2016

MARYLAND COMPREHENSIVE PRIMARY CARE REDESIGN PROPOSAL

PROPOSAL TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES

SUBMITTED BY THE MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Table of Contents

Acronyms

AAPM	Advanced Alternative Payment Model
APM	All-Payer Model (Maryland)
ACO	Accountable Care Organization
AHRQ	The Agency for Health Care Research and Quality
APM	Alternative Payment Model
CCIP	Chronic Care Improvement Program
C-CDA	Consolidated - Clinical Document Architecture
CCM	Chronic Care Management
CE	Coordinating Entity
CHIP	Children's Health Insurance Program
CIN	Clinically Integrated Networks
CMF	Care Management Fee
CMMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPC Model	Comprehensive Primary Care Model (Maryland)
CPC+	Comprehensive Primary Care Plus (CMS)
CPT	Current Procedural Terminology
CRISP	Chesapeake Regional Information System for our Patients
CTOs	Care Transformation Organizations
D-ACO	Duals Accountable Care Organization (Maryland Medicaid)
eCQMs	Electronic Clinical Quality measures
EHR	Electronic Health Record
E & M Codes	Evaluation and Management codes
ENS	Encounter Notification Service
FFS	Fee-for-Service
FTC	The Federal Trade Commission
HCIP	Hospital Care Improvement Program
HCC	Hierarchical Conditional Category (CMS)
HSCRC	Health Services Cost Review Commission (Maryland)
HHS	The Department of Health and Human Services
HIE	Health Information Exchange
LHDs	Local Health Departments
LHICs	Local Health Improvement Coalitions
LTSS	Long-Term Services and Supports
MACRA	The Medicare Access and CHIP Reauthorization Act of 2015
MACRA	Maryland Health Care Commission (Maryland)
MIPS	Merit-Based Incentive Payment Systems
NCQA	National Committee on Quality Assurance
PAU	Potentially Avoidable Utilization
PCH	Person-Centered Home
PCHH	Patient-Centered Health Home
PCMH	Patient-Centered Medical Home
PDP	Patient Designated Provider
PFAC	Patient and Family Advisory Council
PHO	Physician-Hospital Organization
QRDA	Quality Reporting Document Architecture
SGR	Sustainable Growth Rate
SNF	Skilled Nursing Facility
TCM	Naylor Transitional Care Model
TCN	Transitional Care Nurse
TCOC	Total Cost of Care
VBP	Value-Based Payment Program

I. Overview

The purpose of this paper is to present the State of Maryland's proposal for the Maryland Comprehensive Primary Care (CPC) Model to the Centers for Medicare and Medicaid Services (CMS). The Maryland CPC Model is one of the central features of Maryland's Progression Plan that was submitted by Governor Hogan on December 16, 2016.

This concept paper is presented in the following order:

1. **Background/Opportunity:** This section provides a brief overview of the current primary care delivery system in Maryland. The overview is followed by a description of the opportunity to transform the well-entrenched but inefficient ambulatory system of care in Maryland to a modern person centered system with advanced primary care functionality. The context is two landmark systems converging to provide unprecedented opportunity to transform the landscape of health care delivery: the All-Payer Global Budget Hospital System and the dawning of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) age of value based payments to providers.

2. **Guiding Principles:** This section outlines the guiding principles on which the Maryland CPC Model is based. Each principle is enumerated and discussed in context of its short and long term value to the physical, emotional, and social needs of residents as well as the fiscal health of the State.

3. **Model Design:** This section specifies the design of the program from the general structure to its detailed components. Discussion includes how the Maryland CPC Model aligns with CMS' current Comprehensive Primary Care Plus (CPC+) program and the departures from the program that add unique value in the Maryland context.

    A. *Person Centered Homes/Patient Designated Providers.* A person centered home (PCH) provides comprehensive and coordinated care around a person's health care needs. A provider's office is considered the central hub, or home, where facilitation and coordination to other health care professionals takes place. PCHs improve access and efficiency to care by providing more seamless coordination of care and meeting patients where they are in the arc of their lives. This section includes descriptions and the requirements of Maryland's PCH concept and the unique approach to Patient Designated Providers (PDPs).

    B. *Care Transformation Organization (CTO).* CTOs are entities that provide supporting services to practices. The CTOs generate economies of scale in the provision of enhanced services that are challenging or impossible for many small and medium size practices to engage financially or operationally. In addition, CTOs provide education and technical assistance to practices that are tailored to the needs of the provider and patient community.

    C. *Coordinating Entity (CE).* The CE is the entity that coordinates the unique rule sets within the Maryland model, administers the program, and approves PCH and CTO participation.

4. **Care Delivery Redesign:** This section describes how practices participating in the Maryland CPC Model will make transformative changes to the way they deliver care. It also delineates the preliminary roles and responsibilities for achieving transformation between the CTO and PCH.

5. **Payment Design:** This section describes the design of the payments to practices and supporting entities in the Maryland CPC Model.

6. **Learning System Strategy:** The Maryland CPC Model will include a robust learning system to guide practices through their care delivery transformations. The practices themselves will be the primary drivers of practice change, but the learning system will provide support, accountability, and learning opportunities across the Model.

7. **Alignment with Other Models:** This section illustrates the harmony of the Maryland CPC Model with other state models and the synergy gained through the alignment of incentives.

8. **Quantitative Analysis:** This section describes the metrics associated with the Maryland CPC model, including PDP designations, transformation ramp up projections, and expected provider readiness and selection based on informed assumptions.

II. Background and Opportunity

A. Why Redesigning Primary Care in Maryland is Essential

Thirty seven years ago Maryland first achieved All-Payer status for hospital payments. In an effort to further modernize a volume based payment to a value based payment, Maryland received a five-year performance period approval from the Centers for Medicare and Medicaid Services (CMS) in 2014 for the new hospital payment model waiver based on global hospital budgets and quality targets, the All-Payer Model (APM). The APM modernized Maryland's hospital payment system by implementing hospital-specific global budgets and tying growth in per capita hospital spending to growth in Maryland's overall economy. To date, in Phase I of the All-Payer Model, Maryland has been successful in achieving reduced hospital costs, reduced hospital-acquired conditions, and reduced readmissions. The first-year metrics were met: all-payer revenue growth was held to 1.47 percent per capita, compared to the 3.58 percent per capita ceiling; Medicare realized savings in hospital spending of $116 million, a substantial contribution to the five-year requirement of $330 million; quality measures for hospital acquired conditions improved, and hospital readmissions declined. In the second year, 2015, the All-Payer Model generated another $135 million in hospital savings, bringing the total for the first two years to $251 million, or more than two-thirds of the $330 million in savings promised over the first five years of the Model agreement. Further, Maryland's rate of hospital-acquired conditions declined substantially in calendar years 2014 and 2015. The gap between readmission rates in Maryland and the nation as a whole has narrowed as those rates have been decreasing in Maryland under the All-Payer Model. All of these successes are strong evidence that Maryland has made a commitment to shifting hospital payments away from volume and toward value.

While hospital costs have been decreasing in Maryland, future total health care cost savings will need to be realized by aligning and integrating both the hospital and non- hospital providers in a coordinated system of care .The interplay between the need for decreases in preventable hospital use and non-hospital use trends is important to understand and manage, particularly as Maryland moves to second term of the All-Payer Model, slated to begin in January 2019. At that time, Maryland will become accountable for the total cost of care (TCOC) for Medicare fee-for-service (FFS) beneficiaries. Hospitals cannot accomplish this alone. They need to achieve care delivery alignment with non-hospital providers of care (e.g., PDPs), and they need to start that process now.

It is important to note that beneficiaries' direct primary care payments are a small proportion of total health care spending, while primary care providers direct the bulk of the overall costs of care. If beneficiaries' primary care needs are properly managed and supported, it can play an important role in prevention, improving health outcomes and controlling the growth in total health care spending. In preparation for the second term of the All-Payer Model, Maryland has secured a Care Redesign Amendment with CMS that provides authority under the existing Model Agreement for hospitals to pursue care redesign incentive programs with non-hospital providers of care. A portfolio of such programs will be designed and implemented incrementally. To date, the proposed programs are hospital-focused, aimed at the high needs, high-cost patients of today who have the greatest urgency for care supports. This program will complement the Maryland CPC in coordination of patient transitions from hospital to community care.

Redesigning the delivery of primary care to achieve better overall population health outcomes, in concert with implementing Care Redesign Amendment programs targeting Maryland's current high needs patients, prepares the state for success in the second term of the All-Payer Model and prepares primary care clinicians for success in the era of MACRA and Advanced Alternative Payment Models (AAPM). A review of the current state of primary care in Maryland today mirrors the situation in the United States as a whole in that

there is simply a shortage of primary care providers, relative to the need for primary care services. There is maldistribution of primary care practitioners, leading to serious healthcare professional shortages (HPSAs) and medically underserved areas (MUAs) in rural and lower-income urban areas. The Maryland CPC model supports and promotes the growth of primary care by making primary care more attractive as a business opportunity, more satisfying professionally, and more integral in the fabric of health care delivery throughout Maryland.

This proposal outlines an approach to achieve alignment of primary care providers with Maryland's goals under the All-Payer Model by supporting and rewarding them for redesigning their care delivery to promote better health outcomes. The proposal complements Care Redesign Amendment activities and enhances their likelihood of success in controlling TCOC and meeting quality goals of the All-Payer Model.

B. Current State of Primary Care in Maryland: Building a Foundation for Care Redesign

Maryland has significant experience in improving primary care models. Several years ago, the State implemented a Multi-Payer Patient Centered Medical Home Program (MMPP). The MMPP engaged over 330 primary care physicians, five commercial payers, and six Medicaid Managed Care Organizations. MMPP funding incubated the development of the Maryland Learning Collaborative, a program that has supported practice transformation in Maryland since 2011. An evaluation conducted by IMPAQ, International LLC found that the MMPP had a statistically significant positive program impact compared to the baseline 2010 for mean Medicaid total hospital inpatient and outpatient costs in each of the three years of the program and on mean total Medicaid payments for one year of the program. In part due to the success of the program, Medicaid continued the program through June 2016.

CareFirst, the largest insurer in Maryland, has implemented a single patient centered medical home (PCMH) program that now engages over 3,000 Maryland primary care physicians. The CareFirst program was recognized as a state-level PCMH program in October 2010 after an extensive assessment. The CareFirst program now encompasses a substantial portion of their self-insured and fully insured business including state and federal employee programs. CareFirst holds primary care providers accountable for quality and TCOC. CareFirst has reported four consecutive years of success with its model. An evaluation completed by a research team from George Mason University found positive results under the CareFirst model.[1] In 2015, almost 66 percent of participants earned shared savings. CIGNA has implemented a version of the Dartmouth-Hitchcock PCMH model at several practices in Maryland.[2] Additional commercial payers in Maryland have begun to negotiate similar value-based contracts with providers. Many of the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO) are functioning throughout the state, with more scheduled to begin in January 2017. Additionally, plans are underway in Maryland to establish a Dual-Eligible ACO model. Taken together, these initiatives, including the important lessons learned with each, demonstrate Maryland's continued focus on supporting primary care providers and increasing accountability to improve quality health care and reduce cost.

These primary care–focused initiatives, coupled with the accelerant role of the All-Payer Model, are further enhanced by state health information exchange (HIE) infrastructure, which enhances the ability to redesign

[1] Cuellar, A., Helmchen, L.A., Gimm, G. et al., *The CareFirst Patient-Centered Medical Home Program: Cost and Utilization Effects in Its First Three Years*. J GEN INTERN MED (2016) 31: 1382. doi:10.1007/s11606-016-3814-z

[2] Salmon RB, Sanderson MI, Walters BA, Kennedy K, Flores RC, Muney AM., A collaborative accountable care model in three practices showed promising early results on costs and quality of care. Health Aff (Millwood). 2012 Nov; 31(11):2379-87. doi: 10.1377/hlthaff.2012.0354.

care. The Chesapeake Regional Information System for our Patients (CRISP) is Maryland's state designated HIE (see Maryland Agreement, companion document). CRISP is one of the most advanced HIEs in the nation and is expanding its capabilities to provide reliable and usable data for clinicians quickly, at the point of care. Recently CRISP has also taken on the role as state repository of patient-identifiable claims data from CMS in order to enhance care coordination and population health management activities. CRISP recently implemented CAliPHR, an electronic clinical quality measurement (eCQM) tool that can be used by practices to calculate eCQMs in real-time, and is certified to the 2014 edition and will be certified to the 2015 edition in 2017. Innovative clinician-to-clinician communication tools as well as shared care plans are now being piloted within CRISP, with practicing clinicians involved in the design and testing of these tools. This interactive strategy promotes greater adoption of these new features and resources that save clinicians' and patients' time and simplify navigation of the health care system.

Nationwide, the Comprehensive Primary Care Plus (CPC+) program is being promoted as a multi-payer program in selected regions. The CPC+ program offers primary care clinicians the opportunity to focus on patient panel management and improved outcomes. It allows primary care clinicians to depart from the current model of balancing the demands of meeting practice overhead (i.e., maintaining high patient visit volume) with the demands of reporting on quality metrics; a challenging situation that is a significant source of frustration and professional departure among the primary care workforce.

This proposal outlines a Medicare focused "CPC+ like" program open to all qualifying Maryland primary care providers and select specialty providers who function as a patient's primary provider. In this proposed program, Maryland CPC, will align with the All-Payer Model and the proposed programs of the Care Redesign Amendment to deliver safe, cost-effective, and satisfying care to Maryland's residents. Hospitals, specialists, and primary care clinicians of Maryland will be working with the same goals and be incentivized for the same outcomes.

C. Maryland CPC Program Goals

The primary goal of the Maryland CPC Model is to improve the health of Maryland's six million residents. The State has a strong and fundamental belief that in order to meet this goal, it must make significant improvements in the manner in which care is delivered to Maryland residents. Furthermore, the goals of the Maryland CPC Model are consistent with Maryland's vision for the second term of the All-Payer Model:

- Align community providers with hospitals and specialists to foster collaboration in the care of shared patients in order to reduce potentially avoidable utilization;
- Reduce the pool of high needs and super-utilizing patients through better management of the rising risk population to avoid the development of advanced disease;
- Move care to the safest, most appropriate, and most cost-efficient care setting possible;
- Allow clinicians to assume greater overall responsibility for patient populations, thereby providing a path toward sustainability and success for the Maryland CPC Model and All-Payer Model;
- Identify and reduce disparities in care delivery and health outcomes; and
- Foster and implement innovations in health care delivery, including multidisciplinary integration of services.

D. Guiding Principles

Prior to designing the Maryland CPC Model, the State developed 15 principles that were used throughout the planning and design process to guide model development. In the aggregate these principles address the medical and psychosocial needs of all consumers while fostering reductions in unnecessary health care expenses:

1. **Person and Family-Centered Care**. The emphasis in the Maryland CPC Model is on the person. People need providers who are available, attentive and responsive to the entirety of their needs. As such, the Model supports the concept of a person-centered home (PCH) for patients. In a PCH, physicians, advanced practice providers (usually but not always a primary care specialty), and a core care team provide comprehensive management of a person's holistic health needs, taking into account the physical and social environment in which they reside. This includes recognition and respect of a patient's desires and wishes, as well as those of their family. As patients make more informed decisions, unnecessary utilization is reduced, through their respective empowerment.

2. **Concept of "Patient-Designated Provider" (PDP) as Responsible Clinician in a Team-Based Care Model.** Providers' activities in the Maryland CPC Model are built on a foundation of team-based care. Team-based care improves health by distributing the care responsibilities among a team of health care professionals each with his/her clearly defined roles in support of the attributed patient. The provider remains at the center as the leader of the team. Team-based care encourages collaboration among the team so that team members can work directly with the patient. Team-based care leverages the skills and abilities of every member of the team and generates both economies of scale in the delivery of care and greater professional satisfaction in the members of the care delivery team. Team based care adds many valuable and efficient tax professionals to the health care workforce while leveraging their skills to reduce unnecessary utilization.

3. **Regional customization and flexibility to match local needs and leverage local infrastructure and resources.** The Maryland CPC Model will enhance, benefit from, and leverage existing health care transformation efforts within the State, such as ACOs, Clinically Integrated Networks, Local Health Departments, and additional community based health initiatives. Recognizing the patient and provider diversity in Maryland, additional infrastructure will need to be developed to provide practices with services that meet their patient's and provider's needs.

4. **Steady movement from volume to value.** The Maryland CPC Model will help all PDPs with the progressive recognition of the fiduciary responsibility for the quality, cost and experience of the care delivered.

5. **Incremental all-payer approach, in alignment with the Second Term of All-Payer Model.** Conceptually, the model is all-payer in nature because a key component of practice transformation and care redesign is achieving a density of patients within a provider's panel that provides the momentum to drive the change in practice that is necessary. The State recognizes the need for Medicare FFS participation in medical home initiatives, which do not currently exist in any form. Year 1 (2018) of the CPC Model will focus on 800,000 Medicare FFS beneficiaries. Maryland will expand the participation of other payers in the Model over time, providing opportunities for more comprehensive practice transformation as practice capabilities increase and the Model matures. Beyond 2018, Maryland will continue to seek alignment of measures across health systems,

including the needs of pediatric, young and healthy adults, as well as highly specialized Medicaid populations.

6. **Voluntary participation.** The Maryland CPC Model provides incentives, a wide range of technical assistance, and support to encourage provider participation. Providers will not be required to participate in the model, nor select a CTO. Patient participation is also voluntary.

7. **Care Management as a necessary element.** Care management will address all aspects of physical and mental health, social needs, and medication management. Care plans will be developed by multidisciplinary teams and their patients. Care plans will be accessible to all of the patient's providers, and shared among providers across care settings using CRISP's Integrated Care Network (capability under development now). Care management programs will differ depending on local needs and available infrastructure. Regardless of the program, the necessary, qualifying component for participating practices is the ability for their care management programs to holistically treat patients and follow them across care settings.

8. **Provision of evidenced-based care.** Using team-based care, practices will proactively offer timely and appropriate preventive care and reliable, evidence-based management of chronic conditions. Use of evidence-based protocols in team-based care and attention to health disparities will improve population health.

