The Making Care Primary (MCP) Model

Sept. 27, 2023

Presented in Partnership with:

Today's Webinar

- Welcome
- Overview of Model by CMMI Staff
- Hot Topic Deep Dives
- Q&A
- Resources & Wrap Up

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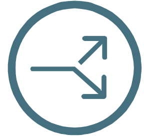
Making Care Primary (MCP) Goals

MCP is a 10.5-year model (beginning July 2024) that provides a pathway from Fee-for-Service (FFS) payment to prospective, population-based payment to support comprehensive primary care that improves care quality and population health outcomes. CMS is eager to partner with other payers to help drive these goals for their beneficiaries.



Comprehensive Primary Care

Ensure patients receive primary care that is integrated, coordinated, person-centered and accountable

New Pathway for Value-Based Care (VBC)

Create a pathway for primary care organizations and practices – especially small, independent, rural, and safety net organizations – to enter into value-based care arrangements

Improved Quality and Outcomes

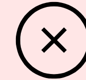
Improve the quality of care and health outcomes of patients

Eligibility to Participate

Organizations that provide primary care services to patients may be eligible to apply to MCP. Due to MCP's payment and quality reporting design, certain organizations are not eligible to participate in MCP.

Organizations Eligible for MCP

- Serve as the regular source of primary care for a minimum of 125-attributed Medicare beneficiaries
- Independent or solo primary care practices
- Group practices
- Federally Qualified Health Centers (FQHCs)
- Health Systems
- Indian Health Programs
- Certain CAHs
- Organizations operating in the listed MCP states

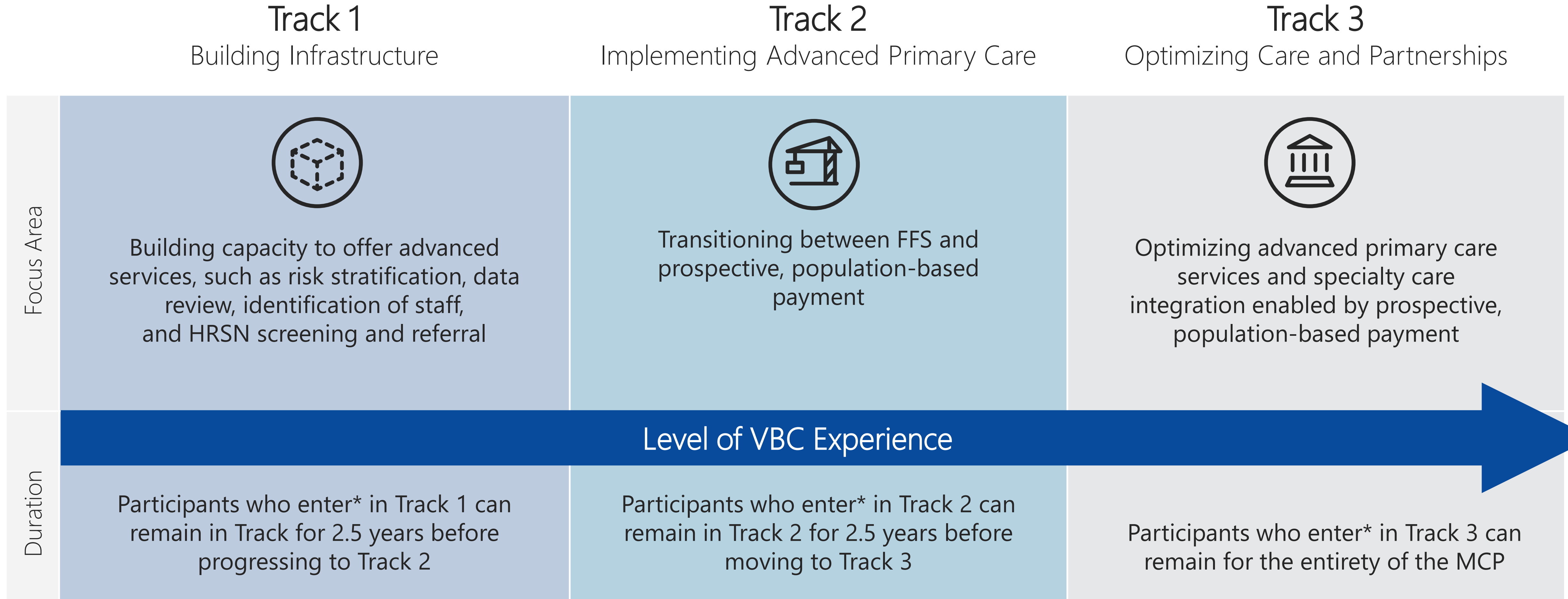


Organizations Not Eligible for MCP

- Rural Health Clinics
- Concierge practices
- Grandfathered Tribal FQHCs
- Primary Care First (PCF) practices and ACO REACH Participant Providers active as of 5/31/23
- Organizations not operating in the listed MCP states
- Organizations enrolled in CMMI models (such as MSSP and ACO REACH) will not be allowed to simultaneously participate in MCP, with the exception of bundled payment models

Participation Track Options Overview

MCP includes three (3) tracks that health care organizations can select from when applying to the model. The three tracks provide opportunities for organizations with differing levels of care delivery and value-based payment experience to enter the model at a point that matches their capabilities at the start of MCP.



