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Innovative Practice Alternatives and Practice Reporting Subgroup Recommendations

MARYLAND HEALTH CARE COMMISSION

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Background

Maryland, under agreement with the Centers for Medicare & Medicaid Services (CMS), launched the All-Payer Model[1] in 2014 to transform the health care delivery system. In 2018, CMS approved the Total Cost of Care (TCOC) Model, which leverages and builds upon the foundation of the All-Payer Model. The TCOC Model priorities include enabling access to quality health care, addressing the health and wellness needs of the senior population, reducing unnecessary emergency department (ED) and hospital utilization, fighting the opioid epidemic, and improving population health. The Maryland Primary Care Program (MDPCP) is a key delivery reform program under the TCOC Model that supports the overall health care transformation process and allows primary care providers to play an increased role in prevention, management of chronic disease, and preventing unnecessary hospital utilization.[2, 3]

The MDPCP Advisory Council (Council) was established by request from the Secretary of the Maryland Department of Health (Secretary), under the authority of Health General § 2-104(d). The Council provides input to the operations of the MDPCP, serving a consultative and advisory role to the Secretary and the MDPCP Program Management Office (PMO). Key responsibilities of the Council include gathering data from MDPCP participants and beneficiaries, making recommendations for inclusion in the State's annual report on MDPCP to CMS, assessing program implementation and recommending improvements, establishing subgroups, and requesting Maryland Department of Health agencies to examine specific issues pertaining to the TCOC Model.[4]

Recommendation Process

The Maryland Health Care Commission convened two subgroups consisting of Council members or their representatives.[5] These subgroups, the Innovative Practice Alternative Subgroup and the Practice Reporting Subgroup, were asked to identify opportunities for enhancing the MDPCP program. The aim of the Innovative Practice Alternative Subgroup was to explore financing opportunities that reward value and quality through additional tracks. The purpose of the Practice Reporting Subgroup was to explore program and practice evaluation metrics, including return on investment, as well as reducing reporting requirements for participating practices. Deliberations of the subgroups resulted in a total of eight recommendations. Proposed recommendations are intended to inform program enhancement considerations.

Since the recommendations were proposed, some have been addressed and/or implemented because of PMO discussions with the Center for Medicare & Medicaid Innovation (CMMI).[6] The

[1] More information about Maryland's All-Payer Model is available at: hscrc.maryland.gov/Pages/default.aspx.
[2] Maryland Department of Health (MDH), Maryland Primary Care Program. Available at: health.maryland.gov/mdpcp/Pages/home.aspx.
[3] MDH, Maryland Primary Care Program Advisory Council Charter. More information is available at: youtube.com/watch?v=HB-euRqflLo&feature=youtu.be.
[4] *Ibid.*
[5] A total of six meetings were held in 2020; each subgroup convened three meetings.
[6] More information is available at: health.maryland.gov/mdpcp/Documents/MDPCP%202019%20Annual%20Report.pdf.

PMO participates in regular meetings with CMMI where updates informed by Council deliberations are provided. The recommendations and their status are outlined in the table below.

Table 1 – Recommendation Status

Count	Recommendation	Status
1	Clarify and streamline the practice enrollment and evaluation process by: • Modifying the Request for Application (RFA) and Practice Participation Agreement (PA); • Developing a PA amendment process for practices to complete (following year one) on an annual basis; and • Improving prevention quality indicators (PQIs) and highlighting the relevance of PQI composite measures for informing MDPCP evaluation.	Reviewed by CMMI in November 2020; CMMI is unable to consider changes for this recommendation.
2	Define practice success in Track 2 in terms of maintaining care transformation requirements, and clarify such requirements in the RFA and PA.	CMMI has not reviewed this item at the time of this report. For more detail, see Recommendation 1 on page 6.
3	Incorporate improvement benchmarks for quality metrics.	CMMI has not reviewed this item at the time of this report. For more detail, see Recommendation 2 on page 8.
4	Allow MDPCP practices the option to report clinical quality measures at the practice site level or National Provider Identifier (NPI) level, versus only the practice site level.	CMMI has not reviewed this item at the time of this report. For more detail, see Recommendation 3 on page 9.

