Making Care Primary (MCP) Model

Overview Webinar

June 27, 2023

Welcome & Introductions

Housekeeping & Logistics

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Today's Presenters

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Agenda

1 | Welcome and Introduction

2 | MCP Overview

3 | Eligibility & Participant Types

4 | Care Delivery Requirements

5 | Payment Structure

6 | Performance Assessment & Example Payment Calculation

**7** | Application, Next Steps, and Resources

8 | Closing

MCP Overview

Existing Gaps, Challenges, and Inequities

MCP aims to encourage care coordination and reduce patient challenges navigating their health care. The figure below illustrates the difference between a disjointed health care system and an integrated, high-quality primary care system based on the needs of the patient and their family.

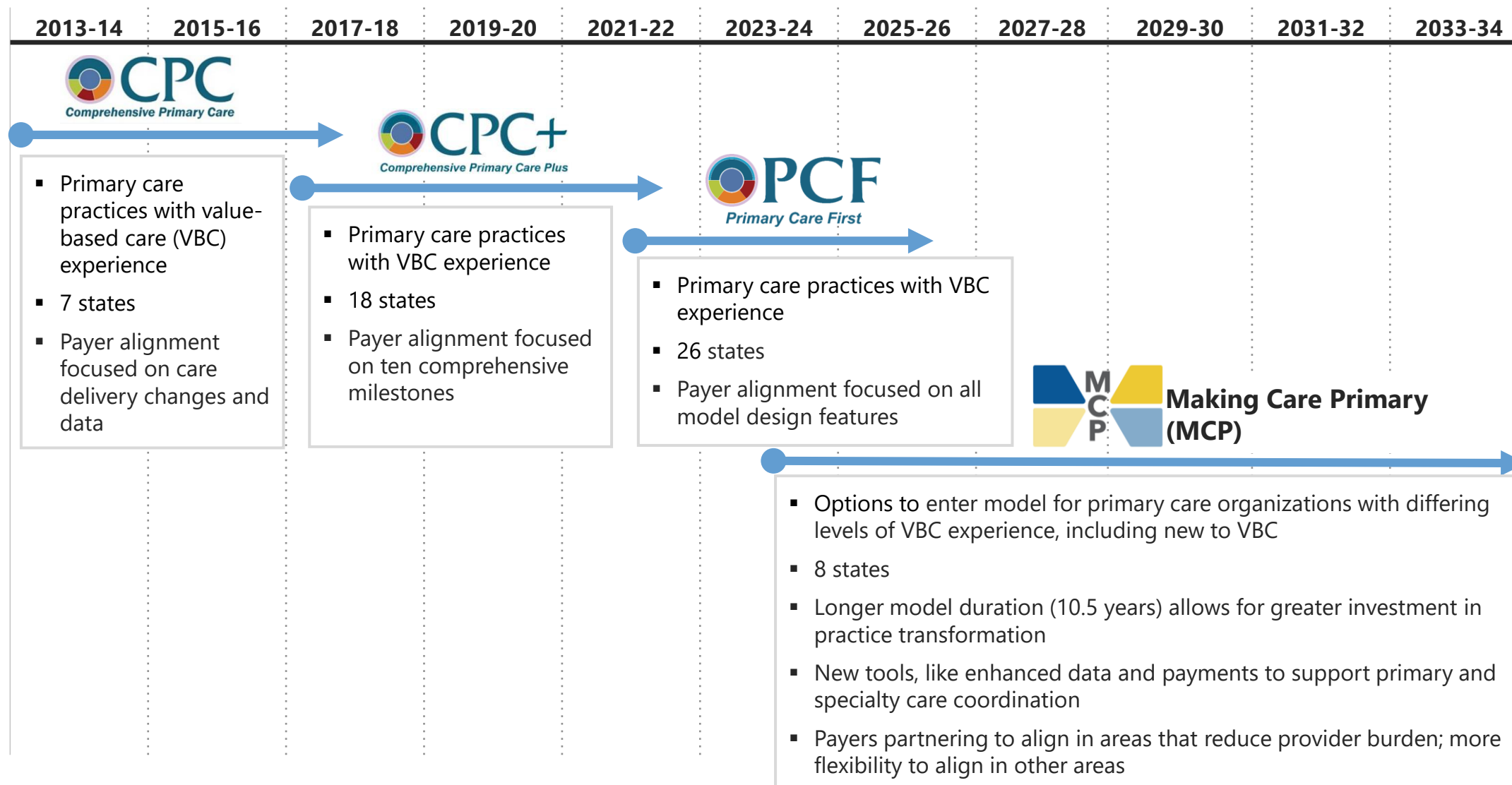**Current State:
A Disjoined System**
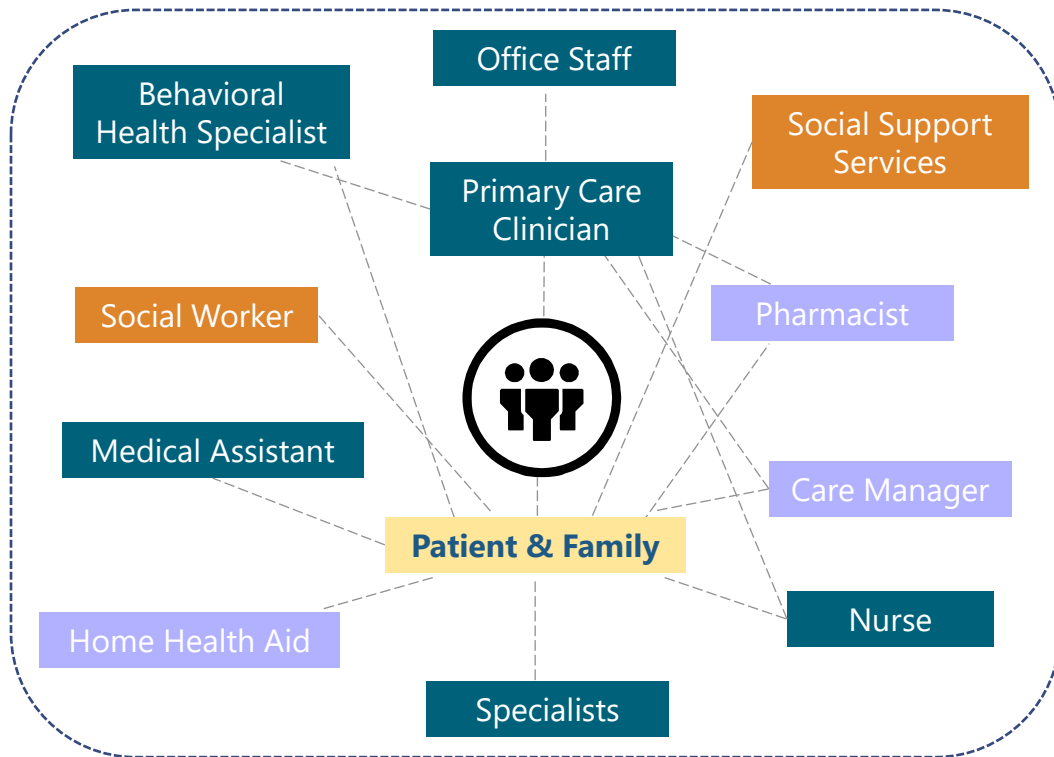
**Desired Future State:
Integrated, High-Quality Primary Care**
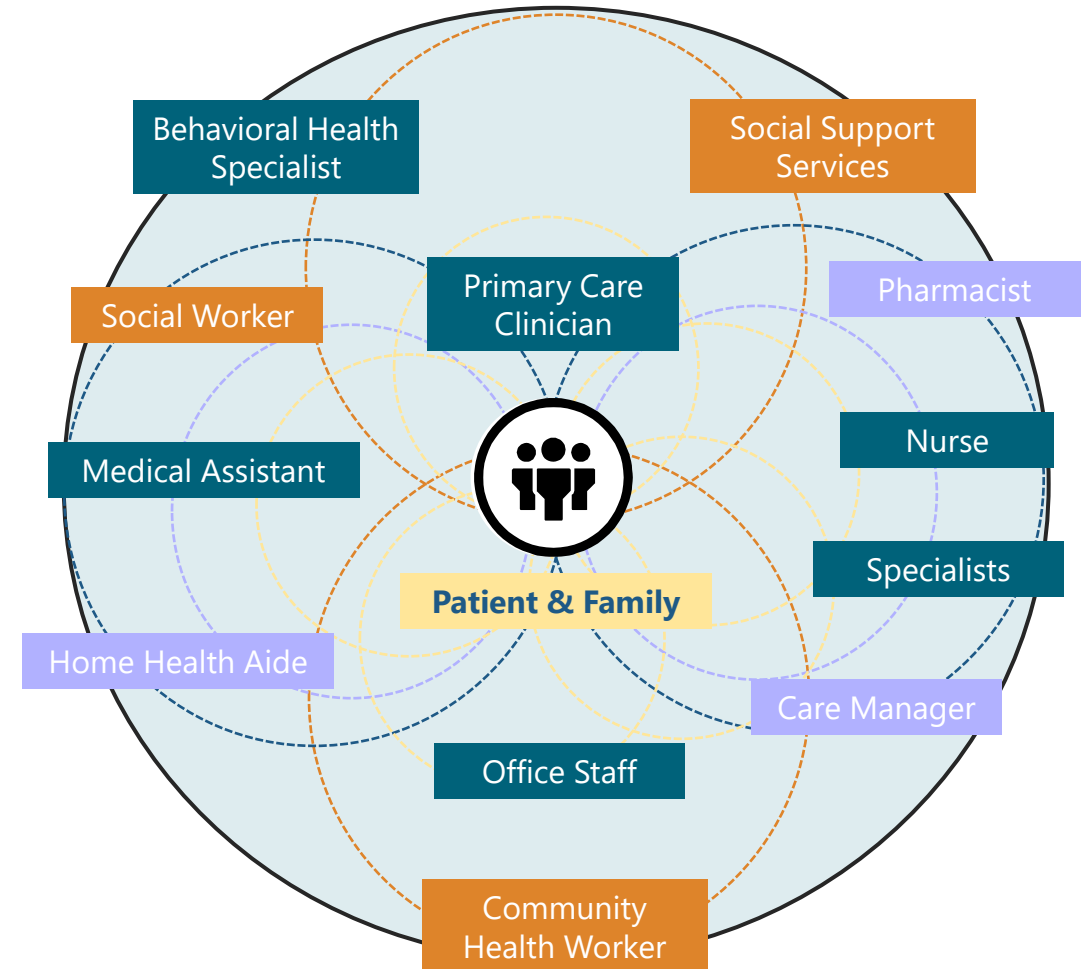
MCP Builds on Insights from Previous Models

