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Acronyms

ABFM American Board of Family Medicine
ACM Ambulatory Co-Management
ACO Accountable Care Organization
ACO REACH Accountable Care Organization Realizing Equity, Access, and Community Health
ADI Area Deprivation Index
AHEAD Advancing All-Payer Health Equity Approaches and Development
AHRQ Agency for Healthcare Research and Quality
APM Alternative Payment Model
APP MIPS APM Performance Pathway
AWV Annual Wellness Visit
BAL Beneficiary Attestation List
BHI Behavioral Health Integration
BPCI-A Bundled Payments for Care Improvement Advanced
CBE Consensus-Based Entity
CCA Collaborative Care Arrangement
CCM Chronic Care Management
CCN CMS Certification Number
CCW Chronic Conditions Warehouse
CF Conversion Factor
CHI Community Health Integration
CI Continuous Improvement
CME Common Medicare Environment
CMS Centers for Medicare & Medicaid Services
CPC+ Comprehensive Primary Care Plus
CPM Chronic Pain Management
CPT Current Procedural Terminology
CQM Clinical Quality Measure
CQMC Core Quality Measures Collaborative
CY Calendar Year
DME Durable Medical Equipment
DOS Date of Service
E&M Evaluation and Management
eCQI Electronic Clinical Quality Improvement
eCQM Electronic Clinical Quality Measure
ED Emergency Department
EDU Emergency Department Utilization
EHR Electronic Health Record
EOM Enhancing Oncology Model
Making Care Primary: Payment and Attribution Methodologies

ESP Enhanced Services Payment
ESRD End-Stage Renal Disease
ETC ESRD Treatment Choices
FAI Financial Alignment Initiative
FFS Fee-For-Service
FPL Federal Poverty Level
FQHC Federally Qualified Health Center
GAF Geographic Adjustment Factor
GPCI Geographic Practice Cost Index
GUIDE Guiding an Improved Dementia Experience
HCC Hierarchical Condition Category
HCPCS Healthcare Common Procedure Coding System
HEDIS Healthcare Effectiveness Data and Information Set
HIPAA Health Insurance Portability and Accountability Act
HRA Health Risk Assessment
HRSN Health-Related Social Needs
IHP Indian Health Program
IPC Interprofessional Consult
IPPE Initial Preventive Physical Examination
IT Information Technology
JSON JavaScript Object Notation
KCC Kidney Care Choices
LIS Low-Income Subsidy
MCP Making Care Primary
MDPCP Maryland Primary Care Program
MEC MCP e-Consult
MIPS Merit-based Incentive Payment System
MSSP Medicare Shared Savings Program
MVP MIPS Value Pathways
NCQA National Committee for Quality Assurance
NPI National Provider Identifier
NPPES National Plan and Provider Enumeration System
NQF National Quality Forum
PA Participation Agreement
PBPM Per-Beneficiary Per-Month
PCF Primary Care First
PCM Principal Care Management
PCPCM Person-Centered Primary Care Measure
PECOS Provider Enrollment Chain and Ownership System
PIN Principal Illness Navigation
Executive Summary

This Executive Summary provides an overview of the payment methodologies that the Centers for Medicare & Medicaid Services (CMS) uses for the Making Care Primary (MCP) model for Performance Year (PY) 2024. The Executive Summary and the detailed technical specifications are organized as follows:

- **Section 1** includes an introduction and background to MCP.
- **Section 2** describes beneficiary attribution, the methodology used to identify Medicare beneficiaries for whom participating organizations are responsible.
- **Section 3** describes the Enhanced Services Payment (ESP).
- **Section 4** describes the Prospective Primary Care Payment (PPCP).
- **Section 5** describes the quality strategy and Performance Incentive Payment (PIP).
- **Section 6** describes the Specialty Integration Payment Codes available in MCP.
- **Section 7** describes the Upfront Infrastructure Payment (UIP).

ES.1 Introduction

MCP is a Center for Medicare and Medicaid Innovation (CMS Innovation Center) advanced primary care model that provides a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments that support the delivery of advanced primary care. MCP will launch on July 1, 2024, and will run through December 31, 2034.

MCP creates a variety of pathways to support delivery of high-quality primary care. To implement this flexibility, the model is structured around Participant “tracks.” There are three Participant tracks, which provide opportunities for Participants with varying experience in value-based care.

