Making Care Primary (MCP)
Model Overview Factsheet

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Making Care Primary (MCP) is a 10.5-year value-based care (VBC) model operated by the CMS Innovation Center (CMMI). CMMI will work with Making Care Primary participants to drive advanced, coordinated, high quality care for patients in their communities. The purpose of this document is to provide an overview of key model design elements for potential model applicants.

Introduction to MCP

While this fact sheet describes policies specific to beneficiaries covered by traditional Medicare, CMS has partnered with State Medicaid Agencies in the listed states to develop or commit to developing aligned Medicaid programs in their states.

For more information on your state's aligned Medicaid program, reach out to your State Medicaid Agency.

- **Number of Participation Options:** 3 Tracks
- **Where MCP will Operate:** CO, NC, NJ, NM, NY, MA, MN, WA
- **Indicate Your Interest:** *Estimated 10 mins to complete a letter of intent (LOI)* [Link]
- **Application & RFA available:** August 2023
- **Application Deadline:** November 2023

Who's Eligible?

Applicants must meet eligibility criteria listed in the MCP Request for Applications (RFA). In general, the following types of organizations that provide primary care may apply:

- Solo primary care practices
- Indian Health Programs[1]
- FQHCs[2]
- Group practices
- Health systems
- Certain Critical Access Hospitals (CAHs)[3]

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 will not be able to concurrently participate in the Medicare Shared Savings Program (MSSP) and MCP (with the exception of the first 6 months).

Only organizations operating in the listed MCP states will be eligible.

Your organization's prior experience with VBC will determine your eligibility for individual Tracks in MCP.

[1] *The term 'Indian Health Program' means any health program administered by the Indian Health Service and any tribal health program as defined by 25 U.S.C. § 1603(25), except that tribal health programs which are Grandfathered Tribal FQHCs are not eligible for MCP.*
[2] *The term "Federally Qualified Health Center" or "FQHC" refers to entities that receive Medicare and Medicaid enhanced payments described at §1834(o) and §1902(bb) of the Social Security Act (the Act), respectively.*
[3] *Critical Access Hospitals that are reimbursed for Outpatient Services under the Standard Payment Method (Method I) are eligible.*

Three Tracks

MCP offers interested organizations three tracks to meet applicants where they are in care delivery transformation, infrastructure capacity, and readiness for payment alternatives to Fee-for-Service. Participants in Tracks 1 and 2 must move to the next Track after a specified time period. Track 3 is not time-limited. To be eligible for Track 1, applicants must have no prior experience in value-based care[1].

Track 1: Building Infrastructure

Participants research and plan an approach to implement advanced primary care services, including:

- risk-stratifying their population
- reviewing data, building out workflows
- identifying staff for chronic disease management
- conducting health-related social needs screening and referral

Payment for primary care will remain fee-for-service (FFS) and CMS will provide additional financial support to help participants build advanced care delivery capabilities. Participants can begin earning financial rewards for improving patient health outcomes.

Track 2: Implementing Advanced Primary Care

Participants build upon work completed in Track 1 by:

- partnering with social service providers and specialists
- implementing care management services
- systematically screening for behavioral health conditions

Payment for primary care will shift partially to prospective, population-based payments and CMS will continue to provide additional financial support as participants build capabilities. Participants are eligible to earn increased financial rewards for improving patient health outcomes and achieving savings.

Track 3: Optimizing Care and Partnerships

Participants expand upon the requirements of Tracks 1 and 2 by:

- using quality improvement frameworks to optimize and improve workflows
- address silos to improve care integration
- enhance social service and specialty partnerships
- deepen connections to community resources

Payment for primary care will shift to fully prospective, population-based payment while CMS will provide additional financial support to sustain care delivery activities while participants can earn greater financial rewards for improving patient health outcomes and achieving savings.

More information on the care delivery requirements, payment, and specialty care integration elements of each track will be available in the MCP RFA and future fact sheets.