MCP builds on insights from past CMS Innovation Center models to make advanced primary care available and sustainable for a more comprehensive pool of participants serving a broader and more diverse set of patients.

Timeline: 2013-14 | 2015-16 | 2017-18 | 2019-20 | 2021-22 | 2023-24 | 2025-26 | 2027-28 | 2029-30 | 2031-32 | 2033-34

CPC – Comprehensive Primary Care
- Primary care practices with value-based care (VBC) experience
- 7 states
- Payer alignment focused on care delivery changes and data

CPC+ – Comprehensive Primary Care Plus
- Primary care practices with VBC experience
- 18 states
- Payer alignment focused on ten comprehensive milestones

PCF – Primary Care First
- Primary care practices with VBC experience
- 26 states
- Payer alignment focused on all model design features

Making Care Primary (MCP)
- Options to enter model for primary care organizations with differing levels of VBC experience, including new to VBC
- 8 states
- Longer model duration (10.5 years) allows for greater investment in practice transformation
- New tools, like enhanced data and payments to support primary and specialty care coordination
- Payers partnering to align in areas that reduce provider burden; more flexibility to align in other areas

MCP Goals

MCP provides a pathway from FFS payment to prospective, population-based payment that supports comprehensive primary care that improves quality, patient experience, and population health outcomes.