- **Track 1** includes organizations that are building capacity to offer advanced services, such as risk stratification, data review, identification of staff for chronic disease management, or Health-Related Social Needs (HRSN) screening and referral. Track 1 Participants also must not have had any value-based care experience in Medicare fee-for-service (FFS) in the 5 years prior to MCP.
- **Track 2** includes organizations that are building on the Track 1 requirements by partnering with social service providers, implementing care management, screening for behavioral health services, and transitioning between FFS and prospective, population-based payment.
- **Track 3** includes organizations that are expanding upon the Track 2 requirements by optimizing primary care delivery, integrating specialty care, and deepening connections to...
Participants entering MCP in Track 3 remain in Track 3 for the entirety of MCP.

Participants will spend the first 2.5 years of the model in the track they select at the beginning of the model, and 2 years in any subsequent track until they reach Track 3, where they will remain for the duration of the model. For each of the MCP tracks, there are specific payments that an MCP Participant is eligible to receive. Table 1 summarizes the payment types and their applicability to each track.

**Table 1: MCP Payment Types by Track**

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>Track 1</th>
<th>Track 2</th>
<th>Track 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enhanced Services Payment (ESP)</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>A quarterly payment that will be adjusted to reflect the attributed population’s risk level.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prospective Primary Care Payment (PPCP)</strong></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>A quarterly payment that is based on the historical primary care spending for each Participant’s attributed beneficiary population.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Performance Incentive Payment (PIP)</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>An upside-only performance-based bonus.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Integration Payment Code: MCP e-Consult (MEC)</strong></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>An e-consult code to address current barriers to e-consult billing.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Integration Payment Code: Ambulatory Co-Management (ACM)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A code for enhanced collaboration and coordination used by Specialty Care Partners and MCP Specialists.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Upfront Infrastructure Payment (UIP)</strong></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>A time-limited lump-sum infrastructure payment. *</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a For eligible Participants only.

MCP includes three types of Participants (“Participant types”): Standard Participants, Federally Qualified Health Centers (FQHCs), and Indian Health Programs (IHPs). Participants are not limited as to which track they may participate in based on their type, though some aspects of the MCP payment methodologies may differ by type.

**ES.2 Beneficiary Attribution**

CMS uses a prospective attribution methodology to assign accountability for Medicare FFS beneficiaries to MCP Clinicians. CMS conducts beneficiary attribution quarterly and assigns beneficiaries to model Participants in order to calculate MCP payments to Participants and to determine the group of beneficiaries whose health outcomes will impact the Participant’s PIP. Because MCP is a test of Participant-level transformation and payment, CMS attributes beneficiaries to the MCP Participant organization, rather than individual clinicians. An MCP Participant organization is composed of a group of National Provider Identifiers (NPIs) billing under the same
Taxpayer Identification Number (TIN) (for Standard Participants) or a group of CMS Certification Numbers (CCNs) (for FQHC Participants).

CMS attributes beneficiaries to Participants based on either voluntary alignment or claims-based attribution.

- Attribution is first determined by CMS based on the beneficiary’s chosen alignment to a clinician on Medicare.gov (voluntary alignment).
- If an MCP-eligible beneficiary is not attributed during the voluntary alignment step of attribution, CMS attributes the beneficiary using claims-based attribution. Specifically, Medicare claims are used to attribute beneficiaries according to recency of Annual Wellness Visit, recency of Welcome to Medicare Visit, or plurality of eligible primary care visits.

Attribution is conducted before the start of each quarter, because MCP makes payments to Participants prospectively (i.e., in advance of) each quarter. For each quarter, MCP uses a 24-month “lookback” period for beneficiary claims.

**ES.3 Enhanced Services Payment (ESP)**

The ESP is a per-beneficiary per-month (PBPM) payment, for Participants in all tracks that is paid prospectively on a quarterly basis. ESPs do not require billing Medicare and are based on each Participant’s attributed beneficiary population. The payment is adjusted to reflect the attributed population’s risk level, with a higher payment for beneficiaries at the highest levels of clinical and social risk. ESPs can be used to support care management, patient navigation, integration with behavioral health and other enhanced care coordination services, consistent with the specific needs of the MCP Participant’s beneficiaries and the goals of MCP’s care delivery model.

