Making Care Primary (MCP): Insights for Applicants & the Transition to Accountable Care

October 24, 2023

2:00-3:00 PM ET

Agenda

- Background and Overview of Model Details
- Tips and Tricks for a Successful CMMI Application
- MCP and the Transition to Accountable Care
- Audience Q&A

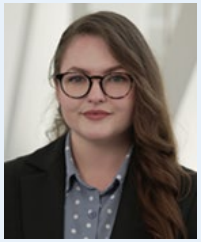
Q&A will take place at the end of the program

You can submit written questions using the **“Questions” tab** (not chat) at any time during the webinar.

Webinar is being recorded

The recording and slides will be available on the NAACOS website within 48 hours.

Speakers



Alyssa Neumann, MPH
Senior Analyst, Regulatory Affairs, NAACOS
As part of NAACOS' government affairs team, Alyssa works on a variety of issues related to ACOs and value-based care including primary care, patient engagement, and care management. Prior to NAACOS, Alyssa served as program coordinator at the Primary Care Collaborative, writing and managing grant projects related to primary care transformation.

Dave Ault
Counsel, Ropes & Gray
Dave has spent years on the forefront of key industry trends and shifts, including the broader transition to value-based reimbursement. A former government litigator and authority on alternative payment models under the Affordable Care Act (ACA), Dave now advises health care providers and payers on regulatory, compliance and litigation issues in health insurance, focusing on value-based contracting. He spent almost a decade with HHS, including serving as director of the Division of Financial Risk within CMMI.

About NAACOS

420
ACO MEMBERS

9M
BENEFICIARY LIVES IN MEMBER ACOS

65%
OF ACOS ARE NAACOS MEMBERS

127
PARTNER ORGANIZATIONS

THOUGHT LEADERSHIP

NAACOS works to advance the ACO model and promote the value of coordinated, patient- centered care through research, publications, and other forms of thought leadership.

EDUCATION

NAACOS offers a variety of educational webinars, conferences, and other events to help ACOs stay up-to-date on the latest developments in the field and learn from experts and peers.

ADVOCACY

NAACOS advocates for ACOs through various means, such as engaging with policymakers, participating in rulemaking, collaborating with other organizations, and communicating with the public.

Founded in 2012, the National Association of ACOs (NAACOS) is a member-led and member-owned nonprofit helping ACOs succeed in efforts to coordinate and improve the quality of care for their patient populations.

Free Trial Membership

NAACOS extends a special invitation to Making Care Primary (MCP) applicants and individuals keen on embracing MCP principles to join our thriving community.

- ✓ Open to non-NAACOS members who are either considering or who have applied for MCP.
- ✓ Complimentary six-month trial membership gives your practice access to NAACOS' comprehensive platform for education, thought leadership, advocacy, and networking.

Background

- In June, CMS announced Making Care Primary (MCP), the latest advanced primary care model set to launch July 1, 2024
  - 10.5-year, multipayer model
  - 8 participating states (CO, MA, MN, NM, NJ, NC, WA, upstate NY)
  - 3 progressive tracks w/ more advanced care delivery changes

> ***Track 1:*** Infrastructure building (no experience with VBC)
>
> ***Track 2:*** Implementing advanced primary care
>
> ***Track 3:*** Optimizing care and partnership

- Designed for providers new to value-based care
- Concurrent participation in Medicare ACO programs is not permitted
- The model could provide an opportunity for practices to gain experience in value-based care prior to joining or forming an ACO

State Partnership

CMS selected MCP regions in part based on alignment with State Medicaid agencies. Level of alignment will vary by state. State-specific resources:

- **Colorado**: Department of Health Care Policy & Financing, CO Academy of Family Physicians, CO Health Institute
- **Massachusetts**: MassHealth Executive Office of HHS, MassHealth Innovations
- **Minnesota**: MN Department of Health Sustainability Roadmap, MN Integrated Health Partnerships
- **New Jersey**: NJ Health Care Quality Institute
- **New Mexico**: NM Health Care Authority
- **New York** (upstate counties*): NY Health Foundation, Community Health Care Association of NYS
- **North Carolina**: NC Medicaid Division of Health Benefits, State Transformation Collaborative, NC Area Health Education Centers MCP Playbook
- **Washington State**: Primary Care Transformation (WA Health Care Authority)

**Eligible New York counties: Putnam; Rockland; Orange; Albany; Schenectady; Montgomery; Greene; Columbia; Rensselaer; Saratoga; Fulton; Schoharie; Washington; Otsego; Hamilton; Delaware; Ulster; Dutchess; Sullivan; Warren; Essex; Clinton; Franklin; Saint Lawrence; Onondaga; Cayuga; Oswego; Madison; Cortland; Tompkins; Oneida; Seneca; Chenango; Wayne; Lewis; Herkimer; Jefferson; Tioga; Broome; Erie; Genesee; Niagara; Wyoming; Allegany; Cattaraugus; Chautauqua; Orleans; Monroe; Livingston; Yates; Ontario; Steuben; Schuyler; Chemung*

Context

- MCP builds on lessons learned from previous CMS Innovation Center (CMMI) primary care models, including the Comprehensive Primary Care Initiative (CPC), CPC+, and Primary Care First (PCF)
- How is MCP different from previous models?

