Making Care Primary (MCP) Frequently Asked Questions

This document reflects questions that were asked by ACP, AAFP, and AMA members as part of a webinar with Medicare and Medicaid Innovation Center staff that took place on Sept. 27, 2023, a recording of which is available here. Slides are also available here.

Key Links and Dates:

- **Nov. 30, 2023** is the deadline to apply for the model.
- Access the Request for Applications (RFA), which explains key details of the model.
- Sign up for the MCP listserv to receive updates about the model.
- Visit the MCP webpage for additional information and resources.
- Submit application-related questions to MCP@cms.hhs.gov.

I. Model Footprint and Payer Participation

Q1. How were the eight states selected? Does CMS plan to add additional states in the future? The eight states were selected based on a variety of factors, including commitments from state Medicaid agencies. At this time, there are no plans to expand the model to additional states.

Q2. What is the status of the Medicaid model development in the selected states? State Medicaid Agencies in each of the eight MCP states are developing their MCP-aligned strategies and plans in consultation with stakeholders in the region, including managed care partners and the provider community. States will be making further announcements about their plan in the coming weeks and months.

Q3. Will Medicare Advantage (MA) patients be included, or only traditional Medicare? To be considered assignable as Medicare beneficiaries under the model, beneficiaries must have Original Medicare as their primary payer and not receive their care from a Medicare Advantage plan, in addition to meeting other eligibility criteria as specified on page 30 of the RFA. MA plans are encouraged to apply to become MCP payer partners in the modes. More details can be found on the MCP Payer Partner Fact Sheet and MCP Payer Partners Guide to Alignment.

Q4. Can you share more about your engagement with commercial payers and the process for letting potential MCP participants know which payers are participating in their regions? CMS is actively engaging with private payers. All interested payer partners will sign Letters of Intent to become MCP Payer Partners by February 2024 so that selected provider applicants will know which payers in their markets are planning to partner with CMS in the model before signing Participation Agreements in Spring 2024.

Q5. Because payer agreements are non-binding, will practices have an opportunity to exit the model if it turns out that a payer that previously indicated interest ends up not participating? Practices interested in taking part in MCP will not be considered part of the model until a Participation Agreement is signed. Once signed, MCP Participants may exit the model annually, including once the model has begun in July of 2024. However, doing so will forfeit all financial support above FFS as well as potential performance-based payments. If a practice receives the Upfront Investment Payment and leaves within the first two years of the model, they may be required to repay that to CMS.

Q6. How will this model help extend physician-managed care to areas of need, such as rural or underserved areas? CMS' goal is to invest in primary care, regardless of where it is, and to provide additional resources that allow primary care practices to broaden services and increase value in the healthcare system. CMS is actively working with health centers in rural areas to address gaps in care.. Engaging rural practices was also part of the intentionality behind making this a 10.5-year model in order to improve sustainability of primary care particularly in these types of areas over a longer period of time.

II. Participation and Eligibility Requirements

Q7. Will I be able to apply to MCP in the future? At this time, CMS does not have plans for any future cohorts of the model so any practices interested in participating are encouraged to submit an application by the Nov. 30, 2023 deadline.

Q8. Will all organizations who are determined to meet requirements be accepted into the model? This model is not competitive and does not have an enrollment cap. Any practice that meets the eligibility criteria is eligible to participate.

Q9. Is the program open to independent physicians? Yes, in fact this model was designed specifically with independent, community-based physician practices in mind to provide them with additional supports to facilitate their participation, including upfront infrastructure payments, a longer agreement period, and replacing fee-for-service payments with prospective payments. CMS is strongly encouraging independent primary care physician practices to apply.

Q10. Are organizations that deliver primary care in more than one state eligible to join MCP in states that are participating, even if their other state locations are not in an MCP-eligible state? Yes. To be considered eligible, an organization must be a legal entity that is authorized to conduct business in the state with the majority (but not necessarily all) of their primary care physical practice site locations located in an MCP-eligible state.