ESPs are meant to support enhanced care management and other primary care services that overlap with covered services under the Medicare Physician Fee Schedule (PFS) and the Medicare FQHC Prospective Payment System (PPS). Because Medicare FFS payment for these enhanced services for the same beneficiaries would be duplicative of the ESP, Medicare will not pay for claims that are submitted for these duplicative services.

Comparatively, ESP support will be highest in Track 1. ESPs progressively decrease from Track 1 to Track 3, although Participants that achieve full PIP potential can maintain or increase their overall revenue when progressing across tracks. The ESP is also risk-adjusted by certain beneficiary characteristics. Specifically, all beneficiaries attributed to a Participant are assigned to one of four clinical risk tiers and one of four social risk tiers. Thresholds determining the clinical and social risk tiers are defined separately for each MCP region. The clinical risk tiers are measured by CMS Hierarchical Condition Categories (HCC) risk scores, and the social risk tiers are measured by Area Deprivation Index (ADI). Finally, apart from the prior classification, beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS) will receive the highest possible ESP to account for
the clinical risk not well-captured for this population. The tiered ESP PBPM amounts are provided in Table 2 below.

Table 2: Risk-Adjusted ESPs by LIS Status, Clinical Risk Tier, Social Risk Tier, and Participant Track

<table>
<thead>
<tr>
<th>Enrolled in Low-Income Subsidy (LIS): $25 for all risk tiers and tracks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not Enrolled in LIS:</strong></td>
</tr>
<tr>
<td><strong>Clinical Risk Tier</strong> (CMS-HCC Risk Score Percentile)</td>
</tr>
<tr>
<td>Tier 1 (≤25th)</td>
</tr>
<tr>
<td>Tier 2 (&gt;25th and ≤50th)</td>
</tr>
<tr>
<td>Tier 3 (&gt;50th and ≤75th)</td>
</tr>
<tr>
<td>Tier 4 (&gt;75th)</td>
</tr>
<tr>
<td>Tier 4 (&gt;75th)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Listed as Not Applicable, because payment for beneficiaries in clinical risk tiers 1-3 is based only on risk score.

**ES.4 Prospective Primary Care Payment (PPCP)**

Each Participant’s PPCP reflects the expected monthly payment for a selected set of primary care services (“PPCP Services”) to be provided to the Participant’s attributed beneficiaries. Across the three MCP tracks, the PPCP changes the payment mechanism for primary care from FFS to a prospective payment, promoting flexibility in how Participants deliver care and allowing them to increase the breadth and depth of the primary care they deliver. It can support services to improve care coordination and enable Participants to serve patients in a way that best meets the needs of the patient, whether by email, phone, or patient portal or in alternative settings, such as the patient’s home. The transition to increasing levels of PPCP is achieved through the following payment policies:

- **Track 1: 0% PPCP and 100% FFS.** Track 1 Participants continue to bill and receive payment from Medicare FFS as usual (and FQHCs will continue to be paid according to the Medicare FQHC PPS).

- **Track 2: 50% PPCP and 50% FFS.** In Track 2, the PPCP is meant to partially replace FFS revenue from primary care services for a practice’s attributed beneficiary population. Track 2 Participants receive a hybrid payment consisting of partial PPCP with reduced FFS payments for primary care services.

- **Track 3: 100% PPCP and 0% FFS.** In Track 3, the PPCP is meant to fully replace FFS revenue from primary care services. Participants receive an alternative to FFS payment made up of full PPCP, and FFS payments for primary care services are not paid.
The services that are affected by these payment policies for Tracks 2 and 3 are referred to as “PPCP Services.” The full list of services is provided Table 13: Services Included in or Impacted by the PPCP. The PPCP Services for Track 2 are a subset of the services for Track 3. The applicable list of PPCP Services depends on Participant type, as follows:

- For Standard Participants, the PPCP is based on primary care services on the PPCP Services list billed under the Medicare PFS.
- For FQHCs, the PPCP is based on the primary care services on the PPCP Services list billed under the Medicare FQHC PPS.
- For Indian Health Programs, the PPCP is based on the same set of services as Standard Participants if the IHP bills the PFS. If the IHP bills the Medicare FQHC PPS, the PPCP is based on the same set of services as FQHCs.

The PPCP is based on Participant-specific historical claims-based spending for attributed beneficiaries, adjusted to account for updates to Medicare payment rates, the Merit-based Incentive Payment System (MIPS), and utilization changes. The resulting value reflects the expected monthly payments for PPCP Services for the Participant’s average MCP beneficiary.

