Making Care Primary Model

Oct 4, 2023

AMERICA'S PHYSICIAN GROUPS

Housekeeping Items

Please keep your microphone muted.

Type questions in the Q & A box or raise your hand to be unmuted.

The meeting materials will be sent to all registrants.

This webinar will be recorded and sent to all registrants.

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Speakers

Sarah Fogler
Deputy Director of Patient Care Models Group

Melissa Cohen
Founding Partner, Coral Health Advisors

Valinda Rutledge
EVP Education and Strategic Initiatives

Jennifer Podulka
VP of Federal Policy

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Today's Agenda

- Welcome- Jennifer Podulka 5 min
- Overview of model- Sarah Fogler - 20 min
- Value of model- Valinda Rutledge-10 min
- Should you participate?- Melissa Cohen- 10 min
- Tips in completing RFA- Jennifer Podulka- 5 min
- Q/A- 10 min

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Overview of Model

Sarah Fogler

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Making Care Primary (MCP)

Overview

October 2023

MCP Goals

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

Comprehensive Primary Care

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

New Payment Pathway for Value-Based Care (VBC)

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

Improved Quality and Outcomes

Improve the quality of care and health outcomes of patients

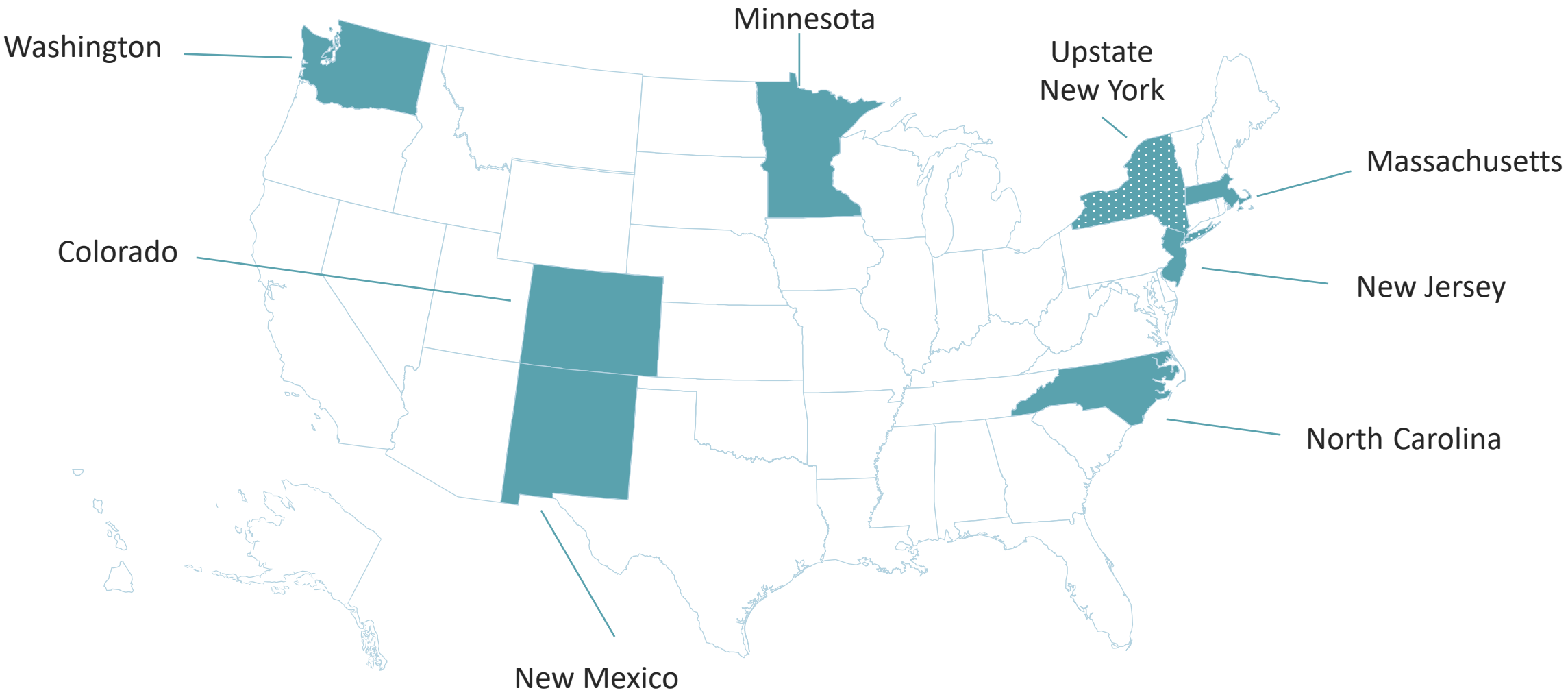
