Discussion Items 9/22/2020 – CMMI Feedback and Council Response

Count	Design Elements	Primary Care First (PCF)	Alignment	Unresolved Items for Further Deliberation	Advisory Council Draft Recommendations 9/22	CMMI Response 9/29
10	**Exclusions**	FQHCs		CMMI: must first address FQHCs' role in Track 2 of MDPCP.	• Include FQHCs. *Commentary:* FQHCs are an integral part of the Maryland health care delivery system. The State gives a high priority to including them as an important part of the statewide health care delivery transformation on a voluntary basis. The State and HRSA recognize their payment system under PPS will require additional modeling to move further toward population based payments and away from FFS.	Discussions with CM to resume in October; will keep PMO updated on T2 progress.
24	**CTO participation**	N/A	N/A	CMMI: Justification needed for why this business relationship should occur under the umbrella of CTOs	• Retain CTOs in Track 3, continue to be optional for practices. *Commentary:* CTOs have become an important part of the health care delivery system in Maryland. Small and medium size practices rely on the CTOs for staffing and other support that they would not be able to access without the coordinated relationship with the CTOs, supported by the State. CTOs also provide a valuable link between hospitals and hospitals systems in Maryland without requiring the systems to employ the practices. In the setting of hospital-owned practices, the CTOs provide consistency in the support of those practices. ***Council Feedback to CMMI Response, 10/6/2020:*** • CTOs provide support services that small practices may not be able to offer otherwise; CTO participation	This doesn't address why CTOs should have a relationship with CMS directly. CTO services can still be provided without CTOs having a PA with CMS. Of note: Our analysis of practice size and CTOs shows that smaller and mid-size practices did not use CTOs at a higher rate than larger practices. Consider: 1) Releasing the CTOs from the confines of a CMS PA could offer more flexibility for individualizing business

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					helps ensure continued participation of small practices and those with the most high-need patients • Logistics of independent contracting could undermine program progress/success • Most CTO administrative tasks are managed by the State, not CMMI • Lessening requirements in the PA and CTO agreements could improve flexibility for business arrangements and services • Incentive for hospitals to serve as CTOs could diminish depending on the level of accountability required and future interplay between hospital and primary care models	arrangements and services. 2) What happens to CTOs after the end of the model?
Care Delivery						
6	**General Options**	Practices have capabilities to deliver five advanced primary care functions: 1) access and continuity; 2) care management; 3) 2comprehensiveness and coordination; 4) patient and caregiver engagement; 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	Agree	CMMI: Details on requirements needed.	• Keep same five advanced primary care functions. Allow practices latitude to develop their own approaches. Limited set of reporting required for practices – to be developed with CMMI. ***Council Feedback to CMMI Response, 10/6/2020:*** • Keep in mind administrative burden • Consider once or twice per year reporting options, based on practice preference for mid-way assessment	What do you envision this reporting to look like? More specifically, what are the goals of reporting in this context? Helpful to approach reporting requirements in terms of its intent rather than its length.

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		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.				
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.	Any Maryland qualifying practitioner	CMMI: Details on requirements needed.	• The eligibility will include the current list of MDPCP eligible providers using the same criteria for inclusion of 125 minimum FFS beneficiaries. *Commentary:* The list of provider types mostly aligns with PCF. The list will include palliative care providers as in PCF and will include Ob- GYNs, Psychiatrists co-located in primary care practices and Preventive Medicine providers	Note: For FQHCs, we do not define eligible practitioners. All primary care services are considered eligible regardless of practitioner types.
		Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location.	Agree	CMMI: Details on requirements needed.	• Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location with the exception of counting the beneficiaries under each FQHCs as the aggregate of their sites	
		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	Agree	CMMI: Details on requirements needed.	• 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.	Would this 70% requirement apply to FQHCs?

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		revenue must come from primary care services.				
		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.	Agree	CMMI: Details on requirements needed.	• Practices will be required to have at least one year in Track 2 of MDPCP and/or 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. ***Council Feedback to CMMI Response, 10/6/2020:*** • Review success elements of CareFirst's program and align the requirements for Track 3 transition for practices; obtain input from payers including Anthem and Amerigroup	How will we assess "experience" for direct entry of new applicants to T3? E.g. What are examples of VBP arrangements, how much experience do they need, are arrangements with other payers acceptable experience, etc. What is the plan for transition from T2 to T3? E.g. what are key indicators other than time spent in T2? Can practices move from T1 to T3?
		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).	Agree	CMMI: Details on requirements needed.	• Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and connect to their regional health information exchange (HIE). *Commentary:* Requirements consistent with PCF.	

