Introduction to the Maryland Primary Care Program: Office Hours Question and Answer Session

Application

1. **Do you have any sense about how many practices will be applying as practices?**
   Since this is a new program, we'll have to use the disclaimer that we can't be certain how many practices or CTOs will be applying, nor how many practices will select the CTO. However, we did do some predictive modeling and we anticipate there will be somewhere between 100 and 600 practices by 2023, in the 5th year of the program. And we've done some predictive modeling, we've seen that a large number of those will come in the first year. It may be as many as 800 to 1,000 providers in the first year.

2. **And how many practices do you think will want to be a CTO?**
   This is something that we'll have to reserve on for right now.

3. **Does CTO need an entirely new unique LLC, or can it use an ACO (or parent company of ACO's) LLC?**
   Yes, they can use an ACO or parent company for the LLC, it does not need its own new LLC. However, it must meet government board's requirements that will be outlined in the participation agreement, that will be out in the fall.

4. **As practices are thinking about enhanced embedded care management services, states frequently come up as an issue. Providers are wondering if they can use the CMF to rent space. Can the CMF be used to merge paying for office space?**
   Unfortunately, no, the CMF cannot be used for paying for office space or renting space or anything like that.

5. **Can a PFAC be shared across multiple practices, if there is a representative participation?**
   No, because we would like each practice to have its own representative PFAC to meet the needs of that practice's populations, and we don't want that spread across multiple practices. Each practice will need to have its own PFAC.

6. **Can you discuss AAPM's standards that must be considered to determine AAPM eligibility for a practice? Just signing up doesn't mean you are AAPM designated.**
   We are currently working with the team at CMMI that makes the designations for advanced APMs and mixed APMs. We don't have specific information at this time. However, a reminder that this is designated as an advanced APM under the medical home standard, which requires that there be 50 clinicians or fewer through the parent organization. We will be asking for that information in the application. At this time, we'll be unable to make determinations for individual practices on whether or not they will meet the advanced APM clinician caps for the medical home standard, and therefore whether or not they will have QPs under the advanced APM, or whether they will be subject to commit.

7. **Will there be space to include more than one parent organization?**
   Currently in the application there is only limited space for a parent organization, we anticipate you to put one set of information. If there are multiple parent organizations necessary, we can follow up at a time after the application to gather that information, as we transition to a separate portal that will govern the way that the model is working and our communication with you folks.

8. **Does the person filling out the application, medical officer, and organization, contact the person who writes the letter of support, do they all have to be the same person?**
   No, they do not have to be the same person.

9. **In question 28, what are the groups of specialists you are referring to?**
   Back to the specialist question. We're not prescribing who the specialists would be in this instance. We're talking about the specialists that the practice would work with for the collaborative care agreement. That's up to the practice to manage. We don't dictate that.

10. **Practices apply by location, not TIN and allocations, is that correct?**
    That is correct.

11. **What happens if a CTO withdraws in a year two, if the practices do not have a second choice in their geography? Any idea if there are state-wide ACO applicants?**
    That has yet to be determined, it might be a possibility. I think we can, we will see what applicants we get that are CTOs, and we'll kind of flesh that out later with practices.

12. **Does the practice application need to be completed annually after the initial application is submitted, or is it auto renewed in the program?**
    No. You don't have to update the application annually, but you will need to go into the provider portal and make sure that you're participating providers are still accurate. You'll need to check that information, but you do not need to reapply annually. I wouldn't consider it auto renewal, but you don't need to reapply annually.

13. **Please define the phrase "public health org" which is in question number 33.**
    Public health organizations are things like our local health departments or other organizations in the community that provide public health services.

14. **Will there be an opportunity to provide attachments in the application?**
    There is the opportunity to provide the letters of support as attachments in the application itself, but those are the only locations for additional attachments.

15. **Regarding question 21 in the application, what is meant by the number of staff for billing and accounting support, available for the practice?**
    We wanted to account for all available staff and usable at the practice. We tried to make the categories as open ended as possible. Fill it out to the best of your ability. A particular category of accounting and billing would be any administration in your front office that you see doing those types of activities.

16. **In question 28, can you please give an example of a group of specialists?**
    This could be a myriad group of specialists. An example could be cardiology, rheumatology, and oncology.

17. **Could you give a few examples of community public health organizations that would meet the requirements?**
    Area aging agencies, department of human services, social services. Those things, those agencies, that provide community public health support.

18. **When filling out staffing, some staff serve two roles, such as IT and practice workflow/transformation support. Is it OK to be duplicative of counting of staff in our responses?**
    My recommendation is, just to estimate to the best of your ability. If you've got someone who's filling in as .5 of an FTE, try to be additive there in that category, and non-duplicative for staff across the board, so we can get a better sense of actual representation of staff available at the location.