✓	More gradual on-ramp to develop advanced primary care capacity and accountability
✓	Additional supports and incentives for integrated care
✓	Longer model test provides participants more time to advance health equity and improve care and outcomes
✓	Learning systems and payer engagement to enable broad and sustainable transformation

- How does MCP fit into CMS's primary care goals?
  - CMMI strategy to support high-quality primary care
  - Primary care model tests
  - HHS Initiative to Strengthen Primary Health Care
  - National Academies report: Implementing High-Quality Primary Care

Model Goals

1

Ensure beneficiaries in participating organizations receive primary care that is integrated, coordinated, person-centered, and accountable.

2

Create a pathway for primary care clinicians, especially small and independent, rural, and safety net, to adopt prospective, population-based payment to become more accountable for cost and quality of care for their population of patients

3

Improve the quality of care and health outcomes while reducing or maintaining program expenditures.

Model Details - Eligibility

Eligible participant organizations:

- Independent or solo primary care practices
- Group practices
- Federally Qualified Health Centers (FQHCs)
- Health Systems
- Indian Health Programs
- Certain CAHs

Not eligible:

- × Rural Health Clinics
- × Concierge practices
- × Grandfathered Tribal FQHCs
- × PCF practices & ACO REACH Participant Providers active as of 5/31/23

Eligibility criteria:

- ✓ 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.
- ✓ Non-FQHCs: Have primary care services account for at least 40% of the applicant's collective Medicare revenue for the list of primary care clinicians employed by the applicant.

Model Details – Requirements by Track

Track 1 (Infrastructure Building): *Building capacity to offer advanced services, such as risk stratification, data review, identification of staff, and HRSN screening and referral*

Care Management	Care Integration	Community Connection
Targeted care management	**Specialty care integration**	**HRSN screening and referral**
• Stratify by risk & empanel • Identify staff/develop workflows for CCM, post-ED and hospital follow-ups	• Use data tools to identify high-quality specialists	• Implement HRSN screening and referral • Develop workflows for referrals to social service providers
Chronic condition management	**Behavioral health integration (BHI)**	**Supporting whole-person care through community supports and service navigation**
• Identify staff/develop workflows to deliver individualized self-management support for chronic conditions	• Identify staff/develop workflows to initiate BHI	• Explore partnerships with social service providers • Identify staff (CHW or equivalent) to deliver services to higher need patients

Model Details – Requirements by Track

Track 2 focus: *Transitioning between fee-for-service (FFS) and prospective, population-based payment*

Care Management	Care Integration	Community Connection
Targeted care management	**Specialty care integration**	**HRSN screening and referral**
• Implement CCM and services for high-risk patients • Implement episodic care management	• Identify high-quality Specialty Care Partners through collaborative care arrangements (CCAs) • Implement enhanced e-consults with at least 1 specialist	• Implement referral workflows to social service providers
Chronic condition management	**Behavioral health integration**	**Supporting whole-person care through community supports & service navigation**
• Begin offering individualized self-management support for chronic conditions	• Implement BHI approach • Systematically screen for key BH conditions	• Establish partnerships with social service providers • Utilize CHW/peer support in navigating HRSNs to higher need patients

Model Details – Requirements by Track

Track 3 focus: *Optimizing advanced primary care services and specialty care integration enabled by prospective, population-based payment*

Care Management	Care Integration	Community Connection
Targeted care management	**Specialty care integration**	**HRSN screening and referral**
• Build on care management programs; offer individualized care plans for high-risk patients	• Established enhanced relationships with SCPs through time-limited co-management	• Optimize social service referral workflows using a quality improvement framework
Chronic condition management	**Behavioral health integration**	**Supporting whole-person care through community supports and service navigation**
• Expand self-management services to include group education and link to community supports	• Optimize BHI workflows using a quality improvement framework	• Strengthen partnerships with social service providers • Optimize use of CHW/peer support using a quality improvement framework