Key Model Design Features

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

- Upfront infrastructure funding for eligible organizations
- Focus on equity, underserved populations, and social-risk adjustment in payment to participants
- Ten-year model with three progressive tracks as well as a 6-month implementation period
- Incorporation of high-quality specialty care partnerships
- Commitment and early engagement with state Medicaid agencies (SMAs)

Participating States

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



Payer Partnership is Core to the Success of MCP

CMS Innovation Center will partner with public and private 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. 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:
  - Performance measurement and reporting
  - Moving primary care payment away from FFS to prospective basis
  - Timely and consistent data sharing
  - Leveraging Technical Assistance
- CMS is partnering with State Medicaid Agencies (SMAs) and other payers to streamline primary care reform and reduce fragmentation to help practices focus on care.

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)

Model Design Overview

Participation Track Options Overview

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

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

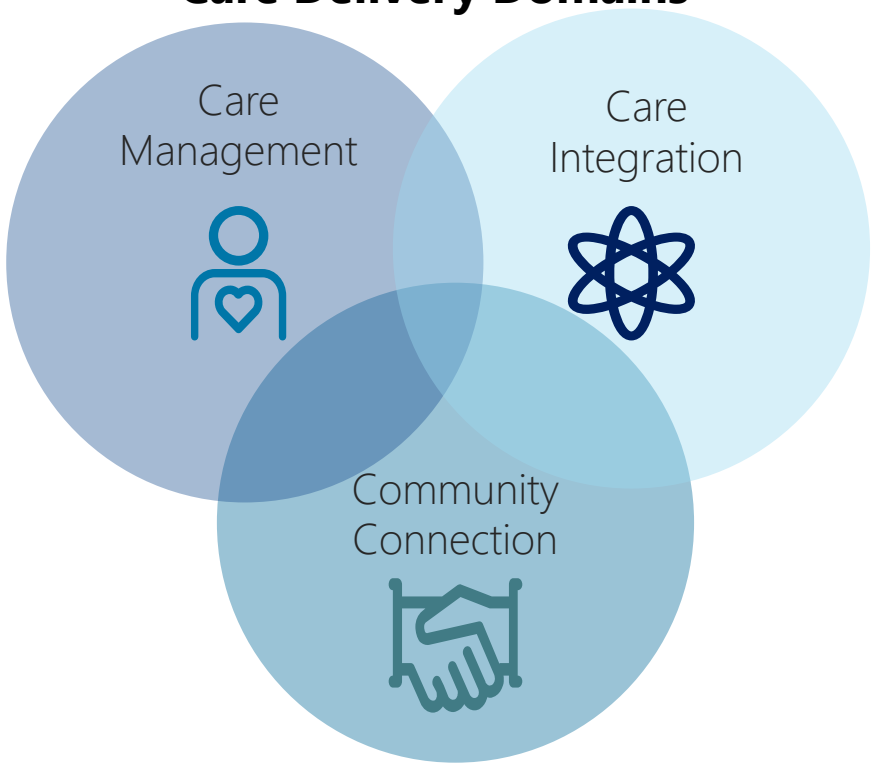
Level of VBC Experience

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.

