Maryland Primary Care Program Care Transformation Organization Application

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The Maryland Primary Care Program (MDPCP) is accepting applications from individual Care Transformation Organizations (CTOs). CMS will accept applications from the CTO itself (a separate legal entity) or the healthcare organization that owns and operates an existing CTO or a CTO that will exist by January 1, 2021.

Applicants should review the MDPCP Request for Application (RFA) to learn about the design and specific requirements of the program.

CTOs are a new concept unique to the Maryland Primary Care Program. CTOs may draw resources from or be created by existing organizations such as Accountable Care Organizations (ACOs), Clinically Integrated Networks (CINs), health plans, etc. The questions below relate to the CTO's ability to support participating practices within the program. Participating practices have the opportunity to select among the approved CTOs or to function without the support of a CTO. It is assumed the participating practices will select CTOs that best meet their needs for support.

If your organization will be creating a CTO specifically for the purposes of this program, please answer the application questions to the best of your ability based on your existing organizational structure.

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at **https://www.cms.gov/AboutWebsite/02_Privacy-Policy.asp**.

Start a New Application:

Please enter your Organization TIN

Is this TIN used to bill Medicare? (Yes/No)

If No is selected:

Please enter the TIN used to bill Medicare.

Please specify whether this TIN is an Employer Identification Number (EIN) or Social Security Number (SSN).

- **Employer Identification Number (EIN)**
- **Social Security Number (SSN)**

If <mark>Yes</mark> is selected:

Please specify whether this TIN is an Employer Identification Number (EIN) or Social Security Number (SSN).

- **Employer Identification Number (EIN)**
- **Social Security Number (SSN)**

Preliminary Questions

This section focuses on background information about your organization. Information in this section will be used to determine whether your organization meets the eligibility criteria for participation in MDPCP.

Where applicable, please answer these questions for the organization that is applying to participate in MDPCP (rather than the organization that owns and operates the CTO).

1. To the best of your knowledge, has anyone employed in your organization had a final adverse legal action (in Section 3 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative. (Yes/No)

If <mark>Yes</mark> is selected:
Please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any. (Up to 2000 characters)

General Questions

The following section asks questions regarding the organizational structure and ownership of your organization. If you have a question about organization structure that is not addressed in the Request for Application (RFA) or in the Application Instructions, please contact CMS at MarylandModel@cms.hhs.gov.

1. Please provide a one-page summary describing your vision of how the CTO will assist practices in delivery of care transformation under this program: (Up to ==4000== characters)
2. Please indicate the status of the proposed CTO on which you have based your responses in this application:
    *   The proposed CTO is currently in existence.
    *   The proposed CTO is owned and operated by a healthcare organization and is currently in existence.
    *   The proposed CTO will be owned and operated by a healthcare organization and does not yet exist.
3. Is your organization part of an ACO that is in or planning to apply to participate in a Medicare shared savings initiative as of January 1, 2021?
    *   Yes, my organization is part of an ACO that is participating in a Medicare shared savings model currently and will continue participation in 2021.
    *   Yes, my organization is part of an ACO that is currently applying to participate in MSSP starting January 1, 2021.
    *   No

If "==Yes==" is selected from Question 4:

i.   ACO Name
ii.   Tax Identification Number (TIN)
iii.   Track level
iv.   Initiative
        a. Next Gen
        b. MSSP
4. Organization Identification:
    Note: The 'Organization Site' name is your entity's legal name. If you use a different name for doing business, please enter it as your 'DBA' name.
    *   TIN Number
    *   i. Organization Site Legal Name
    *   ii. Organization Site Name "doing business as" if different than the Legal Name
    *   ii. Street Address 1
    *   iv. Street Address 2
    *   v. City
    *   vi. State
    *   vii. Zip Code
    *   viii. Organization Site Phone Number
    *   ix. Organization Site Fax Number
    *   x. Website (if applicable)

4b. Is the Organization billing address the same as above address? (Yes/No)
If No is selected:

- i. Organization Site Legal Name
- ii. Organization Site Name "doing business as" if different than the Legal Name
- ii. Street Address 1
- iv. Street Address 2
- v. City
- vi. State
- vii. Zip Code
- viii. Organization Site Phone Number
- ix. Organization Site Fax Number
- x. Website (if applicable)
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5. Is your organization owned by another health care organization, such as a physician group organization, hospital or health system? (Yes/No)
   - a. What is the name of the organization?
   - b. Corporate Street Address 1
   - c. Corporate Street Address 2
   - d. Corporate County
   - e. Corporate State
   - f. Zip Code
   - g. Corporate Phone Number
   - h. How many other primary care organization sites are part of this organization?
   - i. How many physicians and nurse practitioners are part of this organization?
   - j. Are practices affiliated with this organization applying to participate in MDPCP?
     - Yes
     - No
     - Unknown
   - k. Does your organization share a TIN for billing with other organizations that are part of the same health group or system?