Notably, CMS requires that throughout the duration of MCP, Participants continue to bill for PPCP Services provided, to the extent the services meet billing requirements.

**ES.5 Performance Incentive Payment (PIP)**

The PIP is an upside-only payment available for Participants in all tracks, to reward Participants for performance on quality and cost/utilization as measured by the MCP Performance Measure Set. The applicable performance measures and criteria differ by Participant type and track, as shown in Table 3.

Table 3: MCP Performance Measure Set

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data Source</th>
<th>Required for Track 1</th>
<th>Required for Track 2</th>
<th>Required for Track 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure NCQA (CMS165)</td>
<td>Participant-reported</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Diabetes: Glycemic Status Assessment Greater Than 9% NCQA (CMS122)</td>
<td>Participant-reported</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Colorectal Cancer Screening NCQA (CMS130)</td>
<td>Participant-reported</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

(continued)
The total PIP is calculated as a percentage (called the “PIP Percentage Bonus”) of the sum of the Participant’s FFS and PPCP revenue for PPCP Services provided to its MCP attributed beneficiaries. That percentage is determined by the Participant’s performance on the quality measures relative to the criteria for those measures for the Participant’s track. If the Participant achieves the highest performance level (i.e., “full credit”) for all measures, then the PIP Percentage Bonus is 3% for Track 1, 45% for Track 2, and 60% for Track 3. Lower performance levels will result in a lower PIP Percentage Bonus.

For each Participant, a total PIP will be calculated for each performance year starting in 2025. The first part of the PIP (called the “first lump sum PIP”) will be paid upfront in the first quarter of each performance year, and the second part (the “second lump sum PIP”) will be paid in the third quarter of the following year. Once MCP performance data are available, the first lump sum PIP for each performance year will be estimated using aggregate performance data from the prior year.
ES.6 Specialty Integration Payment Codes

One of the goals of MCP is to improve consultation, communication, and coordination between MCP Participants and specialists. To that end, the model includes the following elements for Participants in Track 2 and Track 3:

- Participants in Tracks 2 and 3 that are composed of MCP Clinicians and MCP Specialists have the option to identify one or more Specialty Care Partners, execute a Collaborative Care Arrangement (CCA), and submit their initial Specialty Care Partner List to CMS. Lists must be reviewed and updated annually by Participants to ensure that Specialty Care Partners are meeting the requirements and expectations outlined in their CCAs.

- Participants in Tracks 2 and 3 that are not composed of MCP Clinicians and MCP Specialists must identify at least one Specialty Care Partner, execute a CCA, and submit their initial Specialty Care Partner List to CMS. Lists must be reviewed and updated annually by Participants to ensure that Specialty Care Partners are meeting the requirements and expectations outlined in their CCAs.

- Participants in Tracks 2 and 3 will have access to a new MEC code for all attributed beneficiaries. This code was designed to remove barriers to utilizing current e-consult and FFS Interprofessional Consult (IPC) codes. The MEC code adjusts the current requesting physician IPC code to capture time spent obtaining and implementing specialist recommendations. As shown in Table 13: Services Included in or Impacted by the PPCP, the MEC code will not be included in the Track 2 PPCP Service list. This will allow Participants in Track 2 to receive the full reimbursement rate for this service. In Track 3, the MEC code will be included in the PPCP Service list and will therefore be paid prospectively.

- For Participants in Track 3, Specialty Care Partners and MCP Specialists will gain access to a new ACM code for the enhanced collaboration and communication expected: (1) between the MCP Clinicians and specialists at Specialty Care Partners, or (2) between MCP Clinicians and MCP Specialists.
  - Track 3 Participants that are not composed of MCP Clinicians and MCP Specialists will be required to execute CCAs with Specialty Care Partners to define the communication and data-sharing protocols, expectations for coordination of care (such as when a patient should be shifted back to the primary care clinician for decision-making on care), and expectations for co-management of care.
  - Track 3 Participants that are composed of MCP Clinicians and MCP Specialists will be required to define the communication and data-sharing protocols, expectations for coordination of care (such as when a patient should be shifted back to the primary care clinician for decision-making on care), and expectations for co-management of care within their TIN organization.
ES.7 Upfront Infrastructure Payment (UIP)

The UIP is an optional payment for eligible MCP Participants in Track 1. It is a total payment of $145,000 (split into two lump sum payments) that an MCP Participant may request to offset the additional start-up and ongoing costs often required of organizations new to value-based care models. The three categories of allowed spending are increased staffing, health care infrastructure including health information technology (IT), and the provision of accountable care for patients of underserved communities. These investments often pose a significant financial burden to organizations, including organizations delivering care in underserved areas and organizations that serve medically complex patients. UIPs will provide an opportunity for eligible organizations to build the infrastructure needed to succeed in MCP.