Organizations that start in Track 1, 2, or 3 will have an additional 6 months (or half of a year) in that track, given the mid-year start date for the model. A participant's length of time in a track depends on which track they started in.

Benefits of Participation in MCP

CMS Innovation Center designed MCP with lessons learned from previous primary care models to build a supportive payment and care delivery structure to advance health equity. The following are national and state level supports for participants to achieve model goals.

On-Ramp to VBC

Resources for organizations new to VBC to build accountability over time

Key features:

- Upfront Infrastructure Payment for eligible participants
- Phased in shift from FFS to population-based payment over Tracks 1 and 2
- No downside adjustment based on performance, rewards are focused on key clinical outcomes first

Tools to Improve Care Coordination

Data to improve patient care integration and learning tools to drive care transformation

Key features:

- Specialty care performance data sharing, prioritizing cardiology, orthopedics, and pulmonology
- New specialty integration payments to improve communication and collaboration
- Connection to health information exchange

Health Equity Advancement

Support to deliver coordinated, high-quality health care to diverse populations

Key features:

- Process for identifying and addressing health disparities in the populations that practices serve
- Increased payment for patients that require more intensive services to meet health goals.
- Focus on screening and referrals to address Health Related Social Needs (HRSNs)

Collaboration & Learning

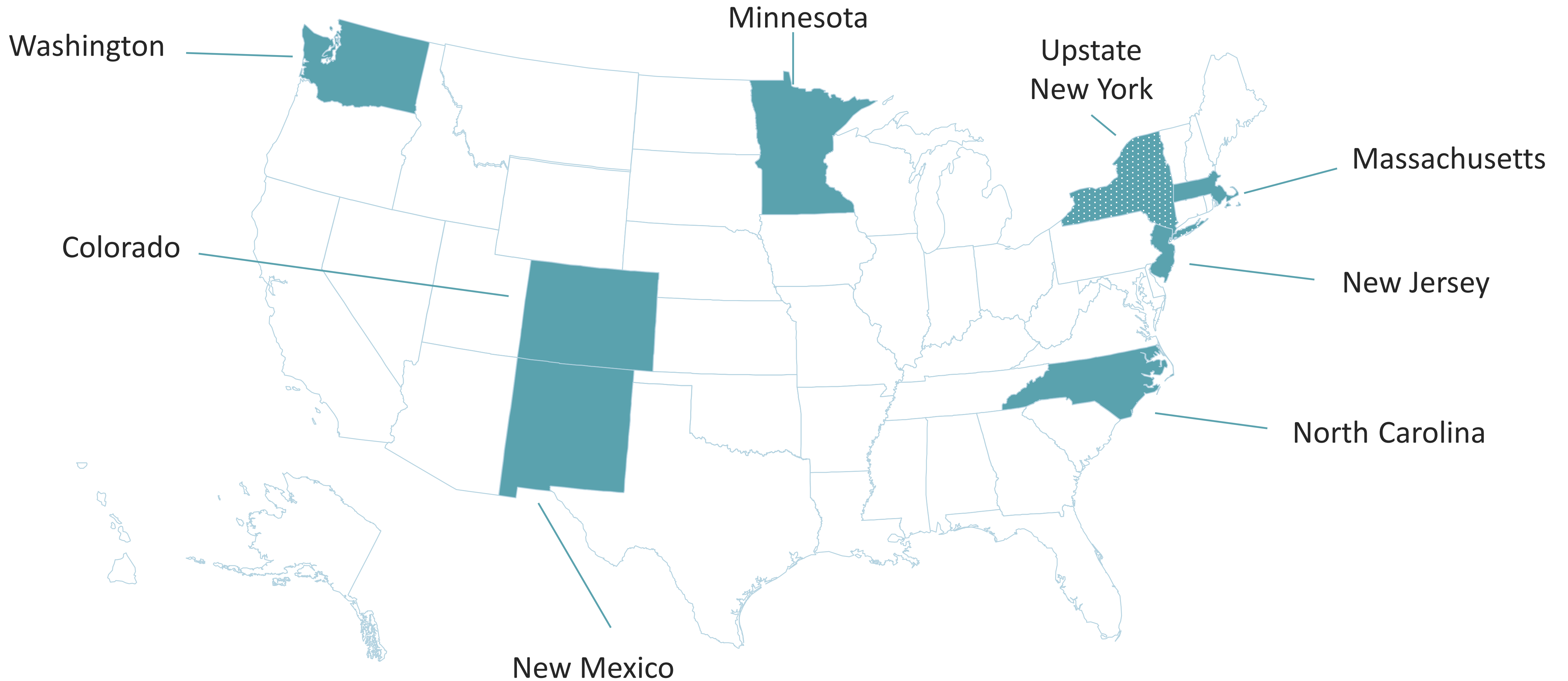
National and state level supports for participants to achieve model goals