Count	Recommendation	Status
5	Improve the utility of the MDPCP portal.	Reviewed by CMMI in November 2020; CMMI is unable to consider changes for this recommendation.
6	Broaden the permitted uses of care management fees to include processes that benefit non-attributed beneficiaries, including establishing behavioral health integration, expanding access to care, and enhancing health information technology.	Reviewed by CMMI in November 2020; CMMI is unable to consider changes for this recommendation.
7	Align the focus areas of care transformation requirements with Track 2 capabilities, including risk stratification, care planning, follow-up care, and behavioral health integration.	CMMI has not reviewed this recommendation at the time of this report. CMMI requested in June 2020 that the Council provide recommendations for a Track 3. Given the proposed Track 3 framework and its implications for care transformation requirements, this recommendation was not developed.
8	Streamline the Care Transformation Survey to: • Allow biannual reporting; • Limit survey questions to approximately 15 per section; • Include binary responses; and • Enable pre-population of the survey with previously submitted responses, while allowing for necessary changes.	CMMI has implemented part of this recommendation - reducing the frequency of reporting from quarterly to biannually. CMMI has also revised the survey to reduce the reporting requirements, however the number of survey questions still poses an administrative burden for practices. Recommendation 4 on page 10 provides more detail.

Recommendations

1. Defining Practice Success in Track 2

Defining practice success in Track 2 in terms of maintaining care transformation requirements[7] is key to accomplishing the overall TCOC model objectives of improved health outcomes and reduced costs. Additionally, specifying how success in maintaining requirements is defined eliminates confusion around how success will be measured after practices have met Track 2 requirements.

Maintaining Track 2 Requirements

a. **Background:**

Transitioning to Track 2 requires practices to implement and sustain new transformation processes and requirements in the five Comprehensive Primary Care Functions of Advanced Primary Care.[8] Requirements include, but are not limited to, engaging attributed beneficiaries and caregivers in a collaborative process for advance care planning. This process includes addressing social determinants of health by facilitating patient access to social resources.[9, 10] Combined, care transformation requirements across the five functions serve as the primary drivers towards achieving MDPCP objectives. These requirements and functions are critical because they facilitate transformation towards patient-centered and team-based care delivered in the right place, at the right time, and in a manner that empowers patients.[11] While the MDPCP RFA notes that practice progress is demonstrated through successfully meeting applicable care transformation requirements, how success in maintaining requirements is defined is unclear.[12]

b. **Rationale:**

Providing information on how success in maintaining requirements is defined:

i. Facilitates continued progress on program objectives and overall TCOC goals beyond the program; and

[7] Key readiness requirements for Track 2 include ensuring attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy (e.g., telehealth; ensuring attributed beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities; facilitating access to resources that are available in practice communities for beneficiaries with identified health-related social needs).
[8] Primary care functions include access and continuity, care management, comprehensiveness, and coordination across the continuum of care, beneficiary and caregiver experience, and planned care for health outcomes. More information is available at: innovation.cms.gov/media/document/request-applications-rfa-2021-pdf.
[9] CMS, Maryland Total Cost of Care Model Maryland Primary Care Program Request for Applications: Version 3.0. Available at: innovation.cms.gov/media/document/request-applications-rfa-2021-pdf.
[10] Maryland Department of Health, *Maryland Primary Care Program Advance Care Planning and COVID-19.* Available at: health.maryland.gov/mdpcp/Documents/MDPCP%20Advance%20Care%20Planning%20and%20COVID-19%2021May20.pdf.
[11] See n. 9, *Supra*.
[12] See n. 9, *Supra*.

ii. Ensures the maintenance of care transformation improvements and related outcomes for Marylanders (e.g., in Track 2, providing alternative approaches to care other than office-based visits can improve access to care and reduce costs associated with ED utilizations).

