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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 began 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 began on January 1, 2019, and ends on December 31, 2026. The initiative has 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 adjust to total cost of care accountability under the Model.

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. To facilitate the meeting of requirements, CMS will 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 Network.)

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 a legal entity that deploys an interdisciplinary care management team to furnish an array of care coordination services to Maryland Medicare beneficiaries attributed to Participant Practices, and performs other activities integral to helping Participant Practices to meet the applicable care transformation requirements under the model. 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). The types of entities eligible to submit CTO applications is not restricted and may include 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 CTO and practice application period will begin on May 10, 2019 and end on June 28, 2019 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, 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. As part of the practice application process, practice applicants will select whether to partner with a participating CTO and. If the practice applicant has selected to partner with a CTO, the practice may specify the CTO with which they wish to partner as part of the application process. Any CTO selections made as part of the application process are non-binding and Participant Practices will have an opportunity to select new CTOs that may be participating in MDPCP for the first time in the 2020 Performance Year prior to the start of the 2020 Performance Year. CMS will send Participant Practices a final list of 2020 Performance Year CTO participants before the start of the Performance Year. 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, if possible, assign the practice to the practice's second CTO choice. 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 Performance Year of participation in the MDPCP.

While CMS will not accept applications to begin participation in the MDPCP in Performance Year 2020 that are submitted after June 28, 2019, CMS intends to accept practice and CTO applications to the MDPCP annually, through calendar year 2023. Primary care practices and CTOs that did not apply during a prior application period or that are not selected to participate in a prior Performance Year may apply to participate in a future Performance Year. CMS expects that 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 with CMS 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 2019 application period and is accepted to participate in Track 1 will participate in the MDPCP from January 1, 2020 until December 31, 2026. A practice selected to participate in Track 1 beginning in Performance Year 2020 must transition to Track 2 no later than the start of Performance Year 2023.

CMS may offer Participant Practices and participating CTOs the opportunity to sign an amended and restated version of the participation agreement with CMS. If a Participant Practice or CTO fails to timely sign an amended and restated version of the participation agreement offered by CMS, CMS may terminate the Participant Practice or participating CTO's participation in MDPCP.

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.

In order for CMS to identify whether the applicant is providing primary care services, 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 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), Preventive Medicine (84), Certified Nurse Midwife (42), and Physician Assistant (97) listed in the National Plan and Provider Enumeration System (NPPES) are eligible. Practitioners with non-eligible specialty codes (i.e., any specialty codes not identified above) in addition to eligible specialty codes listed in the NPPES are not eligible to participate in the MDPCP and should not be included on an applicant practice’s Practitioner Roster. Practitioners identified with a specialty code of Psychiatry (26) must be co-located with an eligible practitioner with a 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 as reflected by an Approved status in the Provider Enrollment, Chain and Ownership System (PECOS)¹;
2. The practice must maintain a minimum of 125 attributed Medicare FFS beneficiaries during each performance year, based on the attribution methodology described in

¹ PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information. More information as well as access to the PECOS system can be found on the PECOS website located [here](#).

[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 (PI) screening. CMS may reject an application or terminate a Practice Participation Agreement on the basis of the results of a PI screening.

PI screening activities help CMS detect and combat fraud, waste, and abuse of the Medicare and Medicaid programs. These activities use identifiers such as National Provider Identification (NPI) numbers, CMS Certification Numbers (CCNs), and Tax Identification Numbers (TINs) to cross-check applicants at a specific point in time across multiple systems to verify eligibility for MDPCP participation. PI screening activities and systems include:

- Use of the PECOS to ensure applicants are enrolled as an active Medicare supplier or provider;
- Review of applicants' billing history to identify delinquent debt and any past or current reviews, audits, investigations, etc. for suspicious and fraudulent activity; and
- Research into any past civil or criminal actions related to behaviors or other factors relevant to participation in the MDPCP and the receipt of federal funds as an MDPCP Participant Practice.

Adverse results from PI screening may relate to a variety of issues, including Medicare enrollment, Medicare billing privileges, outstanding Medicare debt, and current administrative review or investigation by CMS or other federal partners.

