



Back Porch Chat

NC Medicaid Updates

July 20, 2023

Closed Captioning is available for this webinar

Participants can access real-time captioning by clicking "**Show Captions**" within Zoom.

Logistics for Today's Webinar

Question during the live webinar

Technical assistance

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AGENDA

01 NC Medicaid Hot Topics

02 Value Based Payments in NC Medicaid

03 CMMI Making Care Primary

04 Questions and Answers

Bulletin Updates

Tailored Plan Implementation Delayed

- NCDHHS is delaying the implementation of the NC Medicaid Managed Care Behavioral Health and Intellectual/ Developmental Disabilities Tailored Plans (Tailored Plans) scheduled for Oct. 1, 2023, **but will now go forward at a date still to be determined.**

- The delay will allow additional time for the Tailored Plans to **continue to develop their provider networks** and the Department to work collaboratively with the legislature to **achieve the necessary oversight tools** to administer the Tailored Plans on par with other managed care plans.

- The Department and LME/MCOs remain committed is making sure that the transition to Tailored Plans is as seamless as possible for the beneficiaries they will serve. **Beneficiaries who will be covered by the Tailored Plans will continue to receive behavioral health, I/DD, TBI and physical health care as they do today.**

More information on the delay is available here: https://medicaid.ncdhhs.gov/blog/2023/07/11/tailored-plan-implementation-delayed

COVID-19 Updates

Vaccine Administration Update: NC Medicaid will reimburse at the Medicare-approved COVID-19 vaccination administration rate of $65 until Sept. 30, 2024. Effective Oct. 1, 2024, reimbursement for COVID-19 vaccine administration will align with the standard administration rate per COVID-19 vaccine dose.

Counseling Update: The coverage for COVID-19 Vaccine Counseling (CPT 99401) for adults 21 and older ended with the end of the federal PHE on May 11, 2023.

- NC Medicaid will continue to cover COVID Counseling for members who are under age 21 until **Sept. 30, 2024**, per guidance from CMS and consistent with EPSDT.

Testing Update: Point-of-sale (POS) billing for FDA-authorized over the counter (OTC) COVID-19 tests dispensed for use by NC Medicaid beneficiaries in a home setting remains in effect. COVID-19 OTC tests for home use are covered for full Medicaid enrollees through Sept. 30, 2024.

- Coverage of one kit per claim per date of service is allowed up to a maximum of eight tests every rolling 30 days. The eight total tests could be mixed and matched between one-test kit or two-test kits to get a total of eight tests.

For more information, see the bulletin: https://medicaid.ncdhhs.gov/blog/2023/07/14/special-bulletin-covid-19-268-covid-19-testing-vaccination-and-counseling-coverage-after-federal

Audience Response

We are 3 years into Medicaid Managed Care and want to validate how some of our design assumptions are working for you and members in the field. Please share your thoughts about how certain features are functioning in practice.

1. Moving members from Standard Plans to Tailored Plans works:
    a. All the time
    b. Most of the time
    c. Half the time
    d. Often does not work
    e. Never seems to work

Audience Response

We are 3 years into Medicaid Managed Care and want to validate how some of our design assumptions are working for you and members in the field. Please share your thoughts about how certain features are functioning in practice.

2. When members want to change their primary care assignment in managed care, we are hearing it works:
    a. All the time
    b. Most of the time
    c. Half the time
    d. Often does not work
    e. Never seems to work

Audience Response

We are 3 years into Medicaid Managed Care and want to validate how some of our design assumptions are working for you and members in the field. Please share your thoughts about how certain features are functioning in practice.

3. When members want to change their health plan in managed care, we are hearing it works:
    a. All the time
    b. Most of the time
    c. Half the time
    d. Often does not work
    e. Never seems to work

1915(i) State Plan Amendment Approval

NC Medicaid has received approval from the Centers for Medicare & Medicaid Services (CMS) on the 1915(i) State Plan Amendment (SPA), to start 1915(i) services for eligible NC Medicaid members as of July 1, 2023. 1915(i) services are home and community-based services (HCBS) which provide opportunities for Medicaid enrollees to receive services in their own home or community rather than institutions.

Current 1915(b)(3) Service		Future 1915(i) Services
In-Home Skill Building	➤	Community Living and Support
One-time Transitional Costs	➤	Community Transition
Individual Support	➤	Individual and Transitional Support *Integrates existing Individual Support, Transitional Living Skills, and Intensive Recovery Supports into one service*
Transitional Living Skills		
Intensive Recovery Supports*		
Respite	➤	Respite
Supported Employment	➤	Supported Employment

With the approval of the 1915(i) services, members currently receiving 1915(b)(3) services will begin the transition to 1915(i) services as early as July 1, 2023.

Prior to receiving 1915(i) services, members must have a completed 1915(i) assessment performed by their TCM provider or care coordinator and have been deemed eligible for 1915(i) services. **1915(b)(3) services will continue to remain available for members who have not yet completed the 1915(i) assessment and been deemed eligible for 1915(i) services.**

For more information, please see Medicaid bulletin article NC Medicaid Obtains Approval of the 1915(i) State Plan Amendment.

Rates Increased for Obstetrical Maternal Services

Effective July 1, 2023, NC Medicaid has increased the Medicaid rate for Maternal Bundled Payments for pregnancy care. This was a requirement of Senate Bill 20.

*"**SECTION 4.2.(a)** The Department of Health and Human Services, Division of Health Benefits (DHB), shall increase to at least seventy-one percent (71%) of the Medicare rate the Medicaid rate paid for obstetrics maternal bundle payments for pregnancy care."*

Providers can find the applicable rate increases listed on their respective Fee Schedule. **Please note that all rates are at 71% of Medicare or more as legislated and some CPT codes may have been at this rate prior to Senate Bill 20.**

For more information see the bulletin: https://medicaid.ncdhhs.gov/blog/2023/07/14/rates-increased-obstetrical-maternal-services

CPT codes affected by this rate increase	
59400	Routine Obstetrical Care including Antepartum, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care
59409	Vaginal Delivery Only (with or without episiotomy and/or forceps)
59425	Antepartum Care Only; 4-6 visits
59426	Antepartum Care Only; 7 or more visits
59430	Postpartum Care Only
59514	Cesarean Delivery Only
59515	Cesarean Delivery Only including Postpartum Care

Providers are encouraged to review Clinical Coverage Policy 1E-5, Obstetrical Services for a detailed overview of other language and guidance.