Key features:

- Payers partnering to support participants needs for success, including technical assistance, data, and peer-to-peer learning
- Access to independent practice facilitation and coaching, especially for small and safety net organizations who request it

Participating States

MCP will be tested in eight (8) states in partnership with state Medicaid agencies (SMAs) and other payers in each region. Payer partnership fosters alignment on core model features to minimize payer fragmentation, while allowing payers flexibility to tailor their MCP implementation.



Payers as Partners for MCP Success

CMS Innovation Center is partnering with public and private payers to implement MCP, fostering comprehensive primary care organization transformation, and expanding regional primary care enhancement. Through these partnerships, CMS will foster alignment in areas to reduce clinician burden and payer fragmentation, allowing providers to focus on practice transformation.

Directional Alignment

- CMS will work with payers in MCP states to encourage close alignment in areas that directly reduce burden on clinicians
- CMS will partner with payers to establish MCP-aligned plans, with shared goals, learning priorities, and access to data, tools, and peer-to-peer learning

Medicaid Engagement

- CMS has partnered with state Medicaid agencies (SMAs) to streamline primary care payment reform and learning priorities across Medicare and Medicaid
- MCP will continue to work closely with SMAs to streamline requirements and learning supports

Local Implementation

- CMS, SMAs, and payer partners will make practice- and patient-level data available to participants through data sharing efforts within the state
- CMS will provide flexibility for payers to include additional measures that reflect local priorities for their patient population(s)

Payer Partnership Timeline

1

Q3/Q4 2023: CMS discusses potential partnership with payers based on *MCP Payers Guide to Alignment.*

Payers are encouraged to consider how plans can align with MCP goals and design features. Priorities for alignment include payment, performance measurement, long-term data aggregation, and learning tools.

2

February 2024: Deadline for payers to sign Letter of Interest to become MCP Payer Partner.

LOI commitment: 1) Design and implement a primary care model that aims to align with MCP in quality measurement, data provision, and learning strategy; 2) Move primary care providers away from FFS and to value-based payment; 3) Meet regularly with CMMI to further alignment and model development between the date of signature and the conclusion of the MCP model test; 4) Submit a plan to CMS regarding an alternative payment model for primary care and 5) Collaborate with other regional payers to support the MCP's goals of value-based payment and improving primary care patient outcomes

March 2024: Accepted provider applicants sign Participation Agreements to join MCP
July 2024: MCP begins for participating organizations.

3

August 2024: Payer Partners provide details to CMS on their alternative payment model for primary care and how it aligns with MCP.

4

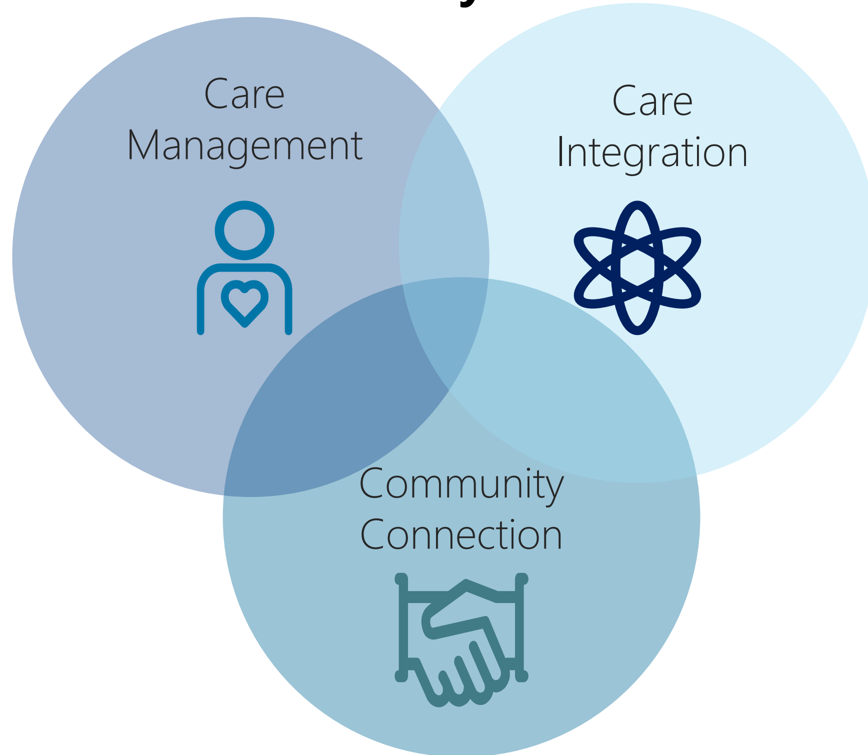
February 2025 – December 2025: Payer Partners sign non-binding Memorandum of Understanding with CMS to advance partnership efforts.

