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PRACTICE SUPPORT

# Making Care Primary (MCP)

# PLAYBOOK

This playbook contains concepts about the MCP model and its design, timelines, evaluation tools, considerations, and resources for potential applicants.

4/3/2024 Version 13

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# MCP Overview

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

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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MCP

## Introduction to MCP

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

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

**Number of Participation Options:** 3 Tracks

**Where MCP will Operate:** CO, NC, NJ, NM, NY, MA, MN, WA

**Indicate Your Interest (optional):** *Estimated 10 mins to complete a letter of intent (LOI)* [Link]

**Application & RFA available:** August 2023

**Application Deadline:** December 14, 2023

## Who's Eligible?

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

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

Organizations Not Eligible for MCP

- Rural Health Clinics
- Concierge practices
- Grandfathered Tribal FQHCs
- Primary Care First (PCF) practices and ACO REACH Participant Providers active as of 5/31/23

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

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

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

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

## Three Tracks

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

### Track 1: Building Infrastructure

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

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

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

### Track 2: Implementing Advanced Primary Care

Participants build upon work completed in Track 1 by:

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

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

### Track 3: Optimizing Care and Partnerships

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

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

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

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

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

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

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

## MCP Multi-Payer Alignment

### Feature 1: Directional Alignment

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

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

### Feature 2: Starting with State Medicaid Agencies (SMAs)

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

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

### Feature 3: Refreshed Investments and Resources

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

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

# MCP Payment Types by Track

## Prospective Primary Care Payment (PPCP)

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

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

## Enhanced Services Payment (ESP)

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

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

## Performance Incentive Payment (PIP)

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

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

## Upfront Infrastructure Payment (UIP)

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

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

**UIP Use Categories:**

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

## Additional Payments to Support Specialty Care Integration:

### MCP eConsult (MEC) Code for Participants

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

### Ambulatory Co-Management (ACM) Code for Specialists

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

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

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

# Performance Incentive Payment (PIP)

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

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

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

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

*[1]Certain measures proposed in the MCP model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer and use provisions related to the NCQA measures can be found at: https://innovation.cms.gov/notices-disclaimers*
**Aligned with other CMS quality programs, including the Universal Foundation Measure Set.*

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

## Example Payment Calculation: Participant A

**Participant A Characteristics**

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

- 200 beneficiaries qualifying for higher ESP support[1]

Performance Period 1 Assumptions:

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


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

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

## Example Payment Calculation: FQHC A

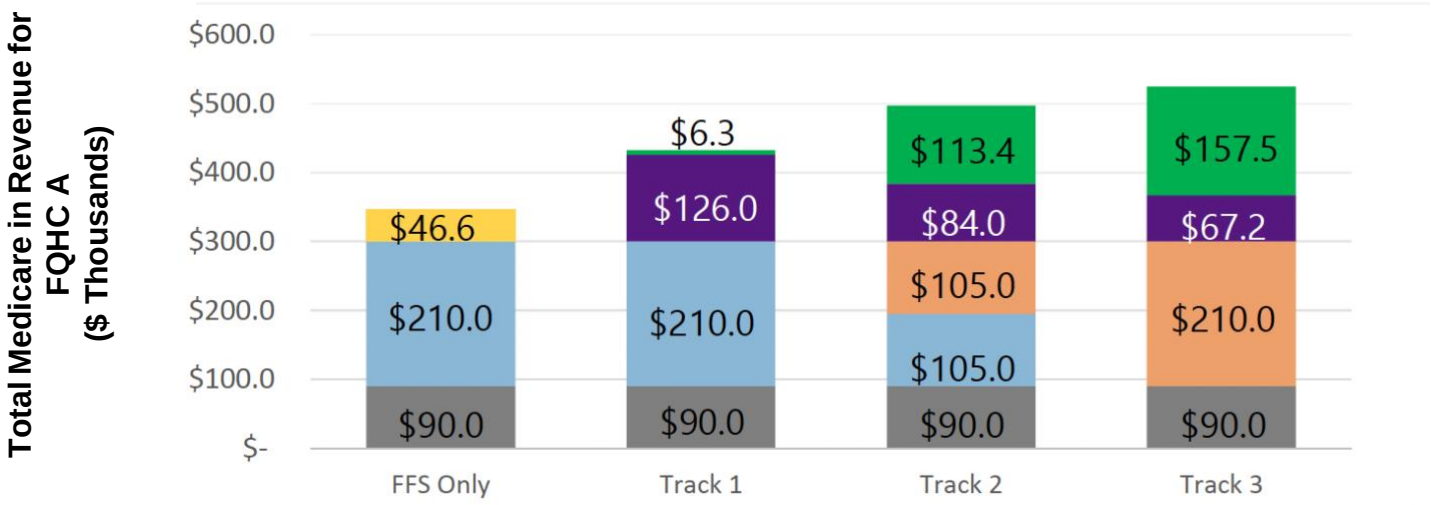
**Participant A Characteristics**

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

- 550 beneficiaries in highest-risk category[1]

