Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
Payment				
1	**Total Monthly Payment**	**Total Monthly Payment:** Practices are paid to deliver advanced primary care in and outside of the office. Practices focused on caring for patients with complex chronic needs and the seriously ill receive increased payments to support their care for these patient populations. Total Primary Care Payment (TPCP): The TPCP will largely replace practices' traditional FFS billing for primary care services. It includes two elements, a lump-sum professional **population-based payment (PBP)** paid on a quarterly basis and a flat base rate per visit primary care fee: #1 - PBP - practices will be divided into four groups based on the average hierarchical condition category (HCC) risk score of their attributed Medicare beneficiaries	**Total Monthly Payment:** Practices are paid to deliver advanced primary care in and outside of the office. Practices focused on caring for patients with complex chronic needs and the seriously ill receive increased payments to support their care for these patient populations. Total Primary Care Payment (TPCP): The TPCP will largely replace practices' traditional FFS billing for primary care services. It includes two elements, a lump-sum professional population-based payment (PBP) paid on a quarterly basis and a flat base rate per-visit primary care fee: #1 - PBP - beneficiaries will be attributed to the practice based on their individual hierarchical condition category (HCC) risk score with the highest complex tier including top 10% HCC and behavioral	• Flat rate should: ○ Reflect current CMS fee schedule ○ Match level three E&M visit fee at year of implementation ○ Increase annually at same rate as E&M fee schedule • Flat rate is not reflective of the actual cost of care; distribution between the PBP and flat rate payment matters ○ Increase the PBPM and raise the payment ceiling overall • Ensure incentive is designed not to reward providers for avoiding treatment of high-risk beneficiary visits • Financial modeling to compare payments from Track 2 to Track 3 would help stakeholders and providers understand how changes might affect them

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
		#2 - Flat $40.82 base rate per visit primary care fee TPCP will include some adjustments to account for variations in cost of care to encourage practices to actively manage their attributed patients to limit their need to seek care from other primary care practices, including a geographic adjustment, risk adjustment, and leakage penalty.	health and dementia diagnoses. There will be 5 tiers in alignment with MDPCP. #2 - Flat base rate per visit primary care fee - pegged to Maryland's historical level 2 primary care E/M fee for year before start of T3 and updated annually	*Key Takeaways* • Base flat rate on current E&M visit levels and modeling; adjust annually • Complete financial modeling to inform payment levels for PBP and flat rate

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
2	**Performance Based Adjustment**	**Performance-Based Adjustment (PBA):** Practices are motivated to reduce acute hospital utilization (AHU) to reduce total costs of care, while meeting quality and experience of care thresholds. Performance-Based Payment Potential (Approximate % of Primary Care Revenue): The PBA has two components: a **regional performance bonus and a continuous improvement bonus**. Practices can receive up to 34% upside bonus or a -10% downside penalty through the regional performance adjustment. Practices can earn up to a 16% bonus through the continuous improvement bonus. The regional performance adjustment and the continuous improvement bonus are added together to determine a practice's quarterly PBA. **During the practice's first year of participation in the model**, the PBA will be determined based on performance on the AHU measure only. The AHU measure will be calculated quarterly	**Performance-Based Adjustment (PBA):** Practices are motivated to reduce ambulatory sensitive ED and hospital admission to reduce total costs of care, while meeting quality and experience of care thresholds. The PBA is an adjustment to the quarterly Performance-Based Payment Potential (Approximate percentage of Primary Care Revenue): Practices can receive up to 34% upside bonus or a -10% downside penalty through adjustments made based on quality and utilization achievement or improvement against national benchmarks. Practices can earn up to a 16% bonus under the continuous improvement bonus. The matrix of adjustments to the PBA will include at a minimum three quality measures aligned with the Maryland State Health Improvement Strategy, one measure of patient assessment of comprehensive care and measures of PQI elimination performance.	• Simplification of formulas and reduction of administrative burden is important for participation, particularly for small practices • Downside risk for practices in high-risk communities could be a barrier to participation • Practice assessment of technology/EHR utilization should help inform readiness to advance to next track (and practice transformation) • PCF requires practices to have 2015 CEHRT – all MDPCP practices currently meet this requirement; functionality varies for those solutions – another level of capability requirements is needed • Need for budget neutrality should be addressed to ensure that bonuses for primary care practices do not have a negative impact on overall TCOC • Referral rates may be more accurate than hospital utilization rates for measuring cost savings