[1]*No experience in value-based care is defined as no previous experience in any Medicare performance-based risk initiative (this definition will be provided in the Request for Applications)*

What Does MCP's Multi-Payer Alignment Approach Mean for Participants?

MCP's multi-payer alignment approach introduces three features to support comprehensive practice transformation, allowing participants to connect more patients to high quality care.

MCP Multi-Payer Alignment

Feature 1: Directional Alignment

CMS will work with payers in MCP states to encourage close alignment in areas that directly reduce burden on clinicians, such as the type and format of quality measures. This means MCP participants will generally:

- Move payments away from FFS for primary care services.
- Report the same core quality measures to MCP payers. MCP payers will have some flexibility to add population-specific measures.

Feature 2: Starting with State Medicaid Agencies (SMAs)

CMS has partnered with SMAs to streamline primary care payment reform and learning priorities across Medicare and Medicaid. MCP participants will receive:

- State and national level resources to foster collaboration with other organizations
- Regular opportunities to connect with state peers

Feature 3: Refreshed Investments and Resources

CMS, SMAs and payer partners will make practice- and patient-level data available to participants through data sharing efforts within the state. CMS and payer partners will make supports available to MCP participants to foster success, including:

- State-level data aggregation and reporting
- Specialty care data for participants to use when building partnerships
- Practice facilitation and coaching, especially for small, independent and safety net organizations who desire that support and need help building capacity
- Peer-to-peer learning

MCP Payment Types By Track

Prospective Primary Care Payment (PPCP)

Track 1 | **Track 2** | **Track 3**

- Replaces fee-for-service revenue for primary care services for beneficiaries attributed to MCP
- Will reflect participants' historical primary care billing for the first three model years; CMS will introduce a methodology that bases a portion of the PPCP on regional spend trends[1] for Track 3 participants

Enhanced Services Payment (ESP)

Track 1 | **Track 2** | **Track 3**

- Risk-adjusted per beneficiary[2] per month (PBPM) payment to participants in Tracks 1, 2, and 3 in addition to payment for typical primary care services; decreases by track as participants build capacity
- Supports ongoing care management activities, such as chronic disease management and health-related social needs (HRSN) screenings

Performance Incentive Payment (PIP)

Track 1 | **Track 2** | **Track 3**

- Upside risk only bonus payment based on quality utilization, and cost; bonus potential increases by track
- Assessed every year

Upfront Infrastructure Payment (UIP)

Track 1 | Track 2 | Track 3

- Infrastructure payment that is only available to Track 1 participants new to VBC arrangements and meet a low revenue threshold, or do not have an e-consult platform[3]
- Eligible participants may receive $72,500 in a lump sum payment at the start of Year 1 and an additional $72,500 at the start of Year 2

UIP Use Categories:

- Increased Staffing
- Social Determinants of Health (SDOH) Strategies
- Health Care Clinician Infrastructure

Additional Payments to Support Specialty Care Integration:

MCP eConsult (MEC) Code for Participants

- Track 2 and 3 participants can receive **$40 per service** (subject to geographic adjustment) when they send an eligible eConsult to any specialist[4]
- Supports increased patient care coordination through the use of eConsults to specialists

Ambulatory Co-Management (ACM) Code for Specialists

- Track 3 Specialty Care Partners in a Collaborative Care Arrangement (CCA) can bill CMS **$50 PBPM** (subject to geographic adjustment) for time-limited co-management activities)
- Supports coordination for time-limited co-management activities

More information on MCP's specialty care approach will be shared in future fact sheets.

[1]CMS will publish more details in the Request for Applications (RFA) (Anticipated release of August 2023).
[2]ESPs are for Medicare FFS beneficiaries attributed to the MCP participant. Aligned payers may introduce similar payments.
[3]CMS is still determining the low revenue threshold for Medicare revenue and will include more details in the Participation Agreement.
[4]Track 2 participants will bill CMS for the MEC code. Track 3 participants will receive their MEC payments as part of the PPCP.