MCP Model Features

Overview of Care Delivery Approach and Domains

The capabilities participants will need to succeed in MCP are organized under three broad care delivery domains shown below. These domains contain requirements that progress through the Tracks as participants build and refine their care delivery, taking full advantage of the payment flexibilities in MCP. Participants will build these services over time, with requirements in each Track necessary for progression into the next Track.

Care Delivery Domains



MCP Participant Requirements

Track 1 Building Infrastructure	Track 2 Implementing Advanced Primary Care	Track 3 Optimizing Care and Partnerships

Meet Care Delivery Requirements, by Track
Participants are required to meet the Care Delivery Requirements in their track by the end of the first full (12-month) performance year.

Complete Baseline and Ongoing Care Delivery Reporting
Participants are required to complete initial baseline care delivery reporting during the first year, and ongoing care delivery reporting *(bi-annually for Tracks 1 and 2; annually for Track 3).*

Health Equity Plan Reporting
Participants are required to develop and implement a Health Equity Plan. The plan will identify disparities in outcomes in their patient populations and implement initiatives to measure and reduce these disparities over the course of the model.

Peer-to-Peer Learning
Participants are encouraged to share best practices, lessons learned, and keys to success via MCP learning events, collaboratives, virtual platforms, and other model and state-based forums.

MCP Payment Types

MCP will introduce six (6) payment types for Medicare FFS to support MCP participants as they work to reach their patient care goals.

Prospective Primary Care Payment (PPCP) — Track 1 | **Track 2** | **Track 3**

Quarterly per-beneficiary-per-month (PBPM) payment (calculated based on historical billing) to support a gradual progression from fee-for-service (FFS) payment to a population-based payment structure.

Enhanced Services Payment (ESP) — **Track 1** | **Track 2** | **Track 3**

Non-visit-based per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's level of clinical (CMS-HCC) and social (ADI) risk to provide proportionally more resources to organizations that serve high-needs patients.

Performance Incentive Payment (PIP) — **Track 1** | **Track 2** | **Track 3**

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures. Structured to maximize revenue stability (half of estimated PIP will be paid in the first quarter of performance year).

Upfront Infrastructure Payment (UIP) — **Track 1** | Track 2 | Track 3

Lump-sum payment for select Track 1 participants to support organizations with fewer resources to invest in staffing, SDOH strategies, and HIT infrastructure.

