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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 and Federally Qualified Health Centers (FQHCs) 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.

Primary care practices and FQHCs 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 these primary care practices’ and FQHCs’ transformation efforts by making payments for enhanced care management as well as performance-based payments to Participant Practices. All eligible primary care practices and FQHCs within the State are invited to apply to participate in the MDPCP (“Applicant Practices”). 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 that are primary care practices (Track 1 and Track 2), with increased care redesign expectations and payments for Participant Practices in Track 2. During Performance Year 2021, FQHCs are eligible to participate only in Track 1. During the application process, Applicant Practices that are primary care 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 Applicant Practice that is a primary care practice will be assigned if selected to participate in the MDPCP. However, if an Applicant Practice that is a primary care practice is selected to participate in the MDPCP, CMS reserves the right to assign the Applicant Practice that is a primary care practice to Track 1 based on CMS’ assessment of the practice’s readiness to meet the applicable care transformation requirements. Participant Practices that are primary care practices that are assigned to Track 1 are expected to transition along the continuum towards comprehensive primary care; as such, Participant Practices that are primary care practices may spend no more than three Performance Years in Track 1 of the MDPCP. Participant Practices that are primary care 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 MDPCP, 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 semiannual basis, CMS will assess the status and progress of Participant Practices in meeting these care transformation 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 for Participant Practices that are primary care practices: a Standard Track (Track 1) and an Advanced Track (Track 2). During Performance Year 2021, FQHCs are eligible to participate only in Track 1. 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 affect 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 MDPCP. 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 may include health plans, Accountable Care Organizations (ACOs), managed service organizations (MSOs), Clinically Integrated Networks (CINs), hospitals, and other practice support organizations. FQHCs and primary care practices applying to participate in MDPCP as Participant Practices are ineligible to submit CTO applications, but may partner with a CTO if selected to participate in the MDPCP.

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 generally 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 Participant Practice to offer independently. In addition, a CTO facilitates a Participant Practice's care transformation by providing support for the improvement of the Participant Practice's process-of-care as part of the care coordination services furnished to the Participant 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, FQHCs, and CTOs in the State. The CTO, primary care practice, and FQHC application period will begin on May 19, 2020 and end on July 14, 2020 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, Applicant Practices will select whether to

partner with a participating CTO. If the Applicant Practice has selected to partner with a CTO, the Applicant 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 2021 Performance Year prior to the start of the 2021 Performance Year. CMS will send Participant Practices a final list of 2021 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 primary care practice or FQHC that wishes to partner with them unless the CTO is unable to do so due to staffing limitations or because the primary care practice or FQHC 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 primary care practice or FQHC is outside the CTO's geographic coverage area, CMS will, if possible, assign the Participant Practice to the Participant 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 Participant Practice, nor will the CTO be required to expand its geographic coverage area.

Applicant Practices that are primary care practices may also indicate a Track preference (Track 1 or Track 2) in their application, but CMS reserves the right to assign a primary care practice to Track 1 based on CMS' assessment of the practice's readiness to meet the applicable care transformation requirements. However, if a primary care 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, Participant Practices that are primary care practices that select or are assigned to Track 1 may remain in Track 1 for a maximum of three Performance Years; Participant Practices that are primary care practices and 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. This requirement does not apply to FQHCs, which are not eligible to participate in Track 2 in Performance Year 2021.

While CMS will not accept applications to begin participation in the MDPCP in Performance Year 2021 that are submitted after July 14, 2020, CMS intends to accept applications to the MDPCP annually, through calendar year 2023 for the 2024 Performance Year. Primary care practices, FQHCs, 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 beginning in a future Performance Year.

Practices, FQHCs, 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 primary care practice, FQHC, 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 primary care practice or FQHC that applies during the 2020 application period will participate in the MDPCP from

January 1, 2021 until December 31, 2026. Participant Practices that are primary care practices that are selected to participate in Track 1 beginning in Performance Year 2021 must transition to Track 2 no later than the start of Performance Year 2024.