Continuous Coverage Unwinding

The **2023 Consolidated Appropriations Act (Omnibus Bill)** delinked the continuous coverage requirement from the federal Public Health Emergency.

NC Medicaid began unwinding recertifications (renewals) on April 1, 2023.

- Recertification process takes 90 days, so the first date someone may lose coverage due to a recertification is July 1, 2023. Beneficiaries could lose coverage before this date due to a change in circumstance that impacts their eligibility.

Renewals & Outcomes (as of 6/30/23)	Count	% Breakdown
Total beneficiaries due for renewal in the reporting period (6/30/23)	223,943	100%
Number of beneficiaries renewed and retained in Medicaid or CHIP (those who remained enrolled)	137,896	61.58%
Number of beneficiaries determined ineligible for Medicaid or CHIP (and transferred to Marketplace)	5,053	2.26%
Number of beneficiaries terminated for procedural reasons (i.e., failure to respond)	30,046	13.42%
Number of beneficiaries whose renewal was not completed (extended for one or three months)	50,948	22.75%

July CMS Unwinding Report (June Data) was submitted to CMS on 7/10/23. June is the first month where recertification termination data was provided to CMS.

Continuous Coverage Unwinding Dashboard

The Department is required to provide **new monthly reports** on application and recertification processing to CMS during the unwinding period.

These reports will be posted publicly on our website: https://medicaid.ncdhhs.gov/federally-required-reports

NC Medicaid Continuous Coverage Unwinding Dashboard

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Medicaid Application and Recertification Progress Following the End of Medicaid Continuous Coverage

Updated Monthly on or around the 15th of the month.
Last updated July 2023 (Data as of June 30, 2023)

Overview of NC Medicaid Recertifications (Renewals) Due Between June 30, 2023 and May 31, 2024

Approximate Statewide Total due for Renewal

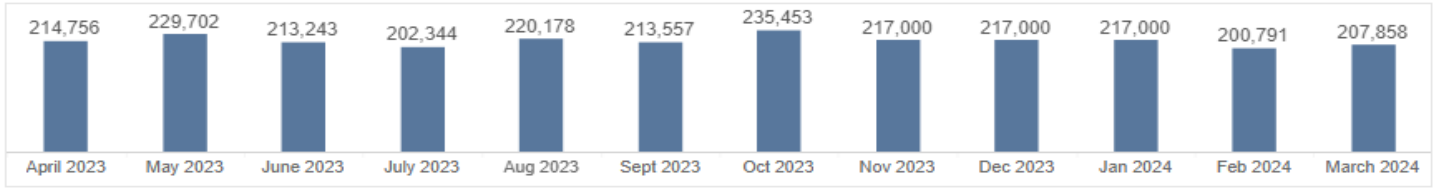
2,588,882
Individuals

Total Statewide Renewal Status

2,155,912	432,970	172,995
Not Started	Initiated	Complete

Medicaid recertification (renewal) is the way a beneficiary's information is reviewed to make sure they are still eligible for Medicaid health coverage. It takes place every 6 or 12 months based on the Medicaid program.

Approximate Number of Renewals to be Initiated Each Month (and due within 90 days)



The approximate number of renewals to be initiated each month are point-in-time estimates gathered by NC Medicaid in February 2023 as part of the State's renewal distribution plan and are subject to change. It includes approximately 440,000 individuals receiving limited Medicaid coverage through the Family Planning Program and several other categories of eligibility that provide partial benefits.This estimate intentionally left out the 314,798 beneficiaries receiving SSI Medicaid since they are not subject to recertification unless they lose SSI.

Monthly Renewals and Outcomes

Renewals

Approximate Number of Renewals to be Initiated Over 12 Months (from Feb 2023 estimate)		2,588,882
Total Beneficiaries for Whom a Renewal was Initiated*	April 2023	134,292
	May 2023	125,702
	June 2023	172,976
	Grand Total	432,970

Outcomes for June 30, 2023 Completed Renewals

Total Renewed and Retained in Medicaid**	137,896
Total Renewed Ex Parte	136,846
Total Renewed Using Renewal Form	1,050
Total Determined Ineligible for Medicaid***	5,053
Total Coverage Ended for Procedural Reasons****	30,046

Reinstatement of Provider Verification

- CMS requires that all Medicaid providers are recredentialed, a process also referred to as reverification. Since March 2020, CMS has allowed for the suspension of reverification due to the Public Health Emergency (PHE), brought on by COVID-19.

- **Provider reverifications resumed May 12th** and includes a special effort to bring current the providers for whom reverification was delayed during the federal PHE.
  - Just over 1,000 notifications are being sent to providers due for reverification each Friday.
  - Notices begin 70 days prior to suspension with reminders at 50, 20, and 5 days.

- Providers who do not submit their reverification application and pay the NC application fee by their suspension due date will receive a Notice of Suspension.
  - The first suspensions occur on Friday, July 21st. As of July 20th, 421 providers have not submitted the required application and are scheduled to suspend.
  - Providers have 50 days to respond before the record is terminated.

Resources:

- Provider Reverification/Recredentialing Webpage – Also contains link to the reverification due date list referenced above.
- Reverification/Recredentialing FAQs
- User Guide: "How to Complete Re-verification in NCTracks"
- NC Medicaid Provider webpage: Access to Medicaid Bulletin articles and Provider Enrollment information. Search "reverification".

Making Care Primary Model Provider Update

On June 8, 2023, the Centers for Medicare & Medicaid Services (CMS) announced a new voluntary primary care payment model for Medicare called Making Care Primary (MCP) that will be tested in eight states, including North Carolina. CMS is offering this model for qualified Medicare providers in North Carolina beginning in July 2024. Medicare is a federal health insurance program for people age 65 or older, people under age 65 with certain disabilities and people with end-stage renal disease.

The MCP Model will provide a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration and drive equitable access to care.

CMS hopes to partner with commercial and public payers in the eight pilot states, including state Medicaid programs, to offer models for their members that are aligned to MCP. CMS' selection of North Carolina as a Medicare pilot state for MCP is a recognition broadly of our innovations and leadership in primary care, care management and addressing health-related social needs, and the goals of MCP align closely with North Carolina Medicaid's existing population health priorities.

