
Centers for Medicare & Medicaid Services

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# Maryland Total Cost of Care Model

# Maryland Primary Care Program

# Request for Applications

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# Abstract

Strengthening primary care is critical to promoting health and reducing overall health care costs in Maryland. The Centers for Medicare & Medicaid Services (CMS) announced the Total Cost of Care (TCOC) Model (the "Model") on May 14, 2018. The Model is expected to begin on January 1, 2019. As part of the Model, CMS is offering primary care practices in the State of Maryland (the "State") the opportunity to participate in the Maryland Primary Care Program (MDPCP). Building on the Comprehensive Primary Care Plus (CPC+) Model, as well as input received in response to the 2015 Request for Information on Advanced Primary Care Model Concepts, CMS believes that the MDPCP can reduce costs and improve the quality of care for Maryland Medicare beneficiaries in a manner that is aligned with the goals of the Model.

Practices participating in the MDPCP ("Participant Practices") are expected to transform the way they deliver primary care in order to provide comprehensive care management and beneficiary-centered care. CMS will support primary care practices' transformation efforts by making payments for enhanced care management as well as performance-based payments to Participant Practices. All eligible primary care practices within the State are invited to apply to participate in the MDPCP. Additionally, CMS is accepting applications from entities that wish to participate in the initiative as a "Care Transformation Organization" (CTO), which, for the purposes of this Model, is defined as an entity that hires and manages an interdisciplinary care management team capable of furnishing an array of care coordination services to Maryland Medicare beneficiaries attributed to Participant Practices.

The MDPCP is expected to begin on January 1, 2019, and end on December 31, 2026. The initiative will have two Tracks for Participant Practices (Track 1 and Track 2), with increased care redesign expectations and payments for Participant Practices in Track 2. During the application process, practices may indicate a preference for one of the two Tracks. CMS will take this preference into account when considering the Track to which the Participant Practice will be assigned. However, after a practice is selected for participation in the MDPCP, CMS reserves the right to assign a practice to Track 1 based on CMS' assessment of the practice's readiness to meet the applicable care transformation requirements. Practices that are assigned to Track 1 are expected to transition along the continuum towards comprehensive primary care; as such, Participant Practices may spend no more than three Performance Years in Track 1 of the MDPCP. Participant Practices that continue participating in the MDPCP for four or more Performance Years must participate in Track 2 by no later than the beginning of their fourth year of participation in the MDPCP.

# MDPCP Overview

Under the authority of Section 1115A of the Social Security Act (the "Act"), CMS in consultation with the State has designed the MDPCP, a primary care delivery and payment redesign initiative within the Model. The MDPCP builds on the progress achieved under the Maryland All-Payer Model and helps health care providers in Maryland prepare for total cost of

care accountability.

The MDPCP aims to transform primary care in Maryland, increasing practitioners' capacity to provide comprehensive primary care. For the purposes of the Model, comprehensive primary care is defined as meeting the following five Comprehensive Primary Care Functions of Advanced Primary Care:

- Care Management
- Access and Continuity
- Planned Care for Health Outcomes
- Beneficiary and Caregiver Experience
- Comprehensiveness and Coordination Across the Continuum of Care

All Participant Practices must perform these five Comprehensive Primary Care Functions of Advanced Primary Care by meeting a set of care transformation requirements specific to each such function. On a quarterly basis, CMS will assess the status and progress of Participant Practices in meeting these care transformation requirements. CMS will also support Participant Practices in meeting the care transformation requirements via Learning Network activities. (Refer to the Section IV of this RFA for additional information regarding the CMS MDPCP Learning.)

To facilitate this care transformation, the MDPCP offers Track 2 Participant Practices Comprehensive Primary Care Payments (CPCP), which are intended to provide a more stable funding stream than the current fee-for-service (FFS) system. This enables Participant Practices to invest in the necessary care management and care coordination resources necessary for care transformation. The MDPCP also offers all Participant Practices a combination of prospective per-beneficiary per-month (PBPM) care management fees and at-risk PBPM performance-based incentive payments, which Participant Practices may use to fund investments in care management staff and activities not directly payable under the existing FFS payment system. These payments advance CMS' ongoing efforts to encourage participation in Alternative Payment Models (APMs).

As in CPC+, the MDPCP involves two Tracks: a Standard Track (Track 1) and an Advanced Track (Track 2). Each Track has its own care transformation requirements and corresponding payment options. Track 2/the Advanced Track requires more comprehensive practice transformation and provides Participant Practices increased payment amounts, relative to Track 1/the Standard Track, to effect this practice transformation.

CMS is also accepting applications from a new type of entity, a Care Transformation Organization (CTO). For purposes of the MDPCP, a CTO is defined as an entity that hires and manages an interdisciplinary care management team capable of furnishing an array of care coordination services to Maryland Medicare beneficiaries attributed to Participant Practices. The interdisciplinary care management team may furnish care coordination services such as:

pharmacist services, health and nutrition counseling services, behavioral health specialist services, referrals and linkages to social services, and support from health educators and Community Health Workers (CHWs). Many different types of entities may submit a CTO application, including health plans, Accountable Care Organizations (ACOs), managed service organizations (MSOs), Clinically Integrated Networks (CINs), hospitals, and other practice support organizations.

A CTO selected to participate in the MDPCP will be paid by CMS for the care coordination services that the CTO's interdisciplinary care management team furnishes to Medicare beneficiaries attributed to each Participant Practice with which the CTO has partnered. While Participant Practices are not required to partner with a CTO, a CTO participating in the MDPCP is required to deploy an interdisciplinary care management team at the request of any Participant Practice that has elected to partner with the CTO under the MDPCP. This deployment facilitates beneficiary access to care management services that might be hard for the practice to offer independently. In addition, a CTO facilitates a Participant Practice's care transformation by providing support for the improvement of the practice's process-of-care as part of the care coordination services furnished to the practices' attributed Medicare beneficiaries. CTOs are an important element of the MDPCP because they allow Participant Practices of all sizes to offer the types of specialized care management staff and processes to their attributed Medicare beneficiaries that can make a difference for those beneficiaries with chronic conditions.

## I. Eligibility and Participation

The MDPCP is open to eligible primary care practices and CTOs in the State. The application process will be staggered. The CTO application period will begin on June 8, 2018 and end on Jul7 23, 2018 at midnight. After this application period has concluded, CMS will publish a list of the CTOs that have been selected to participate in the MDPCP and that have signed a CTO Participation Agreement with CMS, together with information regarding each geographic area in which the CTO will deploy its interdisciplinary care management team (hereinafter referred to as the CTO's "geographic coverage area"). CTOs will indicate their geographic coverage area, comprised of a county or counties in Maryland, in their application. The practice application period will then begin August 1, 2018 and end August 31, 2018 at midnight. As part of the practice application process, practice applicants will select whether to partner with a participating CTO and, if applicable, will specify the CTO with which they wish to partner. While Participant Practices are not required to partner with a CTO, participating CTOs must partner with any practice that wishes to partner with them unless the CTO is unable to do so due to staffing limitations or because the practice is outside of the CTO's geographic coverage area. If a Participant Practice wishes to partner with a CTO that has reached capacity or for which the practice is outside the CTO's geographic coverage area, CMS will determine which CTO will be partnered with the practice based on which CTO the practice identified as its second choice in its application. If a CTO is at capacity due to staffing limitations, CMS will not require the CTO to partner with an additional practice, nor will the CTO be required to expand its geographic

coverage area.

Practices may also indicate a Track preference (Track 1 or Track 2) in their application, but CMS reserves the right to assign a practice to Track 1 based on CMS' assessment of the practice's readiness to meet the applicable care transformation requirements. However, if a practice were to select Track 1 in its application, it is unlikely that CMS would assign it to participate in Track 2. As discussed in the Section II, Part A of this RFA, practices that select or are assigned to Track 1 may remain a Track 1 practice for a maximum of three Performance Years; Participant Practices that continue to participate in the MDPCP for a fourth Performance Year must participate in Track 2 by no later than the beginning of their fourth year of participation in the MDPCP.

CMS will accept practice and CTO applications to the MDPCP annually, beginning with a 2018 application period for the 2019 Performance Year. Primary care practices and CTOs that do not apply during the initial application period or that are not selected to participate in the initial Performance Year may apply to participate in a future Performance Year. The last application period will occur in calendar year 2023 for the 2024 Performance Year.

Practices and CTOs that are accepted to participate in the MDPCP must sign a participation agreement in order to participate in the MDPCP. Each practice and CTO accepted to participate in the MDPCP will participate beginning on January 1 of the next Performance Year through the end of the final Performance Year of the MDPCP, unless their participation is sooner terminated. For instance, a practice that applies during the 2018 application period and is accepted to participate in Track 1 will participate in the MDPCP from January 1, 2019 until December 31, 2026. A practice selected to participate in Track 1 beginning in Performance Year 2019 must transition to Track 2 no later than the start of Performance Year 2022.

## A. Practice Eligibility

For purposes of the MDPCP, a practice is a group of one or more physicians, non-physician practitioners, or combination thereof that furnishes certain specified primary care services at a common location and bills for such services under a single Medicare-enrolled Taxpayer Identification Number (TIN). If the group is a legal entity that furnishes and bills for such primary care services at multiple locations (none of which is itself a legal entity), each location will be considered a separate practice for purposes of the MDPCP. Thus, a legal entity that operates multiple such practice sites must submit a separate application for each practice site, and the MDPCP activities at each participating practice site will be governed by separate participation agreements executed by CMS and the legal entity that operates those practice sites. Each applicant practice must identify in its application:

1) A single practice site address, located in Maryland, at which the practice and all of its participating practitioners furnish the specified primary care services for purposes of the MDPCP; and
2) A single TIN under which the practice bills for purposes of the MDPCP.

The applicant practice must also include in its application a proposed roster of National Provider Identifiers (NPIs) of eligible practitioners who furnish certain primary care services at the practice site address included in the application and wish to participate in the MDPCP (the "Practitioner Roster"). Primary care practitioners with a primary specialty code of General Practice (01), Family Medicine (08), Internal Medicine (11), Obstetrics and Gynecology (16), Pediatric Medicine (37), Geriatric Medicine (38), Nurse Practitioner (50), Clinical Nurse Specialist (89), Psychiatry (26) and Physician Assistant (97) are eligible. However, specialists with these primary specialty codes are not eligible to participate in the MDPCP and should not be included on an applicant practice's Practitioner Roster. Practitioners identified with a primary specialty code of Psychiatry (26) must be co-located with an eligible practitioner with a primary specialty code other than Psychiatry in order to participate in the MDPCP. All NPIs included on an applicant's Practitioner Roster must practice at the single practice site address identified on the application; however, not all physicians or other practitioners that practice at that site must be included on the applicant practice's Practitioner Roster. Those physicians or other practitioners at the practice site not included on the applicant practice's Practitioner Roster would not participate in the MDPCP. In addition to the Practitioner Roster, applicant practices must also submit a staff roster that includes any other persons who would conduct MDPCP activities at the practice site, including, but not limited to non-billing practitioners (e.g., RNs, medical assistants, and care managers).

In order to be eligible to participate in the MDPCP as a Participant Practice, the applicant practice must meet the following criteria:

1. The practice and all NPIs on the applicant's Practitioner Roster must be enrolled in Medicare;
2. The practice must maintain a minimum of 125 attributed Medicare FFS beneficiaries during each performance year, based on the attribution methodology described in Section III, Part A of this RFA;
3. The practice and all NPIs on the applicant's Practitioner Roster must submit Medicare FFS claims on a Medicare Physician/Supplier claim form (Form 837P or Form 1500) and be paid under the Medicare Physician Fee Schedule for office visits; and
4. The practice must meet additional requirements under the participation agreement entered into by the practice and CMS (the "Practice Participation Agreement").

Model participants will be subject to a program integrity screening. CMS may reject an application or terminate a participation agreement on the basis of the results of a program integrity screening.

### Practice Application Information

For reference, Practice application guidance and questions may be found in Appendix 1 of this RFA; however, to be considered for participation in the MDPCP, all practice applications must be completed using the online application referenced in Part 1, Section C of this RFA. The

application must be submitted by the legal entity (e.g., group practice) that operates at the practice site address. If the legal entity operates at multiple practice sites, the legal entity must submit a separate application for each practice site address that it wishes to participate in the MDPCP.

As outlined in Appendix 1, all practices must submit with their application a letter of support from a clinical leader within the practice demonstrating a commitment to the MDPCP and a willingness to provide leadership in support of the practice's participation in the program. If the practice is owned by a person, entity, or organization other than a clinical or other leader who practices at the single practice location identified in the application, or by a separate entity or healthcare organization, the practice must also submit a letter of support from the owner committing to segregate funds that are paid based on the practice site's participation in the MDPCP and assuring that all MDPCP payments will be used in a manner consistent with the MDPCP Practice Participation Agreement. Additionally, all practices must submit a letter executed by both the practice and an authorized representative of a Health Information Exchange (HIE). Such HIE must be capable of enabling the functions described herein, such as the Chesapeake Regional Information System for our Patients (CRISP). This letter should indicate a commitment to achieving the aims of bi-directional connectivity by the end of each practice's first year of participation as a Track 2 practice.

Practices and practitioners that currently participate in certain other CMS initiatives will be ineligible for concurrent participation in the MDPCP. Please reference Section IV, Part C of this RFA for additional information. Additionally, Rural Health Clinics and Federally Qualified Health Centers (FQHCs) are also not eligible to participate in the MDPCP.

Applicants that meet the practice eligibility requirements, successfully complete the practice application process, and can meet the applicable care transformation requirements will be selected to participate in the MDPCP as a Participant Practice. The legal entity that operates at the practice site address must sign a Practice Participation Agreement with CMS as a condition of the practice's participation in the MDPCP. If the same legal entity operates at multiple practice site addresses, it must sign a separate Practice Participation Agreement for each participating practice site address.

## B. Care Transformation Organization Eligibility

CMS is accepting applications from CTOs, which are a new type of legal entity in Maryland intended to support Participant Practices in the MDPCP. CMS is accepting CTO applications from organizations such as ACOs, MSOs, health plans, CINs, hospitals, and other practice support organizations. The CTO applicant may be the CTO itself (a separate legal entity) or may be the organization that owns and operates the CTO.

In order to be eligible to participate in MDPCP as a CTO, the organization must meet the following criteria:

1. The CTO and, if applicable, the healthcare organization that owns and operates the CTO, must pass a program integrity screening conducted by CMS; and
2. The CTO must meet additional requirements under the MDPCP CTO Participation Agreement (described in greater detail below).

### CTO Application Information

For reference, CTO application guidance and questions may be found in Appendix 2 of this RFA; however, to be considered for participation in the MDPCP, all CTO applications must be completed using the online application referenced in Section I.C of this RFA. Organizations submitting a CTO application must submit a letter of support from the CTO's leadership (e.g., CEO or medical director) demonstrating a commitment to the MDPCP and a willingness to provide leadership in support of the CTO's participation in the program, as well as a letter of support from a practice. More detailed descriptions of these letters are included in Appendix 2 of this RFA.

To be considered an eligible CTO, a CTO applicant must demonstrate the ability to support Participant Practices in performing the applicable care transformation requirements outlined in this RFA. CTO applicants will be asked to describe the care management services that they propose to furnish to Medicare beneficiaries attributed to Participant Practices. CMS will evaluate CTO applications based on each organization's or, if applicable, the organization's owner's/operator's history and capability of providing care management services. CMS may choose to consider the breadth and depth of services each CTO proposes to offer to ensure that participating CTOs offer a wide variety of services, as well as the organization's location to ensure that CTOs are geographically dispersed throughout the State.

Applicants that meet CTO eligibility requirements and successfully complete the CTO application process will be selected to participate in the MDPCP as a CTO participant. Selected CTOs or if the CTO is owned by another healthcare organization, the parent organization, must sign a participation agreement with CMS (the "CTO Participation Agreement") as a condition of participation in the MDPCP. The CTO Participation Agreement will outline certain governance requirements for the CTO, including representation from the Participant Practice(s) that have partnered with the CTO under the MDPCP on the CTO's governing body. CTOs will be given appropriate time to establish representation from partner Participant Practices on the governing body once they are partnered with their Participant Practices. Participating CTOs will also have financial accountability for quality and utilization metrics for the Medicare beneficiaries attributed to the practices with which they are partnered under the program. CTOs will also be required to maintain a roster of individuals that compose the CTO's interdisciplinary care management team (the "CTO Roster").