Performance Incentive Payment (PIP)

The PIP is an **upside-only bonus** opportunity intended to reward participants for improving quality of care for patients and preventing costly episodes where possible. The PIP is applied as a percentage adjustment to the sum of primary care FFS revenue and prospective primary care payment revenue.

Track 1	Track 2	Track 3
Potential to receive upside-only PIP of up to **3%** sum of fee-for-service (FFS)	Potential to receive upside-only PIP of **up to 45%** sum of FFS and prospective primary care payments (PPCP)	Potential to receive upside-only PIP of **up to 60%** sum of prospective primary care payments (PPCP)

- A PIP is a percentage adjustment to a participant's payment for primary care services based on performance on the MCP Performance Measure Set.
- MCP participants must report all quality measures for their Track to receive a PIP adjustment. Once in Tracks 2 and 3, they must also meet or exceed the 30th percentile nationally for Total Per Capita Cost (TPCC).
- Continuous Improvement (CI) Measures assess participant performance against their own historical performance, while other measures use a regional or national benchmark.
- More details will be available in the forthcoming MCP RFA.

MCP Performance Measures[1]	Track 1	Track 2	Track 3
Controlling High Blood Pressure*	●	●	●
Diabetes Hba1C Poor Control* (>9%)	●	●	●
Colorectal Cancer Screening*	●	●	●
Person-Centered Primary Care Measure (PCPCM)	●	●	●
Screening for Depression and Follow Up*		●	●
Depression Remission within 12 months		●	●
Screening for Social Drivers of Health*		●	●
Emergency Department Utilization (EDU)		●	●
Total Per Capita Cost (TPCC)		●	●
<u>Continuous Improvement (CI)</u> • **TPCC CI** *(non-FQHCs and non-Indian Health Program (IHP) Participants)**; OR*** • **EDU CI** *(FQHCs and IHP Participants)**		●	●

[1]Certain measures proposed in the MCP model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer and use provisions related to the NCQA measures can be found at: https://innovation.cms.gov/notices-disclaimers

**Aligned with other CMS quality programs, including the Universal Foundation Measure Set.*

To help illustrate how the different payment types work together to support MCP participants, there are two example payment calculations on the next two pages that describe hypothetical example Participant A and FQHC A. Each example provides a breakdown of what each example participant might receive in each MCP participation track in performance period one (1) of the MCP.