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
		based on a rolling four-quarter look-back period and applied to starting in quarter three of year one. **During performance year two and in subsequent performance years, a practice's TPCP will be adjusted based on its performance on five quality and patient experience of care measures, as well as a measure of acute hospital utilization (AHU).** The quality metrics will be incorporated into a Quality Gateway, which is a minimum threshold that practices must meet in order to be eligible for a positive PBA beginning in performance year two. If a practice meets or exceeds the Quality Gateway, its performance on the AHU will then be used to determine whether it receives a positive, negative, or neutral PBA. Practices that fail to meet the Quality Gateway will receive no higher than a 0% PBA in performance year two whether they ultimately receive a neutral PBA (0%) or a	Practices in Track 3 will have already had MDPCP experience eliminating the need for Year 1 adjustments. A practice's TPCP will be adjusted as described above.	*Key Takeaways* • Simplify formulas and reduce administrative burden • Define appropriate risk levels based on practice communities • Incorporate graduated risk • Include referral rates for measuring cost savings
3	**Attribution**	Beneficiary Attribution: Claims-based with voluntary alignment opportunity; proactive identification and assignment of seriously ill and unmanaged beneficiaries	Beneficiary Attribution: Claims-based with voluntary alignment opportunity	

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
4	**Beneficiary Engagement Incentives**	CMS intends to allow practices to reduce or waive the applicable co-insurance (which will be based on the FFS rate for services provided), with practices responsible for covering those costs (i.e., CMS will not compensate practices for the loss in cost sharing revenue). Practices that wish to take advantage of this beneficiary engagement incentive must submit an implementation plan that identifies the categories of beneficiaries who will be eligible for cost sharing support, the types of services furnished by the practice that would be eligible for cost sharing support, and such other information as CMS may require. The implementation plan is subject to CMS approval. Primary Care First practices will be required to implement their cost sharing support policies in accordance with the implementation plan approved by CMS.	CMS intends to allow practices to reduce or waive the applicable co-insurance (which will be based on the FFS rate for services provided), with practices responsible for covering those costs (i.e., CMS will not compensate practices for the loss in cost sharing revenue). Practices that wish to take advantage of this beneficiary engagement incentive must submit an implementation plan that identifies the categories of beneficiaries who will be eligible for cost sharing support, the types of services furnished by the practice that would be eligible for cost sharing support, and such other information as CMS may require. The implementation plan is subject to CMS approval. MDPCP practices will be required to implement their cost sharing support policies in accordance with the implementation plan approved by CMS.	
Additional Considerations	***Population Based Payment (PBP)***	Preserve current method of attributing PBPM payments to individual beneficiaries rather than the average for the practice. In addition, add a 5th tier consistent with the SIP payment level as in MDPCP complex tier. The dollar amounts can mirror PCF with the exception of a closer look at the per visit payment level using representative Maryland data. Progression of financial responsibility over time toward total Population based payment and elimination of claims submission. PBP may also include leakage and geographic adjustments		
Performance Measurement				

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback

5	**Risk Group 1-2**	These measures were selected to be actionable, clinically meaningful, and aligned with CMS's broader quality measurement strategy. Measures include a patient experience of care survey, controlling high blood pressure, diabetes hemoglobin A1c poor control, colorectal cancer screening, and advance care planning.
		
