CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11515	**Date: July 28, 2022**
	Change Request 12828

SUBJECT: Federally Qualified Health Center (FQHC) Participation in and Payment Under the Maryland Primary Care Program (MDPCP) - Implementation Change Request (CR) to correct Business Requirement (BR) 12326.7.2.

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to correct BR 12326.7.2 (from CR 12326), which demands precedence for demo code 83.

For this CR, systems shall be operational to process claims with dates of service on or after January 1, 2023.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

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

Pub. 100-19	Transmittal: 11515	Date: July 28, 2022	Change Request: 12828

SUBJECT: Federally Qualified Health Center (FQHC) Participation in and Payment Under the Maryland Primary Care Program (MDPCP) - Implementation Change Request (CR) to correct Business Requirement (BR) 12326.7.2.

EFFECTIVE DATE: January 1, 2023
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I. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act established a new Center for Medicare and Medicaid Innovation (Innovation Center) within the 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 currently has two tracks for participation and opened Track 2 for Federally Qualified Health Center (FQHC) participation in January 1, 2022. For this change request, systems shall be operational to process claims with dates of service on or after January 1, 2023.

This implementation CR is to correct BR 12326.7.2 (from CR 12326), which demands precedence for demo code 83. This CR removes precedence for 83. The systems shall not apply demonstration code 83 to claims that already have demo codes on the claim record.

The Lewin Group will serve as the specialty contractor responsible for creating MDPCP files.

B. Policy: The Maryland Primary Care Program will follow the theory of care transformation and payment structure embodied in the CPC+ Model. MDPCP will make 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 eight-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; furthermore, practices beginning participation in Track 1 have 3 years to transition to Track 2, preserving physicians' ability to determine how they receive the CMF and when they are ready to shift to a partially capitated payment. Track 2 practices may choose which percentage of their CPCP revenues will be provided in a lump sum payment.

II. 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	
12828.1	The Medicare Contractor shall follow the below demo code precedence rules for deciding the position of demo code '83' on an institutional claim: • The contractor shall set demo code '83' in the first demo code field if there are no other demo codes present on the claim. • The contractor shall set demo code '83' in the next available demo code field if other demo code(s) are present on the claim. If all demo code positions are filled, do not set demo code '83' on the claim record. • If demo code '83' is present in the first demo code field and the claim applies to another demonstration model, move demo code '83' to the next available demo code field and set the other demo code in the first demo code field. If all demo code positions are filled, do not set demo code '83' on the claim record.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Note: Claims that do not meet all the matching criteria for FQHC participation in the MDPCP will continue to not have demo code '83' set on the claim.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. 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

V. CONTACTS

Pre-Implementation Contact(s): Adrienne Wiley, 410-786-3087 or Adrienne.Wiley@cms.hhs.gov , Sarah Mioduski, 5707090931 or Sarah.Mioduski@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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ATTACHMENTS: 0