CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12866	**Date: October 4, 2024**
	Change Request 13392

Transmittal 12643 issued May 15, 2024, is being rescinded and replaced by Transmittal 12866, dated October 4, 2024, to remove CWF from business requirement 13392.1.2 and delete requirement 13392.1.2.1 to resolve the issue of claims looping between MCS and CWF with error code 524B. All other information remains the same.

SUBJECT: Making Care Primary (MCP) Model Implementation

I. SUMMARY OF CHANGES: The Innovation Center has secured approval for the Making Care Primary (MCP) model, a demonstration testing alternative payment models and support to primary care organizations. MCP is designed to test whether implementing new payment methodology and care delivery goals can reduce program expenditures and improve outcomes on key measures.

The purpose of this Change Request (CR) is to implement all of the tenants of the Making Care Primary (MCP) model as it relates to claims-based payments. This includes:

- The implementation of two new Physician Fee Schedule (PFS) and Prospective Payment System (PPS) codes, called the Ambulatory Care Management code (ACM) and the MCP e-Consult Code (MEC)
- Appending the demonstration code for MCP based on the date-of-service (DOS), provider and beneficiary files (which will identify model participant and model beneficiaries), and CPT/HCPCS code
- Reducing codes found in Appendix A by 50% of the normally paid rate for participants in Track 2
- Reducing codes found in Appendix B by 100% of the normally paid rate for participants in Track 3
- Deny claims found in Appendix C for all participants across all tracks, as they are paid through other model mechanisms not utilizing the Medicare FFS Shared Systems

EFFECTIVE DATE: July 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 1, 2024 - Analysis, Design and Coding; July 1, 2024 - Complete Coding, Testing, and Implementation; October 7, 2024 - Implementation of BR 13392.12.4 for CWF only.

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Demonstrations

Attachment - Demonstrations

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II. GENERAL INFORMATION

A. Background: Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Innovation Center to test innovative payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Title XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii) and certain provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b).

For this model and consistent with the authority under section 1115A(d)(1), the Secretary may consider issuing waivers of certain fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in

separately issued documentation. Any such waiver would apply solely to MCP and could differ in scope or design from waivers granted for other programs or models. Thus, participants must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to Section 1115A(d)(1) specifically for MCP.

In addition to or in lieu of a waiver of certain fraud and abuse provisions in sections 1128A and 1128B of the Act, CMS has determined that the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (42 CFR § 1001.952(ii)) will be available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under the MCP participation documentation.

The Innovation Center has secured approval for the Making Care Primary (MCP) model, a demonstration testing alternative payment models and support to primary care participants. MCP is designed to test whether implementing new payment methodology and care delivery goals can reduce program expenditures and improve outcomes on key measures.

MCP participants will begin operations under the model starting July 1, 2024. The model will continue for 10.5 years, and conclude on December 31, 2034. New participants and providers may be added and removed throughout the model and CMS will provide updated files of participants and providers as well as attributed beneficiaries on a monthly basis. Participating providers will continue to submit claims using normal fee-for-service (FFS) processing. In addition to claims-based payments, participating providers may receive enhanced service payments, prospective primary care payments, upfront infrastructure payments and performance incentive payments. These payments shall be processed separate from the claims system and are not addressed in this CR.

The Ambulatory Care Management (ACM) code does not apply to MCP participants organizations, but rather to specialists that choose to partner with them. As described in the business requirements, the ACM code is for specialty care partners, which are not delineated in our provider files. There must be an attributed beneficiary, valid date of service, and valid specialty type as described in Appendix D for an ACM code to be paid.

This model will have one demonstration code applied to claims processed under any track in the model, as described in the business requirements below. However, some requirements will only apply to specific tracks. If true, the specific track the requirement applies to will be named. If not otherwise stated, the requirement applies to all tracks. Tracks will be delineated in the provider and beneficiary attribution files.

B. Policy: Under MCP, the Innovation Center will engage with primary care organizations that have a majority of physical locations within our designated regions. MCP participants will change tracks throughout the life of the model. This will not happen more than once annually.

MCP participants shall continue to bill HCPCS and CPT codes for all patients as they normally do under the traditional Medicare program. The model should have no impact to deductibles or coinsurance required by the beneficiary. No new claims-based payments should be made while the beneficiary is still meeting their deductible, and the 50% payment rate for T2 should not be added unless normal FFS payment would have been added.

The beneficiary attribution process will be conducted outside of the claims system although a list of beneficiaries attributed to the model shall be provided to contractors for the purposes of claims adjudication every month. Patient coinsurance and deductible will, however, be calculated based on traditional fee for service processing for the original code that the provider billed at the allowed amount. Occasionally, claims are incorrectly processed in models, and MCP participating providers and beneficiaries may retroactively be added or removed. In this case, there will be a retroactive effective date. Systems should go back and reprocess the claim, adding or removing payments as necessary based on the track.

Separate from these claims-based payments, MCP participating providers may receive population-based per beneficiary per month payments for attributed beneficiaries as well as performance-based payments. These payments shall be processed outside the fee for service claims processing system and are not addressed in this CR.

MCP participating providers are prohibited from billing HCPCS and CPT Codes listed in Appendix C on any of their attributed beneficiaries. CMS has interpreted Appendix C codes duplicative of the non-claims-based payments participants are receiving under the MCP model.

Except as otherwise specified, MCP claims shall be subject to all other adjustments (e.g., sequestration) and policies applicable to other fee for service claims.

For the ACM code, shared systems should check that:

- *Claim is for an MCP-attributed beneficiary that is attributed to a provider in Track 3*
- *Claim is an appropriate DOS for beneficiary attribution dates*
- *Claim is not billed by institutional provider/FQHC (reject if so)*
- *Rendering Provider is valid specialty type (see Appendix D for specialty types) (not applicable to FQHCs)*
    - *Claim has not already been billed three times by the same specialist **type** for the same beneficiary in the past 12 months*
    - *First come (i.e., first billed), first-serve basis for this, regardless of claim DOS*

For MCP participants billing codes, systems should take action based on Track and participant type.