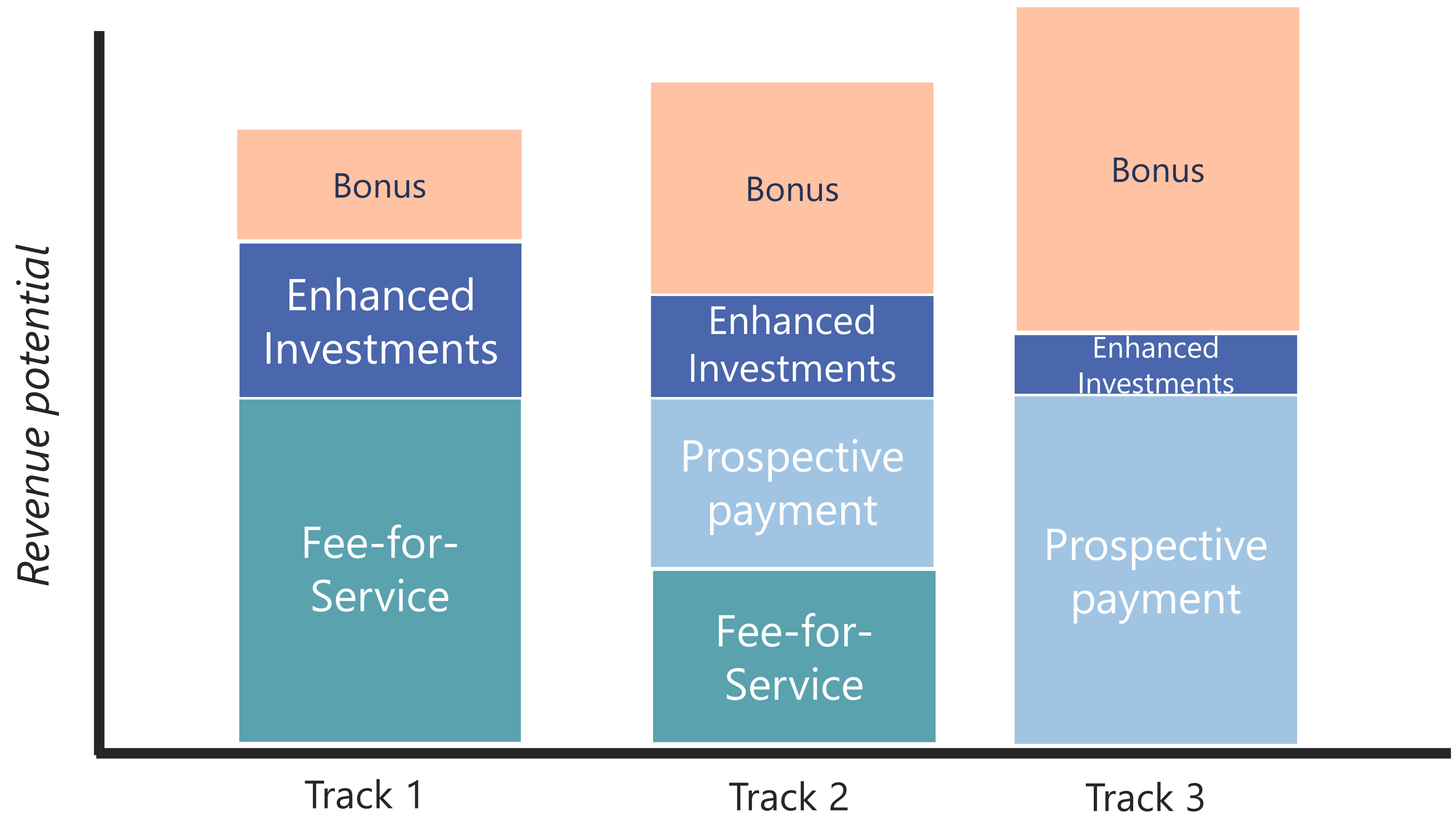
MCP E-Consult (MEC) — Track 1 | **Track 2** | **Track 3**

Ambulatory Co-Management (ACM) — Track 1 | Track 2 | **Track 3**

Payments to support specialty integration strategy to support communication and collaboration for longitudinal primary care and short-term specialized care for chronic conditions. MEC code billable by MCP primary care clinicians while ACM is billable by specialty care partners.

Payment Approach

- **Prospective Primary Care Payment** (PPCP) *increases* over time, while **Fee-for-Service** *decreases*, to support the interprofessional team.
- **Enhanced Services Payments** (ESP) *decrease* over time as practices become more advanced, and potential for payments tied to quality performance increases.
- **Performance Incentive Payment** (PIP) *potential greatly increases* over time to make up for decreases in guaranteed payments.



Illustrative, not to scale

Performance Measurement and Reporting

Mirroring CMS's broader quality measurement strategy, measures for MCP were selected to be actionable, clinically meaningful, and aligned with other CMS quality programs, including the Universal Foundation Measure Set *(as indicated below with an asterisk* "*"). MCP's selected performance measures mirror the model's care transformation goals and incentivize performance through Performance Incentive Payments. Participants will need to exceed the 30th percentile on the TPCC measure to be eligible for a Performance Incentive Payment.

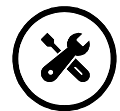
Focus	Measure	Type	Track		
			1	2	3
Chronic Conditions	Controlling High Blood Pressure*	eCQM	X	X	X
	Diabetes Hba1C Poor Control (>9%)*	eCQM	X	X	X
Wellness and Prevention	Colorectal Cancer Screening*	eCQM	X	X	X
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	Survey	X	X	X
Behavioral Health	Screening for Depression with Follow Up*	eCQM		X	X
	Depression Remission at 12 months	eCQM		X	X
Equity	Screening for Social Drivers of Health*	CQM		X	X
Cost/ Utilization	Total Per Capita Cost (TPCC)	Claims		X	X
	Emergency Department Utilization (EDU)	Claims		X	X
	TPCC Continuous Improvement (CI) *(Non-FQHCs and Non-Indian Health Programs (IHPs))*	Claims		X	X
	EDU CI *(FQHCs and IHPs)*	Claims		X	X

Specialty Care Integration Strategy

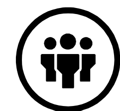
MCP provides participants with payment mechanisms, as well as data, learning tools, and peer-to-peer learning opportunities to support the Specialty Integration Care Delivery requirements, focused on coordination and improving patient care.