Overview of Care Delivery Approach and Domains

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

Care Delivery Domains



MCP Participant Requirements

Track 1 Building Infrastructure	Track 2 Implementing Advanced Primary Care	Track 3 Optimizing Care and Partnerships

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

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

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

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

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.* MCP's selected performance measures mirror the model's care transformation goals and incentivize performance through significant incentive payments.

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*+	CQM		X	X
Cost/ Utilization	Total Per Capita Cost (TPCC)	Claims		X	X
	Emergency Department Utilization (EDU)	Claims		X	X
	TPCC Continuous Improvement (CI) *(Non-health centers and Non-Indian Health Programs (IHPs))*	Claims		X	X
	EDU CI *(Health Centers and IHPs)*	Claims		X	X

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

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.*

Health Equity Strategy

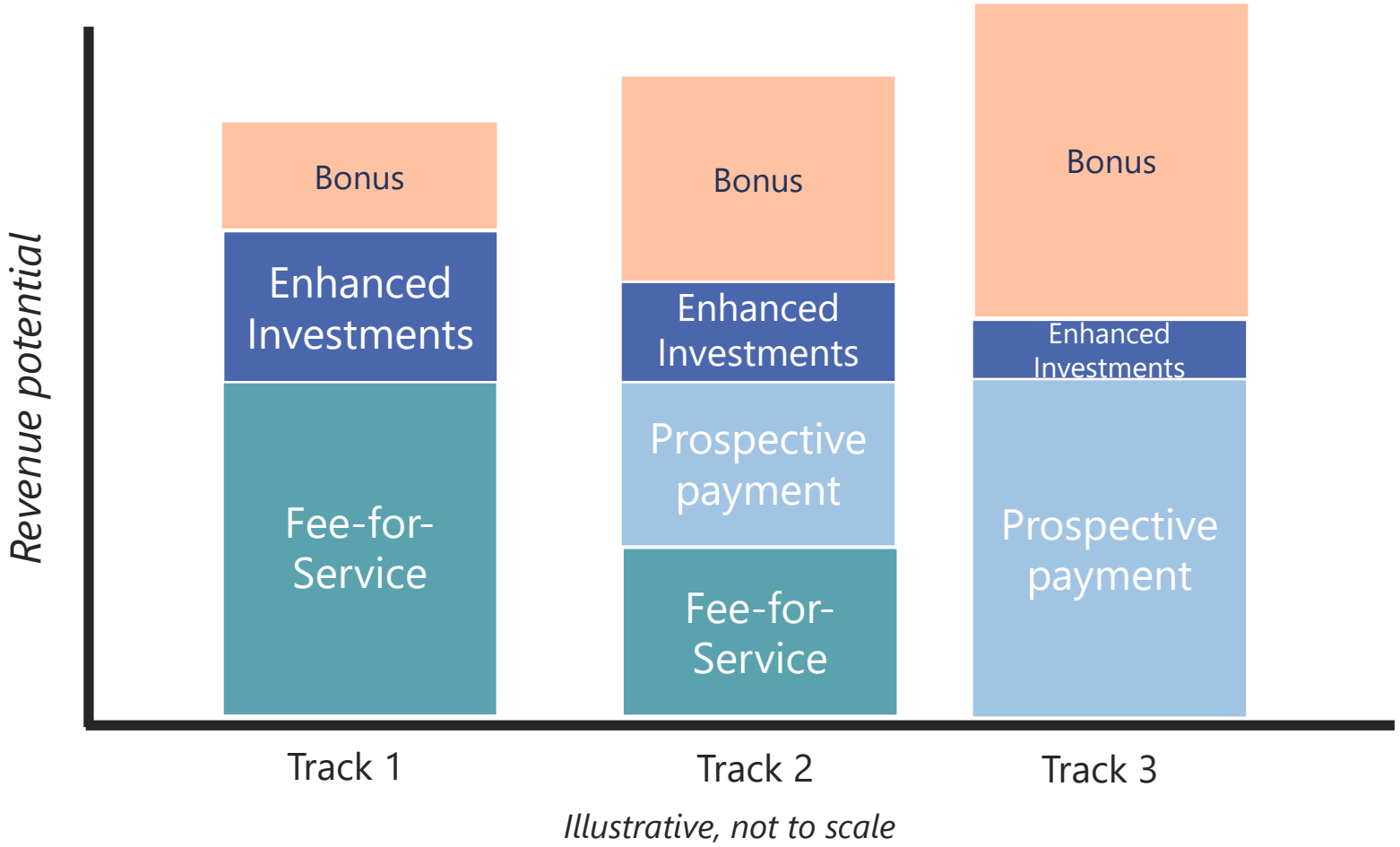
MCP includes several model components designed to work together with the care delivery strategy to improve health equity in alignment with the Innovation Center's Strategy Refresh objective of Advancing Health Equity.[1]

