MDPCP

MARYLAND PRIMARY CARE PROGRAM

HEART Payment Playbook

January 2022

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About the HEART Payment Playbook

The guidance in the *HEART Payment Playbook* was developed in partnership by the Centers for Medicare & Medicaid Services (CMS) and the Maryland Primary Care Program Management Office at the State of Maryland. CMS and the State are jointly invested in the success of HEART payments to improve outcomes for high-risk, high-need beneficiaries.

The *HEART Payment Playbook* is intended to support your practice or Care Transformation Organization (CTO) in:

- Understanding Area Deprivation Index (ADI) and the Health Equity Advancement Resource and Transformation (HEART) payment
- Determining the most effective and appropriate use of HEART funds
- Understanding necessary tracking and reporting of HEART payment usage
- Providing answers to Frequently Asked Questions (FAQs)

Your practice or CTO should use this guide and work with your MDPCP Practice Coach as you determine the most effective use of your HEART payments.

Note that the potential uses of HEART payments in this guide are not fully inclusive of allowable expenditures and are meant to represent a general guide regarding how the funds may be used. CMS will not be able to weigh in on the allowability of specific payment uses for your practice or CTO. The guidance in this document supplements the HEART payment requirements specified in your CMS Participation Agreement. Use the guidance in this document, as well as your Participation Agreement, to determine allowable spending.

Glossary

ADI - Area Deprivation Index
CDC - Centers for Disease Control and Prevention
CMF - Care Management Fees
CMS - Centers for Medicare & Medicaid Services
CRISP - Chesapeake Regional Information System for our Patients
CTO - Care Transformation Organization
CTR - Care Transformation Requirement
EHR - Electronic Health Record
FAQs - Frequently Asked Questions
FFS - Fee for Service
FQHC - Federally Qualified Health Center
HCC - Hierarchical Condition Category
HEART Payment - Health Equity Advancement Resource and Transformation Payment
MDPCP - Maryland Primary Care Program
NIH - National Institutes of Health
PA - Participation Agreement
PBIP - Performance Based Incentive Payment
PBPM - Per Beneficiary Per Month
PFAC - Patient and Family Advisory Council
SDOH - Social Determinants of Health
SNAP - Supplemental Nutrition Assistance Program

Introduction – Why HEART Payments?

The HEART payment provides additional support to MDPCP participants serving socioeconomically disadvantaged populations and promotes the State's and CMS' goal to advance health equity.

Benefits to Patients and Communities

Beneficiaries with high clinical risk and high ADI scores have complex needs. A holistic approach and substantial investment of resources are often needed to improve clinical outcomes and sustain progress on beneficiaries' health goals. The goal of the HEART payment is to address the complex needs of these under-resourced Medicare beneficiaries, improving their social conditions in the short term and their clinical outcomes in the long term.

High ADI is Associated with High Cost and Worse Outcomes

Health outcomes and costs are often strongly driven by social and environmental factors, beyond just medical complexity. ADI is a measure of neighborhood socioeconomic disadvantage, which has been shown to be associated with high healthcare costs and worse outcomes. Studies have shown high ADI to be associated with:

- Worse diabetes control, blood pressure control, and cholesterol control[1] in Medicare Advantage beneficiaries
- Higher readmission rates in Maryland hospitals[2]
- Lower rates of recommended cancer screenings[3]

In a 2020 study of Maryland Medicare Fee-For-Service (FFS) beneficiaries specifically, beneficiaries with high ADI in combination with high Hierarchical Condition Category (HCC) risk scores were shown to have significantly greater healthcare costs.[4]

As such, investing in patients with high complexity and high ADI aims to improve health outcomes and lower costs in this targeted group of high-need individuals.

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[1] Durfey SNM, Kind AJH, Buckingham WR, DuGoff EH, Trivedi AN. Neighborhood disadvantage and chronic disease management. *Health Serv Res*. 2019;54 Suppl 1(Suppl 1):206-216. doi:10.1111/1475-6773.13092

[2] Jencks SF, Schuster A, Dougherty GB, Gerovich S, Brock JE, Kind AJH. Safety-Net Hospitals, Neighborhood Disadvantage, and Readmissions Under Maryland's All-Payer Program: An Observational Study. *Ann Intern Med*. 2019;171(2):91-98. doi:10.7326/M16-2671