9. **Sufficient and timely quality and utilization financial incentives.** Physician payment systems must support, incentivize, and reinforce the desired changes in the health care delivery system. The Maryland CPC Model provides timely funding streams that providers can utilize to transform their practices; giving providers more time and resources to provide superior coordinated care to their patients.

10. **Financial and non-financial incentives for practice transformation.** While the importance of financial incentives cannot be understated, Maryland plans to provide a full range of technical assistance and support to practices to initiate primary care transformation across the State, integrated with and drawing from national and regional learning networks, and CTOs. Nonfinancial incentives will include recognition of PCH status and comparative success in quality metrics.

11. **Aligned and consistent set of quality/outcome/utilization metrics.** The success of payment and service delivery redesign will be measured through enhanced patient experience and quality of care. The Maryland CPC Model will monitor a consistent set of metrics aimed at measuring the system's ability to improve patient experience and deliver quality health care while controlling costs. To the extent possible these metrics will be focused, aligned and constrained to avoid unnecessary duplication with other external reporting requirements.

12. **Efficient data exchange and robust, connected tools for providers.** Providers need actionable data and feedback on cost and utilization, quality, patient experience, and practice transformation. Health information technology facilitates communication between patients and clinicians, and provides information and decision support to clinicians in real time as they are seeing patients. Functional interoperability with seamless integration in workflows is essential. This will make

clinically relevant information available to hospitals, physicians, and other providers at the point of care.

13. **Quality and cost transparency for clinicians and patients.** Transparency can spur innovation and competitiveness to incentivize performance and also allow patients to become more informed, empowered and better consumers of health care services.

14. **Avoidance of unnecessary and duplicative utilization.** A system that provides robust health information technology that encourages communication, reduces prescribing errors, facilitates medication management, and ensures that treating providers have timely clinical laboratory data, imaging and technological results, allergy information, past medical and surgical history, and up-to-date patient problem lists that do not duplicate services provided in other venues.

15. **Recruitment and retention of primary care providers to address health care access requirements.** As overhead costs increase for providers and practices in excess of the increase in payments for units of service, providers have responded by increasing the volume of patients per day to compensate. This has resulted in two very negative consequences. First, the provider must spend less time with the patient, decreasing the quality of the provider-patient interaction. Second, the provider is burdened by a high volume environment, decreasing the recruitment and retention of providers. The Maryland CPC Model seeks to incentivize value over volume through payment and care delivery redesign; creating a reciprocal and rewarding clinical environment for both the provider and patient and thereby reduce the rate of "burnout" and loss of providers.

III. Model Design: The Comprehensive Primary Care Model Design

Maryland CPC Model is designed to make significant improvements in how care is delivered to Maryland residents in order to improve patient experience and health outcomes. In order to do so, Maryland's CPC Model is built upon the foundations of CMS' CPC+ Model, which was designed to support practices along the continuum of transformation to deliver better care to patients and promote smarter spending. The Maryland CPC Model is both a care delivery and payment redesign model. Similar to CPC+, there will be two tracks for practices to choose that involve different care delivery requirements and payment options. As in CPC+, Maryland will allow practices to apply for one of two program tracks, with increasing payment and care redesign expectations as providers move from Tracks 1 to 2.

Care delivery redesign ensures practices in each track have the necessary infrastructure and care processes to deliver better care and improve patient health. In order to facilitate care delivery redesign, Maryland builds upon CPC+ and proposes developing new, transformational infrastructure within the state to augment primary care delivery:

- **Care Transformation Organizations (CTOs).** CTOs are entities that provide services to practices. The CTOs generate economies of scale in the provision of services that are challenging or impossible for many small and medium size practices to engage in financially or operationally, such as pharmacist services, behavioral health counseling services, social services, and support from health educators and Community Health Workers (CHWs). In addition, CTOs provide education and technical assistance to practices that are tailored to the needs of the community through webinars, in-person visits and targeted and remedial based training. Providers are not

required to contract with and receive services from CTOs, but the State expects many providers will do so.

- **Coordinating Entity (CE).** The CE is the entity that coordinates the unique rule sets within the Maryland CPC Model, administers the program, and approves PCH and CTO participation. The CE will be guided by a broadly representative Advisory Board and work closely with external entities to execute its scope of work.

In addition to care delivery redesign built on robust infrastructure, payment redesign facilitates investment in primary care by aligning payment incentives with the care redesign requirements of the model. Together, practices will have the tools needed to deliver high quality, holistic, person-centered care, which will create healthier communities, avoiding unnecessary and costly hospital visits and ultimately leading to reductions in the total costs of care within Maryland.

A. Patient Experience

The patient is at the heart of the Maryland CPC Model. The care delivery and payment transformation described in the sections that follow were developed with the goals of improving the experience and health of patients in the Maryland health care delivery system.

In the current system, patients experience a fragmented health care system, where information does not flow easily from provider to provider, access to providers is often limited to standard office hours, and there is little if any shared decision making between providers and patients. While physical and behavioral health are intricately intertwined, behavioral health is frequently delivered outside of the medical model in a separate health system, with little formal interaction between the two sets of providers. In addition, the provision of high quality health care is essential for the treatment of health conditions, but the full range of factors that influence a person's overall health and well-being are equally as important. These are often ignored by the current health care system and the patient is left to navigate the complex social service and public health system alone or with minimal support.

The Maryland CPC model offers an alternative to the current system. Under this new model, as with all Medicare FFS beneficiaries, they may choose to visit any practice and provider they wish, but those practices that choose to participate in the model will offer enhanced services that better meet their patients' needs. If a patient is attributed to a participating practice, they will have a PCH that is responsible for the delivery of high quality, holistic care. Practices and providers in turn will have more support and technical assistance under the Maryland CPC model through the CTOs, and new payment arrangements to help them transform their practices and meet the needs of their patients.

Consumer Engagement

Person-centered care involves setting goals that are prioritized by the patient, educating patients on self-care and management, joint decisions between patients and their care teams, and engaging the family and caregiver in care and decisions about care, including functional focus and planning. Connecting patients to a variety of social services is equally important.

In a September 2015 report, the Consumer Engagement Task Force (CETF) established by HSCRC concluded that to fulfill the goals of the All-Payer model of better care and better health, "consumers must have access to a health care delivery system that is reflective of their needs and preferences and equips them to be fully engaged in and take ownership of their health and health care. Extensive effort is needed to ensure that consumers understand the All-Payer Model so they can make informed decisions and engage in

the personal lifestyle changes, self-care, and system design that are essential to health care transformation.[3]" The enhanced support for primary care practices will mean faster and better access to care (e.g., decreased wait times for appointments, alternatives to office visits, and 24/7 availability of advice). Patients will be offered information on the enhanced benefits of the Maryland CPC Model so that they can fully utilize all of the services designed to improve their experience with the primary care system.

The following are examples of how the Maryland CPC model will enhance and improve care:

Example Scenario A: Improved Care Management and Integration with Behavioral Health Services

The PCH uses health information technology to identify their high-need patients and develop a comprehensive care plan. In doing so, the PCH identifies a patient with severe depression, anxiety, and asthma who has had several hospital admissions and emergency department visits over the past two years. The patient's provider develops a care plan and uses a team-based approach to care for the patient. The new care plan includes the patient's doctor having a conversation with the patient about their treatment and conducting asthma counseling while a care manager instructs the patient on proper inhaler use. The care manager contacts the CTO to access a mental health counselor, such as a Licensed Clinical Professional Counselor (LCPC), to counsel the patient through in-person home visits and/or telemedicine, as appropriate, to reduce anxiety and depressive symptoms. The PCH, in conjunction with the CTO psychiatrist, prescribe and coordinate the medication used to treat both the physical and behavioral health needs of the patient to reduce the possibility of adverse drug interactions. A pharmacist is available through the CTO to consult with the PCH on both medication compliance and reconciliation. Care plan updates are incorporated electronically and available to the team in real time. The PCH uses quantitative and qualitative data to determine additional methods to address the patient's needs.

Example Scenario B: Improved Transitions of Care

An alternative example illustrates how the Maryland CPC Model will establish smooth and effective transitions of care. In this example, the patient has been hospitalized for an exacerbation of Chronic Obstructive Pulmonary Disease. The hospital care team decides to employ the Naylor Transitional Care Model (TCM), which is a longer-term transitional care program that includes comprehensive discharge planning and extensive at-home follow up. TCM uses the advanced knowledge and skills of a Transitional Care Nurse (TCN) to provide a comprehensive assessment of the patient's needs and coordinate care across the spectrum of service. The TCN makes contact with the patient in the hospital, working with care providers and clinical staff to create a care plan, including medication and symptom management. The TCN conducts a home visit within 24 hours of discharge to evaluate the plan of care at home, and works with the patient and family to adjust its goals as needed. Post-acute care facilities including in home rehabilitation are also contacted. Weekly home visits continue for the first month post-discharge, with telephone contacts between visits. The TCN accompanies the patient to the first follow-up appointment, coordinates with the office based care manager, assesses any other unmet or unanticipated needs, and facilitates communication between all of the patient's caregivers. A key component of this approach is continuity of care between the primary care clinician, the hospital, and any post-acute care facilities.[4]

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[3] Health Services Cost Review Commission. Consumer Engagement Task Force Final Report. September 9, 2015.
[4] Administration for Community Living. *Administration on Aging*, Available at: http://aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/toolkit/docs/AOA_080_Chart6_ExEvidBasedCare.pdf; University of Pennsylvania, Nursing Science. *Essential Elements of Transitional Care Model.* Available at: http://www.transitionalcare.info/essential-elements

PCHs are integral to the TCM. In the Maryland CPC Model, PCHs are active members of teams that work with hospitals and other health care partners to bring about smooth transitions of care and break the cycle of repeated emergency department visits and readmissions for patients' complex medical needs. The hospital-based TCN collaborates with the office-based care manager through the CTO for the attributed patient. At the end of the TCM cycle, there is an informed and thoughtful transfer (i.e., "warm hand-off) from the CTO to the PCH team to ensure that comprehensive person-centered care is delivered in the shadow of a transition and throughout the person's life cycle. The CTO plays an important role in coordination since hospitals traditionally have had a difficult time coordinating directly with multiple providers who may or may not be on staff at the hospital. This system assures a continuity of relationships and effective transitions.

Example Scenario C: Integration with CCIP

Patients will also have the option to participate in a hospital-based care management program entitled Chronic Care Improvement Program (CCIP). The CCIP will be implemented by hospitals in collaboration with community providers. The CCIP strives to link the hospitals' efforts in managing the care of individuals with severe and ongoing health issues that require frequent hospitalizations with ambulatory providers' efforts to care for the same populations, as well as patients with rising needs.

Under global budgets, hospitals are expected to address care transition and care management needs of these complex and high needs patients. These patients require extensive care management resources that are best done in coordination between the hospital and PCH staff. Hospitals and CTOS/practices will develop handoff protocols whereby some patients may remain under hospital care management programs for extended periods, while others may be transitioned to practices through the CTOs more promptly. This will be based on the needs of patients as well as the capabilities of practices. The reporting requirements intrinsic to the CCIP will remain the duty of the hospital administering and monitoring its own CCIP. It is recognized that some patients in a CCIP will graduate to practice-based care management provided by a CTO or a Maryland CPC Model-participating practice.

The approach also aims to facilitate overall practice transformation towards more person-centered care. Patients will experience a seamless transition between the two programs as the CTO will serve as a central source for coordinating care management resources and connecting patients to PCHs. Hospital based care management programs will have coordinated "warm hand offs" of patient care to the office based care facilitated by the CTO.

This central role of the CTO in facilitating the smooth transition across care managers (CCIP to CTO and its care managers deployed to primary care practices) can help avoid the problem of duplicative multiple care managers. The CTO can serve as a "clearinghouse" to avoid the inefficiencies of multiple care managers serving the same patient at the same time.

B. Person Centered Homes and Patient Designated Providers

Ambulatory care practices are key participants in Maryland's CPC Model. Practices participating in the Maryland CPC Model will make transformative changes to the way they deliver care as described below in the Care Delivery Redesign section. As in CPC+, eligibility criteria are coordinated between the two tracks

and increase incrementally from Tracks 1 to 2. Practices select the track of the Model for which they would like to apply.

Eligibility

Participation is voluntary for all providers. Practices within Maryland will apply to the CE to form a PCH. A PCH must include a TIN/NPI combination with the following restrictions:

- A PCH will include PDPs. PDPs will include traditional primary care physicians (e.g., internal medicine, family practice, generalists, etc.) and specialty physicians (e.g., nephrology, pulmonary disease, cardiology, etc.). Certified registered nurse practitioners are able to practice independently in Maryland.
- A PCH must be attributed to a minimum of 150 Medicare beneficiaries across participating PDPs. *Special considerations for minimum beneficiary attribution may be considered by CE based upon specialty and PCH ability to meet requirements set forth by CE.
- A PCH must provide a significant amount of primary care services. At least 60% of services provided by participating PDPs in the PCH must be for primary care. *Special considerations for minimum beneficiary attribution may be considered by CE based upon specialty and PCH ability to meet requirements set forth by CE.
- A PCH must pass program integrity screening.
- A PCH must meet the requirements of the Maryland CPC Participation Agreement.

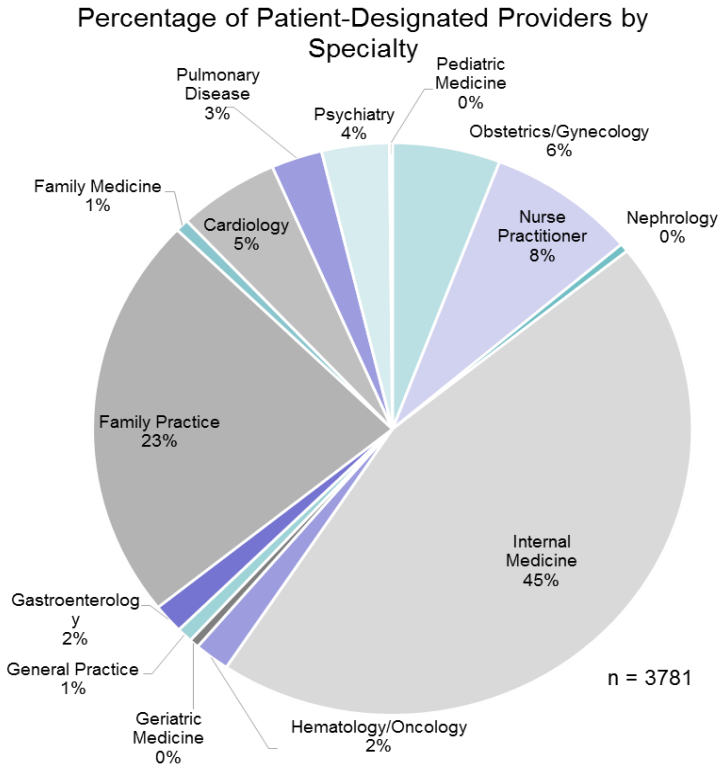
Practitioners that provide services at more than one practice must indicate which practice they are affiliated with for the purpose of the Maryland PCH Model.

All practices must demonstrate track-appropriate readiness, as described in the application to the CE. Model overlap will correspond with CMS rules. As indicated in CPC+, practices currently participating in Tracks 1, 2, or 3 of the Medicare Shared Savings Program may apply to either track. Practices participating in the Next Generation ACO Model or the Advanced Payment ACO Model are not eligible. Concierge practices (any practice that charges patients a retainer fee), Rural Health Clinics, and Federally Qualified Health Centers (FQHCs) are not eligible for the Model at this time.

Patient Designated Providers

The Maryland CPC Model does not limit practice participation to providers who identify as traditional primary care providers. Data analysis revealed that up to one-third of the eligible beneficiary population exclusively use a “specialist” as their provider for evaluation and management (E&M) services. For example, a patient with significant heart failure may exclusively use a cardiologist for their health care needs. The following graph is indicative of that trend.

Figure 1. Percentage of PDPs by Specialty



The Maryland Model is respectful of beneficiary choice, and includes these providers as PDPs. The PDP designation model allows selected specialists with high volumes of E&M codes and who exclusively provide care of the beneficiaries to be considered as PDPs.

This acknowledgement stresses the importance of integrating somatic and behavioral health. This includes the full continuum of behavioral health services, including community-based treatment, residential services, vocational supports, mobile treatment services, health homes, crisis stabilization, and psychiatric rehabilitation. Over one-third of Maryland's 87,728 full-benefit dual-eligible beneficiaries identified in the CY 2012 Medicare and Medicaid eligibility files had at least one Medicare claim with a mental health diagnosis.[5] For these reasons, psychiatrists can be designated as the PDP if they are responsible for the patient's care and are, in effect, the patient's main provider of services. This does not mean that the patient only sees a psychiatrist—in fact, the very linkage stressed in this proposal suggests that patients with serious behavioral health issues should be seeing both behavioral health providers and primary care providers and that these sources of care should be coordinated and linked. The point is that frequently the major provider, such as a psychiatrist working at a community mental health clinic, will be in the lead in providing care and could therefore be considered as the PDP.

The following chart illustrates the potential for strong specialty participation. The Maryland model aims to broaden the impact of practice transformation beyond what is available through CPC+ and move towards

[5] Cannon Jones, S. and Stockwell, J. (2016, Feb 16). An analysis of selected mental health conditions among Maryland full-benefit dual-eligible beneficiaries. p. 2 Baltimore, MD. The Hilltop Institute. UMBC.

statewide delivery system transformation. See Appendix B. Attribution Methodology and Practice Eligibility for a detailed explanation of the Model's attribution methodology and eligibility determinations.

