CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-19 Demonstrations	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12983	**Date: November 27, 2024**
	Change Request 13820

SUBJECT: Making Care Primary (MCP) Informational Unsolicited Responses (IURs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct contractors to flag claims that have already processed as fee-for-service (FFS) if the Making Care Primary (MCP) beneficiary file is updated late as an Informational Unsolicited Response (IUR) and have the pricing corrected as part of the MCP Model, along with other scenarios for reprocessing claims in line with model logic.

EFFECTIVE DATE: July 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 7, 2025

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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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct contractors to flag claims that have already processed as fee-for-service (FFS) if the Making Care Primary (MCP) beneficiary file is updated late as an Informational Unsolicited Response (IUR) and have the pricing corrected as part of the MCP Model, along with other scenarios for reprocessing claims in line with model logic.

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.

Please note this MCP CR is a follow-on to CR 13392 and addresses the following objectives for the April 2025 Release:
• Adding IUR capabilities for when the beneficiary and provider alignment files are received and the dates of service on the history claim are no longer in the model;

• adjusting claims not processed as MCP when the claims have processed as fee-for-service due to the beneficiary alignment file being uploaded late;

• and reprocessing claims when the beneficiary alignment files are received and the dates of service on the history claim were not previously in the model but have been added.

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 Healthcare Common Procedure Coding System (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 Track 2 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.

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.

This CR is a follow-on to CR 13392 and adds addition IURs for reprocessing claims to correct pricing due to issues in beneficiary or provider alignment file issues along with other scenarios relating to MCP model participation.