## C. Selection of Practices and CTOs

Both practice applicants and CTO applicants should apply online and are required to answer all of the questions in their respective online application. (For reference, the application questions

are also included in Appendix 1 and Appendix 2 of this RFA.) The CTO application may be found at https://app1.innovation.cms.gov/mdpcp and the practice application can be found at https://app1.innovation.cms.gov/mdprov/mdprovLogin.

CMS will assess each application to verify that the applicant meets the applicable eligibility requirements and can meet the applicable care transformation requirements. All practice and CTO applicants will be subject to a program integrity screening, which includes, if applicable, an assessment of the applicant's current status in the Medicare program by CMS' Center for Program Integrity (CPI). Additionally, applicants must disclose any sanctions, investigations, probations, actions or corrective action plans to which its practitioners, owners or managers, and/or other participating organizations, entities, or individuals are currently subject or have been subject at any point during the last five years. Further, applicants must not be in arrears in the payment of any obligations due and owing to the State or the federal government, including the payment of taxes and employee benefits. Participants must similarly not become in arrears during the term of their Practice Participation Agreement or CTO Participation Agreement, as applicable.

Given that CMS is testing primary care transformation across the entire State, CMS will accept into the MDPCP all applicant practices that meet the eligibility requirements and that CMS determines can meet the applicable care transformation requirements based on the contents of their application.

Practices and CTOs will be selected for participation in two separate rounds. CMS will first review CTO applications and select CTOs to participate in the MDPCP. Next, CMS will review practice applications and select Participant Practices. As part of their application, practice applicants may choose the CTO with which they would like to partner, if any. Practices and CTOs that submit applications during the 2018 application period, that are selected to participate in the MDPCP, and that sign a Practice Participation Agreement or CTO Participation Agreement with CMS (as applicable) are expected to begin participation in the MDPCP in January 2019. Practices and CTOs that do not apply during the 2018 application period or are not selected to participate in the MDPCP for the 2019 Performance Year may reapply in future years. The application itself is not a legally binding contract and does not require any applicant to sign a participation agreement with CMS, if selected.

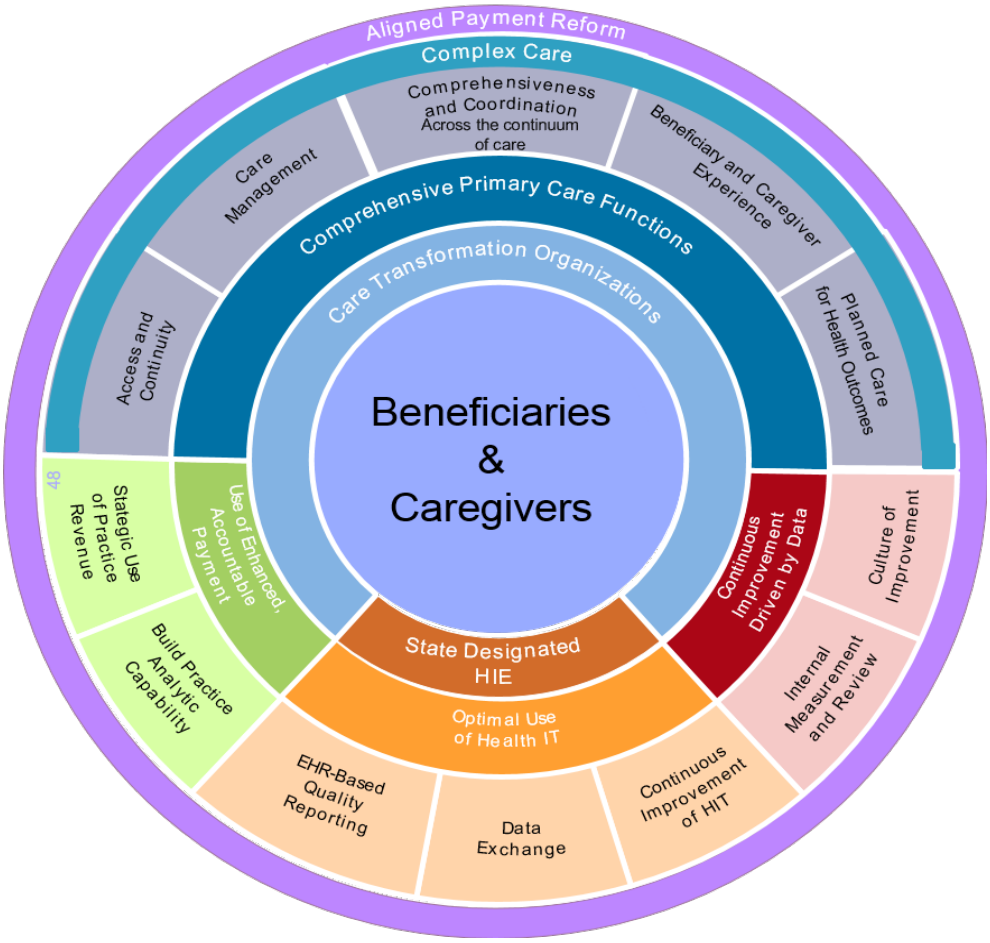
All determinations about whether to accept a practice or a CTO for participation in the MDPCP will be made by CMS at CMS' sole discretion and will not be subject to any administrative or judicial review, per Section 1115A(d)(2) of the Act.

## II. Theory of Care Transformation

By requiring Participant Practices to meet specific care transformation requirements and aligning Medicare payments accordingly, CMS and the State expect that Participant Practices will provide more comprehensive and continuous care. This will likely reduce beneficiaries' complications and overutilization of services in higher cost settings, which in turn should lead to

better quality and lower costs of care. An outline of the theory of action for both Tracks in the MDPCP and the broad overview of the initiative is visually represented by the driver diagram in Figure 1.

*Figure 1. MDPCP Driver Diagram*




The care delivery redesign that CMS and the State believe is necessary to produce the desired outcomes is the same across both Tracks of the MDPCP. The principles of this care redesign are anchored in CMS' new direction for the Innovation Center. The Innovation Center approaches new model design through certain guiding principles, including: choice and competition in the market, provider choice and incentives, patient-centered care, benefit design and price transparency, transparent model design and evaluation, and small scale testing.[1] Driver 1: The Five Comprehensive Primary Care Functions of Advanced Primary Care (the top half of the radial diagram, shown in light blue and grey above) is based upon principles akin to those that underpin CMS' other comprehensive primary care models. The underlying practice structures

[1] https://innovation.cms.gov/Files/x/newdirection-rfi.pdf

and processes required for practices to deliver these functions (shown in the lower half of the radial diagram above) are found in Driver 2: Use of Enhanced, Accountable Payment (shown in green), Driver 3: Continuous Improvement Driven by Data (shown in burgundy), and Driver 4: Optimal Use of Health IT (shown in orange) supported by connectivity to a Health Information Exchange (HIE) capable of carrying out the functions described herein. Participant Practices will be required to redesign the care they furnish to perform the five Comprehensive Primary Care Functions of Advanced Primary Care as an ongoing participation requirement in the MDPCP.

## A. Practice Care Transformation Requirements

While both Tracks of the MDPCP require Participant Practices to redesign the care they furnish in order to perform the same five Comprehensive Primary Care Functions of Advanced Primary Care, the intensity and scope of the underlying care transformation requirements differs from Track to Track. Track 1 Participant Practices will focus on visit-based care, while Track 2 Participant Practices will be asked to redesign both visit-based and non-visit-based care (e.g., phone, email, text message, and secure portal). More information on specific care transformation requirements for each Track will be provided by CMS in a guide entitled *Getting Started with the MDPCP*.

Participant Practices may remain in Track 1 for a maximum of three Performance Years; Participant Practices that continue to participate in the MDPCP for a fourth Performance Year must participate in Track 2 by the start of their fourth year of participation in the MDPCP. CMS will assess each Participant Practice's progress on the applicable care transformation requirements using measures obtained from quarterly practice surveys, on-site assessments, and other means. Practice surveys will ask Track 1 practices to indicate readiness for Track 2. By the beginning of the fourth calendar quarter of a Track 1 practice's third year of participation in MDPCP, the practice must have met all Track 1 care transformation requirements and attest to the practice's readiness to transition to Track 2. Track 1 practices that are unable to attest to their readiness to transition to Track 2 by the beginning of the fourth calendar quarter of their third year of participation in the MDPCP may not continue for a fourth Performance Year; CMS will terminate a Track 1 practice's Participation Agreement if the practice is unable to attest that it is ready to transition to Track 2.

CMS will require practices to perform primary care functions using a framework of care transformation requirements, which gradually increase in scope and intensity over the duration of the MDPCP with markers for regular, measureable progress towards the necessary practice capabilities. Practices will report their progress on the care transformation requirements regularly by responding to practice surveys through a secure web portal (the MDPCP Portal). CMS will support practices by making feedback reports available to use in care coordination, internal quality assessment, and care improvement activities.

The MDPCP includes certain changes to the Medicare FFS payment systems to help support Participant Practices in their efforts to meet the applicable care transformation requirements.

(See Section II, Part A of this RFA for more information.) CTOs will also be available to provide care coordination services to beneficiaries attributed to partner Participant Practices. CMS will also provide a Learning Network to help Participant Practices become accustomed to furnishing advanced primary care. (See Section IV, Part A of this RFA for more information on the MDPCP Learning Network.)

## Driver 1: The Five Comprehensive Primary Care Functions of Advanced Primary Care

The five Comprehensive Primary Care Functions of Advanced Primary Care described below serve as the primary drivers towards achieving the aims of the MDPCP. These functions represent a transformation towards the beneficiary-centered and team-based care delivered in the right place, at the right time, and in a manner that empowers beneficiaries. Below is a summary of each of the primary drivers as related to the care transformation requirements. For more detail on the specific practice care transformation requirements themselves please refer to the guide, *Getting Started with the MDPCP*.

### *1. Access and Continuity*

Effective primary care is built on the relationship between a beneficiary, his or her caregivers, and the team of professionals who provide care for the beneficiary. The foundation is a trusting, continuous relationship between beneficiaries, their caregivers, and the professionals who provide care management. Empanelment is a key ingredient in support of team-based care. Empanelment enables a Participant Practice to determine whether each practitioner and team has a reasonable balance between an attributed beneficiary's demand for care and the capacity to provide that care. Practices in both tracks must empanel (or assign) all attributed beneficiaries to a practitioner or care team so that every beneficiary has the opportunity to build a therapeutic relationship, and the practitioner and care team understand their population of attributed beneficiaries.

A CTO's interdisciplinary care management team may, at the partner practice's request, assist partner practices in meeting the care transformation requirements by providing care coordination services under the supervision of the attributed beneficiary's health care provider who practices at a partner Participant Practice. These care coordination services may be furnished at the Participant Practice's location or in the community, as appropriate.

### *2. Care Management*

Participant Practices will be required to provide care management for high-risk, high-need, and rising risk beneficiaries by integrating a care manager into practice operations. Participant Practices must risk stratify all empaneled beneficiaries as well as provide both longitudinal, relationship-based care management as well as episodic, goal-directed care management as appropriate to best improve outcomes for empaneled beneficiaries. To guide their care management efforts, Track 2 practices will be required to create care plans focused on goals and

strategies congruent with beneficiaries' choices and values.

CTOs must support their partner Participant Practices as part of the care coordination services provided to Medicare beneficiaries attributed to those practices.

### *3. Comprehensiveness and Coordination across the Continuum of Care*

Participant Practices will play an important role in helping attributed beneficiaries and caregivers navigate and coordinate care and services. Primary care practices often serve as the hub through which other health care providers coordinate care.

Comprehensive care will differ based on a beneficiary's needs. In order to meet the care transformation requirements, Participant Practices must use data to identify the hospitals and emergency departments (EDs) responsible for the majority of attributed beneficiaries' hospitalizations and ED visits in order to improve the timeliness of notification and information transfer. Participant Practices must also systematically identify high-volume and/or high-cost specialists serving the beneficiary population using data. Participant Practices in Track 2 will be required to strengthen their referral and/or co-management relationships with specialists and community and social services, ensuring comprehensiveness of service availability for their beneficiaries. Participant Practices will also work toward building capabilities to deliver and integrate behavioral health into care.

All Participant Practices must know where in the medical neighborhood their attributed beneficiaries receive care and should coordinate beneficiary care accordingly. Participant Practices in Track 2 will be required to complete an assessment of their attributed beneficiaries' health-related social needs and to conduct an inventory of resources and supports in the community to meet those needs. For purposes of this systematic assessment, Track 2 Participant Practices must utilize the health-related social needs screening tool developed for the CMS' Accountable Health Communities Model.[2]

Participant Practices must address opportunities to improve transitions of care for attributed beneficiaries, focusing on hospital and ED discharges, as well as post-acute care facility usage and interactions with specialists. Such a transformation will be an ongoing process.

In furnishing care coordination services to attributed beneficiaries, CTOs must, at the partner Participant Practice's request, assist in analyzing where beneficiaries receive care and how best to coordinate that care in the way that achieves the best outcomes. The care coordination services furnished by a partner CTO's interdisciplinary care management team must assist Participant Practices in meeting the care transformation requirements, at the Partner Practice's request.

[2] Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized screening for health-related social needs in clinical settings. The Accountable Health Communities Screening Tool. *Washington, DC: National Academy of Medicine*. Retrieved from https://nam.edu/wp-content/uploads/2017/05/ Standardized-Screening-for-Health-Related-Social-Needsin-Clinical-Settings.pdf.

### *4. Beneficiary and Caregiver Experience*

Even with the most proactive care service provision, beneficiaries and caregivers maintain a critical role in ensuring optimal care delivery. Participant Practices in both Tracks will be required to engage attributed beneficiaries and caregivers in designing and improving care processes using a Patient-Family/Caregiver Advisory Council (PFAC) and other similar strategies to incorporate beneficiary needs and preferences into their care redesign plans. To increase beneficiary engagement, the PFAC will work alongside Participant Practices to engage attributed beneficiaries in goal-setting and shared decision-making.

### *5. Planned Care for Health Outcomes*

Participant Practices in both Tracks will be required to develop an understanding of their attributed beneficiary populations and to respond to those needs accordingly, including to proactively offer timely and appropriate preventive care and reliable, evidence-based management of chronic conditions.

Participant Practices will develop and stage interventions to engage attributed beneficiaries *before* they require hospitalization. To successfully prevent avoidable hospitalizations, Participant Practices may leverage disease registries, staff such as health coaches and educators (including CHWs), and partnerships with the non-clinical community—all of which can help identify and address gaps in care for at-risk beneficiaries. Participant Practices will apply evidence-based protocols for screening, diagnosis, and treatment. Finally, Participant Practices will have the opportunity to request data and reports from Innovation Center and State data systems, in accordance with applicable law, and use the practice's own data to gain a full view of their attributed beneficiaries' utilization of services, quality of care, and total cost of care, to help identify performance improvement opportunities. The State will work to enhance the data Participant Practices receive for planned care and population health.

## Driver 2: Use of Enhanced, Accountable Payment

The five Comprehensive Primary Care Functions of Advanced Primary Care collectively serve as a primary driver toward achieving the aims of the MDPCP, but these changes in patterns of care require a corresponding change in payment. The MDPCP redesigns the Medicare FFS payments made to Participant Practices and CTOs to help them perform care transformation activities and deliver the Comprehensive Primary Care Functions of Advanced Primary Care. Specifically, CMS distributes care management fees (CMFs) to the Participant Practices and CTOs. CMFs can only be used as specified in the MDPCP Practice and CTO Participation Agreements to meet the care transformation requirements. Participant Practices will be required to project revenue and budget payment flows under the MDPCP and must report such projections and budgets, as well as actual expenditures and spending ratios, to CMS. CMS also distributes at-risk performance payments to both the Participant Practices and CTOs to increase accountability for meeting the goals of the MDPCP.

### Driver 3: Continuous Improvement Driven by Data

Participant Practices in both Tracks of the MDPCP will be required to reliably and systematically measure quality and utilization at the practice-level and practitioner- or care team-level. Participant Practices are generally expected to use the captured quality and utilization data to test and implement new workflows and to identify opportunities for continued improvement. Statewide performance dashboard tools will be made available to Participant Practices and CTOs by CMS.