6. Describe the current legal structure of your organization.
   - For profit corporation
   - Non-profit 501(c)(3)

7. Is your proposed CTO organization legally permitted to assume financial risk? (Yes/No)

8. An organization selected as a CTO shall create a governing board to oversee its CTO activities. The governing board shall include primary care practitioners, specialists, and patient representatives to ensure recognition of diverse interests and perspectives in CTO functions.

- Does your organization currently have or agree to create a governing board for the proposed CTO organization that includes health care providers and patient representatives?
  - Yes
  - No
9. Please provide your Organizational NPI (Do not provide an NPI for an individual provider).
10. Please provide your Organizational CCN.

Contacts

- Applicant Contacts
- Organization Contact
- Designated Contact

Patients, Payers, and Service Area

This section asks questions about the demographic makeup of your patient population. Please answer these questions to the best of your ability.

1. Select your preferred service area(s):
   a. Statewide
   b. Allegany County
   c. Anne Arundel County
   d. Baltimore County
   e. Baltimore City
   f. Calvert County
   g. Caroline County
   h. Carroll County
   i. Cecil County
   j. Charles County
   k. Dorchester County
   l. Frederick County
   m. Garrett County
   n. Harford County
   o. Howard County
   p. Kent County
   q. Montgomery County
   r. Prince George's County
   s. Queen Anne's County
   t. Saint Mary's County
   u. Somerset County
   v. Talbot County
   w. Washington County
   x. Wicomico County

            y. Worcester County
2. What is the maximum number of practices you would be willing to work with?
3. Is your organization formally partnered with other health improvement organizations and community groups, including Local Health Departments, Local Health Improvement Coalitions, Health Enterprise Zones, Regional Partnerships, and similar community collaborations:
   a. Formally
   b. Informally
   c. No

When Formally/Informally option is selected:

List

Health Information Technology

1. Please provide the following information for the primary certified EHR system used by your organization and any additional health IT tools that your organization uses (e.g., care management system), if applicable:
   o Add Vendor
2. Please indicate your current level of interaction with CRISP (Check all answers that apply)
   - We currently educate and support practices on the use of services from the State-Designated Health Information Exchange (CRISP).
   - We assist practices in establishing electronic health information exchange with CRISP or a community-based health information exchange network.
   - We use CRISP to view data.
   - We send clinical data (CCDAs or QRDAs) to CRISP on a regular basis.

Care Delivery

The following questions gather information about the ability of your proposed CTO organization to support the requirements of primary care practices under the program. For each question indicate if the answer is based on the current or planned future activities of your proposed CTO organization.

1. Please lay out your approach to care delivery transformation that will exist for the applicant CTO. (Up to 2000 characters)

Care Teams and Care Management

2. Please indicate if you employ (or if a new organization intends to employ) the following care team members and how many of each category.
   - Add Care Team Member
3. Do you have the ability to characterize needs of sub-populations for high-risk patients, identify a practice's capability to meet those needs, and ensure needs are longitudinally met? Currently in place
   a. Planned for future
   b. Not a current or planned activity or service

4. Would you be able to assist a practice to implement self-management support for at least three high-risk conditions?
     a. Currently in place
     b. Planned for future
     c. Not a current or planned activity or service

Data and Quality Measurement

5. Does your organization collect, report, and interpret quality metrics for practices?
     a. Currently in place
     b. Planned for future
     c. Not a current or planned activity or service

Please describe the methodology:

6. Does your organization have the technical infrastructure in place to share data from CMS and participating practices with organizations, CRISP, and other entities on cost, utilization, and quality at regular intervals (e.g., quarterly)?
     a. Currently in place
     b. Planned for future
     c. Not a current or planned activity or service
7. Does your organization use a standard method or tool(s) to stratify patients by risk level?
     a. Currently in place
     b. Planned for future
     c. Not a current or planned activity or service
8. Would you be able to implement a risk-stratification process?
     a. Currently in place
     b. Planned for future
     c. Not a current or planned activity or service

Utilization and Resources

9. Would you be able to assist practices to implement or facilitate collaborative care agreements with at least two groups of specialists?
     a. Currently in place
     b. Planned for future
     c. Not a current or planned activity or service
10. Would you be able to assist practices to convene or facilitate a patient-family advisory council (PFAC) at least twice annually and assist practices to integrate recommendations into care delivery, as appropriate?
     a. Currently in place
     b. Planned for future
     c. Not a current or planned activity or service

11. Do you have the ability to assist practices to integrate behavioral health into care based on one of the options below?