Payment: Once MCP participants enter Tracks 2 and 3, they are expected to implement e-consults as part of their care delivery requirements.

Data: CMS will provide participants with performance data on specialists in their region, prioritizing measures related to cardiology, pulmonology, and orthopedics.



Learning Tools: CMS will partner with stakeholders, state Medicaid programs, and other payer partners to connect MCP participants with each other, specialty practices, and CBOs.



Peer-to-Peer Learning: CMS will provide a collaboration platform and other forums to help participants learn from each other.

Payment Details

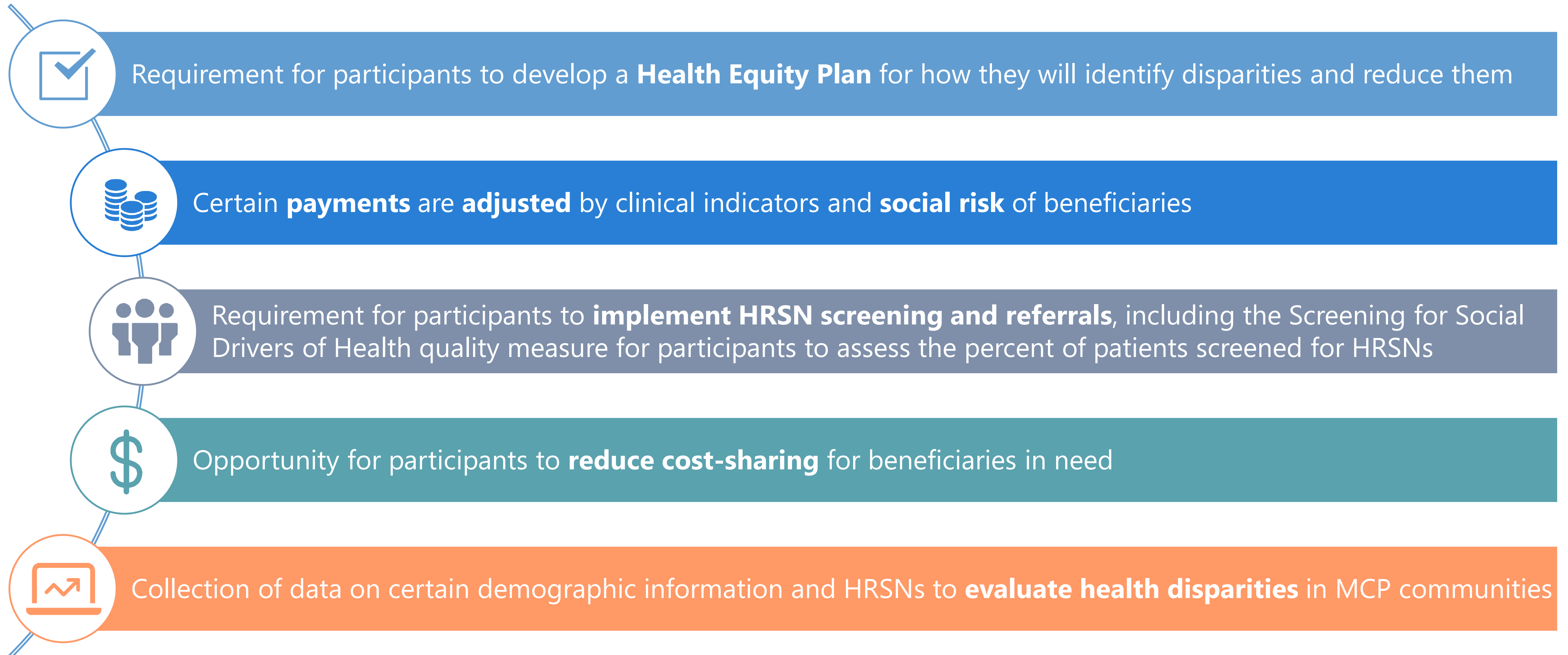
MCP will feature two payment types to encourage specialty care integration and support participants as they take on care delivery requirements:

	MCP eConsult (MEC) Code *Billable by MCP Primary Care Clinicians*	**Ambulatory Co-Management (ACM) Code** *Billable by Specialty Care Partners*
Goal	Address current barriers to eConsult billing, including its inclusion of post-service time to implement the specialist's recommendation	Support ongoing communication and collaboration of shared MCP patients who require both longitudinal primary care and also short-term specialized care to stabilize an exacerbated chronic condition
Eligibility	Participants in Tracks 2 and 3 *(These codes are absorbed into the capitated prospective primary care payments (PPCPs) in Track 3).*	Rostered Specialty Care Partner clinicians *(whose TIN has a Collaborative Care Arrangement (CCA) in place with an MCP Participant)*
Potential Amount	$40 per service (subject to geographic adjustment)*	$50 per month (subject to geographic adjustment)*