[3] Kurani SS, McCoy RG, Lampman MA, et al. Association of Neighborhood Measures of Social Determinants of Health With Breast, Cervical, and Colorectal Cancer Screening Rates in the US Midwest. *JAMA Netw Open*. 2020;3(3):e200618. Published 2020 Mar 2. doi:10.1001/jamanetworkopen.2020.0618

[4] Sapra KJ, Yang W, Walczak NB, Cha SS. Identifying High-Cost Medicare Benificaries: Impact of Neighborhood Socioeconomic Disadvantage. *Pop Health Mgmt*. 2020;23(1):12-19. https://doi.org/10.1089/pop.2019.0016

Area Deprivation Index (ADI) Background

The ADI was defined by a National Institutes of Health (NIH) team and first published[5] in 2003, with the goal of quantifying and comparing social disadvantage across geographic neighborhoods. It is a composite measure, derived through a combination of 17 input variables from census data (see Table 1), which are now estimated annually at the "census block group" level through the US Census Bureau's American Community Survey. Census block groups typically contain 600 to 3,000 people.

Table 1. Components of ADI. A negative coefficient indicates the component correlates with lower ADI (i.e. greater "advantage" or lower "disadvantage").[6]

Census Block Group Component	Factor Score Coefficient
Percentage of population aged ≥25 y with <9 y of education	0.0849
Percentage of population aged ≥25 y with at least a high school diploma	−0.0970
Percentage of employed persons aged ≥16 y in white collar occupations	−0.0874
Median family income	−0.0977
Income disparity†	0.0936
Median home value	−0.0688
Median gross rent	−0.0781
Median monthly mortgage	−0.0770
Percentage of owner-occupied housing units (home ownership rate)	−0.0615
Percentage of civilian labor force population aged ≥16 y unemployed (unemployment rate)	0.0806
Percentage of families below the poverty level	0.0977
Percentage of population below 150% of the poverty threshold	0.1037
Percentage of single-parent households with children aged <18 y	0.0719
Percentage of occupied housing units without a motor vehicle	0.0694
Percentage of occupied housing units without a telephone	0.0877
Percentage of occupied housing units without complete plumbing (log)	0.0510
Percentage of occupied housing units with >1 person per room (crowding)	0.0556

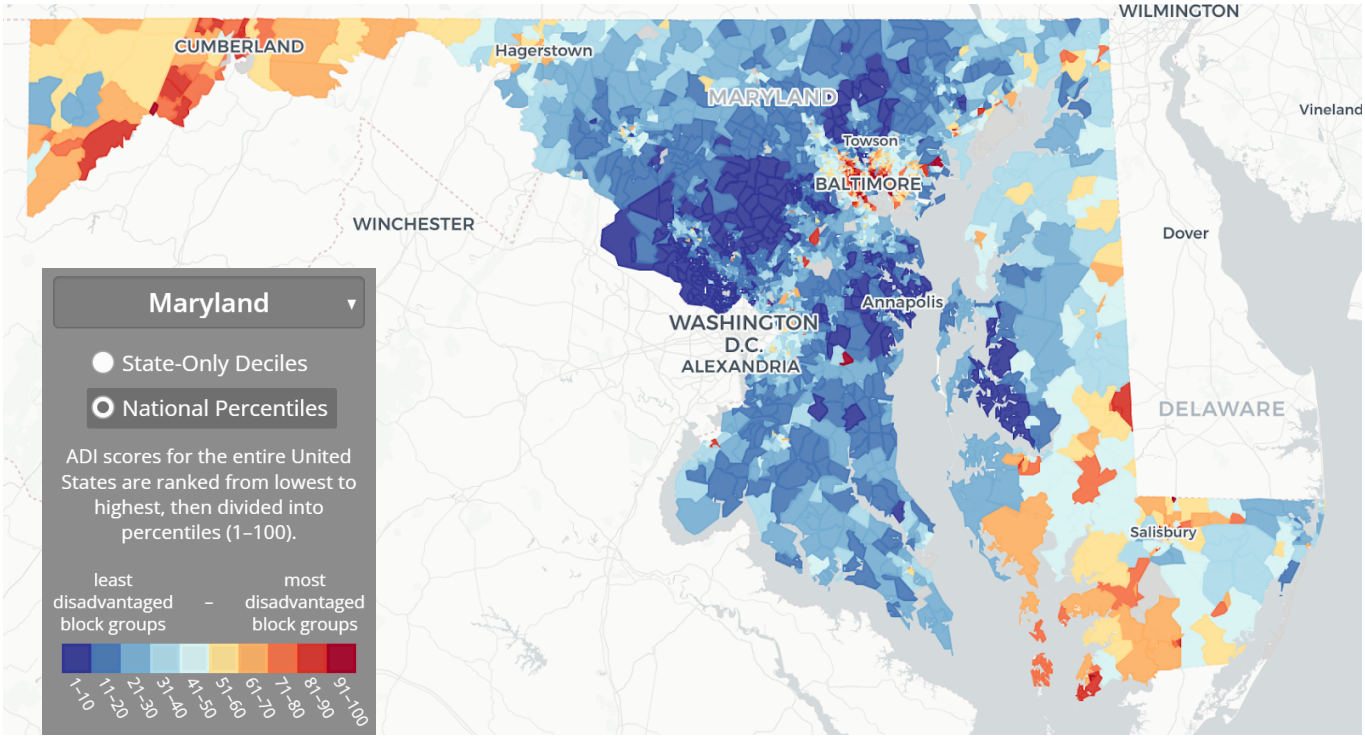
ADI = area deprivation index.
* Components and factor score coefficients drawn from reference 28. All coefficients are multiplied by −1 to ease interpretation (greater ADI means a greater disadvantage).
† Income disparity defined by Singh as the log of 100 × ratio of the number of households with <$10 000 annual income to the number of households with ≥$50 000 annual income.