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 and FQHC Eligibility**

### **Primary Care Practices**

For purposes of the MDPCP, a primary care practice is a group of one or more physicians, non-physician practitioners, or combination thereof that furnishes certain specified primary care services, defined as the services described by the evaluation and management code set that is used to bill for office and outpatient visits under the Medicare Physician Fee Schedule, 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 primary care 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, if selected to participate in MDPCP, 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 ("Practice Participation Agreement"). Each Applicant Practice that is a primary care practice must identify in its application:

- 1) A single practice site address, located in Maryland, at which the primary care 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.

For those Applicant Practices that are primary care practices, in order for CMS to identify whether the practice 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 who 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 for inclusion on the Practitioner



Roster. Practitioners with a non-eligible specialty codes (i.e., any specialty codes not identified above) are not eligible to participate in the MDPCP (even if also identified by an eligible specialty code listed in the NPPES) 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 an eligible 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.

## FQHCs

For purposes of the MDPCP, an FQHC is a legal entity identified by an organizational National Provider Number (NPI), a CMS Certification Number (CCN) and a Taxpayer Identification Number (TIN), and is certified as an FQHC as defined under section 1861(aa)(4) of the Act. In the case of an FQHC that furnishes and bills for such FQHC services (as defined at section 1861(aa)(4) of the Act) at multiple locations (none of which is itself a separate legal entity), the FQHC may choose to apply to participate in the MDPCP either as one Participant Practice, or as a separate Participant Practice for each of its locations. An FQHC that participates as one Participant Practice must submit a single application that includes all of its FQHC sites located in Maryland and, if selected to participate in MDPCP, would sign a single participation agreement with CMS to govern the MDPCP activities that occur at all such FQHC sites. If the FQHC elects for each of its locations to apply to participate as separate Participant Practices, the FQHC must submit a separate application for each such FQHC site and, if selected to participate in MDPCP, the MDPCP activities at each participating FQHC site will be governed by separate participation agreements executed by CMS and the FQHC that operates those FQHC sites. Regardless of whether the participation agreement between CMS and an FQHC governs the MDPCP activities at one FQHC site or at multiple FQHC sites, the participation agreement is referred to herein as an "FQHC Participation Agreement."

Each Applicant Practice that is an FQHC must identify in its application the single organizational NPI under which the FQHC will bill for purposes of the MDPCP, the FQHC's CCN, and its TIN so that CMS can determine whether the FQHC participates in an ACO under the Medicare Shared Savings Program. An FQHC that submits a single application that includes all of its FQHC sites must identify in its application each of the addresses of the FQHC's sites located in Maryland that furnish primary care services, defined as non-mental health G-codes which includes: FQHC new patient visit (G0466), FQHC established patient visit (G0467), and FQHC initial preventive physical exam (IPPE) or annual wellness visit (AWV). An FQHC that submits a separate application for each of its FQHC sites located in Maryland must identify in each such application the address at which the FQHC site furnishes the specified primary care services defined above. An Applicant Practice that is an FQHC is not required to submit a Practitioner

Roster to CMS as part of its application.

## General

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

1. The Applicant Practice and, if applicable, all NPIs on the Applicant Practice's Practitioner Roster must be enrolled in Medicare as reflected by an Approved status in the Provider Enrollment, Chain and Ownership System (PECOS)<sup>1</sup>;
2. The Applicant Practice must maintain a minimum of 125 attributed Medicare FFS beneficiaries during each Performance Year, based on the attribution methodology described in [Section III, Part A](#) of this RFA;
3. For an Applicant Practice that is a primary care practice, all NPIs on the Applicant Practice'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;
4. For an Applicant Practice that is an FQHC, the FQHC must submit claims and be paid under the FQHC Prospective Payment System (PPS) for FQHC services; and
5. The Applicant Practice must meet additional requirements under the participation agreement entered into by the entity and CMS (the Practice Participation Agreement or FQHC Participation Agreement).

Applicants and Model participants will be subject to a program integrity (PI) screening. CMS may reject an application or terminate a Practice Participation Agreement or FQHC 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

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<sup>1</sup> 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](#).

- 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.

## Primary Care Practice and FQHC Application Information

The MDPCP application for primary care practices and FQHCs is located [here](#) and will be open for application from May 19, 2020 through midnight of July 14, 2020.