Performance Period 1 Assumptions:

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




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

## ADDITIONAL INFORMATION

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

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

**Submit an optional non-binding Letter of Intent to indicate your interest** Link

# MCP Example Revenues Factsheet

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*This factsheet describes a hypothetical organization – referred to as Organization A – that participates in the Making Care Primary (MCP) Model. The information in this factsheet explains how Organization A's potential revenue under Medicare fee-for-service (FFS) compares to its potential revenue under MCP.*

MCP uses six payment types to support care delivery and quality improvement goals. MCP provides three track options for organizations to select from when applying to the model, based on their experience with Medicare value-based care.

**Refer to page 31 of the RFA for more information on MCP's payment design.**

**Refer to page 14 of the RFA for more information on the three track options within MCP.**

## Patient Population

Organization A's patient population faces significant barriers to care, and the providers can't always reach patients or help with needs or services that are not covered by Medicare FFS. They help patients with chronic conditions manage their care clinically, but do not have self-management work flows yet.

## Community Partnerships

Organization A has a few specialty care providers they work with in the community but does not have the technology capabilities or workforce to support regular follow-ups with referrals. They are interested in learning more about how to use data to implement team-based care and build community partnerships.

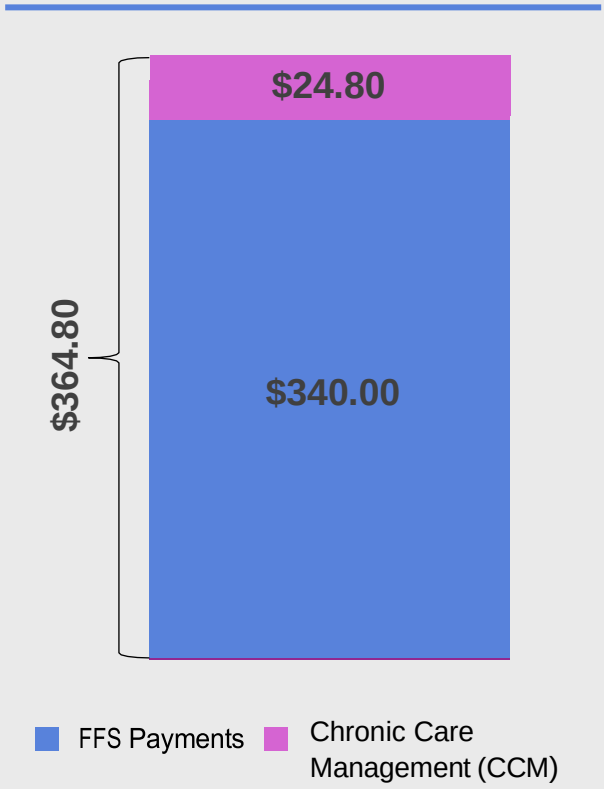
## Technology Capabilities

Organization A doesn't have an e- consultation technology platform and would like to hire more staff to support a team-based care approach with follow-ups and referrals; they are eligible for MCP's upfront infrastructure payment, which is described more fully in the MCP RFA.

### Organization A's Total Revenue Calculation ($ in Thousands) under Medicare FFS

*Total Medicare FFS Beneficiaries: 1,000*

*Chronic Care Management (CCM): $23 per beneficiary per month (PBPM) for 90 beneficiaries*



# Organization A in MCP Track 1

The example below demonstrates a hypothetical revenue calculation for example Organization A's performance characteristics in Track 1 of MCP.

Under MCP Track 1, Organization A qualifies for an Upfront Infrastructure Payment (UIP) and submits a spend plan to receive $72,500 in a lump sum in 2024 and a second lump sum payment in 2025. Organization A reports and receives credit for controlling high blood pressure and the Person-Centered Primary Care Measure (PCPCM)[1]. Organization A bills fee-for-service for primary care services and receives additional payments (Enhanced Services Payments) to expand the use of community health workers (CHWs) to high-risk patients who could benefit from their services.