Figure 2. Providers Eligible to Participate in Maryland CPC Model by Specialty

Specialty	Total Providers	Providers that Meet Eligibility Requirements	
	#	#	% of specialty
Cardiology	428	207	48%
Family Medicine	30	27	90%
Family Practice	974	868	89%
Gastroenterology	238	63	26%
General Practice	62	32	52%
Geriatric Medicine	22	20	91%
Hematology/Oncology	170	72	42%
Internal Medicine	1921	1703	89%
Nephrology	101	18	18%
Nurse Practitioner	373	303	81%
OB/GYN	430	220	51%
Pediatric Medicine	7	6	86%
Psychiatry	236	138	58%
Pulmonary Disease	113	104	92%
	5,105	**3,781**	

Tracks 1 and 2

The Maryland CPC Model utilizes the same tracks as the CPC+ model. Practices will indicate which track they intend to pursue in their initial application. To be eligible for Track 1, practices must be poised to deliver the requirements described in the Care Delivery Redesign section below and demonstrated via their application answers. They must also use a certified EHR. To be eligible for Track 2, practices must also meet the requirements laid out in the Care Delivery Redesign section as well as offer enhanced health IT to meet the required elements of this track. Summary of requirements are as follows:

Figure 3. Summary of Requirements by Tracks

Track 1	Track 2
Care Delivery Redesign requirements for Track 1	Care Delivery Redesign requirements for Track 2
Certified EHR	Certified EHR
	Enhanced Health IT

Selection Process

Practices may participate in the Maryland CPC Model by applying to the CE for selection in 2017 and on an annual basis thereafter. Based on practice requirements developed by the CE, the CE in coordination with CMS will select practices for Track 1 or Track 2 of the Model. There will be an open application period on an annual basis. Track 1 practices will have to transition to Track 2 within three years or exit the program. The CE may exempt practices from this timeframe based on hardship or extenuating circumstances. The CE will establish milestones to ensure that Track 1 practices make progress towards becoming a Track 2 practice and institute a corrective action plan if they fail to make progress. Track 2 practices must remain in good standing with Track 2 requirements or exit after failing to come into good standing through a corrective action plan.

C. Care Transformation Organizations

Maryland has many independent primary care practices with five providers or fewer. To enable smaller practices with fewer capabilities to participate and to generally provide assistance to all practices with transformation efforts, the Maryland CPC Model diverges from CPC+ in the formation of CTOs operating throughout the State. CTOs will provide care management resources, infrastructure, and technical assistance to PCHs. The CTOs generate economies of scale in the provision of services that are challenging for many practices to engage in financially or operationally, such as pharmacist services, behavioral health counseling services, social services, community health workers, and health education. In addition, CTOs provide education and technical assistance to practices that are tailored to the needs of the community through both webinars, in-person visits and targeted and remedial trainings. Providers are not required to contract with and receive services from CTOs, but the State expects many providers will do so.

Eligibility

CTOs are independent legal entities that will be accredited by a national accreditation organization, such as URAC, NCQA, or the Joint Commission. CTOs must be able to contract with providers and provide services as prescribed by the CE and verified by the external accrediting agency. In conjunction with CMS, the CE will establish the criteria for CTO participation in the model in 2017. These requirements will be enumerated in the CTO application, and some of them are listed below in the Service Provision to PCHs section. The CTO must have a governance board that includes primary care and other physicians, health care practitioners and patient representation, in addition to other professionals to ensure diverse interests and perspectives are recognized.

The State anticipates that CTOs will be primarily drawn from existing organizations such as ACOs, managed service organization, health plans, Clinical Integration Networks (CINs), and hospitals. In addition, the State anticipates that established local resources may participate through a subcontract relationship with the CTO to provide population health services (e.g., Local Health Improvement Coalitions (LHICs) and Local Health Departments (LHDs)). Organizations newly formed to fulfill the function of a CTO may also be in position to apply.

Selection Process

CTOs may participate in the Maryland CPC Model by applying to the CE for selection in 2017 in coordination with CMS after an open application process. There will be an open application period on an annual basis. The CTOs will have financial accountability for quality and utilization metrics of the practices they are supporting.

Competition among CTOs

PCHs have the option to contract with a CTO of their choice. PCHs will also be permitted to function without a CTO if they are able to reliably provide the full range of PCH services without external support. While it is envisioned that CTOs will develop around the state, they will not be divided into mutually exclusive regions, and may overlap in terms of geographic areas where they serve practices. No CTO will be given an "exclusive" right to all providers in a region nor will CTOs be able to apply on behalf of providers/practices. Therefore, providers can enter into a contract with the CTO that best meets their needs.

The expectation is the CTO market development will spur healthy competition among the CTOs for the best CTO to contract with physician practices. This will also encourage innovations in care management, improvements and efficiencies in the quality of services the CTOs provide to practices. The CTOs will be unable to compete by "skimping" on services in order to offer lower fees, because CTOs will be required to offer a minimum array of services and technical assistance.

It will be important to avoid situations where a CTO might seek to minimize competition for its own benefit. Diversity in model design and organizational structure will help to stimulate meaningful choice for practices. This healthy competition can be nourished within the constraint that all CTOs must provide the required level of services to practices.

Practices will share in the cost of the assistance they receive. The care management funds will be commensurate for PCH and CTO. There will be a balance between ensuring contribution from PCHs to the CTOs for the technical support they receive, and the corresponding need to maximize participation by the practices through sufficient funding to make practice-based transformation sustainable. As previously mentioned, contracting with a CTO is done on a voluntary basis by the PCHs. PCHs are not compelled to enter into these contracts but they are required to meet the PCH standards and obligations.

Service Provision to PCHs

CTOs will provide services to PCHs whom are not able to independently provide services to achieve better health and higher quality care to their patients. CTOs will provide services in the following five areas:

1. **Care Management**
   Care management in the Maryland CPC Model will differ depending on local needs and available infrastructure. For instance, care management could be office-based or delivered in the community. Care management staff may be practice-employed or contracted through a CTO, or a hybrid. In any configuration, the care managers will identify with their supported practices and the associated patients on a personal level. CTOs will provide a wide array of care management service and technical assistance in support of practice's care management activities.

2. **Data Tools and Informatics**
   CTOs will assist practices with identifying and addressing both individuals and populations at risk through the use of actionable data to inform patient care management and practice-wide transformation. For example, CTOs will develop an inventory of tools for practices to systematically assess patients' psychosocial needs. CTOs will access clinical data from the CE and assist the PCH in risk stratifying their panel of patients, which will then guide care management decisions at the practice level. CTOs will identify hospitals and emergency departments responsible for the majority of a PCH's patients' hospitalizations and ED visits. CTOs will also use hot-spotting to identify individuals in the community who are in need of services and try to connect them to their designated PCHs.

3. **Practice Transformation Technical Assistance**
   The Maryland CPC Model will include a robust learning system to support practices through their care delivery transformations. While the practices themselves will be the primary drivers of practice change, the CTOs play an integral part in supporting and leveraging learning opportunities across the Model. The CTO is required to participate in a regional learning collaborative for the PCH practices. The CTO is also required to provide professional 'practice transformation consultants' to assist practices in fulfilling their practice transformation requirements. While many of these consultants will be clinicians, some will have other training and experience. The goals for the CTOs will be established with the flexibility for a range of individuals to play various roles depending on the skill sets necessary to meet these goals. The roles of the CTO in providing these services are described in the Learning System Strategy section below.

4. **Social Services Connection**
   The Maryland CPC model utilizes a "social determinants of health" framework to integrate critical services that are outside the medical model. The provision of social services is vital for patients to achieve and maintain good health. For example, Medicare beneficiaries with complex medical needs are at risk of falling and sustaining complicating injuries that lead to significant morbidity and mortality. Home visits by trained individuals can identify social and non-medical needs, such as the installation of a ramp and railing for a home entrance instead of steep steps that heighten the risk of a fall; the installation of grab bars in a shower; and arrangement for a friend, family member, or volunteer to take care of small needs in a home such as changing light bulbs placed out of reach that requires a step-ladder, and enabling transportation access. The relatively small expense can avoid enormous outlays associated with injuries resulting from a fall.

   The CTOs will be responsible for developing relationships with key community organizations that provide these social services, such as LHDs, LHICs, faith-based organizations, and other community-based organizations. CTOs will be expected to facilitate agreements between PCHs and these community organizations, as well as connect PCHs to Community Health Workers (CHWs). CHWs can be helpful in extending the reach of medical practitioners into the community; helping to bring patients into care through a trusting and culturally appropriate relationship. Technical assistance provided by the CTOs likely will be needed to bring CHWs into primary care settings. CTOs may also build relationships with state and local Departments of Social Services, Department of Human Resources, Department of Transportation and other agencies working in areas such as transportation and housing, which can contribute to better health. Forging direct relationships between PCH community organizations will be a responsibility of the CTO to ensure that patients' social and non-medical needs are being addressed. Information resources and directories for providers and their care managers will be essential to connect the patient to needed resources.

5. **Hospital Care Coordination**
   Smooth and effective transitions of care are an essential component of practice transformation. CTOs play an important role in connecting patients who have benefitted from hospital-led care management to community-based care management. At the same time, CTOs will assist PCHs with coordinating care for high-risk individuals in the CCIP, which arranges for care management resources from hospitals. This system assures a continuity of relationships, organization of resources, and clean handoffs for both the patient and the providers.

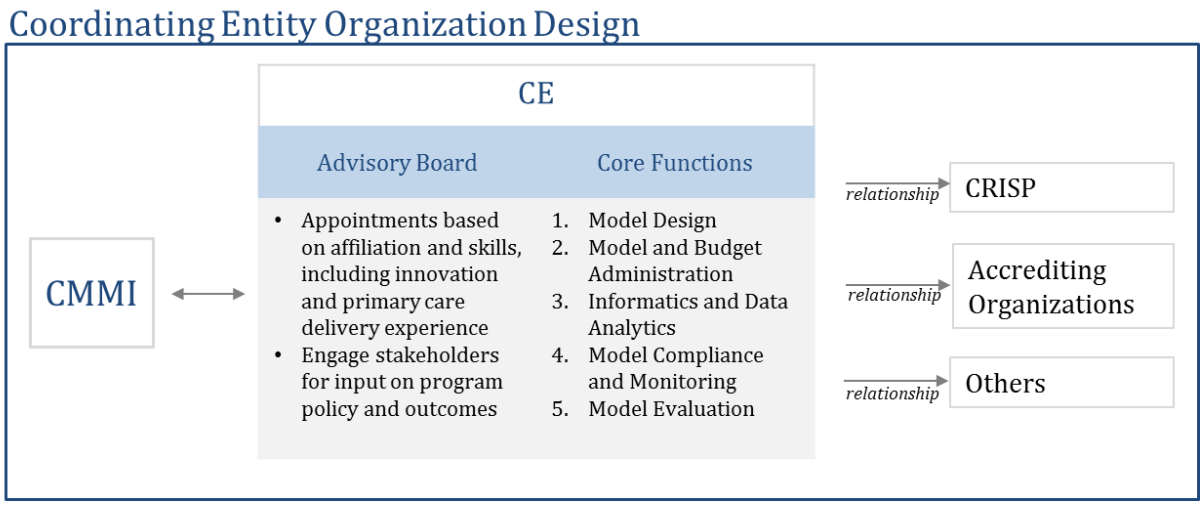
CTOs may identify and wish to offer additional services to practices. They will be allowed to do so and use these services to differentiate themselves from their competitors.

D. Coordinating Entity

The CE is the entity that coordinates the unique rule sets within the Maryland CPC Model, administers the program, and approves practice and CTO participation. The CE's functions are delivered by a combination of three groups: the State, an Advisory Board, and external entities. The state is pursuing legislation in 2017 to establish the CE. The CE will function as proposed below. The ultimate composition will depend upon the outcome of the legislation.

The CE will be guided by a broadly representative Advisory Board and work closely with external entities to execute its scope of work. It is anticipated that the Advisory Board will be comprised of approximately 10-15 members. The Advisory Board will have a mix of public and private members, and appointments will be based on affiliation and skills, including innovation, patient experience and primary care delivery. The CE will utilize the administrative services of the Maryland Health Care Commission (MHCC) as directed and in cooperation with the Advisory Board for selected activities. The CE will collaborate with CMS on key policy and decision-making issues. Structurally, the CE will take the following form:

Figure 4. Coordinating Entity Design



The CE is envisioned to have the following five core functions:

1. Model Design

The CE will assume overall responsibility for the design of the Model. Given the large number of stakeholders involved and strategic decisions required to ensure balanced success, the CE will convene and engage stakeholders through an Advisory Board to ensure that diverse voices around Maryland are incorporated into the Model. The Advisory Board will provide guidance to the CE around many of the features of the Model. The Advisory Board may provide input on key elements of the Model's design, including:

- Rule sets for CTOs and provider participation within the Model, which will be incorporated into the application processes.
- Practice milestones included within the Maryland CPC Model's Learning System.
- Payment logic needed to determine the distribution of care management fees to providers and CTOs.

The CE will be performance-oriented and focus on the continuation of the Model beyond the test period. As such it will strategically monitor quality and utilization metrics reported by the practices and CTOs and make adjustments to the Model as needed. The CE will also monitor performance of other health care delivery innovation models around the country and seek to incorporate promising strategies into the Maryland CPC Model.

2. Model and Budget Administration

Programmatically, the CE will be responsible for overseeing all aspects of the Model administration. The CE will work with partners to perform required services. This includes:

- Incorporating the policies developed by the Advisory Board into the application, releasing a CTO and practice request for application, and selecting CTO and practices into the Model.
- Facilitating the appropriate accreditation systems.
- Developing standardized contract language that defines the business relationship between the practices and CTOs. This feature ensures smaller practices with fewer legal resources are entering into fair business arrangements with their CTO partners.

The CE - in conjunction with CMS - will have budgetary oversight of the Maryland CPC Model that the State will assume. This includes developing and running attribution and algorithms that determine the payment logic for care management fees. In the Model, all practices receive care management fees based upon the risk tier of the practice's attributed beneficiaries. However, if a practice chooses to contract with a CTO, then a portion of those fees will be paid to the CTO and the size of that payment depends on the scope of service the CTOs provide. The CE's partner, CMS, will be responsible for running the Model's attribution logic that will be used to determine the total influx of care management fees into the State.

3. Informatics and Data Analytics

Maryland's CPC Model includes a robust learning system to support practices in their care delivery transformation. Informatics and data analytics will play a key role in the learning system by providing actionable data and feedback on cost and utilization, quality, patient experience of care, and practice transformation. Informatics will also be used to provide benchmarks and track practices' progress in achieving their transformation milestones.

4. Model Compliance and Monitoring

Monitoring is essential to ensure that patients' experience and quality of care is either preserved or enhanced and that PCHs and CTOs are compliant with the Participation Agreement. The CE – in conjunction with CMS - will assume responsibility for monitoring and ensuring that the Maryland CPC Model is being implemented appropriately and effectively at the PCH and CTO level. A focus will be on whether practices and CTOs are using payments properly to meet the Model requirements. Performance monitoring confirms that practices understand and can track their progress towards meeting the care delivery requirements. As in CPC+, the CE and CMS will use program integrity, cost, utilization, and quality data in its monitoring strategy, as well as reports submitted from CTOs and PCHs. The findings from monitoring will guide the selection of additional learning activities.

The CE and CMS will also determine periodically whether PCHs or CTOs should be subject to any administrative action, such as a corrective action plan or termination. A corrective action plan will be imposed when a practice or CTO does not meet the terms of the Participation Agreement, is found to be taking advantage of the Model, or is not meeting quality standards. Practices and CTOs will be expected to remedy the situation within a reasonable time frame. Termination will occur for non-remediable failures as set forth in the Participation Agreement or determined by the CE, or when expected remediation does not occur.

5. Model Evaluation

All participants in Maryland's CPC Model 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 CE may explore foundation support for an independent outcome evaluation group to monitor performance against the goals of population health, quality of care, and cost targets.

IV. Care Delivery Redesign

Practices participating in the Maryland CPC Model will make transformative changes to the way they deliver care. As in CPC+, both tracks require practices to employ the same functions, but the intensity of the delivery differs by track. Practice transformation requirements will be included in the Participation Agreements with PCHs and CTOs and each PCH with support from the CTO will be required to meet the practice transformation requirements. The PCHs will report their progress on the practice transformation milestones to both CMS and the CE. The CTOs will also report on the quality and utilization metrics to both CMS and the CE.

Track 1 practices will deliver all of the requirements found in this section, including the Five Primary Care Functions, adding these services to visit based, fee-for-service care. In addition, Track 2 practices will be asked to redesign visit and non-visit based care (e.g., phone, email, telehealth, text message, and secure portal) to offer more comprehensive care overall. The CTO will assist both Track 1 and 2 practices with achieving the requirements contained in this section. Appendix C is a crosswalk between CPC+ and the Maryland CPC Model that delineates the preliminary/proposed roles and responsibilities of the practices and CTOs in delivering these requirements. These will be finalized in practice and CTO applications.

A. Five Primary Care Functions

1. Access to Care

Effective primary care is built on a trusting, continuous relationship between patients, their caregivers, and the team of professionals who provide care for them. Empanelment is a key ingredient in support of team-based care. Bodenheimer et al define empanelment as, "linking each patient to a care team and a primary care clinician….Empanelment is the basis for the therapeutic relationship that is essential for good primary care.[6]" Empanelment enables the practice to determine whether each clinician and team has a reasonable balance between patients' demand for care and the capacity to provide that care. Demand exceeding capacity impedes prompt access to

[6] Thomas Bodenheimer, Amireh Ghorob, Rachel Willard-Grace, and Kevin Grumbach. The 10 Building Blocks of High-Performing Primary Care. *Ann FamMed* 2014: 166-171.

care and therefore expanding access to this primary care team is vital. Whether through expanded hours, redesigning office workflows, or developing alternatives to traditional office visits, ensuring that patients have timely access to engage the team will enhance that relationship and increase the likelihood that the patient will get the right care at the right time. PCHs will be required to provide increased access to primary care services with support from the CTOs. CTOs also will be required to assist Track 2 practices with offering alternatives to traditional office visits by providing those services for practices and/or providing technical assistance and wrap around support services for the practices.

2. Care Management

PCHs will be required to provide care management for high-risk, high-need patients, as well as rising-risk patients. Practices will identify those patients in two ways: (1) systematically risk stratify their empaneled population to identify the high-risk patients most likely to benefit from targeted, proactive, relationship based (longitudinal) care management; and (2) identify patients based on event triggers (e.g., transition of care setting; new diagnosis of major illness) for episodic (short-term) care management regardless of risk status. Practices will provide both longitudinal care and episodic care management, targeting the care management to best improve outcomes for these identified patients. To guide their care management efforts, practices will analyze internal monitoring and payer data, and use care plans focused on goals and strategies that are congruent with patient choices and values.