As NC Medicaid considers whether to offer a model for NC Medicaid providers that aligns more specifically with MCP, we will engage a broad range of community partners, including providers and prepaid health plans, for feedback.

For more information, see Medicaid bulletin article Making Care Primary Model Provider Update – July 3, 2023.

Value Based Care Delivery

Medicaid Transformation Goal

To improve the health of North Carolinians through an innovative, whole-person centered and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

Audience Response

(1) Medical home payments made to AMH Providers are considered a "value-based payment.“

a. True
b. False

Audience Response

(2) PHPs are required to offer quality performance incentive payments to AMH Tier 3 providers.

a.True
b.False

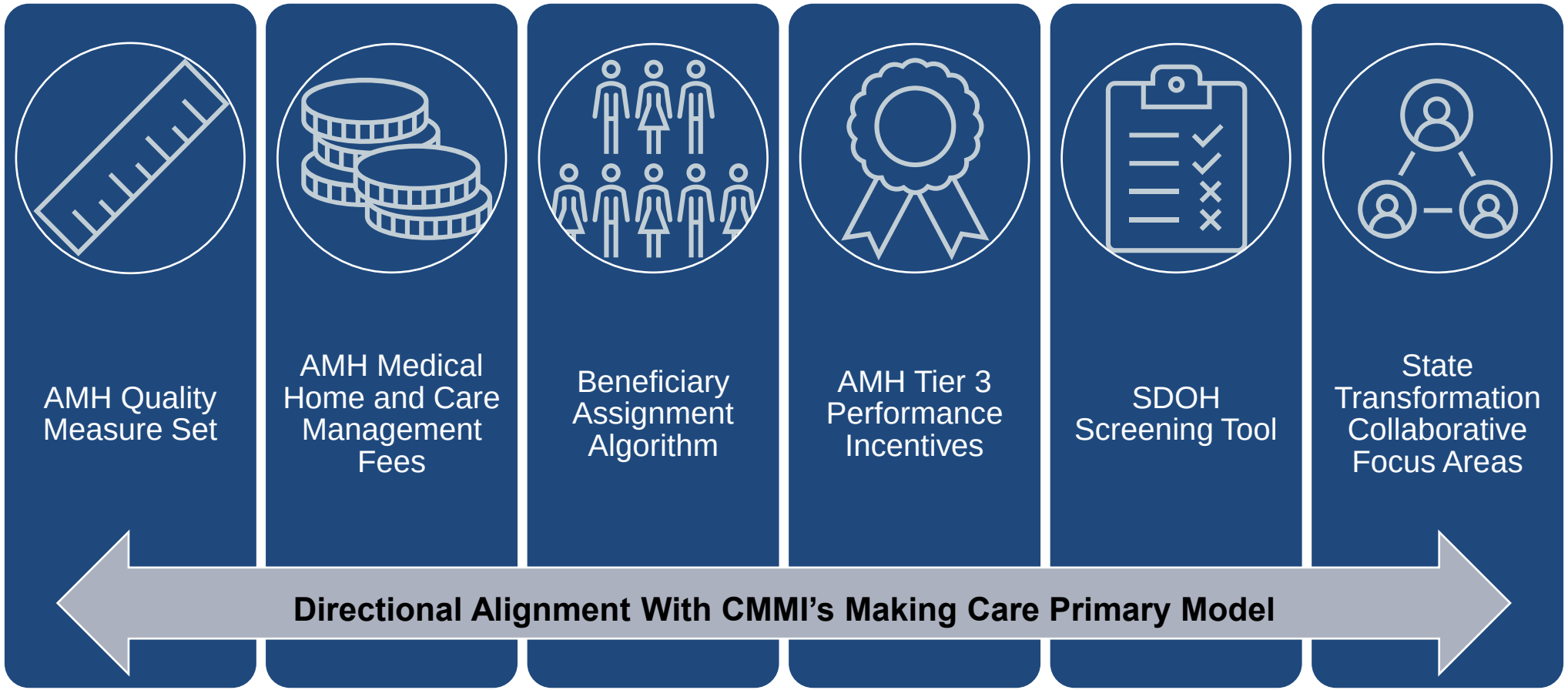
Audience Response

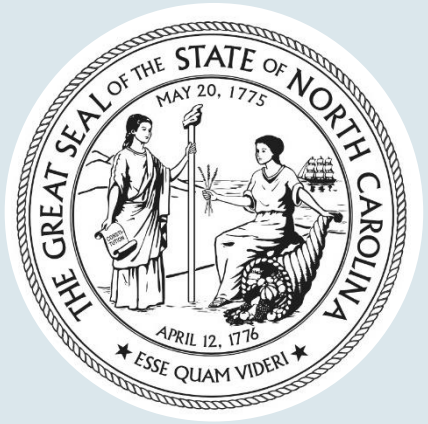
(3) What percent of Standard Plan Medicaid members are served by an AMH Tier 3?

a. 22%
b. 47%
c. 68%
d. 81%
e. 99%

NC Medicaid's Alignment Work

NC Medicaid has established alignment across PHPs in key areas related to value-based payment and is leading work towards alignment with other payers through the State Transformation Collaborative.





Making Care Primary

Agenda

1. Introduction
2. MCP Overview
3. Eligibility & Participant Types
4. Care Delivery Requirements
5. Payment & Performance Structure
6. Multi-Payer Partnership
7. Discussion

MCP Overview

MCP Aim and Components

MCP will aim to achieve high-quality primary care, by providing a pathway for organizations to move from FFS payment to prospective, population-based payment. The model builds on insights from previous CMMI models and has an intentional focus on building 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