## Organization A's Total Revenue Calculation ($ in Thousands) in FFS-only vs. MCP Track 1

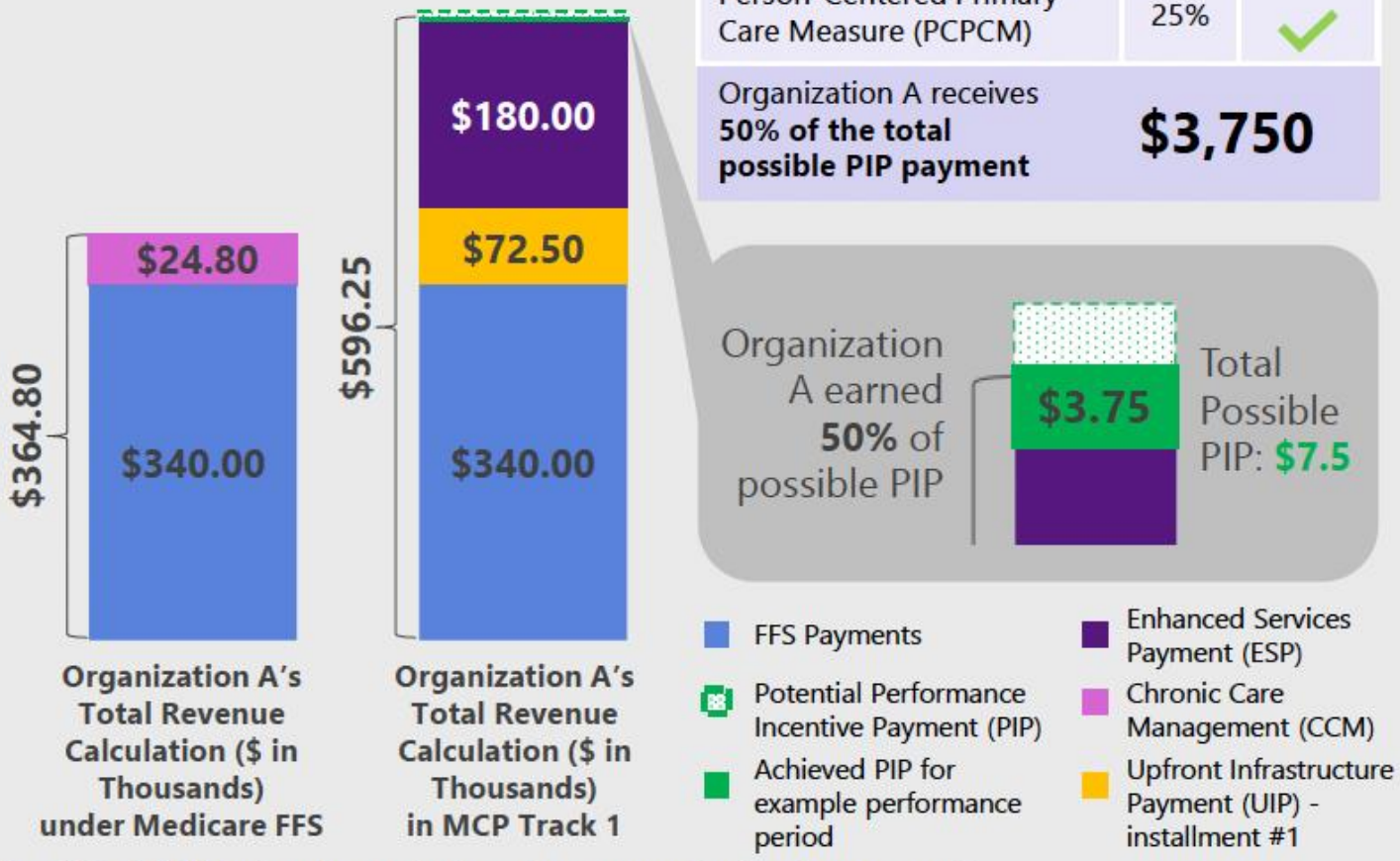
Total MCP-attributed beneficiaries: **1,000**

| | |
|---|---|
| PPCP per beneficiary per month | • $21 based on own historical data |
| Enhanced Services Payments (ESP) | • Average ESP of $15<br>• 200 in highest risk category for ESPs[2] |

**Example PIP Calculation**

| | | |
|---|---|---|
| Diabetes control | 25% | |
| Controlling high blood pressure | 25% | ✓ |
| Colorectal cancer screening | 25% | |
| Person-Centered Primary Care Measure (PCPCM) | 25% | ✓ |

Organization A receives **50% of the total possible PIP payment** **$3,750**




[1]Full credit for PCPCM is given for reporting in performance year 1 and performance year 2.
[2]ESPs will be adjusted to MCP-attributed beneficiaries characteristics, including the Medicare Part D low-income subsidy. The highest possible ESP PBPM in MCP is $25.