- Requirement for participants to develop a **Health Equity Plan** for how they will identify disparities and reduce them
- Certain **payments** are **adjusted** by clinical indicators and **social risk** of beneficiaries
- Requirement for participants to **implement HRSN screening and referrals**, including the Screening for Social Drivers of Health quality measure for participants to assess the percent of patients screened for HRSNs
- Opportunity for participants to **reduce cost-sharing** for beneficiaries in need
- Collection of data on certain demographic information and HRSNs to **evaluate health disparities** in MCP communities

[1]https://innovation.cms.gov/strategic-direction-whitepaper

High-Level Payment Approach

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



Illustrative, not to scale

MCP Payment Types

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

Prospective Primary Care Payment (PPCP)

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

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

Enhanced Services Payment (ESP)

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

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

Performance Incentive Payment (PIP)

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

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

Upfront Infrastructure Payment (UIP)

Track 1 | Track 2 | Track 3

One-time payment for select Track 1 participants to support organizations with fewer resources to invest in staffing, SDOH strategies, and HIT infrastructure.

MCP E-Consult (MEC)

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

Ambulatory Co-Management (ACM)

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

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

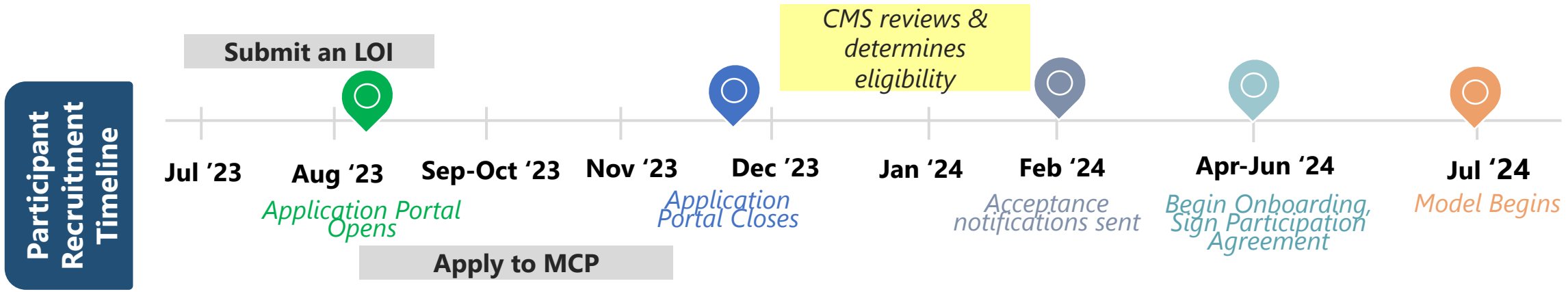
Next Steps

Submit an Application by November 30th

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

Sign up for the MCP listserv and visit the MCP Website for additional information:

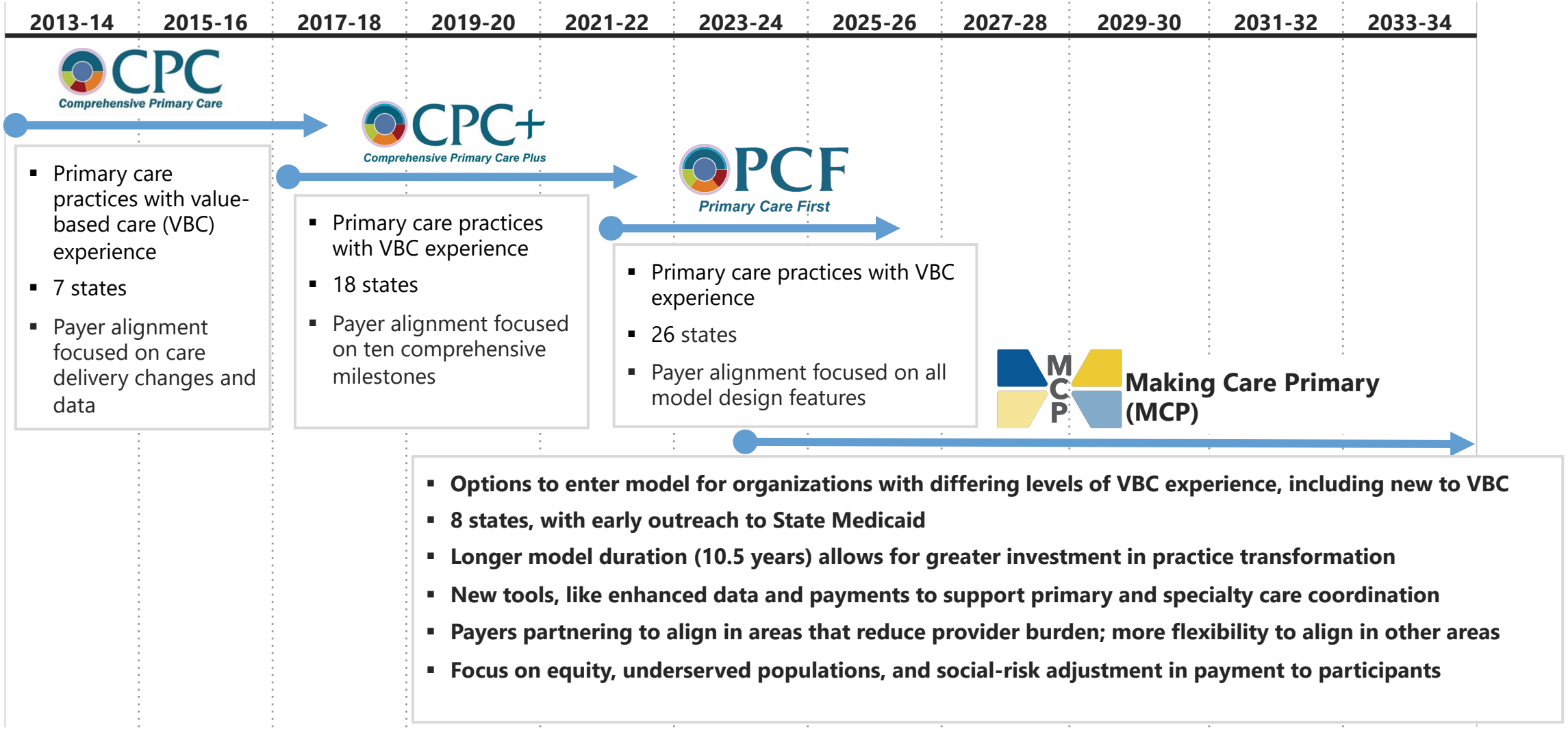
- Visit the MCP Website for events and resources: https://innovation.cms.gov/innovation-models/making-care-primary
- Sign up for our listserv: https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_13126



