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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Draft for Public Comment

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Executive Summary

The purpose of this paper is to present 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 Phase 2 Progression Plan that is being submitted by the Health Services Cost Review Commission by December 31, 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 to a modern person centered system with advanced primary care functionality in the context of 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 psychosocial 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 within the context of the Maryland model.

   A. *Person Centered Homes/Patient Designated Providers.* A person centered home (PCH) provides comprehensive and coordinated care around a person's healthcare needs. A provider's office is considered the central hub, or home, where facilitation and coordination to other healthcare professionals takes place. PCHs improve access and efficiency to care by providing more seamless coordination of care and meeting patients where they are. 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 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. In addition, CTOs provide education and technical assistance to practices that are tailored to the needs of the community through both webinars and in-person visits.

   C. *Coordinating Entity (CE).* The CE is the State sponsored, privately governed entity that coordinates the unique rule sets within the Maryland model, administers the program, and designates practice 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 roles and responsibilities for achieving transformation between the CTO and practices.

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

6. **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.

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 provides a full and clear depiction of the metrics associated with the Maryland CPC model, including PDP designations, transformation ramp up projections, AND provider readiness and selection based on informed assumptions.

I. Background and Opportunity

A. Why Redesigning Primary Care in Maryland is Essential Now

Several years ago, Maryland received approval from the Centers for Medicare and Medicaid Services (CMS) for the all payer hospital payment model, or All Payer Model. The model modernized Maryland's hospital payment system by implementing hospital-specific global budgets and tying growth in per capita hospital spending to growth in the state'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 falling in Maryland under the All-Payer Model.

Of concern, however, is the trend of an increasing total cost of care (TCOC) growth rate for Maryland's Medicare population that is higher than the rest of the nation in CY 2015. This trend is due to the increases in non-hospital costs, which rose faster than the decreases in hospital costs. In CY 2016 through August, non-hospital costs are still increasing more rapidly than the nation, but hospital costs are declining faster than the nation. Therefore, for the CY 2016 results to date, the TCOC growth in Maryland is lower than the nation. 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 Phase II of the All Payer Model, slated to begin in January 2019. At that time, Maryland will become increasingly accountable for TCOC for Medicare FFS beneficiaries. Hospitals cannot accomplish this alone. They need to achieve alignment with non-hospital providers of care (e.g., PDPs), and they need to start that process now.

In preparation for Phase II, Maryland has secured a Care Redesign Amendment with CMS that provides authority in today's Phase I 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 need for care supports. The Maryland CPC Model will focus on giving primary care providers more independent ability to advance community-level low-acuity care to change the delivery paradigm from one of delivery of high-acuity services to one of lower-acuity preventative and chronic disease management services.

Redesigning primary care to achieve better overall population health outcomes, in concert with implementing Phase I Care Redesign Amendment programs targeting the state's current high needs patients, prepares the state for success in Phase II of the All Payer Model and prepares primary care clinicians for success in the era of MACRA and Advanced Alternative Payment Models (AAPM). This proposal outlines an approach to achieve alignment of primary care physicians with Maryland's goals

under the All Payer Model by 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 in Phase I and Phase II 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 the 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 Hitchcock-Dartmouth PCMH model at several practices in Maryland.[2] Other commercial payers in Maryland have also begun to negotiate similar value-based contracts with providers. Many 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-Eligibles 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 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 care. The Chesapeake Regional Information System for our Patients (CRISP) is Maryland's state designated HIE. CRISP is one of the most advanced HIEs in the nation and is expanding its capabilities to provide reliable and consumable 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. Innovative clinician-to-clinician communication tools as well as shared care plans are now being piloted within CRISP, with practicing

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[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.

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 patient 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 more 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 tenuous situation that is a significant source of frustration and drop-out among the primary care workforce.