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

Primary Care Practices: For Applicant Practices that are primary care practices, 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.

For an Applicant Practice that is a primary care 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.

FQHCs: For Applicant Practices that are FQHCs, the FQHC must submit either a single application for all of its FQHC sites located in Maryland, or a separate application for each of its FQHC sites located in Maryland.

For an Applicant Practice that is an FQHC that submitted a single application for all of its FQHC sites located in Maryland, the FQHC must sign an FQHC Participation Agreement with CMS to govern MDPCP activities at all of its FQHC sites. For an Applicant Practice that is an FQHC that submitted a separate application for each of its FQHC sites located in Maryland, the FQHC must sign a separate FQHC Participation Agreement for each such FQHC site.

General: All Applicant Practices must submit with their application a letter of support from a clinical leader within the primary care practice or FQHC demonstrating a commitment to the MDPCP and a willingness to provide leadership in support of the practice's or FQHC's participation in the program. If the Applicant Practice is owned by a person, entity, or organization other than a clinical or other leader who practices at the single primary care practice or FQHC location identified in the application, or by a separate entity or healthcare organization, the Applicant Practice also must submit a letter of support from the owner committing to segregate funds that are paid based on the Applicant Practice's participation in the MDPCP and

assuring that all MDPCP payments will be used in a manner consistent with the Practice Participation Agreement or FQHC Participation Agreement, as applicable. Additionally, all Applicant Practices must submit a letter executed by both the Applicant 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). For an Applicant Practice that is a primary care practice, this letter should indicate a commitment to achieving the aims of full connectivity by the end of the Applicant Practice's first year of participation as a Track 2 practice.

Practices, FQHCs, 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 are not eligible to participate in the MDPCP as Participant Practices.

Applicant Practices that meet the applicable eligibility requirements, successfully complete the application process, and can meet the applicable care transformation requirements will be selected to participate in the MDPCP as a Participant Practice.

## **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 primary care 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 19, 2020 through midnight of July 14, 2020.

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 primary care practice or FQHC.

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 primary care practices and FQHCs with which they are partnered under the program.

### **C. Multi-Payer Strategy**

In an effort to improve population health and reduce overall health care costs, CMS plans to enter in to one or more Memoranda of Understanding ("MOU") with payers who are also interested in supporting comprehensive primary care reform within Participant Practices in Maryland. In Fall 2019, CMS solicited proposals from third-party payers operating in Maryland who were interested in aligning with the principles of advanced primary care in MDPCP. CareFirst submitted a proposal in response to this solicitation, was selected by CMS, and on January 1, 2020, CMS entered into an MOU with CareFirst as an aligned payer.

Applicant Practices 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 Applicant Practices and payers; Participant Practices are not required to enter into arrangements with payers other than CMS under the terms of the applicable MDPCP participation agreement.

Payer Solicitation Information

CMS anticipates releasing a solicitation for additional payers interested in aligning with the principles of advanced primary care in MDPCP annually through calendar year 2023 for the 2024 Performance Year. Each such 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 Participant 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 Participant 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' primary care practices and FQHCs 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 the MDPCP Learning Network and/or provide learning resources to support Participant Practices in performing comprehensive primary care functions.

## D. Selection of Participant Practices and Participating CTOs

Both Applicant Practices 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 application for primary care practices and FQHCs can be found at <https://app1.innovation.cms.gov/mdprov/mdprovLogin>.

CMS will assess each application to verify that the applicant meets the eligibility requirements and can meet the relevant care transformation requirements. All Applicant Practices 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 applicable eligibility requirements and that CMS determines can meet the applicable care transformation requirements based on the contents of their application.