Example Payment Calculation: Participant A

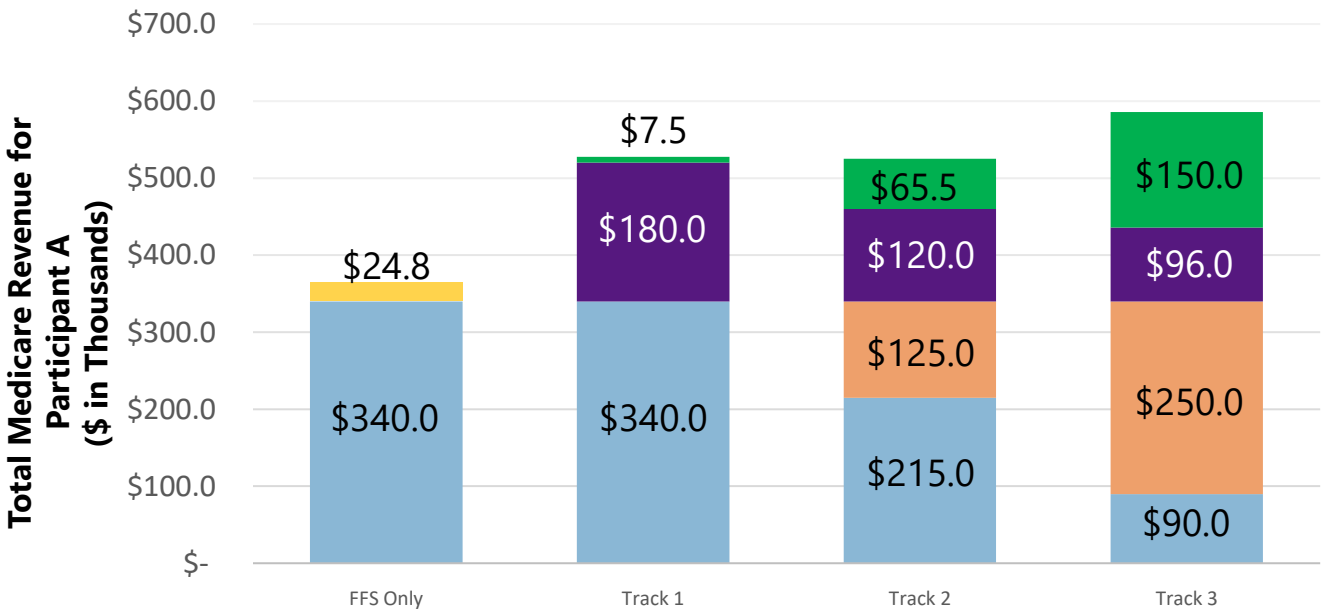
Participant A Characteristics

Total Medicare FFS beneficiaries: **1,000**

- 200 beneficiaries qualifying for higher ESP support[1]

Performance Period 1 Assumptions:

- ✓ Above minimum 30th percentile threshold for TPCC nationally
- ✓ Met the 50th percentile on 3 measures and TPCC
- ✓ Met the 70th / 80th percentile on 3 measures and EDU
- ✗ Did not get credit for TPCC CI
- ✗ Did not qualify for the UIP



- **FFS Carve Out:** Medicare FFS payments for services outside of the PPCP services list.
- **FFS Revenue:** Medicare FFS payments for services included in the PPCP list.
- **Enhanced Services Payment (ESP):** Risk adjusted PBPM payment to support the provision of enhanced services to Participant A's beneficiaries. Participant A's ESPs average **$15 PBPM in Track 1; $10 in Track 2; and $8 in Track 3**.
- **Prospective Primary Care Payment (PPCP):** Hybrid PBPM payment for primary care services based on Participant A's ***own*** historical spending data. Participant A's PPCP is **$21 PBPM**.
- **Performance Incentive Payment (PIP)[2]** Upside-only bonus payment based on Participant A's performance and quality measure data for performance period 1 (July 1, 2024 to December 31, 2024). Participant A earned a PIP of 26% (out of maximum PIP of 45%) during Track 2, which is **$5.46 PBPM ($21 x 0.26)**.
- **Chronic Care Management (CCM)[3]:** Replaced by non-claims based payment of population-based ESPs. Before joining MCP, Participant A billed CCM for 90 of its 1,000 beneficiaries (average **$23 PBPM**).

[1]CMS will adjust ESPs for social and clinical risk indicators, including the Medicare Part D low-income subsidy and Area Deprivation Index. For more information, refer to the MCP RFA (Anticipated release August 2023).
[2]The green shading in visual above indicates bonus payments by track for a hypothetical "Participant A", with high quality scores. MCP participants will be eligible for larger bonuses when they receive high quality scores.
[3]While participants in MCP will not be able to bill CCM codes, most will receive ESP payments that will increase their overall care coordination revenue.