ADI is now reported publicly through the Neighborhood Atlas by a research team at the University of Wisconsin (see Figure 1). It is a relative measure, typically reported by percentile (1-100) or decile (1-10), with a higher percentile indicating greater disadvantage. While ADI can be reported for an individual, it is important to remember that an "individual's ADI" is the ADI of the census block group of their residence, and each individual faces a unique set and degree of social challenges.

[5] Singh GK. Area deprivation and widening inequalities in US mortality, 1969-1998. *Am J Public Health*. 2003;93(7):1137-1143. doi:10.2105/ajph.93.7.1137

[6] Kind AJ, Jencks S, Brock J, et al. Neighborhood socioeconomic disadvantage and 30-day rehospitalization: a retrospective cohort study. *Ann Intern Med*. 2014;161(11):765-774. doi:10.7326/M13-2946

Figure 1. National Percentile ADI Scores for Maryland. From Neighborhood Atlas.



Since 2003, ADI has been used, studied, and validated as a measure of social disadvantage, correlating with many common healthcare outcomes, including cancer screening rates, chronic condition control, hospital readmission, and total cost of care.[3] It is used to adjust risk in Maryland's Readmission Reduction Incentive Program. Measures similar to ADI are used across the US and world; prominent examples include Massachusetts' Neighborhood Stress Score, New Zealand Deprivation Index, and the United Kingdom's Indices of Multiple Deprivation.

HEART Payment Overview

The HEART payment will be an established amount paid Per Beneficiary Per Month (PBPM) for each beneficiary attributed to an MDPCP Practice or Federally Qualified Health Center (FQHC) who is in the 4th HCC risk score tier (75th to 89th percentile of HCC risk scores) or the complex risk tier (90th to 99th percentiles of HCC risk scores) *and* who falls into the highest deprivation quintile of ADI (based on MDPCP beneficiary population). The HEART payment is $110 PBPM, paid to practices in both Tracks 1 and 2 on a quarterly basis.

ADI quintiles for MDPCP will be calculated based on all MDPCP beneficiaries, and updated as the pool of beneficiaries changes with quarterly attribution. ADI quintiles, HCC risk score tiers, and eligibility for the HEART payment will be provided for all attributed beneficiaries in the quarterly Beneficiary Attribution Reports available in the MDPCP Portal beginning Q1 2022. Beneficiaries' ADI scores are also reported in CRISP. Identification of HEART beneficiaries will occur on a quarterly basis along with quarterly attribution determination. Note that if a beneficiary qualifies for HEART payments one quarter, they may not necessarily qualify the following quarter.

CMS is using the national model ADI data from the University of Wisconsin's Neighborhood Atlas to calculate HEART payments. The ADI data is updated periodically, but at the time of this Playbook publication, is calculated using 2019 ADI data.

HEART payments are part of the CMF and will not be tied to an MDPCP participant's performance on quality and utilization measures. In other words, CMS will not recoup an MDPCP participant's HEART payment based on their performance on quality and utilization measures. The HEART payments are subject to eligibility recoupment should a beneficiary no longer be attributed to the practice or FQHC (the Quarterly CMF Adjustment as specified in Article 9.2(e) of the 2022 MDPCP Participation Agreement). The CMF Percentage Payment Option selected by each practice/FQHC and its partner CTO in their CTO Arrangement will apply to the HEART payment, meaning that CTOs will receive the specified percentage of HEART funds.