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		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.	Agree	CMMI: Details on requirements needed.	• The Advanced Primary Care Delivery requirements include 24/7 access, telehealth use, advanced primary care capabilities including behavioral health integration, screening for social determinants of health, referral to community-based organizations to meet social needs, transitional care management, longitudinal care management, patient family advisory councils, patient self-management program access, use of data to influence care management. Requirements also include CRISP connectivity and use of advanced primary care services (ENS panels, Care Alerts, Pre-AH tool)	Confirm the intention is that T3 practices would need to meet ALL these requirements.
19	**AAPM**	AAPM under Medical Home model rule	Agree	CMMI: This requires a certain risk threshold; please address.	• Align with PCF RFA. Practices in Track 3 continue to be considered AAPM under the Medical Home designation. The MDPCP track 3 model meets the definition of a Medical Home Model as defined in 42 CFR 414.1305, and the track 3 model meets the financial risk requirements under the Medical Home Model financial risk and nominal amount standards set forth at 41 C.F.R. 414.1415(c)(2), (4). Per 42 C.F.R. 414.1415(c)(7), the Medical Home Model financial risk and nominal amount standards would only apply to an APM Entity participating in a track 3 practice that is owned and operated by an organization with less than 50 eligible clinicians whose Medicare billing rights have been assigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities (referred to as the "50 eligible clinician limit"). CMS will annually determine if any track 3 practices meet or exceed	

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					the 50 eligible clinician limit. Because the Primary Care First model meets the definition of a Medical Home Model as defined in 42 CFR 414.1305, and the Primary Care First model meets the financial risk requirements under the Medical Home Model financial risk and nominal amount standards set forth at 41 C.F.R. 414.1415(c)(2), (4). Per 42 C.F.R. 414.1415(c)(7), the Medical Home Model financial risk and nominal amount standards would only apply to an APM Entity participating in a Primary Care First practice that is owned and operated by an organization with less than 50 eligible clinicians whose Medicare billing rights have been assigned to the TIN(s) of the organization(s) or any of the organization's subsidiary entities (referred to as the "50 eligible clinician limit"). CMS will annually determine if any rack 3 practices meet or exceed the 50 eligible clinician limit. Because track 3 will not qualify as an Advanced APM under the generally applicable financial risk and nominal amount standards, Track 3 practices that meet or exceed the 50 eligible clinician limit will not be considered participants in an Advanced APM, and eligible clinicians participating in track 3 through these practices will not be eligible to earn will not qualify as an Advanced APM under the generally applicable financial risk and nominal amount standards, Track 3 practices that meet or exceed the 50 eligible clinician limit will not be considered participants in an Advanced APM, and eligible	

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					clinicians participating in track 3 through these practices will not be eligible to earn 5% bonus under this rule	
21	**Track 3 required or optional?**	N/A		Track transitions	• Needs to be sufficiently flexible in risk to accept practices that are small to large, diverse and broadly represent the State • Track 3 will become the only track in MDPCP by 2026. • Practices in Track 1 are required to transition to Track 2 by the end of their 3rd year of participation. • New Track 1 starters beginning in 2022 will be required to transition by the end of their second year of participation. • New 2023 starters will only be accepted if qualifying for Track 2. *Commentary:* Track 2 practices with one or more years in Track 2 will be eligible to transition to Track 3 in 2023. All Track 2 practices must transition to Track 3 by no later than 2026 • MDPCP would be extended to align with current end of Model to allow for T3 to be fully tested, 2023 - 2028	Lots of clarification needed in this section. - Provide details on the risk flexibilities needed "to accept practices that are small to large, diverse and broadly represent the State" - What is the last year for *new* T1 practices? - Will we change the timeline for current T1 practices to move to Track 2? - When are Track 2 practices eligible for Track 3 vs. when MUST they move to Track 3? Consider breaking this out by year for more clarity.

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1	**Total Monthly Payment**	**<u>Total Monthly Payment</u>:** 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 #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	Agree to Population Based Payment Agree to flat fee visit payment	• HCC score at practice level or individual level • Maryland Model effects and complexity • Budget neutrality relative to FFS, current MDPCP program, or increased primary care spending		This item looks like it was moved to the next section and is pending results from modeling

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		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.				
7	**Seriously Ill**	Practices focused on care for complex chronic or seriously ill patients have associated specialized capabilities.	SIP hybrid	SIP hybrid model components/specifics	*Commentary:* No prohibition to having separate stand-alone SIP if CMMI desires.	What does "no prohibition" mean? Is this separate SIP an elective/add on?