Criteria necessary for claims edits for Health Centers:

- CCN is included in provider file
- Beneficiary is included in the beneficiary alignment file, identified by HICN or MBI
- MCP office E/M codes are on PPS claim (see Appendix A and Appendix B, depending on participant track)
- OR, codes are on list of services to deny (see Appendix C)
- Otherwise, claim will process as normal

Criteria necessary for claims edits for non-Health Centers:

- TIN and NPI are both included in provider alignment file
    - Clinician NPI (Type 1), not organizational NPI (Type 2) is CMS 1500 field 24j Rendering Provider ID #
    - Clinician TIN is in CMS 1500 Field 25 Federal Tax ID #
- Beneficiary is included in the beneficiary alignment file, identified by HICN or MBI
- MCP office visit E/M codes are on Part B claim (see Appendix A and Appendix B, depending on participant track)
- OR, codes are on list of services to deny (see Appendix C)
- Otherwise, claim will process as normal

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.1	The contractors shall prepare their systems to process Making Care Primary (MCP) claims with dates of service on or after July 1, 2024.	X	X			X	X		X	CMS, CVM, HIGLAS, NCH, VDC
13392.1.1	The contractors shall use Demonstration Code A5 to identify MCP claims (Benefit Enhancement Indicator is L (indicates Track 1), M (indicates Track 2), or N (indicates Track 3).					X	X		X	CMS, HIGLAS, NCH, VDC
13392.1.2	The contractors shall ensure that the MSP (Medicare Secondary Payer) Claims are exempt from the MCP demonstration code A5.					X	X			
13392.1.2.1	This requirement has been deleted.								X	
13392.2	CMS shall provide MCP contractors with the MCP provider participant files via the Cloud Storage and Retrieval System (CSRS). File format will be CSV and layout will conform to the attached ICD.						X			CMS, VDC
13392.2.1	MCS shall receive a provider participant test file from CMS via CSRS on or about March 11th, 2024 to validate the file layout.						X			
13392.2.2	Contractors shall accept the CSV files from the CSRS and shall process the updated Provider and Beneficiary Alignment files as full replacement files.						X		X	CMS, VDC
13392.2.3	The contractors shall perform validation edits against the new Provider Files to ensure file contains all information needed for the MCP project.						X			
13392.2.4	The contractors shall provide a response file to CMS via the CSRS with accepted and rejected records. CMS shall correct returned invalid MCP Provider Participant files or file records and return the corrected files or file records to MCS.						X			CMS
13392.2.5	MCS shall send the Fiscal Intermediary Shared System (FISS) the initial Provider Alignment file records.					X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.2.6	Contractors shall accept and process the Provider Alignment File according to the batch jobs and/or any off-cycle direction that CMS provides. NOTE: CMS will send the first production file on or before June 25, 2024, so the claims can start processing as of July 1, 2024.					X	X			
13392.2.7	MCS shall update the Model Test Data Entry (MTDE) application for the MCP Provider Participant file. Provider participant test file name: MCP_prov_impl.csv						X			
13392.2.7.1	FISS shall test the UI and extract process of the Model Test Data Entry (MTDE) application for the MCP Provider Participant file.					X				
13392.2.8	MCS shall modify the Provider Accountable Care Organization online screen (NP) to display the new MCP participating provider records, and will include the Benefit Enhancement Indicator.						X			
13392.3	CMS shall send the Common Working File (CWF) the initial beneficiary alignment files in Mainframe format via the CSRS, detailing beneficiaries aligned to the MCP participating providers. **NOTE**: The beneficiary alignment file will be a national file accessible by all MACs. Beneficiary alignment file name which will be sent through CSRS : MCP_bene_prod.csv								X	CMS
13392.3.1	CWF shall receive a beneficiary test file from CMS on or about March 11th, 2024.								X	
13392.3.2	CMS shall include the following data elements on the aligned beneficiary file for the Making Care Primary (MCP) record identifier 'M': • Record Identifier								X	CMS, NCH