Allowable Uses of HEART Payment Funds

The 2022 MDPCP Participation Agreement details allowable uses of HEART Payment Funds in Section II of Appendix A. See Table 2 below for a copy of this section from the 2022 MDPCP Participation Agreement.

This section of the *HEART Payment Playbook* intends to reiterate and provide more context on allowable uses. These potential uses of HEART payments are not fully inclusive of allowable expenditures and are meant to represent a general guide regarding how the funds may be used. CMS cannot provide guidance on specific payment uses for your practice or CTO beyond the information provided in the 2022 MDPCP Participation Agreements and this guide. Practices and CTOs should consult their own legal counsel if further guidance is desired.

Table 2. Care Transformation Requirements for HEART Payments. (2022 MDPCP Participation Agreement, Appendix A, Section II)

Comprehensive Primary Care Functions of Advanced Primary Care	MDPCP Track 1 and MDPCP Track 2
Access and Continuity	• Identify and address barriers to care initiation, continuity, and preventative care for MDPCP Beneficiaries including, but not limited to, language barriers, transportation, cost, and/or health system navigation and health literacy. • Identify and address barriers to care continuity through the use of technology such as telehealth and remote patient management technology
Care Management	• Provide holistic high intensity care management that may include coordination for essential clothing, education/employment support, access to safe exercise facilities, and emergency preparation needs. • Provide an MDPCP Beneficiary experiencing interpersonal violence/toxic stress with services such as ongoing safety planning and management or linkages to community-based social services and mental health agencies with interpersonal violence experience • Provide one-on-one case management or educational services to assist MDPCP Beneficiary in addressing food insecurity and access to safe water. Assist the MDPCP Beneficiary in accessing community-based food and nutrition resources, such as food pantries, farmers market voucher programs, etc.
Comprehensiveness and Coordination across the Continuum of Care	• Facilitate access to health-related legal supports • Facilitate access to food and nutrition care management services • Facilitate access to housing navigation, support, and sustaining services, including access to essential utilities. • Connect the MDPCP Beneficiary to social services to help with finding housing necessary to support meeting medical care needs. • Connect the MDPCP Beneficiary to home remediation services that may eliminate known home-based health and safety risks (i.e. pest eradication, carpet or mold removal)

Beneficiary & Caregiver Experience	• Engage beneficiaries and caregivers in identifying and mitigating barriers to recommended resources (i.e. assistance with enrollment in additional eligible benefits and/or supports) • Build practice capacity to provide culturally competent care and strong patient-provider partnerships through activities such as access to language interpreter services, extending linguistic competency beyond the clinical encounter, providing staff with training on implicit bias, cultural competency, or other related knowledge and skills • Take action to ensure racial, ethnic, and socioeconomic diversity among PFAC members that represents the community served by the practice
Planned Care for Health Outcomes	• Implementation and tracking of social needs assessment screening, customizing electronic health records to capture social determinants and demographic information and linking data through health information exchanges, screening for unfilled prescriptions or underdosing of medications due to cost, behavioral health and substance use screening, intimate partner violence screening, adverse childhood experiences scoring, and/or determining rates of preventive health screenings, vaccinations, and/or management of chronic diseases in order to optimize care of underserved populations fare on MDPCP practice performance on quality, patient experience, and utilization measures • Data collection and analysis, including disaggregated data on race and ethnicity, gender identity, family size and income through the use of social determinants of health (SDOH) screening systems with standards equivalent to or better than those specified by CMS.

For HEART Payment-Qualifying Beneficiaries

The HEART payment should be used to provide additional support for those beneficiaries that qualify for the HEART payment. Permitted uses of funds for these beneficiaries are specified in Article 9.3(e) of the 2022 MDPCP Participation Agreement and include:

- Payment for services that address financial sustainability, language barriers, and social determinants of health such as housing, food, transportation, education, and employment.
- Payment for care transformation, behavioral health, telehealth, remote patient management technology, chronic disease management and prevention services.
- Payment for services intended to promote maternal and infant health
- To pay for the collection and/or analysis of demographic and quality data that will inform and direct services that address the needs of its underserved populations.