Option 1: Care Management for individuals with the identified behavioral health condition should be offered proactive, relationship-based care management (CM), with specific attention to care management of the behavioral health condition (e.g., Major Depressive Disorder/Dysthymia, Generalized Anxiety Disorder, and Panic Disorder). Practices that develop their capabilities to deliver behavioral health care management will:

- Select behavioral health condition(s) to prioritize and methods to identify patients to target for care management. Targeted patients should be higher severity or more complex (e.g., MDD and DM2 with poor glycemic control).
- Identify or develop stepped care, evidence-based, treatment algorithms for behavioral health condition(s) identified for care management, incorporating principles of shared decision making and self-management support.
- Develop a workflow for screening, enrollment in integrated care services, tracking, and communicating with patients.
- Identify a clinician or team member (e.g., RN or BH specialist) who will provide care management and ensure training to support stepped care approach.

Option 2: Primary Care Behaviorist Program (PC Behaviorist)

The PC Behaviorist program integrates BH into the PC workflow through warm handoffs to a co-located BH professional to address behavioral health in the primary care setting and behavioral strategies for management of chronic general medical illnesses, and facilitate specialty care engagement for serious mental illness. Practices that develop their capabilities to deliver the primary care behaviorist program will:

- Select behavioral health condition(s) to prioritize and method to identify patients to target for referral to the primary care behaviorist. Targeted patients should be higher severity or more complex (e.g., MDD and DM2 with poor glycemic control).
- Identify a credentialed BH provider (e.g., psychologist, social worker) trained in the primary behaviorist program of co-located care.
- Identify space in the primary care practice for the BH provider; test and implement a method for engaging BH services.
- Develop a workflow to integrate referrals (warm hand-offs) to the BH specialist.

Options:

- o Yes
- o No

12. Would you be able to assist practices to implement or facilitate collaborative care agreements on behalf of practices with at least two public health organizations based on patient's psychosocial needs, as appropriate?

- o Currently in place
- o Planned for future
- o Not a current or planned activity or service

13. Would you be able to support practices to link patients to supportive community-based resources through active coordination between the health system, community service agencies, and patients and accomplished by a designated staff person?

- o Currently in place
- o Planned for future
- o Not a current or planned activity or service

Access

14. Would you be able to support practices to regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the population, such as telemedicine, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers), and/or expanded hours in early mornings, evenings, and weekends?
   - o Tele-diagnosis
     - Currently in place
     - Planned for future
     - Not a current or planned activity or service
   - o Tele-behavioral health
     - Currently in place
     - Planned for future
     - Not a current or planned activity or service
   - o Tele-consultation
     - Currently in place
     - Planned for future
     - Not a current or planned activity or service
   - o Remote Monitoring
     - Currently in place
     - Planned for future
     - Not a current or planned activity or service
   - o Other (specify)

Letter of Support
Organizations will need to submit several letters of support with their application:
 1. Letter of support from clinical leadership:
Skilled leaders with high levels of emotional engagement and intellectual commitment are essential for successful cultural changes that drive improvements toward better care,

smarter spending, and healthier people. In addition to answering all questions in the application and providing any required supporting documentation, all organizations applying to participate in MDPCP must attach a letter of support from at least one physician leader in the organization.

This letter shall describe how the organization and its care team intends to engage with the practice to provide ongoing leadership in support of MDPCP. The letter shall also define the planned time commitment and briefly describe ongoing strategies to share and address results, challenges, progress, and successes with organization staff and the patient community. This letter shall be no more than one page.
- Upload Letter of Support

2. Letter of support from a practice:
   This letter can be from any practice with whom the CTO has a relationship. In addition to answering all questions in the application and providing any required supporting documentation, all organizations applying to participate in MDPCP must attach a letter of support from at least one practice (can upload up to two).

   This letter shall describe how the practice views the engagement of the CTO that will support the MDPCP. The letter can discuss how well, and in what capacity, the applicant organization has worked with the practice previously. This letter shall be no more than one page.
   - Upload Letter of Support

Certify and Submit

Below is a checklist detailing the documents that your organization is required to submit for consideration in MDPCP. It is the responsibility of the applicant to ensure that all documents required are included with the application. All documents must be signed, scanned, and uploaded to the application portal. Please retain the original, signed letters. If you have any questions about what your organization is required to submit, please contact CMS at MarylandModel@cms.hhs.gov.

- Completed Application
- Letter of support from your practice's clinical leader
- Letter of support from parent or owner of organization (if applicable)
- Letter executed by both the practice and CRISP certifying the applicant's connectivity to CRISP and/or the commitment to achieving connectivity and use of CRISP services.
- I have read the contents of this application and I certify that I am legally authorized to bind the practice. Upon submission of this application I certify to the best of my knowledge that all of the submitted information is true, accurate, and complete. If I become aware that any submitted information is not true, accurate, and complete, I will correct such information promptly. I

understand that the knowing omission, misrepresentation, or falsification of any submitted information may be punished by criminal, civil, or administrative penalties, including fines, civil damages, and/or imprisonment.