Practice Application Information

The MDPCP practice application is located [here](#) and will be open for application from May 10, 2019 through midnight of June 28, 2019.

To be considered for participation in the MDPCP, all practice applications must be completed using the online application. Click [here](#) to view a PDF version of the Practice application questions for reference. 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.

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 full 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 as Participant Practices.

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 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, if the CTO is an operating division of a legal entity, the legal entity that owns and operates the CTO.

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

1. The CTO must have the ability to support Participant Practices in performing the applicable care transformation requirements outlined in this RFA.
2. The CTO must meet additional requirements under the MDPCP CTO Participation Agreement (described in greater detail below).

CTOs and, if applicable, the organization that owns and operates the CTO, will be subject to a program integrity (PI) screening. CMS may reject an application or terminate a CTO Participation Agreement on the basis of the results of a PI screening.

CTO Application Information

The MDPCP CTO application is located [here](#) and will be open for application from May 10, 2019 through midnight of June 28, 2019.

To be considered for participation in the MDPCP, all CTO applications must be completed using the online application. Click here to view a PDF version of the CTO application questions for reference. 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.

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 of Maryland.

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. Multi-Payer Strategy

In an effort to improve population health and reduce overall health care costs, CMS plans to enter into one or more Memoranda of Understanding ("MOU") with payers who are also interested in supporting comprehensive primary care reform within Participant Practices in Maryland.

Practices applying to participate in the MDPCP may enter into arrangements with participating payers for additional support in delivering advanced primary care. Entering into such arrangements is at the discretion of the practices and payers; Participant Practices are not

required to enter into arrangements with payers other than CMS under the terms of the MDPCP Participation Agreement.

Payer Solicitation Information

CMS intends to release a separate payer solicitation in the fall of 2019 and anticipates releasing a similar such solicitation annually thereafter through calendar year 2023 for the 2024 Performance Year. The solicitation will outline a framework for payers to indicate steps they are taking to support the provision of advanced primary care in Maryland that align with CMS' efforts in the MDPCP. The solicitation will ask payers to provide a description of how their strategy is consistent with the principles of the MDPCP described below.

CMS will enter into MOUs with payers that submit proposals in response to the payer solicitation and demonstrate that their approaches to support practices in delivering advanced primary care are consistent with the principles of the MDPCP described below. CMS will evaluate payer proposals to determine the extent of their alignment with the following principles:

Financial Incentives

- Provide an enhanced claims or non-claims based payment to support Participant Practices in providing care not traditionally covered under billable services, such as non-visit-based care or enhanced behavioral health services.
- Provide an at-risk performance-based incentive payment that encourages accountability of Participant Practices based on performance on certain quality and utilization metrics.
- Provide a partially capitated payment, similar to the CPCP, to advanced Participant Practices to create a more predictable revenue stream and reduce dependence of practices on visit-based care for revenue.

Care Management

- Incentivize Participant Practices to target high-risk, high-need members and to ensure these members receive longitudinal care management to reduce potentially avoidable utilization.

Quality Measures

- Require Participant Practices to report certain quality measures that are the same or similar to the eQMs that CMS requires Participant Practices to report in the MDPCP.

Data Sharing

- Share aggregate (patient de-identified) cost and utilization data on members attributed to (or seen by) a payers' practices with CMS for monitoring and evaluation purposes.
- Offer the opportunity to request member-level utilization data to Participant Practices to facilitate care management and follow-up for chronic and acute conditions in accordance with applicable law.

Practice Learning

- Participate in CMS' Learning Network and/or provide learning resources to support Participant Practices in performing comprehensive primary care functions.

D. 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. 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.

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.

As part of their application, practice applicants may identify the CTO with which they would like to partner, if any. The CTO selection that a practice makes in its practice application is non-binding, as Participant Practices will have an opportunity to select new CTOs that may be participating in MDPCP for the first time in the 2020 Performance Year. Practices and CTOs that submit applications during the 2019 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 2020. Practices and CTOs that do not apply during the 2019 application period or are not selected to participate in the MDPCP for the 2020 Performance Year may apply 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.