Building Practice Infrastructure

Although HEART payments are intended to support HEART-qualifying beneficiaries, certain practice-wide uses of funds are permitted in order to allow your practice to build the infrastructure needed to most effectively address needs of HEART-qualifying beneficiaries. A

primary example of this is the implementation of social needs screenings, and data collection and analysis related to social determinants of health, which will inform and direct choices on where and how to target the most prevalent unmet social needs for your population.

The allowable uses of funds to build practice infrastructure are:

- **Social Determinants of Health (SDOH) Screening Implementation**: Implementation and tracking of social needs assessment screening, customizing electronic health records to capture social determinants and demographic information and linking data through health information exchanges, screening for unfilled prescriptions or underdosing of medications due to cost, behavioral health and substance use screening, intimate partner violence screening, adverse childhood experiences scoring, and/or determining rates of preventive health screenings, vaccinations, and/or management of chronic diseases in order to optimize care of underserved populations on MDPCP practice performance on quality, patient experience, and utilization measures.
    - Note: The HEART payment *may* be used only to fund the modification to an electronic health records system to capture the social determinants of health data specified above. The HEART payment *may not* be used to pay for a broader EHR system upgrade that also includes the SDOH modification. Other EHR upgrades may only be paid with PBIP or other non-MDPCP revenues.
- **SDOH Data Collection and Analysis**: Data collection and analysis, including disaggregated data on race and ethnicity, gender identity, family size and income through the use of social determinants of health (SDOH) screening systems with standards equivalent to or better than those specified by CMS.
- **Diversification of Patient and Family Advisory Council (PFAC)**: Taking action to ensure racial, ethnic, and socioeconomic diversity among PFAC members that represents the community served by the practice.
- **Build Capacity for Culturally Competent Care**: Build practice capacity to provide culturally competent care and strong patient-provider partnerships through activities such as access to language interpreter services, extending linguistic competency beyond the clinical encounter, providing staff with training on implicit bias, cultural competency, or other related knowledge and skills.

Staffing

Your practice or CTO may consider using HEART funds for staffing purposes, such as hiring a Community Health Worker to work with HEART-qualifying beneficiaries. If you are using HEART funds for staffing, you must either limit the staff to only work with HEART-qualifying beneficiaries, or you may use HEART payments to pay for only the portion of time staff works with HEART-qualifying beneficiaries.

For example, if your practice hires a Community Health Worker who spends 20% of her time working with HEART-qualifying beneficiaries, you can use your HEART payment to pay 20% of her salary.

Contracting with Community-Based Organizations

Your practice or CTO may consider contracting with a community-based organization that addresses unmet social needs for your population, such as a food pantry or an organization

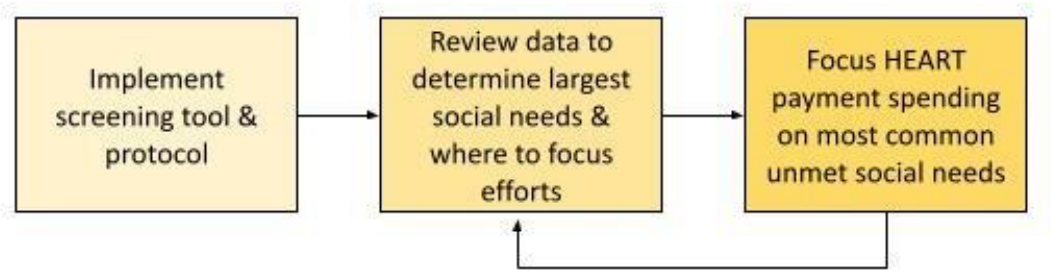
providing employment support. You may use HEART funds to establish a relationship with such a community-based organization, and then to refer HEART-qualifying beneficiaries only.

Identifying Your Practice's Most Prevalent Social Needs

One of the allowable uses of the HEART payment is the collection and/or analysis of demographic and social needs screening data that will inform and direct choices about services that address the needs of practices' underserved beneficiaries.

When considering how to most effectively use your practice's allocated HEART payments, data from social needs screenings can be used to determine the most prevalent unmet social needs in your beneficiary population. The screening data can then guide your practice to uses of the HEART payments that will best benefit your specific patient population as depicted in Figure 2.

Figure 2. Data-Driven HEART Payment Usage Consideration.



Screening for Unmet Social Needs

There are a number of common social needs screening tools of varying lengths and depths and many EHR systems have social risk screening questions built into the patient chart. If your practice does not already screen patients for unmet social needs and document the result of screening in your EHR, the HEART payment can be used to implement an appropriate workflow for your practice.

