

MARYLAND TOTAL COST OF CARE MODEL MARYLAND PRIMARY CARE PROGRAM SOLICITATION FOR PAYER PARTNERS

September 16, 2019

MDPCP Multi-Payer Alignment

In an effort to improve population health and reduce overall health care costs, the Centers for Medicare & Medicaid Services (“**CMS**”) is soliciting proposals from Third-Party Payers that outline a framework indicating the steps the Third-Party Payer is taking and/or will take to support the provision of advanced primary care in Maryland that aligns with CMS’ efforts in the Maryland Primary Care Program (“**MDPCP**”).

The MDPCP is an initiative under the Maryland Total Cost of Care Model (the “**Model**”) that is designed to provide patient-centered care for Medicare fee-for-service (“**FFS**”) beneficiaries who reside in Maryland aimed at reducing costs and improving the quality of care in a manner that is aligned with the goals of the Model. MDPCP is a multi-payer initiative and includes an arm for Medicare FFS beneficiaries (“**MDPCP-FFS**”), as well as an arm for patients who are the Members of other Third-Party Payers (“**MDPCP-OP**”). Through MDPCP-OP, selected Third-Party Payers have the opportunity to further the goals of the initiative for their own Members who are cared for by MDPCP Practices. Broadly, the MDPCP aims to achieve better care, smarter spending, and healthier people.

This Solicitation for Payer Partners requests that Third-Party Payers detail their proposed plan to align with CMS’s efforts in supporting MDPCP Practices participating in both Tracks of MDPCP, beginning in January 2020. Additional information about the care redesign expectations and MDPCP-FFS payments for MDPCP practices participating in Track 2 may be found in the most recent MDPCP Request For Applications on the Innovation Center website [here](#).

Once selected by CMS, CMS plans to enter into a Memorandum of Understanding (“**MOU**”) with each Third-Party Payer operating in Maryland that is interested in supporting comprehensive primary care advancement within MDPCP Practices. The MOU will outline the commitments of those Third-Party Payers who sign an MOU with CMS (“**Payer Partners**”). The Payer Partner may apply these commitments to as many Lines of Business that the Payer Partner offers in Maryland as possible. Under the terms of the MOU, Payer Partners commit to entering into arrangements with MDPCP Practices participating in both tracks of the MDPCP until the end of the MDPCP (December 31, 2026).

CMS will not provide any funding to Payer Partners under the MOU.

MDPCP Payer Partner Alignment

CMS will review and assess Third-Party Payer proposals based on the completeness of the proposals (the required contents for such proposals are detailed in *Appendix A: Required Elements of MDPCP Payer Partner Proposal*) and the extent of their proposal’s alignment with CMS’ approach to the following principles: financial incentives, care management, quality

measures, data sharing and practice learning (these principles are outlined in more detail in *Table 1: Third-Payer Payer Alignment Framework*, below).

The Third-Party Payer’s proposed approach to these principles does not need to be identical with CMS’s MDPCP-FFS approach to these principles, which are outlined in the most recent MDPCP Request for Applications available on the CMS website, but should be oriented so that the incentives and goals align with those of the MDPCP-FFS. Third-Party Payers should be specific and detailed in their proposals, including by providing projected timelines and processes for alignment with these principles if such alignment does not exist at the time the Third-Party Payer submits its proposal. Additionally, Third-Party Payer proposals should highlight any features of the proposal that vary by Line of Business.

Table 1: Third-Party Payer Alignment Framework

<p>Financial Incentives</p>	<ul style="list-style-type: none"> • Provide enhanced claims or non-claims-based payments, similar to the Care Management Fee (“CMF”) in MDPCP-FFS as referenced in the most recent MDPCP Request for Applications available on the CMS website, to support Payer Partner Practices in providing care not traditionally covered as billable office-based services, such as non-visit-based care or enhanced behavioral health services. • Provide an at-risk performance-based incentive payment, similar to the Performance Based Incentive Payment (“PBIP”) in MDPCP-FFS as referenced in the most recent MDPCP Request for Applications available on the CMS website, that encourages accountability of Payer Partner Practices based on the Payer Partner Practices’ performance on certain quality and utilization metrics as defined in this Table below in the row entitled <i>Quality Measures</i>. • Provide a partially capitated payment, similar to the Comprehensive Primary Care Payment (“CPCP”) in MDPCP-FFS as referenced in the most recent MDPCP Request for Applications available on the CMS website, to Payer Partner Practices participating in Track 2 of MDPCP-FFS to create a more predictable revenue stream and reduce dependence of its Payer Partner Practices on visit-based care for revenue.
<p>Care Management</p>	<ul style="list-style-type: none"> • Incentivize Payer Partner Practices to target high-risk, high-need Members to ensure these Members receive longitudinal care management to reduce potentially avoidable utilization.
<p>Quality Measures</p>	<ul style="list-style-type: none"> • Require Payer Partner Practices to report certain quality measures to the Third-Party Payer that are the same or similar to the electronic clinical quality measures (“eCQMs”) that CMS requires MDPCP Practices to report to CMS under the MDPCP-FFS (see Table entitled MDPCP Tentative Electronic Clinical Quality Measure (eCQM) Set for Performance Year 2020 in <i>Appendix A: Required Elements of MDPCP Payer</i>