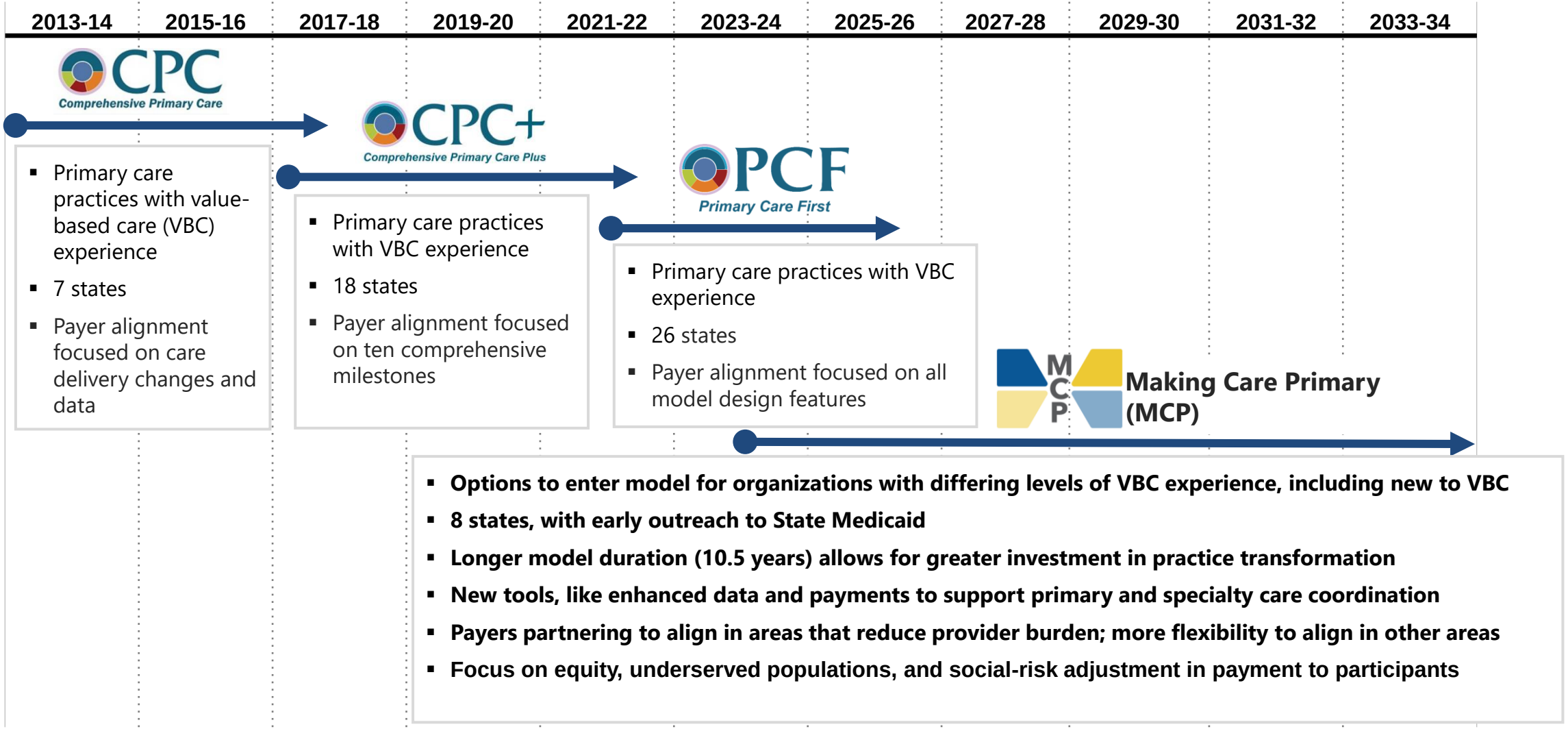
- Integrate Health-Related Social Needs into Care
- Enhanced Services Payments to Enable Improved Health Outcomes
- Quality Strategy Targeting Reduction in Disparities
- Model Reach in Underserved Communities

Partnerships

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

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.



Participation Track Options Overview

MCP includes three (3) tracks that health centers and Indian Health Programs can select from when applying to the model. The three tracks provide opportunities for organizations with differing levels of value-based payment experience to enter the model at a point that matches their readiness at the beginning 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 for HRSN screening and referral	Transitioning from Fee-For-Service (FFS) to prospective, population-based payment	Optimizing advanced primary care services and specialty care integration enabled by prospective, population-based payment
Duration	2.5 years*	2-2.5 years*	5+ years

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.

MCP Participant Application Process and Timeline

Submit a Letter of Intent (LOI) to Apply for MCP

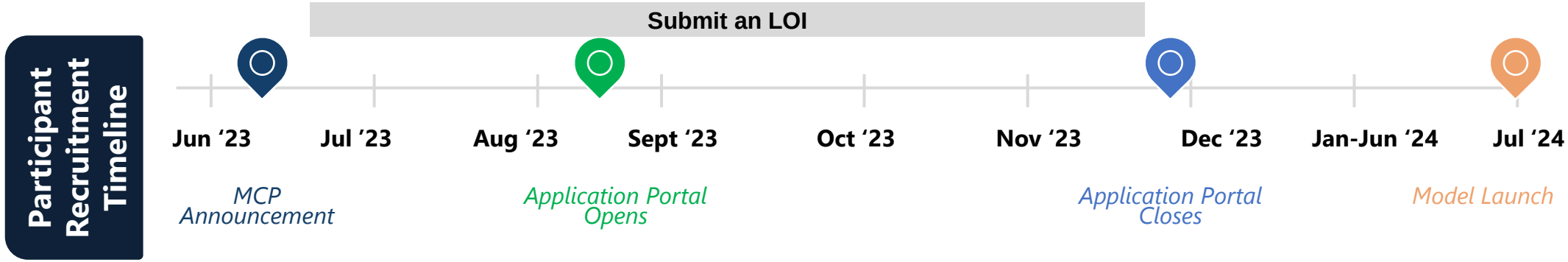
For MCP organizations interested in any of the MCP tracks, CMS encourages you to submit a voluntary, non-binding letter of intent (LOI) to apply at this link. The LOIs help CMS to better support and connect with organizations as they decide if MCP is right for them. The LOI will remain open until November 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.



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

Eligibility and Participant Types

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 operating in the listed MCP states

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 not operating in the listed MCP states
- In general, 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

See Appendix for more information …

Care Delivery Transformation

Overview of Care Delivery Approach

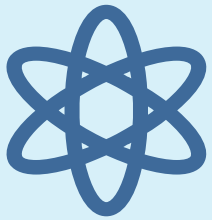
The capabilities participants will need to succeed in MCP are organized under three broad care delivery domains. These domains contain requirements that progress through the Tracks as participants refine their care delivery capacity and quality.

Targeted care management through risk-stratification, empanelment, and timely follow-ups for high-risk patients.

Chronic condition self-management (focusing on diabetes and hypertension), through development of workflows for support and expanded linkages to community supports.

Care Management

Care Integration



Provide behavioral health as part of primary care and strengthen connections with specialty care clinicians to better support patients.