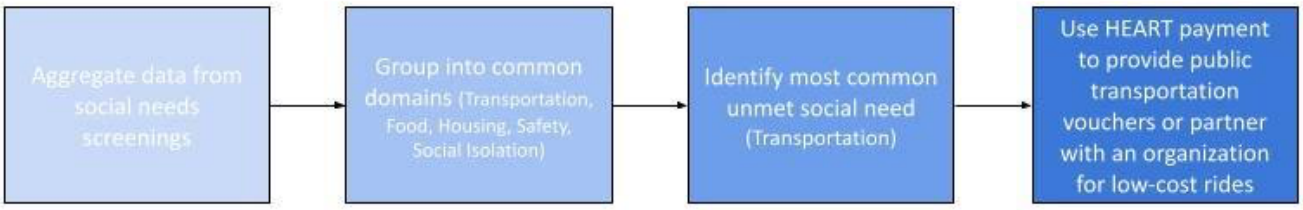
MDPCP providers can also evaluate the effectiveness of their practice's workforce models for screening and responding to unmet needs. The most common workforce models for social needs screening are self-administered (front desk staff or social worker staff ask patients to fill out a paper form or tablet to complete screening questions) and clinician-administered (medical providers or medical residents verbally ask patients questions).[7] To optimize the screening workflow, providers can consider delegating navigation activities, reevaluating the workforce model used for social needs screening, and/or repurposing staff into a different role.

[7] Sandhu S, Xu J, Eisenson H,, Bettger JP. Workforce Models to Screen for and Address Patients' Unmet Social Needs in the Clinic Setting: A Scoping Review. Journals of Primary Care & Community Health. 2021;12:1-12. https://doi.org/10.1177/21501327211021021

Aggregating & Analyzing Data on Social Needs Screenings

After implementing a social needs screening tool and protocol at your practice, aggregating screening data across your patient population can help you determine where to focus efforts with usage of the HEART payments. When aggregating data from social needs screenings, consider grouping needs into common domains, such as transportation, food, housing, safety, and social isolation. Figure 3 walks you through an example of what a practice may find after aggregating data from social needs screening.

Figure 3. Example Workflow for Aggregating Data from Social Needs Screening.



When aggregating data, consider data both for your patient population as a whole and for just those beneficiaries who qualify for HEART payments. The needs for these populations may be different. Your practice can determine effective HEART payment use based on social needs screening data, combined with care team clinical judgement and existing initiatives at your practice.

Consider also using clinical data along with social needs screening data to determine ideal payment usage. For example, if many of your HEART-payment-qualifying beneficiaries experience food insecurity and are diagnosed with diabetes, your practice could implement group diabetes care classes for these beneficiaries and give out a box of healthy food at each class with easy at-home recipes.

Finally, use qualitative data as well by having conversations with the care team on what they see as the highest priority social needs to tackle, based on their everyday experience with patients.

Implementing a Plan for Continued Assessment

Every quarter, attributed beneficiaries change. A plan must be created to reassess and track the largest social needs of a practice's patient population. Continued assessment and monitoring will inform your practice on where you can focus efforts to prioritize social needs.

Implementation of this plan must consider two key factors: *who* and *when*. More specifically, practices should determine which individuals or group of individuals at the practice are dedicated to reassessing and tracking the social needs of the practice's patient population as well as decide on a recurring team at the beginning of each quarter to conduct this assessment activity.

Approaches to Use of HEART Payments

There is flexibility regarding how practices may choose to use the HEART payments, but practices must ensure these funds directly support efforts to address the social needs of beneficiaries eligible for HEART payments, in order to achieve the primary goal of improving health equity. MDPCP practices and CTOs should tailor interventions to your settings, your needs, and your beneficiaries qualifying for the HEART Payment.

Link Beneficiaries to Existing Services and Benefits

When implementing new programs and structures using HEART payments, practices are encouraged to link beneficiaries with existing services and benefits whenever possible, so that the funds are not used to duplicate programs and services that are already available.

Example: Daisy
Care Management
Daisy is a HEART-qualifying beneficiary. In Daisy's last meeting with her Care Manager, her Care Manager mentioned that Daisy has been unreachable over the phone for recent check-ins. Daisy let her Care Manager know that she often cannot pay for phone service for a full month. Daisy's practice uses the HEART payment to help Daisy enroll in the government sponsored Lifeline Program to get phone service. This HEART payment usage meets Daisy's need while taking advantage of an already existing program, rather than creating a duplicative program.