Partner Proposal below).

Data Sharing	<ul style="list-style-type: none">• Share with CMS and CMS’ contractors practice and de-identified patient cost and utilization data on Members attributed to (or seen by) the Payers’ Partner Practices for monitoring and evaluation purposes, as required under 42 C.F.R. 403.1110.• Offer Payer Partner Practices the opportunity to request Member-level cost and utilization data to facilitate care management and follow-up for chronic and acute conditions in accordance with applicable law (including but not limited to the HIPAA Privacy Rule requirements in 45 CFR Part 162 and subparts A and E of Part 164).
Practice Learning	<ul style="list-style-type: none">• Participate in CMS’ Learning Network and/or provide learning resources to support its Payer Partner Practices in performing the Comprehensive Primary Care Functions of Advanced Primary Care.

MDPCP Payer Solicitation Process

To be selected to sign an MOU with CMS, Third-Party Payers must submit their proposals before midnight on **November 1, 2019**. Third-Party Payers operating in Maryland may submit proposals to CMS in either word document or PDF format with responses to the elements detailed in *Appendix A: Required Elements of MDPCP Payer Partner Proposal* to the MarylandModel@cms.hhs.gov mailbox. Please use “Payer Solicitation” in the subject line.

Respondents to this solicitation may be commercial insurers (including plans offered via Maryland or federally facilitated Health Insurance Marketplaces), Medicare Advantage plans, Maryland Medicaid and CHIP programs, Maryland employees program, or other insurance purchasing, Medicaid/CHIP managed care plans, Maryland or federal high risk pools, self-insured businesses or administrators of a self-insured group (third party administrator (TPA)/administrative service only (ASO)). CMS will not disclose the contents of a Third-Party Payer’s proposal, unless required to do so by law.

A Third-Party Payer’s proposal is not binding.

A Third-Party Payer’s proposal will be assessed by CMS staff based on the extent to which it meets the Third-Party Payer Alignment Framework as outlined in *Table 1: MDPCP Payer Partner Alignment Framework*, the completeness of the proposal’s responses to questions in *Appendix A. Required Elements of the MDPCP Payer Proposal*, and the degree to which the Third-Party Payer’s proposed activities align with the MDPCP-FFS.

A Third-Party Payer’s proposal must be sufficiently detailed for CMS to assess and understand the Third-Party Payer’s proposed plan to align its programs with MDPCP-FFS. If CMS approves a Third-Party Payer’s proposal, the Third-Party Payer may then sign an MOU with CMS to memorialize each party’s respective commitments to the goals of the MDPCP.

CMS reserves the right to reject a Third-Party Payer's proposal. Without limitation, CMS may reject a Third-Party Payer's proposal that: (1) does not provide sufficient information to be reasonably assessed against the selection criteria described in this solicitation; and/or, (2) is inconsistent with the objectives of the MDPCP. CMS may contact a Third-Party Payer following its proposal submission before midnight on November 30, 2019, to request that the Third-Party Payer clarify or modify its proposals as part of CMS' review.

Commitment to Ensuring Competitive Markets

Competition in the marketplace promotes quality of care for Medicare beneficiaries and protects access to a variety of practitioners. Thus, all conversations among payers and primary care practices must comply with antitrust law. Nothing in this solicitation shall be deemed to suspend any applicable antitrust laws or regulations, all of which still apply. In the MDPCP, CMS aims to maintain a competitive environment while providing an opportunity for alignment between MDPCP-FFS and Third-Party Payers.