		<u>Utilization:</u>
		Utilization Measure for PBA Calculation Acute Hospital Utilization (AHU) (HEDIS measure)
		
		<u>Quality Gateway (starts in Year 2):</u>
		Patient Experience of Care Survey (CAHPS® with supplemental items) 0005 and 0006 / 321 AHRQ®
		PCF and/or non-PCF reference population Diabetes:
		Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM) 0059 / 001 NCQA® MIPS
		Controlling High Blood Pressure (eCQM) 0018/ 236 NCQA® MIPS Advance Care Plan
			Quality and utilization measures would be the same for all Track 3 practices and not separated by Risk groups. These measures were selected to be actionable, clinically meaningful, and aligned with CMS's and Maryland's broader quality measurement strategy. Measures include a patient experience of care survey, controlling high blood pressure, and diabetes hemoglobin A1c poor control.
			
			<u>Utilization:</u>
			Utilization Measure for PBA Calculation: PQI Hospital/ PQI ED Utilization
			
			<u>Quality Gateway:</u>
			Patient Experience: Patient experience and comprehensiveness of care survey tool selected by State- to include Tier 5
			
			Hemoglobin A1c (HbA1c) Poor Control (>9%) (eCQM) 0059 / 001 NCQA® MIPS
			Controlling High Blood Pressure (eCQM) 0018/ 236 NCQA® MIPS or as recommended and agreed upon between the State and CMMI- subject to annual review and modification
				• Quality measures for Maryland should be established by MDPCP with input from payers and practices
				• Quality measures should:
				  ○ Reflect consideration for administrative burden and potential effect on practice bonuses
				  ○ Be unique/updated to the extent possible while also aligning across payers
				  ○ Account for differences between Medicare, Medicaid, and private payer populations
				  ○ Consider SDOH to assess complex needs
				  ○ Advance health equity
				• Use only quality measures in year one
				• Include EHR and claims data in reporting on quality
				• Ask CMS about addition of COVID vaccination metrics to PCF

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
		(MIPS CQM measure) 0326/47 NCQA® MIPS Colorectal Cancer Screening (eCQM) 0034/113 NCQA® MIPS		*Key Takeaways* • Establish quality measures with input from payers (alignment) and practices, consider measures for SDOH • Include practice input on measure selection • Align quality measures with State models
	Risk Group 3-4	<u>Years 1- 5:</u> Advance Care Plan (MIPS CQM measure) (also used for Practice Risk Groups 1-2) Total Per Capita Cost (MIPS claims measure) (CMS does not use AHU for Risk group 3-4 and instead uses Total Per Capita Cost) <u>Years 2-5 (but administered in Year 1):</u> CAHPS® (beneficiary survey) <u>Years 3-5:</u> 24/7 Access to a Practitioner (beneficiary survey) Days at Home (claims measure)	N/A	See above (Risk Group 1-2)
Additional Considerations	***Quality Measures***	Quality and utilization measures will be aligned with state population health goals as defined in the TCOC contract (and subsequent MOU on goal alignment with private payers.)		
Care Delivery				

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
6	**General Options**	Practices have capabilities to deliver five advanced primary care functions: 1) access and continuity; 2) care management; 3) comprehensiveness and coordination; 4) patient and caregiver engagement; and 5) planned care for population health. <u>Flexibility:</u> In Primary Care First, practices will have latitude to develop their own approaches to care delivery, rather than being required to meet many specific care delivery requirements under the model. Practices will be required to report some information about their care delivery capabilities to ensure program integrity and provide CMS insight into practice progress and opportunities to continuously improve the model.	Practices have capabilities to deliver five advanced primary care functions: 1) Access and continuity; 2)Care management; 3) Comprehensiveness and coordination; 4) Patient and caregiver engagement; and 5) Planned care for population health. <u>Flexibility:</u> In MDPCP, practices will have latitude to develop their own approaches to care delivery, rather than being required to meet many specific care delivery requirements under the model. Practices will be required to report some information about their care delivery capabilities to ensure program integrity and provide CMS and the State insight into practice progress and opportunities to continuously improve the model.	
7	**Seriously Ill**	Practices focused on care for complex chronic or SIP have associated specialized capabilities.	No separate SIP – Complex tier (Tier 5); included in MDPCP program eliminates need for SIP.	• Include SIP as part of program (Tier 5) as opposed to a separate component • Focus SIP/Tier 5 on patients with complex needs and/or fragmented care • Consider including CTOs as potential supports for SIP program