Appendix

MCP Builds on Insights from Previous Models

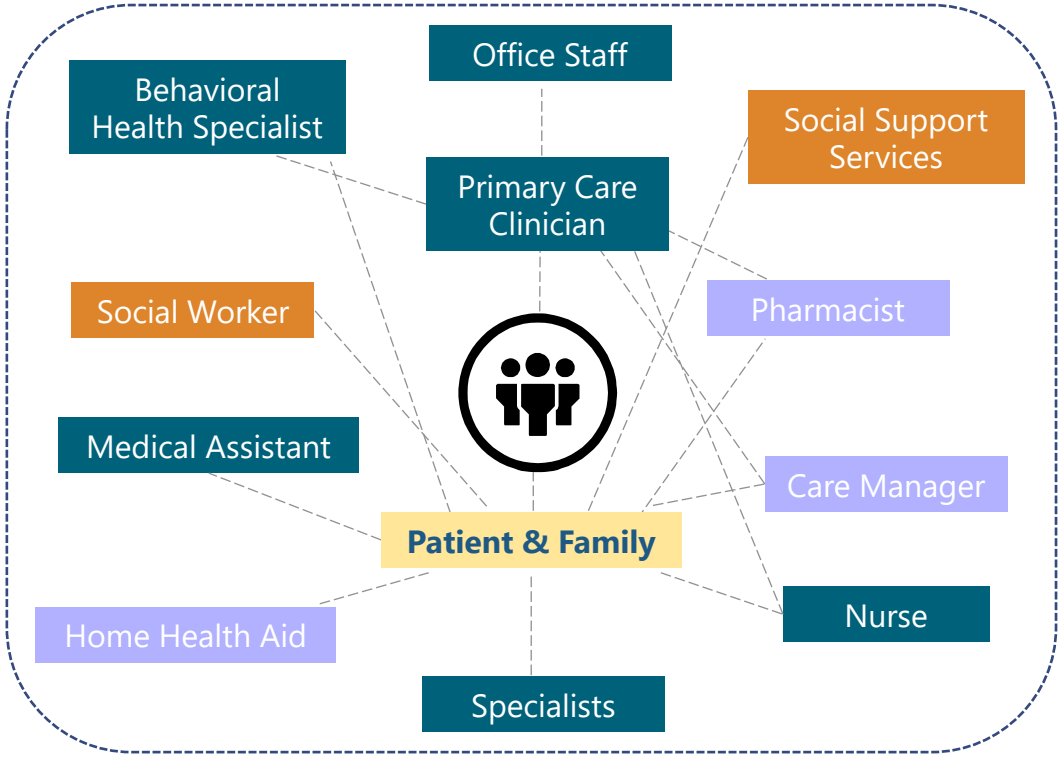
MCP builds on insights from past CMS Innovation Center models to make advanced primary care available and sustainable for a more comprehensive pool of participants serving a broader and more diverse set of patients.