Community Connection

Identify health-related social needs (HRSNs) and collaborate with social service providers to help patients navigate community supports and services.

See Appendix for more information …

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.*

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

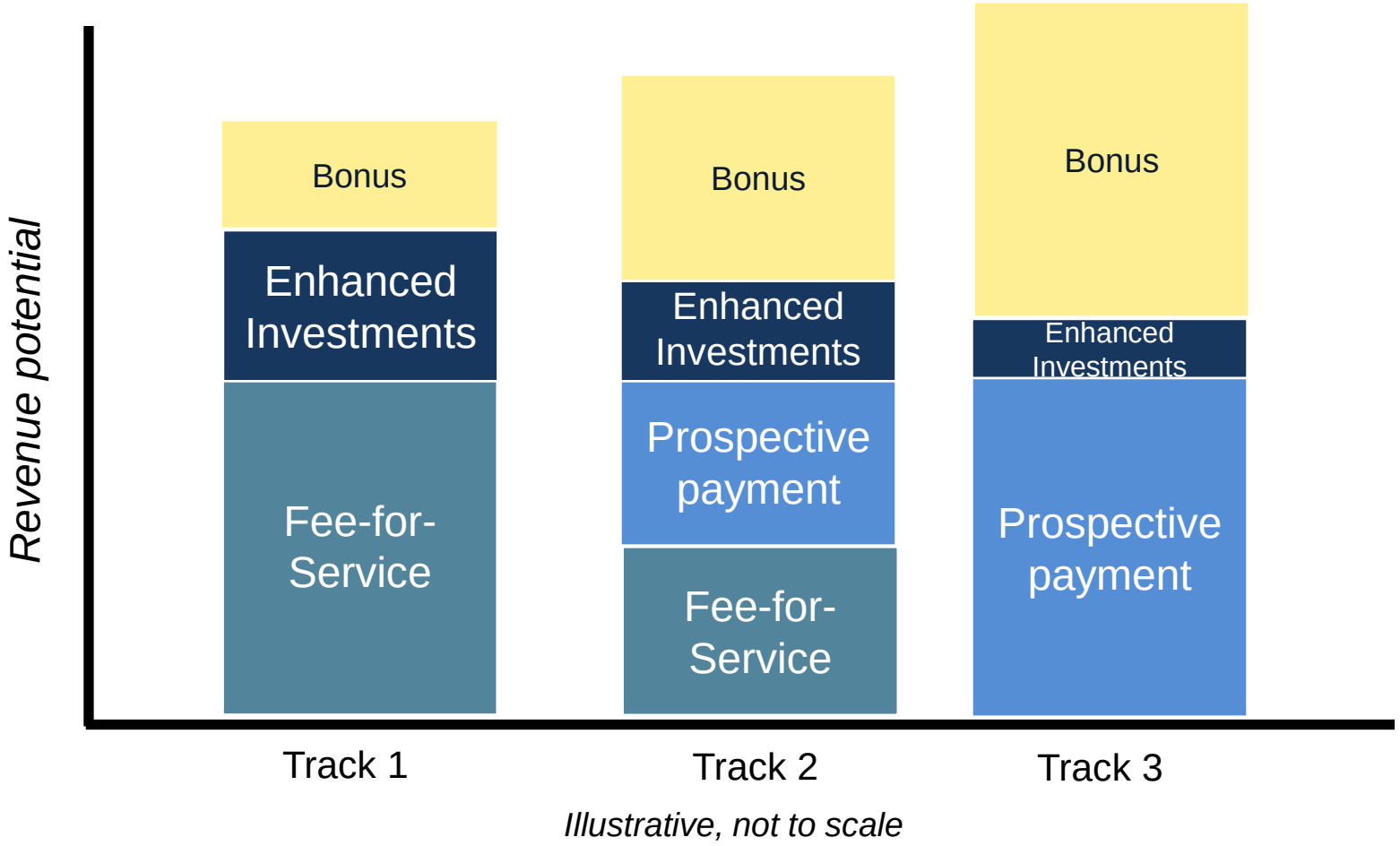
Collaboration opportunities for MCP participants and with the specialty practices and community-based organizations that need to be partners in care for their patients.

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.

Payment & Performance Assessment

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



Illustrative, not to scale

MCP Payment Types

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

Prospective Primary Care Payment (PPCP)

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
■	■	■

Upfront Infrastructure Payment (UIP)

Track 1	Track 2	Track 3
■		

One-time payment. Only certain Track 1 participants will be eligible

MCP E-Consult (MEC)

Track 1	Track 2	Track 3
	■	■

Ambulatory Co-Management (ACM)

Track 1	Track 2	Track 3
		■

Payments to support specialty integration strategy

See Appendix for more information on UIP, MEC, and ACM…

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.*

Enhanced Services Payment (ESP)

Quarterly 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.

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.

