MAKING CARE PRIMARY PROFILE: Track 1 – Building Infrastructure

The Making Care Primary (MCP) Model is intended to improve care for patients by supporting the delivery of advanced primary care services. It will be tested in eight states based on agreements with state Medicaid agencies regarding alignment around program principles and model dimensions that matter to family physicians. Participating states are Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York (upstate), North Carolina and Washington.

MCP offers three tracks designed for participants with varying levels of experience in value-based care: Track 1 – Building Infrastructure; Track 2 – Implementing Advanced Primary Care; and Track 3 – Optimizing Care and Partnerships. Organizations entering Track 1 will remain in this track for 2.5 years and then transition to Track 2. They will spend two years in Track 2 before transitioning to Track 3 for the remainder of the model.

Care Delivery Profile

Organizations will participate in MCP at the tax identification number (TIN) level. However, all MCP care delivery requirements must be met at the practice level. This ensures participants with multiple sites will provide access to MCP-facilitated care delivery services for all patients attributed to an organization.

After the first 12-month performance year (PY) in each track, participants will be required to demonstrate that they are meeting the care delivery requirements in their respective track. If they cannot do so, they must have a comprehensive strategy for implementing those requirements in the following PY. Participants must meet the care delivery requirements in their starting track by the end of the second program year on December 31, 2025. For Track 1, practices must have the care delivery services listed in *Table 1* in place by this date.

Organizations interested in taking part in the MCP Model must submit an application by November 30, 2023, for a model launch date of July 1, 2024. Eligibility criteria for participation are listed on the Centers for Medicare & Medicaid Services (CMS) website.

Table 1. Required Care Delivery Services for Track 1

Care Management	Care Integration	Community Connections
Empanel and risk-stratify patients **Resources:** - Risk-Stratified Care Management Rubric (AAFP) - Risk-Stratified Care Management Scoring Algorithm (AAFP) - *Risk Stratification: A Two-Step Process for Identifying Your Sickest Patients (FPM)* - *The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity (FPM)*	Use specialist performance data provided by CMS to inform the selection of high-quality specialty care partners in the region	Implement universal HRSN screening and provide resources based on screening results **Resource:** - Social Determinants of Health: Guide to Social Needs Screening (AAFP)
Identify staff and develop workflows for chronic and episodic care management **Resource:** - Care management resources (AAFP)	Identify staff and develop workflows using measurement-based care to deliver behavioral health services to patients **Resources:** - Behavioral Health Integration Learning Forum (AAFP; member login required) - Behavioral Health Integration (BHI) Overcoming Obstacles webinar series (AMA)	Develop workflows for referral of beneficiaries with unmet HRSNs to social service providers **Resources:** - Neighborhood Navigator (AAFP) - United Way Connect with your local county health department's CHIP/CHA
Identify staff and develop workflows for chronic condition self-management support services		Explore partnerships with social service providers **Resource:** - The Practical Playbook (CDC/DCFM/de Beaumont Foundation)
		Identify staff to deliver high-impact services to support populations with disparate outcomes for key health conditions and indicators

AAFP = American Academy of Family Physicians; AMA = American Medical Association; CDC = Centers for Disease Control and Prevention; CHIP/CHA = community health improvement plan/community health assessment; CMS = Centers for Medicare & Medicaid Services; DCFM = Duke Community and Family Medicine; HRSN = health-related social needs.

Payment Profile

UPFRONT INFRASTRUCTURE PAYMENT

The upfront infrastructure payment (UIP) is start-up funding to support smaller organizations new to value-based care and ensure that their infrastructure can support the transformational goals of the MCP Model. The UIP is optional and is only available to Track 1 participants who meet the definition of being low revenue (provided in the Request for Applications [RFA] under section 8A. Payment to Support Advanced Primary Care Delivery) or do not have an e-consult platform. The UIP is up to $145,000, with an initial payment of up to $72,500 distributed as a lump sum at the start of the model and a second payment of $72,500 distributed as a lump sum one year later.

FEE-FOR-SERVICE PAYMENT

Track 1 participants will continue to bill fee for service (FFS), except for services considered to be duplicative of the enhanced services payment (ESP) (*Table 2*).

Table 2. Services Considered Duplicative of the ESP

Service	Code
Prolonged E/M without direct patient contact	99358, 99359
Prolonged clinical staff services	99415, 99416
PCM services	99424, 99425, 99426, 99427, G2064a, G2065a
Prolonged CCM services	99437
Non-complex CCM	99439, G2058
Complex chronic care coordination services	99487
CCM services	99489, 99490, 99491
TCM services	99495, 99496
Assessment/care planning for patients requiring CCM services	G0506

CCM = chronic care management; E/M = evaluation and management; ESP = enhanced services payment; PCM = principal care management; TCM = transitional care management.

