



# The Making Care Primary (MCP) Model

December 7, 2023

in partnership with:



# Today's Webinar

- Welcome
- Overview of Making Care Primary by CMMI Staff
- Q&A
- Resources & Wrap Up

# Today's CMMI Speaker:



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CMS Innovation Center

# Making Care Primary (MCP) Goals

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



## Comprehensive Primary Care

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



## New Pathway for Value-Based Care (VBC)

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



## Improved Quality and Outcomes

Improve the quality of care and health outcomes of patients

# Eligibility to Participate

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



## Organizations Eligible for MCP

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






## Organizations Not Eligible for MCP

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

# Participation Track Options Overview

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

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

Level of VBC Experience 

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

# Benefits of Participation in MCP

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



## On-Ramp to VBC

Resources for organizations new to VBC to build accountability over time

### Key features:

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



## Tools to Improve Care Coordination

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

### Key features:

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



## Health Equity Advancement

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

### Key features:

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



## Collaboration & Learning

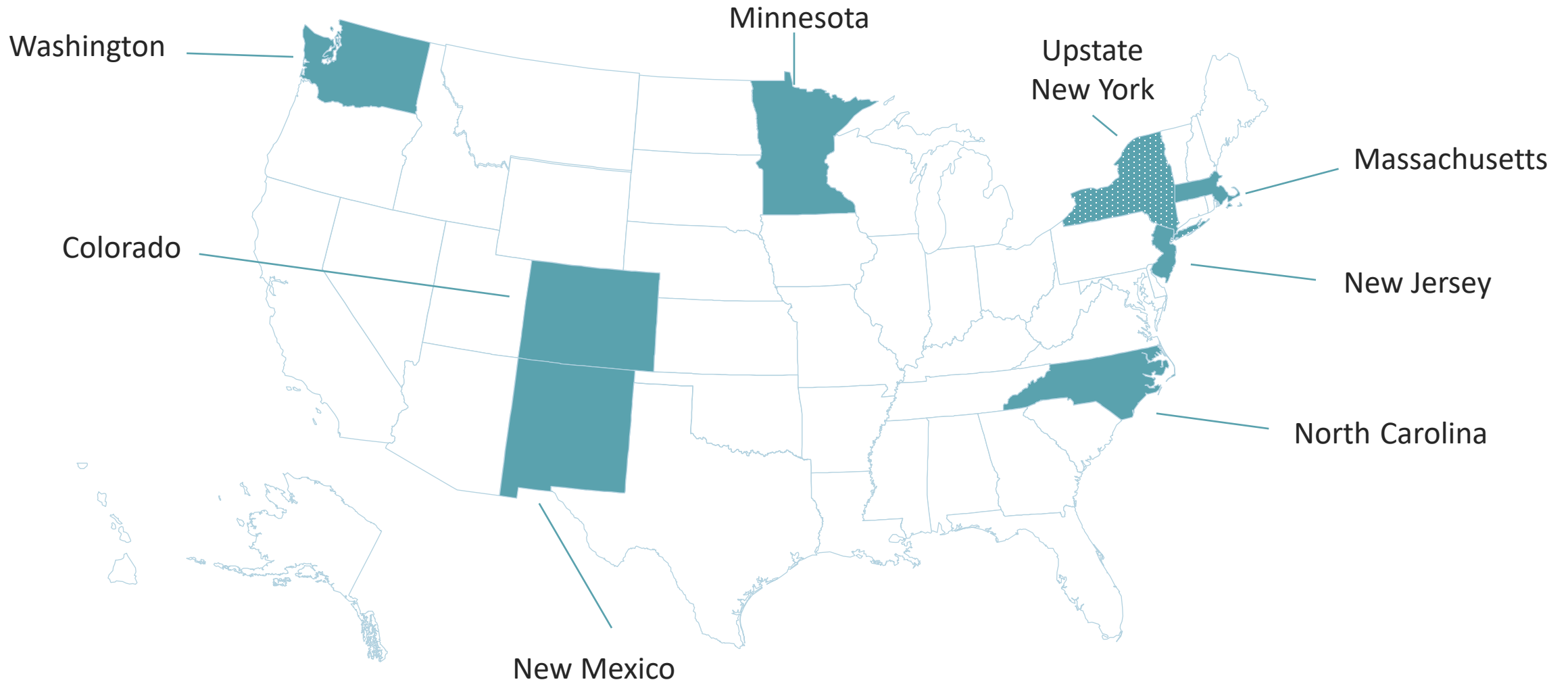
National and state level supports for participants to achieve model goals