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
				Key Takeaways • Develop a hybrid SIP/Tier 5 structure
Participants and Partners				
8	**Eligibility**	Located in one of the selected Primary Care First regions. Include primary care practitioners (MD, DO, CNS, NP, and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine.	Maryland only	
			Include primary care practitioners (MD, DO, CNS, NP, and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine, pediatric, co-located psychiatry, and Ob/Gyn [same existing list for MDPCP].	
		Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location.	Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location.	
		Have primary care services account for at least 70% of the practices' collective billing based on revenue. In the case of a multi-specialty practice, 70% of the practice's eligible primary care practitioners' combined revenue must come from primary care services.	Same as MDPCP	
		Have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to fee-for-service payments such as full or partial capitation.	Progression from Track 2 to Track 3; Track 2 practices have these characteristics. New applicants would attest.	

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
		Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE).	Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE).	
		Attest via questions in the Practice Application to a limited set of advanced primary care delivery capabilities, such as 24/7 access to a practitioner or nurse call line and empanelment of patients to a practitioner or care team.	For new applicants to MDPCP	
		Can meet the requirements of the Primary Care First Participation Agreement.	Meet requirements of the MDPCP Participation Agreement	
		Eligible practitioners (that each practice applicant must identify by NPI in its application) are those in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine. CMS may reject an application on the basis of the results of a program integrity screening.	Eligible practitioners (that each practice applicant must identify by NPI in its application) are those in internal medicine, general medicine, geriatric medicine, family medicine, and/or hospice and palliative medicine, pediatric, co-located psychiatry, and Ob/Gyn [same existing list for MDPCP]. CMS may reject an application on the basis of the results of a program integrity screening.	

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
9	**Participation Options**	1) Practices may choose to participate only in the PCF-General component of Primary Care First, and not in the SIP component, i.e. "PCF-General practices"; 2) Practices may choose to participate only in the SIP component of Primary Care First, and not in the PCF-General component, i.e. "SIP-only practices"; and 3) Practices may choose to participate in both the SIP and PCF-General components of Primary Care First, i.e. "hybrid practices."	Practices shall provide comprehensive care for all attributed beneficiaries. Availability of SIP is TBD-or rolled into MDPCP as Complex tier patients	• Mandatory Track 3 means practices would have to advance to Track 3 to remain in the MDPCP • Track 3 should not be mandatory in year 1; phase in Track 3 given the following considerations: ○ Overall CMS timeline ○ Timeline requirements for progression from one track to the next; two-year period seems appropriate to advance to next Track, depending on performance ○ Accountability of practices performing well that are less tolerant of risk ○ Track 2 practice performance status and interest in moving to Track 3 ○ Prevention of reduction in access to care, particularly for small practices ○ Appropriate and graduated risk levels with consideration for alternatives to HCC scores in future program years ○ Variability in practice capability to succeed in the program based on their geographic location and patient needs

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
				• Development of Track 3 should include detailed plans for: ○ CTO participation ○ Role of CTOs as risk-bearing entities ○ Potential care management fee sharing with CTOs ○ Requirements for disclosures to consumers about risk arrangements ○ Maintaining practice participation following elimination of Track 1
				Key Takeaways • Define basis of participation; mandatory or optional • Determine timeline for phase-out of Track 1, eventual phase-out of Track 2, and phase-in of Track 3 • Determine progression and / or inclusion of SIP program
10	**Exclusions**	FQHCs	FQHCs are permitted to participate	
11	**Payer Alignment**	CMS will also encourage other payers – including Medicare Advantage Plans, commercial health insurers, Medicaid managed care plans, and State Medicaid agencies – to align payment, quality measurement, and data sharing	CMS and the State will also encourage other payers – including Medicare Advantage Plans, commercial health insurers, Medicaid managed care plans, and State Medicaid agencies – to align payment, quality measurement, and	