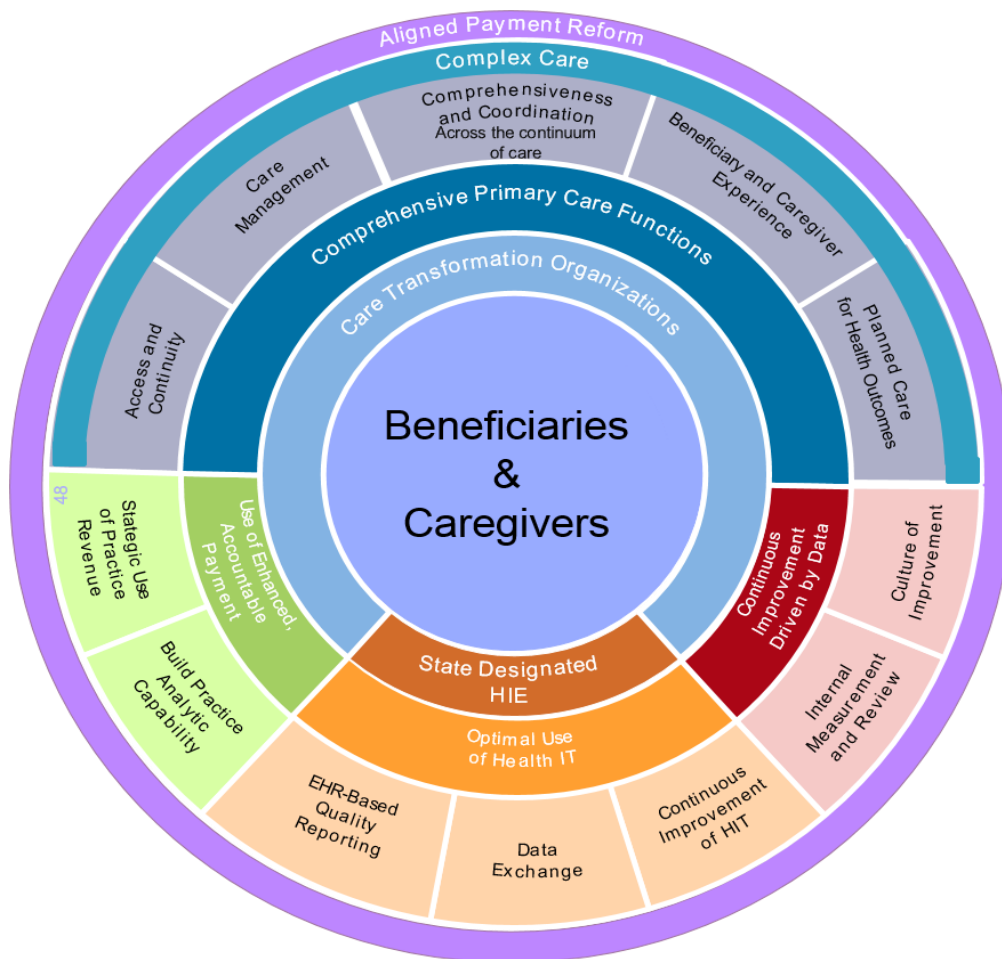
As part of their application, primary care practice and FQHC applicants may identify the CTO with which they would like to partner, if any. The CTO selection that an Applicant Practice makes in its application is non-binding, as Participant Practices will have an opportunity to select new CTOs that may be participating in MDPCP for the first time in the 2021 Performance Year. Primary care practices, FQHCs, and CTOs that submit applications during the 2020 application period, that are selected to participate in the MDPCP, and that sign a Practice Participation Agreement, FQHC Participation Agreement, or CTO Participation Agreement with CMS (as applicable) are expected to begin participation in the MDPCP in January 2021. Primary care practices, FQHCs, and CTOs that do not apply during the 2020 application period or are not selected to participate in the MDPCP for the 2021 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 primary care practice, FQHC, or a CTO for participation in the MDPCP will be made by CMS at CMS' sole discretion and will not be subject to any administrative or judicial review, per section 1115A(d)(2) of the Act.

## II. Theory of Care Transformation

By requiring Participant Practices to meet specific care transformation requirements and aligning Medicare payments accordingly, CMS and the State expect that Participant Practices will provide more comprehensive and continuous care. This will likely reduce beneficiaries' complications and overutilization of services in higher cost settings, which in turn should lead to better quality and lower costs of care. An outline of the theory of action for both Tracks in the MDPCP and the broad overview of the initiative is visually represented by the driver diagram in Figure 1.