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	
13820.1	The contractors shall adjust claims not processed as part of the Making Care Primary (MCP) model when the claims have processed as fee-for-service due to the beneficiary alignment file being uploaded late.	X	X			X	X			
13820.1.1	The contractor shall trigger an IUR when the Beneficiary alignment file is updated late to flag claims that have already processed as fee-for-service in order to have their pricing corrected as part of the MCP Model (demo code 'A5').								X	
13820.1.1.1	CWF shall modify existing IUR 7219 for Part B and Outpatient Claim types for new demo code 'A5', when the Beneficiary file is updated late and Model claims have already been processed as fee-for-service.								X	
13820.1.2	The contractor shall create an adjustment based on IUR Edit 7219.					X	X			
13820.2	The contractor shall trigger a modification to IUR Edit 7219 on or after when the Beneficiary and Provider alignment files are received, and the dates of service on the history claim were not previously in the model but have been added.								X	
13820.2.1	CWF shall modify existing IUR 7219 for Part B and Outpatient Claim types for new demo code 'A5', when the Date of Service (DOS) on the history claim was not previously in the model but has been added.								X	
13820.2.2	The contractor shall create an adjustment based on the IUR Edit 7219.	X	X			X	X			
13820.3	CMS shall provide a list of accepted and prohibited services under the MCP Model appendices. Appendix A = Accepted Healthcare Common Procedure Coding System (HCPCS) codes 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 codes for Track 3 (codes to be reduced by 100% for Track 3 participants) Appendix C = Prohibited HCPCS codes for Track 1, 2 and 3 (codes to be denied for Track 1, 2 and 3)									
13820.4	The contractor shall generate IUR 7219 for Track 1 claim details when the following circumstances are met: • Beneficiary's Health Insurance Claim Number (HICN)/Medicare Beneficiary Identifier (MBI) is on the Beneficiary File, • Provider's Billing Tax Identification Number (TIN)/Rendering National Provider Identifier (NPI) is found on the Provider file (Benefit Enhancement Indicator of L), • Procedure code is found on Appendix A.								X	
13820.5	The contractor shall generate IUR 7219 for Track 2 claim details 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	
13820.6	The contractor shall generate IUR 7219 for Track 3 claim details 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.									
13820.7	The contractor shall generate IUR 7219 for Track 1, 2, and 3 claim details 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, M, or N), • Procedure code is found on Appendix C (applies to Benefit Enhancement Indicators of L (Track 1), M (Track 2), and N (Track 3)).								X	
13820.8	The contractor shall generate IUR 7219 on claim details that processed with the Ambulatory Co-Management (ACM) code (G9038) when the following circumstances are met: • Beneficiary is on the Beneficiary File as a Track 3 (Benefit Enhancement Indicator N), • Provider specialty is on Appendix D. Note that Appendix D only applies to Part B.								X	
13820.9	The Contractor shall use below criteria when generating retro IUR 7219 on a **Part B** claim. 1. Provider and Beneficiary are both aligned to same MCP ID number. 2. The rendering NPI and Tax Identification Number (TIN) in the Part B claim detail will be read to identify an aligned provider. 3. The Date of Service on the claim is within both the Bene and Provider alignment dates. 4. Provider reimbursement amount must be present on the claim. 5. Assignment indicator equals 'A'.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	6. Retro IUR will not apply to Medicare Secondary Payer (MSP) claims. 7. Retro IUR will not apply when reimbursement is made to the Beneficiary. Note: The above validation checks shall apply to Business Requirements (BRs) 13820.4, 13820.5, 13820.6, 13820.7 and 13820.8.									
13820.10	The Contractor shall use below validation checks when generating retro IUR 7219 on an **Outpatient** claim. 1. Both Provider and Beneficiary are aligned to the same MCP ID number. 2. The Provider CCN number in the claim header will be read to identify an aligned provider on an Outpatient claim. 3. The Date of Service on the claim is within both the Bene and Provider alignment dates. 4. Provider reimbursement amount must be present on the claim. 5. Retro IURs will only apply to Outpatient claims with Type of Bill (TOB) 77x. 6. Retro IUR will not apply to Medicare Secondary Payer (MSP) claims. 7. Retro IUR will not apply when reimbursement is made to the Beneficiary. Note: The above validation checks shall apply to BRs 13820.4, 13820.5, 13820.6, 13820.7 and 13820.8.								X	
13820.11	MIST shall perform BETA Testing on February 10, 2025									MIST
13820.12	The MACs shall perform User Acceptance Testing on or about the week of March 10, 2025.	X	X							
13820.13	CMS shall email the secure BOX link to the MAC's designated contact no later than February 3, 2025, in time for testing. If the MACs have any questions, they may contact CMS at:									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CMS - ACO OIT Team (ACO-OIT@cms.hhs.gov) • Eli Boone, eli.boone@cms.hhs.gov • Benjamin Eichberg (benjamin.eichberg@cms.hhs.gov) • Melissa Trible (melissa.trible@cms.hhs.gov)									
13820.14	The MACs shall provide to CMS/OIT the beneficiary data to create the test files no later than February 14, 2025, for User Acceptance Testing (UAT) testing	X	X							
13820.14.1	To assist with the creation of the test files, the MACs shall: • Provide a list of 5 to 15 beneficiaries as indicated by their HICN/MBI	X	X							
13820.15	The MACs shall update provider test data using the Model Test Data Entry (MTDE) application.	X	X							
13820.16	The MACs shall contact CMS, if they have any questions at: Primary Contact: • Eli Boone, eli.boone@cms.hhs.gov • Benjamin Eichberg, benjamin.eichberg@cms.hhs.gov • Melissa Trible, melissa.trible@cms.hhs.gov	X	X							
13820.17	CMS shall facilitate a 1-hour User Acceptance Testing (UAT) Kickoff to discuss testing, on or about the week of March 3, 2025.	X	X			X	X		X	CMS, MIST
13820.18	Contractors shall make themselves available for up to 4 calls during the User Acceptance Testing (UAT) to	X	X			X	X		X	MIST

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	discuss any testing issues.									
13820.19	CMS shall facilitate a 1-hour weekly calls during UAT, beginning the week of March 10, 2025.									CMS
13820.20	The SSMs, the MACs, and other contractors shall submit a list of attendees for the calls to the CMS contacts listed below. The SSMs shall provide the list of attendees by day one of the Program Implement (PI) Planning or sooner. MACs and other contractors shall provide the list of attendees within 5 business days of the issuance date of the CR. • Eli Boone, eli.boone@cms.hhs.gov • Benjamin Eichberg, benjamin.eichberg@cms.hhs.gov • Melissa Trible, melissa.trible@cms.hhs.gov	X	X			X	X		X	MIST

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

VI. CONTACTS

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