MAKING CARE PRIMARY PROFILE: Track 2 – Implementing Advanced Primary Care

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 2 will remain in this track for 2.5 years and then transition to Track 3 for the duration 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 2, 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 2

Care Management	Care Integration	Community Connections
Implement chronic and episodic care management **Resource:** - Care management resources (AAFP)	Identify high-quality specialty care partners, establish CCAs and implement enhanced e-consults (including using the new primary care e-consult code)	Implement social service referral workflows **Resource:** - Social Determinants of Health: Guide to Social Needs Screening (AAFP)
Implement individualized self-management support **Resources:** - Obesity and Healthy Lifestyle: Clinical Guidance and Practice Resources (AAFP) - Diabetes: Clinical Guidance and Practice Resources (AAFP) - COPD: Clinical Guidance and Practice Resources (AAFP)	Implement a BHI approach using standardized tools, and systematically and universally screen for key behavioral health conditions **Resources:** - Behavioral Health Integration Learning Forum (AAFP; member login required) - Behavioral Health Integration (BHI) Overcoming Obstacles webinar series (AMA)	Establish partnerships with social service providers **Resources:** - Neighborhood Navigator (AAFP) - Community Tool Box information on MOUs with community partners (University of Kansas)
		Utilize a CHW or equivalent staff to support patients with high needs **Resource:** - *Making a Business Case for Team-Based Care (FPM)*

AAFP = American Academy of Family Physicians; AMA = American Medical Association; BHI = behavioral health integration; CCAs = collaborative care arrangements; CHW = community health worker; COPD = chronic obstructive pulmonary disease; MOU = memorandum of understanding.

Payment Profile

FEE-FOR-SERVICE PAYMENT

Track 2 organizations will have two components of fee for service (FFS): (1) primary care services included in the prospective primary care payment (PPCP) services (see PPCP section below for more information) and (2) all other FFS. Regardless, organizations will continue to bill 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

CMS has also created a new code called the MCP e-consult code (MEC) to incentivize and encourage the increased use of e-consults by primary care teams. The proposed payment for this code is $40. An MCP primary care clinician will be able to bill the MEC for consultation with any specialist, regardless of whether the consulting specialist is one with whom the primary care clinician has a collaborative care arrangement (CCA).

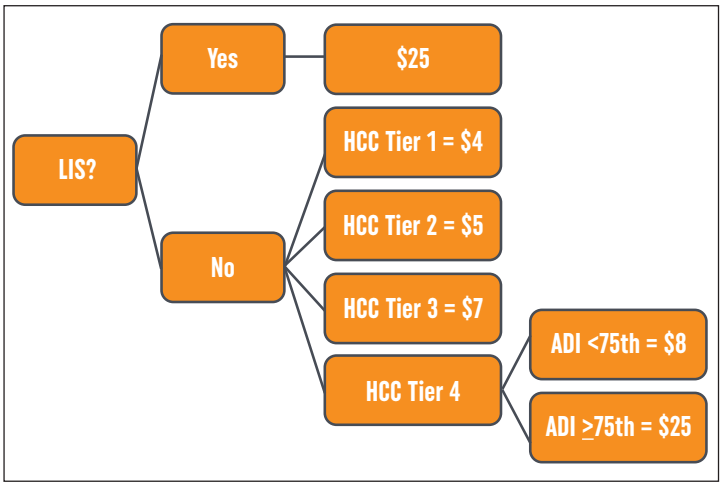
ENHANCED SERVICES PAYMENTS

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.

PROSPECTIVE PRIMARY CARE PAYMENT

The PPCP is a quarterly per patient per month payment calculated for each MCP participant's patient population. It is designed to support a gradual progression from FFS payment for primary care services to a population-based payment structure. The monthly payment amount will be calculated based on each participant's historical billing data for its attributed Medicare patients over a two-year period, and it will be updated annually. The services included in the PPCP for Track 2 can be found in Appendix G of the Request for Applications (RFA). For Track 2 participants, the PPCP is intended to replace about half of a participant's FFS revenue that would have been billed for primary care services. Payments will be paid prospectively, and claims will be reduced accordingly when they are filed.

PERFORMANCE INCENTIVE PAYMENT

Track 2 participants will be eligible for an upside-only performance incentive payment (PIP) of up to 45% of the sum of primary care FFS revenue (see codes in Appendix G of the RFA) and the PPCP. The PIP for Track 2 will be based on performance on seven quality measures, two cost/utilization measures and one measure of continuous improvement (shown in *Table 3*). To be eligible to receive a PIP, organizations must meet or exceed the 30th percentile on the Total Per Capita Cost (TPCC) measure.

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. For the TPCC continuous

improvement measure, practices will receive full credit if they have 5% or greater improvement compared to the previous year, half credit if they have improvement between 3% and 4.9% and no credit if their improvement is less than 3%. In the example shown in *Table 3*, a Track 2 participant would receive a **27.11% PIP** (45% PIP possible, 60.25 X 0.45 = 27.11%).

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

	Performance Measure	Percentage of Overall PIP	Participant Percentile Score	Total Measure Percentage of PIP	PIP
Quality	Person-Centered Primary Care Measure	6%	-	6%	
	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	6%	88	6%	
	Controlling High Blood Pressure	6%	65	3%	
	Colorectal Cancer Screening	6%	48	0%	
	Screening for Social Drivers of Health	6%	54	3%	
	Screening for Depression and Follow-Up Plan	4%	62	2%	
	Depression Remission at 12 Months	4%	32	0%	
Cost	Emergency Department Utilization	18.5%	73	18.5%	
	Total Per Capita Cost	18.5%	68	9.25%	
	TPCC Continuous Improvement	25%	3.2	12.5%	
				60.25%	**27.11%**

PIP = performance incentive payment ; TPCC = Total Per Capita Cost.

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.
- Tracks 2 and 3 provide new payment opportunities and care delivery approaches that can strengthen relationships between primary care clinicians and specialists to improve consultation, communication and coordination.