Figure 1. MDPCP Driver Diagram



The care delivery redesign that CMS and the State believe is necessary to produce the desired outcomes is the same across both Tracks of the MDPCP. The 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.<sup>2</sup> Driver 1: The Five Comprehensive Primary Care Functions of Advanced Primary Care (the top half of the radial diagram, shown in light blue and grey above) is based upon principles akin to those that underpin CMS' other comprehensive primary care models. The underlying practice structures 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. Participant 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 *Advancing Primary Care in the MDPCP*.

Participant Practices that are primary care practices may remain in Track 1 for a maximum of three Performance Years; these primary care 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 semiannual reporting, on-site assessments, and other means. Surveys will ask Track 1 Participant Practices that are primary care practices to indicate readiness for Track 2. By the beginning of the fourth calendar quarter of a primary care practice's third Performance Year of participation in Track 1 of MDPCP, the practice must have met all Track 1 care transformation requirements and attest to the practice's readiness to transition to Track 2. Primary care 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 primary care practice's Practice Participation

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

Agreement if the practice is unable to attest that it is ready to transition to Track 2 at this time. These readiness requirements do not apply to FQHCs, which are not eligible to participate in Track 2 during the 2021 Performance Year.

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 capabilities. Participant Practices will report their progress on the care transformation requirements regularly by responding to 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. Under the MDPCP, 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, *Advancing Primary Care in 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 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 Participant Practice's

request, assist partner Participant 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 and 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 resources to provide care management to at least 5% of their attributed Medicare beneficiaries. To guide their care management efforts, Track 2 practices will be required to create care plans focused on goals and strategies congruent with beneficiaries' choices and values.

CTOs must support their partner Participant Practices as part of the care coordination services provided to Medicare beneficiaries attributed to those Participant 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 and FQHCs 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 Participant 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 Participation Agreement, FQHC Participation Agreement, and CTO Participation Agreement to meet the care transformation requirements. Participant Practices will be required to report to CMS actual expenditures of the CMF and ratios of such expenditures to total primary care practice or FQHC income. 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 Participant Practice. If the Participant Practice is an FQHC that has signed a single FQHC Participation Agreement for all of its FQHC sites, the Participant Practice also needs to collect this information at the FQHC site 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 2015 certified EHR technology (CEHRT) in accordance with the terms of the Practice Participation Agreement, FQHC Participation Agreement, and the Quality Payment Program to ensure remote access to each attributed beneficiary's EHR for the Participant 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 at the Participant Practice. If the Participant Practice is an FQHC that has signed a single FQHC Participation Agreement for all of its FQHC sites, the Participant Practice also needs to collect this information at the FQHC site level.

To be eligible to participate in the MDPCP, an Applicant Practice must submit a letter executed by both the primary care practice or FQHC 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 if the Participant Practice is a primary care practice. For the purposes of the MDPCP, full connectivity is defined as the ability to send and receive clinical information about a practice's or FQHC'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 Participant 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 applicable 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, for a Participant Practice that is a primary care practice, is 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 primary care practitioner of the Participant Practice (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 primary care practice's or FQHC's primary care practitioners.

The CTO must employ and manage an interdisciplinary care management team of health care

providers, which may include nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (such as substance use disorder prevention and treatment providers), chiropractors, licensed complementary and alternative medicine practitioners, and physician assistants. Participant Practices may find that they lack the scale to economically deploy a full interdisciplinary care management team of this nature.<sup>3</sup> 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 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 Participant Practice must receive a standardized screening for health-related social needs using a health-related social needs screening tool.<sup>4</sup> Risk stratification and standardized screening will help to identify the need to refer beneficiaries to social service

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<sup>3</sup> 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/>

<sup>4</sup> Billioux et al., 2017.

