Discussion Items 9/29/2020

Count	Design Elements	Primary Care First (PCF)	Alignment	Unresolved Items for Further Deliberation	Advisory Council Draft Recommendations 9/29	CMMI Response 10/13
21	**Track 3 required or optional?**	N/A		• Track 3 mandatory or optional	• Needs to be sufficiently flexible in risk to accept practices that are small to large, diverse, and broadly represent the State. *Commentary:* To maximize participation, performance bonus adjustments and risk should be ramped up over time. • Track 3 will be mandatory and become the only track in MDPCP by 2026. • MDPCP would be extended to align with the current end of the Maryland Model to allow it to be fully tested, 2023 – 2028.	
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	• Details needed on transition from Track 2 to Track 3 and direct entry to Track 3 • Mandatory or optional risk taking progression	*Note:* Practices in Track 1 are required to transition to Track 2 by the end of their 3rd year of participation. • All practices must transition to Track 2 by 2023. • New practices starting in 2023 and beyond must start in Track 2 or Track 3. • 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. *Commentary:* Transfer of risk away from CMS to providers introduces policy inconsistencies around wrap-around structure (HMO structure, PCP selection, benefit design, etc.) that reduce possibility for success of the model.	

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			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 and meet the algorithmic level of performance consistent with Track 3.			
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.	Agree to Population Based Payment Agree to flat fee visit payment	• HCC score at practice level or individual level • Maryland Model effects and complexity	• Use the current HCC score, "money follows the person" method, to establish population based payments to practices. We are currently engaged in modeling both the average HCC and the current HCC by patient approaches. We anticipate the results to be available to the Advisory Council in the next 30 - 45 days.	

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		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 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.		• Budget neutrality relative to FFS, current MDPCP program, or increased primary care spending	*Commentary:* Preserving this system would create continuity during the transition, consistency of data, and familiarity for current practices. The actuarial payments for each HCC tier will be developed in the modeling. • Include SIP in the current Complex tier. *Commentary:* In the Maryland model, hospitals and practices are already working together to identify "SIP"-like patients and bring them under longitudinal care management. We are looking at data to determine the magnitude of "SIP" patients that are not under care management currently.	
2	**Performance Based Adjustment**	**<u>Performance-Based Adjustment (PBA):</u>** 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	Agree with National benchmarking	• Use of state based performance adjustments consistent with current model and aligned with population health goals • Simplified methods • Annual reporting	•	

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		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 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 negative PBA for each quarter of the second performance year will be determined by their AHU performance. Participating practices that exceed the Quality Gateway must also exceed the 50th percentile of a nationally constructed AHU benchmark. This is to ensure that		• Full PBA from year one in track 3 • Using State benchmarks for quality and utilization; justification if proposing another benchmarking approach • Incorporating a TCOC performance adjustment calculation		

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		practices receiving a PBA are above average at managing avoidable utilization across similar Medicare practices regardless of their location. Practices that fail to exceed the national benchmark but perform above the 25th percentile relative to their regional reference group will receive a 0% regional PBA. Practices that fail to exceed the national benchmark and perform in the bottom quartile of their regional reference group will receive a -10% regional PBA. Practices that exceed these minimum thresholds will be eligible to earn a positive PBA based on how they perform relative to both a regional and individual historical benchmark.				
3	**Attribution**	Beneficiary Attribution: Claims-based with voluntary alignment opportunity; proactive identification and assignment of seriously ill and unmanaged beneficiaries	Agree	•	•	
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	Agree	•	•	

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		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.				

End Discussion Items 9/29/2020

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Count	Design Elements	Primary Care First (PCF)	Alignment	Unresolved Items for Further Deliberation	Advisory Council Draft Recommendations	CMMI Response
Payment						
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 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.	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	• Use the current HCC score, "money follows the person" method, to establish population based payments to practices. We are currently engaged in modeling both the average HCC and the current HCC by patient approaches. We anticipate the results to be available to the Advisory Council in the next 30 -45 days. *Commentary:* Preserving this system would create continuity during the transition, consistency of data, and familiarity for current practices. The actuarial payments for each HCC tier will be developed in the modeling. • Include SIP in the current Complex tier. *Commentary:* In the Maryland model, hospitals and practices are already working together to identify "SIP"-like patients and bring them under longitudinal care management. We are looking at data to determine the magnitude of "SIP" patients that are not under care management currently.	