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• ACO ID Number • Delete Flag (Value D or Space) • Beneficiary HICN • Beneficiary Start Date • Beneficiary Termination Date • Beneficiary Host ID • Gender • Medical data sharing preference • MCP Benefit Enhancement Indicator Track 1 value ‘L’ • MCP Benefit Enhancement Indicator Track 2 value ‘M’ • MCP Benefit Enhancement Indicator Track 3 value ‘N' Note: Benefit Enhancement Indicators L, M, N will be included as new values for the existing “Population Indicator” Field on the beneficiary alignment file.									
13392.3.3	CMS shall send updated aligned beneficiary files on a monthly basis and shall be processed as full replacement files.								X	CMS
13392.3.4	CWF shall perform limited editing to ensure the MCP Beneficiary Alignment file is well-formed. If errors exist a response will be generated with defined error codes. The validation checks will include the actual count of detail records that must match the count in the Trailer record. NOTE: The Interface Control Document (ICD) will define the response file layout and detailed error conditions.								X	
13392.3.4.1	The only valid population indicators for MCP are ‘L’, ‘M’, or ‘N’. If the population indicator field value is equal to a ‘ ‘(space) or any other value not equal to L, M or N for the new MCP model identifier ‘M’, then								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the contractor shall return Error code '20' on the response file. Error Code 20: The data format of the field or the data in the field does not conform to the list of valid values specified.									
13392.3.5	CWF shall send the beneficiary alignment files with the most current Health Insurance Claim Number (HICN) to MCS and FISS, and CWF shall send the file to the Virtual Data Centers (VDCs) when they become available.								X	VDC
13392.3.6	The contractors shall be prepared to accept the data elements on the initial Beneficiary Alignment file for each MCP. NOTE: The Beneficiary Alignment file will contain the data elements identified in the Interface Control Document (ICD) submitted with this CR.					X	X			
13392.3.7	The contractors shall maintain an update date in their internal file which will reflect the date the updated files were loaded into the shared system. NOTE: The field shall be viewable to the MACs.								X	
13392.3.8	MCS shall modify the Beneficiary Accountable Care Organization online screen (NB) to display the new MCP participating Beneficiary records and will include the Benefit Enhancement Indicator.						X			
13392.4	The Contractor shall modify Accountable Care Organization Beneficiary (ACOB) File and online Health Insurance Master Record (HIMR) Display to include the new MCP Model based on the updated Beneficiary Alignment File and the new identifier.								X	
13392.5	CMS shall provide a list of accepted and prohibited services under the MCP Model appendices. Appendix A = Accepted HCPCs for Track 1 and 2 (codes to be reduced by 50% for Track 2									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	participants) (no reduction in codes for Track 1 participants) Appendix B = Accepted HCPCs for Track 3 (codes to be reduced by 100% for Track 3 participants) Appendix C = Prohibited HCPCs for Track 1, 2 and 3 (codes to be denied for Track 1, 2 and 3)									
13392.6	The contractors shall accept and process Track 1 claim details without a reduction in pricing, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary's HICN/MBI is on the Beneficiary File, • Provider's Billing TIN/Rendering NPI is found on the Provider file (Benefit Enhancement Indicator of L), • Procedure code is found on Appendix A.						X			
13392.7	The contractors shall accept and process Track 2 claim details with a 50% reduction in pricing, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary's HICN/MBI is on the Beneficiary File, • Provider's Billing TIN/Rendering NPI is found on the Provider file (Benefit Enhancement Indicator of M), • Procedure code is found on Appendix A.						X			
13392.8	The contractors shall accept and process Track 3 claim details with a 100% reduction in pricing, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary's HICN/MBI is on the Beneficiary File,						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Provider's Billing TIN/Rendering NPI is found on the Provider file (Benefit Enhancement Indicator of N), • Procedure code is found on Appendix B.									
13392.9	The contractors shall accept and deny Track 1 claim details, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary is on the Beneficiary File, • Corresponding Provider is found on the Provider file (Benefit Enhancement Indicator of L), • Procedure code is found on Appendix C.						X			
13392.9.1	Contractors shall deny the claim lines using the following messaging: Claim Adjustment Reason Code (CARC) 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.10	The contractors shall accept and deny Track 2 claim details, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary is on the Beneficiary File, • Corresponding Provider is found on the Provider file (Benefit Enhancement Indicator of M), • Procedure code is found on Appendix C.						X			
13392.10.1	Contractors shall deny the claim lines using the following messaging: Claim Adjustment Reason Code (CARC) 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.		X							
13392.11	The contractors shall accept and deny Track 3 claim details, as well as adding the A5 Demo code to the claim when the following circumstances are met: • Beneficiary is on the Beneficiary File,						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Corresponding Provider is found on the Provider file (Benefit Enhancement Indicator of N), • Procedure code is found on Appendix C.									
13392.11.1	Contractors shall deny the claim lines using the following messaging: Claim Adjustment Reason Code (CARC) 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.		X							
13392.12	The contractors shall accept and process ACM code (G9038) on a detail, when the following circumstances are met: • Beneficiary is on the Beneficiary File as a Track 3 (Benefit Enhancement Indicator N), • Provider specialty is on Attachment D.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.12.1	The contractors shall not allow ACM Code (G9038) to be more than 1 time in a 30 day period per Specialty Type. NOTE: Claims shall be adjudicated on a first come (i.e., first billed), first-serve basis, regardless of the date of service.						X		X	
13392.12.1.1	CWF shall create a new Part B Utilization Edit 5731. • Edit 5731 shall set at the detail line. • Edit 5731 shall return trailers 08 and 39, indicating the detail line(s) causing the reject. • Edit 5731 shall NOT be overridable. • Edit 5731 Error Message: "Making Care Primary (MCP) ACM code billed for a date of service within 30 days of a paid ACM code for the same specialty."								X	
13392.12.2	The contractors shall allow ACM Code (G9038) to be billed up to 3 times in a 12-month time frame per Specialty Type that aligns with the calendar year or "performance year," running from January 1 through December 31 (except for CY 2024, as MCP will be implemented on July 1, 2024). NOTE: Claims shall be adjudicated on a first come (i.e., first billed), first-serve basis, regardless of the date of service.						X		X	
13392.12.2.1	CWF shall create a new Part B Utilization Edit 5732. • Edit 5732 shall set at the detail line. • Edit 5732 shall return trailers 08 and 39, indicating the detail line(s) causing the reject. • Edit 5732 shall NOT be overridable. • Edit 5732 Error Message: "Medicare does not pay for more than three (3) Making Care Primary (MCP) ACM codes per Provider specialty in a 12-month period."								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.12.3	CWF will create new Auxiliary file 'MCPL' that will have the following data elements to maintain counts and frequency, based on the Provider Specialty Type, applicable to Part B claims only, under Track 3: • Beneficiary HIC, MBI • Provider Specialty Type • Service Date • G9038 HCPCS • Start/End date for the 12 months • Claim DCN • Claims count/occurrences • Billing TIN • Rendering NPI • Diagnosis code(s)						X		X	