### Driver 4: Optimal Use of Health IT

In both Tracks, Participant Practices will be required to use certified EHR technology (CEHRT) in accordance with the terms of the Practice Participation Agreement to ensure remote access to each attributed beneficiary's EHR for the practice's care team members. Participant Practices in both Tracks must report on electronic clinical quality measures (eCQMs) and generate quality reports, in accordance with the terms of the Practice Participation Agreement, both at the practice- and care team-level. Track 2 Participant Practices will also be required to implement enhanced health IT tools that support more comprehensive and coordinated care of attributed beneficiaries with complex medical needs.

To be eligible to participate in the MDPCP, a practice must submit a letter executed by both the practice and an HIE representative certifying the applicant's current level of connectivity to that HIE and its commitment to achieving the aims of bi-directional connectivity by the end of its first year as a Track 2 Participant Practice. For the purposes of the MDPCP, bi-directional connectivity is defined as the ability to send and receive clinical information about a practice's attributed beneficiaries to and from the HIE. This will increase and enhance the comprehensiveness of beneficiary data available to the health care providers who treat the attributed beneficiary.

## B. The CTO's Role in the MDPCP

The five Comprehensive Primary Care Functions of Advanced Primary Care require Participant Practices to become a hub for the coordination and management of their attributed beneficiaries' care across the delivery system. In the MDPCP, CTOs will be available to furnish care coordination services to Medicare beneficiaries attributed to partner Participant Practices, helping these practices meet the care transformation requirements under the MDPCP.

CTOs can leverage economies of scale and deploy resources that would be difficult or uneconomical for a partner Participant Practice to deploy by itself. CMS will make CMF payments directly to the CTO for care coordination services furnished by the CTO to attributed Medicare beneficiaries of partner Participant Practices performed to assist the partner Participant Practices in meeting the applicable care transformation requirements. These payments are described in detail in Section III, Part B.1 of this RFA. CTOs must spend CMF payments received from CMS under the MDPCP on care management professionals and support staff who

perform each of the five activities described in further detail in this RFA and the CTO Participation Agreement.

CTO activities are designed to help partner Participant Practices achieve the MDPCP's care transformation requirements. CTOs may not spend payments received from CMS under the MDPCP for performing care coordination or other services independent of the Participant Practices with which they are partnered under the program, nor to provide care coordination services to patients other than Medicare beneficiaries attributed to their partner Participant Practices. Further, CTOs are designed to help Participant Practices advance primary care under the MDPCP and not to support general practice operations such as billing, coding, or clinical work unrelated to the MDPCP. Therefore, CTOs are required to assist partner Participant Practices solely in meeting the care transformation requirements.

The following section describes CTO activities integral to helping partner Participant Practices meet the MDPCP's care transformation requirements. (More information about CMFs can be found in Section III, Part B.1 of this RFA.)

### Activity 1: Care Coordination Services

A CTO's care management staff may furnish care coordination services to Medicare beneficiaries attributed to partner Participant Practices. As part of meeting the care transformation requirements, a Participant Practice's attributed beneficiaries must be empaneled to a primary care practitioner who is a member of the Participant Practice and listed on the practice's Practitioner Roster (or to a care team of such practitioners). All care management staff deployed by the CTO are expected to provide services to the partner Participant Practice's attributed beneficiaries under the supervision of a practice-based primary care practitioner (in the case of an empaneled beneficiary, to the practitioner to whom the beneficiary has been empaneled). CTOs are not permitted to furnish care coordination services to Medicare beneficiaries attributed to partner Participant Practices under the MDPCP without the involvement of the practice's primary care practitioners.

The CTO must employ and manage an interdisciplinary care management team of health care providers, which may include nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (such as substance use disorder prevention and treatment providers), chiropractors, licensed complementary and alternative medicine practitioners, and physician assistants. Participant Practices may find that they lack the scale to economically deploy a full interdisciplinary care management team of this nature.[3] Thus, a CTO may share its care management staff across multiple Participant Practices, so that a full interdisciplinary care management team can economically furnish care management services to a greater number of Medicare beneficiaries attributed to each of the CTO's partner Participant Practices.

[3] Peikes, D. N., Reid, R. J., Day, T. J., Cornwell, D. D., Dale, S. B., Baron, R. J., ... & Shapiro, R. J. (2014). Staffing patterns of primary care practices in the comprehensive primary care initiative. *The Annals of Family Medicine, 12*(2), 142-149. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3948761/

### Activity 2: Support for Care Transitions

A CTO's interdisciplinary care management team must, upon request by the Participant Practice, provide support to attributed Medicare beneficiaries for periods of transitions in care and for 24-hour care management outside of the partner Participant Practice's physical office. Regardless of where the interdisciplinary care management team furnishes care coordination services to attributed Medicare beneficiaries, the interdisciplinary care management team is expected to coordinate with the partner Participant Practice's primary care practitioners by email and telephone and to operate under the practitioners' direction and control.

The increased emphasis on care management and coordination that occurs during transitions of care will extend the partner Participant Practice's ability to provide care coordination services, including onsite visits at a hospital, nursing home, or other institutional settings. CTOs must also, at the partner Participant Practice's request, assist in systematically identifying high-volume and/or high-cost specialists serving the attributed beneficiary population and develop common discharge and medication management plans to ensure that post-discharge care includes plans for practice-based care and medication management.

### Activity 3: Standardized Beneficiary Screening

As required to meet the care transformation requirements related to the Comprehensiveness and Coordination across the Continuum of Care Comprehensive Primary Care Function of Advanced Primary Care, all Participant Practices must risk-stratify their empaneled beneficiaries and each beneficiary attributed to a Track 2 practice must receive a standardized screening for health-related social needs using the health-related social needs screening tool developed for the CMS Accountable Health Communities Model.[4] Risk stratification and standardized screening will help to identify the need to refer beneficiaries to social service organizations, community-based organizations, and public health agencies. The CTO's interdisciplinary care management team may assist in performing this risk stratification and screening and may also refer attributed Medicare beneficiaries to community social service organizations, at the direction of a practitioner from the partner Participant Practice.

### Activity 4: Data Tools and Informatics

To participate in this model, Participant Practices must use CRISP or a similar product from another HIE that is capable of communicating with CRISP in accordance with the terms of the Practice Participation Agreement to ensure remote access to an attributed beneficiary's EHR for care team members, including those deployed by the CTO. The CTO will offer partner Participant Practices assistance in utilizing the common data and health IT systems in order to promote effective strategies for treatment planning and monitoring health outcomes between different health care providers and across multiple settings of care. We expect that this will lead to reductions in unnecessary resource use by avoiding duplication of services. Each practice will be expected to enter into a business associate agreement with its CTO and HIE and to share

[4] Billioux et al., 2017.

clinically meaningful data as permitted by applicable law across the delivery system.

### Activity 5: Practice Transformation Assistance

CTOs must assist partner Participant Practices in meeting the care transformation requirements in order to advance primary care delivery within their practice. A CTO may assist partner Participant Practices with workflow changes that could allow improved integration with care managers and other team members. CTOs will be available to provide care coordination services to Medicare beneficiaries attributed to partner Participant Practices and deploy resources in order to help these practices meet the applicable care transformation requirements under the MDPCP.

## III. Enhanced Financial Support and Accountability for Practices

CMS will support Participant Practices in performing the five Comprehensive Primary Care Functions of Advanced Primary Care through a series of payments that diverge from those made under the Medicare Physician Fee Schedule. For each Participant Practice, the amount of two such payments—the CMF and the at-risk Performance-Based Incentive Payment—is based on the number of Medicare beneficiaries attributed to that Participant Practice. For Track 2 Participant Practices, the MDPCP also involves a hybrid FFS payment that includes an increasing proportion of partially capitated payments. CMS expects that these capitated payments will allow Participant Practices greater flexibility to target their efforts towards those beneficiaries who exhibit the greatest need for care coordination services.

### A. Attribution of Beneficiaries

CMS will use an attribution methodology to identify the beneficiaries expected to be served by a Participant Practice. CMS will use Medicare claims filed during the prior 24 months to determine the Participant Practice to which beneficiaries will be attributed. For beneficiaries who have received Chronic Care Management (CCM) services, an Annual Wellness Visit, or a Welcome to Medicare Visit over the past 24 months, CMS intends to attribute beneficiaries to the Participant Practice that most recently billed for one of those services on the beneficiary's behalf. CMS intends to attribute all other beneficiaries to the Participant Practice of the primary care provider who billed for the plurality of their allowed primary care visits during the most recent 24-month period for which claims data are available. Dual eligible beneficiaries who are enrolled in Medicaid Chronic Health Homes are excluded from the MDPCP attribution and will not be attributed to a Participant Practice for purposes of the MDPCP.

Each Participant Practice will be responsible for the care management of the beneficiaries on its attribution list. CMS will make the attribution lists available to the Participant Practices prior to the start of each performance year. The Financial Methodology document will be made publically available to all practices on CMS' website and will provide further detail on current attribution and payment structure and will be updated yearly with any changes to those aforementioned items.

## B. Payments to Practices

CMS will distribute to Participant Practices up to three separate payment streams based on the number of attributed beneficiaries, performance, and other factors. These streams include CMFs, Performance-Based Incentive Payments, and Comprehensive Primary Care Payments.

### 1. Care Management Fees

CMS will pay Participant Practices in both Tracks a PBPM CMF for attributed Medicare FFS beneficiaries; attributed beneficiaries will not be required to pay cost-sharing on the CMF. Given the similarity between the care transformation requirements under the MDPCP and CCM services covered by Medicare FFS, Participant Practices in both Tracks will not be permitted to bill Medicare for CCM services furnished to attributed Medicare beneficiaries.

Table 1 illustrates the proposed CMF amounts and beneficiary risk tiers for the 2019 Performance Year. The CMF payment amounts for Track 2 practices are higher than those made to Track 1 practices given the increased scope and intensity of the care coordination requirements applicable to Track 2 practices. The CMF payment amount varies across the beneficiary risk tiers to reflect the increased resources required to target care management to attributed beneficiaries with more complex medical needs. Beneficiary risk will generally be based on CMS' hierarchical condition category (HCC) risk scores and claims data for diagnoses. Risk-tier cutoffs will be determined using a regional pool of Medicare FFS beneficiaries. There will be five beneficiary risk tiers, which includes a "Complex" tier for attributed beneficiaries either in the top 10 percent of HCC risk scores or with persistent and severe mental illness, substance use disorder, or dementia.

| *Table 1. Care Management Fee Amounts for 2019 Performance Year* | | | | |
|---|---|---|---|---|
| | **Track 1** | | **Track 2** | |
| Risk Tier | Criteria | PBPM CMF | Criteria | PBPM CMF |
| Tier 1 | 01-24% HCC | $6 | 01-24% HCC | $9 |
| Tier 2 | 25-49% HCC | $8 | 25-49% HCC | $11 |
| Tier 3 | 50-74% HCC | $16 | 50-74% HCC | $19 |
| Tier 4 | 75-89% HCC | $30 | 75-89% HCC | $33 |
| Complex | 90+% HCC or persistent and severe mental illness, substance use disorder or dementia | $50 | 90+% HCC or persistent and severe mental illness, substance use disorder, or dementia | $100 |

Participant Practices will receive significantly higher CMF payments from CMS for attributed beneficiaries who fall into the Complex risk tier to support the enhanced services required for beneficiaries with complex medical needs, who often also have high medical costs. Track 2 Participant Practices will receive a $100 PBPM CMF and Track 1 Participant Practices will receive a $50 PBPM CMF to reflect the complexity of care management for these beneficiaries. The Complex risk tier includes certain beneficiaries with behavioral health, mental health, and substance use conditions. Specifically, CMS will assign beneficiaries to the Complex risk tier who fall within the top 10 percent of the HCC scores, as well as beneficiaries who, according to Medicare claims, have persistent and severe mental illness, substance use disorder, or dementia. An analysis of attributed beneficiaries' HCC scores and diagnoses from the Comprehensive Primary Care initiative informed an estimate that approximately 14 percent of Participant Practices' attributed Medicare beneficiaries would be assigned to the Complex tier.

The CMF must be used to perform activities related to meeting the MDPCP's care transformation requirements (e.g., supporting and augmenting staffing, performing training, and supporting the care management of attributed Medicare beneficiaries). Participant Practices will decide how, specifically, to invest these payments based on their own clinical expertise, provided that they adhere to the terms of the Practice Participation Agreement in doing so.

CMS will monitor the use of CMF payments through the Participant Practices' submissions of budget projections and actual CMF expenditures. CMS will also monitor Participant Practices'

coding and HCC score changes closely throughout the duration of the MDPCP. If significant, unexpected, or irregular up-coding or changes in HCC scores are found to occur, CMS will adjust the CMF payment methodology in order to ensure the actuarial soundness of the MDPCP. CMS may also take remedial action against Participant Practices in accordance with the terms of the Practice Participation Agreement.

The CMF amount may be adjusted by CMS to enable the State to meet the Annual Savings Target in the Maryland Total Cost of Care Model Agreement. In accordance with the terms of the Practice Participation Agreement, CMS may revise the CMF payment amounts over the course of the MDPCP. In the event that CMS decides to make changes to the CMF payment methodology and/or adjust CMFs, CMS will notify Participant Practices of such changes prior to the quarter in which they take effect.

## 2. Performance-Based Incentive Payments

To encourage and reward accountability for beneficiary experience, clinical quality, and utilization measures that drive total cost of care, the MDPCP will include a Performance-Based Incentive Payment (PBIP). CMS will pay the annual PBIP prospectively, but Participant Practices may only retain the PBIP (in whole or in part) if they meet certain annual performance thresholds. Thus, Participant Practices will be at risk for the amounts prepaid, and practices will be required to repay any part or all of their PBIP depending on their performance. In accordance with applicable debt collection regulations, CMS may collect any PBIP owed by a Participant Practice by reducing payments that would otherwise be made to the Participant Practices, including ongoing FFS Medicare payments.

The PBIP will be broken into two distinct components, both paid prospectively:

(1) Incentives for performance on clinical quality/beneficiary experience measures; and

(2) Incentives for performance on certain utilization measures selected by CMS on the grounds that they drive total cost of care.

Participant Practices will receive larger upfront PBIPs in Track 2 than in Track 1, as outlined in Table 2. Participant Practices may retain all or a portion of these amounts, depending on their performance on the clinical quality/beneficiary experience and utilization components, as described in more detail in this section of the RFA. The final calculation methodology will be outlined in the Practice Participation Agreement so that practices more fully understand the payment mechanism prior to the start of the MDPCP.

*Table 2. Performance Year 2019 Performance-Based Incentive Payment Amounts by Track, Per Beneficiary, Per Month (PBPM)*

| Track | Utilization (PBPM) | Quality (PBPM) | Total (PBPM) |
|---|---|---|---|
| Track 1 | $1.25 | $1.25 | $2.50 |

| | | | |
|---|---|---|---|
| Track 2 | $2.00 | $2.00 | $4.00 |

CMS will make a single, annual PBIP to each Participant Practice. This payment includes the clinical quality/beneficiary experience and utilization components. In order to be eligible to retain any portion of the PBIP, the Participant Practice must successfully and completely report on nine eCQMs by the end of each performance year, as specified in the Practice Participation Agreement; however, practices are encouraged to report all 19 eCQM measures. For those Participant Practices that have successfully reported at least nine eCQM measures, the practice's performance on each measure will be assessed against Maryland's average benchmarks with adjustments to ensure Participant Practices continue to drive toward improving quality.

The amount of the PBIP retained by a Participant Practice at the end of each performance year will be based on the practice's performance on the clinical quality/beneficiary experience and utilization measures. CMS will score such performance using a continuous approach with a minimum score of 50 percent (below which a practice keeps none of the PBIP amount) and a maximum score of 80 percent (above which a practice keeps the entire PBIP amount). A 60 percent score results in the Participant Practice keeping 60 percent of its PBIP. However, a Participant Practice's ability to obtain the minimum clinical quality/beneficiary experience score will be an absolute prerequisite for a Participant Practice's ability to retain any portion of the PBIP, such that Participant Practices cannot retain the clinical quality/beneficiary experience-based or the utilization-based portion of their PBIP unless they obtain a minimum clinical quality/ beneficiary experience score of 50 percent. Further details from CMS regarding the PBIP calculation will be included in the Practice Participation Agreement.