Additional Information

For questions about the MDPCP or the solicitation process email the MDPCP Help Desk at marylandmodel@cms.hhs.gov. Please use "Payer Solicitation" in the subject line.

Appendix A. Required Elements of MDPCP Payer Partner Proposal

Please complete the questions below and submit a word document or PDF to the MDPCP Team at marylandmodel@cms.hhs.gov before midnight on November 1, 2019. For questions about the MDPCP or the solicitation process email the MDPCP Help Desk at marylandmodel@cms.hhs.gov. Please use “Payer Solicitation” in the subject line. For more information about MDPCP, please refer to the MDPCP Request for Applications located [here](#).

Please highlight any features of the proposal that vary by Line of Business throughout the proposal.

Description of Payer

*Required Fields

- * Legal Entity Name
- * DBA Name
- * Corporate Address, City, State
- Website

Indicate in the below fields the points of contact for the MDPCP solicitation process (“Solicitation POC”) and for communicating with CMS after payer selection (“Payer POC”), respectively. Please indicate if the Solicitation POC and the Payer POC are the same.

- * Solicitation Point of Contact (POC) Name
- * Solicitation POC Title
- * Solicitation POC Street Address
- * Solicitation POC City
- * Solicitation POC State
- * Solicitation POC Phone
- * Solicitation POC Email
- Solicitation POC Fax

- * Payer POC Name
- * Payer POC Title
- * Payer POC Street Address
- * Payer POC City
- * Payer POC State
- * Payer POC Phone
- * Payer POC Email
- Payer POC Fax

Summary of Intent and Past Experience

1. *Please provide a summary of your intent to commit to aligning with the principles of MDPCP-FFS. Your summary should address why you would like to be a Payer Partner in MDPCP and how you intend to address the following commitments:

- Provide an enhanced claims or non-claims based payment, similar to the Care Management Fee (“**CMF**”) in MDPCP-FFS as referenced in the most recent MDPCP Request for Applications available on the CMS website, to support Payer Partner Practices in providing care not traditionally covered under billable office-based services, such as non-visit-based care or enhanced behavioral health services.
- Provide an at-risk performance-based incentive payment, similar to the Performance Based Incentive Payment (“**PBIP**”) in MDPCP-FFS as referenced in the most recent MDPCP Request for Applications available on the CMS website, that encourages accountability of Payer Partner Practices based on performance on certain quality and utilization metrics as defined in **Table 1: Third-Payer Payer Alignment Framework** row entitled “Quality Measures.”
- Provide a partially capitated payment, similar to the Comprehensive Primary Care Payment (“**CPCP**”) in MDPCP-FFS as referenced in the most recent MDPCP Request for Applications available on the CMS website, to Payer Partner Practices participating in Track 2 of MDPCP-FFS to create a more predictable revenue stream and reduce dependence of its Payer Partner Practices on visit-based care for revenue.
- Incentivize Payer Partner Practices to target high-risk, high-need Members and to ensure these Members receive longitudinal care management to reduce potentially avoidable utilization.
- Require Payer Partner Practices to report certain quality measures to the Third-Party Payer that are the same or similar to the eCQMs that CMS requires MDPCP Practices to report to CMS under the MDPCP-FFS (see Table entitled MDPCP Tentative Electronic Clinical Quality Measure (eCQM) Set for Performance Year 2020 in this *Appendix A: Required Elements of MDPCP Payer Partner Proposal* below).
- Share with CMS and CMS’ contractors practice and de-identified patient cost and utilization data on Members attributed to (or seen by) the Payer Partner Practices for monitoring and evaluation purposes, as required under 42 C.F.R. 403.1110.

- Offer Payer Partner Practices the opportunity to request Member-level cost and utilization data to facilitate care management and follow-up for chronic and acute conditions in accordance with applicable law (including but not limited to the HIPAA Privacy Rule requirements in 45 CFR Part 162 and subparts A and E of Part 164).
- Participate in CMS' Learning Network and/or provide learning resources to support Payer Partner Practices in performing the Comprehensive Primary Care Functions of Advanced Primary Care.

2. *Please briefly describe any primary care models you are currently implementing, and your involvement in any other local, state, or national initiatives to improve or transform primary care payment and care delivery. Include the framework/theory of action for each such model/initiative, a description of the financial arrangements, care management activities, data feedback to practices, and practice coaching/learning activities, and the number and percentage of Maryland primary care practices participating in the model/initiative and the total number of covered lives attributed to participating practices.