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
		with CMS in support of Primary Care First practices.	data sharing with CMS in support of MDPCP practices.	
12	**Application**	Practices must complete a RFA	Practices must complete a RFA, if first year MDPCP participant. Otherwise, transitioning practices will complete a transition request application.	
13	**Performance**	5 years	5 years at a minimum	
14	**Other**	Although CMS is only able to assess and pay the PBA at the practice-level, the Participation Agreement will require participating practices to agree to compensate individual practitioners in their practice in a way that reflects their individual performance on meaningful outcomes-based and process clinical quality measures, patient experience, and AHU. This stipulation provides Primary Care First participants with the flexibility to determine their own compensation arrangements with their practitioners, while also ensuring that the PBA motivates practitioners to take responsibility for their personal performance.	Although CMS and the State are only able to assess and pay the PBA at the practice level, the Participation Agreement will encourage participating practices to compensate individual practitioners in their practice in a way that reflects their individual performance on meaningful outcomes-based and process clinical quality measures, patient experience, and AHU. This stipulation provides MDPCP participants with the flexibility to determine their own compensation arrangements with their practitioners, while also ensuring that the PBA motivates practitioners to take responsibility for their personal performance.	• Consider alternatives to AHU given TCOC focus on reducing avoidable hospital utilization; like transferring patients to alternative care settings (e.g., a primary care office) • Consider weighting quality measures *Key Takeaways* • Utilization metrics should include avoidable hospital and ED visits and compare to national benchmarks
Seriously Ill Population (SIP)				

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
15	**Seriously Ill Population**	CMS will attribute SIP patients lacking a primary care practitioner or care coordination to Primary Care First practices that specifically opt to participate in this payment model option. Practices may limit their participation in Primary Care First to exclusively caring for SIP patients, but in order to do so, such practices must demonstrate in their applications that they have a network of relationships with other care organizations in the community to ensure that beneficiaries can access the care best suited to their longer-term needs. Allowances to some of the eligibility requirements for the Primary Care First general payment model option (such as with respect to historical beneficiary attribution) will be made to facilitate participation in the SIP payment model option. One-time payment for first visit with SIP patient: $325 PBPM ▪ Monthly SIP payments for up to 12 months: $275 PBPM ▪ Flat visit fees: $50 ▪ Quality payment adjustment: up to $50	Complex tier (Tier 5) included in MDPCP program eliminates need for SIP and appropriate payment amounts	
Learning System				
16	**Learning Network and System**	CMS will provide access to a learning system for participating practices, including:	CMS and the State will provide access to a learning system for participating practices, including:	

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
		1) Technical Assistance: Share information about how the model works and what is required for success through onboarding and support resources, such as an implementation guide, newsletters, FAQs, and webinars/office hours. 2) Use of Data for Improvement: Support in the use of data and analytics to guide the operational and care delivery changes necessary for success. 3) Assessment and Feedback: Ongoing and timely assessment of practice capabilities. 4) Learning Communities: Management of practice networks for peer-to-peer sharing and diffusion of promising tactics, e.g., via a web-based collaboration website (PCF Connect) and a national meeting. Practices participating in Primary Care First may invest in practice coaching to achieve their aims in Primary Care First, but these services will not be provided by CMS, because CMS generally expects that Primary Care First practices have already developed advanced primary care capabilities. Where there are opportunities for alignment, e.g., National Meeting and regional in-	1) Technical Assistance: Share information about how the model works and what is required for success through onboarding and support resources, such as an implementation guide, newsletters, FAQs, and webinars/office hours. 2) Use of Data for Improvement: Support in the use of data and analytics to guide the operational and care delivery changes necessary for success. 3) Assessment and Feedback: Ongoing and timely assessment of practice capabilities. 4) Learning Communities: Management of practice networks for peer-to-peer sharing and diffusion of promising tactics, e.g., via a web-based collaboration website (PCF Connect) and a national meeting. Practices participating in MDPCP will receive practice coaching provided by the State to achieve their aims in MDPCP. Where there are opportunities for alignment, (e.g., national meetings and regional in-person meetings) MDPCP intends to participate.	