This proposal outlines a Medicare focused "CPC+like" program open to all qualifying Maryland primary care clinicians and select specialty clinicians who function as a patient's primary provider. 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 the State'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 Phase II 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 needs population;

- Move care to the safest, most appropriate, and most cost-efficient care setting possible;

- Allow clinicians to step gradually into assuming greater financial responsibility for patient populations, thereby providing a glide 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:

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 of 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.

2. **Concept of "Patient-Designated Provider" 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 healthcare 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.

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, and local/community based health initiatives. Recognizing the patient and provider diversity in Maryland, additional infrastructure will be created 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 patient designated providers 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 Phase II 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 fee-for-service participation in medical home initiatives, which do not currently exist in any form. In addition to Medicare FFS, Maryland will be open to 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. In the meantime, the State will seek alignment of measures across programs, to the extent that it makes sense for the underlying population of patients. Pediatric patients and young adults, as well as highly specialized Medicaid populations, have different needs than Medicare patients and older adults.

6. **Voluntary participation.** The Maryland CPC Model provides incentives, technical assistance, and support to encourage provider participation, but providers will not be required to participate in the model.

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 the patients themselves. 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 physician 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 funding streams that providers can utilize to transform their practices; giving providers more time and resources to provide excellent coordinated care to 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.

11. **Aligned and consistent set of quality/outcome/utilization metrics.** Payment and service delivery redesign will only be successful if the patients' experience and quality of care delivered is enhanced. 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.

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 can reduce prescribing errors, facilitate medication management, and ensure that treating providers have timely clinical lab data, imaging and technological results, allergy information, past medical and surgical history, and up-to-date patient problem lists.

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 retention and recruitment of providers. The Maryland CPC Model seeks to incentivize value over volume through payment and care delivery redesign; creating a rewarding clinical environment for both the provider and patient.

II.   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 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 additional infrastructure within the state:

- **Care Transformation Organizations (CTOs).** CTOs are 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 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 both 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 State-sponsored, privately governed entity that coordinates the unique rule sets within the Maryland model, administers the program, and designates practice and CTO participation. A Governing Body will define the rule sets by which the CE administers. The Governing Body of the CE will have diverse representation to ensure a breadth of interests, equality and accountability are persevered.

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 the state.

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, patients 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 chooses to use 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.

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

For example, 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 counselor, such as a Licensed Clinical Professional Counselor (LGPC), to counsel the patient both 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 decide how else to best meet their patient's needs.

Example Scenario B: Improved Transitions of Care

An alternative example illustrates how the 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.

In fact, PDPs are integral to the TCM. In the Maryland CPC Model, PDPs 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 a warm handoff from the CTO to the PDP 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 clean handoffs.

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 physicians and practitioners. 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 additional resources that are not contemplated as part of the Maryland CPC Model, and these patients can fall through the cracks if ongoing care management handoffs to the appropriate providers are not accomplished. 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. Sometimes, patients will require specialized management resources of PDPs other than primary care resources.

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 managers facilitated by the CTO.

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 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 be allowed to apply to the CE to form a Person Centered Home (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.).

- A PCH must be attributed a minimum of 150 Medicare beneficiaries across participating PDPs.

- A PCH must provide a significant amount of primary care services, defined as at least 60% of services provided by participating PDPs in the PCH.

- Traditional primary care physicians and specialty care physicians will be held to the same standards for participation.

- 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 the Original CPC Model or 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 a traditional primary care provider. Data analysis revealed that up to one-third of the eligible beneficiary population exclusively use a "specialist" as their provider for 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.