Clarifying Track 2 Expectations for Practice Requirements Maintenance in the RFA

a. **Background:**

The MDPCP RFA provides an overview of Track 2 requirements for participating practices but does not elaborate on the Track 2 requirements practices will be required to maintain and how success in maintaining these requirements will be defined.[13] For example, practices in Track 2 are required to complete an assessment of their attributed beneficiaries' health-related social needs and conduct an inventory of resources and supports in the community to meet those needs; information on the frequency of assessments after completion of the initial assessment is not included.

b. **Rationale:**

Clarifying the requirements practices must maintain in Track 2 in the RFA provides key benefits including:

i. Encourages practices to evaluate their capacities and carefully plan their approach for advancing to Track 2 and maintaining Track 2 requirements; and

ii. Establishes baseline expectations to facilitate practices' understanding of the requirements for maintaining success in Track 2.

Clarifying Track 2 Expectations for Practice Requirements Maintenance in the PA

a. **Background:**

The MDPCP PA provides guidance on considerations for determining practice readiness for Track 2. The considerations include the practice's quality component and utilization component; practice's capacity to perform Track 2 care transformation requirements; history of compliance with the terms of the PA and with Medicare program requirements; ability to repay any other monies owed; and such other criteria CMS deems relevant. See Appendix for more information. While the PA states the applicable care requirements for Track 2, it does not provide guidance on how practice success will be determined when Track 2 requirements are met.

b. **Rationale:**

Clarifying the requirements in the PA is important because it:

[13] More information is available at: innovation.cms.gov/media/document/request-applications-rfa-2021-pdf.

i. Provides information to practices regarding how their capacity to maintain Track 2 requirements will be measured; and

ii. Ensures practices are accountable and aware of the impact of failing to meet and maintain Track 2 requirements (e.g., repayment of received program funds).

2. Incorporating Improvement Benchmarks

Incorporating improvement benchmarks for quality metrics provides an opportunity for practices to assess their progress across each performance year. Additionally, allowing the use of improvement benchmarks increases opportunities for practice flexibility related to quality performance measurement.

a. **Background:**

The process of benchmarking compares a practice's performance with an external standard. Benchmarking is considered an important tool for motivating practices to engage in improvement work and to help practices understand where their performance falls in comparison to others.[14] Currently, the MDPCP only includes attainment benchmarks which are calculated using the performance of other Maryland providers.[15] Using improvement benchmarks could potentially allow lower performing practices to receive some credit for progress made. Additionally, incorporating improvement benchmarks can stimulate healthy competition and help practices reflect more effectively on their own performance.[16]

b. **Rationale:**

Incorporating improvement benchmarks to be used in tandem with performance attainment benchmarks provides key advantages. Benefits include facilitating the identification of practice strengths and weaknesses and supporting the development of an improvement action plan. In addition, improvement benchmarks help to identify gaps between practices' current performance and the MDPCP performance requirements. Improvement benchmarks can also facilitate continued care transformation by building practice confidence and providing information to prioritize improvement opportunities.

[14] Agency for Healthcare Research and Quality (AHRQ), Module 7. Measuring and Benchmarking Clinical Performance. Available at: ahrq.gov/ncepcr/tools/pf-handbook/mod7.html.
[15] More information is available at: health.maryland.gov/mdpcp/Documents/MDPCP%202019%20Annual%20Report.pdf.
[16] See n. 14, *Supra*.

3. Reporting Clinical Quality Measures

Providing MDPCP practices with the option to report electronic clinical quality measures (eCQMs) at the NPI level, versus practice site (site)[17] level helps alleviate barriers to eCQM reporting. Key barriers to eCQM reporting include the time and effort required to implement reporting processes, inflexible reporting criteria, costs, and limited electronic health record (EHR) reporting functionality.[18]