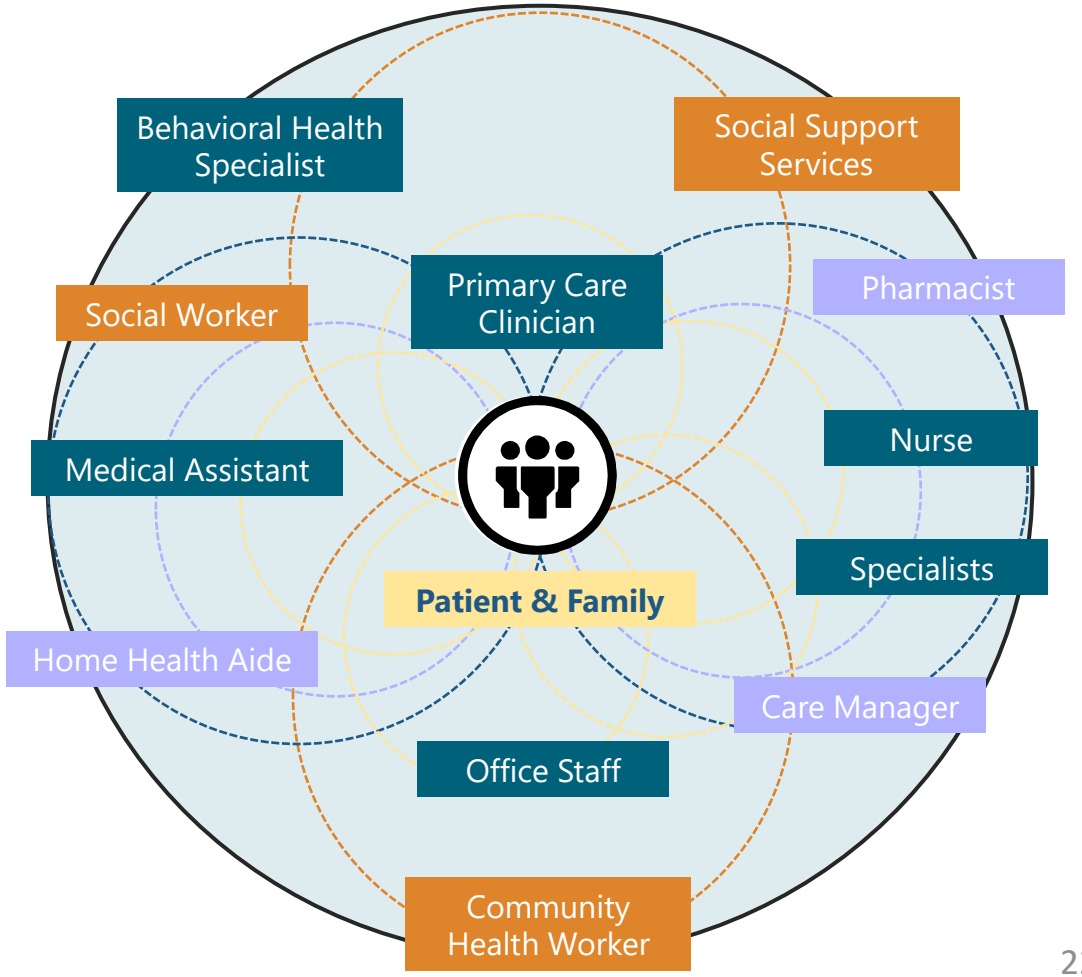
A Vision of High-Quality Primary Care

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

Current State:
A Disjoined System



Desired Future State:
Integrated, High-Quality Primary Care



Comparison to CMMI Primary Care Models

States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model

- **Targets historical underinvestment in primary care** via statewide primary care investment targets.
- **Provides Enhanced Primary Care Payments** to increase investment in primary care.
- **Uses a flexible framework of care transformation activities** to align with existing Medicaid value-based-payment arrangements.

2024 - 2034

Making Care Primary (MCP)

- **Improves care management, community connections, and care integration** by providing capacity building resources to those new to value-based care.
- **Increases access to care and create sustainable change in underserved communities** by facilitating partnerships with state Medicaid agencies, social service providers, Federally Qualified Health Centers (FQHCs) and specialty care providers.

2024-2034

Primary Care First (PCF)

- **Helps primary care practices better support their patients** in managing their health — especially patients with complex, chronic health conditions.
- **Enables primary care providers to offer a broader range of health care services** that meet the needs of their patients. For example, practices may offer around-the-clock access to a clinician and support for health-related social needs.

2021-2025

ACO Realizing Equity, Access, and Community Health (ACO REACH)

- **Encourages health care providers — including primary and specialty care doctors, hospitals, and others — to come together to form an Accountable Care Organization, or ACO.**
- **Breaks down silos and delivers high-quality, coordinated care** to patients that improves health outcomes and manages costs.
- **Addresses health disparities** to improve health equity.