Q11. Does MCP qualify as an Advanced Alternative Payment Model (AAPM)? Does Qualifying AAPM Participant (QP) status apply only to primary care clinicians in the MCP participating practices? MCP Participants in Tracks 2 or 3 of the model may qualify as QPs in AAPMs. MCP Participants in Track 1 would not qualify. Participation in the model is defined by the eligible primary care clinicians who are listed on the MCP clinician list (or, in the case of FQHCs, the list

of all physical practice site CMS Certification Numbers (CCNs) linked to the Tax Identification Number (TIN)) so yes, participation and therefore QP status would only be the participating primary care clinicians in participating practice TINs. Notably, all primary care National Provider Identifiers (NPIs) or CCNs under a participating TIN are required to participate in the model.

Q12. Are Federally Qualified Health Centers (FQHCs) for which the state is the employer eligible for MCP? FQHCs that receive Medicare and Medicaid enhanced payments described at §1834(o) and §1902(bb) of the Social Security Act (the Act), as well as certain outpatient clinics associated with tribal/urban Indian organizations and HRSA-designated Health Centers and look-alikes as defined at §§§1861(aa)(4) and 1905(l)(2)(B) of the Act are eligible to participate.

Q13. Can a non-payer/provider convening organization participate with states to align payers and practices through VBC contracts? To be considered eligible, organizations must (among other criteria) be Medicare-enrolled and serve as a regular source of primary care for 125 or more Medicare beneficiaries, so they must have a direct caregiving role.

Q14. If a system contains both rural health clinic (RHC) and non-RHC sites, can the non-RHC sites participate in MCP? Non-RHC sites under a single TIN would be eligible to participate in the model provided the organization meets all other eligibility criteria.

Q15. What is the process for exiting the model early? Are there any penalties for doing so? Practices will be able to withdraw from the model annually. Track 1 participants that received the up-front infrastructure payments (UIPs) may be required to return UIP funds if they exit the model before entering Track 3. Otherwise, there are no explicit financial penalties for exiting the model before the end of the agreement period. Early termination policies and procedures will be further detailed in Participation Agreements.

III. Track Selection and Model Overlap

Q16. What are some of the major ways this model differs from other CMS models such as Comprehensive Primary Care Plus (CPC+), Primary Care First (PCF), and the Medicare Shared Savings Program (MSSP)? This model was developed to engage clinicians with varying levels of experience in value-based care and provide additional supports to engage practices that have historically faced barriers to AAPM participation, including smaller, independent, rural, and safety net practices. Some of the distinct elements featured in this model include a longer agreement period to promote stability, a ramp up period to build up to enhanced care delivery requirements, up-front infrastructure payments, and upside-only performance incentive payments paid earlier in the performance year.

Q17. If I previously or am currently participating in other CMS models, can I switch to MCP? Would Track 1 be available to me? Practices who are participating in Primary Care First or the ACO REACH (Accountable Care Organizations Realizing Equity Access and Community Health Models) as of May 31, 2023 will not be eligible to participate in MCP. Organizations that previously participated in these and other CMS models before that date are eligible and

encouraged to apply. However, Track 1 is designed for those without previous experience in value-based care, so those with experience in a two-sided risk CMS model within the last five years as defined on page 14 of the RFA would be required to start in either Track 2 or 3.

Q18. Can MCP participants participate in MCP and the "AHEAD" (States Advancing All-Payer Health Equity Approaches and Development) Model simultaneously? No; states and regions that are testing the MCP model are not eligible to apply to the AHEAD Model. States must apply to CMS to participate in the AHEAD model, and CMS discussed the appropriateness of both approaches to improving primary care before selecting regions to test MCP.

Q19. What is the ramp up period? Track 1 is focused on infrastructure building, Track 2 on implementing advanced primary care, and Track 3 on optimizing care and partnerships. MCP participants will remain in Tracks 1 and 2 for two years each (plus an additional six months in whichever Track they start in) before advancing to Track 3, which they will remain in for the remainder of their time in the model. Participants are expected to meet the care delivery requirements of each Track within the first 12 months of joining the respective track.

Q20. Will there be any guidance provided to help organizations decide which track to select? Those with prior experience in value-based care models are ineligible to participate in Track 1 (see prior experience definition in Section 2B of the RFA). Otherwise, it is up to each organization to decide whether Track 2 or 3 is a better fit based on a variety of factors specific to each practice. There are payment differences to consider, including the fact that specialty ambulatory co-management fees are only available in Track 3 and prospective primary care payments are worth 100% of covered FFS services in Track 3 verses 50% in Track 2. Additionally, Track 3 practices are expected to be further along in their collaboration with specialists and community partners. CMS has created a decision tree to help practices understand which might be appropriate for them to begin their MCP experience. The AAFP also developed profiles to help understand practices better understand the requirements for each track. Additional information about the differences between tracks can be found on and Section 2 of the RFA.