13392.12.4	CWF shall create a new HICR function for the MCP Auxiliary File.								X	
13392.13	The contractors shall use the following messages for claim lines processed and subject to the payment adjustments in accordance with the rules of the MCP model, unless otherwise specified in this CR: Claims Adjustment Reason Code (CARC) 132: "Prearranged demonstration project adjustment" Group Code: CO (Contractual Obligation) MSN 60.4: This claim is being processed under a demonstration project. Spanish Translation: Esta reclamación está siendo procesada bajo un proyecto especial.		X							
13392.13.1	The contractors shall deny ACM claim lines when claims have already been billed three times by the same specialist type for the same beneficiary in the past 12 months, and shall use the following messages:		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N640: "Exceeds number/frequency approved/allowed within time period." Group Code: CO (for contractual obligation) MSN 20.5 - "These services cannot be paid because your benefits are exhausted at this time." Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."									
13392.13.2	The contractors shall reject or return as unprocessable claim lines when the MCP ACM code is not billed by an eligible provider specialty and shall use the following messages: **CARC 8** **"The procedure code is inconsistent with the provider type/specialty (taxonomy). Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present."** Remittance Advice Remark Code (RARC): N95 "This provider type/provider specialty may not bill this service." Remittance Advice Remark Code (RARC): N211 "ALERT - YOU MAY NOT APPEAL THIS DECISION." Group Code: CO (for contractual obligation)		X							
13392.13.3	The contractors shall deny ACM claim lines when the ACM code is billed within 30 days of another ACM		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	code for the same beneficiary with the same specialty type and shall use the following messages: CARC 119: "Benefit maximum for this time period or occurrence has been reached." RARC N640: "Exceeds number/frequency approved/allowed within time period." Group Code: CO (for contractual obligation) MSN 20.5 - "These services cannot be paid because your benefits are exhausted at this time." Spanish Version: "Estos servicios no pueden ser pagados porque sus beneficios se han agotado."									
13392.13.4	The contractors shall ensure the amount in the, *"Maximum You May Be Billed,"* section reflects the Beneficiary's liability prior to the MCP reductions, i.e. BE indicators L or M.						X			
13392.13.5	The contractors shall display the full allowed amount on the MSN when the Track 3 reduction is 100%, i.e. BE indicator N.						X			
13392.13.6	The Contractors shall create an edit to return as unprocessable claim lines when the ACM code G9038 is billed with a provider specialty is included on Attachment D and the beneficiary is not on the Beneficiary File as a Track 3 with a Benefit Enhancement Indicator of N.						X			
13392.13.7	Contractors shall return as unprocessable claims lines using the following messaging: Claim Adjustment Reason Code (CARC) 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)									
13392.14	The contractors shall adjust claims: • processed as MCP and the beneficiary and provider combination is no longer active for claim's date of service. OR: • not processed as MCP when the beneficiary and provider combination is active for claim's date of service. NOTE: Adjustments due to the beneficiary and provider combination being active for the claim's date of service shall be completed via a TDL issued to the MACS. NOTE: MCS planned system changes include the creation of automated unsolicited adjustments for provider file related updates to address both bullet points in this BR.	X	X			X	X		X	
13392.14.1	The contractor shall trigger an IUR when the Beneficiary alignment file is received, and the dates of service on the history claim are no longer in the model.								X	
13392.14.1.1	CWF shall modify existing Informational Unsolicited Response (IUR) 7125 for Part B and Outpatient Claim types for new demo code 'A5', when the Date of Service (DOS) on the history claim are no longer in the model.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.14.2	The contractor shall create an adjustment based on the IUR.	X				X	X			
13392.15	The contractors shall accept Making Care Primary (MCP) Demo Code ‘A5’ in the first position for Part B (HUBC) claims								X	
13392.16	The contractors shall accept Making Care Primary (MCP) Demo Code ‘A5' in the first position for Outpatient (HUOP) claims.								X	
13392.17	Effective for Dates of Service on or after July 1, 2024, CWF will modify Part B claims processing to accept MCP Demo ‘A5’ with the following benefit enhancement indicators: • MCP Benefit Enhancement Indicator Track 1 value ‘L’ • MCP Benefit Enhancement Indicator Track 2 value ‘M’ • MCP Benefit Enhancement Indicator Track 3 value ‘N’								X	
13392.18	CWF shall ensure existing consistency edit ‘0014’ to include MCP Demo Code ‘A5’ as a valid Demo when received on Part B (HUBC) claim.								X	CVM
13392.19	CWF shall ensure existing consistency edit ‘0014’ to include MCP Demo Code ‘A5’ as a valid Demo when received on Outpatient (HUOP) claim.								X	CVM
13392.20	CWF shall ensure MCP Demo Code ‘A5’ is posted to claims history (HIMR/CLMH) and transmit to the NCH file when present on HUBC claim.								X	
13392.21	CWF shall ensure MCP Demo Code ‘A5’ is posted to claims history (HIMR/CLMH) and transmit to the NCH file when present on HUOP claim.								X	
13392.22	CWF shall ensure existing consistency edits 92x5 and 97x1 do not set when Other Amount Indicators (‘B4')								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	are present on a detail line of a Part B (HUBC) record for MCP Demo 'A5'. MCP Track 2 Payment Reduction (Paid at 50% of FFS rate) value = 'M' MCP Track 3 Payment Reduction (Paid at 0% of FFS rate) value = 'N'									
13392.23	CWF shall ensure that the new Other Amount Indicators 'B4' for MCP Part B (HUBC) claim is accepted on the detail line. Note: Professional claims, Part B								X	
13392.23.1	The Contractor shall send the new Reduction indicator on the HUBC Transmission Record.						X			
13392.24	CWF shall ensure that the new Other Amount Indicators 'B4' for MCP Part B (HUBC) claim is transmitted to the HCFACLM file (NCH).								X	NCH
13392.25	CWF shall ensure that the MCP Part B (HUOP) claim posts to claim history (HIMR/CLMH). Note: Institutional claims								X	
13392.26	The CMS specialty contractor shall send the Multi-Carrier System (MCS) the initial Provider alignment files detailing MCP participating providers. NOTE: The provider participant file will be a national file accessible by all MACs.						X			CMS
13392.27	The Contractors shall send the Fiscal Intermediary Shared System (FISS) Provider Alignment file records. NOTE: The Provider Alignment File will be sent on a monthly basis initially beginning on or about June, 2024, but based on business need, an ad-hoc file may be sent more frequently, e.g. daily, weekly, etc.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.27.1	MCS shall provide an updated Provider Alignment file to the Fiscal Intermediary Shared System (FISS).						X			
13392.27.1.1	The Contractors shall be prepared to accept the data elements on the updated Provider Alignment file for each MCP participant. NOTE: The Provider Alignment file will contain the data elements identified in the Interface Control Document (ICD). The file shall be processed as a full file replacement.					X				
13392.28	The Contractor shall be prepared to accept the data elements on the initial Provider Alignment file for each MCP participant. NOTE: The Provider Alignment file will contain the data elements identified in the Interface Control Document (ICD).									VDC
13392.29	The Contractors shall send the Fiscal Intermediary Shared System (FISS) the updated Beneficiary Alignment file records.					X			X	
13392.29.1	The Contractors shall create/modify online screens to display Beneficiary Alignment File data to include file update history, similar to BR 13392.30 for the Provider Alignment file.					X				