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2	**Performance Based Adjustment**	**<u>Performance-Based Adjustment (PBA):</u>** 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 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	Agree with National benchmarking	• Use of state based performance adjustments consistent with current model and aligned with population health goals • Simplified methods • Annual reporting • Full PBA from year one in track 3 • Using State benchmarks for quality and utilization; justification if proposing another benchmarking approach • Incorporating a TCOC performance adjustment calculation		

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		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 negative PBA for each quarter of the second performance year will be determined by their AHU performance. Participating practices that exceed the Quality Gateway must also exceed the 50th percentile of a nationally constructed AHU benchmark. This is to ensure that practices receiving a PBA are above average at managing avoidable utilization across similar Medicare practices regardless of their location. Practices that fail to exceed the national benchmark but perform above the 25th percentile relative to their regional reference group will receive a 0% regional PBA. Practices that fail to exceed the national benchmark and perform in the bottom quartile of their regional reference group will receive a -10% regional PBA. Practices that exceed these minimum thresholds will be eligible to earn a positive PBA based on how they perform relative to both a regional and individual historical benchmark.				
3	**Attribution**	Beneficiary Attribution: Claims-based with voluntary alignment opportunity; proactive identification and assignment of seriously ill and unmanaged beneficiaries	Agree			
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).	Agree			

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		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.				
Additional Considerations		*Population Based Payment (PBP)*				
Performance Measurement						
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 (MIPS CQM measure) 0326/47 NCQA® MIPS		• PBA based on State's priorities • Creation of varying risk levels within track 3 (e.g., less than 100% capitated, similar to various levels of CPCP in track 2)	•	

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		Colorectal Cancer Screening (eCQM) 0034/113 NCQA® MIPS				
	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)		• Same as above		
Additional Considerations		*Quality Measures*				
Care Delivery						
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; 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.	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 w CMMI.	

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Count	Design Elements	Primary Care First (PCF)	Alignment	Unresolved Items for Further Deliberation	Advisory Council Draft Recommendations	CMMI Response
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.	
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.	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	
		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 revenue must come from primary care services.	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.	
		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.	
		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.	
		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	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-	

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		empanelment of patients to a practitioner or care team.			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)	
		Can meet the requirements of the Primary Care First Participation Agreement.		• Meet MDPCP requirements		
		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.		• Add full complement of MDPCP providers		
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"; 3) Practices may choose to participate in both the SIP and PCF-General components of Primary Care First, i.e. "hybrid practices."	SIP Hybrid			
10	**Exclusions**	FQHCs		• CMMI: 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.	
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	Agree			

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		align payment, quality measurement, and data sharing with CMS in support of Primary Care First practices.				
12	**Application**	Practices must complete a RFA	Agree			
13	**Performance**	5 years	Agree			
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.	Agree			
Seriously Ill Population (SIP)						
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.		N/A	• (See above)	

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		• 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				
Learning System						
16	**Learning Network and System**	CMS will provide access to a learning system for participating practices, including: 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		• Hybrid Learning System- State and CMMI		

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		Meeting and regional in-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.	Agree			
18	**Reporting**	Care Delivery Achievement Data (limited, less than care delivery in MDPCP/CPC+) eCQM submissions (annual) CAHPS submissions (annual)	Agree			
Quality Payment Program and Model Overlap						
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 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).	

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					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 clinicians participating in track 3 through these practices will not be eligible to earn 5% bonus under this rule.	
20	**Overlaps**	See FAQs				
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 2 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.	
22	**Track 1 phase-out**		Agree			

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23	**Total Cost of Care Accountability**	N/A	Agree			
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.	
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	• Details needed on transition from T2 to T3 and direct entry to T3 • Mandatory or optional risk taking progression		

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			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 and meet the algorithmic level of performance consistent with Track 3.			

**Row numbers highlighted in blue indicate discussion items for 9/29, included above.*

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