Track 1 practices will build capabilities in behavioral health, self-management support, and medication management to better meet the needs of patients. Track 2 practices will provide more intensive care management for their patients with complex needs and will build additional practice capabilities in assessment and management of patients with complex needs, such as those with cognitive impairment, frailty, or multiple chronic conditions. The CTOs will support the practices with technical assistance and practice transformation support. Appendix D provides examples of how PCHs and CTOs participating in the Maryland CPC Model will manage the health of their populations.

Furthermore, practices may choose to work with hospitals through the CCIP program. In that program, hospitals will be responsible for care management of certain patients who are frequent users of hospital services. Once the hospital team has stabilized the patient, the hospital-based care managers will coordinate with the CTO to transition the patient to their PDP and receive the suite of services provided by the practice and CTO. The CE and CMS will develop subsequent details and rule-sets to determine the coordination between CCIP and the Maryland CPC Model.

3. Comprehensiveness and Coordination

Comprehensiveness in the primary care setting refers to the aim of practices meeting the majority of its patient population's medical, behavioral, and health-related social needs in pursuit of each patient's health goals. Comprehensiveness adds both breadth and depth to the delivery of primary care services, builds on confident relationships, and is associated with lower overall utilization and costs, less fragmented care, and better health outcomes.

Practices will increase the comprehensiveness of their care based on the needs of their practice population. Strategies to achieve comprehensiveness involve the use of analytics to identify needs at a population level and prioritize strategies for meeting key needs. For some aspects of care, practices can best achieve comprehensiveness by ensuring patients receive offered services within

the practice (rather than elsewhere) and also by adding additional services within the practice that may have previously required a referral to a specialist. Other care and services are best obtained outside of the primary care practice and this should be facilitated through referrals and/or co-management with specialists and linkages with community and social services. CTOs will play a key role in assisting practices with identifying needs within their patient populations, offering services to meet those needs, and providing connections to community-based and social services.

Practices will act as the hub of care for their patients, playing a central role in helping patients and caregivers navigate and coordinate care. Practices will address opportunities to improve transitions of care, focusing on hospital and ED discharges, as well as post-acute care facility usage, and interactions with specialists. Moreover, this work involves building the capability and network of services both within the medical neighborhood, and the community, to improve patient care. CTOs will assist practices in analyzing where their patients receive care and how best to organize their practice to deliver or coordinate that care in the way that achieves the best outcomes. Such a transformation will be an ongoing process, not a point-in-time conversion.

4. Patient and Caregiver Experience

Optimal care and health outcomes require patient and caregiver engagement in the management of their own care and in the design and improvement of care delivery. Practices in both tracks will organize a Patient and Family Advisory Council (PFAC) to help them understand the perspective of patients and caregivers on the organization and delivery of care, as well as its ongoing transformation practices, and will use the recommendations from the PFAC to help them improve their care and ensure its continued patient-centeredness. As is required in CPC+, practices will engage patients in goal setting and shared decision-making, using decision aids and specific techniques (e.g., motivational interviewing) to support patients in the process. Practices in Track 2 will also implement self-management support for at least three high risk conditions and provide support for caregivers of persons with functional disabilities.

5. Planned Care and Population Health

Participating practices will organize their care to meet the needs of the entire population of patients they serve. Participating practices will demonstrate the capacity to identify and address individuals and populations at risk. Interventions will need to be developed by providers to engage patients before they require an inpatient stay. The development of disease registries, utilization of health coaches and educators, including CHWs, and engagement with the broader non-clinical community to identify and address gaps in care for at-risk patients, will be critical. Application of evidence-based protocols for screening, diagnosis, and treatment will be followed. Finally, use of a data system that provides a full view of the practice panel's population utilization of services, quality of care and TCOC will identify performance improvement opportunities. CRISP will work to enhance the data services provided to practices for planned care and population health, while the CTOs will ensure robust technical assistance to optimize practice's use of data. Further, to participate in Maryland CPC Model, they will have made a commitment to achieve Tier 3 participation with CRISP.

B. Use of Enhanced Accountable Payment

Modeled off of CPC+, the Maryland CPC Model redesigns payments in the system to allow practices to undertake key transformative activities. Practices and CTOs will be held accountable to use additional funding strategically by projecting revenue and undertaking budgeting exercises that will in turn guide their

actions. Practices and CTOs will also use funding to build analytic capabilities to identify opportunity for improvements.

C. Continuous Improvement Driven by Data

Practices will be required to regularly measure and report quality at the practice level and panel or care team level. Practices will use the captured quality data to test and implement new workflows and identify opportunities for continued improvement. CTOs will also be responsible for the quality of care provided by the practices they contract with, incentivizing them to work closely with the practices to implement improvement processes and enhance the quality of care provided at each practice. Statewide performance dashboard tools may be developed at the CE level to enable transparency; informing patients about CTO and PCH progress.

D. Optimal Use of Health IT

In both tracks, practices will use health IT and will be required to have remote access to their EHR to ensure 24/7 access to care teams. Practices in both tracks will report on electronic clinical quality measures (eCQMs) and generate quality reports, both at the practice and panel/care team level. Track 2 practices will be required to implement enhanced tools that support more comprehensive and coordinated care of patients with complex needs. CTOs will assist practices in achieving optimal use of health IT, including maximizing utilization of CRISP.

V. Payment Redesign

A key theme of this proposal is that physician payment systems must support, incentivize, and reinforce the desired changes in the health care delivery system. The prevalent physician payment system remains the FFS system that drives volume over value. Under the Maryland CPC Model, a combination of care management funds, performance-based payments, and for Track 2 PCHs up-front, non-visit-based payments, will enable practices to undertake alternative approaches to interact with and care for patients and make investments in care management activities and staff that are not reimbursable under the existing model. The changes in physician payment in Maryland will be an extension of CMS's initiative to encourage physician migration to value-based and Advanced Alternative Payment systems.

In general, the payments will mirror those made under CPC+ and are described in greater detail below.

A. Attribution

Medicare FFS beneficiaries are not restricted as to their choice of providers in the Maryland CPC Model. Providers must voluntarily elect and be approved to participate in program for beneficiaries and providers to receive resources, payments, and benefits under Maryland CPC Model.

The attribution model follows their historical preferences for attribution and determination of payment to providers. As in CPC+, the Maryland CPC Model will use a prospective attribution methodology based on a plurality of primary care claims to identify the population of Medicare FFS beneficiaries for which each participating practice is accountable. While patients may be attributed to a certain provider or practice in the Model, they still have the ability to visit other providers as they determine necessary. Beneficiaries that are not attributed to a primary care practice under the E&M attribution methodology may be attributed to a willing specialist that has provided exclusive E&M services to the beneficiary.

To ensure practices are eligible, CMS will run attribution for applicant practices before practices sign their Participation Agreements. Attribution methodologies will continue to be examined and may be altered in

future years of the Model. Appendix B contains a breakdown of the attribution methodology used in the Maryland CPC Model.

B. Care Management Fee

As in CPC+, practices will receive a prospective, monthly, per-beneficiary-per-month care management fee (CMF) for attributed Medicare beneficiaries. The CMF is designed to give practices flexibility to provide "wrap-around" services that are traditionally not considered to be separately billable. Beneficiaries are not responsible for any cost-sharing for care management services. The CMF will be calculated based on the risk tier of the PCH's attributed beneficiaries.

CPC+ provides differential CMF payments by track. In contrast, all CMF payments in the Maryland CPC Model are made at the Track 2 level regardless of the PCH track at the time. In the Maryland CPC Model, the CTOs will be eligible to receive a portion of the CMF, derived from its relationship with the PCHs. Providing all CMF payments at the Track 2 level will allow the CTOs to be fully funded as they assist practice's transformation from Track 1 to Track 2 and achieve the population health goals of the Model. The division of payments between the PCH and CTO will be determined by the CE and will generally be based upon the proportion of services provided by the CTO to the practice. A portion of the CMF provided to the CTOs will be at risk, meaning that payments will be "clawed back" and future payments reduced if CTOs fail to meet quality and cost targets. A quality and outcomes framework for CTO accountability will be developed by the CE and CMS, including population health measures and measures aligned with the TCOC.

Since PCHs engage with a CTO on a voluntary basis, should they not require the services of a CTO they will retain the entire CMF funding and be held accountable to meet all applicable milestones without CTO support. The tables below illustrate the proposed CMF amounts by risk tier.

Figure 5. Proposed CMF by Risk Tier

Risk Tier	Attribution Criteria	Track 1 and 2
Tier 1	01-24% HCC	$9
Tier 2	25-49% HCC	$11
Tier 3	50-74% HCC	$19
Tier 4	75-99% HCC	$33
Complex/SUD/BH	90+% HCC or Dementia	$100
Average		**$28**

C. Performance Based Incentive Payments

Practices will also receive a prospective performance-based incentive payment from CMS that will be considered at risk. If practices fail to meet annual performance thresholds, CMS will recoup unwarranted payments. As in CPC+, the payment will be broken into two components, both paid prospectively: clinical quality/patient experience measures and utilization measures that drive TCOC. The table below illustrates the proposed payments:

Figure 6. Proposed Performance Based Incentive Payments by Track

Track	Utilization (PBPM)	Quality (PBPM)	Total (PBPM)
Track 1	$1.25	$1.25	$2.50
Track 2	$2.00	$2.00	$4.00

The CE and CMS will score the payments using a continuous approach with a minimum, under which a practice keeps none of the incentive, and a maximum, under which a practice keeps the entire incentive. For example, if a practice's total score is 60%, then the practice keeps 60% of the incentive.

The utilization scores will be based on hospital and emergency department utilizations. The quality scores will be based on the eCQMs aligned with other applicable and aligned quality metrics in the State to simplify reporting. The consumer assessment is based on the standard ambulatory measurement of health care providers and systems (CG-CAHPS) measures. These will be calculated at the practice level.

D. Track 2 Comprehensive Primary Care Payments (CPCPs)

CMS will change the payment mechanism for practices in Track 2 to promote flexibility in how practices deliver care. Traditionally, practices must see patients face-to-face in order to receive payments. In Maryland's CPC Model, CMS will pay practices in a hybrid fashion: part up front per-beneficiary-per-month (called the Comprehensive Primary Care Payment [CPCP] and paid quarterly) and part fee-for-service (paid based on claims submission). This will support the flexible delivery of comprehensive care and encourage practices to increase the depth and breadth of care they deliver. In particular, the CPCP allows for the provision of services delivered in or outside of an office visit.

The upfront payment CPCP is paid based on a practice's per-beneficiary-per-month revenue plus 10% during a historical period, without any cost-sharing on the CPCP. Fee-for-service payments during the year are then reduced proportionately to account for the upfront payment. Beneficiary cost sharing will apply to the full amount prior to the proportional reduction. The CPCP and reduced FFS will only apply to office E&M codes. As in CPC+, there will be two hybrid payment options available to practices: one will pay 40% upfront and 60% of the applicable FFS payment, and the other will pay 65% upfront and 35% of the applicable FFS payment. Practices will be able to accelerate to one of these two hybrid payment options. The table below illustrated the proposed payments and the options for acceleration.

Figure 7. CPCP Proposed Payment Options

	2018	2019	2020	2021	2022
CPCP% / FFS%	10%| 90%				
Options available to practices	25%|75%	25%|75%			
	40%|60%	40%|60%	40%|60%	40%|60%	40%|60%
	65%|35%	65%|35%	65%|35%	65%|35%	65%|35%

VI. Learning System Strategy

The Maryland CPC Model will include a robust learning system to support practices through their care delivery transformations and monitor compliance and success. The practices themselves will be the primary drivers of practice change, but the learning system will provide support and learning opportunities across the Model. A process of building compliance with the Maryland CPC Model, peer learning, and collective growth will be a large part of this program.

The goals of the learning system mirror those of CPC+, but the delivery of services differs in the Maryland CPC Model. CMS will either contract with a learning system contractor to support the Maryland CPC Model's learning system or provide funds to the State under a cooperative agreement with the State. While the details of the Learning System are still in development, all PCHs will engage with the Learning System, and CTOs with the Learning System contractors will be required to:

- Lead a regional action group to address local issues or a particular programmatic need.
- Perform site visits with their affiliated practices in order to perform practice transformation consultancy services.
- Provide professional 'practice transformation consultants' to assist practices in fulfilling their practice transformation requirements. The consultants will be clinical staff employed by the CTO and will serve as the liaison for the practices' Learning Leads. In turn each practice must designate a member of their practice to serve as its Learning Lead. The Learning Lead is responsible for overseeing the completion of practice reporting requirements and attending learning events hosted by the CTO.

VII. Health IT Support to Practices

CMS will offer practices regular feedback data to inform their efforts to impact patient experience, clinical quality measures, and utilization measures that drive TCOC. The goal is to provide regular Medicare fee-for-service cost and utilization data in a clear, actionable way. The State envisions CMS providing this information to the CE, who will in turn work closely with CRISP to analyze and provide practices and CTOs with at least quarterly practice-level feedback reports and regionally aggregated reports per such practices' request.

CRISP is well positioned to support care delivery system transformation through the existing resources described below. Hospitals in Maryland and Washington, D.C. submit near real time admission, discharge, and encounter information to CRISP. CRISP receives and exchanges information with several other facilities in states that border Maryland. CRISP's functions extend beyond those of a traditional information exchange.

CRISP's Encounter Notification Service (ENS), which notifies physicians, other providers and care managers when patients are hospitalized, has become a critical coordination service in the State. A new web-based capability to proactively manage patient transitions allows a care manager to quickly and efficiently detect recent inpatient and emergency department admissions and recent discharges. High needs individuals and their care team members can also be identified through the new capabilities. More than one million Encounter Notifications are being sent and received, steadily growing over the last six months.

A key CRISP initiative is increased connectivity of ambulatory practices. New ambulatory integration capabilities allow physicians to view clinical data and receive hospitalization alerts. This helps to coordinate

follow-up with patients who have had an acute episode and to reach out to attending physicians; monitor the prescribing and dispensing of drugs that contain controlled dangerous substances; and view more comprehensive patient information including treatments with other physicians and providers to make more informed treatment plans. In addition, new automated reports allow physicians and other providers to monitor and improve quality performance, reduce redundant testing and treatment, and easily communicate treatments delivered. New capabilities automate physician and other providers' workflow, reducing unnecessary manual work. Approximately 5,500 Maryland providers are currently connected to CRISP. At the end of October 2016, over 1,100 physicians are sharing clinical and encounter data with CRISP and 4,200 more physicians are sharing encounter data only. This represents a rapid increase in ambulatory connectivity over the past year, incorporating approximately one-third (over 5,500) of Maryland's 15,000 physicians.

CRISP is currently piloting two key strategies that makes them well-positioned to support care delivery transformation: (1) offering basic care management software as a shared platform; and (2) supporting hospital-selected care management software with data feeds. Both of these programs will help to create an environment where risk assessments, care plans, care plan updates and other important information and tools can be shared among hospitals, care managers, physicians and other providers involved in the coordinated care of an enrolled patient.

CRISP also provides reporting and analytics resources to inform decision-making. These efforts fulfill several different functions, including guiding care coordination, identifying populations, and providing metrics for care monitoring. Analytics data draw from multiple sources including Medicare data, HSCRC case mix data, Census and population data, and CRISP reported data and provider panels. These data are enriched with analytics and methodologies such as geocoding. In addition, CRISP offers ambulatory providers the CAiPHR tool, an end-to-end eCQM tool. Providers can send C-CDAs or QRDAs to CRISP, and CAliPHR will calculate eCQMs in real time. CAiPHR has been certified to ONC's 2014 Edition, and will be certified to the 2015 Edition in 2017.

These investments continually improve the richness of clinical information available at the point-of-care and the tools that are used for care coordination.

VIII. Quality Strategy

The Maryland CPC Model includes a robust quality strategy to ensure the Model is meeting its goal of improving care for Maryland's residents. As in CPC+, the Maryland CPC Model will use eCQMs, patient experience of care, and outcomes measures to track experience and quality of care, identify gaps in care, and focus quality improvement activities. High quality care, quality improvement, or both will be rewarded through the performance-based incentive payment for both tracks.

Maryland also intends to incorporate a small set of population health measures that broadly represent the focus under the All-Payer Model, which have large, long-term impacts on population health. This small scorecard of measures will serve as a guiding focus for all parties in the State under the next Phase of the All-Payer Model. These measures are currently in development, but will represent the most influential factors that drive improved health outcomes in Maryland, can be feasibly be addressed by the health care system, and can be incrementally measured and deployed at a geographic level to provide timely feedback to the system.

A. Practices

Practices will be required to report annually on the practice-level measures enumerated in the CPC+ RFA. The final measure list for each performance year will be communicated to practices accepted in the Model in advance of the first performance period beginning January 1, 2018. Practices will be required to report all eCQMs at the practice site level to the CE and CMS. Practices will also utilize the quality data in an ongoing basis to effect continuous practice improvement. The eCQMs, utilization data, and patient experience of care measures will be included as pay for performance measures. Practices will use Certified Electronic Health Record Technology (CEHRT) to facilitate this data collection and analysis. Certification helps providers and patients be confident that the electronic health IT products and systems they use are secure, can maintain data confidentiality, and can work with other systems to share information.[7]

B. CTOs

CTOs will also be held accountable for the quality and utilization metrics of the practices they serve. The following outline organizes the proposal for three goal areas that will guide the work of the CTOs. This approach accounts for the anticipation that performance-based incentives payments will be tied to performance in quality and utilization measures for the CTOs. Therefore, targets under each goal area will be used to measure the effectiveness of CTOs, and tie them to relevant populations. Overlap with other CTOs including PCHs who take on CTO responsibilities will necessitate CTOs to collaborate to meet broader quality, utilization, and outcomes measures. Where appropriate and in alignment with the All-Payer Model Progression Plan, Maryland proposes to hold CTOs progressively accountable for entire geographic areas.