Example Payment Calculation: FQHC A

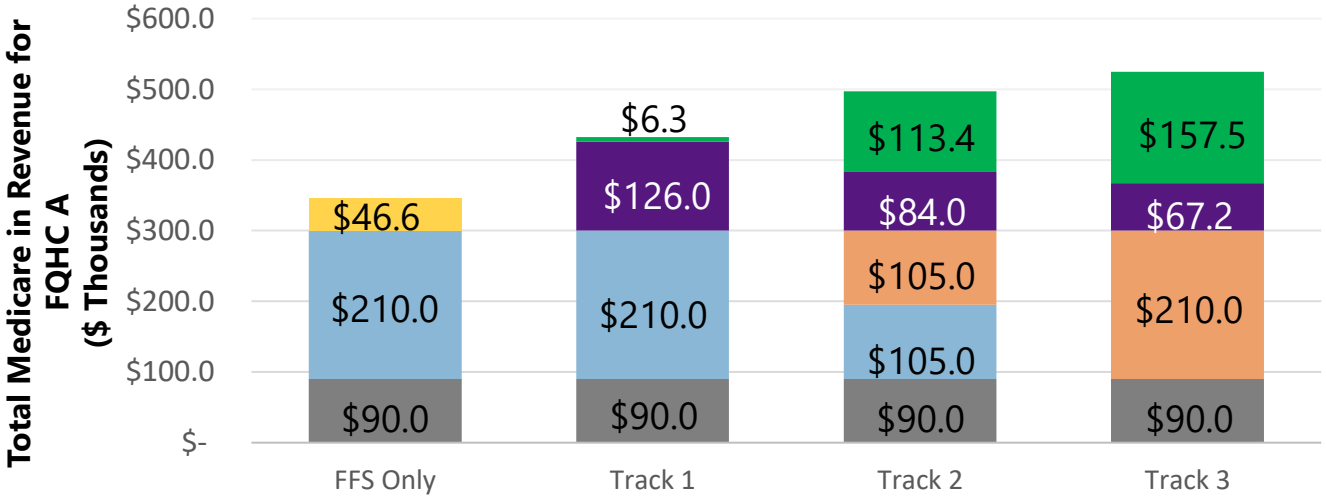
Participant A Characteristics

Total Medicare FFS beneficiaries: **1,000**

- 550 beneficiaries in highest-risk category[1]

Performance Period 1 Assumptions:

- ✓ Above minimum 30th percentile threshold for TPCC nationally
- ✓ Met the 50th percentile on 3 measures and TPCC
- ✓ Met the 70th / 80th percentile on 3 measures and EDU
- ✗ Did not get credit for EDU CI
- ✗ Did not qualify for the UIP



- **FFS Carve Out:** Medicare FFS payments for services outside of the PPCP services list.
- **FFS Revenue:** Medicare FFS payments for services included in the PPCP list.
- **Enhanced Services Payment (ESP):** Risk adjusted PBPM payment to support the provision of enhanced services to FQHC A's beneficiaries. FQHC A's ESPs average **$19 PBPM in Track 1; $16 in Track 2; and $15 in Track 3**.
- **Prospective Primary Care Payment (PPCP):** Hybrid PBPM payment for primary care services based on FQHC A's ***own*** historical spending data. For this example, FQHC A's PPCP is **$25 PBPM**. PPCP is 50% in Track 2 and 100% in Track 3.
- **Performance Incentive Payment (PIP)[2]:** Upside-only bonus payment based on FQHC A's performance and quality measure data for performance period 1 (January 1, 2025 to December 31, 2025). FQHC A earned a PIP of 26% (out of maximum PIP of 45%) during Track 2, which is **$6.50 PBPM ($25 x 0.26)**.
- **Chronic Care Management (CCM)[3]:** Replaced by non-claims based payment of population-based ESPs. Before joining MCP, FQHC A billed CCM for 138 of its 1,000 beneficiaries (average **$28 PBPM**).

[1]CMS will adjust ESPs for social and clinical risk indicators, including the Medicare Part D low-income subsidy and Area Deprivation Index. For more information, refer to the MCP RFA (Anticipated release August 2023).
[2]The green shading in visual above indicates bonus payments by track for a hypothetical "FQHC A", with high quality scores. MCP participants will be eligible for larger bonuses when they receive high quality scores.
[3]While participants in MCP will not be able to bill CCM codes, most will receive ESP payments that will increase their overall care coordination revenue.

Additional Information

Send questions you have about the model to
MCP@cms.hhs.gov

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

Submit an optional Letter of Intent to indicate your interest
Link