19. **Is it true that the person filling out the application, medical officer, organization contact, and the person who writes the letter of support, can be but do not have to be the same person?**
    They absolutely can be the same person, and do not have to be the same person. There is an instance where one of the names will carry over, if it is the person filing the application is the same, but in most instances, you'll have to rewrite information into the application itself. But they can certainly be the same or a different individual.

20. **If the CTO government's requirements will not be released until Fall, along with other requirements, how do you know whether to apply?**
    The government's requirements will very closely mirror the government's requirements for ACOs. And less or significantly all of that, I think it would be reasonable to consider applying. Again, application process is entirely voluntary. But, the best kinds we can give at this point is that it will closely mirror the ACO governing structure. And we'd like to remind folks that the application is non-binding. It would be the participation agreement that would bind the CTOs with CMMI.

21. **At what point do practices select their quality measures?**
    Practices will select those, the quality measures, during the first performance year. There will be more information regarding that process in the *Getting Started with MDPCP* guide.

22. **If a hospital system comprised of more than 50 providers is applying to be a CTO, and its employed practices applied to participate, do the physicians participating qualify as participating in an AAPM?**
    We are unable to provide specific guidance at this time. We have to continue to refer to the QPP website, because these determinations will not be made until later on in the process.

23. **Will CMS place a list of eligible clinicians? Based on internal information, we have some OB/GYN clinicians that would meet the minimum Medicare-beneficiary requirement. We want to confirm with CMS.**
    The minimum Medicare beneficiary requirement is across the practices. If there are OB/GYN clinicians you think would meet that requirement, then yes. It's just important to remember that it's across the practice.

24. **How much guidance is an ACO allowed to provide member practices during the application process? What if that ACO plans to apply as a CTO? Any legal concerns?**
    We would just suggest that folks consult their lawyers regarding those type of issues. We're not comfortable with giving legal advice around that.

25. **Do patients being cared for by Maryland PCP, that live outside Maryland, be counted as part of the attribution?**
    Yes

26. **Is there a specific requirement for the clinical leadership for the CTO application, specifically, can it be a clinical manager within the market? Or should it be from a medical director, or clinical leadership, in the overall parent company?**
    We do not specify a requirement.

27. **For question 23 in the application regarding the health IT tools, are you looking for EHR products only, or other IT tools? If other, can you give some examples of other health IT tools that should be listed?**
    Some of the other health IT tools might be care-management software, predictive modeling, risk stratification tools, or other similar tools that are useful for practices and care transformation organizations to provide better care. There are multiple rows in the application so you can put in as many tools as you see fit.

28. **Re: question 12, regarding assuming risk. Will CTOs need to demonstrate a repayment mechanism to legally assume risk?**
    (Model Team to provide a response.)

Payment

29. **Can a CTO offer both payment options to each practice? Specifically, over 70/30, or does the CTO need to choose one or the other to offer to every practice?**
    It's important to note here that the practice decides what payment option to offer, depending on if they have a lead care manager currently employed in the practice or feel they need another lead care manager, or they do not have a lead care manager. Things like that will need to be considered. The CTO does not dictate the payment options.

30. **At what point do practices select the CMF CTO option, option 1 or option 2, given their track?**
    We are still trying to build that system to collect that information, but we will be collecting that prior to the launch of the program.

31. **For track 2 practices, how does the AAPM bonus option work with the reduced fee schedule and partial capitation?**
    We're going to have to continue to defer all questions around AAPM until later in 2018. But we sincerely hope that we will have a determination on this prior to the model launch in 2019.

32. **Clinicians are defined by CMS, but what if a PA is a navigator and not a billable PA? Does the PA count as part of the 50, or less?**

I apologize for all questions around advanced APM. Those are not determinations that are made by the model team. We have to work with our colleagues at CMS. I'm not going to be able to provide specific information around advanced APM status or payments now. We're going to make that information available as soon as possible.

33. **Are non-billing clinicals still part of the 50-limit group to be eligible for MACRA?**
    We would like to refer you a website as we're waiting on determination for specifically, the Maryland Primary Care Program. Please go to qpp.cms.gov., for more information about the quality payment program.

34. **How do beneficiaries get notified of their right to not share data?**
    Once practices and features are selected, we'll be sending out a welcome package of information. There'll be information in there on how to opt out of your data, but it will be similar to ACO opt out for data sharing.

35. **Can CMS be used to purchase an enhanced EMR system, to better capture line and report quality data?**
    No. The CMS cannot be used for that purpose.

36. **Are fraud and abuse waivers expected to be made available under the MDPCP, similar to those available in the ACO models?**
    No, there are no fraud and abuse waivers, they are not available.

37. **Does the 50% spend requirement of a CTO of the CMF apply to the situation when a practice supplies their own care manager, i.e., the CMS is split between the CTO and care manager 70/30?**
    That applies regardless of the payment option that's chosen by the practice.