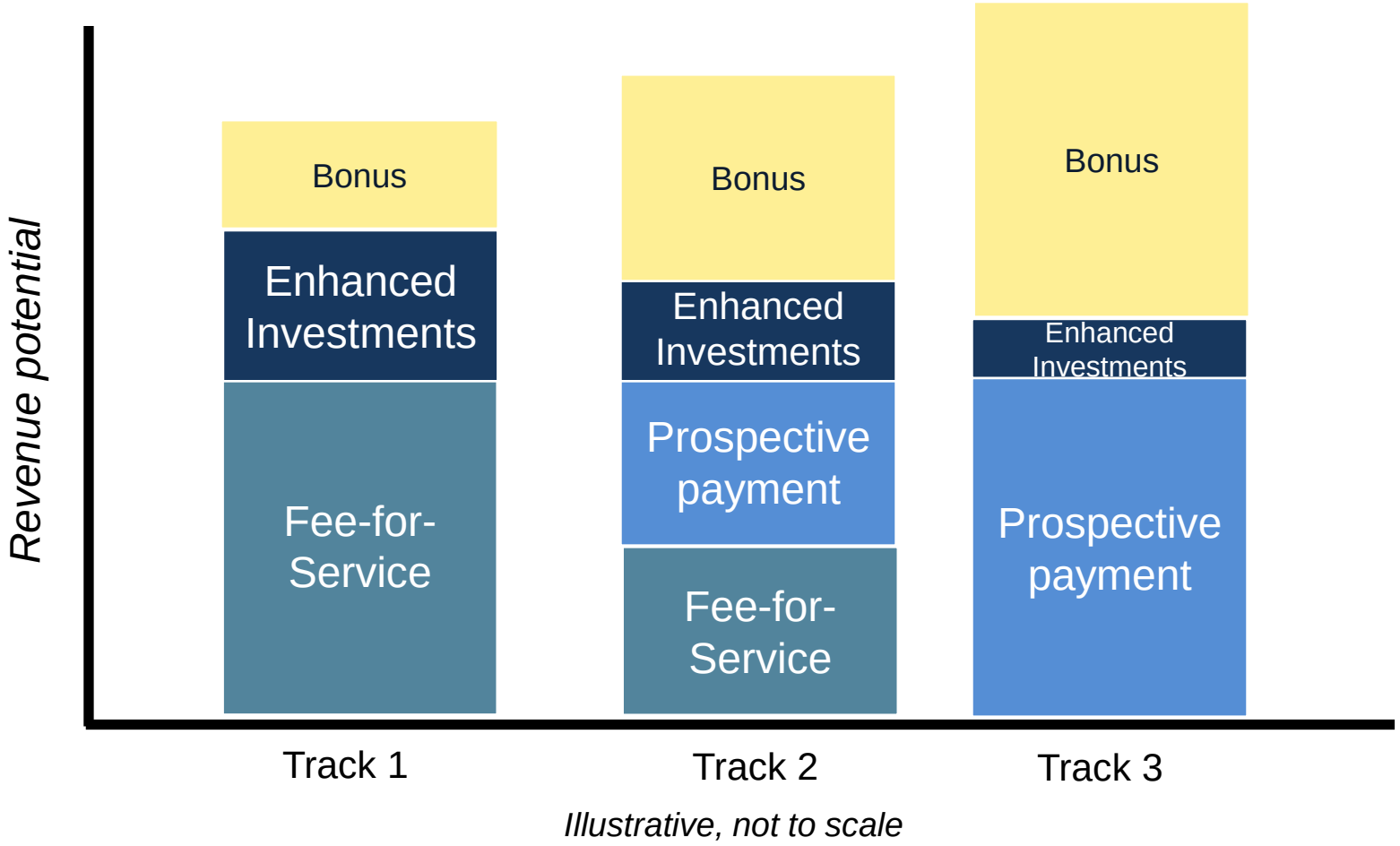
Calculation Details

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 to qualify for any PIP
- Quality measures will have varying degree of impact on the PIP calculation based on the participant's track*
- Regional 50% percentile will earn half-credit; 70%/80% earns full credit for quality/utilization measures
- 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.*

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



Illustrative, not to scale

Multi-Payer Partnership

Payer Partners are Critical to Model Success

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

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.

Questions?

Additional Information and Resources

Help Desk

MCP@cms.hhs.gov

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

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QUESTIONS?

Appendix

MCP Eligibility: 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

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 be required to provide behavioral health as part of primary care and strengthen connections with 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.*

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

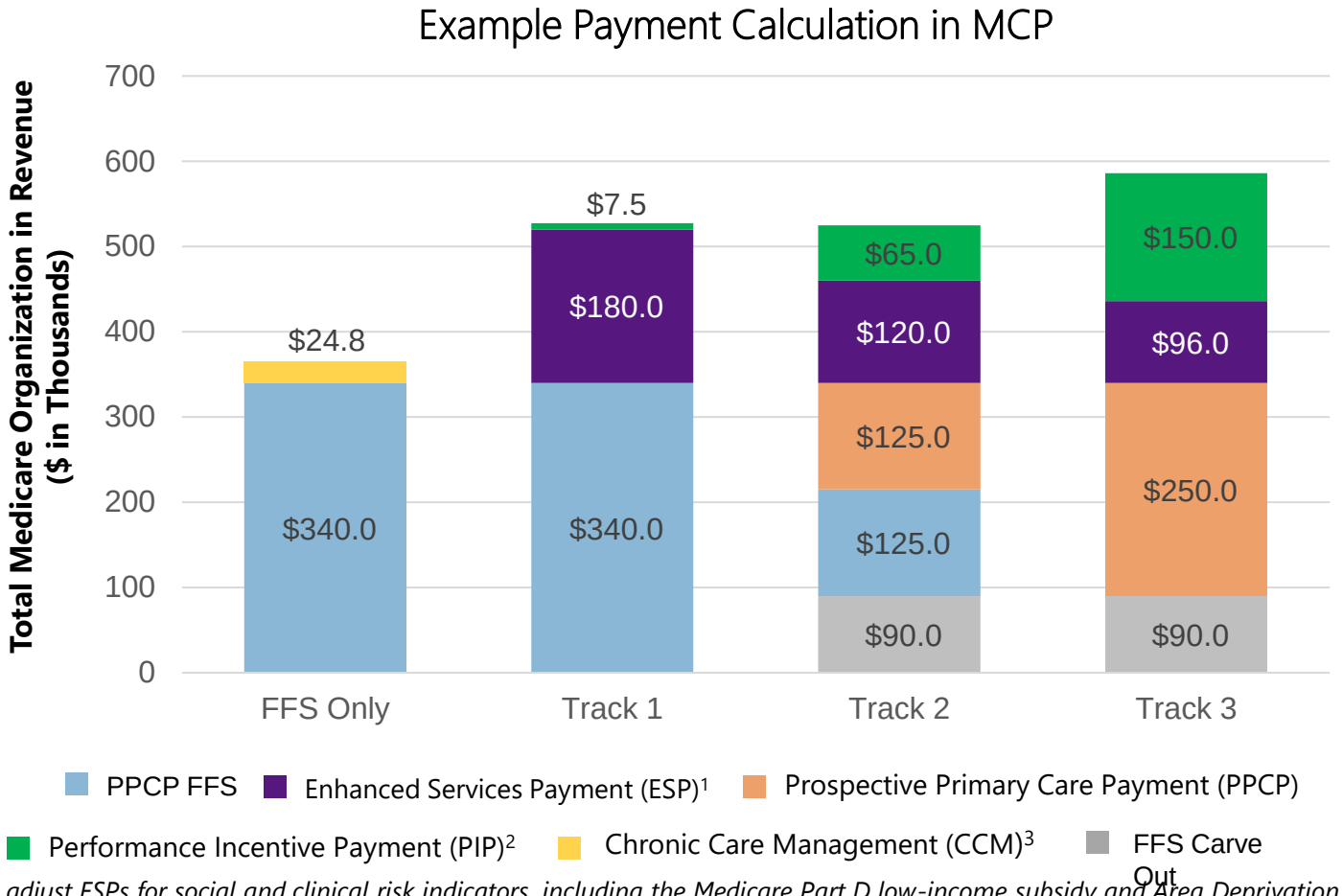
- Small improvement can yield significant cost and quality improvement over time across common chronic conditions.
- Focuses on building participant capacity to deliver equitable, team-based care and improve outcomes over time on key metrics like hypertension and diabetes control.