> **Goal 1: Improve Co-Management of Physical and Behavioral Health Conditions.** Rationale: CMS and Maryland have a focus on improving the integration of physical and behavioral health. Part of the CTO framework is to help connect PDPs with behavioral health resources.
>
> **Goal 2: Improve Chronic Care Management and Prevention.** Rationale: Hold CTOs accountable for a roll-up of their attributed PDPs chronic care measures and work towards better management and prevention of chronic conditions in the community.
>
> **Goal 3: Provide Patient-Centered Care.** Rationale: Ensure the Model is providing patient-centered care and meeting the needs of a person-centered home.

IX. Quantitative Analysis

A. Projections of Provider Participation

Maryland has undertaken a quantitative analysis to project participation in the Maryland CPC Model by providers. The projections are based on data provided by CRISP and other state agencies, and reflect the eligibility requirements of the Maryland CPC Model.

The projections demonstrate three scenarios: optimistic, standard, and conservative. This reflects a range of uncertainty about how robust the take-up of the Model will be, and how quickly PDPs will apply and be approved. The standard scenario reflects what is considered to be the most likely occurrences given the

[7] Centers for Medicare and Medicaid Services. *Certified EHR Technology*. Available at: https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/certification.html

scope of existing practice transformation, while the other two are more and less optimistic than the standard forecast.

The first step was to project the number of practices that would choose the Merit-based Incentive Payment System (MIPS) over the Maryland CPC Model. MIPS subjects practices to wider swings in their payments from Medicare, which over time will reach a range of plus or minus 9% of Medicare payments and would not provide the three-part set of payment incentives under the Maryland CPC Model. Providers may view this program as a conservative option, with fewer requirements.

For those practices entering the Maryland CPC Model, the projections below presume that some PDPs will initially enter Track 1 while others will initially enter Track 2. The projections also include estimates of the number of PDPs initially entering Track 1 that will progress to Track 2 as well as those practices that enter Track 1, but do not progress to Track 2 within three years and will leave the program.

The estimates of the number of PDPs who will have a "state of readiness" for Track 2 are informed by data collected by the State. The State assumed that practices that meet the following characteristics would be ready for Track 2:

- Designated as having CRISP Ambulatory Connectivity at either Level 2 or Level 3;
- Participation in advanced delivery models in Maryland, such as an ACO or patient-centered medical home;
- NCQA recognition in PCMH; or
- Participating in the EHR Incentive Program.

These characteristics do not automatically make a PDP ready to participate in Track 2 as some will not be ready despite these accomplishments. However, it indicates that a substantially higher proportion of PDPs with these accomplishments will be ready for Track 2 participation, and the projections factor that into the participation probabilities.

Given these caveats, the tables below depict the estimates of participation and ramp-up under three scenarios:

Figure 8. Standard Scenario Projections

Year	2018	2019	2020	2021	2022	2023
Track 1	643	771	739	501	366	141
Track 2	643	1,093	1,537	2,032	2,205	2,366
Total	**1,286**	**1,864**	**2,276**	**2,533**	**2,571**	**2,507**

Figure 9. Optimistic Scenario Projections

Year	2018	2019	2020	2021	2022	2023
Track 1	817	980	939	588	466	150
Track 2	1,225	1,593	2,083	2,661	2,937	3,198
Total	**2,042**	**2,573**	**3,022**	**3,249**	**3,403**	**3,348**

Figure 10. Conservative Scenario Projections

Year	2018	2019	2020	2021	2022	2023
Track 1	327	425	464	379	267	114
Track 2	218	446	674	923	1,094	1,185
Total	**544**	**871**	**1,138**	**1,302**	**1,361**	**1,299**

B. The importance of outreach

As indicated earlier, these projections are not "given" or "exogenous" to the Maryland CPC Model. The extent to which the optimistic, standard, or conservative estimate turns out to be closest to what actually happens will depend upon the strength of the Maryland's outreach to the provider community. Moreover, Maryland State Government cannot do this alone. The State will need the assistance of various stakeholder groups, with whom it has an ongoing and integrated dialogue.

As the estimates above show, in 2023 the number of PDPs participating could range from a low of 1,299 under the conservative scenario to a high of 3,348 under the optimistic scenario.

Preliminary stakeholder discussions and advice from experts indicates that many physicians in Maryland remain unaware of MACRA and the specific payment reform options. Among those who are aware, there are likely some misperceptions, and a number of concerns. Some of these concerns could be addressed through an open and forthright outreach that objectively explains both the degree of risk for practices and the three different types of funding streams that practices can obtain in the Maryland CPC Model. It will be important to explain that doing nothing will not be costless for practices—they will be exposed to

Medicare payment reductions for remaining on the sidelines. A companion paper will provide a communications plan to enhance participation by practices.

X. Alignment with Other Models

The Maryland CPC Model will be designed as a flexible program that will integrate with the other models currently under development in the All-Payer Model Progression Plan. Providers across the spectrum will be able to access a powerful set of tools and financial supports to provide improved care to their patients. This, in turn, will help Maryland achieve its goals of more affordable care, improved population health, and better experience of care, while meeting the performance requirements under the All-Payer Model.

In alignment with the All-Payer Model Progression Plan and the effort toward development payment and delivery system transformation in Maryland, the State has initiated a strategy to enhance primary care delivery. With the initial focus on hospitals and global budgets, the All-Payer Model created a foundation for payment and delivery transformation for all patients and payers. As Maryland moves to the second term of the All-Payer Model in January 2019, ambulatory, non-hospital providers will take on increased responsibility for health, care outcomes, and TCOC for Medicare fee-for-service beneficiaries. Hospitals cannot accomplish this work alone. The All-Payer Model must build in increased collaboration with non-hospital providers of care, and work is under way now to do this. The approaching tide of chronic disease burdened populations spur all of the participants in this new initiative to begin the transformation process as soon as possible.

A. CCIP

The CCIP and the Maryland CPC Model will work together to ensure care management resources are appropriately utilized for beneficiaries. In effect, Maryland will create an integrated system of care management for Medicare beneficiaries across population acuity levels. The focus will be on identifying and targeting patients based on their level of need and connecting them to appropriate resources. The Maryland CPC Model will align with the CCIP, a hospital-based program, by creating warm-hand offs between care management resources working within each model. Under global budgets, hospitals are expected to address care transition and care management needs of the complex and high needs patients.

These patients require very labor and time intensive care management resources that are best done in coordination between the hospital and PCH staff. Hospitals and CTOS/practices will develop handoff protocols. Some patients may remain under hospital care management programs for extended periods, while others may be transitioned to CTOs/PCHs more promptly. This will be based on the needs of patients as well as the capabilities of practices. Sometimes patients will require specialized management resources of PDPs other than primary care resources. Ideally using the CTO as an organizing and coordinating force, hospital care managers will work closely with community-based care managers, PDPs, and the PCH to ensure continuous and longitudinal care coordination for the beneficiary. The system will allow the hospitals to connect with the community-based providers, provide needed care management resources and data, and pay particular attention to rising risk and high-risk beneficiaries to prevent potentially avoidable hospital utilization. Maryland expects the integration and design to evolve over time, with modifications dependent upon need.

By integrating these models, Maryland accomplishes several objectives. It creates substantial coordination across the system for both patients and providers, reducing complexities of the care relationship that result in inefficiencies and poor outcomes when two systems duplicate and compete for resources. This is an opportunity to construct a reinforcing system across all providers and care settings that sends clear signals

about practice transformation and population health management to every single provider. Simultaneously, it indicates to CMS that public and private stakeholders in Maryland have a unified vision for improving primary care and care coordination in all populations. As previously stated, the State believes that long term control of TCOC begins by investment in broad-based primary care. The development of the Maryland CPC Model that is strategically aligned to the All-Payer Model demonstrates that the State is focused on bringing TCOC under control by transforming the healthcare delivery throughout the continuum of care.

Maryland has been presented with a great opportunity to move the health care delivery system from taking accountability for all hospital costs to taking accountability for TCOC. The Maryland CPC Model provides CMS with an opportunity to test a model that has shown promise on the hospital side, while recognizing its limitations to address TCOC without incorporating non-hospital care for a true population health effort. The Maryland CPC Model intends to align the models in Maryland, improve population health, and control TCOC by addressing a person-centered, population health, risk stratification, global accountability, care coordination, and incentive alignment. All are core components of a broad-based, patient designated provider system of primary care operating within an All-Payer Model framework.

B. Dual Eligible Population

The Department of Health and Mental Hygiene (DHMH) is developing a strategy to deploy new ACOs specifically for people who are eligible for both Medicaid and Medicare, dual eligible beneficiaries. The Dual Eligible ACOs (D-ACOs) are intended to be the pathway for the State to meet its goal of including the Medicare and Medicaid total cost of care for dual eligible beneficiaries in the next iteration of the All-Payer Model. D-ACOs are designed to integrate Medicare and Medicaid service delivery for dual eligible beneficiaries by creating a sustained care coordination intervention that bridges the divide between social determinants, long-term care, behavioral health, and physical health. D-ACOs will drive this integration by fully aligning financial incentives and creating accountability for improving beneficiaries' health outcomes.

The D-ACOs will be deployed initially in Baltimore City, Baltimore County, Montgomery County, and Prince George's County in 2019 and may be expanded in future years. The D-ACOs will initially target individuals who are eligible for full Medicaid benefits; they will not include people with partial Medicaid benefits or developmental delays. An estimated 47,000 dual eligible beneficiaries will be initially covered. The total Medicare and Medicaid spending for these individuals approaches $2 billion per year – estimated to be split equally between the two programs.[8]

The Maryland CPC Model aims to extend delivery system redesign for the fully dually eligible in the counties not covered by the D-ACO model. This population will remain in the fee-for-service payment system and may benefit from the enhanced primary care proposed under the Maryland CPC Model. To the extent that these beneficiaries receive primary care (or in some cases, specialty care where a specialist is a PDP), from practices participating in the Maryland CPC Model, they can benefit from the enhanced services offered by these providers. This would include linkages to behavioral health services, care management, and an array of social services. Such services should be especially helpful for dual eligible beneficiaries. In addition, PCHs that will be created under the Maryland CPC Model could serve as a Person-Centered Health Home within D-ACOs, as long as they meet the requirements applicable to dual eligible beneficiaries.

[8] The Maryland All-Payer Model Progression Plan. Proposal Submitted by the Department of Health and Mental Hygiene. December 2016.

XI. Conclusion

The Maryland CPC Model is one of the centerpieces of Maryland's Progression Plan for the second term of the All-Payer Model. By focusing heavily on primary care practice transformation and the avoidance of unnecessary hospital and emergency department utilization, the Maryland CPC Model will help sustain and enhance the savings already achieved since the All-Payer Model was implemented in January 2014 and establish a foundation for improving the health of all Maryland residents.

By aligning physician incentives with those under which hospitals are currently operating, the Maryland CPC Model will help physicians and other clinicians more efficiently and effectively manage the care of the 850,000 Medicare beneficiaries in Maryland. The Maryland CPC Model promises to break down the silos that separate the many professionals who are seeing these patients and unite the fragmented care delivery system. This new Model provides the continuity of care, technical assistance, learning systems and the funding streams to support care delivery transformation. It reaches upstream to address the social determinants of health. The combination of delivery and financing reform holds the promise to improve the future of health and lower total health spending.

Maryland looks forward to a continuation of the State's excellent working relationship with the federal government to enhance the accomplishments of the All-Payer Model. The Maryland CPC Model can make a significant contribution toward achieving this goal.

Appendix A. Glossary of Terms

1. *Accountable Care Organization (ACO)* – An organization of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated, high quality care to the patients that they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When a Medicare ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. There also are many ACOs and similar provider-lead delivery system models in Medicaid and in private sector health care. (CMS.gov: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html*)

2. *Advanced Alternative Payment Model (AAPM)* – One of two new payment paths under the Medicare Quality Payment Program. An AAPM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. Advanced APMs are a subset of APMs, that let practices earn more for taking on some risk related to their patients' outcomes. Practitioners may earn a 5 percent incentive payment by going further in improving patient care and taking on risk through an AAPM. In 2017 this will include practitioners who receive 25 percent of their Medicare Part B payments through an AAPM or see 20 percent of their Medicare patients through an AAPM. (CMS.gov: *https://qpp.cms.gov/learn/apms*)

3. *All-Payer Model Agreement* – A five-year initiative launched in early 2014 between Maryland and the Centers for Medicaid and Medicare Services (CMS) that updated Maryland's 36-year-old Medicare waiver to allow the State to adopt new policies that reduce per capita hospital expenditures and improve health outcomes as encouraged by the Affordable Care Act. Under the Agreement, Maryland limits all-payer per capita hospital growth, including inpatient and outpatient care, to 3.58 percent. The Agreement also allows Maryland to limit annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate per year. (HSRC: (*http://www.hscrc.state.md.us/documents/md-maphs/stkh/MD-All-Payer-Model-Agreement-(executed).pdf*)

4. *All-Payer Model Amendment* – An Amendment to the All-Payer Model Agreement, approved by the Centers for Medicare and Medicaid Innovation (CMMI) in September 2016, for Care Redesign. The Amendment allows Maryland hospitals to create programs on an ongoing basis under a specific framework. For example: Hospitals and their care partners can access comprehensive Medicare data to accelerate a broader, more intense focus on care coordination and total cost of care; the State has regulatory flexibility to implement hospital care redesign to align hospitals, physicians and other community providers with a focus on improved episodes of care, particularly for those in need of complex and chronic care; the State can increase awareness of the total cost of care and promote delivery system transformation with supportive payment mechanisms; and the State can work to qualify the All-Payer Model for Merit-Based Incentive Payment Systems (MIPS) and Advanced Alternative Payment Models (AAPMs) status. (HSCRC: *http://www.hscrc.state.md.us/care-redesign.cfm*)
http://www.hscrc.state.md.us/documents/md-maphs/ac/2016-08-01/7-28-16-Updated-Progression-Strategy-Blueprint.pdf

5. *Alternative payment model (APM)* – An APM is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. The Department of Health and Human Services (HHS) has set a goal of tying 30 percent of Medicare fee-for-service (FFS) payments to quality or value through *alternative payment models* by 2016, and 50 percent by 2018. HHS has also set a goal of

tying 85 percent of all Medicare fee-for-service to quality or value by 2016, and 90 percent by 2018. (CMS.gov: *https://qpp.cms.gov/learn/apms; https://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/*)

6. *Attribution*—The process of designating patients to certain medical practices so that these practices can serve as their primary care home and take responsibility for their primary care and care management. Attribution may be based on analysis of medical claims, for example looking back one year. Medicare fee-for-service beneficiaries are not restricted as to their choice of providers. The attribution model follows patient historical preferences for attribution and determination of payment to providers. As in CPC+, the Maryland CPC Model will use a prospective attribution methodology based on a plurality of primary care claims to identify the population of Medicare FFS beneficiaries for which each participating practice is accountable.

7. *Behavioral Health Center* – An organization dedicated to providing rapid access to specialty *behavioral health* services that include high value, comprehensive, whole person care. Behavioral health is comprised of treatment for mental illness and substance use disorders.

8. *Care coordination* – The Agency for Health care Research and Quality (AHRQ) identified more than 40 definitions of *care coordination* and *related terminology*, and developed a working definition drawing together common elements: Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care. (AHRQ: *http://www.ahrq.gov/research/findings/evidence-based-reports/caregaptp.html*)

9. *Care Management Fee (CMF)*—A monthly fee designed to give primary care practices the flexibility to provide "wrap-around" services that are traditionally not considered to be separately billable.

10. *Care Redesign Programs* – There are currently two voluntary, hospital-led programs that are part of the Care Redesign Amendment to the All-Payer Model Agreement: the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP). Both are designed to align hospitals and their Care Partners through common goals and incentives. Additional Care Redesign Programs can be added under the All-Payer Model Amendment. (HSCRC: *http://www.hscrc.state.md.us/care-redesign.cfm*)

11. *Care Transformation Organizations (CTOs)* – A component of the Maryland Comprehensive Primary Care Model. A regional entity (e.g., ACO, RP, local health department, LHIC, or CIN) that organizes, contracts, and deploys care management resources; serves as a transformation resource and Learning Network outlet; provides access to medical and non-medical resources; ensures continuity across providers and single care manager for ease of experience for patient, utilizing CRISP and coordinating entity tools. (HSCRC: *http://www.hscrc.state.md.us/documents/md-maphs/ac/2016-09-12/9-12-16-Primary-Care-Model-Presentation.pdf*)

12. *CMS—Centers for Medicare & Medicaid Services*—CMS manages the Medicare and Medicaid programs, as well as the Children's Health Insurance Program (CHIP) and providing oversight of

the Health Insurance Marketplaces. These programs provide health coverage for over 100 million Americans. [9]

13. *Comprehensive Primary Care Model*—The Maryland Comprehensive Primary Care Model is designed to improve the health of Marylanders by delivering person-centric, efficient, and cohesive primary care. This model enhances the CMS CPC+ model by adding Care Transformation Organizations (defined above) that provide to care managers to practices and/or the services of a wide range of professionals both inside and outside the medical model, to assist practices in better serving patients and improving outcomes. Under this model, the patients designate their own provider, which includes specialists. A provider of primary care is therefore defined as Patient Designated Provider (PDP).

14. *Coordinating Entity (CE)*—The Coordinating Entity (CE) would provide the certification, infrastructure, management of the flow of funds, and oversight functions in support of the Care Transformation Organizations (CTOs) that are a central feature of the Maryland Primary Care Model. The CE ensures that the outflow of funds to practices is fully supported by the flow of funds into the Model from federal, State, and practice contributions. It would also run program analytics including risk identification and stratification. This would enable practices to receive payments that reflect the risk profile of their patient population. An additional function of the CE would be to build connections to various programs and initiatives around the State. This includes hospital-based care management programs and ACOs, as well as initiatives led by county health departments and local health improvement councils (LHICs). The CE additionally provides certification to PCHs who choose to not elect a CTO.