The example below demonstrates a hypothetical revenue calculation for example Organization A's performance characteristics in Track 3 of MCP.

Organization A now offers individualized care plans and self-management support for diabetes and hypertension. They have implemented new screening workflows for colorectal cancer and depression. Organization A also works with community organizations and Specialty Care Partners to support patients with health-related social needs.

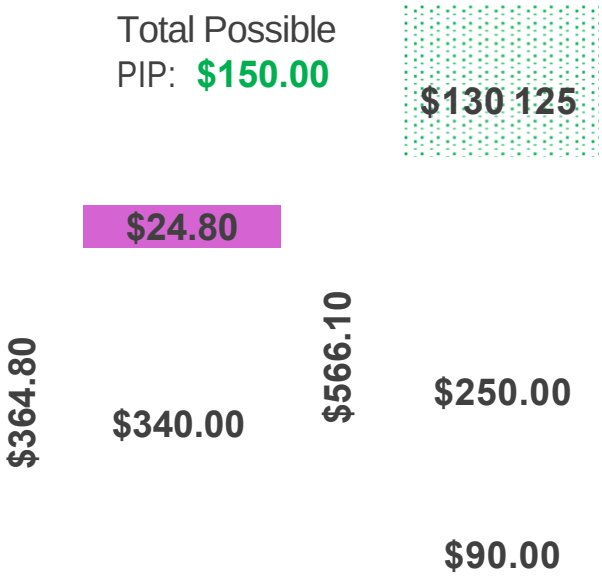
Organization A feels confident using available data to monitor patient health trends and understand payment. They use prospective payments to fund and implement care improvements.

## Organization A's Total Revenue Calculation ($ in Thousands) in FFS-only vs. MCP Track 3

Total MCP-attributed beneficiaries: **1,000**

| | |
|---|---|
| PPCP per beneficiary per month | $21 based on own historical data |
| Enhanced Services Payments (ESP) | Average ESP[3] of $8<br>200 in highest risk category for ESPs |

Total Possible PIP: **$150.00**




| Example PIP Calculation | | |
|---|---|---|
| PCPCM | 6% | |
| Diabetes Control | 6% | |
| Controlling High Blood Pressure | 6% | |
| Colorectal Cancer Screening | 6% | |
| Screening for Social Drivers of Health | 6% | |
| Screening for Depression & Follow-Up Plan[4] | 4% | Half credit given |
| Depression Remission at 12 months[4] | 4% | |
| EDU[4] | 18.5% | |
| TPCC | 18.5% | |
| TPCC CI | 25% | |
| Organization A receives **86.75% of the total possible PIP payment** in this example performance period | **$130,125** | |

[3]As participants progress across Tracks, ESP amounts decrease in each corresponding risk tier. For more information, refer to the Enhanced Services Payment section of the MCP RFA.
[4]Half credit is given for depression screening, depression remission, and EDU if participants are ≥50th but <80th percentiles.

# MCP Timeline with Key Dates

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- **July 2023 – November 2023 -** Participants may submit a Letter of Intent (LOI) Letter of Intent (LOI)
- **August 2023** – The MCP Request for Application (RFA) will be released so interested practices can prepare for application. Request for Application (RFA)
- **September 4, 2023 –** The application portal will open.
- **November 30, 2023** – The application portal will close. All applications must be submitted by this date.
- **December 2023 – January 2024** – Applications will be reviewed for determination.
- **February 2024** – Participants will begin receiving determination letters.
- **March 2024** – (ACO Participants Only) should begin discussing an exit strategy with their ACO.
- **April 2024 – July 2024** – Onboarding for participants will take place.
- **May 6, 2024** - Deadline for electronic signatures on the Participation Agreement (PA), HIPAA form and Track Change request **has been extended from April 19th**.
- **July 2024** – Enhanced Services Payment (ESP) and Prospective Primary Care Payment (PPCP) will be distributed **in early July**.
- **July 2024** – **(Track 1 only)** final determination for practices that were approved for Upfront Infrastructure Payment (UIP) eligibility.
- **July 1, 2024 –** The MCP Model launches.
- **July 1 – August 31, 2024 – (Track 1 only)** The UIP spending plan must be submitted within 45 days of the date of CMS's final written determination decision notice.
- **August 2024 –** Payer Partners must submit their Payer Plan to CMS, describing their alternative payment model for primary care in accordance with MCP.
- **August 1 – December 30, 2024 –** First UIP payment to qualified participants.
- **October 2024 –** ESP and PPCP payments will be distributed **in early October**.
- **January 2025 -** ESP and PPCP payments will be distributed **in early January**.
- **January 1 – March 30, 2025** – First Performance Incentive Payment (PIP) payment.
- **April 2025** - ESP and PPCP payments will be distributed **in early April**.
- **February 2025 to December 2025 –** Payer Partners must sign a non-binding Memorandum of Understanding (MOU) with CMS to further partnership initiatives.