a. **Background:**

Clinical quality measures (CQMs) provide a standardized means of measuring and comparing delivery of care.[19] eCQMs are clinical quality measures that are specified in a standard electronic format and designed to use structured, encoded data present in EHRs.[20] The MDPCP requires practices to generate quality reports that include information on eCQMs at the practice site level. Consistent with the State's focus on diabetes prevention and in alignment with the overall population health goals under Maryland's TCOC Model, MDPCP eCQMs include: Controlling High Blood Pressure, Diabetes: Hemoglobin A1c (HbA1c) Poor Control, and Screening for Abnormal Blood Glucose in Overweight/Obese Patients.[21] The use of eCQMs in the MDPCP allows care services to be measured in a clinically meaningful way, and can facilitate improvement in care, identification of differences in care or outcomes among various populations, and improvements in care coordination between health care providers.[22] Reporting on eCQMs allows practices to track their progress on care transformation requirements and helps ensure practices are delivering effective, safe, efficient, patient-centered, and timely care.[23]

b. **Rationale:**

NPI-level reporting in comparison to site level reporting, reduces participants' administrative burden.

i. The time and effort required to report eCQMs, costs, and frequency of reporting updates contribute to practices' reporting burden and is increased at the site

[17] The practice site is defined as a group of one or more physicians, or physicians and non-physician practitioners, each of whom is listed on the practice roster, that bills for primary care services furnished at a single site under a single Medicare-enrolled TIN belonging to the MDPCP practice.
[18] Knierim KE, Hall TL, Dickinson LM, et al. Primary Care Practices' Ability to Report Electronic Clinical Quality Measures in the EvidenceNOW Southwest Initiative to Improve Heart Health. JAMA Network Open, (2019). Available at: 10.1001/jamanetworkopen.2019.8569.
[19] CMS, A Quick Guide to the Clinical Quality Measures. Available at: cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/guidetocqms_remediated_2011.pdf.
[20] The Joint Commission, Electronic Clinical Quality Measures. Available at: jointcommission.org/measurement/specification-manuals/electronic-clinical-quality-measures/.
[21] The eCQMs are tentative for the 2021 program year. More information is available at: innovation.cms.gov/media/document/request-applications-rfa-2021-pdf.
[22] HealthIT, What are Clinical Quality Measures? Available at: healthit.gov/faq/what-are-clinical-quality-measures.
[23] CMS, Electronic Clinical Quality Measures Basics. Available at: cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures#:~:text=Measuring%20and%20reporting%20eCQMs%20helps,Patient%20Safety.

level. Because site-level clinical quality reporting is not supported by most EHRs, it often requires practices to employ a full-time person to meet quality reporting requirements. Practice-level reporting can mitigate this administrative burden by reducing associated costs. When compared to site level reporting, NPI-level reporting offers key advantages including easier validation of data accuracy and accessible information to support continuous feedback on quality improvement efforts.[24] Allowing NPI-level reporting ensures providers can use eCQMs, in combination with real time patient level data analytics, to support evidence-based clinical decision making at the point of care.

ii. NPI-level reporting can help mitigate the challenges around data documentation by enhancing reporting efficiency and data accuracy. Small practices often report eCQMs manually due to challenges around automatic data extraction from their EHR system; this can be more burdensome at the site level. Site-level reporting involves aligning eCQM reporting across clinical workflows, which can be difficult to manage for different primary care specialties. Additionally, variable data documentation practices and validity across physicians can affect eCQM data completeness and reliability.[25] NPI-level reporting can facilitate easier data gathering and reporting.

4. Streamlining the Care Transformation Survey

While CMMI has approved some changes to simplify the Care Transformation Survey (survey), including reducing the frequency of reporting from quarterly to biannually, further streamlining is needed to reduce practices' reporting burden and improve operations. In response to the PMO annual report, CMMI affirmed its commitment to working with the PMO to refine and reduce survey response burden for future performance years. Simplifying the survey to incorporate changes related to pre-population, reducing the number of survey questions, and including binary responses facilitates a better user experience for practices.

a. **Background:**

The survey assesses MDPCP practices' progress on applicable care transformation requirements[26] and measures practice readiness to transition to the next Track.[27] The MDPCP practices are required to complete the survey biannually through a secure web portal. The survey covers requirements under each of the five Comprehensive Primary Care Functions of Advanced Primary Care and includes questions regarding assistance received from a practice coach or CTO in meeting care transformation requirements.