The Participant Practice's performance on the quality/beneficiary experience component of the PBIP will be based on performance on eCQMs and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group Survey metrics, which are funded by the Agency for Healthcare Research and Quality (AHRQ). The Participant Practice's performance on the utilization component will be based on Medicare claims-based measures of inpatient admissions and ED visits, which are available in Healthcare Effectiveness Data and Information Set (HEDIS).

Quality will be prioritized over utilization. CMS reserves the right to revise the measures used to compute the PBIP in order to align with State-wide Population Health Goals under the TCOC Model. CMS will only add, revise, or drop measures after consultation with the Maryland Department of Health and other stakeholders. These measures will be revisited annually in conjunction with the State's proposals for Population Health Goals under the Model. Participant Practices will be made aware of any changes to the PBIP calculation methodology prior to the start of the performance year in which such changes are scheduled to take effect.

Participant Practices may concurrently participate in the MDPCP and be part of an ACO participating in the Medicare Shared Savings Program (Shared Savings Program) or the

Medicare ACO Track 1+ Model. However, if a Participant Practice is a dual-participant in the MDPCP and the Shared Savings Program or the Track 1+ Model, the MDPCP Participant Practice will not be eligible to receive the PBIP. Instead the total cost of care for the Participant Practice's attributed beneficiaries will be included in the expenditure calculations for the ACO under the Shared Savings Program or the Track 1+ Model. Such a Participant Practice will not be required to report quality scores through the MDPCP, but must take part in quality reporting through the ACO under the Shared Savings Program or Track 1+ Model.

### 3. Comprehensive Primary Care Payments for Track 2 Practices

Medicare FFS payments will remain unchanged for Participant Practices in Track 1. In Track 2, to support the flexible delivery of even more comprehensive and coordinated care, CMS will pay Participant Practices in a hybrid fashion: part upfront PBPM (paid quarterly) and part reduced FFS (paid based on claims submission).

This upfront PBPM payment is called the Comprehensive Primary Care Payment (CPCP) and is paid based on a Participant Practice's Medicare payments for Evaluation & Management (E&M) services. No beneficiary cost-sharing is owed on the CPCP; beneficiary cost-sharing amounts will be based on the full FFS payment amount prior to the proportional reduction to account for the CPCP. Medicare FFS payments for E&M services during the performance year are then reduced proportionately to account for the upfront CPCP.

A Participant Practice's payment options will change based on how long the Participant Practice has been participating in Track 2 of the program, as shown in Table 3. To allow Participant Practices to gain experience with this hybrid payment model, Track 2 Participant Practices may select a 10 percent upfront CPCP payment (with 90 percent of the applicable FFS payment) or a 25 percent upfront CPCP payment (with 75 percent of the applicable FFS payment) for their first year of participation in the MDPCP. Track 2 Participant Practices also have the option to select a payment option with a greater portion of their E&M revenues in the form of a CPCP (either 40 percent or 65 percent in the form of a CPCP). However, for any year after the first performance year, a Participant Practice may not choose an option with a lower CPCP percentage than they selected for a previous performance year. By the start of their fourth year of participation in the MDPCP (based on the year that they joined the program), Participant Practices in Track 1 must transition to Track 2 and thus must also choose one of the CPCP options by no later than the start of their fourth year of participation in the MDPCP.

The CPCP and reduced FFS payment will apply only to office E&M services billed by the Participant Practices and paid by Medicare. It is important to retain some unreduced FFS payments to protect beneficiary access as well as to incentivize the provision of certain services (such as vaccine administration). In an effort to recognize practice diversity, CMS will allow Participant Practices to accelerate to an increased percentage of payment in the form of the CPCP over the course of their participation in Track 2 of the MDPCP, as illustrated in Table 3.

| *Table 3. Comprehensive Primary Care Payment Options Available to Track 2 Participant Practices* | | | |
|---|---|---|---|
| | Yr1 in MDPCP **Track 2** | Yr2 in MDPCP **Track 2** | Yr3+ in MDPCP **Track 2** |
| Percent of E&M Revenues through CPCP versus Percent of E&M Revenues through FFS | 10% / 90% | N/A | N/A |
| | 25% / 75% | 25% / 75% | N/A |
| | 40% / 60% | 40% / 60% | 40% / 60% |
| | 65% / 35% | 65% / 35% | 65% / 35% |

When both the upfront CPCP and reduced FFS payments are taken together, the payment structure is designed to increase Medicare FFS revenue by between 4 - 6.5 percent over a Participant Practice's historical level, not including CMF payments and PBIPs. An increase of 6.5 percent is expected for Participant Practices that choose the 65 percent upfront CPCP option, while a 4 percent increase in such revenue is expected for those that choose the 40 percent upfront CPCP option.

CMS will conduct a reconciliation based only on E&M services furnished by practitioners not on the practice's Practitioner Roster to attributed Medicare beneficiaries. Under this partial reconciliation construct, CMS presumes that beneficiaries unsatisfied with the care they receive from practitioners on a Participant Practice's roster are more likely to receive primary care services from other practitioners. Thus, increases in E&M services delivered by practitioners other than those on the Participant Practice's Practitioner Roster to practice-attributed beneficiaries would lead to a partial recoupment of the CPCP from a Participant Practice. Conversely, significant decreases in E&M services delivered by practitioners other than those on the Participant Practice's Practitioner Roster could lead to an additional CPCP payment to a Participant Practice. This type of partial reconciliation would protect CMS from spending significantly more on E&M services across all primary care practices in Maryland.

## C. Partnerships between Practices and CTOs

Under the MDPCP, Participant Practices will be allowed to partner with participating CTOs. CMS will announce a list of CTOs selected to participate in the MDPCP that have signed a CTO Participation Agreement with CMS prior to selecting practices to participate in the MDPCP. Applicant practices may identify a first and second choice of the participating CTOs to partner with during the practice application process. CTOs will indicate their geographic coverage area, comprised of a county or counties in Maryland, in their application. While practices are not required to partner with a CTO, participating CTOs must

partner with any practice that wishes to partner with them unless the CTO is unable to due to staffing limitations or because the practice is outside of the CTO's geographic coverage area. If a practice wishes to partner with a CTO that has reached capacity and/or if the practice is outside of the CTO's geographic coverage area, CMS will make a determination as to which CTO may partner with the practice. Each year, at a time and in a manner specified by CMS, practices may request to switch CTOs or choose not to partner with any CTO.

CMS expects that Medicare beneficiaries attributed to a Participant Practice will receive the same types of care management services regardless of the CTO partnership status of the Participant Practice to which they have been attributed. Similarly, all Participant Practices will be required to meet the same five Comprehensive Primary Care Functions of Advanced Primary Care regardless of whether the Participant Practice has partnered with a CTO. In each instance the Participant Practice remains responsible for meeting the applicable care transformation requirements. Failure to meet these care transformation requirements may result in remedial action or termination of a Participant Practice's Participation Agreement, regardless of whether the Participant Practice has partnered with a CTO.

If a Participant Practice partners with a CTO, CMS will make a CMF payment to the partner CTO. CMS will pay the CTO the CMF payment directly and will reduce monthly CMF payments to the CTO's partner practice(s) by a corresponding amount. The overall CMF amount paid by CMS to both the practice and the CTO will be based on the number of Medicare beneficiaries attributed to the Participant Practice.

Each Participant Practice that chooses to partner with a CTO may choose one of two CTO payment options described in this section of the RFA. Under both CTO payment options, CTOs must hire care management professionals and deploy them at the direction of the partner Participant Practice and in accordance with the Practice Participation Agreement and CTO Participation Agreement. Care management professionals may spend part of their time furnishing services to Medicare beneficiaries attributed to each of the CTO's partner Participant Practices, as the primary purpose of the CTO's participation in the MDPCP is to support Participant Practices who may not be able to provide additional resources full-time. The CTO must deploy interdisciplinary care management teams and is expected to develop strong linkages with behavioral health providers. In supporting the CTO's partner Participant Practices in meeting the care transformation requirements, the CTO must focus on building an interdisciplinary care management team to furnish care coordination services to Medicare beneficiaries attributed to Participant Practices.

Under both CTO payment options, a Participant Practice must also use quarterly practice surveys (in the MDPCP Portal) to demonstrate its progress toward meeting the applicable care transformation requirements with the support of a CTO. The CTO must support partner Participant Practices in fulfilling the care transformation requirements by performing the activities applicable to the CTO payment option selected by the partner Participant Practice and demonstrate its progress in performing these activities through quarterly surveys.

### 1. CTO Payment Option 1

The CTO will receive 50 percent of the CMF payment; the remaining 50 percent of the CMF will be paid to

the partner Participant Practice. Under Option 1, the CTO will provide each partner Participant Practice with at least one Lead Care Manager for every 1000 attributed Medicare FFS beneficiaries. The Lead Care Manager is defined as an individual who is fully dedicated to care management functions of the Participant Practice under the MDPCP. Under Option 1, the Lead Care Manager must be a full-time employee (FTE) of the CTO. The Lead Care Manager must work with practice-based practitioners who have primary responsibility for care management of all beneficiaries attributed to the practice. The CTO may provide additional care managers as necessary to fulfill specialized care management needs that the practice may have.

### 2. CTO Payment Option 2

The CTO will receive 30 percent of the CMF; the remaining 70 percent of the CMF payment will be paid to the partner Participant Practice. Under Option 2, the partner Participant Practice has its own Lead Care Manager for every 1000 attributed Medicare FFS beneficiaries, so the CTO does not need to deploy a Lead Care Manager to the practice. However, the CTO will provide the practice with access to an interdisciplinary care management team. The CTO's interdisciplinary care management team will supplement the Lead Care Manager who is employed by the practice.

## D. Use of Funds by CTOs

At the heart of the MDPCP is an interdisciplinary care management team centered on the needs of the beneficiary. During the CTO's first Performance Year, CTOs will be required to spend at least 50 percent of their CMF payments on deploying care management professionals. The remaining 50 percent of the CTO's CMF payments must be used only to support the CTO's partner Participant Practices in meeting the care transformation requirements and in accordance with the CTO Participation Agreement. Beginning in the CTO's second Performance Year, CTOs will be required to spend more than the majority of their CMF payments on deploying care management professionals. This adjustment will help ensure that comprehensive primary care is being furnished to beneficiaries attributed to partner Participant Practices. The main difference between a CTO's first Performance Year and subsequent Performance Years is the percentage of the CMF that must be used to deploy care management professionals, as opposed to other activities in support of the Participant Practices. The specific percentage of the CTO's CMFs that must be spent on deploying care management professionals will be determined by CMS in advance of each Performance Year. CTOs will be required to report to CMS their CMF expenditures and spending ratios to assist CMS to determine appropriate CMF spending limitations, ratios, and requirements for CTOs in future performance years.

For the purposes of a CTO's spending limitations, a care management professional is anyone who meets the definition of "auxiliary personnel" as defined at 42 CFR § 410.26(a)(1). Care management professionals do not include administrative staff, data analysts, or consultants. This requirement that a CTO spend a certain portion of the CMF payments received from CMS on deploying care management professionals does not prohibit a CTO from spending additional funds from another source on infrastructure, IT systems, or overhead necessary for the CTO to assist its partner Participant Practices in meeting the care transformation

requirements. The limitations on the use of CMF payments will be further specified in the CTO Participation Agreement, with additional guidance in *Getting Started with the MDPCP*.

### E. Accountable Payments for CTOs

CMS intends to hold CTOs accountable for their performance through a CTO-specific Performance-Based Incentive Payment (CTO PBIP) that is separate from the Participant Practices' PBIP. (Participant Practices that choose to partner with a CTO will receive their full at-risk PBIP from CMS, as long as those Practices are not concurrently participating in a Shared Savings Program ACO or Track 1+ Model ACO). CMS will pay a CTO an at-risk PBIP in the amount of $4 PBPM based on the number of Medicare beneficiaries attributed to the CTO's partner Participant Practices. CMS will pay the CTO PBIP prospectively, but will require the CTO to repay any part or all of their PBIP based on the CTO's performance on the quality and utilization performance measures. The CTO will thus be at risk for the CTO PBIP amounts prepaid.

The CTO's performance for purposes of the CTO PBIP will be calculated using the same PBIP measures and calculation methodology applied to practices. However, the CTO's performance will be calculated indirectly based on aggregated clinical quality/beneficiary experience outcomes and utilization measures from all of the CTO's partner Participant Practices. The applicable subset of measures will be identified in the CTO Participation Agreement. Using performance measures from the CTO's partner Participant Practices to determine whether CMS will recoup all or a portion of a CTO's PBIP creates an incentive for the CTO to help its partner Participant Practices succeed under the MDPCP. As discussed in Section III, Part B of this RFA, CMS reserves the right, after consultation with the State and relevant stakeholders, to revise the quality measures used to compute the PBIP in order to align with the Population Health Goals under the Model.

CMS further also reserves the right to add additional population health measures to the PBIP calculation methodology for CTOs that align with the State's Population Health Goals but differ from the measures used to calculate the PBIP for Participant Practices. For instance, CMS may hold Participant Practices accountable for process and outcome measures and hold CTOs accountable for outcomes measures at a broader geographic level. Any changes in the population health measures or methodology for the CTO PBIP will be made available to CTOs prior to the performance year in which such changes would take effect.

## IV. Additional Supports and Information for Participant Practices

Participant Practices will have access to the MDPCP Portal, a website through which CMS will make assessment and feedback reports available to Participant Practices so they can understand their progress in building the capabilities required to deliver comprehensive primary care. CMS will also provide important program information through the MDPCP Portal, including a list of the practice's attributed beneficiaries and the payment amounts that the practice will receive. Additionally, CMS will make data reports and quarterly performance reports for the PBIP available upon request in accordance with applicable law through the MDPCP Portal. Practices that participate in the MDPCP can expect a robust set of supports, including:

- Electronic MDPCP Portal:
    - Assessment and feedback reports
    - List of attributed Medicare beneficiaries
    - Prospective payment amounts based on number of attributed Medicare beneficiaries (CMF and PBIP)
    - Medicare claims data on attributed Medicare beneficiaries (if requested by the practice)
    - Quarterly performance reports – quality/beneficiary experience and utilization measures
- Learning Network:
    - Practice coaching
    - Connections to learning forums and to other Participant Practices in the State
    - Networking with other Participant Practices and CTOs
    - Getting Started with the MDPCP
    - Affinity and Action Groups

## A. The MDPCP Learning Network

The MDPCP will include a robust Learning Network to support Participant Practices in meeting their care transformation requirements. All Participant Practices and CTOs may participate in the MDPCP Learning Network. The MDPCP Learning Network will bring Participant Practices and CTOs together to facilitate peer-to-peer learning and to provide opportunities for sharing lessons learned and best practices.

The Learning Network will be comprised of both Participant Practice Networks and CTO Networks. While some learning activities and resources will be designed for the entire Learning Network, other learning activities will be designed specifically for Participant Practices or CTOs.

The Learning Network has a specific set of goals:

1. **Provide ongoing learning support to Participant Practices and CTOs** on the five Comprehensive Primary Care Functions of Advanced Primary Care, eligibility requirements, and requirements for participation in the MDPCP.
2. **Provide benchmarks and track progress in the development of Participant Practice capability** to deliver comprehensive and advanced primary care through the MDPCP care transformation requirements.
3. **Provide rapid data feedback** to requesting Participant Practices on cost and utilization, quality, beneficiary experience of care, and practice transformation; and to facilitate Participant Practice use of feedback reports, eCQMs, CAHPS Clinical & Group Survey data, and data from Participant Practices reported to CMS. Also, provide feedback to CMS on structural and process changes in Participant Practices, the specific tactics employed by these practices to achieve the MDPCP's aims, and critical practice needs, so as to guide adjustments in learning and

adjustments in CMS processes for testing, evaluating, and monitoring of the MDPCP.

4. **Network Participant Practices and CTOs** across the State to foster peer-to-peer learning and innovation and to create communities of Participant Practices and CTOs. Participant Practices and CTOs will also have access to a CMS-developed web-based Connect site for robust online collaboration and sharing among Participant Practices, within and across Tracks.
5. **Coach and facilitate Participant Practices** to support the building and use of the capabilities required to improve care, improve health outcomes, and reduce total cost of care.
6. **Identify exemplary Participant Practices and best practices** to highlight useful strategies in comprehensive primary care and to encourage adoption by other Participant Practices.
7. **Collaborate in the State environment** to leverage health IT and data capabilities, and to join efforts to build community and stakeholder engagement, all in an effort to support Participant Practices in delivering comprehensive and advanced primary care.