15. *Chronic care management (CCM)* – The non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) significant chronic conditions. In addition to office visits and other face-to-face encounters (billed separately), these services include communications with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff). The creation and revision of electronic care plans is also a key component of CCM. CCM services are defined by CMS for Medicare billing purposes as at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored. (CMS.gov: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf*)

16. *Clinically Integrated Networks (CIN)* – Clinical Integration is a structured collaboration between community and a collection of health care providers, such as physicians, hospitals, and post-acute care treatment providers, that come together to improve patient care and reduce overall health care cost. The Federal Trade Commission (FTC) describes "clinical integration" as certain types of collaborations among otherwise independent health care providers to improve quality and contain costs. The 1996 joint FTC/Department of Justice Statements of Antitrust Enforcement Policy in Health Care expressly recognize the relevance of such integration to the antitrust analysis of health care provider networks that seek to collectively negotiate contracts with payers on behalf of their members. The FTC further defined that a physician hospital organization

[9] Centers for Medicare and Medicaid Services. *CMS Covers 100 Million People*. Available at: https://www.cms.gov/

("PHO") negotiating common rates for competing participating providers, must: develop and implement detailed, evidence-based clinical practice guidelines; limit participation in the program to providers committed to accepting the limitations on independent decision-making, which the guidelines entail; measure and evaluate each participating provider's compliance with the guidelines; and ensure investment from all participating providers of time, energy and financial resources in the development and enforcement of the clinical guidelines, as well as the computer infrastructure needed to facilitate such integration. (FTC.gov: *https://www.ftc.gov/news-events/events-calendar/2008/05/clinical-integration-health-care-check*).

17. *Complex and Chronic Care Improvement Program (CCIP)* – A Care Redesign Program allowing hospitals to provide care management resources to community providers and practitioners to improve care for high and rising-risk patient with complex and chronic conditions. The CCIP is authorized under the All-Payer Model Care Redesign Amendment. Care Partners who choose to participate may receive incentive payments from hospitals based on defined activities that improve quality of care and reduce potentially avoidable utilization of hospitals. The CCIP aims to: strengthen primary care supports for complex and chronic patients in order to reduce avoidable hospital utilization; enhance care management through tools such as effective risk stratification, health risk assessments, and patient-driven care profiles and plans; and facilitate overall practice transformation towards person-centered care that produces improved outcomes and meets or exceeds quality standards. (HSCRC: *http://www.hscrc.state.md.us/care-redesign.cfm*)

18. *Comprehensive Primary Care Plus (CPC+)* – A national advanced primary care medical home model that aims to strengthen primary care through a regionally based multi-payer payment reform and care delivery transformation. CPC+ will include two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices. CPC+ provides care management fees and in some cases, quarterly bonus payments to primary care practices, a portion of which may be recovered depending upon provider performance. (CMS.gov: *https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus*)

19. *Consumer* – A Maryland resident who accesses/uses/needs health care services in the Maryland health care system.

20. *CRISP—Chesapeake Regional Information System for our Patients*. CRISP is a regional health information exchange (HIE) serving Maryland and the District of Columbia. CRSIP is Maryland's State Designated HIE, as described in the Companion Document, "State-Designated Health Information Exchange Designation Agreement). This nonprofit organization is advised by a wide range of stakeholders responsible for health care in the region. A health information exchange allows clinical information to move electronically among disparate health information systems. Secure information on patients can be shared with providers in real time to help them provide the best care possible, and to work in teams to meet an array of patient needs.[10]

21. *Duals Accountable Care Organization (D-ACO*) – A model to operationally and financially integrate Medicare and Medicaid services for individuals dually-enrolled in both programs. Groups of doctors and hospitals voluntarily assume responsibility for the quality and the cost of health care. The D-ACOs will operate on a shared savings model to create incentives to achieve better health outcomes for beneficiaries across their total spectrum of services. Only those dual eligible beneficiaries with full Medicaid benefits would be enrolled in the D-ACO.

[10] CRISP. *Home Page*. Available at: https://www.crisphealth.org/

22. *E & M codes—Evaluation and Management codes:* Evaluation and Management codes (E & M) provide the process by which physician/patient encounters are translated into five-digit CPT billing codes. CPT stands for current procedural terminology.

23. *eCQMs*—Electronic Clinical Quality measures. These measures use data from Electronic Health Records and/or health information technology systems to measure quality of care. CMS uses eCQMs in a variety of quality reporting and incentive programs.

24. *EHR*—Electronic Health Record. An electronic health record provides a wide range of information about patients in a secure electronic form, replacing paper files for each patient. The EHR may contain the patients' problem list, the medications they are using, their medical history, and care plan. The goal is to make different computerized EHR systems compatible, or "interoperable," so that information can be shared across providers in a timely and secure fashion.

25. *Encounter Notification Service (ENS)*—Encounter Notification Service (ENS) notifies physicians, other providers and care managers when patients are in the emergency department or are hospitalized.

26. *Geographic value-based incentive* – A vehicle to incorporate responsibility for Medicare total cost of care in hospital global budgets through incentives based on the Medicare total cost of care growth in each hospital's service area.

27. *HIE*—Health Information Exchange. HIEs allow the mobilization of health care information across organizations in a region or community. HIEs allow physicians, hospitals, nurses, pharmacists, and other health care providers to appropriately access and securely share a patient's vital health information.[11]

28. *Hospital Care Improvement Program (HCIP)* – A Care Redesign Program under the All-Payer Model Care Redesign Amendment to incentivize hospital-based providers to implement care redesign interventions that reduce internal hospital costs and encourage effective acute care events and effective transitions of care. The HCIP aims to: Improve inpatient medical and surgical care delivery; provide effective transitions of care; ensure an effective delivery of care during acute care events, beyond hospital walls; encourage the effective management of inpatient resources; and reduce potentially avoidable utilization with a byproduct of reduced cost per acute care event. Care Partners who choose to participate may receive incentive payments based on reducing internal costs through a reduction in unnecessary utilization and resources, efficient practice patterns, and improved quality. (HSCRC: http://www.hscrc.state.md.us/care-redesign.cfm)

29. *LHICs*—Local Health Improvement Coalitions. LHICs are panels of local health departments, hospitals, physicians, community organizations and other local entities. They strive to integrate community health and medical care. They develop prototypes of data tools and new mapping techniques to reach and better serve high-cost individuals in their areas.[12]

[11] HealthIT.gov. *What is Health Information Exchange?* Available at: https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie

[12] Department of Health and Mental Hygiene. *SIM Local Health Improvement Coalition (LHIC) Stakeholder Group*. Available at: http://hsia.dhmh.maryland.gov/Pages/lhic.aspx

30. *Learning System Strategy* – The Maryland CPC Model will include a robust learning system to support practices through their care delivery transformations. The practices themselves will be the primary drivers of practice change, but the learning system will provide support, accountability, and learning opportunities across the Model.

31. *Long-term services and supports (LTSS)* – Long-term services and supports (LTSS) are designed to meet the personal and health needs of individuals living with disabilities, chronic diseases, complex medical needs, impaired mobility or impaired cognitive function. These services range from home health and personal care services (such as bathing and dressing) designed to help people live successfully and independently at home to services provided in institutional settings, such as nursing homes. About one-half of people who require LTSS are older than age 65 and one-half are people with disabilities under age 65. As our population ages, the number of individuals who need these types of services will grow. Medicaid is now the largest payer of Long-Term Services and Supports (LTSS), accounting for 41 percent of all LTSS spending in the United States. As a comparison, Medicare accounts for 20 percent, direct out-of-pocket care spending accounts for 15 percent and private financing options such as long-term care insurance, reverse mortgages, annuities and trusts make up the remaining 24 percent. (NCSL: *http://www.ncsl.org/research/health/medicaid-and-long-term-services-and-supports.aspx*)

32. *MACRA* – The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is bipartisan federal legislation signed into law on April 16, 2015**.** The law includes new funding for technical assistance to providers and for measure development and testing. It enables new programs and requirements for data sharing, and establishes new federal advisory groups. In the simplest possible terms, MACRA terminates the Sustainable Growth Rate (SGR) Formula that has determined Medicare Part B reimbursement rates for physicians and replaces it with new ways of paying for care. Under MACRA, participating providers will be paid based on the quality and effectiveness of the care they provide. (CMS.gov: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf*)

33. *Maryland Comprehensive Primary Care (CPC) Model:* This model is the central feature of the primary care model being presented by Maryland to CMMI. The key elements of this model are: (1) *Person Centered Homes/Patient Designated Providers.* A person-centered home (PCH) provides comprehensive and coordinated care around a person's health care needs; (2) *Care Transformation Organization (CTO).* CTOs are newly designated, private entities that provide services to practices. The CTOs generate economies of scale in the provision of services that are challenging or impossible for many small and medium size practices to engage financially or operationally; and (3) *Coordinating Entity.* CE is the State sponsored, privately advised entity that coordinates the unique rule sets within the Maryland model, administers the program, and designates practice and CTO participation.

34. *Merit-based incentive payment system (MIPS)* –Currently, Medicare measures the value and quality of care provided by doctors and other clinicians through a patchwork of programs, including the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program. Through the Medicare Access and CHIP Reauthorization Act (MACRA), Congress streamlined and improved these programs into one new Merit-based Incentive Payment System (MIPS). Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS. MIPS is expected to improve the relevance and depth of Medicare's value and quality-based payments and increase clinician flexibility by allowing clinicians to choose measures and activities appropriate to the type of care they provide. MIPS allows Medicare clinicians to be paid for providing high quality, efficient

care through success in four performance categories: Cost, quality, clinical practice improvement activities, advancing care information. (CMS.gov: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf*)

35. *Naylor Transitional Care Model*—The Naylor model addresses the transition from hospital to the community. The hospital care team may decide to employ the Naylor Transitional Care Model (TCM), which is a longer-term transitional care program that includes comprehensive discharge planning and extensive at-home follow up. TCM uses the advanced knowledge and skills of a Transitional Care Nurse (TCN) to provide a comprehensive assessment of the patient's needs and coordinate care across the spectrum of service. The TCN makes contact with the patient in the hospital, working with care providers and clinical staff to create a care plan, including medication and symptom management. The TCN conducts a home visit within 24 hours of discharge to evaluate the plan of care at home, and works with the patient and family to adjust its goals as needed.

36. *NCQA*—National Committee on Quality Assurance is an organization that measures quality of care and publishes report cards on health plans and clinicians. NCQA publishes the Health Effectiveness Data and Information Set (HEDIS), which provides 83 quality measures across five domains of care. They also publish report cards on the performance of health plans and clinicians.

37. *Non-hospital spending* – Health care spending that occurs outside of inpatient or outpatient hospital settings, such as physician office services, diagnostic testing in the community, post-acute care, and long-term care.

38. *Open-access scheduling*-- Open access scheduling covers a variety of scheduling approaches, including completely unscheduled (as in the case of an ED or urgent care center), open blocks of time on certain days, and a specific number of appointments kept open in each clinic or practice session. A practice could utilize more than one of these options, as well as traditionally scheduled appointments. The imperative is to do what makes sense for the patients and the providers. The model of open access is to "do today's work today" and address patients' problems and requests to be seen as they occur rather than with appointed times in the future. When done correctly and in the right situations, open access can be a highly effective model and can promote high patient and provider satisfaction.

39. *Patient-Centered Medical Home (PCMH)* – A care delivery model whereby treatment is coordinated through the primary care physician to ensure a patient receives the necessary care when and where he or she needs it, in a manner that empowers the patient as an integral part of the care team. (ACP: https://www.acponline.org/practice-resources/business/payment/models/pcmh/understanding/what-pcmh)

40. *Patient Designated Providers (PDPs)* – A primary care provider who is selected by a patient to take responsibility for coordinating services from all providers; this leader should be paid adequately for performing a care coordination role. (HSCRC: *http://www.hscrc.state.md.us/documents/md-maphs/ac/2016-09-12/9-12-16-Advisory-Council-Strategy-Deck.pdf*)

41. *Performance-based incentive payment*—a quarterly performance-based incentive payment from CMS that will be considered at risk. If practices fail to meet annual performance thresholds, CMS will recoup unwarranted payments.

42. *Person Centered Homes*—A person centered home (PCH) provides comprehensive and coordinated care around a person's health care needs. A provider's office is considered the central hub, or home, where facilitation and coordination to other health care professionals takes place. PCHs improve access and efficiency to care by providing more seamless coordination of care and meeting patients where they are.

43. *PFAC*—Patient and Family Advisory Council. Practices participating in the comprehensive primary care model will organize a Patient and Family Advisory Council (PFAC) to help them understand the perspective of patients and caregivers on the organization and delivery of care, as well as its ongoing transformation through Maryland CPC Practices. Practices will use the recommendations from the PFAC to help them improve their care and ensure its continued patient-centeredness.

44. *Practitioner* – A person who practices medicine or one of the allied health care professions; one who has met the requirements of and is engaged in the practice of medicine, dentistry or nursing. (Medical Dictionary: http://medical-dictionary.thefreedictionary.com/practitioner)

45. *Person and family-centered care approach* – The person-centered planning process is an ongoing process involving the beneficiary, their family, and other supports. Its intent is to identify and address a beneficiary's changing strengths, capacities, goals, preferences, needs, and desired outcomes. The information gathered in the process along with medical assessments is used to create a person-centered care plan. The plan is necessary to address a beneficiary's long-term care needs, and should include medical as well as social factors. (CMS.gov: *https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/hcbs-tk2-care-plan-requirements-booklet.pdf)*

46. *Patient-Centered Health Home (PCHH)* – A medical home (or person-centered medical home) (PCMH) is a care model that involves the coordinated care of individual's overall health care needs (and where individuals are active in their care. A health home (e.g., a Medicaid health home) — as defined in Section 2703 of the Affordable Care Act — offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses. (SAMHSA: *http://www.integration.samhsa.gov/integrated-care-models/health-homes*)

47. *Population health* – The health outcomes of a group of individuals, including the distribution of such outcomes within the group. (HRSA: *http://www.hrsa.gov/advisorycommittees/bhpradvisory/nacnep/Meetings/132-01-12-16/cms-population-health.pdf*) Population health in Maryland includes long-term planning in a broad sense that encompasses the social determinants of health, such as housing, nutrition, and transportation.

48. *Potentially avoidable utilization (PAU)* – PAU is defined as hospital care that is unplanned and can be prevented through improved care, care coordination, or effective community-based care; or patient complications and care cost increases that result from a potentially preventable complication occurring in a hospital. (HSCRC: *http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/GBR-PAU/Components-of-Potentially-Avoidable-Utilization.pdf*)

49. *Skilled nursing facility (SNF)* – A health-care institution that meets federal criteria for Medicaid and Medicare reimbursement for nursing care including especially the supervision of the care of every patient by a physician, the employment full-time of at least one registered nurse, the maintenance of records concerning the care and condition of every patient, the availability of nursing care 24 hours a day, the presence of facilities for storing and dispensing drugs, the implementation of a utilization review plan, and overall financial planning including an annual operating budget and a three-year capital expenditures program. A SNF could be part of a nursing home or hospital. Medicare certifies these facilities if they have the staff and equipment to give skilled nursing care, therapy services, and/or other related health services. SNF care is health care given when someone needs skilled nursing or therapy staff to manage, observe, and evaluate their care. Examples of skilled care include intravenous injections and physical therapy. Medicare will only cover skilled care when individuals meet certain conditions. (Medicare.gov: *https://www.medicare.gov/Pubs/pdf/10153.pdf*)

50. *TCOC*—Total cost of care. CMS is examining total cost of health care for Medicare beneficiaries in Maryland to monitor the impact of the All-Payer Model on costs across not only hospitals, as in the past, but also across other health service categories. CMS will be examining the impact on physician services under Part B of Medicare, post-acute, home health, and long-term care services.[13]

51. *Value-based payment program* – A strategy used by purchasers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments, to payments that are more closely related to outcomes. In Medicare, value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of Medicare's larger quality strategy to reform how health care is delivered and paid for. Value-based programs also support Medicare's three-part aim: Better care for individuals; better health for populations; lower cost. (CMS.gov: *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html*)

52. *Team-based care*--Team-based care improves health by distributing the care responsibilities among a team of health care professionals each with his/her clearly defined roles in support of the attributed patient. The provider remains at the center as the leader of the team. Team-based care encourages collaboration among the team so that team members can work directly with the patient at the "top of their licenses." Teams can also include well-trained non-clinicians who add to and extend primary care capacity. Some panels use two or three clinical assistants for each clinician. This is all part of primary care practice transformation, although they do not use that term. In team-based practices most routine care is provided before the clinician enters the examining room so that the visits can focus on patients' concerns, issues requiring the clinician's level of expertise, treatment options, and shared care plans.[14]

53. *Telemedicine*-- Telemedicine can be an effective modality to increase access to care. The American Telemedicine Association defines telemedicine as the remote delivery of health care

[13] Maryland Hospital Association. "Monitoring Total Cost of Care. January 9, 2014. Available at: http://www.hscrc.state.md.us/documents/md-maphs/wp-sub/MHA-Total-Cost-of-Care-paper-revised-01-10-2014.pdf

[14] Thomas Bodenheimer, Amireh Ghorob, Rachel Willard-Grace, and Kevin Grumbach. The Ten Building Blocks of High-Performing Primary Care. *Am Fam Med* 2014; 166-171.

services and clinical information using telecommunications technology.[15] Telemedicine services may include: virtual visits for medical or behavioral health care, mobile health access, direct to consumer telehealth, peer to peer technology based solutions and remote patient monitoring. Each of these technology-based solutions offers a unique approach to bringing health care services or information to patients, their care givers or providers across distances in a way that increases access to services that may have otherwise been unavailable.

[15] American Telemedicine Association. *About Telemedicine.* Available at: http://www.americantelemed.org/about/about-telemedicine

Appendix B. Attribution Methodology and Practice Eligibility

Summary of Results and Logic

Overall, the team identified approximately 515,000 beneficiaries (including dually eligible beneficiaries less those attributed to Dual-ACO counties) attributed to 3,781 eligible providers representing 1,232 unique practices.