Q21. Once in the model, can MCP participants advance to Tracks 2 or 3 early, or skip Track 2 for example? No, the length of time participants spend in each Track will be standardized, so if a participant starts in Track 1, they would spend 2.5 years in Track 1 then spend two years in Track 2 before advancing to Track 3. There would not be an option to skip Track 2 completely and advance straight from Track 1 to Track 3.

IV. Patient Attribution

Q22. How will CMS determine to which participating provider a patient will be assigned for purposes of capitated and quality payments? MCP will utilize a three-step prospective quarterly attribution featuring (in order of prioritization): 1) voluntary attribution; 2) the most recent annual wellness visit or welcome to Medicare visit during the last two years; or 3) claims-based alignment based on the plurality of primary care/chronic care management visits (based

on count) during the previous two years. More information on beneficiary eligibility and attribution can be found on pages 29-31 of the RFA.

Q23. Under Primary Care First's (PCF's) "leakage" policy, specialty services provided by Nurse Practitioners and Physician Assistants could be mis-identified as primary care services and used to retroactively lower PCF payments, which could make it challenging for PCF participants to accurately predict revenue under the model. Does MCP do anything to correct for this? MCP has a partial reconciliation policy for its quarterly prospective primary care payments (PPCP) that differs from PCF's leakage policy in a few key ways. First, downward adjustments will only be made if primary care services performed outside the practice exceed certain thresholds. Second, this determination is based on total primary care spend, rather than number of services. Third, the amount that can be reconciled will be limited to set amounts, ensuring practices are able to maintain a predictable revenue over time. Finally, MCP will treat primary care services provided by practitioners in different locations under the same TIN as covered services under MCP, unlike PCF. There is not currently a carve-out based on provider type or specialty designation. More information can be found on page 41 of the RFA.

V. Payment Methodology

Q24. Will state Medicaid agencies and other participating payers feature the same model payments as Medicare, including the enhanced services payment? Other partnering payers will design primary care models that align with MCP on priority elements, such as moving primary care payment away from FFS, but may differ in the specific payments that support primary care. Payers may exercise some flexibility in designing payment approach that are aligned with MCP, but also exhibit differences based on payer experience and resources, subject to approval by CMS.

Q25. The upfront infrastructure payments (UIPs) are set at two installments of $72,500. Does CMS have in mind a number of participants it is planning to accept into Track 1 and award these to? No, there is not a specific number of participants CMS plans to accept in Track 1 and award UIPs to. CMS will access the eligibility criteria and make awards in that fashion.

Q26. Can the MCP E-Consult (MEC) Payment for primary care clinicians continue to be billed in Track 3 when the ambulatory co-management payment for specialists begins? In Track 3, the quarterly Prospective Primary Care Payment (PPCP) will completely replace primary care FFS reimbursement for certain services (see Appendix G in the RFA), including the MEC. So, the MEC will continue to be factored into PCP reimbursement in the model in Track 3 but will be incorporated as part of the PPCP.

Q27. Can you describe the purpose of the enhanced services payment (ESP) in greater detail? For example, will physicians be able to use this payment for telehealth care coordination with other physicians and nurses while the patient is in the hospital? The ESP is intended to support the aims of the model, which include delivering comprehensive and connected primary care, a pathway to value-based care for primary care practices, and improved quality and patient

outcomes. These payments are intended to be flexible based on each participant's patient needs and do not require separate billing, so they could be used for a variety of purposes, including telehealth or working with a care manager to provide chronic disease supports.

Q28. How often should specialists bill for new specialty care integration services? Ambulatory co-management (ACM) payments can be billed up to three times by the same specialist for the same shared MCP beneficiary within a year, including the initial consultation.

Q29. Does track 2 have a reduced fee-for-service (FFS) reimbursement from Medicare? Yes. The Prospective Primary Care Payment (PPCP) is a quarterly payment designed to gradually replace FFS payments for certain primary care services for the attributed beneficiary population, starting with 50% in Track 2 and 100% in Track 3. For a complete list of services that will be incorporated into the PPCP payment, see Appendix G on page 82 of the RFA.