To be eligible for UIPs, an MCP Participant must have applied to participate in Track 1, must be determined by CMS to be eligible for Track 1, and must meet at least one of the following criteria: (1) not have an e-consult technology solution or electronic health record (EHR) enhancement that allows two-way communication and the secure sharing of patient records between primary care clinicians and specialists and/or (2) meet the definition of a “low revenue” Participant.1

---

1 A “low revenue” Participant is one for which the Participant’s total Medicare Part A and Part B FFS revenue is less than 35% of the total Part A and Part B FFS expenditures for the Participant’s attributed beneficiaries.
1 Introduction

Making Care Primary (MCP) is a Center for Medicare and Medicaid Innovation (CMS Innovation Center) advanced primary care model that provides a pathway for primary care clinicians with varying levels of experience in value-based care to gradually adopt prospective, population-based payments that support the delivery of advanced primary care. MCP will launch on July 1, 2024, and will run through December 31, 2034. For more information on MCP, see https://www.cms.gov/priorities/innovation/innovation-models/making-care-primary.

This document is the first in a series of documents that provide MCP Participants with the necessary information to understand the financial aspects of MCP. It provides information on each MCP payment component, including details on the methodology and calculations. Additional policy documents that are forthcoming will provide details on other elements of model operations; those additional policy documents include the Participant Management Guide and the Quality Measurement Methodology.

- **Section 1** provides information on MCP’s performance years, Participant types and tracks, and payment types.
- **Section 2** describes the attribution of beneficiaries to model Participants.
- **Section 3** provides background on the Enhanced Services Payment (ESP), a per beneficiary per month (PBPM) payment intended to support development of the model’s required care delivery capabilities that will be adjusted to reflect the attributed population’s risk level, with a higher payment for beneficiaries at the highest levels of clinical and social risk.
- **Section 4** provides details for the calculation of the Prospective Primary Care Payment (PPCP), which is a quarterly payment that is based on the historical primary care spending for each Participant’s attributed beneficiary population.
- **Section 5** provides details on the Performance Incentive Payment (PIP), which is an upside-only bonus that is calculated as a percentage of the amount paid to each Participant for qualifying services for their attributed beneficiaries. The percentage adjustment is based on the Participant’s performance on measures in the MCP Performance Measure Set.
- **Section 6** provides information on payment for specialty integration services including the MCP e-Consult code (MEC) and the Ambulatory Co-Management code (ACM).
- **Section 7** provides information on the Upfront Infrastructure Payment (UIP), which is a time-limited, lump sum infrastructure payment that will be available to some model Participants.

1.1 MCP Performance Years

Table 4 lists MCP’s performance years. Note that each performance year (PY) is a calendar year, except for the first one, which is only 6 months long (July 2024 – December 2024).
Table 4: MCP Performance Years

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2024</td>
<td>July 1, 2024</td>
<td>December 31, 2024</td>
</tr>
<tr>
<td>2025</td>
<td>January 1, 2025</td>
<td>December 31, 2025</td>
</tr>
<tr>
<td>2026</td>
<td>January 1, 2026</td>
<td>December 31, 2026</td>
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<td>2034</td>
<td>January 1, 2034</td>
<td>December 31, 2034</td>
</tr>
</tbody>
</table>

1.2 MCP Participant Types and Tracks

MCP creates a variety of pathways to support delivery of high-quality primary care. To implement this flexibility, the model is structured around Participant “tracks.” There are three Participant tracks, which provide opportunities for Participants with varying experience in value-based care, from Participants new to advanced care delivery to Participants with more robust capabilities.

- **Track 1** includes organizations that are building capacity to offer advanced services, such as risk stratification, data review, identification of staff for chronic disease management, or health-related social needs (HRSN) screening and referral. Track 1 Participants also must not have had any value-based care experience in the 5 years prior to MCP. Participants entering MCP in Track 1 will remain in Track 1 for 2.5 years before progressing to Track 2.