# MCP Basics

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## Model Overview:

- North Carolina is one of 8 states selected by CMS.
- Aims to improve care for beneficiaries by supporting the delivery of advanced primary care services,
- Provides 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.
- Provides a pathway for State Medicaid agencies to design Medicaid programs to align with MCP in key areas.
- Attempts to strengthen coordination between patients' primary care clinicians, specialists, social service providers, and behavioral health clinicians, ultimately leading to chronic disease prevention, fewer emergency room visits, and better health outcomes.
- Potential for alignment with other commercial and public payor value-based payment models.

## Eligibility Criteria:

- Be a legal entity formed under applicable state, federal or Tribal law authorized to conduct business in North Carolina.
- Be Medicare-enrolled.
- Bill for services furnished to a minimum of 125 attributed Medicare fee-for-service beneficiaries.
- Have the majority (at least 51%) of primary care sites (physical locations where care is delivered) located in North Carolina.
- Not be a rural health clinic, concierge practice, current Primary Care First (PCF) practice, current ACO REACH participant provider or grandfathered Tribal FQHC, or concurrently participate in a MSSP ACO Model after the first six months of participating in MCP.

## Key Points to Consider:

- One cohort entry into the program in 2023 with Application or RFA (non-binding) due December 14, 2023.
- Letter of Intent available now on the website, should be submitted first and non-binding.
- 10.5 year program and practices can exit during that time but there may be some penalties.

## MCP & Three Domains for Care Delivery:

Each of these domains has specific care delivery requirements for participating organizations in each track:

- **Care Management**: participants will build their care management and chronic condition self-management support services, placing an emphasis on managing chronic diseases such as diabetes and hypertension, and reducing unnecessary emergency department (ED) use and total cost of care.

- **Care Integration**: in alignment with CMS' Specialty Integration Strategy, participants will strengthen their connections with specialty care clinicians while using evidence-based behavioral health screening and evaluation to improve patient care and coordination.

- **Community Connection**: participants will identify and address health-related social needs (HRSNs) and connect patients to community supports and services.

## MCP includes several model components designed to improve health equity:

- Some payments will be adjusted by clinical indicators and social risk.
- Participants will be required to develop a strategic plan for how they will identify disparities and reduce them.
- Participants will be required to implement HRSN (health-related social needs) screening and referrals.
- Participants will be allowed to reduce cost-sharing for patients in need.
- CMS will measure the percentage of patients screened for HRSNs.
- CMS will collect data on certain demographic information and HRSNs to evaluate health disparities.

## Model Design with Three Progressive Tracks:

MCP's **three progressive tracks** are designed to recognize participants' varying experience in value-based care—from under-resourced participants to those with existing advanced primary care experience in alternative payment models. MCP aims to give these organizations flexibility, allowing them to choose their participation track and receive payments that reflect each participant's experience towards accountable care. Again, MCP is a three-track model with one track reserved for organizations with no prior value-based care experience. Most primary care practices will fall in either tracks 1 and 2.

### Track 1: Building Infrastructure

Participants research and plan an approach to implement advanced primary care services, including: risk-stratifying their population, reviewing data, building out workflows, identifying staff for chronic disease management, conducting health-related social needs screening and referral.

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

### Track 2: Implementing Advanced Primary Care

Participants build upon work completed in Track 1 by: partnering with social service providers and specialists, implementing care management services, systematically screening for behavioral health conditions.

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

### Track 3: Optimizing Care and Partnerships

Participants expand upon the requirements of Tracks 1 and 2 by: using quality improvement frameworks to optimize and improve workflows, address silos to improve care integration, enhance social service and specialty partnerships, deepen connections to community resources.

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

## For More Information:

**Website address:** https://innovation.cms.gov/innovation-models/making-care-primary
**Detailed Fact Sheet**: https://innovation.cms.gov/media/document/mcp-ovw-fact-sheet

# MCP Primary Readiness Tool

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**Key Requirements of MCP and the Rationale for Understanding and Implementation**

**Over the course of the 10.5-year program, practices will be expected to implement Advanced Primary Care concepts and services. The following terms are important topics and issues to understand and consider for participation in MCP.**