13392.30	The Contractor shall create/modify an online screen(s) to display Demo Code A5 on the MCP Provider Alignment File to include file updates/history.					X				
13392.31	The Contractors shall ensure the ACO ID, Demo code, Benefit enhancement indicators, Other adjustment indicator, and value codes for MCP claims are passed to the downstream systems including but not limited to National Claims History (NCH) and Integrated Data Repository (IDR)					X	X		X	IDR, NCH
13392.32	The Contractor shall apply the MCP demo code A5 according to the demo code precedence:					X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	MCP is usurped by all demos except 96, 83, and 78. Codes that take priority over MCP are 31, 94, 87, 93, 97, 92, 74, 86, 75, 98, 99, 82, 91									
13392.33	The Contractor shall apply demo code A5 for Track 1 (Appendix A) of the MCP Model to Institutional claims when: • Type of Bill (TOB) 77X. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 1 based on BE Indicator/Record Type value 'L' in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The from date on the claim-header is on or within the effective start and end date for the matching records in the beneficiary and provider participant file. • Medicare is the primary payer on the claim. • The HCPCS code listed on the claim detail line is from Appendix A with no reduction for Track 1. Note: Deductible does not apply to FQHC claims.					X				
13392.34	The Contractor shall create and edit to reject the line when the MEC code is billed on an FQHC claim. • TOB 77X • HCPCS code G9037 • Track 1 Note: The demo code should not be added.					X				
13392.34.1	The following ANSI Information should be used: The Contractors shall reject the claim lines using the following ANSI information:	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CARC 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 “No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)									
13392.35	The Contractor shall allow the MEC code G9037 if billed on an FQHC claim if the following criteria is met for track 2: • TOB 77X • The criteria had been met for demo code A5 to be applied. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 2 based on BE Indicator /Record Type value ‘M’ in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier ‘M’ as the provider. • The HCPCS code should be allowed at the full rate and no reductions should apply.					X				
13392.36	The Contractor shall allow the MEC code G9037 if billed on an FQHC claim if the following criteria is met for track 3: • TOB 77X • The criteria had been met for demo code A5 to be applied. • The claim from date is on or after 07/01/2024.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The claim has an aligned provider that is participating in Track 3 based on BE Indicator /Record Type value 'N' in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The HCPCS code should be reduced by 100%.									
13392.37	The Contractor shall create a reason code and return to provider (RTP) when HCPCS code G9038 is billed on an FQHC claim.	X				X				
13392.38	The Contractor shall apply demo code A5 for Track 2 (Appendix A) of the MCP Model to Institutional claims when: • TOB is 77X (FQHC). • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 2 based on BE Indicator/Record Type value 'M' in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The from date on the claim-header is on or within the effective start and end date for the matching records in the beneficiary and provider participant file. • Medicare is the primary payer on the claim. • The HCPCS code listed on the claim detail line is from Appendix A. • Services should be reduced by 50%.					X				
13392.39	The Contractor shall apply demo code A5 for Track 3 (Appendix B) of the MCP Model to Institutional claims when: • Type of Bill (TOB) 77X; • The claim from date is on or after 07/01/2024;					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The claim has an aligned provider that is participating in Track 3 based on BE Indicator/Record Type value N in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The from date on the claim-header is on or within the effective start and end date for the matching records in the beneficiary and provider participant file. • Medicare is the primary payer on the claim. The HCPCS code listed on the claim detail line is from Appendix B. • Services should be reduced by 100%.									
13392.40	The Contractor shall create a reason code to reject HCPCS codes identified in Appendix C at the line level for demo A5 when: • Type of Bill (TOB) 77X. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in model. • The claim is for an aligned beneficiary participating in model. • Medicare is the primary payer on the claim.					X				
13392.41	The Contractors shall use the ANSI information below for all HCPCS codes rejected from Appendix C. • Group Code: CO Contractual Obligation • Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment." • Remittance Advice Remark Code (RARC): N211 "ALERT - YOU MAY NOT APPEAL	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	THIS DECISION."									
13392.42	The Contractor shall define an aligned provider using the CCN to apply the payment mechanisms for Track 2 and Track 3, (BE indicator 'M' or 'N') for institutional FQHC claims.					X				
13392.43	The Contractor shall apply a 50% reduction for MCP claims with the BE indicator 'M' for Track 2 (Appendix A), when the following criteria is met: • TOB is 77X (FQHC). • The claim has met the criteria to assign demo code A5. • The provider is aligned to the MCP Model. • The beneficiary is aligned to the same MCP Model Identifier as the provider. • The claim from date is on or within the beneficiary's effective start and end date from the ACOB Auxiliary File. • Line item date of service on the claim is equal to or falls within the effective start and end date of the Track 2 BE indicator M. • Line item date of service on the claim must be equal to or within the effective and end dates of the beneficiary ACOB alignment file. • Do not consider the beneficiary aligned if the ACOB Drop flag is set. • The billing providers CCN is found on the CCN provider file based on the from and through dates of service on the claim. • Line item date of service must be equal to or within the effective and end dates of the provider (using the CCN) alignment file. • The HCPCS code listed in Appendix A • Do not consider the provider aligned if the effective and end dates are the same.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.44	The Contractor shall apply a reduction for MCP claims with the BE indicator 'N' for Track 3 (Appendix B) when the following criteria is met: • The claim TOB is 77X (FQHC). • The claim has met the criteria to assign demo code A5. • The HCPC code is listed on Appendix B (Track 3) reduced by 100% • The provider is aligned to the MCP Model. • The beneficiary is aligned to the same MCP Model Identifier as the provider. • The claim from date is on or within the beneficiary's effective start and end date from the ACOB Auxiliary File. • Line item date of service on the claim is equal to or falls within the effective start and end date of the Track 3 BE indicator 'N'. • Line-item date of service on the claim must be equal to or within the effective and end dates of the beneficiary ACOB alignment file. • Do not consider the beneficiary aligned if the ACOB Drop flag is set. • The billing providers CCN is found on the CCN provider file based on the from and through dates of service on the claim. • Line-item date of service must be equal to or within the effective and end dates of the provider (using the CCN) alignment file. • The HCPCS code listed in Appendix B that are eligible to a reduction 100%. • Do not consider the provider aligned if the effective and end dates are the same.					X				
13392.45	This requirement has been deleted.					X				NCH
13392.46	The Contractors shall send fields related to the MCP Track 2 and Track 3, (BE indicator M and N) reductions and value codes to support the Provider Statistical and Reimbursement (PS&R) reporting.					X				PS&R