Q30. Is the up-front infrastructure payment (UIP) per provider or per organization? In other words, would a single provider practice receive the same amount as a 20-provider practice? The UIP is paid per participating organization. CMS will require participants to provide a spend plan for usage of UIP funding and will determine the size of the payment based on the need.

Q31. Will the new CPT code G2211 be separately paid in Tracks 2 and 3? Yes; for the purposes of MCP, G2211 will be paid separately through the claims system for all tracks.

Q32. Do MCP payments replace chronic care management (CCM) billing codes? Yes; CCM services, along with principal care management (PCM) and transitional care management (TCM) services will be considered duplicative of the Enhanced Services Payments (ESPs), which are prospective, quarterly, per beneficiary payments to support enhanced care management and coordination that do not require separate billing.

VI. Performance Measurement

Q33. Can you clarify how quality scoring will impact performance incentive payments (PIPs)? MCP participants must report all quality measures to be eligible for a PIP. Additionally, all Track 2 and 3 participants must surpass the 30th percentile on the Total Per Capita Cost measure to qualify for a PIP. Quality measures will be scored on a per-measure basis. Generally, scoring at or above the 50th percentile for each measure will result in half credit for the measure and scoring at or above the 70th or 80th percentile (depending on whether a participant is in Tracks 2 or 3) will earn full credit for that measure. For improvement measures, participants will be awarded half credit for improving on their own past performance by more than three percent and awarded full credit for improving their past performance by more than five percent. Each measure is worth a different weight of the total performance score. To learn more, see the Performance Assessment section of the RFA beginning on page 25.

Q34. Will quality measures be compared against other MCP practices or anyone who reports the measure, including non-MCP practices in MIPS? Participants will generally be compared

against all peer practices, including those not in MCP, for eCQM and utilization measures. Because the Person-centered Primary Care Measure is new, practices will receive full credit in the first two years for successfully reporting the measure. CMS will issue further guidance on the Social Drivers of Health measure, which is still under development.

Q35. Where can I find the performance measures that will be used in the model? Slide 15 of the webinar presentation and pages 27-28 and 46-37 of the RFA contain more information about quality measurement and scoring, including the specific measures that will be used and their respective weights toward the total performance score. Generally, Track 1 will feature four equally weighted measures (controlling high blood pressure; diabetes hemoglobin A1c poor control; colorectal cancer screening; and a person-centered primary care survey measure). Tracks 2 and 3 will feature ten measures- seven quality measures and three cost/utilization measures, including a continuous improvement measure. FQHCs and Indian Health Programs will be scored on the same measures, except instead of continuing improvement on total per capita cost, they will be measured on continued improvement on emergency department usage.

Q36. Will quality data be reported and scored for participating commercial payers in the same way as Medicare? Partnering commercial and Medicaid payers will align, as feasible, with Medicare measures in MCP. Partnering payers may for example add measures specific to their population that are not adequately captured by the Medicare measure set (e.g. young adults, pediatrics).

VII. Specialty Integration

Q37. What payments are specialists eligible for under the model? In Track 3, specialists whose organization has an active Collaborative Care Arrangement (CCA) with an MCP Participant and are considered an MCP Specialty Care Partner can bill ambulatory co-management (ACM) payments at an average of $50 with geographic adjustments for up to three times per year including the initial consult. ACM billing requirements generally align with those for principal care management (PCM) services, except patients do not have to be at significant risk of death, acute exacerbation, or functional decline and the specialist must agree to take on a co-management role for that patient based on terms established in the care coordination agreement. In addition, MCP Participants may elect to share a portion of their performance improvement payment (PIP) with their Specialty Care Partners but are not required to do so. Such terms should be clearly spelled out in care coordination agreements (CCAs). Specialists are not eligible to apply as MCP Participants.

Q38. How will services and outcomes be attributed and assessed between specialty and primary care physicians? Does this model include any type of mechanism to incentivize specialty partners to be resource conscious or deliver cost-effective care? Attribution is done at the primary care organization level. CMS looks at total per capita cost so there is an element where costs for services provided beyond the four walls of the primary care practice are considered. CMS has also created two new payable codes to incentivize and reward primary-specialty coordination including MCP E-Consults, which can be billed by MCP participating

primary care practices starting in Track 2 for collaboration with any specialist (including those they do not have a care coordination agreement with), and ambulatory co-management services, which can be billed by specialty care partners starting in Track 3.