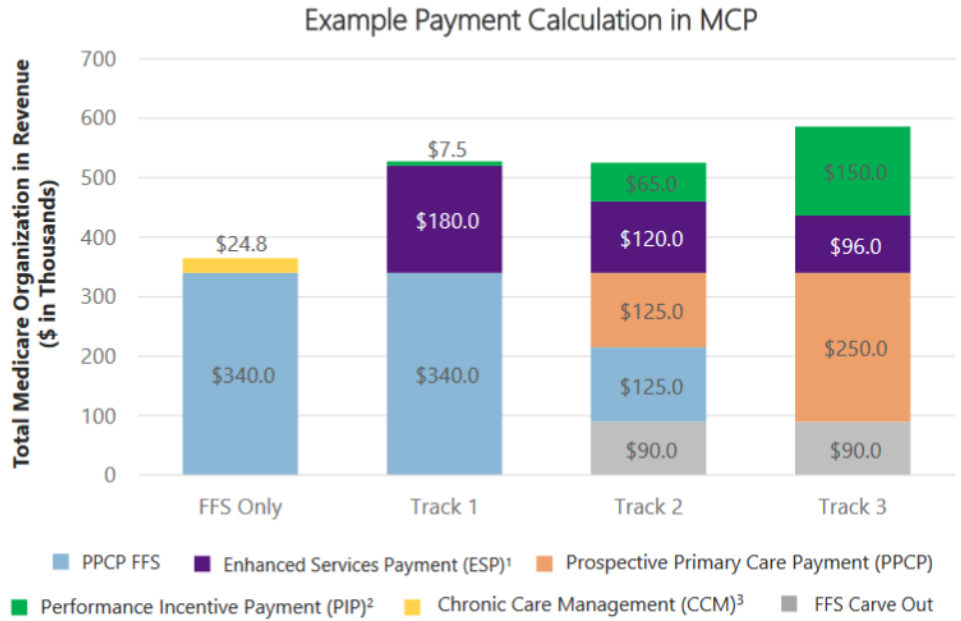
Model Details – Financial Methodology

Six payment types will support MCP participants as they work to achieve care delivery and quality improvement goals.

Upfront Infrastructure Payment (UIP) Track 1	**Enhanced Services Payment (ESP)** Tracks 1, 2, 3
• Optional upfront payment for certain Track 1 participants to fund infrastructure development	• Non-visit-based PBPM paid quarterly • Risk-adjusted per beneficiary (HCC, ADI, LIS) • Gradually decreases from Track 1 to 3
Performance Incentive Payment (PIP) Tracks 1, 2, 3	**Prospective Primary Care Payment (PPCP)** Tracks 2, 3
• Upside-only payment to reward improvements in outcomes and quality • Varies by track [1: up to 3%, 2: up to 45%, 3: up to 60%]	• Quarterly PBPM based on historical claims • Replaces FFS billing [50% in Track 2, 100% in track 3]
MCP E-Consult (MEC) Tracks 2, 3	**Ambulatory Co-Management (ACM)** Track 3
• Billable by PCPs up to $40 per service	• Billable by SCPs up to $50 per month

Example Payment Calculations

The graphic below illustrates the proportion of revenue each payment would make up for an average MCP Participant. The calculations below are based on a hypothetical organization with 1000 attributed MCP patients (and assuming equal representation in each HCC/ADI tier), and assuming they met the 50th percentile on 3 measures, 70th / 80th percentile on 3 measures, did not get credit for TPCC CI.



The hypothetical organization has the following characteristics:

- **1,000** attributed MCP patients with **200** in highest-risk category (e.g., LIS or HCC/ADI tier 4)
- **$21** PPCP PBPM based on own historical spending data
- Average ESP of $15 in Track 1, $10 in Track 2, and $8 in Track 3
- Prior to MCP, billed CCM for **90 beneficiaries** (average $23 PBPM)

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

[2]The green shading in visual above indicates bonus payments by track for a hypothetical "Participant A", with high quality scores. MCP participants will be eligible for larger bonuses when they receive high quality scores.

[3]While participants in Track 1 will not be able to bill a coordination code, they will receive larger ESP payments which CMS anticipates will correct for any revenue loss from CCM.

Model Details – Performance Assessment

Quality Performance Measure

Mirroring CMS's broader quality measurement strategy, measures were sele
CMS quality programs, including the Universal Foundation Measure Set *(as*
MIPS Value Pathways (MVP) and MIPS APM Performance Pathway (APP) mea
Measures Collaborative (CQMC) Primary Care Core Measures.

New measure developed by the Larry A. Green Center

Replaces Consumer Assessment of Healthcare Providers and Systems (CAHPS), used in other models

Focus	Measur				
Chronic Conditions	Controlling High Blood Pressure*	eCQM	X	X	X
	Diabetes Hba1C Poo 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
	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.