### Key features:

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

# Participating States

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





# Payers as Partners for MCP Success

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



## Directional Alignment

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



## Medicaid Engagement

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



## Local Implementation

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

# Payer Partnership Timeline

1

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

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

2

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

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

**March 2024: Accepted provider applicants sign Participation Agreements to join MCP**

**July 2024: MCP begins for participating organizations.**

3

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

4

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



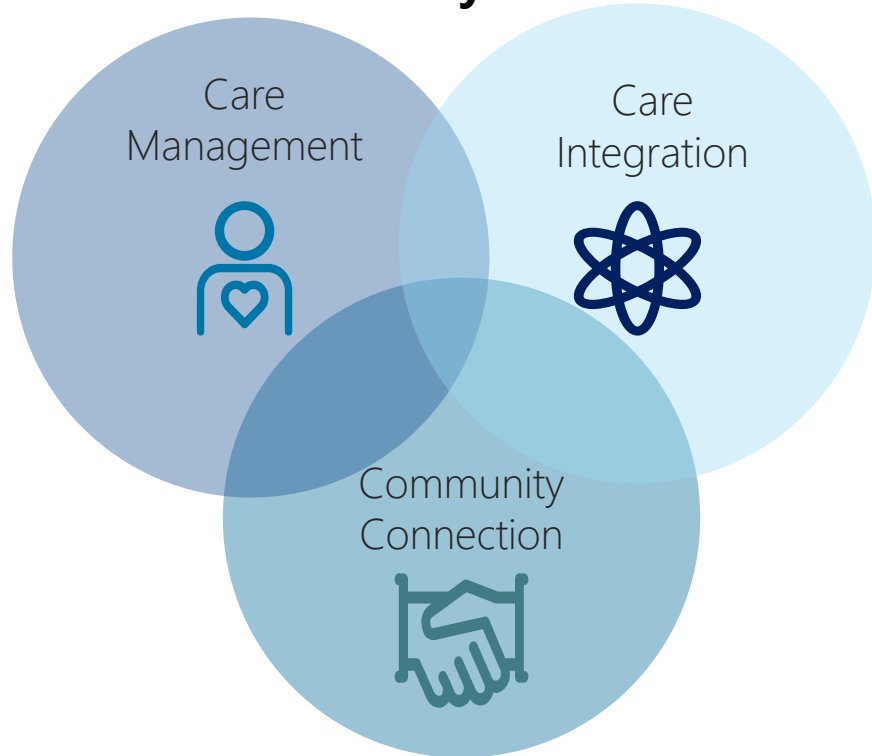
# MCP Model Features

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# Overview of Care Delivery Approach and Domains

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

## Care Delivery Domains



## MCP Participant Requirements

Track 1 Building Infrastructure	Track 2 Implementing Advanced Primary Care	Track 3 Optimizing Care and Partnerships
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### Meet Care Delivery Requirements, by Track

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

### Complete Baseline and Ongoing Care Delivery Reporting

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

### Health Equity Plan Reporting

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



### Peer-to-Peer Learning

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

# MCP Payment Types

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

## Prospective Primary Care Payment (PPCP)

Track 1	Track 2	Track 3
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Quarterly per-beneficiary-per-month (PBPM) payment (calculated based on historical billing) to support a gradual progression from fee-for-service (FFS) payment to a population-based payment structure.

## Enhanced Services Payment (ESP)

Track 1	Track 2	Track 3
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Non-visit-based per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's level of clinical (CMS-HCC) and social (ADI) risk to provide proportionally more resources to organizations that serve high-needs patients.

## Performance Incentive Payment (PIP)

Track 1	Track 2	Track 3
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Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures. Structured to maximize revenue stability (half of estimated PIP will be paid in the first quarter of performance year).

## Upfront Infrastructure Payment (UIP)

Track 1	Track 2	Track 3
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Lump-sum payment for select Track 1 participants to support organizations with fewer resources to invest in staffing, SDOH strategies, and HIT infrastructure.