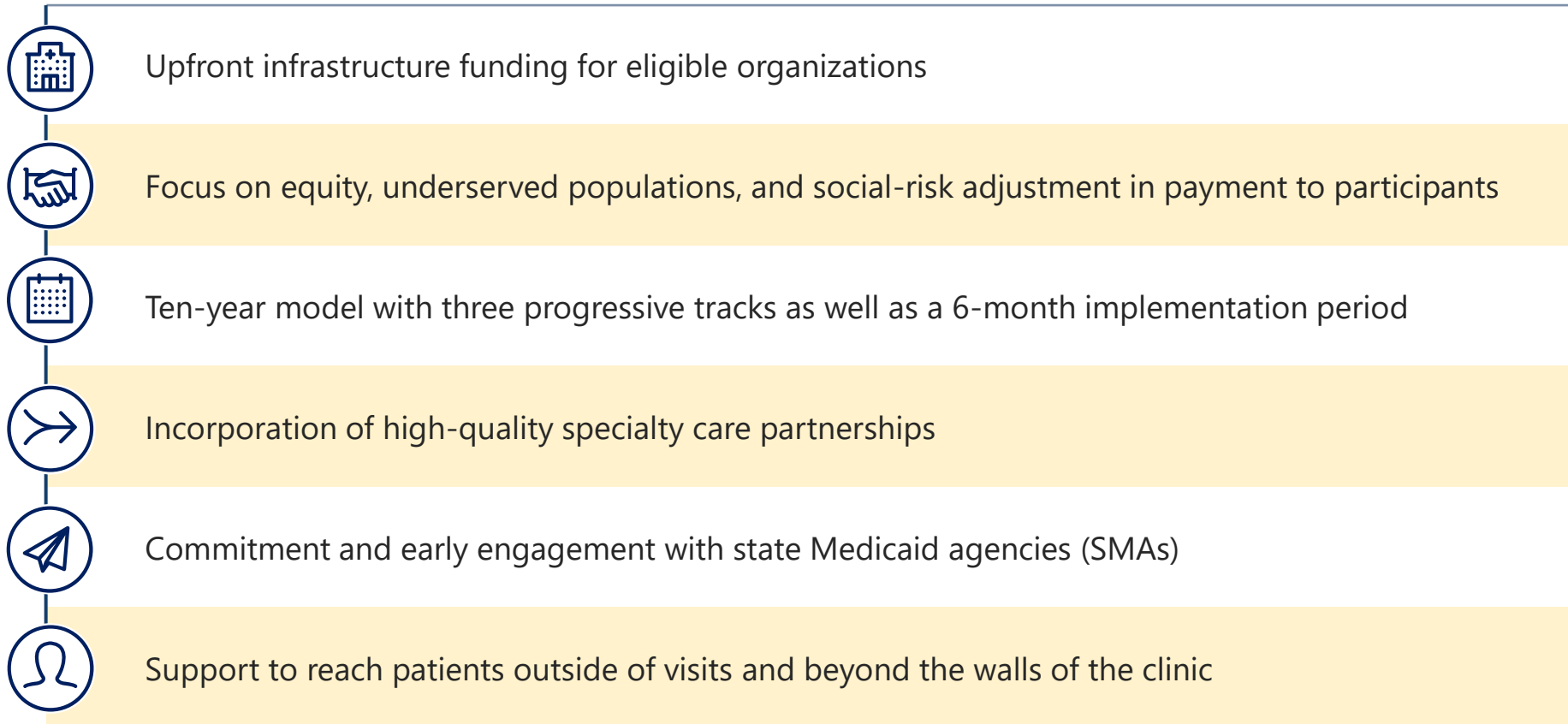| Comprehensive Primary Care	New Payment Pathway for Value-Based Care (VBC)	Improved Quality and Outcomes
Ensure patients receive primary care that is integrated, coordinated, person-centered and accountable	Create a pathway for primary care organizations and practices – especially small, independent, rural, and safety net organizations – to enter into value-based care arrangements	Improve the quality of care and health outcomes of patients

MCP Aim and Components

MCP will aim to achieve widely accessible high-quality care while testing a new payment and care delivery structure that builds on insights from previous models and has an intentional focus on advancing health equity and partnerships to increase alignment.

Integrated, Coordinated, Person-Centered Care

- Interprofessional Care Team
- Care Management and Coordination
- Specialty Care Integration
- Community Supports and Services
- Capabilities Built Over Time

Flexible, Enhanced Prospective Payment with Accountability

- Progression to Prospective Payment
- Progression in Accountability
- Payment for Specialty Integration
- Practice Definition and Attribution
- Regulatory Flexibilities

Achieve equitable health outcomes through widely accessible high quality, affordable, person-centered care with accountability for outcomes

Advance Health Equity

- Integrate Health-Related Social Needs into Care
- Enhanced Services Payments to Enable Improved Health Outcomes
- Quality Strategy Targeting Reduction in Disparities
- Model Reach in Underserved Communities

Partnerships

- State-Based Implementation
- Multi-Payer Directional Alignment
- Stakeholder and Beneficiary Engagement
- State-Based Learning System

Key Model Design Features

MCP includes the following design features, which incorporate insights, address lessons learned from previous CMS Innovation Center models, and integrate stakeholder feedback.

Upfront infrastructure funding for eligible organizations

Focus on equity, underserved populations, and social-risk adjustment in payment to participants

Ten-year model with three progressive tracks as well as a 6-month implementation period

Incorporation of high-quality specialty care partnerships

Commitment and early engagement with state Medicaid agencies (SMAs)

Support to reach patients outside of visits and beyond the walls of the clinic

Benefits of Participation in MCP

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

On-Ramp to VBC

Resources for organizations new to VBC to build accountability over time

Key features:

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

Tools to Improve Care Coordination

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

Key features:

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

Health Equity Advancement

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

Key features:

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

Collaboration & Learning

National and state level supports for participants to achieve model goals

Key features:

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

Eligibility and Participant Types

Participating States

MCP selected eight (8) states using several factors, including geographic diversity, health equity opportunity, population, and in partnership with state Medicaid agencies (SMAs) to better align Medicare and Medicaid payers on quality measurement, data requirements, and learning priorities.