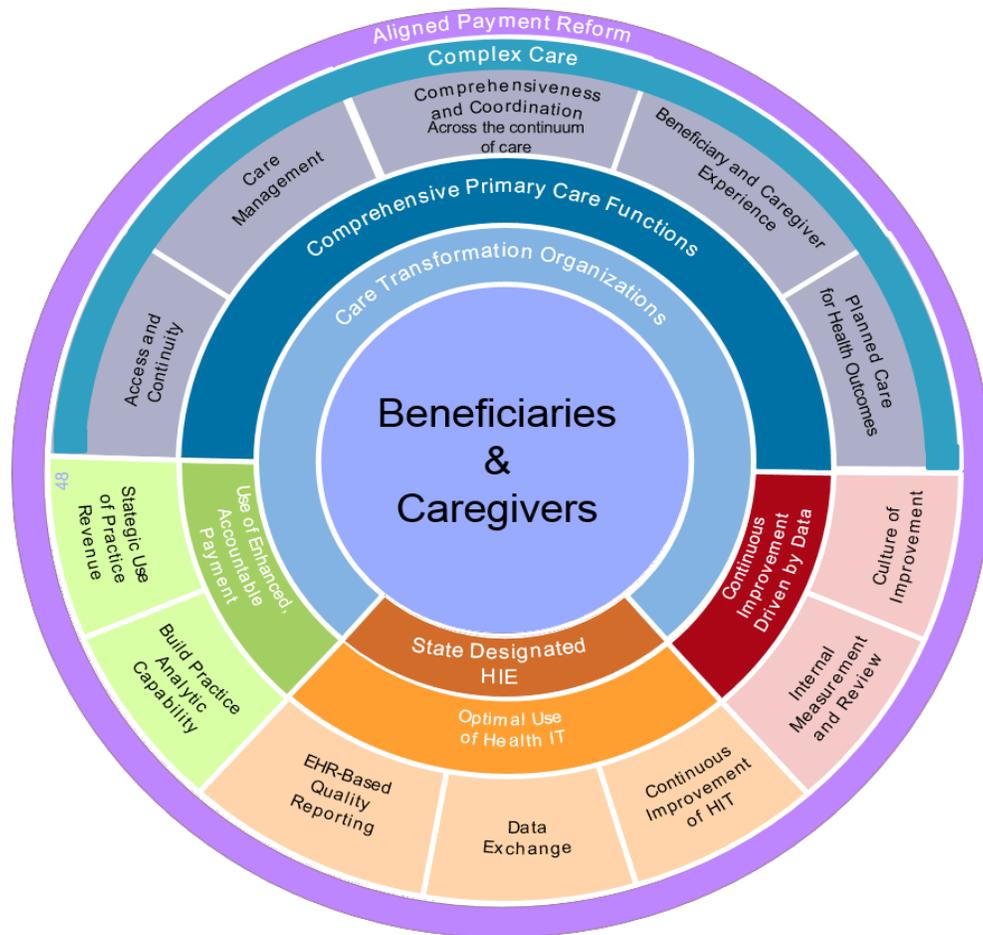
All determinations about whether to accept a practice or a CTO for participation in the MDPCP will be made by CMS at CMS' sole discretion and will not be subject to any administrative or judicial review, per Section 1115A(d)(2) of the Social Security Act (the Act).

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.² Driver 1: The Five Comprehensive Primary Care Functions of Advanced Primary Care (the top half of the

² <https://innovation.cms.gov/Files/x/newdirection-rfi.pdf>

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 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. Practices in both Tracks will be asked to redesign primary care delivery with a focus on care management of all attributed patients and an increasing focus on value-based care that expands care delivery beyond the FFS environment of the office. 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 Performance Year of participation in the MDPCP. CMS will assess each Participant Practice's progress on the applicable care transformation requirements using data 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 Performance 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 Performance 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 Participant 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. Participant 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 Participant 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.) Participating 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. Participant 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 that end, all Participant Practices will be required to maintain at least 5% of their attributed Medicare beneficiaries in care management. 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 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 build 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 a health-related social needs screening tool.

