predict the total cost of care based on the number and complexity of chronic conditions. The HSCRC used the CMS-HCC scores to adjust the analysis to ensure an equivalent risk mix in the MDPCP population and the comparison group.

Difference-in-Difference Analysis

To measure the impact of MDPCP, HSCRC used a difference-in-difference analysis. Difference-in-difference analysis is an approach that compares the changes in outcomes over time between a population enrolled in a program (the treatment group) and a population that is not in a program (the comparison

group). For this evaluation HSCRC is comparing the MDPCP program with non-participating primary care practices in Maryland.

The difference-in-difference approach ensures that the impact of the MDPCP program is isolated from any exogenous impacts that affect both the MDPCP population and the non-MDPCP population. An example of an exogenous factor is the COVID-19 pandemic. The pandemic caused decreases in health utilization and costs fell for the entire population. The difference-in-difference analysis shows the impact of the MDPCP program after the impact of the pandemic and other exogenous factors has been removed.

A limitation of using non-participating practices as the comparison group is that there is potential selection bias between participating and non-participating practices—physician practices that choose to participate in MDPCP might be different from those that do not participate in some unknown way that impacts their relative costs. This selection bias may influence the results of this evaluation. From a scientific perspective, a better comparison group would be one with no selection bias. However, no such group exists in Maryland, as all primary care practices have the option to participate in MDPCP. In addition, the HSCRC does not have enough data on non-Maryland Medicare beneficiaries to construct an out-of-state comparison group. Thus, non-participating providers in Maryland are the best available comparison group for this analysis.[6]

Evaluation Results

As directed by the Committees, the HSCRC analyzed the impact that MDPCP had on the Medicare total cost of care and on inpatient utilization. Table 3 below shows the results of that analysis. The impact of the MDPCP program is shown in the 'Difference-in-Difference' row. Negative numbers indicate that MDPCP performed better than the comparison group and positive numbers indicate that MDPCP performed worse than the comparison group. The 2019 and the 2020 columns show the growth rate in those years. The 'Cumulative Trend' column shows the total impact of the program relative to 2018, the year before the program began.

The impact of the MDPCP on the total cost of care has been volatile. In 2019, total cost of care increased slightly while in 2020 total cost of care declined slightly. As shown in the cumulative trend column, MDPCP has resulted in a small cumulative reduction (about 0.5 percent) in total cost of care in the first two years of the program, even after accounting for the investment of additional payments made by CMS. In aggregate, savings due to MDPCP were approximately $16 million in 2020.

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[6] CMMI has contracted with Mathematica to conduct an evaluation of the TCOC Model – including the primary care program, Mathematica will use a difference-in-difference analysis to evaluate the impact of MDPCP. Mathematica may use a different comparison group in the difference-in-difference analysis that CMMI uses to evaluate MDPCP. The first CMS evaluation of the MDPCP will be available in 2022 or 2023.

While the impact on total cost of care has been inconsistent, the impact on inpatient utilization is clearer. The program has demonstrated a clear and growing reduction in hospital utilization. The cost savings generated from reduced hospital utilization by MDPCP have been partially offset by the care management fees paid to the primary care physicians, the savings have been sufficient to cover this additional investment in primary care .

Table 3: MDPCP Evaluation Results, 2019-2020

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

The HSCRC also analyzed the racial diversity of participation in MDPCP. The table below shows the demographics of the MDPCP Medicare beneficiary population compared with the demographics of the Statewide Medicare beneficiary population. As shown below, MDPCP is slightly less racially diverse than the overall Medicare population. There is a larger proportion of white beneficiaries and small proportion of other racial groups in MDPCP.

Table 4: Demographics of the MDPCP Medicare Population Compared to Statewide Medicare Beneficiary Population, 2020 year

	Statewide		MDPCP	
Asian	21,405	3%	6,036	2%
Black	190,989	25%	66,192	21%
Hispanic	10,361	1%	2,698	1%
White	519,462	67%	221,797	72%
Total	**777,808**	**100%**	**309,198**	**100%**

The HSCRC attempted to analyze the racial diversity of providers who participated in the MDPCP program but was unable to acquire accurate data because this data is not currently collected. Because of this, an accurate analysis of the racial makeup of MDPCP providers could not be included in this report.

Conclusion

The results of this study suggest that, in the first two years of operation, MDPCP has demonstrated a small amount of cost savings, even after accounting for investments. Given the year-to-year volatility in the growth rate more time will be needed to assess whether these results are due to statistical variation or a

meaningful program impact. However, the utilization reductions are significant and increased in magnitude in 2020. The MDPCP program increased payments to primary care practices by more than 10% for the purpose of establishing team-based care. The savings from lower utilization has been sufficient in 2020 to offset those additional payments. If the program continues to result in fewer hospitalizations, it is likely that cost savings will continue to grow.