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 program, 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 or FQHC Participation Agreement, as applicable, 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 Participant 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 applicable care transformation requirements in order to advance primary care delivery within their primary care practice. A CTO may assist partner Participant Practices with workflow changes that could allow improved integration with care managers and other team members. CTOs will be available to provide care coordination services to Medicare beneficiaries attributed to partner Participant Practices and deploy resources in order to help these Participant 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 and FQHC PPS. 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 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 on a quarterly basis during the Performance Year. The MDPCP 2020 Payment Methodology document will be made available in the application portal. CMS will provide Participant Practices with the MDPCP 2021 Payment Methodology document before the start of the 2021 Performance Year. The MDPCP Payment Methodology document will provide further detail on the attribution and payment structure outlined in the Practice Participation Agreement and FQHC Participation Agreement and will be updated yearly.

## B. Payments to Participant Practices

CMS will distribute to Participant Practices up to three separate payment streams based on the number of attributed beneficiaries, performance, Track, 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.

**Error! Reference source not found.** illustrates the CMF amounts and beneficiary risk tiers for the 2021 Performance Year. The CMF payment amounts for Track 2 Participant Practices are higher than those made to Track 1 Participant Practices given the increased scope and intensity of the care coordination requirements applicable to Track 2 Participant 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 2021 Performance Year

	Track 1	Track 2
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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/or 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 23 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 or FQHC Participation Agreement, as applicable, in doing so.

CMS will monitor the use of CMF payments through the Participant Practices' submission of actual CMF expenditures and spending ratios. 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 or FQHC Participation Agreement, as applicable.

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 and FQHC 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 and FQHC Participation Agreement so that Applicant Practices more fully understand the payment mechanism prior to the start of their participation in the MDPCP.

Table 2. Performance Year 2021 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 based on the beneficiary

attribution list described in Section III.A of this RFA for the first calendar quarter of the Performance Year. 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 or FQHC Participation Agreement, as applicable.

The amount of the PBIP retained by a Participant Practice at the end of each Performance Year will be based on the Participant 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 Participant Practice keeps none of the PBIP amount) and a maximum score of 80 percent (above which a Participant 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 and FQHC 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.<sup>5</sup> The Participant Practice's performance on the utilization component will be based on Medicare claims-based measures of inpatient admissions and ED visits, which are available in Healthcare Effectiveness Data and Information Set (HEDIS).

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

Participant Practices may concurrently participate in the MDPCP and be part of an ACO

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<sup>5</sup> CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services.

participating in the [Medicare Shared Savings Program](#) (Shared Savings Program). However, if a Participant Practice is a dual-participant in the MDPCP and the Shared Savings Program, the MDPCP Participant Practice will not be eligible to receive the PBIP, nor will its CTO partner, if applicable, receive any PBIP associated with that Participant Practice. 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. Such a Participant Practice will be required to report quality scores through the MDPCP, for monitoring and evaluation purposes and must also take part in quality reporting through the ACO under the Shared Savings Program.

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

Medicare FFS and PPS 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 historic 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 **Error! Reference source not found.** 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 Track 2 of 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 Participant Practice's first Performance Year in Track 2 of the program, 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), primary care 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. This requirement does not apply to FQHCs, which are not eligible to participate in Track 2.

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 **Error! Reference source not found.**

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. This reconciliation construct applies only to practices in Track 2, and as such, does not apply to FQHCs.

## C. Partnerships between Participant 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 application process for primary care practices and FQHCs. CTOs will indicate their geographic coverage area, comprised of a county or counties in Maryland, in their application. While Participant Practices are not required to partner with a CTO, participating CTOs must partner with any Participant Practice that wishes to partner with them unless the CTO is unable to due to staffing limitations or because the Participant Practice is outside of the CTO's geographic coverage area. If a primary care practice or FQHC wishes to partner with a CTO that has reached capacity and/or if the practice or FQHC is outside of the CTO's geographic coverage area, CMS will make a determination as to which CTO may partner with the practice or FQHC. Each year, at a time and in a manner specified by CMS, Participant 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 with CMS, 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 Participant Practice(s) by a corresponding amount. The overall CMF amount paid by CMS to both the Participant 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 or FQHC Participation Agreement, as applicable, and the 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 an interdisciplinary care management team 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 semiannual practice reporting (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 applicable 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 Participant Practice's semiannual 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 the practitioners of the Participant Practice who have primary responsibility for care management of all beneficiaries attributed to the Participant Practice. The CTO may provide additional care management professionals as necessary to fulfill specialized care management needs that the Participant Practice may have. The CTO must support its partner Participant Practices in maintaining resources to provide care management to 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 partner 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 Participant Practice. However, the CTO will provide the Participant 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 Participant Practice. The CTO must support its partner Participant Practices in maintaining resources to provide care management to 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 applicable 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 partner 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 and specified in the CTO Participation Agreement. 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 applicable 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 Participant Practices are not concurrently participating in a Shared Savings Program 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 Participant 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 CTO 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 Participant Practice's attributed beneficiaries and the payment amounts that the Participant Practice will receive. Practices and FQHCs 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 Participant Practice)
- Learning Network:
  - Participant Practice coaching
  - Connections to learning forums and to other Participant Practices in the State
  - Networking with other Participant Practices and CTOs
  - A variety of guidance materials from CMS, including Getting Started with the MDPCP, Advancing Primary Care in the MDPCP, and the Quality Measures Reporting Guide.

