CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13132	**Date: March 20, 2025**
	Change Request 13932

Transmittal 13054 issued January 16, 2025, is being rescinded and replaced by Transmittal 13132, dated March 20, 2025, to revise Business Requirements (BRs) 13932.1, 13932.4, 13932.4.1, 13932.4.2, and 13932.5. This correction also adds BRs 13932.4.3 and 13932.4.4. All other information remains the same.

SUBJECT: Update - Federally Qualified Health Center (FQHC) Participation in and Payment Under the Maryland Primary Care Program (MDPCP) for Healthcare Common Procedure Coding System (HCPCS) Codes 99453 and 99454

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to amend the list of Healthcare Common Procedure Coding System (HCPCS) codes for Federally Qualified Health Centers (FQHCs) participating in the Maryland Primary Care Program (MDPCP), specifically to include codes 99453 and 99454.
EFFECTIVE DATE: July 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 7, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Demonstrations

Attachment - Demonstrations

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II. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act established a new Center for Medicare and Medicaid Innovation (Innovation Center) within the Centers for Medicare & Medicaid Services (CMS) to test new payment and service delivery models that have the potential to reduce Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) expenditures while maintaining or improving the quality of care for beneficiaries.

In 2014, the State of Maryland and Innovation Center launched the Maryland All-Payer Model, under which, the State operates the nation's only all-payer hospital rate regulation system and places acute care hospitals on global budget payments for all hospital inpatient and outpatient services. Under this model, the State of Maryland committed to meeting a number of quality targets and limiting annual hospital cost growth for all payers including Medicare.

The Maryland Total Cost of Care (TCOC) Model, launched in 2019, builds on the Maryland All-Payer Model's existing hospital global budgets and creates financial alignment between hospitals and nonhospital providers and suppliers. The MDPCP is a key component of the TCOC model that aims to further reduce hospital spending under the global budget system by reducing hospitalization rates throughout the state. The MDPCP will promote comprehensive primary care transformation using a similar structure to the Comprehensive Primary Care Plus (CPC+) Model, which focuses on rewards for effective care management, provider performance, and population health improvement. The MDPCP also includes a new type of participant, a Care Transformation Organization ("CTO"), which is an entity primarily intended to furnish care coordination services to Medicare beneficiaries attributed to participating practices that have partnered with the CTO. We introduced CTOs to address the difficulties that practices in CPC Classic and CPC+ have had in hiring adequate levels of staff to perform care management services. MDPCP has two Tracks for participation and opened the more advanced Track 2 for FQHC participation in 2022.

This CR seeks to amend the list of Healthcare Common Procedure Coding System (HCPCS) codes for MDPCP-participating FQHCs with a date of service on or after January 1, 2025. The Lewin Group will serve as the specialty contractor responsible for creating MDPCP files.

B. Policy: MDPCP follows the theory of care transformation and payment structure embodied in the CPC+ Model. MDPCP makes three types of payments to participating practices to assist them in providing comprehensive, advanced primary care. Theoretically, this combination of integrated continuum of care management and practice-based care transformation will reduce the hospitalization rate and thus increase Medicare savings.

The Innovation Center anticipates engaging approximately 20-30 percent of Maryland's estimated 4,000 primary care practices over the 8-year model period in an alternative payment arrangement based on a practice's attributed beneficiary panel. The MDPCP payment arrangement includes a Care Management Fee (CMF), a Performance-Based Incentive Payment (PBIP, at risk based on performance on utilization and quality measures), and for participants in the more advanced Track 2, a partially Capitated Comprehensive Primary Care Payment (CPCP). The CPCP provides a specified percentage of the practice's expected E&M revenue in quarterly lump sum payments, with the remaining percentage made in the form of reduced Fee-for-Service (FFS) payments to the provider at the time certain Evaluation and Management (E&M) services are rendered.

Participation in MDPCP and partnership with a CTO are voluntary. Track 2 practices may choose which percentage of their CPCP revenues are provided in a lump sum payment.