Washington

Minnesota

New York

Massachusetts

Colorado

New Jersey

North Carolina

New Mexico
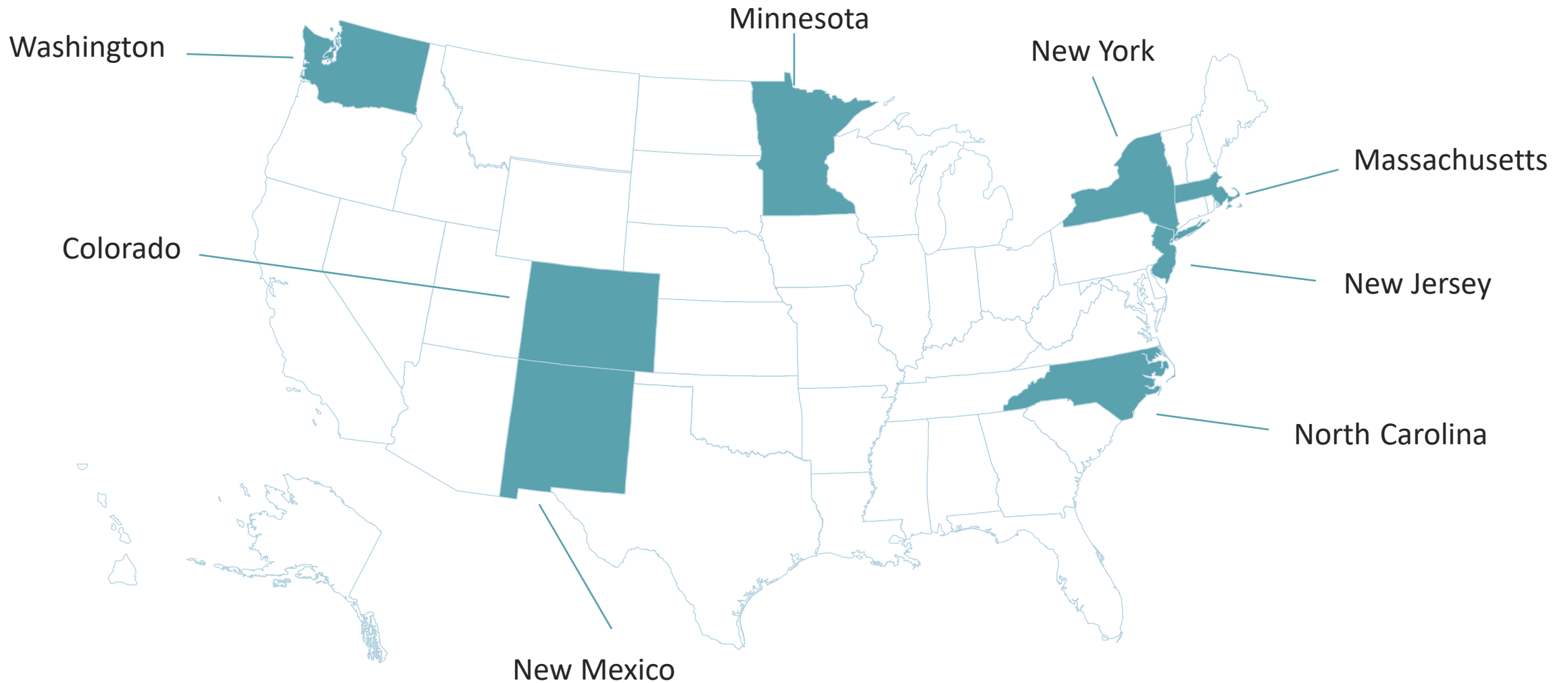
Eligibility to Participate

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

✓ Organizations Eligible for MCP

- Independent or solo primary care practices
- Group practices
- Federally Qualified Health Centers (FQHCs)
- Health Systems
- Indian Health Programs
- Certain CAHs

✕ 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.

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.

FQHC: *entities that receive Medicare and Medicaid enhanced payments described at §1834(o) and §1902(bb) of the Social Security Act (the Act), respectively. As defined at §§§1861(aa)(4) and 1905(l)(2)(B) of the Act, the term "FQHC" includes certain outpatient clinics associated with tribal/urban Indian organizations in addition to HRSA-designated Health Centers and "look-alikes."* **Indian Health Programs:** *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.* **Concierge practice:** *a doctor or group of doctors charges a membership fee before seeing or accepting a patient into a practice.* **Rural Health Clinic:** *a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of 42 CFR 405 and 491.* **Eligible CAHs:** *Critical Access Hospitals (CAHs) that are reimbursed for Outpatient Services under the Standard Payment Method (Method I) are eligible.*

Overlaps with Other Medicare Programs

In general, CMS will not allow organizations and clinicians to participate in MCP while participating in other Innovation Center Accountable Care Organization (ACO) models and programs. MCP's overlap policy is described below, and more information will be listed in the forthcoming Request for Applications (RFA).

CMMI Models

Not-Eligible

In general, organizations enrolled in CMMI models or will not be allowed to simultaneously participate in MCP, with the exception of bundled payment models.

Bundled Payment Model Participation

Eligible

Organizations and their clinicians that participate in bundled payment models (e.g., BPCI Advanced) can participate simultaneously in MCP.

Medicare Shared Savings Program (SSP)

Time-limited Eligibility

CMS will make a one-time MCP eligibility exception for organizations and individuals participating in SSP in 2024, but **plan to withdraw from SSP before 1/1/2025**.

- During the 2024 performance year, these organizations can still participate in SSP, but must engage in MCP learning and reporting activities

- For these organizations and individuals, MCP payments and quality measurement will begin 1/1/2025

Participation Track Options Overview

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

	Track 1 Building Infrastructure	Track 2 Implementing Advanced Primary Care	Track 3 Optimizing Care and Partnerships
Focus Area	Building capacity to offer advanced services, such as risk stratification, data review, identification of staff, and HRSN screening and referral	Transitioning between FFS and prospective, population-based payment	Optimizing advanced primary care services and specialty care integration enabled by prospective, population-based payment
	Level of VBC Experience →		
Duration	Participants who enter* in Track 1 can remain in Track for 1 2.5 years before progressing to Track 2	Participants who enter* in Track 2 can remain in Track 2 for 2.5 years before moving to Track 3	Participants who enter* in Track 3 can remain for the entirety of the MCP

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

Payer Partners

CMS Innovation Center will partner with public and private payers to implement MCP. Through these partnerships, CMS will foster alignment in areas to reduce clinician burden and provide flexibility to encourage increased payer participation.

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

- MCP participants will collect and report required data in the same format and report the same quality measures to MCP payers

Medicaid Engagement

- CMS has partnered with SMAs to streamline primary care payment reform and learning priorities across Medicare and Medicaid

- MCP will continue to work closely with state Medicaid agencies (SMAs) to streamline requirements and learning supports

Local Implementation

- CMS, SMAs, and payer partners will make practice- and patient-level data available to participants through data sharing efforts within the state

- CMS will provide flexibility for payers to include additional measures that reflect local priorities for their patient population(s)

CMS will partner with aligned payers to establish shared goals, learning priorities, and ensure that participants have the supports they need to be successful, including access to health information exchange and peer-to-peer learning.