Count	Design Elements	Primary Care First (PCF)	Track 3 MDPCP Suggested Changes - Under Discussion	Summary of CMMI Comments and Advisory Council Feedback
		person meetings in the 18 existing CPC+ Track 1 and 2 regions, the Learning System for Primary Care First will be integrated into the existing learning system structure designed for CPC+ Tracks 1 and 2.		
Data Sharing				
17	**Data Sharing**	Medicare FFS expenditure and utilization data and Medicaid data, as available, are delivered, as requested by participating practices in accordance with applicable law, clearly and actionably on a quarterly basis at the practice- and National Provider Identifier (NPI)-level with identifiable information on performance of the participating practitioners.	Medicare FFS expenditure and utilization data and Medicaid data, as available, are delivered, as requested by participating practices in accordance with applicable law, clearly and actionably on a quarterly basis at the practice- and National Provider Identifier (NPI)-level with identifiable information on performance of the participating practitioners.	
18	**Reporting**	Care Delivery Achievement Data (limited, less than care delivery in MDPCP/CPC+) eCQM submissions (annual) CAHPS submissions (annual)	Care Delivery Achievement Data (limited) eCQM submissions (annual) CAHPS submissions (annual) tool tbd	
Quality Payment Program and Model Overlap				
19	**AAPM**	AAPM under Medical Home model rule	AAPM under Medical Home model rule	
20	**Overlaps**	See FAQs	Overlap rules will be the same as PCF	
Considerations for Maryland Specific Issues				
21	**Track 3 required or optional?**	N/A	Track 3 would be optional. If not made optional, it would become the only track for MDPCP. This may disadvantage and ultimately exclude current small and medium size practices from ongoing participation. The ability to sustain a broad coordinated statewide primary	

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			care delivery system would be greatly diminished.	
22	**Track 1 Phase-out**	N/A	Track 1 should be phased out. We are in agreement that Track 1 was always considered to be a transitional track as practices built the full Advanced Primary Care capabilities. Phasing this track out over the next few years should pose little harm. Current Track 1 practices must move to Track 2 or be eliminated from the program by the end of 2022. Phasing out Track 1 after that time poses little risk.	
23	**Total Cost of Care Accountability**	N/A	There is considerable State and CMMI interest in reducing the costs of care for Medicare FFS beneficiaries but primary care accountability does not fit the TCOC model. The MDPCP was designed to support that effort by broadly improving the health of the beneficiaries and thereby reducing avoidable and unnecessary high cost hospital and emergency department use (PQIs). This remains the goal. However, there is a disconnect in the Global Budget Hospital payment system that separates utilization reductions from effective reductions in hospital payments and PBPM costs. Under this system in the first year of the MDPCP, overall reductions in hospital and ED utilization were offset with increased payment per unit service and failed to fully reflect PBPM cost reductions. There is an additional concern that placing the burden of reducing Total Costs of Care responsibility on primary care providers	

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			exaggerate their ability to influence the majority of these costs. Therefore, we recommend holding practices accountable for reducing the avoidable hospital and ED utilization.	
24	**CTO Participation**	N/A	We would anticipate the option for CTO partnerships would remain for Track 3 practices. Given the lack of CMF in Track 3 and change in payment structure, we should allow the practices and CTOs to determine their own configuration for sharing payments.	• Provide some framework or guidance to practices and CTOSs on how to configure shared payments *Key Takeaways* • Continue to include CTOs as a support option for practices
25	**Track Transitions**	N/A	Practices currently in the program would request a Track transition and need to meet the requirements set out for the Track. The transition from Track 2 to Track 3 may be based on the practice requesting that transition without any other requirements anticipated. Practices moving from Track 1 to Track 3 would need to meet criteria similar to those established when moving from Track 2 to Track 3. Newly applying practices to MDPCP would need to request that Track and attest to meeting specified criteria in the RFA process, as well as meet the algorithmic level of performance consistent with Track 3.	