CMS is associating the following Demonstration Code with the claims from FQHCs participating in the MDPCP: 83.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13932.1	The Contractor shall add HCPCS codes 99453 and 99454 to the following existing criteria for setting Demonstration Code 83 as implemented in CR 12326: • Date of Service on or after January 1, 2025; and • Type of Bill (TOB) 77X; and • The provider is participating in an MDPCP-participating FQHC per the file received from CMS; and					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The beneficiary is participating in an MDPCP-participating FQHC per the file received from CMS; and • The provider and beneficiary MDPCP Model Identifier Numbers must match; and • The statement covered from date for the claim is between the effective start date and end date (inclusive) for the matching records in the beneficiary and participant file; and • HCPCS codes: 99453 and 99454									
13932.2	The Contractor shall apply the MDPCP percentage reduction from the Provider's Participant file record to provider reimbursement on 77X TOBs with Demonstration Code 83 on service lines with HCPCS codes 99453 and 99454.					X				
13932.3	The Contactor shall calculate coinsurance using the payment amount prior to the MDPCP reduction. NOTE: Deductible does not apply to FQHC claims.					X				
13932.3.1	The Contractor shall apply the MDPCP reduction, Demonstration Code 83 prior to sequestration.					X				
13932.4	The Fiscal Intermediary Shared System (FISS) shall create a utility to identify claims eligible for the model from January 1, 2025, through July 6, 2025, using the following criteria: • TOB 77X; and • The provider is participating in an MDPCP-participating FQHC for the file received from CMS; and					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The beneficiary is participating in an MDPCP-participating FQHC for the file received from CMS; and • The provider and beneficiary MDPCP Model Identifier Numbers must match; and • The statement covered from date for the claim is between the effective start date and end date (inclusive) for the matching records in the beneficiary and participant file; and • HCPCS codes: 99453 or 99454 NOTE: FISS shall use OPER-ID 'C13932-83' to quickly identify adjustments for demonstration code 83 related to this Change Request.									
13932.4.1	FISS shall include 77X Type of Bill (TOB) with s/location of PB9997 and a statement coverage with a date of service start of January 1, 2025, through July 6, 2025. FISS shall use Bill Frequency type 'J' for adjusted claims. NOTE: FISS shall reject claims with a cancel date greater than the spaces and claims whose frequency is a '0'.					X				
13932.4.2	The Contractor shall make any adjustments that were identified on the one-time utility.					X				
13932.4.3	The Contractor shall create a report to generate when the utility is run that will display the details of the claims eligible for the model. Report fields shall include: • Provider; • Health Insurance Claim Number (HICN); • Original Document Control Number (DCN); • Original TOB; • Adjusted DCN; and					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Statement Coverage Dates (Dates of Service from and to)									
13932.4.4	For all claims with the MDPCP FQHC adjustment amount, the Contractor shall use the Reason Adjustment Codes (RARC) 'OT' for the ADJ-REAS-CD field on Claim Page 06 (MAP1036). NOTE: FISS shall use 'S' (System) for the ADJ REQ ID field on Claim Page 06 (MAP1036).					X				
13932.5	For all claims with the MDPCP FQHC adjustment amount, the Contractor shall use the following messages on the provider remit: Group Code: CO (Contractual Obligation) Claim Adjustment Reason Codes (CARC) 132 – Prearranged demonstration project adjustment. Medicare Summary Notice (MSN) 60.4 – This claim is being processed under a demonstration project. Spanish Translation - Esta reclamación está siendo procesada bajo un projecto especial. NOTE: FISS shall apply the Group Code of CO and the CARC of 132 as requested to the Provider Remit. For adjustments for current demonstration code 83, FISS shall assign MSN 60.4 to the MSN when Value Code 'QI' is present and greater than 0.					X				

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Pre-Implementation Contact(s): Adrienne Wiley, adrienne.wiley@cms.hhs.gov , Abid Khan, abid.khan@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

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ATTACHMENTS: 0