Q39. Since partnering with specialists is mandatory starting in Track 2, is CMS having active conversations with specialty groups and community-based organizations to promote partnering with MCP participating primary care practices? How else will CMS be supporting primary care practices in establishing these partnerships? MCP participants are not required to execute a collaborate care arrangement until the end of their first year in Track 2, so those starting in Tracks 1 or 2 will have time to prepare. CMS is in regular communication with industry partners about participation in the model, including those representing specialties, and plans to provide further support through additional guidance about collaborative agreements, individual practice coaching, and by hosting educational sessions.

Q40. What types of practice transformation support will be provided to model participants by CMS? How will practice coaching work? The RFA mentions that these resources are time-limited, how long does CMS expect to make these available? Will there be any sort of application process or eligibility requirements to access them? MCP will provide national and state-based practice supports for participating organizations. At a national level, CMS will provide: (1) technical assistance to ensure that participants have the information they need to understand how the model works and the expectations and requirements of participation; (2) a collaboration platform to help participants share ideas, tools, and resources and learn from each other; (3) data feedback with actionable information on cost and utilization for the Medicare beneficiaries served by the participant; and (4) a peer learning strategy for participants to share tactics, strategies and care delivery methods that they are using to successfully improve health outcomes and advance health equity for their patients. Within MCP states, CMS will join with stakeholders, the state Medicaid programs, and other payer partners to: (1) connect MCP participants with each other as well as with the specialty practices and community-based organizations that may be partners in care for their patients; (2) make coaching and facilitation resources available to participants, especially small, independent and safety-net organizations who are new to value-based care and who need help building change management capacity and using data for improvement; and (3) contribute to data aggregation and health information exchange resources 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.

Q41. Why were orthopedics, pulmonary and cardiology chosen as specialties for mandatory care integration as part of the model? Will CMS add additional specialties in future years? CMS assessed ambulatory care management codes and identified a few distinct episodes of care where there appeared to be gaps between primary and specialty care. These three specialties stood out as being integral to those identified services. CMS does not intend to add additional specialties to the short list of three from which MCP Participants must execute at least one collaborative care agreement; however, the tentative list of specialties with whom

MCP Participants are encouraged to coordinate with and add to their specialty care partner list is much larger, which can be found on pages 17 and 18 of the RFA.

Q42. Are ambulatory co-management (ACM) payments limited to orthopedics, pulmonary and cardiology specialty care partners? No, ACM payments can be made to any specialty practice listed on an MCP Participant's Specialty Care Partner List and with a signed care coordination agreement in place with the MCP Participant.

Q43. Can MCP practices partner with multiple practices within the same specialty- or is it limited to one practice per specialty type? There is no limit to the number of specialty practices that an MCP Participant can partner with, including within the same specialty.

Q44. Will specialty cost information shared with participating MCP primary care practices include the total cost of a care episode? CMS currently plans to deliver aggregate information on specialty costs in a region, as well as claim-level information on specialty care furnished to attributed beneficiaries. CMS does not plan to provide summarized information on care episodes at this time but may consider including this information in reports in the future.

VIII. Data Sharing and Integration

Q43. Can you provide more detail about what type of data CMS will provide in a timely fashion to help practices make workflow adjustments in practice? CMS will provide access to a data dashboard that allows participants to view recent claims data for their patients, including specialty data and services provided outside the primary care office, as well as current performance on claims-based quality measures. For participants that want to run their own analysis outside of the provided data dashboard, CMS will also provide a quarterly claims and claims line feed (CCLF) file to participants.

Q44. Will CMS temporarily make this data available via any other means other than a Health Information Exchange, particularly as practices are still ramping up during Track 1? CMS will make Medicare data available directly to Participants through a data dashboard that will exist outside of regional HIEs. Over time, CMS and payer partners will endeavor to align formatting of provided patient data so that all-payer data can be accessed from a common location but expects this will not be available at the beginning of the model.

Q45. Is CMS working with vendors to ensure that features of the model, including new billable codes such as the specialty ambulatory co-management fee, are incorporated into electronic health record (EHR) systems? CMS regularly engages with EHR vendors and will be briefing them on the importance of these codes as the model continues development.