Adapted from Centers for Medicare & Medicaid Services. Making Care Primary request for applications. Version: 1. August 14, 2023. Accessed September 15, 2023. https://www.cms.gov/files/document/mcp-rfa.pdf

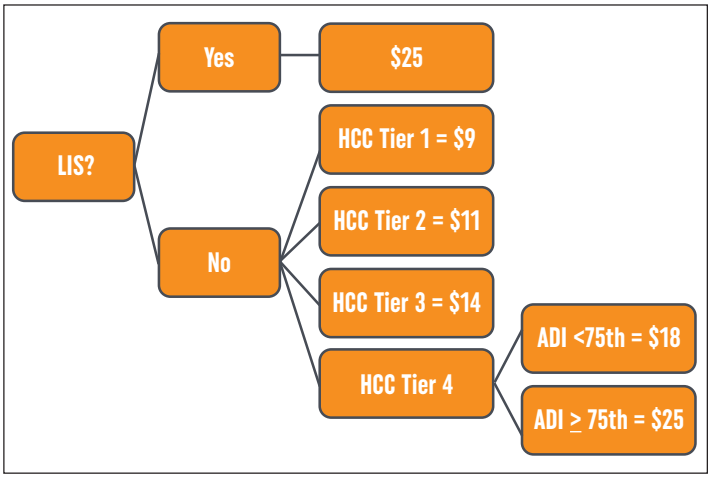
ENHANCED SERVICES PAYMENTS

Enhanced services payments are risk-adjusted per patient per month payments intended to support care management, patient navigation, behavioral health and other enhanced care coordination services. Organizations will receive a different payment amount per patient depending on the following three factors:

1. Whether the patient is enrolled in the Medicare Part D low-income subsidy (LIS)
2. Area Deprivation Index (ADI) score based on the patient's residence compared to a regional reference population
3. Patient's most recent CMS-hierarchical condition categories (HCC) risk score

Figure 1 shows how ESPs are determined based on these factors.

Figure 1. ESP Risk-Adjusted Payments by LIS Status, CMS-HCC Risk Tier and ADI Social Risk Tier



ADI = Area Deprivation Index; CMS = Centers for Medicare & Medicaid Services; ESP = enhanced services payment; HCC = hierarchical condition categories; LIS = low-income subsidy.

PERFORMANCE INCENTIVE PAYMENT

Track 1 participants will be eligible for an upside-only performance incentive payment (PIP) of up to 3% of primary care FFS revenue (see codes in Appendix G of the RFA). The PIP for Track 1 will be based on performance on four quality measures (shown in *Table 3*). Participants will receive full credit for a measure if they exceed the 70th percentile, half credit if they score between the 50th and 70th percentiles and no credit if they do not meet the 50th percentile. Full credit will be given for reporting the Person-Centered Primary Care Measure (PCPCM) for PY2 and PY3. In the example shown in *Table 3*, a Track 1 participant would receive a **1.875% PIP** (3% PIP possible, 62.5 X 0.03 = 1.875%).

Table 3. Example PIP Calculation Based on Participant's Quality Performance

Performance Measure	Percentage of Overall PIP	Participant Percentile Score	Total Measure Percentage of PIP	PIP
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	25%	88	25%	
Controlling High Blood Pressure	25%	65	12.5%	
Colorectal Cancer Screening	25%	48	0%	
Person-Centered Primary Care Measure	25%	-	25%	
			62.5%	**1.875%**

PIP = performance incentive payment.

Talking With Decision Makers

Before discussing the MCP Model with decision makers in your organization, you may find it helpful to review the *FPM* article *Making a Business Case for Team-Based Care*. In addition, consider using the following key talking points:

- Prospective payments will be a big advantage for organizations seeking to engage in value-based payment that do not have substantial experience in infrastructure or risk-based models.
- The payments can help support investment in the care management and navigation necessary to perform well, providing a major opportunity to scale primary care and invest in teams that are needed to care for a community.
- The MCP Model emphasizes collaboration with behavioral health clinicians and community health workers. Traditionally, these valuable assets have been unable to generate much revenue. The model makes collaborations possible and even profitable.
- Track 1 does not consider cost as a measure of performance, allowing systems to continue specialty-driven revenue production while investing in and transforming primary care.