Percentage of Patient-Designated Providers by Specialty
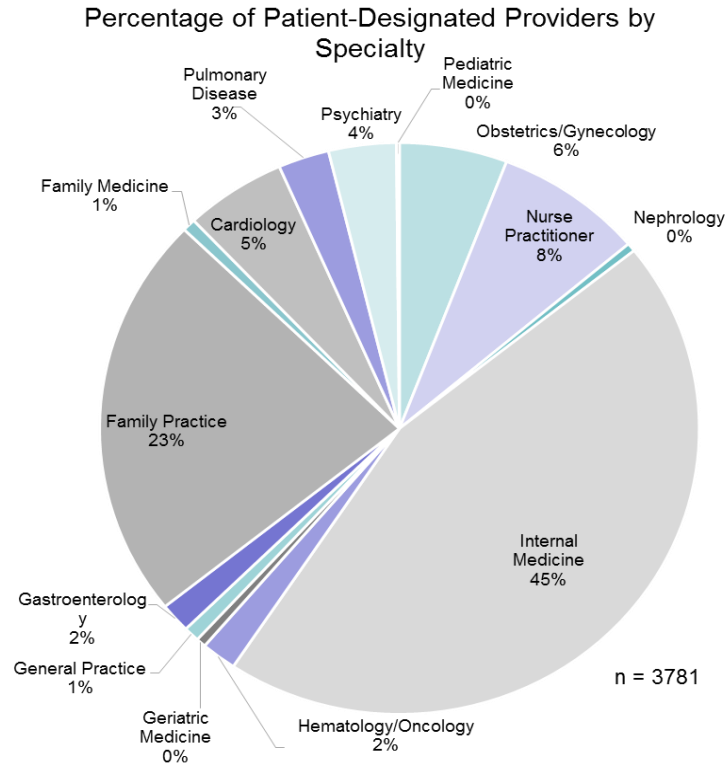
The Maryland Model is respectful of beneficiary choice, and includes these providers as PDPs. The PDP designation model allows selected specialists with high volumes of E&M codes and exclusive care of the beneficiaries to be considered as PDPs. The following chart illustrates the potential for strong specialty participation. Therefore, the Maryland model aims to broaden the impact of practice transformation beyond what is available through CPC+ and move towards statewide delivery system transformation.

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%

Specialty	Total Providers	Providers that Meet Eligibility Requirements	
	#	#	% of specialty
OB/GYN	430	220	51%
Pediatric Medicine	7	6	86%
Psychiatry	236	138	58%
Pulmonary Disease	113	104	92%

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.

Selection Process

Practices may participate in the Maryland CPC Model by applying to the CE for selection in 2017. Based on practice requirements developed by the CE, the CE 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 in 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 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, 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. 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 Care Management Provision to PCHs section. The CTO must have a governance board that includes 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 eligible to apply.

Selection Process

CTOs may participate in the Maryland CPC model by applying to the CE for selection in 2017 after an open application process. There will be an open application period on an annual basis. The CTOs will be held accountable 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 CTO services described below. 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 that allowing the market to develop will spur healthy competition among the CTOs for the best CTO to contract with physician practices. This will also encourage innovations in care management and 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.

Practices will share in the cost of the assistance they receive. The care management funds will be divided between the practice and their selected CTO. There will be a balance between ensuring some contribution from practices for all the assistance they will receive, and the corresponding need to maximize participation by the practices by keeping the assistance affordable to them and allowing sufficient funding to make practice-based transformation sustainable.

Service Provision to PCHs

CTOs will provide services to PCHs to help them deliver better health and higher quality care. 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 geographically 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 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 create 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. 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, and community-based organizations. CTOs will be expected to facilitate agreements between PCHs and these organizations. Direct relationships between the PCH and the 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 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. The transition from hospital-led care management to community-based care management will be coordinated through CTOs. At the same time, CTOs will assist community-based 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.

6. **Other**

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 a state sponsored, public-private partnership that will administer the Maryland CPC Model, including distribution of payments from payers, analytics and evaluations, contracting, accreditation of the CTOs and PCHs, and other functions to ensure compliance with the model. The CE's functions are delivered by a combination of three groups: the State, a Governing Board, and external entities.