- **Track 2** includes organizations that are building on the Track 1 requirements by partnering with social service providers, implementing care management, screening for behavioral health services, and transitioning between fee-for-service (FFS) and prospective, population-based payment. Participants entering MCP in Track 2 will remain in Track 2 for 2.5 years before progressing to Track 3. Participants moving into Track 2 from Track 1 will spend 2 years in Track 2 before progressing to Track 3.

- **Track 3** includes organizations that are expanding upon the Track 2 requirements by optimizing primary care delivery, integrating specialty care, and deepening connections to community resources, enabled by prospective, population-based payments. Participants entering MCP in Track 3 remain in Track 3 for the entirety of MCP. Participants moving into Track 3 from Track 2 will stay in Track 3 for the remainder of the model.
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Care delivery requirements and alternative payment methodologies increase in scope and complexity from Track 1 through Track 3. For each of the MCP tracks, there are specific payments that an MCP Participant is eligible to receive.

Within MCP, there are three Participant types, which are defined based on the reimbursement systems under which they bill Medicare FFS, and on the populations the organizations primarily serve. These Participant types are: Standard, Federally Qualified Health Center (FQHC), and Indian Health Program (IHP). Participants are not limited as to which track they may participate in based on their type, though some aspects of the MCP payment methodologies may differ by type.

1.3 MCP Payment Types

A summary of the payment types available to MCP Participants is provided below. Table 5 highlights which track is eligible for these payments. As mentioned above, details on each type of payment are provided in Sections 3 – 7.

The Enhanced Services Payment (ESP) is a per-beneficiary-per-month (PBPM) payment, for Participants in all tracks that is paid prospectively on a quarterly basis. The payment is adjusted to reflect the attributed population’s risk level, with a higher payment for beneficiaries at the highest levels of clinical and social risk. ESPs can be used to support care management, patient navigation, integration with behavioral health, and other enhanced care coordination services, consistent with the specific needs of the MCP Participant’s beneficiaries and the goals of MCP’s care delivery model.

The Prospective Primary Care Payment (PPCP) is a PBPM payment, for Participants in Track 2 and Track 3, that is paid prospectively on a quarterly basis. The PPCP is designed to support a gradual progression from FFS payment for primary care services to a population-based payment structure. These payments are designed to allow practices to deliver enhanced, comprehensive services without the incentive to increase volume of patients or services to achieve a favorable financial outcome. The PPCP is based on the historical primary care spending for each Participant’s attributed beneficiary population.

The Performance Incentive Payment (PIP) is an upside-only payment available for Participants in all tracks, to reward Participants for performance on quality and cost/utilization as measured by the MCP Performance Measure Set. The PIP is calculated as a percentage of the sum of the Participant’s FFS and PPCP amounts for PPCP Services they provide for their MCP-attributed beneficiaries. The potential percentage adjustment increases from Track 1 to Track 3. The first part of the estimated PIP will be paid upfront in the first quarter of each performance year, and the second part will be paid in the third quarter of the following year (reconciled based on performance).

There are two additional payments available for Specialty Integration:
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- **MCP e-Consult (MEC):** Participants in Track 2 will be eligible to bill an e-consult code that is unique to MCP. For Participants in Track 3, this code will be included in the list of PPCP Services. The aim of the MEC code is to address current barriers to e-consult billing, including post-service time to implement the specialist’s recommendation.

- **Ambulatory Co-Management (ACM):** In-house MCP Specialists in Track 3 or Specialty Care Partner physicians who have a Collaborative Care Arrangement (CCA) with an MCP Participant in Track 3 will be eligible to bill a coordination code that is focused on communication and collaboration and that is unique to MCP. The goal of this payment is to support ongoing communication and collaboration of shared MCP patients who require both longitudinal primary care and also specialized care to stabilize an exacerbated chronic condition.

Finally, the **Upfront Infrastructure Payment (UIP)** is a time-limited, lump sum infrastructure payment for eligible Track 1 Participants. This start-up financial support can be used by Participants to improve the quality and efficiency of items and services furnished to patients by investing in increased staffing, health care infrastructure, and the provision of accountable care for patients in underserved communities, which may include addressing social determinants of health.

Table 5 summarizes the MCP payment mechanisms available by track.