Full Medicare Beneficiaries residing in Maryland were attributed to providers who billed for the plurality of beneficiary's 2015 Office Visits AND minimum of 25 Total Office Visits in 2015 (from attributed Maryland beneficiaries) during the most recently available 12-month period, attributed to Traditional Primary Care Providers first and subsequently Specialist Primary Care Providers. Traditional Primary Care Providers were defined as providers with a primary specialty of Internal Medicine; General Practice; Geriatric Medicine; Family practice; Pediatric Medicine; Nurse Practitioner; or Obstetrics/Gynecology. Specialist Primary Care Providers were defined as providers with a primary specialty of Cardiology; Gastroenterology; Psychiatry; Pulmonary Disease; Hematology/Oncology; or Nephrology.

Providers were considered eligible for the program if their primary practice had at least 150 attributed Medicare beneficiaries and primary care services represented at least 60% of all services provided by the practice. Primary Care Services were defined as office visits, home visits, nursing home visits, specialist visits, consultations, immunizations/vaccinations, and other testing codes.

The following sections outline a step-by-step approach that Maryland has taken to determine the number of beneficiaries, providers, and practices that will be eligible to participate in the program, defines eligibility under the Maryland CPC Model, and identifies any adaptations made from CPC+.

I. Beneficiary Eligibility

A. Requirement: Beneficiaries included in the Model must be eligible Medicare beneficiaries

To be eligible for this initiative and aligned with a practice, beneficiaries must:

Beneficiary Requirement	CPC+	Maryland Model
Have both Medicare Parts A and B;	✓	✓
Have Medicare as their primary payer;	✓	✓
Not have end stage renal disease (ESRD) or be enrolled in hospice;	✓	
Not be covered under a Medicare Advantage or other Medicare health plan;	✓	✓
Not be institutionalized; Not be incarcerated;	✓	
May be enrolled in the Medicare Shared Savings Program	✓	✓
Not be enrolled in the Next Generation ACO Model, ACO Investment Model, or Advanced Payment ACO Model; or any other program or model that includes a shared savings opportunity with Medicare FFS initiative;	✓	✓
Reside in one of the regions selected for this model	✓	✓

B. Beneficiary Eligibility Results

Of the approximately 850,000 Medicare beneficiaries in Maryland, approximately 750,000 meet the eligibility criteria in 2015 (including approximately 90,000 dually eligible beneficiaries).

II. Beneficiary Attribution

A. Requirement: Beneficiaries must be attributed to a provider that provides most of their care.

To be eligible for this initiative and aligned with a practice, beneficiaries must be attributed to a provider based on the following logic:

CPC+	Maryland Model
1. Aligned with the practice that either billed for the plurality of their primary care allowed charges OR that billed the most recent claim (if that claim was for CCM services) during the most recently available 24-month period, attributed to Primary Care providers.	1. Aligned with the provider who billed for the plurality of beneficiary's 2015 Office Visits AND minimum of 25 Total Office Visits in 2015 (from attributed Maryland beneficiaries) during the most recently available 12-month period, attributed to Traditional Primary Care Providers first and subsequently Specialist Primary Care Providers.
2. If a beneficiary has an equal number of qualifying visits to more than one practice, the beneficiary will be aligned to the practice with the most recent visit.	2. If a beneficiary has an equal number of qualifying visits to more than one practice, the beneficiary will be aligned to both practices.

B. Requirement: Beneficiaries must be attributed to a provider that provides the beneficiary's primary care.

In CPC+, a primary care practitioner is defined as a Physician (MD or DO), nurse practitioner (NP), physician assistant (PA), or Clinical Nurse Specialist (CNS) who has a primary specialty designation of family medicine, internal medicine, or geriatric medicine. However, the Maryland CPC Model team was concerned this definition of Primary Care Provider would be too restrictive and would exclude specialist providers who may serve as the main provider of primary care services.

The team tested two possible definitions of Primary Care Providers (see Table below), and settled on the following definition, known as Patient Designated Providers which is a Traditional + Specialist PCP Model that includes traditional PCP specialties (Internal Medicine, General Practice, Geriatric Medicine, Family practice, Pediatric Medicine, Nurse Practitioner, OB/GYN), as well as selected specialists (Cardiology, Gastroenterology, Psychiatry, Pulmonary Disease, Hematology/Oncology, and Nephrology).

Provider Type	Definition	Eligible PDPs (#)
Traditional PCP	Attribution restricted to providers with primary specialty: Internal Medicine; General Practice; Geriatric Medicine; Family practice; Pediatric Medicine; Nurse Practitioner; OB/GYN	3,819
Specialist PCP + Traditional PCP	**First Run: Attribution restricted on Traditional PCP Definition** **Second Run: Attribution of remaining unattributed beneficiaries to providers with primary specialty: Cardiology; Gastroenterology; Psychiatry; Pulmonary Disease; Hematology/Oncology; and Nephrology.**	**5,105**

C. Beneficiary Attribution Results

The Traditional + Specialist Model was selected, resulting in 5,105 eligible PDPs with approximately 630,000 attributed beneficiaries.

III. Provider Eligibility

A. Requirement: The cost of primary care services must represent 60% of total costs in a practice during the most recently available time period (CPC+: 24 month, Maryland: 12-month), excluding hospital and emergency department costs.

The CPC+ Model uses a definition of Primary Care Services that is restricted to general office and home visits, Transitional Care Management, and Chronic Care Management. However, the Maryland CPC Model team was concerned this definition of Primary Care Services would be too restrictive and would exclude specialist providers the model hoped to include.

The team tested four possible definitions of Primary Care Services (see Table below), and chose Definition 4 of Primary Care Services, which expands upon the CPC+ definition of primary care services and adds other E & M codes, immunizations/vaccinations, and other testing. Because practices can select which providers are included in CPC+ and therefore which providers contribute to the 60% requirement, the Maryland model excludes providers whose individual % of primary care services was less than 20% for use in modeling (**Definition 4M**).

Def.	Codes	PDPs (#)	PDPs (% of 5105)
1	CPT Codes (CPC+ Definition): Office/Outpatient Visit E&M (99201-99205 99211-99215); Complex Chronic Care Coordination Services (99487-99489); Transitional Care Management Services (99495-99496); Home Care (99341-99350); Welcome to Medicare and Annual Wellness Visits (G0402, G0438, G0439); Chronic Care Management Services (99490) OR	2158	42.3%

Def.	Codes	PDPs (#)	PDPs (% of 5105)
	Office Visits (M1A, M1B); Home Visit (M4A); Nursing Home Visit (M4B) BETOS Codes		
2	Definition 1 + Specialist Visits (M5B, M5D); Consultations (M6) BETOS Codes	3071	60.2%
3	Definition 2 + Immunizations/Vaccinations (O1G) BETOS Codes	3597	70.5%
4	Definition 3 + Other Testing BETOS Codes (T2A Electrocardiograms, T2B Cardiovascular Stress Tests, T2C EKG Monitoring, T2D Other Tests)	3805	74.5%
4M	**Definition 4, but for modeling purposes excluding providers whose individual % of primary care services was less than 20%**	**4183**	**81.9%**

B. Requirement: The practice must provide health services to a minimum of 150 attributed Medicare fee-for-service beneficiaries.

Following the CPC+ requirement, the Maryland Model requires practices to provide health services to a minimum of 150 attributed Medicare fee-for-service beneficiaries. Approximately 4,660 providers participate in practices meeting the 150 beneficiary requirement. The table below shows the distribution of providers by number of beneficiaries:

# of Beneficiaries	PDPs (#)	PDPs (% of 5105)
<25	56	1.1%
25+	81	1.6%
50+	152	3.0%
100+	87	1.7%
125+	68	1.3%
150+	**4661**	**91.3%**

C. Provider Eligibility Results

There were 3,781 providers practicing in eligible practices with both at least 150 attributed beneficiaries and greater than 60% primary care services. Approximately 562,000 beneficiaries were attributed to these 3,781 eligible providers.

# of Beneficiaries	<60% Primary Services	>60% Primary Services	Total PDPs
Less than 150	42	402	444
150+	880	**3,781**	4661
Total	922	4,183	5105

Specialty	Total Providers	Providers that Meet Eligibility Requirements	
	#	#	% of specialty
Cardiology	428	207	48%
Family Medicine	30	27	90%
Family Practice	974	868	89%
Gastroenterology	238	63	26%
General Practice	62	32	52%
Geriatric Medicine	22	20	91%
Hematology/Oncology	170	72	42%
Internal Medicine	1921	1703	89%
Nephrology	101	18	18%
Nurse Practitioner	373	303	81%
OB/GYN	430	220	51%
Pediatric Medicine	7	6	86%
Psychiatry	236	138	58%
Pulmonary Disease	113	104	92%
	5,105	**3,781**	

IV. Dually Eligible Beneficiary Limitations

A. Requirement: Dually Eligible Beneficiaries are eligible for the model except those residing in one of the Dual-ACO Counties.

After excluding the Dual Eligible Beneficiaries living in one of the Dual-ACO Counties, there are approximately 515,000 beneficiaries attributed to the providers in this model.

Appendix C. Comparison of CPC Plus and Maryland CPC Model

The following tables contain a comparison of CPC+ to the Maryland CPC Model. Final practice and CTO requirements will be contained in the respective requests for applications.

Table 1. Practice Selection and Attribution Comparison

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Practice Selection	Primary care practices identified by TIN/NPI combination. • At least 60 percent of services provided by practice must be for primary care; • Operates at a single physical location; • A minimum of 150 beneficiaries must be attributed to the primary care practice. Practitioners that provide services at more than one CPC+ practice indicate which CPC+ practice they are part of for the purposes of payment and alignment.	PCH identified by TIN/NPI combination. • At least 60 percent of services provided by practice must be for primary care; **Special considerations may be considered for minimum 60% primary care services based on specialty/PCH ability* • Operates at a single physical location; • A minimum of 150 beneficiaries must be attributed to the practice. **Special considerations may be considered for minimum 150 beneficiaries based on specialty/PCH ability* Practitioners that provide services at more than one Maryland CPC practice indicate which participating practice they are part of for the purposes of payment and alignment. The PCH will typically be a primary care practice but may also be a specialist or a behavioral health provider. The eligibility criteria for applications are TBD in 2017 in conjunction with CMMI. Track 1 practices will have to transition to Track 2 within three years or exit the program. The CE will develop the rules for hardship exemptions for the progression from Track 1 to Track 2.	The State anticipates that CTOs will be primarily drawn from existing organizations such as ACOs, managed service organizations, health plans, Clinical Integration Networks (CINs), and hospitals, though newly formed organizations may also serve in this role. Established community based organizations may subcontract to CTO (e.g., Local Health Departments). The CTO will form an ACO-like entity and sign a participation agreement with an oversight entity that will include CMS and the CE that includes governance requirements. CTO participation will be determined by an open application process to CMS/CE which will establish the essential functions. Practices choosing to work with a CTO will have the opportunity to move to a different CTO on an annual basis, pending contract execution.

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Attribution Methodology	Beneficiaries are prospectively aligned to practices based on: • the plurality of their primary care services; or • the most recent claim for CCM within a 24-month look back. There is no opt-out for beneficiaries aligned to a CPC+ practice; nor is there an option to designate a preferred CPC+ practice.	The Maryland CPC Model will use a prospective attribution methodology based on a plurality of primary care claims to identify the population of Medicare FFS beneficiaries for which each participating practice, the PCH, is accountable. Beneficiaries are prospectively aligned to practices based on two-step process: 1. Beneficiaries are prospectively aligned to primary care practices based on the plurality of their primary care services during the most recently available 12 month time period; 2. Beneficiaries that are not attributed to a primary care practice under the E&M attribution methodology may be attributed to a willing specialist that has provided exclusive E&M services to the beneficiary. To ensure practices are eligible, CMS will run attribution for applicant practices before practices sign their Participation Agreements. <u>CCIP Attribution/Integration with CPC</u> Hospital will identify eligible patients and through their care management staff and applicable CTOs will coordinate patient enrollment and provider Partner Care Agreements through the PDP office. Participating beneficiaries will positively elect services under the CCIP in partnership with the PDP, receiving hospital based care management services under CCIP until services no longer warranted. Transition to management ("warm hand off") under PDP guidance in the community PCH will allow beneficiary to transition out of CCIP services and into	The CTO is responsible for all beneficiaries attributed to the PCH practices that have contracted with the CTO. The CTO will be responsible for some performance and utilization and ultimately population health outcome metrics for beneficiaries that reside in their service area. While the level of support to PCHs will vary, all beneficiaries attributed to a PCH who have an agreement with CTO will also be attributed to the CTO. <u>CCIP Attribution</u> CTO coordinates efficient use of care management resources between hospital and PCHs. Depending on development of CCIP, the CTO may have responsibility for beneficiaries attributed to the PCH practices participating in the CCIP and the Maryland CPC Model.

	CMS CPC+ Model	Maryland PCH	Maryland CTO
		Maryland CPC Model when CCIP services no longer needed. CTO may assist process.	

Table 2. Payment Design Comparison

<table>
<tr><th></th><th>CMS CPC+ Model</th><th>Maryland PCH</th><th>Maryland CTO</th></tr>
<tr><td colspan="4">Payment Design</td></tr>
<tr><td>Care Management Fees</td><td>CMS makes a prospective, monthly, PMPM to practices for all of their aligned beneficiaries. CMF determined on the basis of Risk Tier, primarily based on the HCC of the beneficiaries according to the table below:

Track 1

<table><tr><th>Risk Tier</th><th>Criteria</th><th>CMF $</th></tr><tr><td>Tier 1</td><td>01-24% HCC</td><td>$6</td></tr><tr><td>Tier 2</td><td>25-49% HCC</td><td>$8</td></tr><tr><td>Tier 3</td><td>50-74% HCC</td><td>$16</td></tr><tr><td>Tier 4</td><td>75-99% HCC</td><td>$30</td></tr><tr><td>Average</td><td></td><td>$15</td></tr></table>CMF for Track 2 practices have higher dollar amount and include a ‘complex’ category:

<table><tr><th>Risk Tier</th><th>Criteria</th><th>CMF $</th></tr><tr><td>Tier 1</td><td>01-24% HCC</td><td>$9</td></tr><tr><td>Tier 2</td><td>25-49% HCC</td><td>$11</td></tr><tr><td>Tier 3</td><td>50-74% HCC</td><td>$19</td></tr><tr><td>Tier 4</td><td>75-89% HCC</td><td>$33</td></tr></table></td><td>The CMF will be calculated based on the risk tier of the PCH’s attributed beneficiaries. CMS / CE will calculate the CMF for the practice. All PCHs will receive a CMF equivalent to the payments paid the CPC+ Track 2 practices risk tiers.

CTOs are also eligible to receive a portion of the CMF, derived from its contractual relationship with the PCH. Several different arrangements will be made available to PCH from which to choose and based upon this choice, the CE will determine percentage of CMF between PCH and CTO. PCH is not required to contract with a CTO and may retain 100% of the CMF if they meet all the requirements of care transformation activities.

The definition of ‘complex’ beneficiaries will be expanded to include those with a substance use disorder or a behavioral health condition, such as bipolar or severe depression, or a dementia diagnosis.

<table><tr><th>Risk Tier</th><th>Criteria</th><th>CMF $</th></tr><tr><td>Tier 1</td><td>01-24% HCC</td><td>$9</td></tr><tr><td>Tier 2</td><td>25-49% HCC</td><td>$11</td></tr><tr><td>Tier 3</td><td>50-74% HCC</td><td>$19</td></tr><tr><td>Tier 4</td><td>75-89% HCC</td><td>$33</td></tr></table></td><td>The CTO will receive up to a percentage of the PBPM of the overall CMF for each PCH that has signed up with the CTO. The CTO will receive its share of CMF from a CMS contract under the direction of the CE. The CTO’s share will be based on the level of technical assistance and infrastructure support provided to practices related to the requirements under the Maryland CPC Model. CTOs cannot receive 100% of CMF.

This portion of the CMF payments going to the CTO will be at risk and recouped based on end of the year reconciliation.</td></tr>
</table>

<table>
<tr><th></th><th>CMS CPC+ Model</th><th>Maryland PCH</th><th>Maryland CTO</th></tr>
<tr><td colspan="4">Payment Design</td></tr>
<tr><td></td><td>
<table>
<tr><td>Complex</td><td>90+% HCC or Dementia</td><td>$100</td></tr>
<tr><td>Average</td><td></td><td>$28</td></tr>
</table>
The CMF is paid monthly and replaces the CCM without any beneficiary cost sharing.</td><td>
<table>
<tr><td>Complex/ SUD/BH</td><td>90+% HCC or Dementia</td><td>$100</td></tr>
<tr><td>Average</td><td></td><td>$28</td></tr>
</table>
The CMF is paid monthly and replaces the CCM fees without any beneficiary cost sharing.</td><td></td></tr>
<tr><td>Performance-Based Incentive Payment (PBIP)</td><td>Incentive payments are made prospectively and will be recouped in part or whole if practices fail to meet quality targets. The amounts are PBPM as below:
<table>
<tr><th>Risk Tier</th><th>Utilization $</th><th>Quality $</th></tr>
<tr><td>Track 1</td><td>$1.25</td><td>$1.25</td></tr>
<tr><td>Track 2</td><td>$2.00</td><td>$2.00</td></tr>
</table>
The practices may keep a portion of their incentive payments based on their performance on the quality and utilization measures. A 60% score results in the practice keeping 60% of their payment.

The utilization scores will be based on hospital and emergency department utilizations. The quality scores will be based on the eCQM and CAHPS measures. These are calculated at the practice level.</td><td>The PCH will receive PBPM incentive payments similar to the CPC+ practices; the magnitude of the payment is commensurate to the Track and the risk tier of the beneficiaries. The utilization measures will also be based on the hospital and ED utilization.