[24] See n. 18, *Supra*.
[25] See n. 18, *Supra*.
[26] Care transformation requirements vary depending on practices' performance Track. More information is available at: innovation.cms.gov/media/document/request-applications-rfa-2021-pdf.
[27] See n. 9, *Supra*.

The 2020 survey contains a large number[28] of questions addressing overlapping topic areas. For example, questions regarding assistance provided by State coaches and the PMO are repeated for each primary care function and can be consolidated into a single question.

b. **Rationale:**

Streamlining the current survey is necessary to address practice concerns, including survey length and administrative burden due to time spent completing the survey. Simplifying the survey to incorporate the below changes will increase alignment with program requirements. Recommended changes are described in order of preference.

i. Pre-population – Considering that some survey responses may not change at the end of the reporting period, it is beneficial to allow responses to be pre-populated. Questions related to ongoing practice activities for advanced primary care functions (e.g., How do you identify beneficiaries for self-management support?) can be prepopulated. Allowing pre-population and enabling practices to change their responses as needed will facilitate easier completion of the survey. Practices will be able to confirm that prior responses are still valid through attestation. Additionally, pre-populated responses will provide an opportunity for practices to compare their prior and current responses during the survey completion process to self-assess progress.

ii. Binary Responses – Generally, binary responses are quicker and perceived as less complex than multi-category response surveys; replacing multi-category answer options with binary selections does not decrease survey validity.[29] Survey questions that include multi-category answer options can be revised and formatted to allow binary responses. Providing the option for practices to select one out of two responses will save practices a significant amount of time, making it more suitable for administration in the clinical setting. In addition, it may reduce operational costs for practices as some MDPCP practices hire a person solely to meet reporting requirements.

iii. Reducing Survey Questions – Whereas longer, time-consuming surveys can result in inaccurate responses, shorter surveys are likely to increase data quality due to decreased respondent fatigue.[30] Reducing the number of survey questions for each comprehensive Primary Care Function of Advanced Primary Care to about 15 helps to alleviate practice burden associated with data gathering and tracking efforts. Additionally, it provides practices the

[28] The current survey is approximately 157 questions.
[29] Dolnicar, S., Grün, B., & Leisch, F. Quick, simple and reliable: Forced binary survey questions. *International Journal of Market Research*, (2011). Available at: doi.org/10.2501/IJMR-53-2-231-252.
[30] *Ibid*.

opportunity to redirect staff reporting resources to other care transformation and improvement areas.

Remarks

As the MDPCP works to accomplish its primary goal of sustainable transformation in primary care delivery across the State, it is influenced by the commitment and engagement of participating practices. Continuous process improvement informed by stakeholder perspectives and feedback is key to identifying MDPCP enhancement opportunities. Advancing primary care delivery through a collaborative approach to program development will support the State's TCOC objectives.[31]

[31] More information on the TCOC objectives (page 1) and using a collaborative approach to program development (page 35) is available at: hscrc.maryland.gov/Documents/Modernization/TCOC-State-Agreement-CMMI-FINAL-Signed-07092018.pdf.

Appendix

Readiness Assessment: Summary

Article 1.5(b) of the Practice Participation Agreement provides the following guidance on Track 1 to Track 2 transitions for MDPCP Practices:

> *If the MDPCP Practice is participating in Track 1 under this Agreement during a Performance Year, CMS may take into account the following considerations in determining whether the MDPCP Practice may transition to Track 2 for the next Performance Year: the MDPCP Practice Site's Quality Component and Utilization Component; the MDPCP Practice Site's capacity to perform the Track 2 Care Transformation Requirements; the MDPCP Practice's history of compliance with the terms of this Agreement and with Medicare program requirements; the MDPCP Practice's ability to repay any Other Monies Owed; and such other criteria CMS deems relevant.*

Transition to Track 2 – Request Process

No later than the practice's third Performance Year, practices must request to transition to Track 2 to continue MDPCP participation. By summer 2019, CMS will announce instructions for making this formal request to move to Track 2 and the deadline for submitting the request. To move to Track 2, the practice must also indicate acceptance of partial pre-payment of evaluation and management fees by including their election for the Comprehensive Primary Care Payment (CPCP) Percentage for the upcoming Performance Year.