The CE will be directed by a broadly representative Governing Board and work closely with external entities to execute its scope of work. It is anticipated that the Governing Board will be comprised of approximately 10-15 members. The Governing Board will have a mix of public and private members, and appointments will be based on affiliation and skills, including innovation and primary care delivery transformation experience. The Secretary of Health and Mental Hygiene reserves the ability to appoint three seats on the Board. The CE will utilize the administrative services of the Maryland Health Care Commission as directed and in cooperation with the Governing 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, which emphasizes governmental guidance and private operation:

Coordinating Entity Organization Design
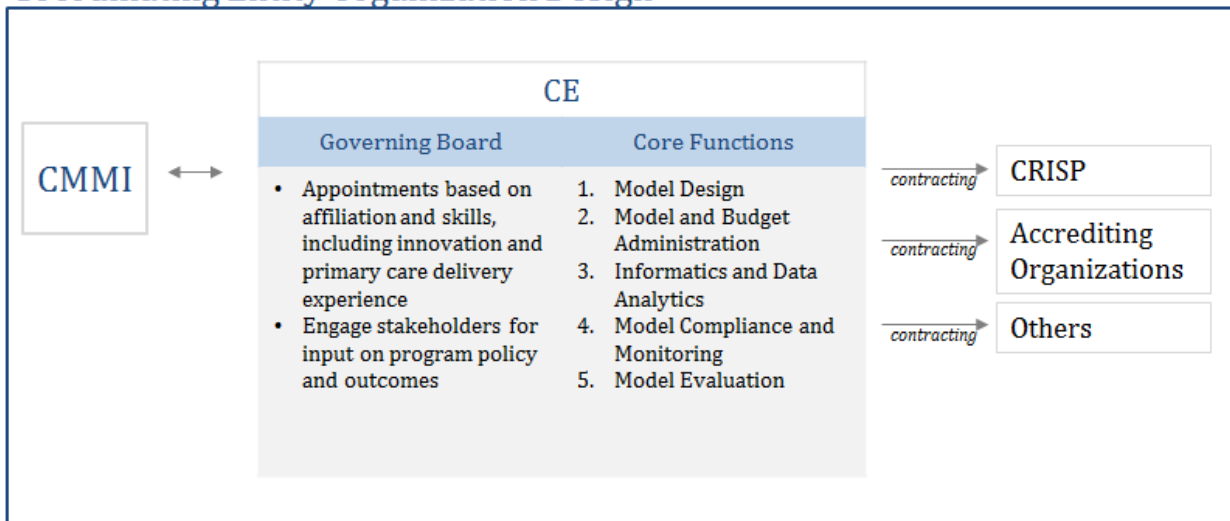
The CE is envisioned to have the following five core functions. As appropriate, the services will be delivered broadly by the CE's public-private partnership.

1. Model Design

The CE will assume overall responsibility for the design of the Model. This includes developing the rule set for CTOs and provider participation within the Model, which will be incorporated into the application process. The CE will be responsible for the development of the Maryland CPC Model Learning System, including determining the practice milestones. The Governing Board will also strategically monitor quality and utilization metrics reported by the practices and CTOs, and make adjustments to the Model as needed. The Governing Board will also be responsible for approving the payment logic needed to determine the distribution of care management fees to providers and CTOs.

Given the large number of stakeholders involved and strategic decisions required to ensure balanced success, the CE will convene and engage stakeholders effectively and ensure that diverse voices around the State are incorporated into the Model. The CE will be performance-oriented and focus on the continuation of the Model beyond the test period. 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 the application and selection process for both the CTOs and practices. This includes incorporating the policies developed by the Governing into the application. The CE will work with State delegated partners, such as CRISP, the State-Designated HIE, to perform required services. The CE will make available to CTOs external accrediting bodies that they may contract with to secure accreditation. The CE will also develop standardized contract language that define 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. The CE plays a key role in that learning system by providing actionable data and feedback on cost and utilization, quality, patient experience of care, and practice transformation. The CE will also provide benchmarks and track practices' progress in achieving their transformation milestones. The CE will also measure regional population health outcomes. These responsibilities will be delegated to CRISP to report to the CE.