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.47	The Contractors shall use the ANSI information below for all claims with the MCP reduction applied. • Group Code: CO Contractual Obligation • Claims Adjustment Reason Code (CARC): 132 "Prearranged demonstration project adjustment."	X				X				
13392.48	The Contractor shall ensure that demo code A5 is included on all outbound 837 crossover claims transmitted to the COB Contractor (COBC) and shall balance in accordance with Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 837 version 5010 requirements.					X				BCRC
13392.49	The Contractor shall calculate coinsurance for claims with demo code A5 present in the same manner as they would in the absence of the demonstration, i.e. based on the amount Medicare would have paid in the absence of the demonstration. Note: Deductible does not apply to FQHC claims					X				
13392.50	The Contractor shall apply any clean claim interest payments based off the amount after applying the MCP Reduction for claims with BE indicators M or N. The clean claim interest calculation will occur after the application of the reduction.					X				
13392.51	The Contractor shall send the Value Code "Q0" (zero) for institutional claims and Value Code of "Q1" for Institutional Claims on the CWF claim transmission record and to the IDR for purposes of data analysis and reporting.					X			X	IDR
13392.52	The Contractors shall apply and tally the actual amount of the MCP reduction to Value Code "Q1".					X				HIGLAS
13392.53	The Contractor shall send the MCP FQHC payment adjustment, Value Code "Q0" (zero) and Value Code "Q1" to the Common Working File (CWF) for					X			X	NCH