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 partner Participant Practices in meeting the care transformation requirements, at the Participant Practice's request.

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 and the Quality Payment Program 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.

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 commitment to achieving the aims of full connectivity by the end of its first year as a Track 2 Participant Practice. For the purposes of the MDPCP, full 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 a menu of the range of 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, dietitians, 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.

Activity 2: Support for Care Transitions

A CTO's interdisciplinary care management team must, upon request by the partner 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

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/>

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 a health-related social needs screening tool.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 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

⁴ Billioux et al., 2017.

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 a 24 month lookback period to determine the Participant Practice to which beneficiaries will be attributed. 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 at the start of each Performance Year. The MDPCP 2019 Payment Methodology document will be made available in the application portal. CMS will provide Participant Practices with the MDPCP 2020 Payment Methodology document before the start of the Performance Year. The MDPCP Payment Methodology document 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 2020 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 2020 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 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 prepaid Performance-Based Incentive Payment (PBIP). CMS will pay the annual PBIP prospectively, but a Participant Practice may retain the PBIP (in whole or in part) only if it meets certain annual performance thresholds. Thus, a Participant Practice will be required to repay any part or all of its PBIP depending on its 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 Practice, including ongoing Medicare FFS payments.

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

- (1) Incentives for performance on clinical quality/patient 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/patient 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 2020 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/patient 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 the required eCQMs by the end of each performance year, as specified in the Practice Participation Agreement.

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/patient 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/patient 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/patient 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.⁵ 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

⁵ CAHPS is a program of the Agency for Healthcare Research and Quality, U. S. Department of Health and Human Services.

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 and its CTO partner, if applicable, 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 Performance 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 Performance 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 Performance 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 FFS. 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	10% / 90%	N/A	N/A
	25% / 75%	25% / 75%	N/A
Percent of E&M Revenues through FFS	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 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 attest to this support in the Partner Practice's quarterly reporting.

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. The Lead Care Manager is defined as an individual who is fully dedicated to care management functions of the Participant Practice under the MDPCP. 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 management professionals as necessary to fulfill specialized care management needs that the practice may have. The CTO must support its partner Participant Practices in maintaining at least 5% of their attributed Medicare beneficiaries in care management. The CTO will be required to outline their service offerings in their application and will finalize the services offered to each Participant Practice in their CTO arrangement with the Participant Practice.

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, 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. The CTO must support its partner Participant Practices in maintaining at least 5% of their attributed Medicare beneficiaries in care management.

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 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.

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 to CMS 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/patient 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 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.

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, PBIP, and, if applicable, CPCP)
 - Medicare claims data on attributed Medicare beneficiaries (if requested by the practice)

- 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. **Assess learning needs and track progress in the development of Participant Practice capability** to deliver comprehensive and advanced primary care through the MDPCP care transformation requirements.
3. **Understand and share** the changes that Participant Practices make and the specific tactics they deploy to achieve their aims in MDPCP in order to facilitate peer-to-peer learning and innovation and to create communities of Participant Practices and CTOs.
4. **Develop a robust network of Participant Practices and CTOs** across the state of Maryland to foster peer-to-peer learning and innovation. Participant Practices and CTOs will have access to an online collaboration platform to support sharing within and across Tracks.
5. **Leverage the health IT, data capabilities, and community and stakeholder resources** in Maryland to support Participant Practices in delivering comprehensive primary care.
6. **Coach and facilitate Participant Practices** in meeting MDPCP care transformation requirements and building the workflows required for Participant Practices to improve care, improve health outcomes, and reduce total cost of care.

To achieve these goals, the Learning Network will sponsor and convene a series of learning activities such as webinars, in-person learning sessions and affinity groups to bring together groups of Participant Practices and CTOs to learn from each other. The work of the Learning Network will be informed by Participant Practices and CTOs to move both groups toward success in the MDPCP.