The Maryland CPC Model will also require infrastructure to implement its different elements. CRISP is well positioned to support care delivery system transformation through the existing resources described in the HIT Support to Practices section below. The CE and CRISP will coordinate closely to support the data analytics needs of practices.

4. Model Compliance and Monitoring

Monitoring is essential to ensure that patients' experience and quality of care is either preserved or enhanced and that practices 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 practice and CTO level. A focus will be on whether practices and CTOs are using payments properly to meet the model requirements. Moreover, 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 the practices themselves. The findings from monitoring will guide the selection of additional learning activities.

The CE and CMS will also determine periodically whether practices or CTOs should be subject to any administrative action, such as a Corrective Action Plan (CAP) or termination. A CAP 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 (usually six months). 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 contract with an independent outcome evaluation group to monitor performance against the goals of population health, quality of care, and cost targets.

III. 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 report on the quality and utilization metrics of the practices they are supporting 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. A crosswalk between CPC+ and the Maryland CPC Model will delineate the roles and responsibilities of the practices and CTOs in delivering these requirements.

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. Expanding access to this primary care team is vital. Whether through expanded hours 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, potentially avoiding costly urgent and emergent care. PCHs will be required to provide multiple points of access to primary care and CTOs 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 targeted care management for high-risk, high-need patients, as well as rising-risk patients. Practices will work with CTOs or deliver the CTO functions as identified above to 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 (and in conjunction with CTOs) 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.

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 the element of relationship that is at the heart of effective primary care, and is associated with lower overall utilization and costs, less fragmented care, and better health outcomes.

Practices participating in CPC+ 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, primary 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 participating in CPC+ 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.

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 through Maryland CPC 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 other non-clinical individuals including community health workers, 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 required 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 dashboard tools may be developed at the CE level to inform patients about CTO and PCH progress.

D. Optimal Use of Health IT

In both tracks, practices will use certified 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.

IV. Payment Redesign

A key theme of this report 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 fee-for-service system that drives volume over value. Under the Maryland CPC Model, clinicians will receive up-front, non-visit-based payments from Medicare, as well as performance-based payments, to enable them to make investments in care management activities and staff that are not reimbursable under the old model. The changes in physician payment in Maryland will be variations of the 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 fee-for-service beneficiaries are not restricted as to their choice of providers. 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.

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.

B. Care Management Fee

As in CPC+, practices will receive a monthly care management fee (CMF) for attributed Medicare beneficiaries without any beneficiary cost-sharing on the CMF. The CMF is designed to give practices flexibility to provide "wrap-around" services that are traditionally not considered to be separately billable. All CMF payments to the State are made at the Track 2 level regardless of the PCH capability at the time. This 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.

Beneficiary risk will be based on HCC risk scores and, in Track 2, claims data for diagnoses.

In the Maryland CPC Model, the CTOs will also receive a portion of the CMF, depending on the PCH's arrangement with the CTO. The division of payments between the practice and CTO will be coordinated by the CE and will generally be based upon the proportion of services provided by the CTO to the practice. 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.

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.

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	90+% HCC or Dementia	$100

Risk Tier	Attribution Criteria	Track 1 and 2
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. CTOs will *not* receive a performance-based incentive payment.

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:

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

CMS will 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 quality metrics in the State to simplify reporting. The consumer assessment is based on the standard ambulatory measurement of healthcare 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). CMS believes 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.

	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%

V.   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 and learning opportunities across the Model.

The goals of the learning system mirror those of CPC+, but the delivery of services differs in the Maryland CPC Model. The CE and CTOs will assume the roles and responsibilities of the learning system as detailed in the table below. However, if a practice chooses not to work with a CTO, they must fulfill these requirements in another manner.