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).

MCP 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.



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)

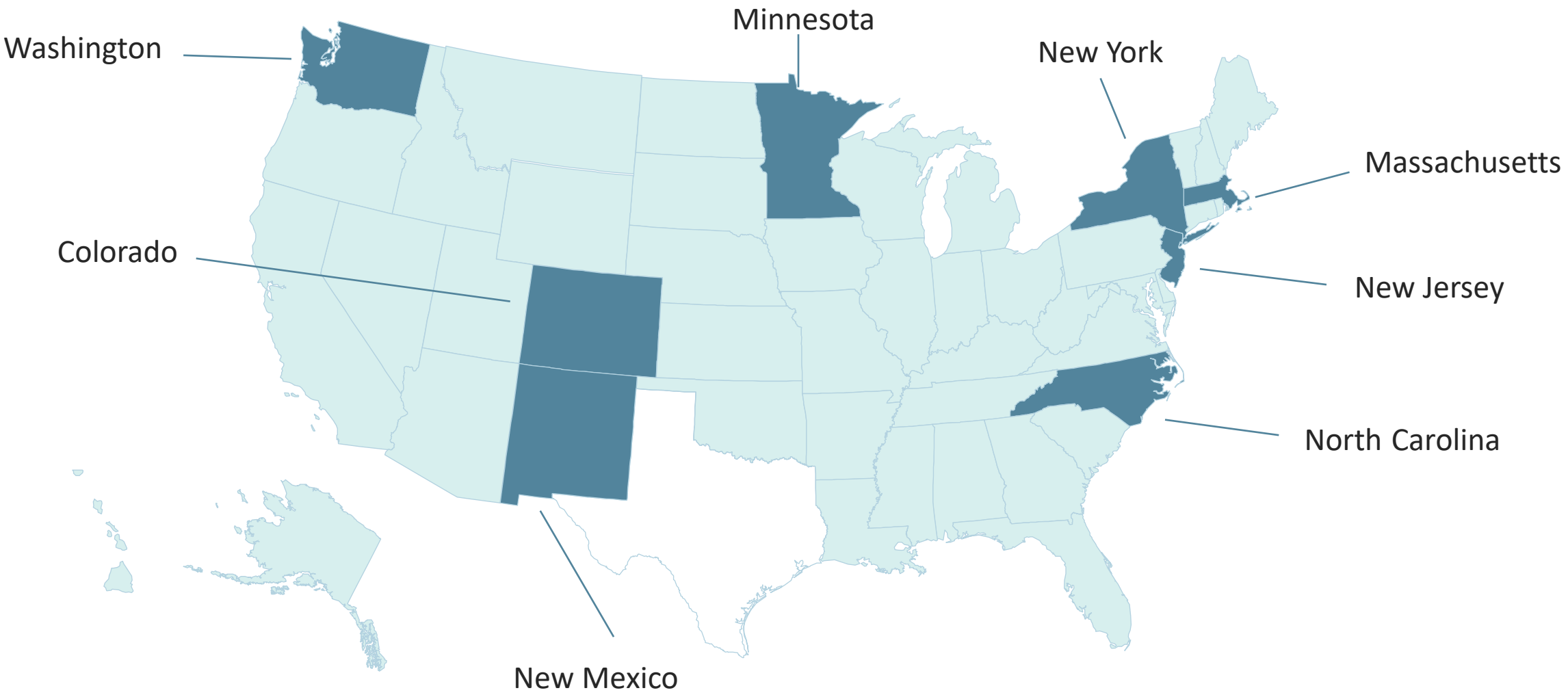
[1]CMS will adjust ESPs for social and clinical risk indicators, including the Medicare Part D low-income subsidy and Area Deprivation Index. For more information, refer to the MCP RFA that will be released in August 2023.

[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 Tracks 1 – 3 will be able to bill this code, they will receive larger ESP payments which CMS anticipates will correct for any revenue loss from CCM.

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.