2021-2026

Value of Model

Valinda Rutledge

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Current VBM Challenges

Slowing adoption
Limited resources in Primary Care
Cost of Infrastructure
Risk tolerance
Unaddressed SDOH variables

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Value of Model

10-year length model with 3 progressive tracks

Prospective payments (PPCP, ESP, UIP) with upside-only risk

Facilitate partnerships with specialists and CBO

Glidepath to VBC for inexperienced organizations

Opportunity to Align with Medicaid Agencies

Support activities to reduce health disparity

PPCP: Prospective Primary care payment
ESP: Enhanced Service Payments
UIP:Upfront Infrastructure Payment

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Payment Types

1. UIP: Upfront Infrastructure Payment (only for eligible Track 1)
2. PPCP: Prospective Primary care payment
3. ESP: Enhanced Service Payments
4. PIP: Performance Incentive Payments
5. MEC: MCP E-Consults
6. ACM : Ambulatory Co-Management

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Should you participate?

Melissa Cohen

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Making Care Primary
Participation Considerations

10/04/23

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Key Considerations for Potential Applicants

Eligibility:
Current participants of PCF and ACO REACH are not eligible
2024 MSSP Participants are eligible to participate if they transition to MCP in 2025

Track 1 is only for those inexperienced with VBC. Infrastructure payments only available for Track 1.

Timeline: Will your organization be ready to start in July of 2024? What would you need to have in place for that to be true?

Financial Model: This is a Primary Care Model, NOT a TCOC Model. The opportunity for bonus payments is at a smaller scale. Compared to ACOs, CMS does not expect aggregators or enablers to participate in the same way.

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Key Considerations for Potential Applicants

Model Length: This is a 10.5 year model. While it will be iterative over time, it guarantees a certain level of stability and predictability.

Multi-payer participation: There will be variability among States and payers regarding alignment to the payment model. How much does that matter to you? Will PCP capitation for Medicare patients alone be sufficient to sustain your care model without other payer participation. How will your state and other payers participate?

Care Model: How do model requirements align with your current care model? A payment model should enable the changes you want to make.

- Is your practice looking for a way to better engage specialists, or CBOs to address SDOH?
- What resources would you need to be successful? How does the payment model support that?

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Key Considerations for Potential Applicants

Contracting with CMS:

Being a participant in an ACO that has contracted with CMS is different than having your own contract.

PROS:

- Ownership of Model Strategy
- Decide where to make investments
- Decide how to distribute funds
- Full accountability for model success

CONS:

- Responsible for meeting model requirements, staying abreast of policy changes
- Responsible for cost of quality reporting (eCQMs) and infrastructure
- Full accountability for model success

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I am not eligible – How may this model affect me?

I am in an MCP Region but I am an MSSP ACO:

- Be aware of the options presented to practices in your region and consider how/why it may be attractive to them. Are you competitive?
- Be prepared to talk to your practices about the model and how MCP is different.
- Explain the difference between being an ACO participant versus an entity contracting with CMS.

I am in an MCP Region but I am an ACO REACH Participant:

- As an ACO participant, would any of the tools or resources provided by CMS in this model be helpful to you? What if any of these tools could your ACO provide?
    - Connection with CBOs
    - Opportunities for specialty engagement
    - Support with infrastructure
    - Performance data

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I am not eligible – How may this model affect me?

I am NOT in an MCP Region:

Pay attention to model requirements and methodology. CMS iterates as they create new models and those changes find their way into other programs

- Health Equity Adjustments
- Health Equity Plan Requirements
- PCP Capitation Methodology
- New Codes
  - E-consults
  - Ambulatory Co-Management

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Tips in Completing RFA

Jennifer Podulka

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RFA Submission Tips

- Confirm participation criteria
- Run program integrity checks
- Assess Health IT Requirements for HIE and eCQM reporting
- Need a letter of support from owner to aggregate payments
- Select Track after competence assessment
- Financial modeling of PPCP Services
- Upfront infrastructure funding required to submit spending report

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Fall Conference 2023
OCTOBER 30 – NOVEMBER 1
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