CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11157	**Date: December 13, 2021**
	Change Request 12326

Transmittal 10936, dated August 11, 2021 is being rescinded and replaced by Transmittal 11157, dated, December 13, 2021 to update the language in business requirements 12326.7.1 and 12326.20. All other information remains the same.

SUBJECT: Federally Qualified Health Center (FQHC) Participation in and Payment Under the Maryland Primary Care Program (MDPCP) - Implementation

I. SUMMARY OF CHANGES: The Maryland Primary Care Program (MDPCP) has two Tracks for participation and is opening the more advanced Track 2 for Federally Qualified Health Center (FQHC) participation beginning January 1, 2022. For this change request, systems shall be operational to process claims with dates of service on or after January 1, 2022.

EFFECTIVE DATE: January 1, 2022 - FISS will begin development of CR; April 1, 2022 - Continue development, testing, and delivery of CR
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2022 - FISS will begin development of CR; April 4, 2022 - Continue development, testing, and delivery of CR

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: 11157	Date: December 13, 2021	Change Request: 12326

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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 Centers for Medicare and 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 Maryland Primary Care Program (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 is opening the more advanced Track 2 for Federally Qualified Health Center (FQHC) participation beginning January 1, 2022. For this change request, systems shall be operational to process claims with dates of service on or after January 1, 2022. 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.

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

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	
12326.1	Contractors shall prepare their systems to process Track 2 of the Maryland Primary Care Program (MDPCP) for MDPCP Federally Qualified Health Center (FQHC) adjustment claims on or after January 1, 2022.					X				CMS, VDC
12326.2	Contractors shall be prepared to accept the data elements on the initial MDPCP FQHC Provider file and Beneficiary Participant file that identify the selected participating providers and beneficiaries subject to Track 2 of the MDPCP adjustment. The data elements of these files are documented in an attachment to this Change Request (CR).					X				
12326.2.1	The contractor shall create a process to load the MDPCP FQHC Provider and Beneficiary Participant files. Updated files shall be processed as full replacement files.					X				VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12326.2.2	The contractor shall create/modify online screens to display the Demo 83 MDPCP FQHC Provider and Beneficiary Participant file data in view mode only.					X				
12326.2.3	CMS shall transmit a recurring MDPCP FQHC Provider and Beneficiary Participant file to the Virtual Data Center (VDC). Note: The MDPCP FQHC Participant files will be sent on a quarterly basis beginning on or around April 5, 2022.					X				CMS, VDC
12326.3	The contractor shall produce MDPCP FQHC Provider and Beneficiary Participant response files that indicate the result of processing the records. The response files will be sent via Electronic File Transfer (EFT). The data elements of the response files are documented in an attachment to the CR.					X				VDC
12326.3.1	The contractor shall use the CMS provided status codes to report on the acceptance/rejection of the individual records in the file received.					X				
12326.3.2	CMS shall create a procedure for the VDCs to use to report issues with the MDPCP FQHC files.									CMS, VDC
12326.3.3	The VDCs shall transmit the MDPCP FQHC final file responses via EFT.									VDC
12326.3.4	The VDCs shall use the CMS established procedures to contact the appropriate parties if the files are not received or if there are issues with the files. When applicable, CMS shall send a full replacement file via EFT.									CMS, VDC
12326.4	To assist with the testing files creation, contractors shall provide a list of at minimum 15 test Medicare Beneficiary Identifiers (MBIs), 5 CMS Certification Numbers (CCNs) for FQHC providers in a single Excel file (i.e., Excel spreadsheet) to CMS via email.	X								STC