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

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

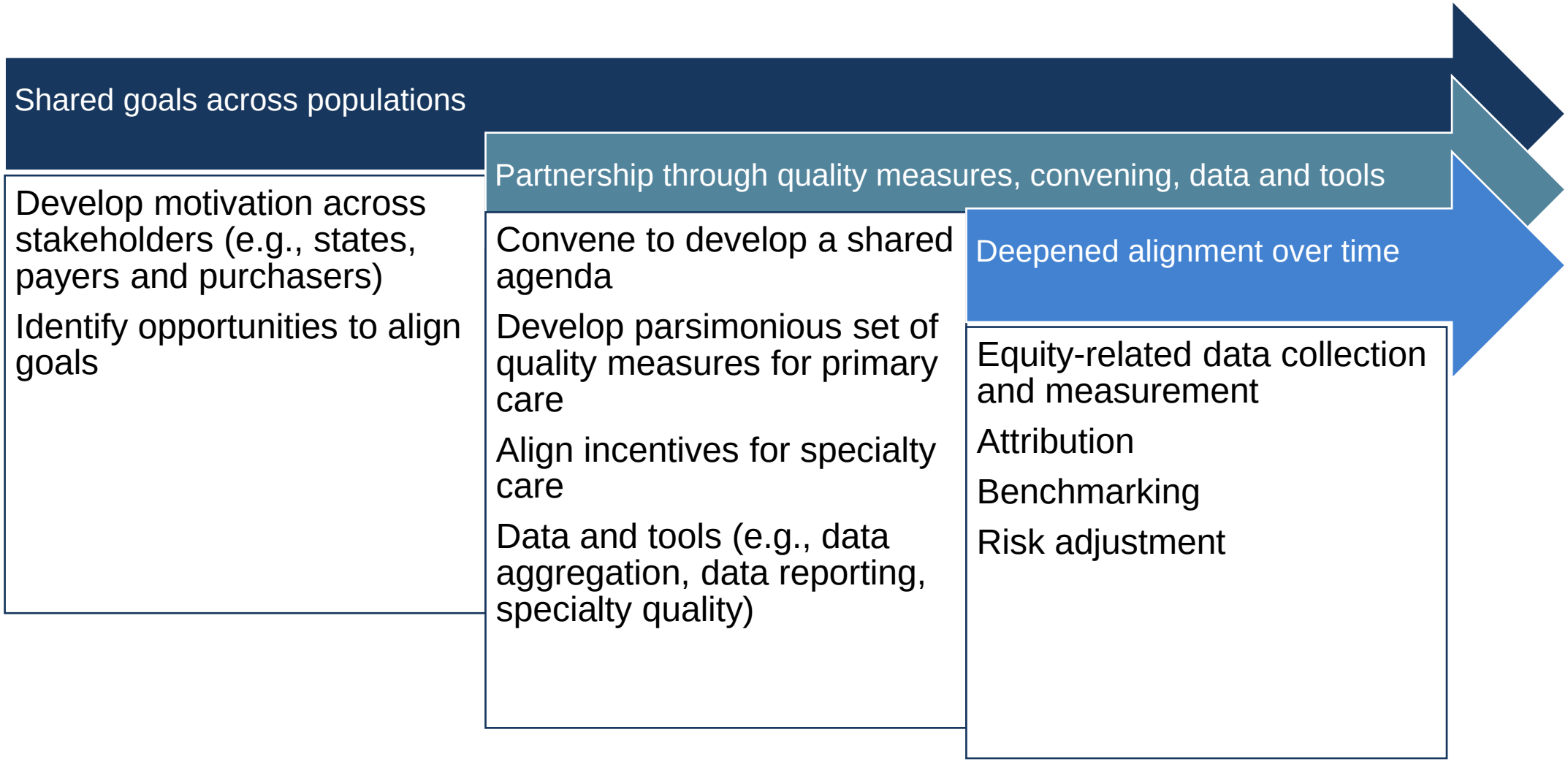
Amount: $145,000 per eligible Track 1 participant

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


Shared goals across populations
Develop motivation across stakeholders (e.g., states, payers and purchasers)
Identify opportunities to align goals
Partnership through quality measures, convening, data and tools
Convene to develop a shared agenda
Develop parsimonious set of quality measures for primary care
Align incentives for specialty care
Data and tools (e.g., data aggregation, data reporting, specialty quality)
Deepened alignment over time
Equity-related data collection and measurement
Attribution
Benchmarking
Risk adjustment

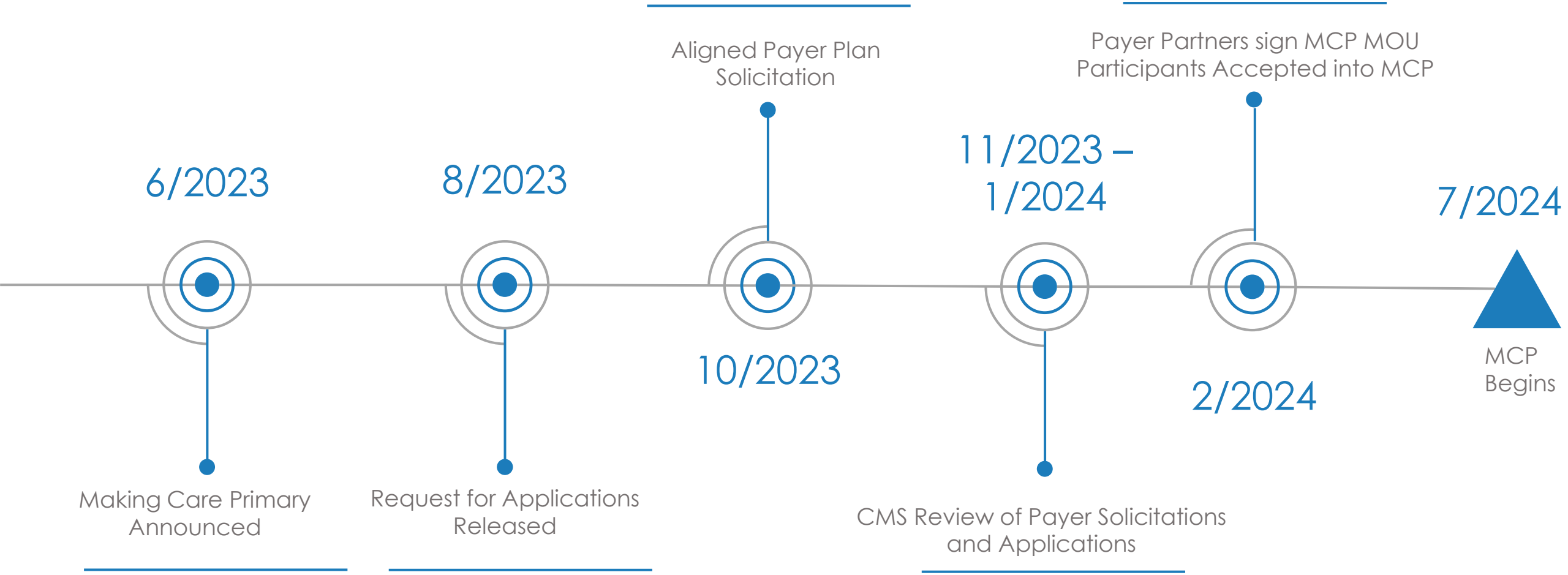
Performance Measures

Mirroring CMS's broader quality measurement strategy, measures for Medicare 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) and other existing measure sets.

Focus	Measure	Type	Track		
			1	2	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	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)*	Claims		X	X
	EDU CI *(Health Centers and IHPs only)*	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/

Making Care Primary Timeline



Identify shared goals for high-quality primary care

- **Common areas of focus and concern (health disparities, primary care access, etc.)**
- **Opportunities to align incentives on shared goals (quality measurement, non-FFS payment)**

Commit to align around a limited, core set of model principles to be augmented by payer partners

- **Data infrastructure and provision goals (what is the current infrastructure)**
- **Convening to align learning resources across payers (how do we resource in partnership)**

Partner to develop regional strategy for engaging other payers and regional priorities to increase alignment in other areas over the course of the 10-year model