Incentive payments PBPM are made prospectively and will be recouped in part or whole if practices do not meet quality and utilization targets. Amounts are based on the PCH’s track. The amounts are as below:
<table>
<tr><th>Risk Tier</th><th>Utilization $</th><th>Quality $</th></tr>
<tr><td>Track 1</td><td>$1.25</td><td>$1.25</td></tr>
<tr><td>Track 2</td><td>$2.00</td><td>$2.00</td></tr>
</table>
The practices may keep a portion of their incentive payments based on their performance on quality and utilization measures. CMS will score the payments using a continuous approach with a minimum, under which a practice keeps none of the incentive, and a maximum, under which a practice keeps the entire incentive. A 60% score results in the practice keeping 100% of their payment. Further rules from CMS are forthcoming.</td><td>A percentage of the CMF payment paid directly to the CTO will contain performance incentives. CTOs will be held accountable for quality, utilization, and outcomes of the beneficiaries under management by PCHs working with the CTO. The measures may differ from the CPC+ quality measures.</td></tr>
</table>

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Payment Design			
		Score areas are as follows: • The utilization scores will be based on hospital and emergency department utilizations. • The quality scores will be based on the eCQMs and CG-CAHPS measures laid out in CPC+. Measures will be revisited annually.	
Comprehensive Primary Care payment (CPCP)	Track 2 practices will be paid some portion of their E&M revenues via an upfront PMPM payment. The practice's FFS revenues will be discounted by an offsetting amount. • The CPCP payments are based on historical E&M costs inflated by 10%. • There are two options for paying practices: 40% CPCP and 60% FFS or 65% CPCP and 35% FFS. • There will be a partial reconciliation based on E&M revenues provided outside the CPC+ practice. Reconciliation process is TBD as additional payers, beyond Medicare, participate in this model.	Track 2 PCHs will also be paid CPCP. The historical E&M revenues will be similarly adjusted for the PCHs. PCHs will have the same options for dividing revenues between CPCP and FFS. CMS will institute the same reconciliation process with the PCH practices. Intent is transformations occur for the practice and not the beneficiary. • The CPCP payments are based on historical E&M costs inflated by 10%. • There are two options for paying practices: 40% CPCP and 60% FFS or 65% CPCP and 35% FFS.	N/A

Table 3. Five Primary Care Functions Comparison

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Five Primary Care Functions			
Access to Care	CPC+ providers have several care delivery requirements to increase access to care. The Track 1 practices must: 1.1. Achieve and maintain at least 95% empanelment to practitioner and/or care teams. 1.2. Ensure patients have 24/7 access to a care team practitioner with real-time access to the HER. 1.3. Organize care by practice-identified teams responsible for a specific, identifiable panel of patients to optimize continuity. The Track 2 practices must perform requirements (1.1 – 1.3) and the following: 1.4. Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as telemedicine, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends.	PCHs will be required to provide additional access to care to their attributed beneficiaries. The requirements include: 1.1. Achieve and maintain at least 95% empanelment to practitioner and/or care teams. 1.2. Ensure patients have expanded access to practitioners outside of normal office hours; including 24/7 access to a care team practitioner with real-time access to the EHR. 1.3. Choose a CTO-organized behavioral health care team for the practice. Integrate the care team within the practice, OR 1.4. Delineate behavioral health care teams that include PCH staff which are responsible for a specific identifiable panel of patients to optimize continuity.	The CTO will be responsible for ensuring that practices are capable of providing the following services: 1.5. Regularly offer at least multiple alternatives to traditional office visits in a way that best meets the needs of the population, such as telemedicine, phone visits, group visits, home visits, mobile clinics, or alternate location visits (e.g., senior centers and assisted living centers). Provide TA and wrap around support services to facilitate improved health.
Care Management	The Track 1 CPC+ practices must meet the following care management requirements: 2.1. Risk-stratify all empaneled patients.	The PCH practices must meet the following requirements in order to provide comprehensive care management.	The CTO is responsible for the following activities: 2.12. CTO will train care managers to accomplish tasks as well as "boots on

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Five Primary Care Functions			
	2.2. Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management. 2.3. Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empaneled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management. 2.4. Ensure patients with ED visits receive a follow up interaction within 3 days. 2.5. Contact at least 75% of patients who were hospitalized in target hospital(s), within 2 business days. The practices in Track 2 of CPC+ must perform activities 2.2. – 2.5. and the additional activities: 2.6. Use a two-step risk stratification process for all empaneled patients: ● Step 1 - based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition). ● Step 2 - adds the care team's perception of risk to adjust the risk-stratification of patients, as needed.	2.1. Integrate care manager into practice operations. 2.2. Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empaneled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management. 2.3. Provide targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a defined risk stratification process and who are likely to benefit from intensive care management. 2.4. Ensure patients with ED visits receive a follow up interaction within 3 days of discharge. 2.5. Contact at least 75% of patients who were hospitalized, within 2 business days. 2.6. PCH provide final risk stratification of patient; PCH provides clinical interpretation of this and assigns level of CM based on risk stratification of patient. The Track 2 CPC+ practices must also meet the following requirements:	the ground" workflow transformation on all aspects of advanced primary care. 2.13. CTO will work with CRISP to support care plans available to all care team members, in and outside the PCH. 2.14. The CTO will analyze risk stratification data from CE/ CRISP/ CMS/ APCD. The CTO will then provide summarized clinical risk stratification data to PCH.

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Five Primary Care Functions			
	2.7. Use a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management.	2.7. Integrated care manager uses a plan of care centered on patient's actions and support needs in management of chronic conditions for patients receiving longitudinal care management. 2.8. Develop a plan of care for the management of chronic conditions for patients that need to receive longitudinal care management. 2.8. Provide longitudinal consults with specialists, such as behavioral health specialists and pharmacists, for the practice-based care management teams. 2.9. Use a two-step risk stratification process for all empaneled patients: ● Step 1 - based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition); ● Step 2 - adds the practice based care team's perception of risk to adjust the risk-stratification of patients, as needed. 2.10. Ensure that complex patients with ED visits receive a follow up e-visits, phone visits, group visits, home visits, mobile clinics, or alternate location visits within 3 days of discharge. 2.11. Ensure that at least 75% of complex patients that were hospitalized have an	

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Five Primary Care Functions			
		interaction with the care management team, within 2 business days.	
Comprehensiveness and Coordination	CPC+ practices in Track 1 of CPC+ are required to perform the following care redesign activities to ensure that beneficiaries have comprehensive and coordinated care: 3.1. Systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payer's data. 3.2. Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payer's data. The CPC+ practices in Track 2 of CPC+ are required to perform activities 3.1 and also perform the following: 3.3. Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports. 3.4. Choose and implement at least one option from a menu of options for integrating behavioral health into care. 3.5. Systematically assess patients' psychosocial needs using evidence-based tools.	The Track 1 PCH's are required to meet the following requirements: 3.1. Systematically assess patients' psychosocial needs using evidence-based tools. 3.2. Conduct an inventory of resources and supports to meet patient's psychosocial needs. The Track 2 PCHs are required to perform activities 3.1 and 3.2, and also the following: 3.3. Enact collaborative care agreements with at least two groups of specialists identified based on analysis of CMS/other payer reports. 3.4. Choose and implement at least one option from a menu of options for integrating behavioral health into care, as appropriate. 3.5. Characterize needs of sub-populations for high-risk patients, identify practice capability to meet those needs, and ensure needs are longitudinally. 3.6. Enact collaborative care agreements with at least two public health organizations based on patient's psychosocial needs, as appropriate.	The CTOs are responsible meeting the following requirements: 3.7. Develop an inventory of tools to systematically assess patients' psychosocial needs and make these available to the PCHs. 3.8. Assist the PCHs to systematically identify high-volume and/or high-cost specialists serving the patient population using CMS/other payer's data; this will be done in conjunction with CRISP and MHCC, leveraging information from CMS and practice data on volumes, cost and quality. 3.9. Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS/other payer's data. Utilize CRISP Reporting Services.

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Five Primary Care Functions			
	3.6. Conduct an inventory of resources and supports to meet patient's psychosocial needs. 3.7. Characterize important needs of sub-populations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time.		
Patient and Care giver Engagement	In order to ensure that patients and caregivers are collaborating with joint decision making, practices in CPC+ are required to engage in the following activities: 4.1. Convene a patient-family advisory council (PFAC) at least once in PY2017 and integrate recommendations into care, as appropriate. 4.2. Assess practice capability and plan for support of patients' self-management. Practices in CPC+ Track 2 are required to engage in the following additional activities: 4.3. Convene a patient-family advisory council (PFAC) in at least two quarters in PY2017 and integrate recommendations into care, as appropriate. 4.4. Implement self-management support for at least 3 high risk conditions.	Track 1 and 2 PCHs must meet the following requirements: 4.1. Assess practice capability and plan for support of patients' self-management; 4.2. Convene a patient-family advisory council (PFAC) in at least once (for Track 1 PCHs) or at least twice (for Track 2 PCHs) in PY2017 and integrate recommendations into care, as appropriate. Track 2 PCH must also meet the following requirement: 4.3. Implement self-management support for at least 3 high risk conditions.	The CTO must meet the following requirements: 4.4. Convene an annual patient and caregiver advisory meeting that includes CTO care management teams and members from the PCHs.

	CMS CPC+ Model	Maryland PCH	Maryland CTO
Five Primary Care Functions			
Planned Care and population Health	The CPC+ practices in Track 1 are required to engage in the following care redesign activities: 5.1. Use feedback reports provided by CMS/other payers at least quarterly on at least 2 utilization measures at the practice-level and practice data on at least 3 electronic clinical quality measures (derived from the EHR) at both practice- and panel-level to inform strategies to improve population health management. Practices in Track 2 of CPC+ are also required to engage in the following activities: 5.2. Conduct care team meetings at least weekly to review practice- and panel-level data from payers, and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.	The PCH practices in Track 1 are required to engage in the following care redesign activities: 5.1. Use feedback reports at least quarterly on at least 2 utilization measures at the practice-level and practice data on at least 3 electronic clinical quality measures (derived from the EHR) at both practice- and panel-level to inform strategies to improve population health management. 5.2. Make a commitment to achieve Tier 3 participation with CRISP. Track 2 PCH practices are also required to engage in the following activities: 5.3. Conduct care team meetings at least weekly to review practice- and panel-level data and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals in CPC+.	The CTO is required to meet the following requirements. Provide the PCHs with TA to assist them in: 5.4. Develop feedback reports using CMS data at least quarterly on at least 2 utilization measures at the population level and 3 clinical quality measures (derived from the EHR) at the panel-level to inform strategies to improve population health management. 5.5. Conduct care team meetings at least monthly with the CTO deployed care teams and public health organizations. 5.6. Use CMS data reports to guide testing of tactics to improve care, population health, and practice goals in the Maryland CPC Model.

Table 4. Learning System Comparison

CMS CPC+ Model	CMS CPC+ Model	Maryland PCH
The CPC+ practice is required to participate in the National and Regional Learning Systems. The following activities (based on the CPC practice milestones) are required with the National Learning System:	The PCH practice is required to participate in a regional learning system. The PCH practice are required to perform the following activities: ● Participate in an Action Group (addressing, for example, one of the following: integration of behavioral	The CTOs role in the Learning System is still in development. CTOs will be required to provide professional 'practice transformation consultants' to assist practices in fulfilling their practice transformation requirements. The consultants will be clinical staff employed by the CTO and will

CMS CPC+ Model	CMS CPC+ Model	Maryland PCH
• Participation in an Action Group (addressing, for example, one of the following: integration of behavioral health, medication management, or self-management support). • Attendance at three face-to-face meetings annually and in web-based meetings monthly. • Sharing of materials and/or resources (e.g., a documents or experiential story) on the collaboration site. The CPC+ practice is required to participate in the Regional Learning Systems by designating a member of the practice that is a Learning Lead. That practitioner is required to: • Oversee the completion of practice reporting requirements. • Attend learning events hosted by the regional collaborative. • Engage with payers and HIT vendors.	health, medication management, or self-management support). • Attendance at quarterly face-to-face meetings and in web-based meetings monthly. The PCH practice is also required to designate a member of the practice as a Learning Lead, that member is required to: • Oversee the completion of practice reporting requirements. • Attend learning events hosted by the CTO.	serve as the liaison for the practices' Learning Leads.

Appendix D. Theory of Care Management

High performing practices stratify the needs of their patients and design interventions and care teams to match those needs.[16] The table below provides examples of how PCHs and CTOs participating in the Maryland CPC Model will manage the health of their populations. These interventions largely mirror those found in Appendix C. Comparison of CPC Plus and Maryland CPC Model, but are not identical. Final practice and CTO requirements will be contained in the respective requests for applications.

	Description of the Population	Care Management Concept	PCH Intervention	CTO Intervention
Low Acuity Care Management	Beneficiaries within the first three CTO risk tiers (e.g. a beneficiary who's HCC score is between the 1st and 75th percentiles).	Empanelment, team-based care, and alternative visits seek to provide improved access for patients, better quality, higher satisfaction, and also relieve clinicians from the pressure of having to see large numbers of patients in rapid succession. Access to primary care will be increased to allow for 24/7 access to PCH. This will allow beneficiaries with low acuity conditions to receive care from the PCH instead of an Emergency Department; this will further improve continuity of care by concentrating the provision of care within a single organization.	The PCH will: • Achieve and maintain at least 95% empanelment to practitioner and/or care teams • Ensure patients have 24/7 access to a care team practitioner with real-time access to the EHR; phone and electronic access to the practice that includes nurse advice line and electronic scheduling • Offer expanded hours in early mornings, evenings, and weekends • Perform gap analysis for required medical interventions and preventative services • Track 2 only: Regularly offering at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends	The CTO is required to assist participating PCHs with meeting their practice milestones by providing technical assistance and practice transformation support, including: • Providing evidence-based success of improved workflows that improve access, quality, and satisfaction for patient and providers • Supporting workflow changes and implementations, including favorable contracting with technology vendors for m-health and e-heath solutions • Providing targeted resources for needs using pharmacists, health educators, LCSWs, and other wrap around care management supports • Providing technical assistance for PCH practice to create disease registries, gap analysis, and use advanced CRISP generated HIT reports on population health, including costs of care • Ensuring Track 2 PCHs can offer alternatives to traditional office visits

[16] Thomas Bodenheimer, Amireh Ghorob, Rachel Willard-Grace, and Kevin Grumbach. The 10 Building Blocks of High-Performing Primary Care. *Ann FamMed* 2014: 168.

	Description of the Population	Care Management Concept	PCH Intervention	CTO Intervention
High-Intensity Care Management	Beneficiaries in the highest risk tiers (HCC score in the 75+ percentile).	Beneficiaries with multiple chronic conditions will receive longitudinal care management. The care managers will play a central role with the clinician on the care team. Regional linkages between hospitals and other specialty groups will ensure better coordination across multiple settings of the delivery system.	The PCH will provide: • Targeted, proactive, relationship-based (longitudinal) care management to all patients identified as at increased risk, based on a risk stratification process and who are likely to benefit from intensive care management • Care managers who develop a plan of care for the management of chronic conditions for patients that need to receive longitudinal care management • Extended visit times with team members to address all relevant problems • Care coordination with specialists and ancillary services • Perform gap analysis for required medical interventions and preventative services • Develop disease registries to monitor the status of populations of patients with targeted conditions to create quality improvement intervention strategies, such as diabetes or hypertension • Evaluations of patients for psycho-social issues • Immediate continuity of care for patients with ED and hospital visits	The CTO will: • Identify hospitals and EDs responsible for the majority of patients' hospitalizations and ED visits, and assess and improve timeliness of notification and information transfer using CMS data • Facilitate coordination of services and communication between hospital care managers and PCH care managers (CCIP to Maryland CPC Model) • Coordinate resource deployment of CMs, as requested by PCHs • Provide targeted resources for needs using pharmacists, health educators, LCSWs, and other wrap around care management supports • Provide technical assistance for PCH practice to create disease registries, gap analysis, and use advanced CRISP generated HIT reports on population health including costs of care • Develop an inventory of tools to systematically assess patients' psychosocial needs.
Super Utilizer Management	Beneficiaries with more than 3 hospitalizations within the previous 12 month period.	For the highest intensity populations, care management is more effective when combined with non-office based visits and other public health interventions.	The PCH will: • Provide short-term (episodic) care management along with medication reconciliation to a high and increasing percentage of empaneled patients who have an ED visit or hospital admission/discharge/transfer and who are likely to benefit from care management	The CTO will: • Facilitate the "warm hand offs" between hospital care management team and PCH care management. The Hospital will provide a CM to manage patient while in hospital setting and post-acute as long as needed. Hospital CM will communicate with CTO and PDP regarding progress of patient and arrange for services for

	Description of the Population	Care Management Concept	PCH Intervention	CTO Intervention
			• Ensure patients with ED visits receive a follow up interaction within 3 days of discharge (e-visits, phone visits, group visits, home visits, mobile clinics, or alternate location visits allowable) • Contact at least 75% of patients who were hospitalized, within 2 business days • Use online and site based visits for complex medication management coordinated through the CTO • Enact collaborative care agreements with at least two public health organizations based on patient's psychosocial needs	extended period of time that allow for patient to avoid re-hospitalization. Hospital CM maintains responsibility of patient. When patient is stabilized, hospital provided CM will be transferred to care of community-based CM at PCH. • Provide assistance in utilizing collaborative agreements with public health organizations • Coordinate resource deployment of CMs as requested by PCHs • Provide targeted resources for needs using pharmacists, health educators, LCSWs, and other wrap around care management supports
Behavioral Health/SUD Management	Beneficiaries with a chronic mental health condition (including Bipolar Disorder, Schizophrenia, Schizophrenia and Other Psychotic Disorders, and Depressive Disorders). Beneficiaries with substance (alcohol or drug) use disorders.	Beneficiaries with behavioral conditions often have different care management needs and utilizations patterns than other patients and require a set of complementary interventions to augment traditional care coordination – for example, assistance navigating social service organizations.	The PCH will: • Systematically assess patients' psychosocial needs using evidence-based tools • Choose and implement at least one option from a menu of options for integrating behavioral health into care; CTO to provide variety of resources • Characterize important needs of sub-populations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time. • Utilize care managers to assist in targeted care management and navigation of social service resources	The CTO will: • Develop an inventory of tools to systematically assess patients' psychosocial needs – Mirth Care program through CRISP; • Conduct an inventory of resources and supports to meet patients' psychosocial needs • Deploy the services of LCSW to the PCH as needed both direct and telemedicine • Educate PCH providers in care for behavioral health issues • Develop access to community behavioral health resources and make available to PCH