## MCP E-Consult (MEC)

Track 1	Track 2	Track 3
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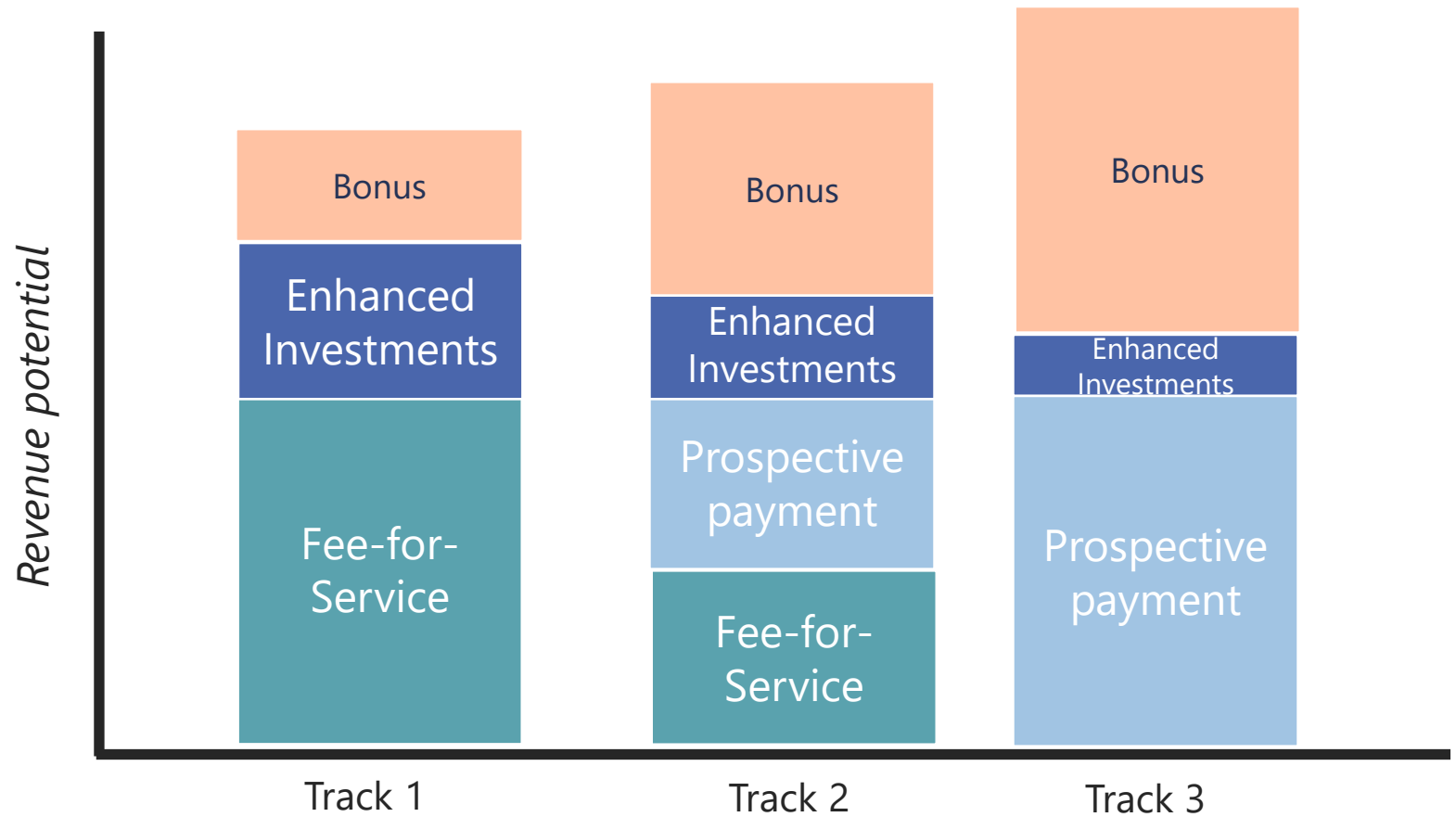
Payments to support specialty integration strategy to support communication and collaboration for longitudinal primary care and short-term specialized care for chronic conditions. MEC code billable by MCP primary care clinicians while ACM is billable by specialty care partners.

## Ambulatory Co-Management (ACM)

Track 1	Track 2	Track 3
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# Payment Approach