To drive change among Participant Practices, the Learning Network will convene learning activities such as webinars, learning sessions, affinity groups, and action groups that bring together groups of Participant Practices and CTOs working on similar process changes. The MDPCP Learning Network will provide orientation to MDPCP operational requirements and to the logic and purpose of the key drivers, change concepts, and specific tactics in the delivery of comprehensive primary care through webinars and regular communication, including hypothetical case studies and briefs that spotlight specific practice tactics. Each Participant Practice will identify an individual who will function within the practice, or within a group of practices, as a Practice Lead to facilitate practice change. This approach will enhance ownership at the practice level for practice change. The Learning Network will be informed by Participant Practices and CTOs to move both groups toward success in the MDPCP.

## B. Data Sharing

In the MDPCP, CMS will offer Participant Practices the opportunity to request regular data feedback to help inform their care transformation efforts. CMS will aim to provide requested Medicare FFS cost and utilization data in a clear, actionable way. Participant Practices will also report quality metrics for purposes of the PBIP. Participant Practices will submit eCQMs to the State, which will in turn provide that information to CMS.

CMS will offer Participant Practices the opportunity to request practice-level and certain beneficiary-level Medicare beneficiary data (Parts A and B claims) for use in care management and other clinical activities. CMS will provide Participant Practices that request such data with quarterly practice-level feedback reports. The reports will summarize Medicare FFS cost and utilization, as well as provide beneficiary-level lists of ED visits, hospitalizations, and other high-cost services (e.g., imaging) used during the previous calendar quarter. CMS will also offer reports of cost and quality data about subspecialists to help Participant Practices select cost-effective specialty partners.

All data sharing and data analytics in the MDPCP will comply with applicable law, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[5], as amended. Medicare beneficiaries may opt out of CMS providing this form of data sharing in response to a Participant Practice's request.

## C. Concurrent Participation in Other CMS Initiatives

Participant Practices may participate in both the MDPCP and other CMS initiatives (including, without limitation, the Accountable Health Communities Model and the Medicare Diabetes Prevention Program Expanded Model), with the exception of those initiatives that would require participating health care providers to appear on a Participation List or an Affiliated Practitioner List as those terms are defined for purposes of the Quality Payment Program. For example, in the Next Generation ACO Model, each participating ACO is required to submit a list of Medicare providers and suppliers that are part of that ACO. As a result, health care providers may not participate in a Next Generation ACO and be part of a Participant Practice in the MDPCP.

There are two exceptions to this rule:

1. **Medicare Shared Savings Program and Track 1+ Model.** Primary care practices may participate concurrently in the MDPCP and in Tracks 1, 2, or 3 of the Shared Savings Program, the Track 1+ Model, or successor initiatives and Tracks. Practices participating in the Shared Savings Program, the Track 1+ Model, or successor initiatives and Tracks can participate in either Track of the MDPCP. However, practices within an ACO that is participating in the ACO Investment Model (AIM), Next Generation ACO Model, or any other shared savings initiative may not participate in the MDPCP.
2. **Care Redesign Program.** Primary care physicians participating in the Care Redesign Program (CRP) as a Care Partner for one or more CRP participant hospitals may be eligible to participate concurrently in the MDPCP. Each CRP Track has a specific set of Care Partner Qualifications that limit what types of providers and suppliers may participate as Care Partners for that Track, and such qualifications may prohibit practitioners from participating concurrently in the MDPCP. Any such prohibitions will be identified in the CRP Track's Care Partner Qualifications set forth in the Track Implementation Protocol. CMS retains the right to establish and amend the Care Partner Qualifications for each CRP Track and prohibit certain types of providers and suppliers from participating as Care Partners in the CRP.

## D. The Quality Payment Program

Under the Quality Payment Program, both components of the Model (which includes a hospital payment Track and both Track 1 and Track 2 of the MDPCP Track) qualify as Advanced Alternative Payment Models (Advanced APMs). Track 1 and Track 2 of the MDPCP meet the criteria to be Advanced APMs.

[5] Public Law 104–191, 110 Stat. 1936

The financial risk standards applied in making this determination with respect to the MDPCP Track are the financial risk and nominal amount standards specific to medical home models. These financial risk and nominal amount standards apply only to APM entities that are owned and operated by an organization with fewer than 50 eligible clinicians whose Medicare billing rights have been reassigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities.

The APM entity under the MDPCP Tracks of the Model is the Participant Practice. Thus, only eligible clinicians who are on the Participation List (Practitioner Roster) of a Participant Practice with fewer than 50 eligible clinicians will be considered to participate in an Advanced APM. For Quality Payment Program payment years 2019 through 2024, those eligible clinicians who meet the qualifying APM participant (QP) threshold based on sufficient participation in the MDPCP are excluded from the Merit-based Incentive Payment System (MIPS) reporting requirements and payment adjustments and qualify for a 5 percent APM incentive payment. For Participant Practices that exceed the 50 eligible clinician limit for the medical home standard, practitioners cannot qualify for a 5 percent APM incentive payment through the MDPCP. Practitioners in these practices are subject to the MIPS reporting requirements and payment adjustment unless they are otherwise excluded. The MDPCP is a MIPS APM, and the APM scoring standard will apply for any MIPS eligible clinicians in the practice.

Tracks 2 and 3 of the Shared Savings Program and the Track 1+ Model are also Advanced APMs. Primary care practices concurrently participating in the MDPCP and a Shared Savings Program ACO, Track 1+ Model ACO, or an ACO participating in a successor initiative or Track will forego the MDPCP prospectively paid, retrospectively reconciled PBIP, and instead will participate in the ACO's shared savings/shared losses arrangement. Determinations about the APM incentive will be based upon the track of the Shared Savings Program or Track 1+ Model in which they participate. More information about the Quality Payment Program is available at https://qpp.cms.gov/.

# V. Requirements and Reporting

Participant Practices and CTOs will be required under their respective Participation Agreements to report certain operational data as well as other information to CMS through the MDPCP Portal. Reporting by Participant Practices and CTOs allows CMS to track progress on the relevant program requirements and to understand the practice's and CTO's capabilities. The Participant Practice will also be required to report on the quality of care it provides.

## A. Care Transformation Requirements

Participant Practices must meet the applicable care transformation requirements related to the five Comprehensive Primary Care Functions of Advanced Primary Care. These requirements may change over the course of the MDPCP. CMS will notify participants of any such changes to the care transformation requirements at least one calendar quarter prior to the start of the performance year in which such changes would take effect. A guide, *Getting Started with the MDPCP*, will be released by CMS that provides detailed instructions on how to meet and report practice care transformation requirements. This will be made available to Participant Practices and CTOs annually.

Both Participant Practices and CTOs will be required to fill out quarterly surveys through the MDPCP Portal in order to demonstrate that Participant Practices have successfully met the applicable care transformation requirements. CMS will also use surveys through the MDPCP Portal to collect other programmatic information, including regarding the anticipated use of any CMFs paid to Participant Practices and CTOs. Failure to complete the surveys may result in remedial action or in termination from the MDPCP.

As discussed previously, a Participant Practice may spend the CMF received from CMS on any of the five Comprehensive Primary Care Functions of Advanced Primary Care, but the practice will be required to provide an annual report on how the funds were spent. For a CTO, all CMF payments received from CMS must be spent on deploying care management professionals and to assist partner Participant Practices in meeting their care transformation requirements. Use of the PBIP by both Participant Practices and CTOs, and of CPCP payments by Track 2 Participant Practices, will not be restricted under the terms of the Practice Participation Agreement or CTO Participation Agreement.

## B. Quality Reporting

The MDPCP includes a robust quality strategy to ensure that the program meets its goal of improving care for Maryland's Medicare beneficiaries. CMS will use eCQMs, patient-reported outcome measures (PROMs), and utilization measures to track beneficiary experience and the quality and cost of care; to identify gaps in care; and to focus quality improvement activities. High quality of care, quality improvement, or both, will also be rewarded with a PBIP, as outlined in Section III of this RFA.

Participant Practices in both Track 1 and Track 2 will be required to report annually on the practice-level eCQMs listed in Appendix 3 of this RFA. The current list, which mirrors the list used under the CPC+ Model for 2018, may be updated to include a subset of the eCQMs included in the 2018 Quality Payment Program final rule for use in the MIPS. The final measure list for Performance Year 2019 will be communicated to practices and CTOs selected to participate in the MDPCP in advance of the start of that Performance Year (January 1, 2019). Participant Practices will be required to report at least 9 eCQMs, but will be encouraged to report all 19 eCQM measures. The eCQMs, utilization measures, and beneficiary experience of care measures will be included in the computation of the PBIP.

In addition, Participant Practices are required to do the following:

- Use a 2014 or later edition certified EHR technology, with a commitment to transition to a 2015 or later edition certified EHR technology. This requirement may be updated to be consistent with future Quality Payment Program requirements;
- Achieve bi-directional connectivity with an HIE by the end of the practice's first year of participation in Track 2 of the MDPCP; and
- Use a quality reporting tool to enable Participant Practices to electronically report eCQMs.

CMS may update the quality measures that Participant Practices must report for future performance years. CMS will rely on the State to solicit feedback from stakeholders on which measures will be included in the

MDPCP. In the future, CMS also intends to incorporate a small set of population health measures into the PBIP calculation methodology that broadly represent the focus of the Model, which includes an aim for large, long-term impacts on population health. These measures will serve as a guiding focus under the Model, including the MDPCP Track. These measures are currently in development.

### 1. Electronic Clinical Quality Measures

The use of eCQMs ensures practitioners and Participant Practices have insight into the quality of the care they provide. The eCQMs were selected from the portfolio of health IT-enabled measures included in other CMS quality reporting programs. Measures from each of the six quality domains of the National Quality Strategy (i.e., patient safety, effective clinical care, person and caregiver-centered experience and outcomes, communication and care coordination, community/population health, and efficiency and cost reduction) are included in the set.

The eCQM measures that CMS will require Participant Practices to report under the MDPCP target a primary care beneficiary population, and, where feasible, are outcome measures instead of process measures. Prior to the start of Performance Year 1 (2019), CMS will communicate the finalized list of eCQMs that Participant Practices must track for Performance Year 1 (2019) and report to CMS in 2020.

### 2. Beneficiary Experience of Care

A subset of the CAHPS Clinician & Group Survey will be administered by CMS to attributed beneficiaries to measure experience of care across the population of Medicare beneficiaries attributed to MDPCP Participant Practices.

### 3. Patient-Reported Outcome Measures

In addition, for Medicare beneficiaries attributed to Track 2 Participant Practices, CMS will collect PROMs survey data, after the surveys are administered by Participant Practices, to screen for and capture attributed beneficiaries' reported clinical outcomes for a set of common medical and social problems that are disease agnostic—such as depression, problems with physical functioning, social isolation, or pain—instead of focusing only on beneficiaries with a specific disease or condition. To identify attributed beneficiaries with complex medical needs, Participant Practices will be required to administer the PROMs surveys at specified intervals during each performance year, but no less than two times annually.

## C. Program Integrity, Monitoring, and Remedial Action

Prior to the start of the MDPCP and periodically thereafter, CMS will conduct a program integrity screening on applicant and participant practices as well as all NPIs listed on a Participant Practice's Practitioner Roster or the CTO's CTO Roster in combination with the practice's and CTO's associated TINs. The results of a program integrity screening may be used by CMS to reject an application, to terminate a Participation Agreement, or to take other remedial action against a practice or CTO. Additionally, Participant Practices and CTOs will be subject to documentation and reporting requirements and will be required to participate in CMS' monitoring of the MDPCP in order to help CMS ensure appropriate and effective implementation of the program. Monitoring is essential to ensure that

beneficiaries' experiences and quality of care is either maintained or improved, and that Participant Practices and CTOs comply with the Practice Participation Agreement and CTO Participation Agreement, respectively. Moreover, monitoring helps CMS confirm that Participant Practices understand and can track their progress towards meeting the applicable care transformation requirements.

The Practice Participation Agreement and the CTO Participation Agreement will set forth specific monitoring activities, which may include, without limitation, CMS review of the following:

- *Care Transformation Requirements Achievement Data*: Quarterly Participant Practice reporting on care transformation activities and progress submitted to CMS.
- *CMS Care Delivery Flag Report*: CMS will prepare a quarterly "Flag Report" based on Participant Practices' submissions to CMS that identifies areas of concern as well as areas of high-quality performance.
- *Practice Revenue and Expense Data*: Quarterly Participant Practice submissions to CMS, including a prospective view and a retrospective look at the Participant Practices' and CTOs' expected and actual use of CMFs, PBIPs, and—as applicable—CPCPs.
- *Cost, Utilization, Beneficiary Experience, and Quality Data*: Review of cost, utilization, beneficiary experience, and quality data on a least an annual basis to identify Participant Practices that are or are not performing well.

Track 2 Participant Practices may be subject to increased monitoring and/or feedback from CMS to assess whether they are stinting on care and whether such activity may be related to the partially capitated payment rate under the CPCP.

In addition to the monitoring activities described above, Participant Practices and CTOs will be required to maintain copies of all documentation related to their expected budgets and actual expenditures of payments received under the MDPCP and their care delivery and transformation work under the MDPCP for a period of at least 10 years. Participant Practices and CTOs will also be subject to audit by CMS. To the extent possible (and practicable), Participant Practices and CTOs will receive advance notice of upcoming audits. CMS may decide to audit a Participant Practice and/or a CTO based the practice's performance on utilization and quality measures, practice revenue and expense data, and other practice-reported information.

During the MDPCP, CMS may determine certain Participant Practices and CTOs should be subject to remedial action, such as a Corrective Action Plan (CAP), suspension of MDPCP payments, or even termination from the MDPCP. Remedial action may be imposed when CMS determines a Participant Practice or CTO does not meet the terms of its MDPCP participation agreement, fails to meet the MDPCP's quality standards, or under certain other circumstances to be specified in the Practice Participation Agreement and CTO Participation Agreement. Participant Practices and CTOs subject to a CAP will be expected to implement the corrective actions imposed by the CAP during a specified time frame (usually six months). Participant Practices and CTOs that fail to successfully implement a CAP or otherwise cannot address areas of concern or that are unable to meet the requirements of their Practice Participation Agreement or CTO Participation Agreement may be terminated from the MDPCP by CMS.

### D. Participation in CMS' Evaluation

All participants in the MDPCP, including both Participant Practices and CTOs, will be required to cooperate with efforts to conduct an independent, federally funded evaluation of the Model, which may include: participation in surveys, interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive formative and summative evaluation. The evaluation will be used to inform CMS about the effect of the MDPCP within the TCOC Model and its ability to affect primary care transformation and aligned payment reform in Maryland.[6]

## VI. Authority to Test Model

Section 1115A of the Social Security Act (SSA) established the Innovation Center, and provides authority for the Innovation Center to test innovative payment and service delivery models that are expected to reduce Medicare, Medicaid, and CHIP spending while preserving or enhancing the quality of beneficiaries' care.

While CMS is committed to improving care for beneficiaries, the Agency reserves the right to decide not to move forward with all or part of the Model, including the MDPCP, for any reason and at any time, as is true for all models tested under Section 1115A authority. Similarly, as implementation of the MDPCP progresses, CMS reserves the right to terminate or modify the Model, including the MDPCP, if it is deemed that it is not achieving the goals and aims of the initiative or Section 1115A of the Act.

Under section 1115A (d)(1) of the SSA, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of section 1934 as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b). No fraud and abuse waivers are being issued for the MDPCP under the TCOC Model. Thus, notwithstanding any other provision of this RFA or the MDPCP Practice Participation Agreement and CTO Participation Agreement, all individuals and entities must comply with all applicable fraud and abuse laws and regulations.

## VII. Amendment

CMS may revise the terms of the MDPCP in response to operational or other matters. The terms of the MDPCP as set forth in this Request for Applications may differ from the terms of the MDPCP as set forth in the Practice Participation Agreements or CTO Participation Agreements. Unless otherwise specified in the relevant participation agreement, the terms of the participation agreements, as amended from time to time, shall constitute the terms of the MDPCP.