## 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 guidance materials 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. **Foster peer-to-peer learning and innovation for Participant Practices and CTOs** via 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 a series of learning activities 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 Participant Practices as they make these changes, led from within.

## B. Data Sharing

In the MDPCP, CMS will offer Participant Practices and qualified CTOs the opportunity to request regular data feedback to help inform their care transformation efforts. Where legally

accurate in its representation of the reasons such Participant Practices and CTOs are seeking such data, requests should be made using the *HIPAA-Covered Disclosure Request Attestation and Data Specification Worksheet* in the Practice Participation Agreement, FQHC Participation Agreement, and CTO Participation Agreement. Specifically, CMS will offer Participant Practices and participating CTOs the opportunity to request practice-level and certain beneficiary-level Medicare beneficiary data (Parts A and B claims) for use in care management and quality improvement purposes. Participant Practices and participating CTOs may reuse such data in accordance with applicable laws, participation agreements and other controlling documents such as data use agreements.

The State may provide Participant Practices and participating CTOs that request such data with monthly practice-level 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 work with 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 or FQHC Participation Agreement, as applicable; 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),<sup>6</sup> 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.

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<sup>6</sup> Public Law 104–191, 110 Stat. 1936

There are two exceptions to this rule:

1. **Medicare Shared Savings Program.** Primary care practices and FQHCs may participate concurrently in the MDPCP and in any track of the Shared Savings Program. Primary care practices participating in the Shared Savings Program can participate in either Track of the MDPCP; FQHCs may participate in any Track of the Shared Savings Program, but are only eligible to participate in Track 1 of MDPCP in 2021. However, primary care practices and FQHCs within an ACO that is participating in the ACO Investment Model (AIM), or any other shared savings initiative may not participate in the MDPCP.
2. **Care Redesign Program.** Primary care physicians participating in the [Care Redesign Program](#) (CRP) as a Care Partner for one or more CRP participant hospitals may be eligible to participate concurrently in the MDPCP. Each CRP Track has a specific set of Care Partner Qualifications that limit what types of providers and suppliers may participate as Care Partners for that Track, and such qualifications may prohibit practitioners from participating concurrently in the MDPCP. Any such prohibitions will be identified in the CRP Track's Care Partner Qualifications set forth in the Track Implementation Protocol. CMS retains the right to establish and amend the Care Partner Qualifications for each CRP Track and prohibit certain types of providers and suppliers from participating as Care Partners in the CRP.

## D. The Quality Payment Program

Under the Quality Payment Program, both components of the Model (which includes a hospital payment Track and both Track 1 and Track 2 of the MDPCP Track) qualify as Advanced Alternative Payment Models (Advanced APMs) (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 Participant Practices are subject to the MIPS reporting requirements and payment adjustment unless they are otherwise excluded. The MDPCP is a MIPS APM. Only MIPS eligible clinicians (MIPS ECs) are subject to the MIPS payment adjustments. Participant

Practices that are FQHCs may be exempt from MIPS if they bill for Medicare Part B services exclusively through the FQHC payment methods because MIPS does not apply to these facility payments. However, if the Participant Practice FQHC bills for Medicare Part B services under the PFS, then payment for such other services would be subject to the MIPS payment adjustments unless the Participant Practice FQHC's billing thresholds are below the low volume exclusion threshold determination or the Participant Practice FQHC meets another exclusion. For more information regarding MIPS please refer to the Quality Payment Program website link in the paragraph immediately below.