Resources and Support for MCP Participants

CMS and payer partners will create resources for MCP participants to be successful in the MCP model. This includes partnering in state efforts to create an environment for practice change.

Nationwide Support

Technical assistance to help MCP participants understand model requirements, rules of participation, payment, attribution, measurement, and waivers

Virtual platform for collaboration and coordination within and across regions to support learning and continuous improvement

Data feedback with actionable data on cost and utilization for the Medicare beneficiaries served by the participant.

Reporting platform enabling participants to share the tactics, strategies, and care delivery methods they are using to improve health outcomes and advance health equity for their patients with peer comparisons.

State-Based Support

Collaboration opportunities for MCP participants and with the specialty practices and community-based organizations that need to be partners in care for their patients.

Practice facilitation and coaching resources for those who need help building capacity and who desire support in making the changes in workflow and organization of care they need to succeed in the model and to advance health outcomes and health equity.

Data aggregation and health information exchange resources necessary to give participants a full view of the care their patients receive and to enable comprehensive and coordinated care across primary care, acute and sub-acute care, specialty care, and community-based services.

Care Delivery Requirements

Overview of Care Delivery Approach and Domains

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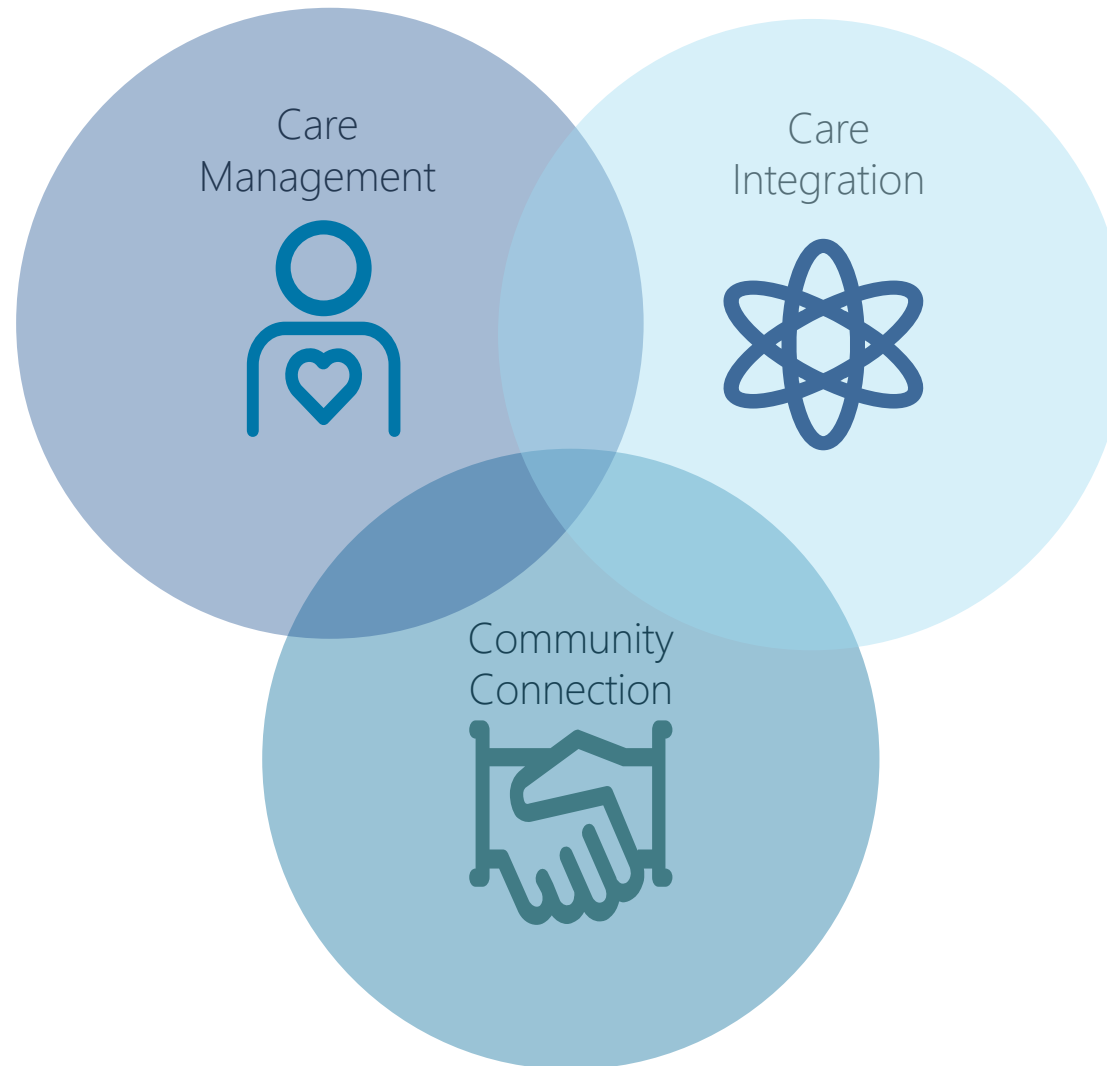
Care Management Domain

MCP provides payment for care management and chronic condition self-management into prospective, population-based payment and flexibility in providing those services. The requirements in this domain address the provision of those services with an emphasis on improving outcomes in diabetes and hypertension and reducing avoidable emergency department (ED) use and hospitalization.

	Track 1 Infrastructure Building	Track 2 Improving Efficiency	Track 3 Optimizing Care
Targeted Care Management	▪ Stratify by risk and empanel patients ▪ Identify staff and develop workflows to provide chronic care management, and timely post-emergency department and hospitalization follow-ups for high-risk patients	▪ Implement *chronic* care management and services for high-risk patients ▪ Implement *episodic* care management to provide timely follow-ups for high-risk patients post ED visit and hospitalization	▪ Build on care management programs by offering individualized care plans for high-risk patients
Chronic Condition Management	▪ Identify staff and develop workflows to deliver individualized self-management support services for patients with chronic conditions	▪ Begin offering individualized self-management support services for chronic conditions	▪ Expand self-management services to include group education and linkages to community supports

Care Integration Domain

MCP participants will have the ability to provide behavioral health as part of primary care and strengthen connections behavioral health and specialty care clinicians to better support patients.