[6] See generally 42 C.F.R. § 403.1110.

# Appendix 1: Practice Application Guidance and Questions

Welcome to the Maryland Primary Care Program Practice Application!

The Maryland Primary Care Program (MDPCP) is accepting applications from individual primary care practice sites geographically located in the State. For purposes of the MDPCP, a practice is a group of one or more physicians, non-physician practitioners, or combination thereof that bills certain primary care services under a single Medicare-enrolled TIN at a single practice site location. A practice owned by an individual(s) other than the practitioners who practice at the practice, or by a separate entity or healthcare organization must complete its own application, but the owner of the practice must sign the MDPCP Practice Participation Agreement with CMS.

Practices interested in applying to MDPCP should review the Request for Application (RFA) to learn about the design and specific requirements of the program, and to determine which program track best suits the applying practice.

*Let's get started….

Track 1 of MDPCP targets practices poised to deliver the five primary care functions, detailed in Care Delivery Design Section of the MDPCP RFA. Track 2 of MDPCP targets practices proficient in comprehensive primary care that are prepared to increase the depth, breadth, and scope of medical care delivered to their patients, particularly those with complex needs. Track 2 practices must also be able to receive partial capitation payments.

Practices applying to MDPCP must answer all application questions. CMS will consider the applicant practice's Track preference, but will assign practices to either Track 1 or 2 based on responses to this application. Please note that all participating practices must be in Track 2 by the end of their third year in the program. CMS reserves the right to seek additional information from MDPCP applicants after the application period closes.

Questions about the MDPCP Application should be directed to MarylandModel@cms.hhs.gov. CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested practices and CTOs have access to information regarding MDPCP.

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp.

### Preliminary Questions

1. As of January 1, 2019, will your practice be a:
   a. Concierge practice? *Help note: A concierge practice is one where patients pay a monthly or annual retainer fee to the practice to receive care.*
      i. Yes
      ii. No

   b. Rural Health Clinic?
      i. Yes
      ii. No

c. Federally Qualified Health Clinic (FQHC)?
    i. Yes
    ii. No
d. Critical Access Hospital (CAH)?
    i. Yes
    ii. No
e. Medicaid approved Health Home provider (link for reference: https://mmcp.dhmh.maryland.gov/Pages/Health-Homes.aspx)

*If practices check "Yes" for questions 1a-1d take them to a screen stating: Concierge practices, Rural Health Clinics, Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs) are not eligible for the MDPCP program. If your practice falls into one of these categories currently and will continue to do so after January 1, 2019, your practice will be automatically deemed ineligible to participate.

If any of these criteria will apply to you, you can click "Exit Application"

* If practice selects "Yes" for add: Please also note: If your practice is otherwise eligible but employs a clinician who provides concierge services, that clinician will be excluded from participation in MDPCP and the practice's continued eligibility for MDPCP will be based on the remaining clinicians.
*If practice selects "Yes" for 1d add:

2. To the best of your knowledge, has your practice or anyone employed in your practice had a final adverse legal action (as defined on page 12 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose this information could be grounds for application denial or immediate termination from the initiative.
    a. Yes
    b. No

    If yes, please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any.
3. Will your practice be using certified EHR technology by January 1, 2019?
    a. Yes
    b. No

* If "Yes" show screen asking to: Provide CMS HER Certification ID (hyperlink for detailed instructions on how to obtain CMS EHR certification.

### General Questions

This section focuses on background information about your practice. Information in this section will be used to

determine whether your practice meets the baseline eligibility criteria for participation in MDPCP. If a practice is accepted to participate in MDPCP and CMS later learns that answers to the questions in this section have changed or are no longer accurate, CMS reserves the right to terminate the practice's participation in the program immediately.

For purposes of this application, a practice site is defined as the single "bricks and mortar" physical location where patients are seen, unless the practice has a satellite office. A satellite is a separate office that acts purely as a geographic extension of a single practice site; the satellite shares management, resources, EHR, clinicians, and attributed beneficiaries with the main practice location. Practices that are part of the same medical group or health system, even if they share some clinicians or staff, are generally not considered satellites of one practice site. Where applicable, please answer these questions for the practice site that is applying to participate in MDPCP (rather than the parent organization, group, or health system).

4. Will your practice be participating in any of the Medicare or other initiatives below as of January 1, 2019? Please select all that apply. For more information about program overlap policies, please see the Frequently Asked Questions document located here.

    a. Transformation Clinical Practice Initiative (TCPi) – participation in learning activities
    b. TCPi – participation as part of a Practice Transformation Network or Support and Alignment Network
    c. Accountable Health Communities
    d. Advance Payment ACO Model
    e. Million Hearts Model
    f. Next Generation ACO Model
    g. ACO Investment Model (AIM)
    h. Other CMS shared savings program
    i. Other non-Medicare PCMH model
    j. None of the above

* If practice selects f. or g., take them to a screen that reads: You have selected a program that has a no-overlap policy with MDPCP. If you are accepted to participate in MDPCP and you intend to withdraw from a program that has a no-overlaps policy with MDPCP, please list the program and planned withdrawal date below:

Practices can select more than one answer choice. When selecting f or g, a warning window will appear. The program name selected will auto-populate and they will input the withdrawal date. After clicking Save and Continue, the data will appear next to the selected program. This can occur for as many programs where the boxes are checked. If practices want to edit their answer, they will unselect and reselect the box, which will open the warning window again.

Program:_____Planned withdrawal date: _____

5. *Will your practice be participating in, or is your practice part of an ACO currently applying to participate in, the Medicare Shared Savings Program (MSSP), as of January 1, 2019?
    a. Yes, my practice is part of an ACO that is participating in MSSP currently and will continue

participation in 2019.

b. Yes, my practice is part of an ACO that is currently applying to participate in MSSP starting January 1, 2019.
c. No

* If practices answer 5a or 5b insert the following textboxes:

ACO Name (drop down list):

CMS will provide the data for this drop down list when regions are available. Please put dummy data in for now, the list should also have an "Other" option, in addition to the data.

ACO TIN (numeric field with TIN verification function):

6. Practice identification:
    a. Practice Site Name:
    b. Practice "doing business as" (DBA) Name:
    c. Street Address 1:
    d. Street Address 2:
    e. City:
    f. State:
    g. Nine digit ZIP Code:
    h. Practice Site Phone Number:
    i. Practice Site Fax Number:
    j. Website (if applicable):
    k. Does your practice have satellite offices?
        i. Yes
        i. Yes. Please provide the following for each satellite office
            (1) Organization Site Name:
            (2) Organization "doing business as" (DBA) Name:
            (3) Street Address 1:
            (4) Street Address 2:
            (5) City:
            (6) State:
            (7) Nine digit ZIP Code:
            (8) Organization Site Phone Number:
            (9) Organization Site Fax Number:
            (10) Website (if applicable):
        ii. No
        iii. Unknown
7. CMS will assign practices to Track 1 or 2 based on responses to this application. CMS will consider the preference for a practice to start the program in Track 1 or Track 2. All practices must meet the Track 2 requirements by the end of their third year of participation in the program. Please indicate your track preference below.

a. Track 1
b. Track 2

### *Practice Structure and Ownership*

This section asks questions about the organizational structure and ownership of your practice. If you have a question about practice structure that is not addressed in the Request for Applications (RFA) or in the Application Instructions, please contact CMS at MarylandModel@cms.hhs.gov.

8. *Is your practice owned by another health care organization, such as a group practice, hospital or health system?
    a. Yes
    b. No
        i. If Yes:
            1. What is the name of the organization?
            2. Corporate Street Address 1:
            3. Corporate Street Address 2:
            4. Corporate County
            5. Corporate State
            6. Corporate (9)-digit Zip Code
            7. Corporate Phone Number
            8. How many other primary care practice sites are part of this organization?
            9. How many physicians are part of this organization?
            10. How many Medicare Eligible Professionals (EPs) are part of this organization?
            11. Are other practice sites in this organization applying to participate in MDPCP?
                a. Yes (Please identify them by Practice Name and TIN:
                b. No
                c. Unknown
            12. Do all practice sites that are part of this organization share one Electronic Health Record system?
                a. Yes
                b. No
                c. Unknown
            13. Does your practice share a TIN for billing with other practices that are part of the same health group or system?
                a. Yes
                b. No
                c. Unknown

                If no

                i. Who owns this practice? (SELECT ALL THAT APPLY)
                1. Physicians in the practice
                2. Non-physician practitioners (nurse practitioners or physician assistants) in the practice
                3. Other (Specify)
9. Does your practice use more than one billing TIN?
    a. Yes

b. No
c. Unknown

10. Please list all TINs your practice has used to bill Medicare since January 1, 2013:

*Insert the "Add a new TIN" function and the TIN verification (they have to enter the number twice and a check will appear if the numbers match). There should be unique numbers in each row. Copy and paste should not be allowed.

11. What billing TIN will your practice use to bill primary care services in your practice?

* Next to the list of TINs, have a check box next to each TIN for practices to select the one TIN they would like to use in 2019 from this list. They can only select one. It should be clear which one they have selected, through a highlight or a checkbox.

*TIN verification needed*

12. Applicant Contact (This should be the person filling out the application)
    a. First Name:
    b. Last Name:
    c. Title/Position:
    d. Does this person work in the practice?
        i. Yes
        ii. No
    e. Relationship with the practice:
    f. Business Phone Number:
    g. Business Phone Number Extension:
    h. Alternative Phone Number (e.g. cell phone):
    i. E-mail Address:
    j. Street Address 1:
    k. Street Address 2:
    l. City:
    m. State:
    n. ZIP Code:
    o. This application requires a letter of support from a clinical leader in your practice. Please enter the name of the clinical leader that will sign this letter: _____.
    More information about the letter can be found on the "Letter of Support" tab.

13. Practice Contact (if applicable) If your applicant contact does not work in your practice, you will also need to fill out the "Practice Site Contact" field. This person must work in your practice. They will receive your practice's acceptance/rejection letters.
    *Please provide the name of a contact who works in the practice:*
    a. First Name:
    b. Last Name:
    c. Title/Position:
    d. Business Phone Number:
    e. Business Phone Number Extension:
    f. Alternative Phone Number (e.g. cell phone):

g. E-mail Address:
h. Street Address 1:
i. Street Address 2:
j. City:
k. State:
l. ZIP Code:

14. Health IT Contact (if applicable)
*Please provide the name of a contact who works in the practice:*
    a. First Name:
    b. Last Name:
    c. Title/Position:
    d. Business Phone Number:
    e. Business Phone Number Extension:
    f. Alternative Phone Number (e.g. cell phone):
    g. E-mail Address:
    h. Street Address 1:
    i. Street Address 2:
    j. City:
    k. State:
    l. ZIP Code:

### *Clinician and Staff Information*

This section asks questions about the clinicians in your practice. Unless otherwise indicated, please answer only for the primary care clinicians that will be participating in MDPCP.

15. What is the total number of individual physicians (MD or DO), nurse practitioners (NPs), physician assistants (PAs), and Clinical Nurse Specialists (CNSs) who provide patient care at your practice and practice under their own National Provider ID (NPI)? Please include all full-time and part-time clinician staff, regardless of their practice specialty.
    a. Fill in number of Physicians
    b. Fill in number of NPs
    c. Fill in number of PAs
    d. Fill in number of CNSs

16. *For purposes of the MDPCP program, a primary care clinician is defined as a physician (MD or DO), nurse practitioner (NP), physician assistant (PA), or Clinical Nurse Specialist (CNS) who has a primary specialty designation of Internal Medicine, General Practice, Geriatric Medicine, Family Medicine, Pediatric Medicine, Nurse Practitioner, OB/GYN, and Psychiatry. Of the total individual clinicians who provide patient care at your practice site, how many are primary care clinicians? Please include full-time and part-time staff.
    a. Fill in number of Physicians
    b. Fill in number of NPs
    c. Fill in number of PAs

d. Fill in number of CNSs

*If a number in any row of question 16 is larger than a number in any row of question 15, practices should have this warning pop up.

Warning Window: Your answers indicate that the number of primary specialty practitioners in your practice (family medicine, internal medicine, or geriatric medicine) is greater than the total number of practitioners who provide patient care under any specialty in your practice. Please check your numbers.

17. Do any of the primary care clinicians who practice at your site also practice at other locations?
    a. Yes
    b. No

    Explanation:

18. For each primary care clinician in your practice that would participate in the program, please provide the following information:
    a. Clinician Name (Last, First, MI)
    b. National Practitioner ID (NPI)
    c. Maryland Board of Physicians License Number
    d. Clinician Type:
        i. Physician (MD or DO)
        ii. Clinical Nurse Specialist or Nurse Practitioner
        iii. Physician Assistant
    e. Specialty
    f. Is this Clinician board certified in this specialty?
        i. Yes
        ii. No
        iii. Unknown
        iv. N/A
    g. If applicable, is the clinician current with maintenance of certification?
        i. Yes
        ii. No
        iii. Unknown
        iv. N/A
    h. This clinician works at the practice (or satellite office):
        i. Part-time
        ii. Full-time

        If part time, how many hours per week does this clinician work at the practice site?
    i. Does this clinician also practice at another practice location (besides a satellite office)?
        i. Yes
        ii. No

        If yes, is the clinician's billing TIN the same at all practices?

Is the other site applying to participate in MDPCP?

1. Yes
2. No
3. Name of site:

* Needs to be a button to identify one of the staff as the clinical leader, and a pop-up describing this person will be expected to submit a letter of support.

19. *Please describe current Meaningful Use attestation progress among the clinician s in your practice who are Eligible Professionals (EPs) under the EHR Incentive Program(s).
    a. Percent of total number of Medicare EPs who plan to attest to Meaningful Use Stage 2:
    b. Percent of total number of Medicaid EPs who plan to attest to Meaningful Use Stage 2:

**NPI Verification**

A verification box with a summary of each NPI added in this section.
These are the NPIs listed in your application.

- YYYYYYYYYY
- YYYYYYYYYY
- YYYYYYYYYY

Does each NPI listed reference a primary care practitioner who practices at this individual practice?
*Please note that if your NPIs are incorrect this could significantly delay review and processing of your application"*

- ❖ Confirm ALL NPIs are correct
- ❖ No

If No, hyperlink to section of the app with NPI input, question 18. If confirmed, continue with the application.

### *Practice Activities*

This section asks about the various activities that occur at your practice, including types of care provided, teaching and training, and certifications that your practice may have.

20. Which statement best characterizes your practice (*select mark all that apply*):
    a. The practice is a single-specialty primary care practice.
    b. The practice is a primary care practice with other integrated clinicians, or is a multi-specialty practice.
    c. The practice participates in other lines of business besides primary care, such as urgent care on weekends and/or physical exams for an insurance company.
    d. If the above answer is b:
        i. Do the clinicians in your practice share an EHR with other types of clinicians in the practice?
            1. Yes
            2. No
            3. Unknown
    e. If the above answer is c:
        i. Please describe the other lines of business in which your practice participates:

21. Is your practice engaged in training future clinicians and staff?
    a. Yes. Please briefly describe the engagement (e.g., family medicine residency clinic, occasional rotating NP students)

b. No
c. Unknown

22. Please select all organizations through which your practice has achieved Medical Home recognition:
    a. National Committee for Quality Assurance (NCQA-PCMH)
    b. The Joint Commission (TJC), previously known as Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
    c. Accreditation Association for Ambulatory Healthcare (AAAHC-Triple A)
    d. Utilization Review Accreditation Commission (URAC)
        a. Specify recognition level received __
    e. State-based Recognition Program
        a. Specify State and Program_____
        b. Specify recognition level received _____
    f. Insurance Plan-based Recognition Program
    g. Other (Specify):
    h. My practice does not have recognition as a "medical home."

## Health Information Technology

This section asks questions about the Health Information Technology (health IT) capabilities of your practice.