Example: Freddy
Access and Continuity
Freddy is a HEART-qualifying beneficiary. In his last social needs screen, he indicated that he is sometimes worried that his food would run out before he had money to buy more. In addition to connecting Freddy to an existing local food pantry, Freddy's practice also uses HEART funds to support Freddy in applying for Supplemental Nutrition Assistance Program (SNAP), so he has an ongoing source of food assistance.

Identifying Most Effective Use of Payment through Community Engagement

Funds may also be used to determine the greatest needs that a practice's beneficiaries identify to inform a practice's priorities for the use of HEART payments.

Example: MDPCP Practice
Comprehensiveness and Coordination across Continuum of Care
A MDPCP practice determines 3 potential effective uses for their HEART payments and wants to pitch the 3 uses to their PFAC to determine which payment use will be most beneficial for their population. 1. The practice recognizes that their PFAC does not represent the diversity of their patient population and acknowledges that currently, their PFAC only includes patients that have free time to participate in volunteer activities. 2. The practice decides to pay PFAC participants for their time at meetings, allowing people with barriers, such as those needing to pay for care of family members during the PFAC meeting, to have a voice on the PFAC. 3. After forming a more diverse PFAC, the practice receives better quality feedback on which potential HEART payment usage will best support their patient population.

Provide Services to Beneficiaries to Meet their Particular SDOH Needs

HEART payments can be used to provide services to beneficiaries to address social determinants of health.

Example: Carmen
Access and Continuity
Carmen is a HEART-qualifying beneficiary, and she has not been taking her medications regularly. At her last visit, Carmen let her provider know that she gets home late from work and doesn't have transportation to get to the pharmacy to pick up her medications when the pharmacy is open. Carmen's practice uses the HEART payment to help Carmen set up mail delivery for her medications, and provides public transportation and rideshare vouchers for Carmen to use to get to the pharmacy and back if needed. On top of that, Carmen's practice also helps Carmen enroll in medication discount programs.

Community Health Workers

Community Health Workers are healthcare team members who help bridge the gap between healthcare and communities, through experience as members of the communities which they serve, plus professional training. Community Health Worker integration and workflows are

diverse and customized to practice and beneficiary needs. Your practice or CTO may consider employing a Community Health Worker directly or contracting with an organization that employs Community Health Workers. Helpful resources for Community Health Worker implementation include:

- CDC Community Health Worker Toolkit and integration checklist
- Robert Wood Johnson Foundation guide on Integrating Community Health Workers into Health Care Teams

As noted previously, if you are using HEART funds for staffing (including Community Health Worker staffing), you must either limit the staff to only work with HEART-qualifying beneficiaries, or you may use HEART payments to pay for only the portion of time staff works with HEART-qualifying beneficiaries.

Consider Your Total Payment Size in Determining Use of Funds

For practices with fewer beneficiaries eligible for HEART funds, it will be important to effectively maximize the funds received. For practices receiving fewer total HEART payments, prioritizing the identification of beneficiaries' social needs and linking beneficiaries to existing services to address those needs may allow practices to more effectively meet the needs of a greater number of beneficiaries.

Practices with more beneficiaries eligible for HEART payments will have greater flexibility on their use of available funds and may have more opportunities to provide a mix of referred and direct services to their beneficiaries. It is also important to note that practices have the flexibility to change how they use their HEART payments at any point, as long as changes to the use of HEART payments are intended to improve health equity for a practice's eligible beneficiaries.

Share Successes with Other MDPCP Practices!

As you move forward and use your HEART payments, share the strategies, structures, and programs that successfully address beneficiaries' social needs. You are also encouraged to share challenges encountered and lessons learned to create opportunities for discussion and collaboration with other practices.

You can always share with other practices and CTOs on Connect! In addition, the MDPCP Program Management Office will hold webinars throughout 2022 on the HEART payment. Reach out to your MDPCP Practice Coach if you would like to highlight your success on a webinar.

Frameworks for Developing and Implementing Interventions

Many approaches and frameworks exist to guide healthcare entities in addressing social needs and can guide your practice or CTO as you consider how you will spend HEART payments. Such resources include:

- National Academies of Science, Engineering, and Medicine's 2019 report Integrating Social Care into the Delivery of Health Care
- Patient-Centered Outcomes Research Institute's Evidence Map of social needs interventions.