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the (HUOP) record.									
13392.54	The Contractors shall report all claims paid under the MCP Model on the provider Remittance Advice (RA) together with all FFS claim payments.					X				
13392.55	The Contractors shall show the final payment amount and the reduction amount for claims where the Provider's BE indicators M or N was applied to the claim on all RAs created.					X				
13392.56	The Contractor shall display the reductions for Track 2 and Track 3 in the REDUCTION field on the Standard Paper Remittance (SPR) and PC-Print. NOTE: The reduction amount field is a header field on the SPR and therefore cannot be changed based on the BE flags and demo codes found on a claim. The field name needs to be all-encompassing.					X				
13392.57	The Contractors shall ensure that the MSN will show the amount that would have been paid if not for the Provider's MCP reduction as the provider paid amount, i.e. BE indicators M or N.					X				
13392.58	The Contractors shall ensure the amount in the, "Maximum You May Be Billed," section reflects the Beneficiary's liability prior to the MCP reductions, i.e. BE indicators M or N.	X				X				
13392.59	The Contractors shall display the full allowed amount on the MSN when the Track 3 reduction is 100%, i.e. BE indicator N.					X				
13392.60	The Contractors shall display MSN Message, 63.10 on MCP claims where BE indicator L, M or N for Track 1 through 3, is present on the claim-header or claim-detail. MSN 63.10 You received this service from a provider who coordinates your care through an organization participating in a CMMI Model. For more information	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	about your care coordination, talk with your doctor or call 1-800-MEDICARE (1-800-633-4227). Spanish translation: "Recibió este servicio de un proveedor que coordina su cuidado a través de una organización que participa en el Modelo CMMI. Para obtener más información sobre la coordinación de su cuidado, hable con su médico o llame al 1-800-MEDICARE (1-800-633-4227)."									
13392.61	For all claims with the MCP FQHC adjustment amount, the contractors shall use the following ANSI information: Group Code: CO (Contractual Obligation) CARC 132 – Prearranged demonstration project adjustment. Spanish Translation - Esta reclamación está siendo procesada bajo un projecto especial.	X				X				
13392.62	The Contractor shall calculate 1) the total allowed charges (after Traditional FFS processing); then 2) apply the sequestration adjustment when applicable; 3) then apply the MCP reduction for claims when: The Provider has BE indicators, M or N identified on the Provider Alignment File for Track 2 and Track 3.					X				
13392.63	The Contractor shall continue to apply sequestration, when applicable, to the value code amounts. Note: The value codes on the face of the claim should continue to show the full amount before Sequestration, the reduction should occur in the background.					X				
13392.64	CMS shall create a future recurring CR to update changes to tables found in Appendix's that store information for: • HCPCS in Tracks 1 and 2 (Appendix A) • HCPCS in Track 3 (Appendix B)									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• HCPCS to be denied (Appendix C) • Specialty types – MCS only (Appendix D) Note: **For HCPCS in Appendix C: Institutional claims will be rejected and Professional/Provider HCPCS codes will be denied.**									
13392.65	CMS shall send the Shared System Maintainer (SSM) the initial provider participant file for MCP via the Cloud Storage and Retrieval System (CSRS) User Interface (UI) After the initial file, full replacement files with any updates will be supplied as needed and will be processed by the SSMs. NOTE: The file(s) will be a national file(s) accessible by all Medicare Administrative Contractors (MACs). Provider participant test files are: MCP_prov_impl.csv Provider participant regular production files are: MCP_prov_prod.csv CMS contacts are: Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov); Melissa Trible (melissa.trible@cms.hhs.gov); Sonja Madera (sonja.madera@cms.hhs.gov)									CMS
13392.66	MCS shall accept the MCP provider participant file layout to support the MCP processing change.						X			
13392.67	MCS shall create response files acknowledging receipt of the MCP provider participant file.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13392.68	MCS shall produce response files that indicate the file was processed and whether or not there were any errors. The response files shall be accessible through the CSRS UI.						X			
13392.69	CMS shall provide MCS with the MCP provider participant file no later than the ALPHA testing time frame. CMS Contacts: Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov); Melissa Trible (melissa.trible@cms.hhs.gov); Sonja Madera (sonja.madera@cms.hhs.gov)									CMS
13392.70	CMS shall upload the initial MCP provider participant testing files in the CSRS application on or before June 3, 2024 so the test data can become available in User Acceptance Testing (UAT) for the contractor. CMS Contacts: Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov); Melissa Trible (melissa.trible@cms.hhs.gov); Sonja Madera (sonja.madera@cms.hhs.gov)									CMS
13392.71	CMS shall send the Shared System Maintainer (SSM) the initial beneficiary alignment file for MCP via the Cloud Storage and Retrieval System (CSRS) User Interface (UI) After the initial file, full replacement files with any updates will be supplied as needed and will be processed by the SSMs.									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	NOTE: The file(s) will be a national file(s) accessible by all Medicare Administrative Contractors (MACs). Beneficiary Alignment test files are: MCP_bene_impl.csv Beneficiary Alignment regular production files are: MCP_bene_prod.csv CMS contacts are: Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov); Melissa Trible (melissa.trible@cms.hhs.gov); Sonja Madera (sonja.madera@cms.hhs.gov)									
13392.72	CWF shall accept the MCP beneficiary alignment file layout to support the MCP processing change.								X	
13392.73	CWF shall create response files acknowledging receipt of the MCP beneficiary alignment file.								X	
13392.74	CWF shall produce response files that indicate the file was processed and whether or not there were any errors. The response files shall be accessible through the CSRS UI.								X	
13392.75	CMS shall create a CSV test file using the file format in the attached standard ICD file layout and upload the file using the Cloud Storage and Retrieval System (CSRS) user interface (UI) on or before June 3, 2024. CMS contacts: Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov); Melissa Trible (melissa.trible@cms.hhs.gov);									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Sonja Madera (sonja.madera@cms.hhs.gov)									
13392.76	CMS shall provide MCS/SSM with the MCP provider participant file no later than the ALPHA testing time frame. CMS Contacts: Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov); Melissa Trible (melissa.trible@cms.hhs.gov); Sonja Madera (sonja.madera@cms.hhs.gov)									CMS
13392.77	CMS shall upload the initial MCP beneficiary alignment testing files in the CSRS application on or before June 3, 2024 so the test data can become available in User Acceptance Testing (UAT) for the contractor. CMS Contacts: Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov); Melissa Trible (melissa.trible@cms.hhs.gov); Sonja Madera (sonja.madera@cms.hhs.gov)									CMS
13392.78	The MACs shall provide to CMS that data to create the test files no later than April 12, 2024. To assist with the creation of the test files, the MACs shall: • Provide a list of at a minimum 5 to 15 providers as indicated by TIN-oNPI-CCN for Part A MACs and TIN-iNPI for Part B MACs • Provide a list of 5 to 15 beneficiaries as indicated by their HICN/MBI • CMS will email the secure BOX link to the MAC's designated contact in time for testing.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	If the MACs have any questions, they may contact CMS at: CMS - ACO OIT Team (ACO-OIT@cms.hhs.gov); Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov); Melissa Trible (melissa.trible@cms.hhs.gov); Sonja Madera (sonja.madera@cms.hhs.gov)									
13392.79	CMS shall facilitate a 1-hour User Acceptance Testing (UAT) Kickoff to discuss testing, on or about the week of May 15, 2024.									CMS
13392.80	CMS shall facilitate 1-hour weekly calls during UAT testing, beginning the week of June 10, 2024.									CMS
13392.81	The Contractors and SSMs shall submit to CMS the list of attendee's email addresses to be invited to the testing calls within 5 days after the CR is issued in final. Contact for emails: Benjamin Eichberg benjamin.eichberg@cms.hhs.gov Sonja Madera sonja.madera@cms.hhs.gov	X	X			X	X		X	CMS, HIGLAS, VDC
13392.82	CWF shall provide an updated Beneficiary Alignment file with the most current Health Insurance Claim Number (HICN) to MCS/FISS.								X	
13392.82.1	The Contractors shall be prepared to accept the data elements on the updated Beneficiary Alignment file for each MCP participant. NOTE: The Beneficiary Alignment file will contain the data elements identified in the Interface Control Document (ICD). The file shall be processed as a full file replacement.					X				
13392.83	The Contractor shall create an edit to return as unprocessable claim lines when the MEC code G9037						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	is billed and the beneficiary and provider are not aligned to Tracks 2 or 3 with the following criteria: • HCPCS code G9037 • Track 1 Note: Demo code A5 should not be added as criteria has not been met.									
13392.83.1	The Contractors shall return as unprocessable claim lines using the following messages: CARC 96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC): N83 "No appeal rights. Adjudicative decision based on the provisions of a demonstration project." Group Code: CO (for contractual obligation)		X							
13392.84	The Contractor shall accept and process the MEC code G9037 billed on a claim line if the following criteria is met for track 2: • The criteria had been met for demo code A5 to be applied and added to the claim. • The claim from date is on or after 07/01/2024 • The claim has an aligned provider that is participating in Track 2 based on BE Indicator /Record Type value 'M' in the provider participant file.						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The HCPCS code should be allowed at the full rate and no reductions should apply.									
13392.84.1	This requirement has been deleted.		X							
13392.85	The Contractor shall accept and process the MEC code G9037 billed on a claim line if the following criteria is met for track 3: • The criteria had been met for demo code A5 to be applied. • The claim from date is on or after 07/01/2024. • The claim has an aligned provider that is participating in Track 3 based on BE Indicator /Record Type value 'N' in the provider participant file. • The claim is for an aligned beneficiary with the same MCP Model Identifier 'M' as the provider. • The HCPCS code should be reduced by 100%						X			
13392.85.1	This requirement has been deleted.		X							
13392.86	The contractor shall conduct UAT testing.	X	X							
13392.87	Contractors shall make table/file updates to create a new adjustment reason code for overpayments identified under Making Care Primary (MCP) Model. 38 - Overpayment Identified under Making Care Primary (MCP) Model	X	X							HIGLAS
13392.87.1	The Contractor shall modify reason code(s) as necessary to allow the contractors to add Adjustment Reason code 38.					X				
13392.88	HIGLAS shall map the Shared System Reason code '38' to the HIGLAS Reason Code '38' for both Part A									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	and Part B Orgs.									
13392.89	Contractors shall use the Reason Code '38' when initiating the MCP model adjustments for the recoupment of overpayments.	X								
13392.90	Contractors shall use the Reason Code '38' and existing Discovery Code 'C' when initiating the MCP model adjustments for the recoupment of overpayments.		X							
13392.91	Contractors shall follow the normal non-935 recoupment process for these adjustments.	X	X							HIGLAS
13392.92	Contractors shall ensure the 935 Indicator is not set (i.e., set the 935 Indicator to 'N' for these adjustments as they are not eligible for the Section 935 appeal rights).		X							
13392.93	HIGLAS shall map the MCP overpayments to existing Part A transaction types for adjustment reason code '38'. APROV-CLA (Non-935 overpayment) ABENE-CLA (Beneficiary non-935 overpayment) Note: HIGLAS will ignore the 935 Indicator and create the non-935 transactions for Part A when adjustments received with Adjustment Reason Code '38' as the MCP model overpayments are not eligible for 935 appeal rights.									HIGLAS
13392.94	Contractors shall use the following verbiage for the 'Reason for Overpayment' in the provider (Part A and Part B) demand letter enclosure for the new HIGLAS Reason code '38': 'Per the Making Care Primary (MCP) Model billing rules, this payment was made to you in error.'									HIGLAS
13392.95	Contractors shall use the following verbiage for the 'Reason for Overpayment' in the beneficiary (Part A									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	and Part B) demand letter enclosure for the new HIGLAS Reason Code '38': "The claim was processed incorrectly causing an overpayment to be made." Spanish Translation: "La reclamación fue procesada incorrectamente ocasionando un pago en exceso."									
13392.96	FISS shall allow contractors to add, update and remove codes listed in Appendix A, B and C via online PARM.					X				
13392.97	The contractors shall ensure that only participating providers accepting assignment will be included in the MCP Model.						X			
13392.97.1	Contractors shall process non-participating non-assigned claims as regular fee for service.						X			
13392.98	CMS shall provide an update for "Appendix C – Prohibited Healthcare Common Procedure Coding System (HCPCS) for Track 1, 2 and 3" of the Making Care Primary Model on an annual basis beginning July 1, 2025.									CMS
13392.99	The Contractor shall pay MEC HCPCS Code G9037 from the Medicare Physician Fee Schedule (MPFS) when the criteria has been met for Demo Code A5 to be applied to the claim for an aligned provider that is participating in Track 2 or Track 3 of the MCP Model. The HCPCS Code will include a Status of 'A' in the MPFS. For FQHCs, coinsurance should be based on the lesser of the submitted charges. There is no deductible for FQHC services. Allow the HCPCS Code to be billed with or without a visits code.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Pay from MPFS, based on fee schedule.									