38. **Are behavioral health services required to be integrated as part of a practice site and to be available to needed beneficiaries?**
    We are receiving a lot questions around the behavioral health per-location tele-health piece, and we hope to put out some guidance very soon around this. We will likely follow very similarly to how ACOs provide these services, but we will be providing some guidance around this in the coming months.

39. **Does a participating practice or applicant TIN have to have billing history with Medicare in the past, or can it be new?**
    Yes, it has to have a billing history agreed with Medicare in the past. For CTOs they can be new, but for a participating, they must have a history, a Medicare claims history.

40. **Is the claims history similar to MSSP ACOs?**
    We can't speak to the MSSP ACOs, but it would be any Medicare claims history.

Lead Care Manager

41. **How firm is the 1 to 1,000 lead care manager-to-beneficiary noted in the RFA?**
    That is a good guidance. It obviously can't be down to the single digit relevance, because that would

not be practical. It's a good general guidance to be about one per thousand fee-for-service beneficiaries.

42. **From a lender angle, if the practice does not have an embedded care manager, the CTO will receive the 30% cut of track 1 or track 2. Does the ratio care managers to Medicare need changed, or can the CTO count the CM at the practice as meeting that guideline?**
That ratio applies regardless of where the care manager is coming from, whether it's coming through the practice, or it's supplied by the CTO. We still see that 1 to 1,000 ratio as a standard or a best practice.

43. **Re: CMF funds supporting that ratio, and under track 2, option 1, does the practice or the CTO employ the behavioral health specialist?**
On the first part about the business model for the lead care manager, [the 1 to 1,000 ratio] is the general requirement. We can't really speak to your ability to make CMS funds support that ratio. We're happy to talk about that maybe by submitting a question through our mailbox, we can have some more discussion around that. Can't really say too much more about that, but I will say that under track 2, option 1, your question about the practice or the CTO employing the behavioral health specialist, we don't specify what that looks like. That's really up to the practice and/or the CTO to design those roles.

    Just to expand on the answer on the behavioral health per location, we're very certain that there are two methodologies that are highly acceptable, and that is to have a behavioral health-trained individual practitioner within the office practice setting who provides behavioral health services. That could be a primary care provider whose received special training in behavioral health and takes care of those needs. Or, per location, of a specific behavioral health provider. It could be a psychiatrist, a psychologist, a clinically licensed clinical social worker, or other who provides those services. There are open questions in regard to tele-health serving as the ability to be co-located. And this is something that will require some further discernment to get a clarification. That will be presented as soon as it's available.

Driver Diagram/Change Package

44. **Will additional information be available regarding where the lines of responsibility are drawn between CTOs and practices? If the CTO is being asked to perform a lot of the activities, how will the practice transform? We've seen practices with various levels of engagement and ability. How can we ensure this results in practice transformation?**
The roles of the CTOs are to assist the practices in transformation. Not that they do transformation or that they are responsible for providing those services. The entire goal is for the practices to be able to perform those services with the assistance and the encouragement of the CTOs. And they will provide staff to assist the practices where they need to have additional staffing to perform those services. But it's never the intention that the CTO performs those services.
In the provider portal, practices and features will be asked to report on their progress in meeting the care transformation requirements. And CTOs will also be reporting on assisting practices in the end of care transformation requirements, that is part of the way that we'll determine how practice transformation is progressing in practices and CTOs.

45. **Can you please give a specific example of enacting collaborative care agreements with public health organizations in track 2?**
    There's no requirement, or there will be no requirement for an actual contractual collaboration. There's a strong encouragement for practices to reach out and collaborate with community resources, such as public health services and others in the community, to help assist the patients with their non-medical or social determinants of health, which we feel are very important to them.

46. **Can the CTO use the CMS to provide technical support to practices who need assistance with optimizing clinical quality data collection, building out templates to capture the data, and resulting in accurate data reporting?**
    If it's related to meeting the care transformation requirements, we see this as an appropriate use of CMS.

47. **Must the CTO accept all practices that list them within their capture area?**
    Yes, CTOs must accept all practices unless there is ability for CTOs to demonstrate or to pre-demonstrate that they only have a limited capacity.

48. **When can practices change their CTOs?**
    They may be able to do that on an annual basis.

49. **If practices can change CTOs yearly, what is the deadline for them to apply for that change and give advance warning for the CTOs to plan? Specifically, in ACOs. Practices who want to term have to do it by September for the end of that year.**
    We have not specified that yet. I think that we would probably follow something very similar. But yes, practices can change CTOs annually, and there will be more information regarding that in the *Getting Started with MDPCP* guide.

50. **Do CTOs receive CCLF files or reports via CRISP that are adequate for participation required activities?**
    The CTOs will participate in the program via the portal that we have set up, which claims data and what files are moving in which systems are still being determined. There will be multiple places where CTOs will have access to certain types of data to work with their practices.