Guidance on Tracking and Reporting Usage of HEART Payment

Financial Reporting

Participants should record and track HEART payment expenditures separately from all other practice and MDPCP revenues per Payment Policies requirements in the 2022 MDPCP Participation Agreements.

Participants will be asked to report on use of HEART payments as part of annual Financial Reporting in the MDPCP Portal. Financial reporting for HEART funds will be similar to reporting on use of CMF in terms of structure and level of detail: HEART expenditures will be reported across a number of categories but reported expenditures do not need to be tied to specific beneficiaries.

Participants should track total HEART payment funds spent by activity. In tracking, participants should delineate between payments spent at the beneficiary level and payments spent at the broader practice level, without linking dollar amounts to specific beneficiaries. In other words, if a practice receives $1,100 in HEART payments, the practice should be able to delineate that, for example, $600 went to beneficiary-level interventions (and what activities those were; spending per activity), and $500 that went to practice-level HEART activities (and what those activities were; spending per activity), but payments do not need to be tied to specific beneficiaries.

Care Transformation Requirement (CTR) Reporting

Beginning in Q1 2022 CTR Reporting, participants will be asked to report on HEART payment-related plans and activities. Multiple choice questions will aim to gather insight into whether practices identified priorities for utilizing HEART payments, how those priorities were chosen, any barriers to selecting priorities, and whether practices began implementing activities using HEART payments. The Q1 2022 CTR Reporting questions will be available in advance of the reporting period via MDPCP Connect.

CTOs will be asked to report on whether and how they supported partner practices in HEART payment-related activities.

HEART Payment FAQs

Q1: How will I know which beneficiaries qualify for HEART payments?

A1: Beneficiary-level information related to HEART payments will be provided for all attributed beneficiaries in the quarterly Beneficiary Attribution Reports available in the MDPCP Portal beginning in Q1 2022. To access this data, download the report posted on the Payment & Attribution page in the MDPCP Portal for the applicable quarter. The payment summary tab displays the number of attributed beneficiaries within each ADI quintile, the number of beneficiaries receiving the HEART payment, and total practice-level quarterly HEART payment. The Attributed Beneficiary tab includes each attributed beneficiary's HCC risk score, ADI quintiles, and HEART payment indicator (HEART payment paid this quarter – Yes/No).

Q2: Will CTO HEART payments have the same split as CMF payments? Will CTOs need to spend HEART payments on HEART-eligible beneficiaries as well?

A2: Yes. HEART payments are part of the CMF and are subject to the CTO split selected by each practice and CTO. CTOs are expected to adhere to the same requirements as practices for appropriate use of the HEART payments.

Q3. How did you arrive at the specific ADI and HCC thresholds?

A3: The HCC risk tiers are defined in the 2022 MDPCP Participation Agreements and are based on percentile distributions. ADI quintiles used for the HEART payment are based on the MDPCP beneficiary population, divided evenly into five groups.

Q4: What will practices need to report on their use of HEART payment? Will they need to track and report every dollar linked to particular patients? What is the level of granularity for reporting?

A4: Practices are required to report on certain categories of HEART spending at the practice level (not at the patient level) as part of annual financial reporting. See the "Guidance on tracking and reporting usage of HEART payment" section of this *HEART Payment Playbook* for more detail. While financial reporting is performed at the practice level, practices must maintain accounting records to substantiate the reporting per Article 13 of the 2022 MDPCP Participation Agreements. CMS will request such records for review if a practice is selected for audit.

Q5: How is the top quintile of ADI defined? What is the ADI score cutoff?

A5: ADI quintiles for MDPCP will be based on the MDPCP beneficiary population, divided into five groups of equal size. Therefore, there is no established ADI score that places a beneficiary in the top tier, as the quintiles may change with quarterly attribution.

Q6: How can practices/CTOs evaluate whether their use of HEART payments has been effective?

A6: Regular review of HEART payment beneficiary outcomes (utilization), beneficiary feedback on services, PFAC feedback, and other meaningful information and data sources more specific to selected HEART payment interventions and activities can inform whether the use of payments

was effective. Practices should identify appropriate data points and establish a regular schedule for review.

Q7: Can the HEART payment be used for purchasing durable medical equipment or medications for a HEART-qualifying beneficiary?

A7: No, this is not allowable. This is a prohibited use of CMF payment. As stated in the PA, CMF payments cannot be used "to pay for the purchase of drugs, biologicals, or other medications [and] to pay for the purchase of imaging equipment or other durable medical equipment."