Learning System Goals	Responsibility
Orient practices to CPC+, aim, key drivers and changes, and requirements of participation.	CMS and CE via State
Provide actionable data and feedback on cost and utilization, quality, patient experience of care, and practice transformation.	CE via CRISP
Facilitate practice use of the CPC Feedback Report, data from payer partners, eCQMs, CAHPS data, and data reported to CE and CMS from practices.	CTOs
Provide benchmarks and track progress in the development of practice capability to deliver comprehensive and advanced primary care through the CPC care delivery requirements.	CE via CRISP and State who will push information to CTOs
Network practices within and across regions to foster peer-to-peer learning and innovation and to create communities of primary care practices.	CTOs
Coach and facilitate practices requiring tailored and remedial support, as appropriate, to build the capabilities required and to use these capabilities to improve care and health outcomes and reduce TCOC.	CTOs
Identify exemplar practices and successful practice tactics to highlight useful strategies in comprehensive primary care and encourage adoption by other practices.	CTOs

Learning System Goals	Responsibility
Collaborate in the regional environment to maintain aligned payment reform, leverage health IT and multi-payer data capabilities, and to join efforts to build community and stakeholder engagement, all in an effort to support practices in delivering comprehensive and advanced primary care.	CTOs
Provide critical feedback to CMS and the CE on structural and process changes in CPC practices, the specific tactics deployed by these practices to achieve the CPC aims, and critical practice needs, so as to guide adjustments in the learning system and adjustments in CMS and the CE processes for managing the initiative.	CTOs
Ensure model compliance and implement program integrity efforts	CMS and CE

In support of these goals, the CTOs will create a regional learning collaborative for practices. These activities include:

- Action groups to address unmet population health needs, such as integration of behavioral health, medication management, or self-management support. CTOs must tailor the Action Groups to the population health measures studied in the CPC Feedback Reports and practices must participate in at least one action group.

- Quarterly face-to-face meetings. CTOs must host these meetings with practices and the care teams, as well as host regular webinar meetings.

- Biannual site visits. CTOs must visit all practices biannually and conduct comprehensive needs assessment of each practices' practice transformation activities.

The CTO is also required to provide professional 'practice transformation consultants' to assist practices in fulfilling their practice transformation requirements. The consultants must 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.

VI.   HIT Support to Practices

In CPC+, 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 CPC+ model aims to provide regular Medicare fee-for-service cost and utilization data in a clear, actionable way. The State envisions CMS providing that 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, DC 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. As of 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 5,400) of Maryland's 15,000 physicians.

CRISP is currently piloting two key strategies: (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.

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

VII. 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 patient reported outcomes measure 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.

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 and at the panel level for internal practice improvement. The eCQMs and patient experience of care measures will be included as pay for performance measures. Practices must use ONC certified health IT meeting the requirements of the EHR Incentive Programs, as defined at 42 C.F.R. § 495.4.

CTOs will also be held accountable through reporting requirements. The following outline organizes the proposal for goal areas for review by the CE. This approach accounts for the anticipation that CMF 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 entire populations impacted by the CTOs and the PCHs it assists. While the measure set is still under development by CMS and the State, the State has identified the following four goals for the CTOs:

> Goal 1: Improve co-management of physical and behavioral health conditions

> Goal 2: Decrease potentially avoidable utilization

> Goal 3: Address risk factors for poor health including chronic disease

> Goal 4: Provide patient-centric care

VIII. 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 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. While 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, some providers may view this program as a safer 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 is 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 makes 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:

Standard Scenario

Year	2018	2019	2020	2021	2022	2023
Track 1	643	643	418	321	225	64
Track 2	643	1,221	1,794	2,180	2,330	2,343
Total	**1,286**	**1,864**	**2,212**	**2,501**	**2,555**	**2,408**