IV. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information:N/A

VI. CONTACTS

Pre-Implementation Contact(s): Sonja Madera, Sonja.Madera@cms.hhs.gov , Melissa Trible, melissa.trible@cms.hhs.gov , Lauren McDevitt, Lauren.McDevitt@cms.hhs.gov , Benjamin Eichberg, Benjamin.Eichberg@cms.hhs.gov , Donna Schmidt, Donna.Schmidt@cms.hhs.gov , Janice Maxwell, Janice.Maxwell@cms.hhs.gov , Mark Baldwin, Mark.Baldwin@cms.hhs.gov , Cindy Pitts, Cindy.Pitts@cms.hhs.gov , Nora Fleming, nora.fleming@cms.hhs.gov , Cynthia Thomas, Cynthia.Thomas@cms.hhs.gov , Thomas Dorsey, Thomas.Dorsey@cms.hhs.gov , Tracey Mackey, Tracey.Mackey@cms.hhs.gov , Elizabeth Seeley, elizabeth.seeley1@cms.hhs.gov , Rae Ann Sprecher-Frey, rae.sprecher-frey@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 4

Appendix A – Accepted HCPCs for Track 1 and 2
(codes to be reduced by 50% for Track 2 participants)
(no reduction for Track 1 participants, with Track 1 claims processed as normal FFS)

Service	**Code(s)**
Office/outpatient visit for the evaluation and management (E&M) of a patient	99202-99205, 99211-99215, 99415, 99416, G2212
Home care/domiciliary care E&M	99341, 99342, 99344, 99345, 99347-99350
Online digital E&M	99421-99423
Audio-only E&M services	99441-99443
Technology-based check-in services	G2010, G2012, G2252
Remote physiologic monitoring (RPM) non-face-to-face treatment management services	99091, 99453, 99454, 99457, 99458
Remote therapeutic monitoring (RTM) non-face-to-face treatment management services	98975-98977, 98980, 98981
Advance care planning	99497, 99498
Welcome to Medicare and annual wellness visits	G0402, G0438, G0439
Administration of health risk assessment (HRA)	96160, 96161
FQHC All-Inclusive visit	G0466, G0467
FQHC IPPE or AWV visit	G0468
FQHC Distant Site Telehealth visit	G2025
FQHC Virtual Communication Services	G0071

Appendix B – Accepted HCPCs for Track 3
(codes to be reduced by 100% for Track 3 participants)

Service	**Code(s)**
Office/outpatient visit for the evaluation and management (E&M) of a patient	99202-99205, 99211-99215, 99415, 99416, G2212
Home care/domiciliary care E&M	99341, 99342, 99344, 99345, 99347-99350
Online digital E&M	99421-99423
Audio-only E&M services	99441-99443
Technology-based check-in services	G2010, G2012, G2252
Remote physiologic monitoring (RPM) non-face-to-face treatment management services	99091, 99453, 99454, 99457, 99458
Remote therapeutic monitoring (RTM) non-face-to-face treatment management services	98975-98977, 98980, 98981
Advance care planning	99497, 99498
Welcome to Medicare and annual wellness visits	G0402, G0438, G0439
Administration of health risk assessment (HRA)	96160, 96161
FQHC All-Inclusive visit	G0466, G0467
FQHC IPPE or AWV visit	G0468
FQHC Distant Site Telehealth visit	G2025
FQHC Virtual Communication Services	G0071
Depression, substance use disorder, and alcohol misuse screening and counseling services	G0396-G0397, G0442-G0444, G2011
Care management services for behavioral health conditions	99484
Cognition and functional assessment for patient with cognitive impairment	99483
Behavioral health integration (BHI) services	99492, 99493, 99494, G2214, G0512
MCP e-Consult	G9037
Interprofessional consult (IPC) services	99452

Appendix C – Prohibited HCPCs for Track 1, 2 and 3
(codes to be denied for Track 1, 2 and 3)

Service	**Code**
Principal care management (PCM) services	99424, 99425, 99426, 99427
Complex chronic care coordination services	99487, 99489
Chronic care management (CCM) services	99490, 99491, 99437, 99439, G2058
Transitional care management (TCM) services	99495, 99496
Assessment/care planning for patients requiring CCM services	G0506
CCM or General Behavioral Health Integration (BHI) Services (for FQHCs)	G0511
Chronic Pain Management (CPM)	G3002, G3003
Community Health Integration (CHI) Services	G0019, G0022
Social Determinants of Health Risk Assessment	G0136
Principal Illness Navigation (PIN) Services	G0023, G0024, G0140, G0146

Appendix D – Approved Rendering Provider specialty types for ACM code billing

specialty_rfrnc_desc	specialty_rfrnc_cd
Addiction Medicine	79
Advanced Heart Failure and Transplant Cardiology	C7
Allergy-Immunology	03
Cardiac Electrophysiology	21
Cardiovascular Disease (Cardiology)	06
Medical Oncology	90
Nephrology	39
Neurology	13
Neuropsychiatry	86
Obstetrics-Gynecology	16
Ophthalmology	18
Dermatology	07
Endocrinology	46
Gastroenterology	10
Geriatric Medicine	38
Geriatric Psychiatry	27
Hematology	82
Hematology-Oncology	83
Hospice-Palliative Care	17
Infectious Disease	44
Internal Medicine	11
Interventional Cardiology	C3
Orthopedic surgery	20
Interventional Pain Management	09
Peripheral Vascular Disease	76
Physical Medicine and Rehabilitation	25
Psychiatry	26
Pulmonary Disease	29
Rheumatology	66
Sleep Medicine	C0
Sports Medicine	23
Urology	34