23. Please provide the following information regarding the primary EHR system used by your practice site, as well as any additional health IT tools that your practice uses:

| **Primary EHR System** | | |
|---|---|---|
| **Vendor Name** | **Product Name** | **Version** |
| | | |
| | | |
| | | |
| | | |

24. Please indicate your current level of connectivity with CRISP
    a. Tier 1: View clinical data & receive hospitalization alerts, initial connectivity to CRISP, Encounter Notification Service (ENS), clinical query portal, Prescription Drug

Monitoring Program (PDMP) Benefits

b. Tier 2: Send encounter information about your patients and contribute to a more comprehensive patient profile and improve data sharing among providers treating the same patients, autosubscribed patient lists for ENS
c. Tier 3: Send clinical information about your patients to CRISP who will serve to further contribute to comprehensive patient profiles, CAliPHR: Clinical Quality Measures (CQM) Reporting Tool, Enhanced Analytic Reporting

## Patient Demographics

This section asks questions about the demographic makeup of your patient population. Please answer these questions to the best of your ability.

25. Percentage of patients by insurance type:
    a. Commercial or private __%
    b. Medicare %
    c. Medicaid %
    d. Uninsured %
    e. Other %
    f. Is this based on collected data or best estimate?
        i. Collected
        ii. Best Estimate

26. Are you in a designed Health Professional Shortage Areas (PDF) or Medically Underserved Areas/Populations (MUA/P) https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx ?
    a. Yes
    b. No

## Care Delivery

The following questions gather information about your practice site's delivery of primary care. Please answer the following questions based on the current activities at your practice site:

### *Care Management*

27. *Patients:
    a. are not assigned to specific clinician panels.
    b. are assigned to specific clinician panels and panel assignments are not routinely used by the practice for administrative or other purposes.
    c. are assigned to specific clinician panels and panel assignments are routinely used by the practice mainly for scheduling purposes.
    d. are assigned to specific clinician panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.

28. *Non-physician practice team members:
    a. play a limited role in providing clinical care.
    b. are primarily tasked with managing patient flow and triage.
    c. provide some clinical services such as assessment or self-management support.
    d. perform key clinical service roles that match their abilities and credentials

29. *The care managers used by our practice for managing the care for patients:

a. does not apply
b. are employed by another organization and located externally.
c. are employed by another organization and located internally.
d. are employed by our practice and located internally

30. *Care plans:

a. are not developed or recorded.
b. are developed and recorded but reflect clinicians' priorities only.
c. are developed collaboratively with patients and families and include self-management and clinical goals.
d. are developed collaboratively, include self-management and clinical management goals, are routinely recorded, and guide care at every subsequent point of service.

31. A standard method or tool(s) to stratify patients by risk level:
    a. is not available.
    b. is available and not consistently used to stratify all patients.
    c. is available and is consistently used to stratify all patients and is inconsistently integrated into all aspects of care delivery.
    d. is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery.

32. Follow-up by the practice with patients seen in the Emergency Department (ED) or hospital:
    a. generally does not occur.
    b. occurs only if the ED or hospital alerts the primary care practice.
    c. occurs because the primary care practice makes proactive efforts to identify patients.
    d. is done routinely because the primary care practice has arrangements in place with the ED and hospital to both track these patients and ensure that follow-up is completed within a few days.

33. Would you be able to implement a two-step risk stratification process for all empaneled patients as outlined below?

    Step 1 - based on defined diagnoses, claims, ED visit, hospital discharge or another algorithm (i.e., not care team intuition); and

    Step 2 - adds the practice based care team's perception of risk to adjust the risk-stratification of patients, as needed.

    a. Yes
    b. No

34. Would you be able to implement collaborative care agreements with at least two groups of specialists?
    a. Yes
    b. No

35. Do you have the ability integrate behavioral health into care based on one of the options below?
    a. Yes, Option Number ____
    b. No

i. Option 1: Care Management for Mental Illness Individuals with the identified mental health condition should be offered proactive, relationship-based care management (CM), with specific attention to care management of the mental health condition (e.g., Major Depressive Disorder/Dysthymia, Generalized Anxiety Disorder, and Panic Disorder). Practices that develop their capabilities to deliver care management for mental illness will:
    - Select mental health condition(s) to prioritize and method to identify patients to target for care management. Targeted patients should be higher severity or more complex (e.g., MDD and DM2 with poor glycemic control).
    - Identify or develop stepped care, evidence-based, treatment algorithms for mental health condition(s) identified for care management, incorporating principles of shared decision making and self-management support.
    - Develop a workflow for screening, enrollment in integrated care services, tracking, and communicating with patients.
    - Identify a clinician or team member (e.g., RN or BH specialist) who will provide care management and ensure training to support stepped care approach.

ii. Option 2: Primary Care Behaviorist Program (PC Behaviorist) The PC Behaviorist program integrates BH into the PC workflow through warm handoffs to a co-located BH professional to address mental illness in the primary care setting and behavioral strategies for management of chronic general medical illnesses, and facilitate specialty care engagement for serious mental illness. Practices that develop their capabilities to deliver the primary care behaviorist program will:
    - Select mental health condition(s) to prioritize and method to identify patients to target for referral to the primary care behaviorist. Targeted patients should be higher severity or more complex (e.g., MDD and DM2 with poor glycemic control).
    - Identify a credentialed BH provider (e.g., psychologist, social worker) trained in the primary behaviorist program of co-located care.
    - Identify space in the primary care practice for the BH provider; test and implement a method for engaging BH services.
    - Develop a workflow to integrate referrals (warm hand-offs) to the BH specialist.

36. Do you have the ability to characterize needs of sub-populations for high-risk patients, identify practice capability to meet those needs, and ensure needs are longitudinally met?
    a. Yes
    b. No

37. Would you be able to implement collaborative care agreements with at least two public health organizations based on patient's psychosocial needs, as appropriate?
    a. Yes
    b. No

38. Would you be able to convene a patient-family advisory council (PFAC) at least twice per year and

integrate recommendations into care, as appropriate?

a. Yes
b. No

39. Would you be able to implement self-management support for at least three high risk conditions?
    a. Yes
    b. No

40. Linking patients to supportive community-based resources:
    a. is not done systematically.
    b. is limited to providing patients a list of identified community resources in an accessible format.
    c. is accomplished through a designated staff person or resource responsible for connecting patients with community resources.
    d. is accomplished through active coordination between the health system, community service agencies, and patients and accomplished by a designated staff person.

### *Access*

41. Does your practice have a preferred patient/provider ratio?
    a. greater than 2500 patients per provider
    b. 2000-2500 patients per provider
    c. 1000-2000 patients per provider
    d. 500-1000 patients per provider

42. Patient after-hours access (24 hours, 7 days a week) to a physician, PA/NP, or nurse:
    a. is not available or limited to an answering machine.
    b. is available from a coverage arrangement (e.g., answering service) that does not offer a standardized communication protocol back to the practice for urgent problems.
    c. is provided by a coverage arrangement (e.g., answering service) that shares necessary patient data with and provides a summary to the practice.
    d. is available via the patient's choice of email or phone directly with the practice team or a clinician who has real-time access to the patient's electronic medical record.

43. Does your practice regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as telemedicine, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends?
    a. Yes
    b. No

Tele-health is the delivery of health education and services using telecommunications and related technologies in coordination with health care clinicians. Tele-health encompasses clinical and non-clinical services delivered remotely to patients including but not limited to virtual consultations with primary care providers and/or specialists. Among other things, tele-health aims to increase access to care, improve transitions of care, and reduce hospital readmissions. For purposes of this survey, tele-health does not include use of phone calls, fax, or e-mail independently.

44. Does the practice provide tele-health services?
    a. Yes. If yes, what type of services are provided via tele-health?

i. Tele-diagnosis (i.e., the process whereby a disease diagnosis or prognosis is made by evaluating data transmitted between distant medical facilities)
ii. Tele-behavioral health (i.e., using technology to virtually provide mental health services from a distance)
iii. Tele-consultation (i.e., virtually connecting health care clinicians with other health care clinicians and/or patients)
iv. Remote Monitoring (i.e., electronic data capture and Internet-enabled review by health care clinicians, particularly used in the management of chronic diseases)
v. Other (specify):

b. No
c. Unknown

### *Quality Improvement*

45. Quality improvement activities:
    a. are not organized or supported consistently.
    b. are conducted on an ad hoc basis in reaction to specific problems.
    c. are based on a proven improvement strategy in reaction to specific problems.
    d. are based on a proven improvement strategy and used continuously in meeting organizational goals.

46. Staff, resources, and time for quality improvement activities:
    a. are not readily available in the practice.
    b. are occasionally available but are limited in scope (due to some deficiencies in staff, resources, or time).
    c. are generally available and usually at the level needed.
    d. are all fully available in the practice.

## Care Transformation Organization Selection

If the practice intends to partner with a Care Transformation Organization (CTO), please indicate from the following list……should include the approved CTOs and an option to choose none.

Include a text box for a primary CTO selection. (first choice)

Include a text box for a secondary CTO selection. (second choice)

## Letters of Support

Practices will need to submit several letters of support with their application:

1. **Letter of support from clinical leadership:**

   Skilled leaders with high levels of emotional engagement and intellectual commitment are essential for successful cultural changes that drive improvements toward better care, smarter spending, and healthier people. In addition to answering all questions in the application and providing any required supporting documentation, all practices applying to participate in the MDPCP must attach a letter of support from at least one physician, leader in the practice.

This letter shall describe how the physician intends to engage with the care team(s) to provide ongoing leadership in support of MDPCP. The letter shall also define the planned time commitment and briefly describe ongoing strategies to share and address results, challenges, progress, and successes with practice staff and the patient community. This letter shall be no more than one page.

2. **Letter of support from parent of owner organization.**

   If your practice is owned by a person, entity, or organization OTHER than a clinical or other leader that works in the practice site, your practice must attach a letter of support from the parent/owner committing to segregate funds that are paid in conjunction with MDPCP, and assuring that all funds flowing through this initiative will be used for infrastructure and/or salaries in the participating practice. The letter of support must also demonstrate a commitment to compensate the clinicians and staff in practices participating in Track 2 of MDPCP in a manner that rewards quality of care, not just patient visit volume, and is consistent with the Comprehensive Primary Care Payment.

3. **Letter confirming CRISP connectivity**

   To be eligible to participate in the MDPCP, a practice must submit a letter executed by both the practice and a health information exchange (HIE) representative certifying the applicant's current level of connectivity to that HIE and its commitment to achieving the aims of bi-directional connectivity by the end of its first year as a Track 2 Participant Practice. For the purposes of the MDPCP, bi-directional connectivity is defined as the ability to send and receive clinical information about a practice's patients to and from the HIE. This will increase and enhance the comprehensiveness of patient data available to the health care providers who treat that patient.

### Application Checklist

Below is a checklist detailing the documents that your practice is required to submit for consideration in MDPCP. Not all documents are required from all applicants. Some documents are specific to the Track for which an applicant is applying, and some are required only from practices with specific ownership organization. It is the responsibility of the applicant to ensure that you include all documents that are required for your specific circumstances. All documents must be signed, scanned, and uploaded to the application portal at [LINK]. Please retain the original, signed letters. If you have any questions about what your practice is required to submit, please contact CMS at MarylandModel@cms.hhs.gov.

- ☐ Completed Application
- ☐ Letter of support from parent or owner of organization (if applicable)
- ☐ Letter of support from your practice's clinical leader
- ☐ Letter confirming *commitment to achieving bi-directional connectivity with CRISP by the end of its first year as a Track 2 Participant Practice.*

- ☐ I have read the contents of this application and I certify that I am legally authorized to bind the practice. Upon submission of this application I certify to the best of my knowledge that all of the submitted information is true, accurate, and complete. If I become aware that any submitted information is not true, accurate, and complete, I will correct such information promptly. I understand that the knowing omission,

misrepresentation, or falsification of any submitted information may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

## Appendix 2: CTO Application Guidance and Questions

Welcome to the Maryland Primary Care Program Care Transformation Application!

The Maryland Primary Care Program (MDPCP) is accepting applications from individual Care Transformation Organizations (CTOs). CMS will accept applications from the CTO itself (a separate legal entity) or the healthcare organization that owns and operates an existing CTO or a CTO that will exist by January 1, 2019.

Applicants should review the MDPCP Request for Application (RFA) to learn about the design and specific requirements of the program.

CTOs are a new concept unique to the Maryland Primary Care Program. CTOs may draw resources from or be created by existing organizations such as Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), health plans, etc. The questions below relate to the CTO's ability to support participating practices within the program. Participating practices have the opportunity to select among the approved CTOs or to function without the support of a CTO. It is assumed the participating practices will select CTOs that best meet their needs for support.

Questions about the MDPCP RFA should be directed to MarylandModel@cms.hhs.gov. CMS may publicly share questions or responses or compile them into a Frequently Asked Questions compendium to ensure that all interested practices and CTOs have access to information regarding MDPCP.

If your organization that will be creating a CTO specifically for the purposes of this program, please answers the application questions to the best of your ability based on your existing organizational structure.

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp.

## Preliminary Questions

This section focuses on background information about your organization. Information in this section will be used to determine whether your organization meets the eligibility criteria for participation in MDPCP.

Where applicable, please answer these questions for the organization that is applying to participate in MDPCP (rather than the organization that owns and operates the CTO.

1. To the best of your knowledge, has anyone employed in your organization had a final adverse legal action (in Section 3 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative.
   a. Yes
   b. No

   If yes, please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any.

The following section asks questions regarding the organizational structure and ownership of your organization. If you have a question about organization structure that is not addressed in the Request for Applications (RFA) or in the Application Instructions, please contact CMS at MarylandModel@cms.hhs.gov.

## General Questions

2. Please provide a one-page summary describing your vision of how the CTO will assist practices in delivery of care transformation under this program.
3. Please indicate the status of the proposed CTO on which you have based your responses in this application:
   a. The proposed CTO is currently in existence.
   b. The proposed CTO is owned and operated by a healthcare organization and is currently in existence.
   c. The proposed CTO will be owned and operated by a healthcare organization and does not yet exist.
4. Will your organization be participating in any other value-based initiatives as of January 1, 2019?

a. Yes
b. No

5. Is your organization part of an ACO that is in or planning to apply to participate in a Medicare shared savings initiative as of January 1, 2019?

   a. Yes, my organization is part of an ACO that is participating in a Medicare shared savings model currently and will continue participation in 2019.
      i. ACO name:
      ii. Taxpayer Identification Number (TIN):
      iii. Track level:
      iv. Initiative: (Next Generation, MSSP)
   b. Yes, my organization is part of an ACO that is currently applying to participate in MSSP starting January 1, 201.
      i. ACO Name
      ii. TIN:
      iii. Track level:
      iv. Model: (Next Gen, MSSP)
   c. No

6. Organization identification:

   a. Organization Site Name:
   b. Organization “doing business as” (DBA) Name:
   c. Street Address 1:
   d. Street Address 2:
   e. City:
   f. State:
   g. Nine-digit ZIP Code:
   h. Organization Site Phone Number:
   i. Organization Site Fax Number:
   j. Website (if applicable):
   k. Does your organization have satellite offices?
      i. Yes. Please provide the following for each satellite office
         (1) Organization Site Name:
         (2) Organization “doing business as” (DBA) Name:
         (3) Street Address 1:
         (4) Street Address 2:
         (5) City:
         (6) State:
         (7) Nine-digit ZIP Code:
         (8) Organization Site Phone Number:
         (9) Organization Site Fax Number:

(10) Website (if applicable):

ii. No

iii. Unknown

7. Is your organization owned by another health care organization, such as a physician group organization, hospital or health system?

    a. Yes
    b. No
        i. If Yes:
            1. What is the name of the organization?
            2. Corporate Street Address 1:
            3. Corporate Street Address 2:
            4. Corporate County:
            5. Corporate State:
            6. Corporate (9)-digit Zip Code:
            7. Corporate Phone Number:
            8. How many other primary care organization sites are part of this organization?
            9. How many physicians and nurse practitioners are part of this organization?
            10. Are practices affiliated this organization applying to participate in MDPCP?
                a. Yes:
                b. No
                c. Unknown
            11. Does your organization share a TIN for billing with other organizations that are part of the same health group or system?
                a. Yes
                b. No
                c. Unknown

8. Applicant Contact (This should be the person filling out the application):

    a. First Name:
    b. Last Name:
    c. Title/Position:
    d. Does this person work in the organization?
        i. Yes
        ii. No
    e. Relationship with the organization:
    f. Business Phone Number:
    g. Business Phone Number Extension:

h. Alternative Phone Number (e.g. cell phone):
i. E-mail Address:
j. Street Address 1:
k. Street Address 2:
l. City:
m. State:
n. ZIP Code:
o. This application requires a letter of support from a clinical leader in your organization. Please enter the name of the clinical leader that will provide a signed letter of support for this application: _____.