To achieve their aims in MDPCP, most Participant Practices will need to redesign the care they furnish. The MDPCP Learning Network is designed to support and facilitate MDPCP practices as they make these changes, led from within.

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. Specifically, 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.

The State may provide Participant Practices that request such data with monthly practice-level See revisions.feedback reports. Such reports could 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. The State may also offer reports of cost and quality data about subspecialists to help Participant Practices select cost-effective specialty partners.

Participant Practices will also report quality metrics for purposes of the PBIP. Participant Practices will be required to submit eCQMs to the State under the terms of the Practice Participation Agreement; the State will, in turn, provide that information to CMS.

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),⁶ 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

⁶ Public Law 104–191, 110 Stat. 1936

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) (located [here](#)). Track 1 and Track 2 of the MDPCP meet the criteria to be Advanced APMs. 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. CMS will provide guidance to Participant Practices regarding 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 collect other programmatic information, including information regarding the use of any CMFs paid to Participant Practices and CTOs. Failure to complete the reporting requirements under the terms of the Practice Participation Agreement and CTO Participation Agreement 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 eQMs, 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 practice-level eQMs. A tentative list of eQMs for Performance Year 2020 appears in [Appendix 1](#) of this RFA. The list of eQMs for Performance Year 2020 will be listed in the Practice Participation Agreement. CMS may update the eQM list for future Performance Years. Instructions regarding the submission of eQMs appear in the MDPCP Payment Methodologies document. Participant Practices will be required to report on the required eQMs. The eQMs, utilization measures, and patient 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 2015 or later edition certified EHR technology. This requirement may be updated to be consistent with future Quality Payment Program requirements;
- Achieve full connectivity with an HIE by the end of the practice's first year of participation in Track 2 of the MDPCP; and
- Electronically report eQMs to the State.

CMS may update the quality measures that Participant Practices must report for future Performance Years. CMS may solicit feedback from stakeholders on which measures Participant Practices should be required to report under the MDPCP. CMS also intends to incorporate measures based on the State's population health goals that broadly represent the focus of the Model (which includes an aim for large, long-term impacts on population health), into the PBIP calculation methodology. For PY2020, the population health measures used to implement the State's population health goals under the Model will focus on obesity and weight management consistent with the State's focus on diabetes prevention. CMS will align the Participant Practice-specific measures used for purposes of calculating the PBIP accordingly.

1. Electronic Clinical Quality Measures

The use of eQMs ensures practitioners and Participant Practices have insight into the quality of the care they provide. The eQMs 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 eQM 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. A tentative list of such measures is provided in [Appendix 1](#).

2. Patient Experience of Care

A subset of the CAHPS Clinician & Group Survey will be administered by CMS to a sample of the Participant Practice's entire patient population to measure experience of care.

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*: Annual Participant Practice submissions to CMS, including a retrospective look at the Participant Practices' and CTOs' actual use of CMFs, PBIPs, and—as applicable—CPCPs.

- *Cost, Utilization, Patient Experience, and Quality Data:* Review of cost, utilization, patient 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 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 that 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. 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.⁷

VI. Authority to Test Model

Section 1115A of the Act 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

⁷ See generally 42 C.F.R. § 403.1110.

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.

Appendix 1: MDPCP Tentative eCQM Set for Performance Year 2020

MDPCP Tentative eCQM Set for Performance Year 2020				
CMS ID#	NQF #	Measure Title	Measure Type/ Data	Domain
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
CMS137v6	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process/eCQM	Effective Clinical Care
CMS69v5	0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up <i>*CMS is considering adding this measure for PY2020</i>	Process/eCQM	Effective Clinical Care

CG-CAHPS Measure			
Component	Domain	Source	Measure Title
Quality	Patient Experience	NQF#0005	CG-CAHPS survey

Utilization Measures			
Utilization	Emergency Department Utilization	HEDIS	Ambulatory care: summary of utilization of ambulatory care in the following categories: ED visits
Utilization	Inpatient Hospital Utilization	HEDIS	Inpatient utilization— general hospital/acute care: summary of utilization of acute inpatient care and services in the following categories: total inpatient, and medicine.