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



*Illustrative, not to scale*

# Performance Measurement and Reporting

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

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

# Specialty Care Integration Strategy

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



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



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



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



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

## Payment Details

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

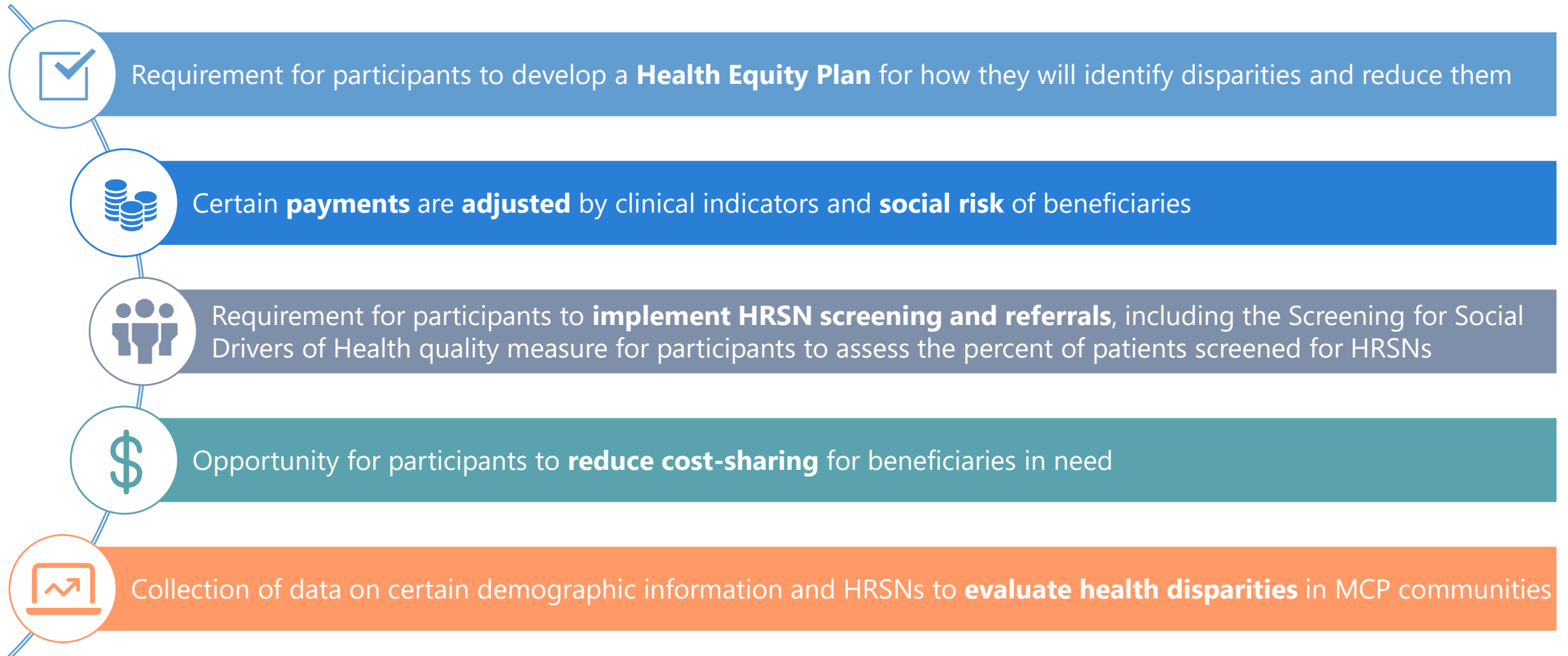
	MCP eConsult (MEC) Code <i>Billable by MCP Primary Care Clinicians</i>	Ambulatory Co-Management (ACM) Code <i>Billable by Specialty Care Partners</i>
<b>Goal</b>	Address current barriers to eConsult billing, including its inclusion of post-service time to implement the specialist's recommendation	Support 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
<b>Eligibility</b>	Participants in Tracks 2 and 3 ( <i>These codes are absorbed into the capitated prospective primary care payments (PPCPs) in Track 3.</i> )	Rostered Specialty Care Partner clinicians ( <i>whose TIN has a Collaborative Care Arrangement (CCA) in place with an MCP Participant</i> )
<b>Potential Amount</b>	\$40 per service (subject to geographic adjustment)*	\$50 per month (subject to geographic adjustment)*

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



# Health Equity Strategy

MCP includes several model components designed to work together with the care delivery strategy to improve health equity in alignment with the Innovation Center’s Strategy Refresh objective of Advancing Health Equity.<sup>1</sup>



<sup>1</sup><https://innovation.cms.gov/strategic-direction-whitepaper>

# Next Steps



## Submit an Application by December 14<sup>th</sup>

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

### Payer Partner Recruitment Timeline

- **February 2024:** Deadline for payers to sign Letter of Interest (LOI) to become MCP Payer Partner.
- **March 2024:** Accepted provider applicants sign Participation Agreements to join MCP.
- **July 2024:** MCP begins for participating provider organizations. August 2024: Payer Partners provide CMS with Payer Plan, detailing their alternative payment model for primary care and how it aligns with MCP. February 2025 –December 2025: Payer Partners sign non-binding Memorandum of Understanding (MOU) with CMS to advance partnership efforts.

# Questions and Answers?

# Additional Information

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



## Help Desk

Reach out to [MCP@cms.hhs.gov](mailto:MCP@cms.hhs.gov)  
for questions



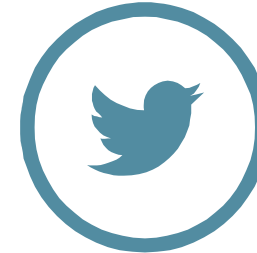
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