Optimistic Scenario

Year	2018	2019	2020	2021	2022	2023
Track 1	817	898	572	408	286	82
Track 2	1,225	1,960	2,466	2,821	3,097	3,255
Total	**2,042**	**2,858**	**3,038**	**3,229**	**3,383**	**3,337**

Conservative Scenario

Year	2018	2019	2020	2021	2022	2023
Track 1	327	392	310	261	180	49
Track 2	218	512	812	1,039	1,179	1,253
Total	**544**	**904**	**1,122**	**1,300**	**1,359**	**1,302**

B. The importance of outreach

As indicated earlier, these projections are not "given" or "exogenous" to the Primary Care 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 and creativity of the State's outreach to the provider community. Moreover, Maryland cannot do this alone. The State will need the assistance of various stakeholder groups, with whom it has an ongoing dialogue.

As the estimates above show, in 2023 the number of PDPs participating could range from a low of 1,302 under the conservative scenario to a high of 3,337 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 detailed communications plan to enhance participation by practices.

IX.   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 to development payment and delivery system transformation in Maryland, the State has initiated a strategy to enhance primary care delivery. With its focus on hospitals, the All-Payer Model creates a foundation for payment and delivery transformation for all patients and payers. As Maryland moves to the second phase of the All-Payer Model in January 2019, providers will take on increased responsibility for health, care outcomes, and TCOC for Medicare fee-for-service beneficiaries. Hospitals cannot accomplish this 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 rapid aging of the population and related increase in the number of patients with chronic conditions spur all of the participants in this new initiative to begin the transformation process as soon as possible.

Primary care that drives improved quality of care and population health is essential to meet the needs of chronically ill patients, slow disease progression, and prevent the need for care received in higher acuity care settings. However, primary care settings lack the resources to meet the full range of needs of the growing number of patients with chronic conditions. Needed resources include care management, care coordination, and connection to social services. Accordingly, Maryland is developing the proposed Maryland CPC Model in conjunction with CMS.

Redesigning primary care to achieve better overall population health outcomes must also be done in concert with implementing the Care Redesign Amendment programs targeting the State's highest need patients, enabling better alignment of hospitals and providers in managing the neediest patients in Maryland. Tying these approaches together will ensure continued success in the second term of the All-Payer Model. The integration of the CCIP and the Maryland CPC Model prepares PDPs for success in the era of MACRA, and most importantly provides needed supports to Medicare patients. The Maryland CPC Model, in concert with the current All-Payer Model and the programs of the Care Redesign Amendment, will provide a unique laboratory of fully aligned providers of care.

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 these complex and high needs patients. These patients require additional resources that are not contemplated as part of the Maryland CPC Model. Hospitals and CTOs/practices will develop handoff protocols to prevent patients from "falling through the cracks." Some patients may remain under hospital care management programs for extended periods, while others may be transitioned to CTOs/practices 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 utilization. Maryland expects the integration and design to evolve over time, with designs to vary on the needs of local preferences.

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 health of all populations.

Maryland has been presented with a great opportunity to move the healthcare 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 system, population health, risk stratification,

global accountability, care coordination, and incentive alignment. All are core components of a broad-based, patient designated provider model of primary care operating within an All Payer Model framework.

X. Conclusion

The Maryland CPC Model is one of the centerpieces of Maryland's Progression Plan for Phase 2 of the All-Payer Model. By focusing heavily in the early years on the Medicare fee-for-service population, we 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 operating, the Maryland CPC Model will help physicians and other clinicians better manage the care of the many Medicare patients with chronic illnesses. The Maryland CPC Model promises to transcend the silos that separate the many professionals who are seeing these patients, perpetuating the fragmented care delivery system. This new Model provides the technical assistance, learning systems and the funding streams to support care delivery transformation. It reaches upstream to address the forces outside the health care system. The combination of delivery and financing reforms 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 build on and enhance the accomplishments of the All-Payer Model. The Maryland CPC Model can make a significant contribution toward achieving this goal.