- **Advanced Primary Care (APC)** - The foundation of APC is strong 1:1 patient-provider relationships underpinned by data-driven intelligence, referral management and care coordination, and integrated health coaching. APC is a primary care model that emphasizes comprehensive, team-based and person-focused care, the integration of behavioral and physical health services and high-quality outcomes. APC leverages realigned incentives between payers, providers, and patients — giving everyone the freedom to prioritize health outcomes over reimbursement.
- **Risk Tolerance** – practices need to understand that the prospective payment model brings the risk of outspending the payment received for the attributed population.
- **Prospective Payment** – Need to understand that this is like capitation and the only payment received for an attributed population will be a per member per month payment paid quarterly. The prospective payment applies to practices in Track 2 (50% of total payment) and Track 3 (100% of total payment). The prospective payment will be based on a 2-year lookback at Medicare claims.
- **SDOH/HRSN Screening and Referral Process** – Must develop a robust process to identify patients with needs and a process to refer them to appropriate community resources using internal resources or a system such as NCCare360.
- **Care Management** – Must have or develop robust care management services to monitor and manage the care of the population, especially high-risk patients and those going through a transition of care.
- **High Risk Patient Engagement** – Consider developing Community Health Worker services to engage with high-risk populations.
- **Behavioral Health Integration** – Must have or develop integrated behavioral health to meet the needs of the attributed population. An example would be the evidence-based Collaborative Care Model.
- **Risk Stratification** – Must have or develop a robust risk stratification process to identify high-risk patients in need of care management and/or CHW intervention.
- **Total Per Capita Cost** – The measure is an average of per capita costs across all attributed beneficiaries and includes all Medicare FFS Parts A and B standardized allowable charges incurred by each attributed beneficiary in the quarter. Practices may be able to review their current TPCC performance by logging into QPP.cms.gov.
- **Specialty Care Partners** – Participants will execute Collaborative Care Agreements with specialists to facilitate closer coordination.
- **Current MSSP Participation** – Need to understand that MCP participating practices will be required to terminate their current MSSP relationship. Check with your MSSP ACO for termination requirements.

**Track Evaluation Tool** – Consider this list and use it to determine current readiness and future fit with your organization. Higher average rankings show preparedness for Track 2 or Track 3, the prospective payment process, and Advanced Primary Care.

| | Low | Medium | High |
|---|---|---|---|
| Risk Tolerance | | | |
| Understanding of prospective payment | | | |
| Current level of SDOH screening | | | |
| Current level of SDOH referrals | | | |
| Current level of interaction and partnership with social service agencies or human services organizations | | | |
| Current risk stratification process | | | |
| Current level of care management | | | |
| Current level of chronic condition self-management support services | | | |
| Current provision of group education | | | |
| Current level of linkages to community-based supports for chronic conditions | | | |
| Current use of Community Health Worker | | | |
| Current use of Health Coaches | | | |
| Willingness to leave current MSSP arrangement | | | |
| Willingness to submit periodic updates and reports to CMS (bi-annually for Track 1 and 2, annually for Track 3) | | | |
| Current level of Behavioral Health Integration | | | |
| Willingness to execute Collaborative Care Arrangements with Specialty Care Partners | | | |
| Relationship with specialists and ability to collaborate on care coordination and quality improvement | | | |
| Current capability to conduct e-Consults with specialists (will be required in Track 2) | | | |
| Ability to develop and implement a Health Equity Plan | | | |
| Ability to generate reports with demographic and HRSN data | | | |
| Currently connected to and sharing data with a Health Information Exchange (HIE) | | | |
| Current level of quality performance measurement | | | |
| Current level of quality improvement activities | | | |
| Current level of data analysis, internal reporting, and data informed process change | | | |
| Understanding of current cost performance (TPCC) | | | |
| Current level of NC HealthConnex utilization (patient portal and NC*Notify) | | | |
| Current quality performance in Diabetes care | | | |
| Current quality performance in managing hypertension | | | |
| Current performance in attributed patients' use of Emergency Department | | | |
| Current total cost of care for attributed patients (reverse measure – lower is better) | | | |

The following table from the Making Care Primary Request for Application shows the expected progression through the three tracks for each care delivery domain and category. Use this table to consider the future and how the Advanced Primary Care model fits the organization's culture and goals.