	Track 1 Infrastructure Building	Track 2 Improving Efficiency	Track 3 Delivering Exceptional Care
Specialty Care Integration	▪ Use data tools to identify high-quality specialists	▪ Identify high-quality Specialty Care Partners through collaborative care Arrangements (CCAs)* ▪ Implement enhanced e-consults with at least one specialist	▪ Establish enhanced relationships with Specialty Care Partners through time-limited co-management relationships
Behavioral Health Integration (BHI)	▪ Identify staff and develop workflows to initiate a BHI approach grounded in measurement-based care (MBC) *MBC is the systematic monitoring of patient outcomes through the use of standardized measurement instruments and the analysis of measurement data to inform clinical decision-making.***	▪ Implement a BHI approach using MBC, including measurement tools and data to inform treatment decisions ▪ Systematically and universally screen for key behavioral health conditions, such as depression and substance use disorder	▪ Optimize BHI workflows using a quality improvement framework

CCAs which are meant to be a tool that MCP participants use during the model and CMS will support participants as they prepare for this step.
** The Joint Commission (2022). Outcome Measures Standard. https://www.jointcommission.org/what-we-offer/accreditation/health-care-settings/behavioral-health-care/outcome-measures-standard/

Community Connection Domain

MCP participants will identify and work to address health-related social needs (HRSNs) in their patient populations and collaborate with social service providers to help patients navigate community supports and services.

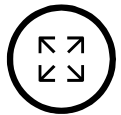|	Track 1 Infrastructure Building	Track 2 Improving Efficiency	Track 3 Delivering Exceptional Care
HRSN Screening & Referral	▪ Implement HRSN screening and referral ▪ Develop workflows for referrals to social service providers	▪ Implement referral workflows to social service providers	▪ Optimize social service referral workflows, using a quality improvement framework
Supporting Whole-Person Care Through Community Supports and Service Navigation	▪ Explore partnerships with social service providers to meet HRSNs ▪ Identify staff [a community health worker (CHW) or equivalent professional with shared lived experience]* to deliver services to higher need patients	▪ Establish partnerships with social service providers ▪ Utilize CHW/professional with shared lived experience in navigating and coordinating HRSNs to higher need patients	▪ Strengthen partnerships with social service providers ▪ Optimize use of CHW/outreach staff with shared lived experience using a quality improvement framework

*Note: Staff (a CHW or equivalent professional with shared lived experience) does not need to be employed by the MCP participant. For example, participants may utilize existing navigators in community-based organizations. However, the identified resource must assist all referred beneficiaries.
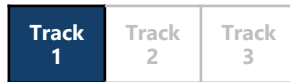
Payment Structure

MCP Payment Types

MCP will introduce six (6) payment types to support MCP participants as they work to achieve care delivery and quality improvement goals.
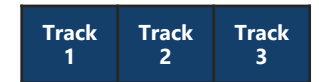
Upfront Infrastructure Payment (UIP)
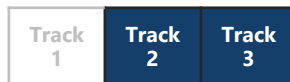*Optional, and only certain Track 1 participants will be eligible*

Track 1	Track 2	Track 3

Enhanced Services Payment (ESP)

Track 1	Track 2	Track 3

Performance Incentive Payment (PIP)

Track 1	Track 2	Track 3

Prospective Primary Care Payment (PPCP)

Track 1	Track 2	Track 3

MCP E-Consult (MEC)

Track 1	Track 2	Track 3

Ambulatory Co-Management (ACM)

Track 1	Track 2	Track 3

Upfront Infrastructure Payment (UIP)

Start-up funding to support smaller organizations with fewer resources participate in and be successful in MCP through investments in infrastructure to support MCP's transformational goals as they take on the Model's care delivery and health IT capabilities. Optional payment only available to eligible Track 1 participants.

Eligibility: "Low-revenue" Track 1 participants and Track 1 applicants without an e-consult platform
("Low revenue" criteria will be specified in the Request for Applications)

Timing: Initial $72,500 distributed as a lump sum at the start of model; second payment of $72,500 distributed as a lump sum one year later

Amount: $145,000 per eligible Track 1 participant

MCP participants will submit a spend plan with anticipated spending prior to receiving the UIP, and report on how the UIP funds were spent

Reconciliation: Any unspent or misused UIPs must be repaid to CMS at the end of the participant's 30-month Track 1 participation period and can be recouped if the participant withdraws or CMS terminates its participation in the model prior to entering Track 3

Examples of Permitted Uses

- ***Increased staffing*** such as hiring nurse care managers to implement SDOH screening, behavioral health clinicians to integrate behavioral health treatment into primary care setting; or encouraging partnerships with healthcare systems and local CBOs to connect individuals with culturally and linguistically tailored, accessible health care services and supports

- ***SDOH strategies*** such as partnering with CBOs to address SDOH needs; providing patient caregiver supports; or implementing systems to provide and track patient referrals to community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across communities where beneficiaries reside

- ***Health care clinician infrastructure*** such as investing in CEHRT system enhancements and upgrades; expanding HIT systems to include patient portals, telehealth systems for video visits, and/or e-consult technology; or developing infrastructure that would enhance sociodemographic data collection

Enhanced Services Payment (ESP)

Non-visit-based per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's risk level to provide proportionally more resources to organizations that serve high-needs patients, as they develop capabilities and provide enhanced services. Designed to support care management, patient navigation, connection to behavioral health, and other enhanced care coordination services, according to specific needs of patient population.

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Prospective quarterly payment

Potential Amount: Track-based amount based on participant's MCP attributed population and adjusted for social and clinical risk factors, including CMS Hierarchical Condition (HCC), Low Income Subsidy (LIS), and Area Deprivation Index (ADI). *Average* adjusted ESP PBPM amounts will be $15 in Track 1, $10 in Track 2, and $8 in Track 3. The $25 payment for Tier 4 ADI/HCC and LIS beneficiaries remains fixed across tracks.

See *Calculation Details* for more information on how CMS will determine ESP payment amounts.