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	Contractors shall send the file on or around December 10, 2021, to adrienne.wiley@cms.hhs.gov and laura.snyder@cms.hhs.gov using the below file layout: 1. MBI 2. CCN 3. Effective/Term dates All fields will be contained on a single line. NOTE: Only Novitas is required to test, but CMS encourages other Medicare Administrative Contractors (MACs) to test as well.									
12326.4.1	The contractor shall receive a test file from CMS containing a sample of providers/beneficiaries that are selected for FQHC participation in the MDPCP. The list shall include MBIs and CCNs for FQHC facilities, workload, and MAC ID. The MACs shall use this test file for testing purposes only.	X								CMS, VDC
12326.4.2	CMS shall provide the MDPCP FQHC test files to the contractors by these dates: The Shared System Maintainer (SSM) at least 90 days prior to production installation, on or around January 3, 2022. The System Testing Center (STC) two months prior to production installation, on or around February 1, 2022. VDCs to transmit to the MACs one month prior to production installation, on or around March 1, 2022.	X				X				CMS, STC, VDC
12326.5	CMS shall inform contractors of the availability of the production versions of the MDPCP FQHC Files via the Part A Functional Work Groups (FWG) Distribution lists on or around March 15, 2022**.**									CMS, VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12326.6	On or about March 15, 2022, CMS shall push the final production files to the VDC, and the VDC shall upload the files to the MACs specific to their contractor workload(s).									CMS, VDC
12326.7	Contractors shall use Medicare Demonstration Special Processing Number, (Demonstration Code herein), ‘83’ to identify MDPCP FQHC claims.					X			X	BCRC, IDR, NCH
12326.7.1	Contractors shall set Demonstration Code 83 when the claim has the following criteria: • Type of Bill (TOB) 77x, and • The provider is participating in the MDPCP FQHC model per the file received from CMS; and • The beneficiary is participating in the MDPCP FQHC model 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 • Revenue code: 052X with G0466, G0467, or G0468; or • HCPCS codes: G2025 or G0071 **NOTE**: MSP claims are to be excluded from this requirement.					X				
12326.7.2	The contractor shall set Demonstration Code 83 **in the first Demonstration Code field**. If other Demonstration Codes are present on the claim, move Demonstration Code 83 to the first position, and move the remaining codes down one position. (Claims that do not meet all the matching criteria for FQHC participation in the MDPCP will not have the Demonstration Code 83 applied and will process as normal non-model claims).					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12326.8	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 G2025 and G0071.					X				
12326.8.1	The contactor shall calculate coinsurance using the payment amount prior to the MDPCP reduction. NOTE: Deductible does not apply to FQHC claims.					X				
12326.8.2	The contractor shall apply the MDPCP reduction, Demonstration Code 83 prior to sequestration.					X				
12326.9	The contractor shall update the FQHC Pricer interface to include new fields for the MDPCP reduction, and return model adjustment amounts for MDPCP reduced claims. Refer to the attached New FQHC Pricer Field Information.					X				FQHC Pricer
12326.9.1	The contractor shall modify the FQHC Pricer interface to add the following fields: • Demonstration Code • MDPCP reduction percentage					X				FQHC Pricer
12326.9.2	The contractor shall pass Demonstration Code 83 and the MDPCP reduction percentage to the FQHC Pricer.					X				FQHC Pricer
12326.9.3	The FQHC Pricer shall reduce the payment for FQHC service lines by the MDPCP reduction percentage when the Demonstration Code is 83 and the revenue code is 052x with HCPCS codes G0466, G0467, or G0468. This amount should be returned to FISS. Note: This amount will be returned in the existing return buffer line level payment field and accumulated into the existing total claim level payment field.									FQHC Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12326.9.4	The FQHC Pricer shall calculate the coinsurance based on the payment prior to the MDPCP reduction. This amount should be returned to FISS as the coinsurance amount. Note: This amount will be returned in the existing return buffer line level payment field and accumulated into the existing total claim level payment field.									FQHC Pricer