Model Details

- Participants must meet the care delivery requirements in their starting Track by the end of PY2 (12/31/25).
- ***Health Equity***:
  - Participants will be required to develop and implement a Health Equity Plan based on the CMS Disparities Impact Statement.
  - MCP will require all participants to collect and report certain demographic data and health-related social needs (HRSN) data on their patients.
  - Cost sharing reduction program: MCP participants may have the opportunity to implement a program to provide certain high-value primary care services to a subgroup of Medicare FFS beneficiaries without collecting beneficiary cost-sharing.

Considerations for Applicants

- MCP participation will be at the organizational TIN level.
  - All Applicants must submit a single application for all of the primary care site(s) operating under its TIN.
  - For applicant FQHCs, all CCNs for all practice site(s) should be submitted on the application.
- CMS expects that all Tracks in MCP will meet the criteria for being a MIPS APM in PY 2 and beyond; only Tracks 2 & 3 are expected to qualify as Advanced APMs.
- Practices currently participating in a MSSP ACO may apply, but will have to withdraw participation from MSSP by 12/31/2024
- The request for applications (RFA) includes additional details on eligibility, care delivery requirements, and payment methodologies
  - The application portal is open through 11/30/2023

Application Tips - Timeline

Now – 11/30/2023	**Application Open (non-binding, no LOI)**
December 2023 – February 2024	**CMS Review Applications**
February 2024	**CMS Announces Application Decisions**
April 2024 – June 2024	**Onboarding and Participation Agreement Execution**

Application Tips

- **Decide to Apply**
  - Now or never
  - Apply as multiple TINs (think admission ticket)
- **Apply**
  - Aim high (for the most advanced track(s) you desire)
  - 2 buckets
    - Care Bucket
      - Review the Care Delivery Requirements
        - Use as a rubric
      - Specialty Care Partner
    - Governance/Organization bucket
  - Must submit provider list (except FQHCs)
    - Do not include Specialty Care Partner
  - Be as specific as you can without pinning yourself in
    - If you end up implementing differently, they could terminate or Cap?
    - In terms of care interventions, specific populations, etc.
  - Don't wait until the deadline

Application Tips

- **Sign Participation Agreement**
  - *Use intervening months to consider whether participation is appropriate*
    - Switching back to an ACO or other program? Desire to terminate altogether?
    - Financial modeling
      - Are the “Duplicative Enhanced Services Payments” acceptable?
  - *Align partners*
    - Participant Partners
    - Vendors
    - Collaborative Care Arrangements

MCP & The Transition to Accountable Care

Primary care is the foundation of the ACO model

- CMS has stated the aim of this model is to provide an on ramp for practices who have not participated in value-based care models.
- ACOs with practices concurrently participating in CMMI's primary care models have been highly successful
- Primary care models are most successful when nested within a total cost of care framework
  - The most recent CPC+ evaluation found that while the model overall did not reduce expenditures, Track 1 CPC+ practices simultaneously participating in MSSP did achieve reductions in total expenditures in PY4 and performed better on some quality metrics
- NAACOS is committed to increasing investment in primary care and has called for CMS to establish an option for ACOs to implement population-based payments for primary care.
  - CMS noted they are developing this approach in a blog; a PBP in ACOs will create a smoother transition for practices moving from MCP into ACOs in the future

MCP & The Transition to Accountable Care

- ***Key success factors across VBC models:***
  - **Risk-stratification**: increase clinical focus on most at-risk patients
  - **Provider engagement**: align incentives and empower providers to manage cost and outcomes
  - **Team-based care**: work collaboratively with other providers, care team members, specialists, and social services to deliver coordinated, whole-person care
  - **Population health data & analytics**: leverage actionable data to actively engage patients, track performance, identify gaps in care, and implement targeted interventions
- MCP competencies can prepare practices to succeed in future total cost of care arrangements

Additional Resources

- American Academy of Family Physicians (AAFP): Making Care Primary resources
  - MCP calculator
  - How to Succeed in Value-Based Care
- Primary Care Development Corporation (PCDC): Know Before You Enroll webinar
- Commonwealth Fund: MCP: An Important Advance for Integrated Behavioral Health Care
- CHESS Health Solutions: Empowering Advanced Primary Care Providers in the Journey to Value
- CMMI: model webpage, FAQs, overview factsheet, applicant tracks factsheet, payer partner factsheet, model overview webinar, FQHC and IHP overview webinar, model intro video

Questions?

Thank you!

Contact Information:

NAACOS IT: support@naacos.com | 202-640-1850

Alyssa Neumann: aneumann@naacos.com | 202-964-4460

Membership questions: membership@naacos.com