Calculation Details

The decision tree below describes the steps CMS will use to determine ESP payment for each MCP patient:

Enrolled in Low-Income Subsidy?	
No	**Yes**
Amount varies based on patient's HCC and ADI-designated risk tier (see table below)	$25

CMS-HCC Clinical Risk Tier (Risk Score Percentile)	ADI Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
Tier 1 (< 25th)	NA±	$9	$4	$2
Tier 2 (25th – 49th)	NA±	$11	$5	$2.50
Tier 3 (50th – 74th)	NA±	$14	$7	$3.50
Tier 4 (≥75th)	Tier 1, Tier 2, or Tier 3 (< 75th)	$18	$8	$4
	Tier 4 (≥75th)	$25		

Notes: 1) MCP payments are for Medicare FFS beneficiaries attributed to the MCP and will be subject to geographic adjustments.
2) ± Listed as NA, or Not Applicable, because payment for patients in HCC tiers 1 to 3 is only based on LIS or HCC.

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Prospective Primary Care Payment (PPCP)

Quarterly per-beneficiary-per-month (PBPM) payment that is calculated for each participant's patient population and is designed to support a gradual progression from fee-for-service (FFS) payment for primary care services* to a population-based payment structure. These payments are designed to allow practices to deliver enhanced, comprehensive services without the incentive to increase volume of patients or services to achieve a favorable financial outcome.

Eligibility: Participants in Tracks 2 and 3

Timing: Prospective quarterly payment

Potential Amount: For the first two PYs, the amount is based on each participant's historical billing data for its attributed Medicare beneficiaries over a two year period and will be updated annually; CMS will introduce a regional component to the payment methodology by PY3.

Reconciliation: Amount is partially reconciled against actual claims expenditures based on portion of primary care services sought by beneficiaries outside the participant organization. See *Calculation Details* for more information on how CMS will determine PPCP amounts.

Calculation Details

The type of payment for primary care services will vary based on an organization's MCP Track.

Payment Type for Primary Care Services	Track 1	Track 2	Track 3
Prospective Primary Care Payment (PPCP)	0%	50%	100%
Fee-for-Service (FFS)	100%	50%	0%

Data sources for billing calculation differs by organization type:

- **FQHCs:** PPCP based on services billed under the Medicare FQHC Prospective Payment System (PPS)
- **Non-FQHCs:** PPCP based on services billed under the Physician Fee Schedule (PFS)

The primary care services included in or affected by the PPCP will be shared in the MCP Request for Applications (RFA) that will be released in August 2023.

Performance Assessment

Performance Measure Set

MCP emphasizes whole-person care by including a diverse set of performance measures that are aligned with the care delivery requirements and provide an opportunity to receive incentive payments via the Performance Incentive Payment (PIP) by demonstrating strong performance.

Balance of Measures of Clinical Quality and Cost

- Includes a diverse set of performance metrics that balance clinical quality, patient-reported outcomes, utilization, and cost.

Quality Measure Alignment with Care Delivery

- Small improvement can yield significant cost and quality improvement over time across common chronic conditions.

- Focuses on building participant capacity to deliver equitable, team-based care and improve outcomes over time on key metrics like hypertension and diabetes control.

Incorporating Health Equity into Performance Assessment

- Includes a measure of health-related social needs and tailors the continuous improvement assessment for FQHCs and Indian Health Programs.

- Seeks to minimize participant burden for reporting and consider feasibility of measure collection, including alignment with HRSA's Uniform Data System (UDS).

Quality Performance Measures

Mirroring CMS's broader quality measurement strategy, measures were selected to be actionable, clinically meaningful, and aligned with other CMS quality programs, including the Universal Foundation Measure Set *(as indicated below with an asterisk "*")*, *Quality Payment Program (QPP)*, *MIPS Value Pathways (MVP) and MIPS APM Performance Pathway (APP) measure sets, and the National Quality Forum (NQF)'s Core Quality Measures Collaborative (CQMC) Primary Care Core Measures.*

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

+*Screening for Social Drivers of Health (Quality ID#487) is a new, evolving measure focused on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure specifications are currently under development and CMS will work with participants to ensure they have the appropriate health IT infrastructure information to successfully report this measure.*

Performance Incentive Payment (PIP)

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Half of estimated PIP will be paid in the first quarter of each performance year and second half will be paid in the third quarter of the following performance year

Potential Amount: Track-based percentage adjustment (see table to the right) to the sum of payments for primary care services (FFS and/or PPCP)

Risk: Upside only; paid up-front and reconciled based on performance

See *Calculation Details* for more information on how CMS will determine PIP.

Calculation Details

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)

- MCP participants must report all required quality measures and achieve the national 30th percentile on TPCC

- Quality measures will have varying degree of impact on the PIP calculation based on the participant's track*

- Participants in Tracks 2 and 3 will have the opportunity to receive larger PIPs for continuous improvement (CI) in care delivery and improving outcomes

More information on how MCP's quality measures will impact the PIP calculation, refer to the MCP Request for Applications (RFA) that will be released in August 2023.

Example Calculation

The graphic below illustrates the proportion of revenue each payment would make up for an average MCP Participant. The calculations below are based on a hypothetical organization with 1000 attributed MCP patients (and assuming equal representation in each HCC/ADI tier), and assuming they met the 50th percentile on 3 measures, 70th / 80th percentile on 3 measures, did not get credit for TPCC CI.