## Appendix C: MCP Care Delivery Requirements

This table summarizes the progressive care delivery requirements, across tracks and domains.

| Care Delivery Requirements by Track | | | |
|---|---|---|---|
| | **Track 1** | **Track 2**<br>*Same requirements as Track 1*<br>+ | **Track 3**<br>*Same requirements as Track 2*<br>+ |
| **Care Management Domain** | | | |
| **Targeted Care Management** | • Empanel and risk stratify all patients<br>• Identify staff and develop workflows to provide chronic care management to high-risk patients, with an emphasis on hypertension and diabetes management<br>• Identify staff and develop workflows to provide timely follow-ups for high-risk patients post ED visit and hospitalization | • Implement chronic care management for high-risk patients most likely to benefit, with an emphasis on hypertension and diabetes management<br>• Implement episodic care management to provide timely follow- ups for high-risk patients post ED visit and hospitalization | • Implement individualized care plans for high-risk patients most likely to benefit, with an emphasis on hypertension and diabetes management |
| **Chronic Condition Management** | • Identify staff and develop workflows to deliver individualized self-management support services for chronic conditions, with an emphasis on hypertension and diabetes management | • Implement individualized self-management support services for chronic conditions, with an emphasis on hypertension and diabetes management | • Expand self-management services to include group education and linkages to community-based supports, as appropriate |

| | | | |
|---|---|---|---|
| **Care Integration Domain** | | | |
| **Specialty Care Integration** | • Use MCP data tools to identify high-quality specialists | • participants identify high-quality Specialty Care Partners through Collaborative Care Arrangements and Specialty Care Partner List<br>• Furnish MCP e-Consult services with at least one specialist | • Establish enhanced relationships with high-quality specialists through time-limited co-management |
| **Behavioral Health Integration** | • Identify staff and develop workflows to initiate a behavioral health integration (BHI) approach grounded in measurement- based care (MBC)[58] | • Implement a BHI approach utilizing measurement-based care, including using standardized measurement tools and measurement data to inform treatment decisions.<br>• Systematically and universally screen for key behavioral health conditions, including depression and substance use disorder | • Optimize BHI workflows using a quality improvement framework |
| **Community Connection Domain** | | | |
| **Health- Related Social Needs (HRSN) Screening and Referral** | • Implement universal HRSN screening & provide referral resources<br>• Develop workflows for referring beneficiaries with unmet HSRNs (i.e., positive screens) to social service providers in the community (i.e., community-based organizations (CBOs) and/or public health organizations) | • Implement social service referral workflows with clear roles and responsibilities for MCP participant and social service provider partners | • Optimize social service referral workflows, using a quality improvement framework, to improve approaches for assessing and managing socially complex beneficiaries through social service partners. |

| | | | |
|---|---|---|---|
| **Supporting Whole-Person Care Through Community Supports and Service Navigation** | • Explore partnerships with social service providers (i.e., community based (CBOs) and/or public health organizations) to meet beneficiaries HRSNs<br>Identify staff (a community health worker (CHW) or equivalent professional with shared lived experience) who will navigate and coordinate health-related and social support services to higher need beneficiaries, such as addressing social isolation; supporting stress management; supporting chronic disease management; monitoring for gaps in care; accessing low-income benefits; and/or other appropriate support services. | • Establish partnerships with social service providers<br>• Utilize CHW (or equivalent professional with shared lived experience) in navigating and coordinating health-related and social support services to higher need beneficiaries | • Strengthen partnerships with social service providers<br>• Optimize the use of a CHW/professional with shared lived experience, using a quality improvement framework, in navigating and coordinating health-related and social support services to higher need beneficiaries |

[58] Measurement-based care 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. The Joint Commission (2022). *Outcome Measures Standard.* https://www.jointcommission.org/what-we-offer/accreditation/health-care-settings/behavioral-health-care/outcome-measures-standard/

**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.*

# MCP Care Management & Quality Data Considerations

NC AHEC

**The MCP care delivery approach communicates its vision for care delivery through three domains:**

- **Care Management**: participants will build their care management and chronic condition self-management support services, placing an emphasis on managing chronic diseases such as diabetes and hypertension, and reducing unnecessary emergency department (ED) use and total cost of care.

- **Care Integration**: in alignment with CMS' Specialty Integration Strategy, participants will strengthen their connections with specialty care clinicians while using evidence-based behavioral health screening and evaluation to improve patient care and coordination.

- **Community Connection**: participants will identify and address health-related social needs (HRSNs) and connect patients to community support and services.

**To be eligible to apply to participate in MCP, an organization must:**

- Be a legal entity formed under applicable state, federal, or Tribal law authorized to conduct business in each state in which it operates.
- Be Medicare-enrolled.
- Bill for health services furnished to a minimum of 125 attributed Medicare beneficiaries.
- Have the majority (at least 51%) of their primary care sites (physical locations where care is delivered) located in an MCP state.

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

- Key features: Specialty care performance data sharing with prioritization for cardiology, orthopedics, and pulmonology. New specialty integration payments made to specialists that have care management agreements with the purpose of improving communication and collaboration. Connection to health information exchange is necessary.
- 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.
- Implement a behavioral health integration 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.
- Small improvements can yield significant cost and quality improvement over time across common chronic conditions. Focus on building participant capacity to deliver equitable, team-based care and improve outcomes over time on key metrics like hypertension and diabetes control.