Lines of Business

3. *Please describe the Lines of Business you propose to be included in MDPCP-OP and total number of covered lives within each Line of Business. We will ask about your proposed payment model design for MDPCP-OP by Line of Business in the Payment Models section below.
4. *Please describe the Lines of Business you offer but are not proposing to include in MDPCP-OP and the total number of covered lives for each such Line of Business and explain why you are not proposing to include these Lines of Business in MDPCP-OP.

For Payers with Self-Insured Clients:

In order to support the enhanced delivery of primary care in Maryland, it is also important for self-insured Third-Party Payers to adopt the principles of comprehensive primary care.

5. *In addition to your fully insured business, do you currently provide administrative services only (ASO) arrangements to purchasers?
6. *What proportion of the Lines of Business this proposal proposes to include in MDPCP-OP are ASO arrangements?

Payment Models. Please describe separately for each Line of Business, if there are differences, including for ASO clients.

7. *Please describe support for care not typically billable during office-based visits.

Your answer should include the following information:

- The form of this support, for example, is it in the form of claims-based or non-claims-based payments?
- What type of care delivery is this payment intended to support (e.g., telehealth, enhanced behavioral health, care management)?
- Please identify the amount of claims-based or non-claims-based support or the methodology for arriving at the payment amount.
- Is your payment risk-stratified? If yes, provide minimum and maximum amounts or the methodology for arriving at the payment amount and how you arrived at the amount or the methodology for arriving at the payment amount.
- Include any calculation or cost build up you used to ensure that the proposed fee is adequate to support MDPCP Practices in each track of the MDPCP-FFS and for each Line of Business.

8. *Will you base your proposed performance-based incentive payments on any of the following metrics: Clinical quality, Utilization, Cost of care, Other. Please describe each of the metrics (as applicable).

9. *Please describe your proposed performance-based incentive arrangement and/or performance-based incentive payments.

Please include the following information in your answer, as applicable:

- Calculation of incentive
 - Cost of Care calculation and contribution to overall incentive amount
 - Quality of care calculation and contribution to overall incentive amount
 - Utilization Measure calculation and contribution to overall incentive amount
 - Aggregation Methodology, if any
 - Other
- Frequency and timing of incentive payment
- Expected incentive payment amount as a dollar amount or percentage of revenue

10. *Please describe your proposed alternative payment arrangement in lieu of a FFS payment for Partner Practices participating in Track 2 of MDPCP-FFS.

Your answer should include the following information:

- Are alternatives to fee-for-services payments currently in place for some or all of practices with whom you have a relationship?
 - What number of practices have these alternative payments in place?

- How is practice readiness to receive these payments determined?
- If alternative payments are currently in place, please describe the type of payment: partial capitation with or without downside risk, full capitation with or without downside risk, sub-capitation with or without downside risk, other. Include details on the amount of risk (if applicable) and the capitation amount (if not fully capitated).
- If alternative payments are not currently in place, please describe plans, including:
 - A detailed timeline by which alternative payments will be put into place. Provide milestones for ensuring progress towards meeting that timeline.
 - Describe the methods you use or are considering using for this payment (i.e., partial capitation with or without downside risk, full capitation with or without downside risk, sub-capitation with or without downside risk, other). Provide the rationale for this approach and the method for calculating the amount of the alternative payment.

Attribution and Data Sharing with Primary Care Practices

11. *Please describe your proposed approach to identify Members served by Partner Practices:

- Timing of Attribution (options: retrospective or prospective)
- Attribution Frequency (options: monthly, quarterly, annually, other)
- Attribution Approach/Algorithm

12. *Please describe your *current* strategy for sharing data with primary care practices in Maryland:

- The level of data shared (Select all that apply)
 - Member
 - Physician
 - Practice
 - Other
- Reporting frequency (Select one)
 - Monthly
 - Quarterly
 - Annually
 - Other
- Data on the following:
 - Cost data

- Utilization data
- Real-time hospital and ER data

14. *Please describe your *proposed* strategy for sharing data with Partner Practices, only in ways that it would differ from the current strategy, and please include the following information:

- The level of data shared (Select all that apply)
 - Member
 - Physician
 - Practice
 - Other
- Reporting frequency (Select one)
 - Monthly
 - Quarterly
 - Annually
 - Other
- Data on the following:
 - Cost data,
 - Utilization data
 - Real-time hospital and ER data

15. *Please describe your *current* approach to integrating data from a state-designated Health Information Exchange, such as the Chesapeake Regional Information System for our Patients (CRISP), into the payer data shared with primary care practices.