Example Payment Calculation in MCP
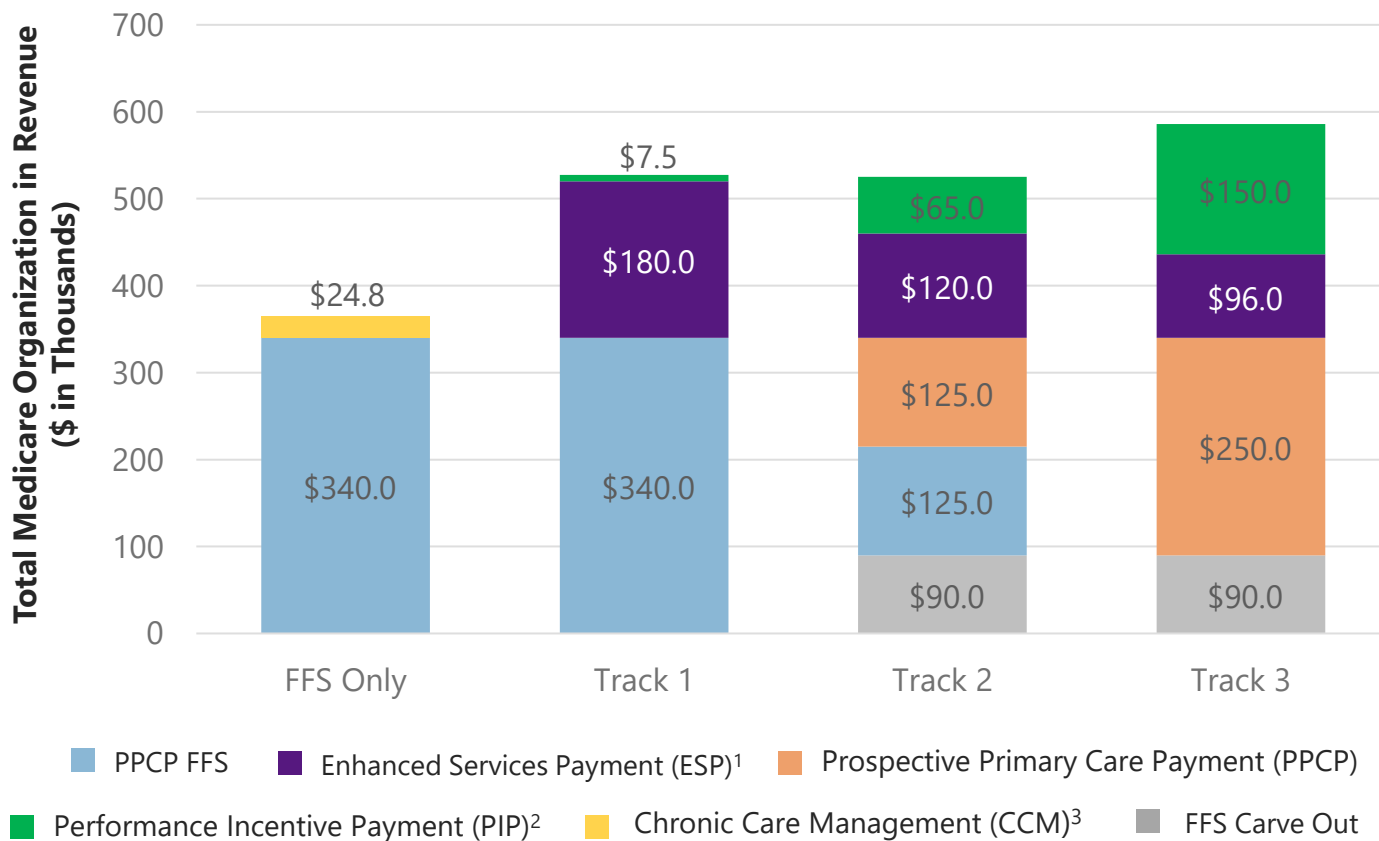
The hypothetical organization has the following characteristics:

- **1,000** attributed MCP patients with **200** in highest-risk category (e.g., LIS or HCC/ADI tier 4)

- **$21** PPCP PBPM based on own historical spending data

- Average ESP of $15 in Track 1, $10 in Track 2, and $8 in Track 3

- Prior to MCP, billed CCM for **90** beneficiaries (average $23 PBPM)

Legend:
- PPCP FFS
- Enhanced Services Payment (ESP)[1]
- Prospective Primary Care Payment (PPCP)
- Performance Incentive Payment (PIP)[2]
- Chronic Care Management (CCM)[3]
- FFS Carve Out

[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 that will be released in 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 Track 1 will not be able to bill a coordination code, they will receive larger ESP payments which CMS anticipates will correct for any revenue loss from CCM.

Specialty Care Integration Strategy

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

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

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

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

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

Payment Details

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

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

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

Application, Next Steps, and Resources

Application Process and Timeline

Submit a Letter of Intent (LOI) to Apply for MCP
For MCP organizations interested in any of the MCP tracks, CMS encourages you to submit a voluntary, non-binding letter of intent (LOI) to apply at this link. The LOIs help CMS to better support and connect with organizations as they decide if MCP is right for them. The LOI will remain open until November 2023 when both the MCP LOI and Application Portal will close.
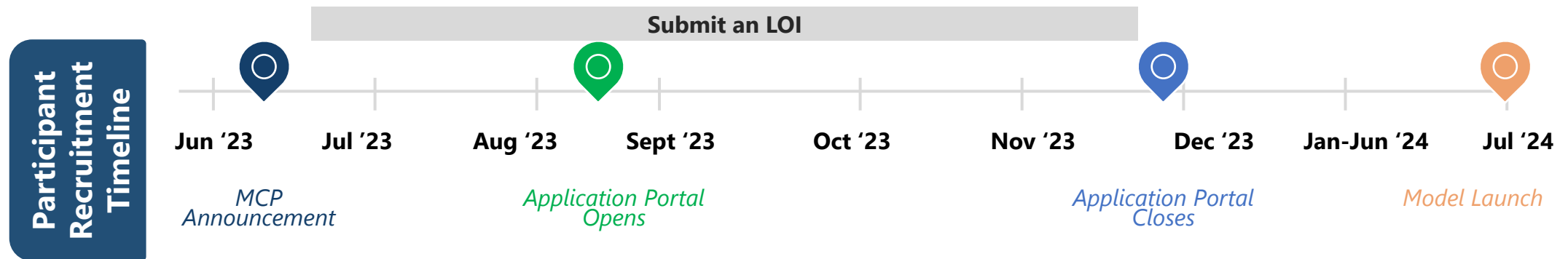
Sign up for the MCP listserv
MCP will announce when the MCP Request for Applications (RFA) is available, as well as additional events resources during to help stakeholders understand MCP before the application deadline.

Prepare for Application
The MCP RFA will be released in August 2023. Interested stakeholders can prepare for application by using the resources above to prepare for application and reach out with questions about MCP.

		Submit an LOI				

Participant Recruitment Timeline

Jun '23	Jul '23	Aug '23	Sept '23	Oct '23	Nov '23	Dec '23	Jan-Jun '24	Jul '24
MCP Announcement			Application Portal Opens			Application Portal Closes		Model Launch

Payer engagement will continue throughout the participant recruitment cycle in preparation for MCP launch.

Questions & Answers

Closing & Resources

Additional Information and Resources

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

Visit

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

Help Desk

MCP@cms.hhs.gov
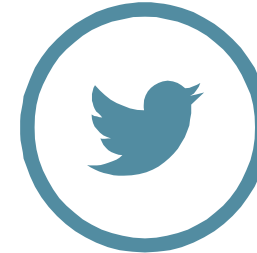
Listserv

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Thank you

Thank you for attending today's MCP Overview Webinar!