### 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 | | |
|---|---|---|---|---|---|
| **Chronic Conditions** | | | 1 | 2 | 3 |
| | 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 |
| | EDI 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 ad CMS will work with participants to ensure they have the appropriate health IT infrastructure information to successfully report this measure.

# MCP Calculators

NC AHEC

NC AHEC offers a calculator developed by the American Academy of Family Physicians and endorsed by CMMI. The purpose of this calculator is to help determine the financial benefits and economic feasibility of the MCP model and its individual tracks. You can also use the calculator to compare your current FFS situation. Please note that this is an educational resource. The practice should consult with its medical and administrative leadership, revenue cycle management team, accountable care organization or clinically integrated network, accountant and legal team to ensure due diligence is fully exercised.

**View the calculator here:**
**AAFP MCP Calculator**

# MCP Implementation Tracker

NC AHEC

After the first 12-month performance year in each Track, participants will be required to demonstrate that they are meeting the care delivery requirements in their respective Track or must have a comprehensive strategy for implementing those requirements in the following performance year.

Participants must meet the care delivery requirements in their starting Track by the end of PY2 (12/31/25). Participants will be required to report to CMS information on their care delivery capabilities and progress at least bi-annually for Tracks 1 and 2, and at least annually for Track 3, and will be subject to other documentation requirements.

The following MCP Implementation Tracker will help practices identify and track their progress with fulfilling components of each Track. Practices are able to document the appropriate team members, needs and status of each task.

The MCP Implementation Tracker is available at https://public.3.basecamp.com/p/cQV2Taqd1zZ65Jd3EF4hMFaC.

# MCP Reference Library

NC AHEC

- **Making Care Primary (MCP) Model:** https://innovation.cms.gov/innovation-models/making-care-primary
- **MCP Resources (including webinars about program for practice applicants):** https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary
- **Care Primary (MCP) Model - Frequently Asked Questions** https://innovation.cms.gov/mcp/faqs
- **MCP – Care Delivery Requirements (CMS/video file)** innovation.cms.gov/media/video-file/mcp-ovw-webinar-recording-p2
- **MCP – Application Process, Next Steps, and Resources (CMS/video file)** innovation.cms.gov/media/video-file/mcp-ovw-webinar-recording-p3
- **NCAFP RFA Checklist** https://public.3.basecamp.com/p/nVDeT7mD45FFDdnm2LybS2P8
- **NCAFP MCP Overview Presentation:** https://public.3.basecamp.com/p/mGYGsZqJJkRB2m4JiJg8XdVp
- **CMS Innovation Center: Model Implementation and Center Performance** https://www.gao.gov/products/gao-18-302
- **Primary Care First (PCF) Model Evaluation of the First Year (2021)** https://innovation.cms.gov/data-and-reports/2022/pcf-first-eval-aag-rpt
- **Making Care Primary Model Provider Update – July 3, 2023** https://medicaid.ncdhhs.gov/blog/2023/07/03/making-care-primary-model-provider-update-july-3-2023
- **Center for Medicare and Medicaid Innovation Primary Care Models** https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/cms-primary-cares-initiative.html
- **Making Care Primary: A Run-Down on CMMI's Newest Value Model** https://blogs.claconnect.com/healthcareinnovation/making-care-primary-a-run-down-on-cmmis-newest-value-model/
- **CMS Announces the Making Care Primary Model, a Multistate Initiative to Strengthen Primary Care** https://www.jdsupra.com/legalnews/cms-announces-the-making-care-primary-5323041/
- **CMS Innovation Center Outlines Primary Care Strategy** https://qi.ipro.org/2023/06/12/cms-innovation-center-outlines-primary-care-strategy/
- **Transforming Primary Care: CMS Launches Making Care Primary (MCP) Model** https://www.mintz.com/insights-center/viewpoints/2146/2023-08-08-transforming-primary-care-cms-launches-making-care
- **CMS' Latest Innovation Model – The Making Care Primary (MCP) Model Includes Focus on Social Determinants of Health** https://www.foley.com/en/insights/publications/2023/06/cms-innovation-model-making-care-primary-mcp
- **CMS' Latest Innovation Model – The Making Care Primary (MCP) Model Includes Focus on Social Determinants of Health** https://www.natlawreview.com/article/cms-latest-innovation-model-making-care-primary-mcp-model-includes-focus-social

- **Understanding The Making Care Primary (MCP) Model**
  https://www.netrinhealth.com/making-care-primary-model/