12326.9.5	The FQHC Pricer shall return the reduced amount based on the MDPCP percentage to FISS.					X				FQHC Pricer
12326.9.6	The contractor shall accept the following fields in the return buffer from the FQHC PRICER: • MDPCP reduction amount					X				FQHC Pricer
12326.10	The contractor shall create a new line level field to display the amount of the MDPCP reduction. The reduced amount returned from the FQHC Pricer should also be displayed in this field. NOTE: This field should also be added to the Expert Claims Processing System (ECPS).					X				
12326.11	The contractor shall tally the line level MDPCP reduction amounts and report the total in payer only value code QI.					X				
12326.11.1	The contractor shall not report value code QI and amount to the BCRC.					X				
12326.12	The contractor shall pass the MDPCP line level reduction field as well as value code QI and amount to the downstream systems.					X				IDR, PS&R
12326.12.1	The contractor shall pass the value code QI and amount to the downstream systems. Note: Payer value code QI is defined as: FQHC MDPCP DEMO					X				HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
12326.13	The contractor shall send the MDPCP FQHC payment adjustment amount, value code QI, on the Common Working File (CWF) for FQHC Facility Claim (HUOP) record.					X				NCH
12326.14	The contractor shall accept new Demonstration Code ‘83’ MDPCP FQHC in the first position of the Demo field for HUOP claims.								X	
12326.15	CWF shall ensure that Demonstration Code 83 is carried to the claim history and transmitted to the National Claims History (NCH) file when present on HUOP claims.								X	NCH
12326.16	The contractor shall modify Outpatient consistency edit '0014' to add a new Demonstration Code '83' as a valid value for MDPCP FQHCs for Dates of Service on or after January 1, 2022, for record type HUOP.								X	
12326.17	For all claims with the MDPCP FQHC adjustment amount, contractors shall use the following messages on the provider remit: Group Code: CO (Contractual Obligation) CARC 132 – Prearranged demonstration project adjustment. MSN 60.4 – This claim is being processed under a demonstration project. Spanish Translation - Esta reclamación está siendo procesada bajo un projecto especial.					X				
12326.18	Contractors shall ensure that the Medicare Summary Notice (MSN) will show the amount that would have been paid if not for the MDPCP FQHC adjustment as the provider paid amount.					X				
12326.19	Contractors shall participate in a single, one-hour long teleconference with CMS during the UAT testing period to discuss problems identified during testing at	X				X			X	CMS, VDC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	a date to-be-determined by CMS. This date shall be communicated on a future FWG call. NOTE: CWF shall be notified to attend the call.									
12326.20	FISS shall create a utility to identify claims eligible for the model from January 1, 2022 through March 31, 2022 using the following criteria: • Type of Bill (TOB) 77X, and • The provider is participating in the MDPCP FQHC model for the file received from CMS; and • The beneficiary is participating in the MDPCP FQHC model 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 • Revenue code: 052X with G0466, G0467, or G0468; or • HCPCS codes: G2025 or G0071 **NOTE**: MSP claims are to be excluded from this requirement. **NOTE**: The utility will be dependent upon timing of the CMS MDPCP FQHC Provider and Beneficiary Participant file. **NOTE**: The utility will be dependent upon MDPCP FQHC Provider and Beneficiary Participant file receipt\processing logic.					X				
12326.20.1	FISS shall create a report to generate when the utility is run that will display the details of the claims eligible for the model.					X				