16. *Please describe your *proposed* approach, only in ways that it would differ from the current approach, to integrating data from a state-designated Health Information Exchange, such as the CRISP, into the payer data shared with Partner Practices.

17. *Please describe any *current* data analytics tools or platform which you provide for primary care practices to analyze and use the data that you provide.

18. *Please describe any *proposed* data analytics tools or platform, only in ways that it would differ from the current tools or platform, which you will provide for Partner Practices to analyze and use the data that you will provide.

Quality and Patient Experience Measures

19. *What types of quality measures do you currently collect from practices in your primary care model?
- Claims-based quality measures (such as Healthcare Effectiveness Data and Information Set (HEDIS®))¹

¹ HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- Clinical Quality Measures
 - Patient experience measures (such as Consumer Assessment of Healthcare Providers and Systems (CAHPS®))²
 - Patient reported outcomes measures
 - Structural quality measures
 - Quality measures unique to your organization
 - Other
20. *What types of quality measures do you plan to collect from practices in your primary care model, if different from current quality measures?
- Claims-based quality measures (such as HEDIS®)
 - Clinical Quality Measures
 - Patient experience measures (such as CAHPS®)
 - Patient reported outcomes measures
 - Structural quality measures
 - Quality measures unique to your organization
 - Other
21. *How are quality measures currently reported for practices in your primary care model?
- Self-report by practices
 - Abstracted directly from EHR
 - Other
22. *Please describe any quality measure alignment you have created with other payers.
23. *Please provide your list of current quality measures that are tied to payment for primary care practices.
24. *Please provide your list of proposed quality measures that are tied to payment for primary care practices.
25. *Please provide your list of current quality measures not tied to payment but reported by primary care practices for quality improvement.
26. *Please provide your list of proposed quality measures not tied to payment but reported by primary care practices for quality improvement.
27. *Please review the list of quality measures in the table entitled MDPCP Tentative Electronic Clinical Quality Measure (eCQM) Set for Performance Year 2020 below. Based on the list of measures in the table below, can the MDPCP-FFS measures replace

² CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

any of your existing quality measures? If not, which quality measures that you currently or propose to collect would be most analogous to the MDPCP quality measures listed below?

CMS ID#	Measure Title	Measure Type/ Data	Domain
CMS165v6	Controlling High Blood Pressure	Outcome/eCQM	Effective Clinical Care
CMS122v6	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	Outcome/eCQM	Effective Clinical Care
CMS137v6	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process/eCQM	Effective Clinical Care
CMS69v5	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process/eCQM	Effective Clinical Care

Measures in the MDPCP Tentative eCQM Set for Performance Year 2020 table above were captured from the reporting requirements identified in the most recent MDPCP Request for Applications available on the CMS website and may be subject to change.

Definitions

“Comprehensive Primary Care Functions of Advanced Primary Care” means the five functions that a MDPCP Practice must perform under the terms of the MDPCP Practice Participation Agreement with CMS to transform to beneficiary-centered and team-based primary care. The Comprehensive Primary Care Functions of Advanced Primary Care include: access and continuity; care management; comprehensiveness and coordination across the continuum of care; patient and caregiver experience; and planned care for health outcomes.

“Line of Business” means a health insurance product or plan offered by a Third-Party Payer.

“MDPCP Practice” means an entity that executed an MDPCP Practice Participation Agreement with CMS to participate in MDPCP.

“MDPCP Practice Participation Agreement” means the participation agreement between an MDPCP Practice and CMS pursuant to which the MDPCP Practice complies with the requirements of the MDPCP.

“Member” means an individual who holds a contract with a Third-Party Payer providing for enrollment of the individual in a health plan offered by that Third-Party Payer.

“Payer Partner” means a Third-Party Payer operating in the state of Maryland that has signed an MOU with CMS outlining each party’s respective commitments to the goals of the MDPCP.

“Payer Partner Practice” means an MDPCP Practice that has entered into a Payer Partnership with a Third-Party Payer.

“Payer Partnership” means an arrangement between an MDPCP Practice and a Payer Partner.

“Third-Party Payer” means an entity that provides, or pays the cost of, a health plan, to include the payer.