In summary, practices interested in moving to Track 2 will submit the following:

1) Formal request to participate in Track 2; and

2) CPCP Percentage Election form.

CMS will notify practices of their approved transition to Track 2 by late fall of the Performance Year in which the request for Track 2 participation is submitted.

Criteria for Approval

CMS will assess the practice's readiness for Track 2 based on meeting criteria in the following domains:

a. Part 1: Care Transformation Requirements [quarterly reporting]
    a. Meet all Track 1 requirements
    b. Demonstrate Track 2 readiness
b. Part 2: CRISP requirements [data provided by CRISP]
c. Part 3: Compliance with Practice Participation Agreement
d. Part 4: Performance on Quality and Utilization Measures

e. Part 5: Acceptance and election of CPCP percentage

Part 1: Care Transformation Requirements

Practices report their progress on care transformation requirements biannually to CMS through the MDPCP Portal. The PMO provides practice coaches to assess progress on care transformation requirements. The coach then identifies and guides the practice through areas for improvement. The requirements and associated questions in reporting are shown in the table below.

Comprehensive Primary Care Functions	MDPCP Requirements	Associated Questions in Portal Reporting
1. Access and Continuity	1.1. Empanel attributed beneficiaries to practitioner or care team.	• Empanelment Status: % of beneficiaries empaneled
	1.2. Ensure attributed beneficiaries have 24/7 access to a care team or practitioner with real-time access to the EHR.	• Is 24/7 coverage provided with real-time access to your practice's EHR?
	Readiness for Track 2 Requirement: Ensure attributed beneficiaries have regular access to the care team or practitioner through at least one alternative care strategy.	Communication: In the last quarter, in which of the following ways did your practice provide alternative approaches to care other than traditional office-based visits? (Select all that apply) • We did not provide alternative approaches to care • Visits in alternative locations (e.g., nursing facilities, hospitals, senior centers) • Home-based care (e.g., primary care home visits) • Medical group visits (e.g., shared medical appointments) • Video-based conferencing (i.e., telehealth or telemedicine) • Medical visit over an electronic exchange (i.e., phone or, e-visit, portal) • Other, please specify When beneficiaries need it, my practice can provide: • Same or next-day appointments • Office visits on the weekend, evening, or early morning

		• Telephone advice on clinical issues during office hours • Telephone advice on clinical issues on weekends and/or after regular office hours • Email or portal advice on clinical issues
2. Care Management	2.1 Ensure all empaneled, attributed beneficiaries are risk stratified.	• Do you risk stratify your empaneled beneficiaries?
	2.2 Ensure all attributed beneficiaries identified as increased risk and likely to benefit receive targeted, proactive, relationship-based (longitudinal) care management.	In the first Table: percentage (%) of beneficiaries under care management out of total empaneled
	2.3 Ensure attributed beneficiaries receive a follow-up interaction from your practice within one week for ED discharges and two business days for hospital discharges.	• Overall ED follow-up rate* • Overall hospital follow-up rate* *Aggregate across all EDs/hospitals for which data is reported
	2.4 Ensure targeted, attributed beneficiaries who have received follow-up after ED, hospital discharge, or other triggering event receive short-term (episodic) care management.	• Indicate how you identify beneficiaries for episodic care management. This refers to short-term, goal-directed care management for beneficiaries who are not already in longitudinal care management, as a result of their risk status. (Select all that apply)
	Readiness for Track 2 Requirement: Ensure attributed beneficiaries in longitudinal care management are engaged in a personalized care planning process, which includes at least their goals, needs, and self-management activities.	What type of clinician and staff at your practice is/are primarily responsible for each of the following care management and coordination activities? (Select all the activities that apply in your practice) • Developing and monitoring care plans • Providing beneficiary education and self-management support