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): Laura Snyder, Laura.Snyder@cms.hhs.gov , Adrienne Wiley, Adrienne.Wiley@cms.hhs.gov

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 3

MDPCP FQHC Adjustment Response File Layout (DRAFT)

Code Description/Explanation:

00 = Success/The record was processed successfully.

01 = Invalid Record Identifier

10 = Header Record Missing/Not the First Record on the File

11 = Header Record Date Error/The Header Record date is missing or invalid.

22 = Provider Number Error, Provider Number is not numeric (Provider Alignment File Only)

23 = Beneficiary MBI Error, MBI is incorrect length or BIC is missing or invalid value (Beneficiary Alignment File Only)

24 = Effective Start Date Error, the effective start date is not a valid date

25 = Effective End Date Error, the effective end date is not a valid date

26 = Adjustment Percentage Error, the Adjustment Percentage is not numeric (Provider Alignment File Only)

30 = Trailer Record Missing

32 = Trailer Record Count Error/ The Trailer Record Count in the Trailer does not equal the number of detail records sent by CMS

New FQHC Pricer Field Information

Input to the FQHC Pricer –

- Demonstration Code (claim level): PIC X(02)
  FQHC Pricer API Request:
  Variable Name: demoCodes

- MDPCP Reduction Percentage (claim level): PIC 9V99
  FQHC Pricer API Request:
  Variable Name: mdpcpReductionPercentage

Output from the FQHC Pricer –

- MDPCP Reduction Amount (line level): PIC 9(9)V99
  FQHC Pricer API Response:
  Variable Name: mdpcpReductionAmount

API Contract for the new fields (These will be added to the end of the API request and response.)

```
        "demoCodes" : {
  "uniqueItems" : true,
  "type" : "array",
  "description" : "The demo code(s).",
  "example" : 12,
  "items" : {
    "type" : "string"
  }
 },
 "mdpcpReductionPercentage" : {
  "maximum" : 1.00,
  "exclusiveMaximum" : false,
  "minimum" : 0.00,
  "exclusiveMinimum" : false,
  "type" : "number",
  "description" : "The MDPCP reduction percentage.",
  "example" : 0.87
 }
 "mdpcpReductionAmount" : {
  "maximum" : 999999999.99,
  "exclusiveMaximum" : false,
  "minimum" 0.00: ,
  "exclusiveMinimum" : false,
  "type" : "number",
  "description" : "The MDPCP reduction amount.",
  "example" : 123456789.01
 }
```

Name: **Beneficiary Alignment File**

Header Record	Format	Label	Values
Record Identifier	11 bytes, alphanumeric, expected value=MPC-BEN-HDR	Identifies Header Record	MPC-BEN-HDR
File Creation Date	8 bytes, numeric, CCYYMMDD format	Date file created	
Filler	38 bytes, alphanumeric, expected value = spaces	Filler values	

Detail Record	Format	Label	Values
Record Identifier	11 bytes, alphanumeric, expected value=MPC-BEN-DTL	Identifies start of detail lines	MPC-BEN-DTL
MDPCP Model Identifier	9 bytes, alphanumeric		T#MD####
MBI	11 bytes, alphanumeric	Beneficiary MBI	
Effective Start Date	8 bytes, numeric, expected format=CCYYMMDD		
Effective End Date	8 bytes, numeric, expected format=CCYYMMDD		

Trailer Record	Format	Label	
Record Identifier	11 bytes, alphanumeric, expected value=MPC-BEN-TRL	Identifies Last record	MPC-BEN-TRL
Detail Record Count	10 bytes, numeric	Count of Detail lines	
Filler	36 bytes, alphanumeric, expected value = spaces	Filler values	

Provider Participant Alignment File

Header Record	Format	Label	Values
Record Identifier	11 bytes, alphanumeric, expected value=MPC-PRV-HDR	Identifies Header Record	MPC-PRV-HDR
File Creation Date	8 bytes, numeric, CCYYMMDD format	Date file created	
Filler	38 bytes, alphanumeric, expected value = spaces	Filler values	

Detail Record	Format		
Record Identifier	11 bytes, alphanumeric, expected value=MPC-PRV-DTL	Identifies start of detail lines	MPC-PRV-DTL
MDPCP Model Identifier	9 bytes, alphanumeric		T#MD####
Participating FQHC Provider Number	10 bytes, numeric	Provider Number (a.k.a. CCN)	
Adjustment Percentage	4 bytes, numeric, 9v99	Percentage reduction in payments, expressed as a fraction	0.40
Effective Start Date	8 bytes, numeric, expected format=CCYYMMDD	Date eligible for participation	
Effective End Date	8 bytes, numeric, expected format=CCYYMMDD	Date ineligible or withdrawn	

Trailer Record	Format		
Record Identifier	11 bytes, alphanumeric, expected value=MPC-PRV-TRL	Identifies Last record	MPC-PRV-TRL
Detail Record Count	10 bytes, numeric	Count of Detail lines	
Filler	36 bytes, alphanumeric, expected value = spaces	Filler values	