**To account for regional cost differences, MCP will apply a geographic adjustment factor (GAF) to the MEC and ACM.*

Health Equity Strategy

MCP includes several model components designed to work together with the care delivery strategy to improve health equity in alignment with the Innovation Center's Strategy Refresh objective of Advancing Health Equity.[1]



[1]https://innovation.cms.gov/strategic-direction-whitepaper

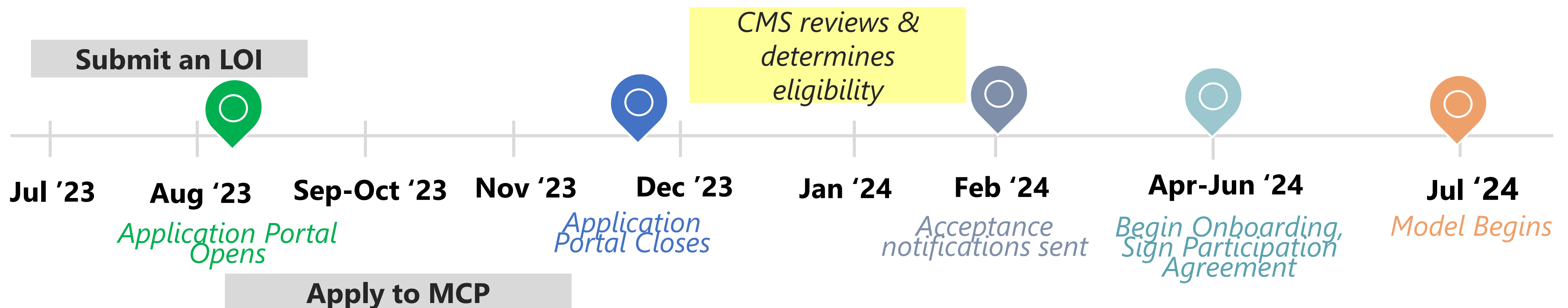
Next Steps

Submit an Application by November 30th

- Interested organizations are encouraged to begin their applications even if they are not prepared to submit at this time; doing so helps CMS provide more tailored support to applicants.
- Submit questions on your application to MCP@cms.hhs.gov

Sign up for the MCP listserv and visit the MCP Website for additional information:

- Visit the MCP Website for events and resources: https://innovation.cms.gov/innovation-models/making-care-primary
- Sign up for our listserv: https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_13126



Q&A Deep Dives

1. Model/Track Selection
2. Multi-Payer Alignment
3. Specialty Coordination

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Open Q&A

We will start with questions submitted by attendees in advance.

Please enter any additional questions you have for our CMMI speakers in the Q&A box and we'll get to as many as we can!

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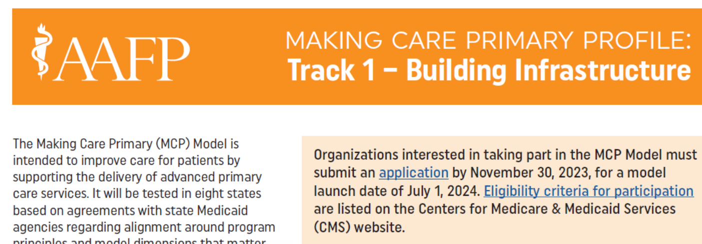
Resources

MCP Track Profiles



AAFP

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 ...

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	Identify staff and develop workflows using measurement-based care	Develop workflows for referral of beneficiaries with unmet HRSNs to social service providers

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

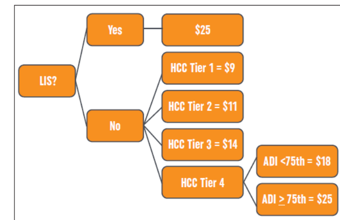
ENHANCED SERVICES PAYMENTS

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



[AAFP Center for Medicare and Medicaid Innovation Primary Care Models Webpage]

MCP Calculator

Acronyms

- **ADI** – Area Deprivation Index
- **BHI** – Behavioral Health Integration
- **CCM** – Chronic Care Management
- **CMS** – Centers for Medicare & Medicaid Services
- **CPT** – Current Procedural Terminology
- **CY** – Calendar Year
- **E/M** – Evaluation and Management
- **ESP** – Enhanced Services Payment
- **FFS** – Fee-for-Service
- **GPCI** – Geographic Practice Cost Index
- **HCC** – Hierarchical Condition Categories
- **HCPCS** – Healthcare Common Procedure Coding System
- **HRA** – Health Risk Assessment
- **IPC** – Interprofessional Consult