3. Comprehensiveness and Coordination across the Continuum of Care	3.1 Ensure coordinated referral management for attributed beneficiaries seeking care from high-volume and/or high-cost specialists, as well as EDs and hospitals.	• Identify the high-volume or high-cost specialists and health care organizations with whom you have coordinated referral management. (Select all that apply)
	3.2 Ensure attributed beneficiaries with behavioral health needs have access to care consistent with at least one option from a menu of options for integrated behavioral health supplied to attributed beneficiaries by the practice	• What is your practice's primary strategy for addressing behavioral health needs? If you are planning to integrate one of the behavioral health models listed below, please select that option.
	Readiness for Track 2 Requirement: Facilitate access to resources that are available in your community for beneficiaries with identified health-related social needs	• Do you routinely screen your beneficiaries for unmet social needs?
4. Beneficiary & Caregiver Experience	4.1 Convene a Patient-Family/ Caregiver Advisory Council (PFAC) at least annually and integrate PFAC recommendations into care and quality improvement activities.	Which of the following steps has your practice achieved to implement and integrate the PFAC? (Select all that apply) • We have not taken any of these steps • Identified staff participants • Recruited beneficiary participants • Defined mission and vision of PFAC • Determined structure of the PFAC (e.g., number of beneficiaries or family advisors, frequency of meetings, term lengths, and other meeting logistics) • Incorporated PFAC recommendations into practice • Communicated PFAC recommendations to beneficiaries and staff • Developed a sustainability plan for the PFAC

	Readiness for Track 2 Requirement: Engage attributed beneficiaries and caregivers in a collaborative process for advance care planning	How does your practice identify beneficiaries for advance care planning? (Select all that apply) • We do not systematically identify beneficiaries for advance care planning • High-risk status (using the practice's two-step risk stratification methodology) • Beneficiaries with serious illness and/or based on age (e.g., cancer diagnosis, end-stage kidney disease, heart failure, COPD) • Clinician or care team referral/identification
5. Planned Care for Health Outcomes	Readiness for Track 2 Requirement: 5.1 Continuously improve your performance on key outcomes, including cost of care, electronic clinical quality measures, beneficiary experience, and utilization measures.	How often do care teams at your practice have structured huddles focused on beneficiary care? • Never • Only as needed or ad hoc • At least daily • At least weekly • At least every two weeks • At least monthly How often do care teams at your practice have scheduled care team meetings to discuss high-risk beneficiaries and planned care? • Never • Only as needed or ad hoc • At least daily • At least weekly • At least every two weeks • At least monthly

Part 2: CRISP Requirements

MDPCP will check practice activity in CRISP to confirm that practices requesting to move to Track 2 meet the following criteria:

CRISP Requirements	
1. Care Alerts	Complete Care alerts within EHR/CRISP for high-risk patients
2. Transitions of Care	View CRISP data during Transitions of Care
3. Encounter Notification Service rosters (ENS)	Submit beneficiary rosters (patient panels) to CRISP and configure encounter alerts to enable appropriate follow-up activities

Part 3: Compliance with Practice Participation Agreement

Practice must be satisfactorily compliant with the Practice Participation Agreement.

Confirm that:

- Practice is not on a Corrective Action Plan.
- If, during program monitoring, a practice missed a Participation Agreement requirement, that the practice resolved the issue and was in compliance as of the next monitoring period.

Part 4: Performance on Quality and Utilization Measures

Performance results will not be included in the assessment for practices requesting to move to Track 2 during PY 2019, for Track 2 participation beginning PY2020. Inclusion of performance results will be reconsidered for PY 2020 requests.

Part 5: Acceptance and Election of CPCP Percentage

Practice must accept pre-payments for evaluation and management payments by electing the CPCP percentage.