**Table 5: MCP Payment Mechanisms by Track**

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>Track 1</th>
<th>Track 2</th>
<th>Track 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced Services Payment (ESP)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Prospective Primary Care Payment (PPCP)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Performance Incentive Payment (PIP)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MCP e-Consult (MEC) a</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ambulatory Co-Management (ACM) b</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Upfront Infrastructure Payment (UIP)</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

a The MEC code is included in the PPCP in Track 3.
b Only Specialty Care Partners and MCP Specialists bill the ACM code.

The relationship among the PPCP, ESP, and PIP, as well as current FFS payments, is summarized in the bullets and Figure 1 below. The UIP, MEC, and ACM payments are not included in the summary.

- **PPCP increases** from Track 1 to Track 3, while FFS **decreases**, to support the interprofessional team. Specifically, Track 1 PPCPs are 0% PPCP and 100% FFS, Track 2 PPCPs are 50% PPCP and 50% FFS, and Track 3 PPCPs are 100% PPCP and 0% FFS.

- **ESPs decrease** from Track 1 to Track 3 as practices become more advanced, and the potential for payments tied to quality performance increases (in the form of the PIP).
- PIP potential greatly *increases* over time to make up for decreases in guaranteed payments from ESPs and FFS.

*Figure 1: Illustration of Relationship between MCP Payment Types*

From July 1, 2024, through December 31, 2024, MCP Participants that are also in a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) for PY 2024 will continue to bill on an FFS basis regardless of the track they are in, and are not eligible to receive any MCP payments, including ESP, PPCP and UIP.
2 Beneficiary Attribution

This section describes the methodology for attributing beneficiaries to MCP Participants. CMS uses attribution to:

- Calculate the Enhanced Services Payment (ESP) amounts;
- Calculate the Prospective Primary Care Payments (PPCPs) and apply fee-for-service (FFS) claims reductions for Track 2 and 3 Participants;
- Identify beneficiaries included in the claims-based quality measures; and
- Identify beneficiaries for whom the MCP e-Consult (MEC) code and Ambulatory Co-Management (ACM) code may be billed.

2.1 Overview

Attribution is a tool used to assign beneficiaries to primary care organizations.

Attribution methodologies consider the following: (1) what unit (e.g., Participant, clinician) a beneficiary is assigned to; (2) how the beneficiary is attributed; (3) the period of the attribution; and (4) how often the attribution is made.

- **Unit of assignment.** Because MCP is a test of Participant-level transformation and payment, CMS attributes beneficiaries to the MCP Participant organization, rather than individual clinicians. An MCP Participant organization is composed of a group of National Provider Identifiers (NPIs) billing under the same Taxpayer Identification Number (TIN) (for Standard Participants), or a group of CMS Certification Numbers (CCNs) (for Federally Qualified Health Center (FQHC) Participants).

- **How the beneficiary is attributed.** CMS attributes beneficiaries to an MCP Participant based on either voluntary alignment or claims-based attribution.
  
  - Attribution is first determined by CMS based on the beneficiary’s chosen alignment to a clinician on Medicare.gov (voluntary alignment). CMS prioritizes beneficiary choice in MCP attribution by placing voluntary alignment as the initial step in
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Beneficiaries can select a primary care clinician whom they consider to be responsible for providing and coordinating their health care, and the location (including FQHC locations) where they receive care on Medicare.gov.

- If an MCP-eligible beneficiary is not attributed during the voluntary alignment step of attribution, CMS attributes the beneficiary using claims-based attribution, where Medicare claims are used to attribute beneficiaries to a Participant by recency of Annual Wellness or Welcome to Medicare Visit, and then, if necessary, plurality of eligible primary care visits.

- **Period of attribution.** To support the MCP Care Delivery model, CMS pays Participants prospectively (i.e., in advance) so that they may make investments consistent with the aims of MCP. To pay Participants prospectively, CMS performs attribution before each payment quarter based on historical data (i.e., beneficiaries’ attestations made by the end of a 24-month “lookback” period or beneficiaries’ visits to Participants obtained through claims during the 24-month lookback period).

- **How often the attribution is made.** Because the intent of attribution is to accurately estimate the number of beneficiaries in an MCP Participant for purposes of calculating payments, CMS performs attribution quarterly to facilitate quarterly payments to Participants.

Eligible Medicare beneficiaries are prospectively attributed to a Participant, who will receive model-specific payments for those beneficiaries and be held accountable for their quality outcomes.