Instructions

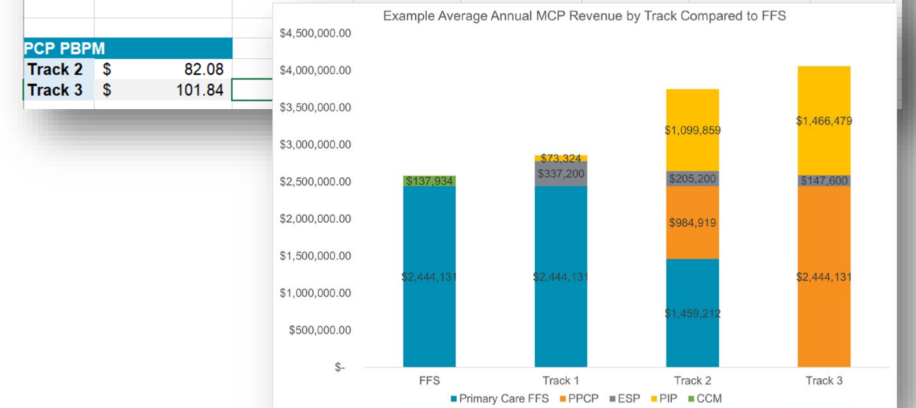
1. Organizations will participate in the Making Care Primary (MCP) Model at the tax identification number (TIN) level. Identify the number of traditional Medicare patients you have in your organization, and enter this number into cell B2 on the 'Organization Data' tab.
2. Enhanced services payments (ESP) are risk-adjusted per benefi... (PBPM) payments intended to support care management, patie... behavioral health and other enhanced care coordination servic... will receive a different payment amount per patient depending... three factors: (1) whether the patient is enrolled in the Medicare... income subsidy (LIS); (2) Area Deprivation Index (ADI) score bas... residence compared to a regional reference population; and (3)... recent Centers for Medicare & Medicaid Services-hierarchical c... (CMS-HCC) risk score.
   a. For each patient enrolled in LIS who is in the participant's att... fee-for-service (FFS) population, CMS will pay the highest fix... of $25 PBPM. Enter the number of LIS patients in your traditic... population in cell B4 on the 'Organization Data' tab.
   b. If you are able to pull a report of the HCC scores of your Medic... the number of patients who fall into the following tiers in the c...
      i. CMS-HCC Clinical Risk Tier 1 (<25th percentile) – cell B5 o... Data' tab
      ii. CMS-HCC Clinical Risk Tier 2 (25th percentile to 49th perc... the 'Organization Data' tab
      iii. CMS-HCC Clinical Risk Tier 3 (50th percentile to 74th perce... the 'Organization Data' tab

Patient Panel Information	
Estimated number of Medicare FFS beneficiaries	2000
Risk tiers	
Number of Medicare FFS beneficiaries enrolled in Medicare Part D LIS	100
CMS-HCC Clinical Risk Tier 1 (<25th)	500
CMS-HCC Clinical Risk Tier 2 (25th - 49th)	500
CMS-HCC Clinical Risk Tier 3 (50th -74th)	500
CMS-HCC Clinical Risk Tier 4 (≥75th) and ADI <75th	200
CMS-HCC Clinical Risk Tier 4 (≥75th) and ADI ≥75th	200
PIP estimate	100%

Services Duplicative of ESP	
Number of visits for Medicare FFS patients for previous consecutive 12 months:	
99358	
99359	24

	Primary Care FFS	PPCP	ESP	PIP	CCM	Total revenue	% of FFS
FFS	$ 2,444,130.86	-	-	-	$137,933.92	$ 2,582,064.78	100%
Track 1	$ 2,444,130.86	$ -	$337,200.00	$ 73,323.93	-	$ 2,854,654.79	111%
Track 2	$ 1,459,211.55	$ 984,919.31	$205,200.00	$1,099,858.89	-	$ 3,749,189.75	145%
Track 3	$ -	$2,444,130.86	$147,600.00	$1,466,478.52	-	$ 4,058,209.38	157%

PCP PBPM	
Track 2	$ 82.08
Track 3	$ 101.84



Additional Information

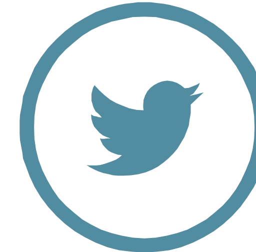
For more information and to stay up to date on upcoming MCP events:

Visit

https://innovation.cms.gov/innovation-models/making-care-primary

Help Desk

Reach out to MCP@cms.hhs.gov for questions



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