The ENHANCED Track, BASIC Track (Level E, only), and Track 2 of the Shared Savings Program are also Advanced APMs. Primary care practices concurrently participating in the MDPCP and a Shared Savings Program ACO 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 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 participating CTOs will be required under their respective participation agreements with CMS to report certain operational data as well as other information to CMS through the MDPCP Portal. Reporting by Participant Practices and participating CTOs allows CMS to track progress on the relevant program requirements and to understand the Participant Practice's and participating 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, including designating a Lead Care Manager. 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 regarding how to meet and report practice care transformation requirements. This guidance will be made available to Participant Practices and participating CTOs annually.

Both Participant Practices and CTOs will be required to complete reporting semiannually through the MDPCP Portal in order to demonstrate that Participant Practices are making progress toward or 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, FQHC Participation Agreement, or CTO

Participation Agreement, as applicable, 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 Participant Practice will be required to provide an annual report on how the funds were spent. For a participating 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 participating CTOs, and of CPCP payments by Track 2 Participant Practices, will not be restricted under the terms of the Practice Participation Agreement, FQHC 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 experience of care surveys, 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 2021 appears in [Appendix 1](#) of this RFA. The final list of eQMs for Performance Year 2021 will be listed in the Practice Participation Agreement and FQHC Participation Agreement. CMS may update the eQm list for future Performance Years. Instructions regarding the submission of eQMs appear in the *MDPCP Quality Reporting Guide*. 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 Participant 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 Performance Year 2021, the population health measures used to implement the State’s population health goals under the Model will focus on Screening for Abnormal Blood Glucose in Overweight/Obese Patients and Substance Use Screening and Intervention, consistent with the State’s focus on diabetes prevention and Substance Use Disorder. CMS will align the Participant Practice-specific measures used for purposes of calculating the PBIP accordingly.

### **1. Electronic Clinical Quality Measures**

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

The eCQM measures that CMS will require Participant Practices to report under the MDPCP target a primary care beneficiary population, and, where feasible, are outcome measures instead of process measures. 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 may 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 Practices 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 primary care practice’s and CTO’s associated TINs. FQHCs will be required to undergo the program integrity screening, but will not have their NPIs vetted, as they are exempt from the Practitioner Roster requirement. 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 Participant Practice or CTO. Additionally, Participant Practices and participating 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 participating CTOs comply with the Practice Participation Agreement, FQHC Participation Agreement, and CTO Participation Agreement, respectively. Moreover, monitoring helps CMS confirm that Participant Practices and participating CTOs understand and can track their progress towards meeting the applicable care transformation requirements.

The Practice Participation Agreement, the FQHC 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*: Semiannual 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 participating CTOs' actual use of CMFs.
- *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 and participating CTOs 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 participating 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 participating CTOs will also be subject to audit by CMS. To the extent possible (and practicable), Participant Practices and participating CTOs will receive advance notice of upcoming audits. CMS may decide to audit a Participant Practice and/or a participating 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 participating 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 participating 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, FQHC Participation Agreement, and CTO Participation Agreement. Participant Practices and participating 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 participating 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, FQHC Participation Agreement, or CTO Participation Agreement, as applicable, may be terminated from the MDPCP by CMS.

#### **D. Participation in CMS' Evaluation**

All participants in the MDPCP, including both Participant Practices and participating 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.<sup>7</sup>

### **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 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 Act, 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

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<sup>7</sup> See generally 42 C.F.R. § 403.1110.

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, FQHC 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, FQHC 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 2021

MDPCP Tentative eCQM Set for Performance Year 2021				
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	Outcome/eCQM	Effective Clinical Care
TBD for 2022	TBD	Screening for Abnormal Blood Glucose in Overweight/Obese Patients	Process/eCQM	Population Health

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.