   More information about the letter can be found on the "Letter of Support" tab.

9. Organization Contact:

   a. First Name:
   b. Last Name:
   c. Title/Position:
   d. Business Phone Number:
   e. Business Phone Number Extension:
   f. Alternative Phone Number (e.g. cell phone):
   g. E-mail Address:
   h. Street Address 1:
   i. Street Address 2:
   j. City:
   k. State:
   l. ZIP Code:

10. Health IT Contact:

   a. First Name:
   b. Last Name:
   c. Title/Position:
   d. Business Phone Number:
   e. Business Phone Number Extension:
   f. Alternative Phone Number (e.g. cell phone):
   g. E-mail Address:
   h. Street Address 1:
   i. Street Address 2:
   j. City:
   k. State:
   l. ZIP Code:

11. Describe the current legal structure of your organization.

a. For profit corporation:
b. Public/private partnership:
c. Non-profit 501(c)(3):
d. Government agency:
e. Other:

12. Is your proposed CTO organization legally permitted to assume financial risk?

    a. Yes

    b. No

13. An organization selected as a CTO shall create a governing board to oversee its CTO activities. The governing board shall include primary care practitioners, specialists, and patient representatives to ensure recognition of diverse interests and perspectives in CTO functions.

    Does your organization currently have or agree to create a governing board for the proposed CTO organization that includes health care providers and patient representatives?

    a. Yes

    b. No

### *Patients, Payers, and Service Area*

14. If you are applying as a stand-alone or as a subsidiary of another organization please enter the percent of patients you or the parent organization provide services for the following insurance types:

    a. Commercial: __ %

    b. Private/self-pay: __ %

    c. Medicare: __%

    d. Medicaid: __%

    e. Uninsured: __ %

    f. Other: __%

    g. How were the percentages determined?

        i. Actual data
        ii. Best Estimate

15. Select your preferred service area(s):

    a. Statewide

    b. List counties alphabetically

16. What is the maximum number of practices you would be willing to work with? (text box

with up to 6 numeric characters needed for the response)

17. Is your organization formally partnered with other health improvement organizations and community groups including Local Health Departments, Local Health Improvement Coalitions, Health Enterprise Zones, Regional Partnerships, and similar community collaborations:
    a. Formally
        i. List: _____
    b. Informally
        i. List: _____
    c. No.

## Health Information Technology

18. Please provide the following information for the primary certified EHR system used by your organization and any additional health IT tools that your organization uses (e.g. care management system), if applicable:

| **Primary Certified EHR System** | | |
|---|---|---|
| **Vendor Name** | **Product Name** | **Version** |
| | | |
| | | |
| | | |

19. Please indicate your current level of interaction with CRISP (*Check all answers that apply*):
    a. We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).
    b. We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.
    c. We use CRISP to view data.
    d. We send administrative encounter data to CRISP on a regular basis.

e. We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.

## *Care Delivery*

The following questions gather information about the ability of your proposed CTO organization to support the requirements of primary care practices under the program. For each question indicate if the answer is based on the current or planned future activities of your proposed CTO organization.

20. Please lay out your approach to care delivery transformation that will exist for the applicant CTO. (2000 characters)

### *Care Teams and Care Management*

21. Please indicate if you employ (or if a new organization intend to employ) the following care team members and how many of each category:

    a. Care Managers – RNs
        i. Currently in place
        (1) How many? _____
        (2) Ratio to patients? _____
        ii. Planned for future
        (1) How many? _____
        (2) Ratio to patients? _____
        iii. Not a current or planned activity or service

    b. Care Managers – Medical Assistants
        i. Currently in place
        (1) How many? _____
        (2) Ratio to patients? _____
        ii. Planned for future
        (1) How many? _____
        (2) Ratio to patients? _____
        iii. Not a current or planned activity or service

    c. Care Managers – Other:_____
        i. Currently in place
        (1) How many? _____
        (2) Ratio to patients? _____
        ii. Planned for future
        (1) How many? _____

(2) Ratio to patients? _____

iii. Not a current or planned activity or service

d. Licensed Social Workers

i. Currently in place

(1) How many? _____

(2) Ratio to patients? _____

ii. Planned for future

(1) How many? _____

(2) Ratio to patients? _____

iii. Not a current or planned activity or service

e. Behavioral Health Counselor

i. Currently in place

(1) How many? _____

(2) Ratio to patients? _____

ii. Planned for future

(1) How many? _____

(2) Ratio to patients? _____

iii. Not a current or planned activity or service

f. Community Health Workers

i. Currently in place

(1) How many? _____

(2) Ratio to patients? _____

ii. Planned for future

(1) How many? _____

(2) Ratio to patients? _____

iii. Not a current or planned activity or service

g. Practice Transformation Consultants

i. Currently in place

(1) How many? _____

(2) Ratio to patients? _____

ii. Planned for future

(1) How many? _____

(2) Ratio to patients? _____

iii. Not a current or planned activity or service

h. Pharmacists

i. Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future
(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

i. Nutritionist

i. Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future
(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

j. Psychiatrist

i. Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future
(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

k. Psychologist

i. Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future
(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

l. Administrative Support

i. Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future

(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

m. Health IT support
i. Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future
(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

n. Billing/Accounting Support
i. Data Anal Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future
(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

o. Data Analysts
i. Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future
(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

p. Other_____
i. Currently in place
(1) How many? _____
(2) Ratio to patients? _____

ii. Planned for future
(1) How many? _____
(2) Ratio to patients? _____

iii. Not a current or planned activity or service

22. Do you have the ability to characterize needs of sub-populations for high-risk patients, identify a practice's capability to meet those needs, and ensure needs are longitudinally met?

    a. Currently in place
    b. Planned for future
    c. Not a current or planned activity or service

23. Would you be able to assist a practice to implement self-management support for at least three high-risk conditions?

    a. Currently in place
    b. Planned for future
    c. Not a current or planned activity or service

***Data and Quality Measurement***

24. Does your organization collect, report, and interpret quality metrics for practices?

    a. Currently in place
        i. Please describe the methodology.
    b. Planned for future
        i. Please describe the methodology.
    c. Not a current or planned activity or service

25. Does your organization have the technical infrastructure in place to share data from CMS and participating practices with organizations, CRISP, and other entities on cost, utilization, and quality at regular intervals (e.g., quarterly)?

    a. Currently in place
    b. Planned for future
    c. Not a current or planned activity or service

26. Does your organization use a standard method or tool(s) to stratify patients by risk level:

    a. Currently in place
        i. _____ (Product name) is available and not consistently used to stratify all patients.
        ii. _____ (Product name) is available and is consistently used to stratify all patients, but is inconsistently integrated into all aspects of care delivery.
        iii. _____ (Product name) is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery via the EHR or care management software.
    b. Planned for future
        i. _____ (Product name) is available and not consistently used to stratify all patients.

ii. _____ (Product name) is available and is consistently used to stratify all patients, but is inconsistently integrated into all aspects of care delivery.

iii. _____ (Product name) is available, consistently used to stratify all patients, and is integrated into all aspects of care delivery via the EHR or care management software.

c. Not a current or planned activity or service

27. Would you be able to implement a two-step risk stratification process as outlined below?

    Step 1 - based on defined diagnoses, claims, ED visit, hospital discharge or another algorithm (i.e., not care team intuition) using the standard tool identified in question 28; and

    Step 2 - adds the organization based care team's perception of risk to adjust the risk-stratification of patients, as needed.

    a. Currently in place
    b. Planned for future
    c. Not a current or planned activity or service

***Utilization and Resources***

28. Would you be able to assist practices to implement or facilitate collaborative care agreements with at least two groups of specialists?

    a. Currently in place
    b. Planned for future
    c. Not a current or planned activity or service

29. Would you be able to assist practices to convene or facilitate a patient-family advisory council (PFAC) at least twice annually and assist practices to integrate recommendations into care delivery, as appropriate?

    a. Currently in place
    b. Planned for future
    c. Not a current or planned activity or service

***Behavioral Health and Community Resources***

30. Do you have the ability to assist practices to integrate behavioral health into care based on one of the options below?

    a. Currently in place; Roman Numeral Option Number ____
    b. Planned for future; Roman Numeral Option Number ____
    c. Not a current or planned activity or service

        i. Option 1: Care Management for Mental Illness Individuals with the identified mental health condition should be offered proactive, relationship-based care management (CM), with specific attention to care management of the mental health condition (e.g., Major Depressive Disorder/Dysthymia, Generalized

Anxiety Disorder, and Panic Disorder). Practices that develop their capabilities to deliver care management for mental illness will:

- Select mental health condition(s) to prioritize and method to identify patients to target for care management. Targeted patients should be higher severity or more complex (e.g., MDD and DM2 with poor glycemic control).
- Identify or develop stepped care, evidence-based, treatment algorithms for mental health condition(s) identified for care management, incorporating principles of shared decision making and self-management support.
- Develop a workflow for screening, enrollment in integrated care services, tracking, and communicating with patients.
- Identify a clinician or team member (e.g., RN or BH specialist) who will provide care management and ensure training to support stepped care approach.

ii. Option 2: Primary Care Behaviorist Model (PC Behaviorist) The PC Behaviorist model integrates BH into the PC workflow through warm handoffs to a co-located BH professional to address mental illness in the primary care setting and behavioral strategies for management of chronic general medical illnesses, and facilitate specialty care engagement for serious mental illness. Practices that develop their capabilities to deliver the primary care behaviorist model will:

- Select mental health condition(s) to prioritize and method to identify patients to target for referral to the primary care behaviorist. Targeted patients should be higher severity or more complex (e.g., MDD and DM2 with poor glycemic control).
- Identify a credentialed BH provider (e.g., psychologist, social worker) trained in the primary behaviorist model of co-located care.
- Identify space in the primary care practice for the BH provider; test and implement a method for engaging BH services.
- Develop a workflow to integrate referrals (warm hand-offs) to the BH specialist.

33. Would you be able to assist practices to implement or facilitate collaborative care agreements on behalf of practices with at least two public health organizations based on patient's psychosocial needs, as appropriate?

    a. Currently in place
    b. Planned for future
    c. Not a current or planned activity or service

34. Would you be able to support practices to link patients to supportive community-based resources through active coordination between the health system, community service

agencies, and patients and accomplished by a designated staff person:

a. Currently in place
b. Planned for future
c. Not a current or planned activity or service

### *Access*

35. Would you be able to support practices to regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as telemedicine, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends?

    a. Tele-diagnosis (i.e., the process whereby a disease diagnosis or prognosis is made by evaluating data transmitted between distant medical facilities);
        i. Currently in place
        ii. Planned for future

    b. Tele-behavioral health (i.e., using technology to virtually provide mental health services from a distance);
        i. Currently in place
        ii. Planned for future

    c. Tele-consultation (i.e., virtually connecting health care practitioners with other health care practitioners and/or patients);
        i. Currently in place
        ii. Planned for future

    d. Remote Monitoring (i.e., electronic data capture and Internet-enabled review by health care practitioners, particularly used in the management of chronic diseases); and
        i. Currently in place
        ii. Planned for future

    e. Other (specify):
        i. Currently in place
        ii. Planned for future

    f. Not a current or planned activity or service

### *Letters of Support*

Organizations will need to submit several letters of support with their application:

1. Letter of support from clinical leadership:

Skilled leaders with high levels of emotional engagement and intellectual commitment are essential for successful cultural changes that drive improvements toward better care, smarter spending, and healthier people. In addition to answering all questions in the application and providing any required supporting documentation, all organizations applying to participate in MDPCP must attach a letter of support from at least one physician leader in the organization.

This letter shall describe how the organization and its care team intends to engage with the practice to provide ongoing leadership in support of MDPCP. The letter shall also define the planned time commitment and briefly describe ongoing strategies to share and address results, challenges, progress, and successes with organization staff and the patient community. This letter shall be no more than one page.

2. Letter of support from a practice. This letter can be from any practice with whom the CTO has a relationship. In addition to answering all questions in the application and providing any required supporting documentation, all organizations applying to participate in MDPCP must attach a letter of support from at least one practice (can upload up to two).

This letter shall describe how the practice views the engagement of the CTO that will support the MDPCP. The letter can discuss how well, and in what capacity, the applicant organization has worked with the practice previously. This letter shall be no more than one page.

### *Application Checklist*

Below is a checklist detailing the documents that your organization is required to submit for consideration in MDPCP. It is the responsibility of the applicant to ensure that all documents required are included with the application. All documents must be signed, scanned, and uploaded to the application portal. Please retain the original, signed letters. If you have any questions about what your organization is required to submit, please contact CMS at MarylandModel@cms.hhs.gov.

- ☐ Completed Application
- ☐ Letter of support from your organization's clinical leader
- ☐ Letter of support from a practice

I have read the contents of this application and I certify that I am legally authorized to bind the CTO. Upon submission of this application I certify to the best of my knowledge that all of the submitted information is true, accurate, and complete. If I become aware that any submitted information is not true, accurate, and complete, I will correct such information promptly. I understand that the knowing omission, misrepresentation, or

falsification of any submitted information may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.

## Appendix 3: MDPCP eCQM Set[7]

| Group 1: Outcome Measures – Report Both Outcome Measures | | | | | |
|---|---|---|---|---|---|
| Measure Type | CMS ID# | NQF# | Measure Title | Measure Type/ Data Source | Domain |
| Outcome Measures | CMS165v6 | 0018 | Controlling High Blood Pressure | Outcome/eCQM | Effective Clinical Care |
| | CMS122v6 | 0059 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) | Outcome/eCQM | Effective Clinical Care |

| Group 2: Other Measures – Report At Least 7 Other Measures | | | | | |
|---|---|---|---|---|---|
| Measure Type | CMS ID# | NQF# | Measure Title | Measure Type/ Data Source | Domain |
| Cancer | CMS125v6 | 2372 | Breast Cancer Screening | Process/eCQM | Effective Clinical Care |
| | CMS130v6 | 0034 | Colorectal Cancer Screening | Process/eCQM | Effective Clinical Care |
| | CMS124v6 | 0032 | Cervical Cancer Screening | Process/eCQM | Effective Clinical Care |
| Diabetes | CMS131v6* | 0055 | Diabetes: Eye Exam | Process/eCQM | Effective Clinical Care |
| | † CMS134v6 | 0062 | Diabetes: Medical Attention for Nephropathy | Process/eCQM | Effective Clinical Care |
| Medication Management | CMS156v6 | 0022 | Use of High Risk Medications in the Elderly | Process/eCQM | Patient Safety |

[7] The final eCQM measure list for PY 2019 will be announced in advance of January 1, 2019. This list is subject to change.

| Measure Type | CMS ID# | NQF# | Measure Title | Measure Type/ Data Source | Domain |
|---|---|---|---|---|---|
| Care Coordination | CMS50v6 | N/A | Closing the Referral Loop: Receipt of Specialist Report | Process/ eCQM | Communication and Care Coordination |
| Mental Illness/ Behavioral Health | CMS2v7 | 0418 | Preventive Care and Screening: Screening for Depression and Follow-Up Plan | Process/ eCQM | Community/ Population Health |
| | CMS160v6† | 0712 | Depression Utilization of the PHQ-9 Tool | Process/ eCQM | Effective Clinical Care |
| | CMS149v6 | 2872 | Dementia: Cognitive Assessment | Process/ eCQM | Effective Clinical Care |
| Substance Abuse | CMS138v6 | 0028 | Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention | Process/ eCQM | Community/ Population Health |
| | CMS137v6 | 0004 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Process/ eCQM | Effective Clinical Care |
| Safety | CMS139v6 | 0101 | Falls: Screening for Future Fall Risk | Process/ eCQM | Patient Safety |
| Infectious Disease | † CMS147v7 | 0041 | Preventive Care and Screening: Influenza Immunization | Process/ eCQM | Community/ Population Health |
| | † CMS127v6 | N/A | Pneumococcal Vaccination Status for Older Adults | Process/ eCQM | Community/ Population Health |
| Cardiovascular Disease | † CMS164v6 | 0068 | Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet | Process/ eCQM | Effective Clinical Care |
| | †§ CMS347v1 | N/A | Statin Therapy for the Prevention and Treatment of Cardiovascular Disease | Process/ eCQM | Effective Clinical Care |