Prospective attribution and payment assume that all attributed beneficiaries continue to be eligible for the entire quarter. However, some beneficiaries become ineligible before or during the quarter, after attribution has been completed. In each quarterly payment cycle, CMS will determine how many beneficiaries became ineligible to be attributed in a prior quarter and will apply a deduction to the upcoming quarter’s payment for their previous overpayments, as described in Section 3.6.2.1 (Debits for Beneficiary Ineligibility).

### 2.2 Eligible Beneficiaries

To be eligible for attribution in a given quarter, beneficiaries must meet the following criteria in the most recent month with available data:

- Have both Medicare Parts A and B;
- Have Medicare as their primary payer;
- Not have end-stage renal disease (ESRD) at the time of initial attribution;\(^2\)

\(^2\) Note that this criterion only applies to beneficiaries who have not been attributed to an MCP Participant previously—if the beneficiary has been attributed previously, then developing ESRD does not disqualify a beneficiary from being attributed to an MCP Participant.
• Not be enrolled in hospice;
• Not be covered under a Medicare Advantage or other Medicare health plan;
• Not be institutionalized;
• Not be incarcerated;
• Not be aligned or otherwise attributed to an entity participating in certain other CMS programs or models, as listed in Section 2.4.1; and
• Not have elected Medicaid Health Home services³.

CMS verifies most of these criteria using the Medicare Enrollment Database. CMS verifies institutional status using Medicare Skilled Nursing Facility Assessment data, known as the Minimum Data Set; CMS identifies a beneficiary as institutionalized if they have ever had a quarterly or annual assessment. CMS uses Medicare’s Master Data Management system to determine attribution to other CMS programs and models.

CMS analyzes eligibility using the most recent month of data available before the quarter begins. Beneficiaries are determined to be eligible as of the first day of that month. For example, beneficiaries must meet all eligibility criteria on June 1, 2024, to be eligible for attribution in the first quarter (July 1, 2024–September 30, 2024) of PY 2024.

As noted above, Participants will receive retroactive payment deductions (MCP Payment Adjustments) for beneficiaries who are later found to have become ineligible during previous quarters.

2.3 Attribution Steps

CMS attributes eligible beneficiaries to MCP Participants through two broad sequential processes: voluntary alignment and claims-based attribution. In the voluntary alignment process, CMS assesses any selection that eligible beneficiaries have made on Medicare.gov to determine if the beneficiary may be attributed to an MCP Participant (Section 2.3.1). In the claims-based attribution process, if a beneficiary is not attributed via voluntary alignment, CMS identifies eligible beneficiaries’ primary care claims during the 24-month lookback period to determine if the beneficiary may be attributed to an MCP Participant by the presence of a Welcome to Medicare or Annual Wellness Visit or, if necessary, by the plurality of primary care visits (Section 2.3.2). CMS then evaluates whether any beneficiaries are also aligned to other Medicare programs before finalizing attribution (Section 2.4).

³ Note that this criterion is incumbent on the MCP Participant to inform CMS.
CMS runs the beneficiary attribution algorithm and provides each Participant with a list of attributed Medicare beneficiaries on a quarterly basis throughout the model.

As described in the sections below, there are sometimes different parameters used for Standard Participants, FQHC Participants and IHP Participants. Attribution for Indian Health Program (IHP) Participants will follow the approach for FQHC Participants if the IHP bills the Medicare FQHC Prospective Payment System (PPS) and will follow the approach for Standard Participants otherwise.

### 2.3.1 Voluntary Alignment

Voluntary alignment is a mechanism of attribution that uses a Medicare beneficiary’s selected primary care clinician to attribute the beneficiary to a practice. The Medicare beneficiary selects their primary care clinician through attestation. The voluntary alignment process involves electronic retrieval of beneficiary attestations and verification of the eligibility of the attested clinician.

CMS assesses voluntary alignment on Medicare.gov on a quarterly basis.

#### 2.3.1.1 Beneficiary Attestations on Medicare.gov

To make an attestation, a beneficiary must first create an account on Medicare.gov. They can then visit the [Find and Compare Health Care Providers](https://www.medicare.gov) webpage on Medicare.gov and follow the directions under “Add your favorite providers.” CMS will distribute a voluntary alignment factsheet for MCP Participants.

Although any beneficiary with an account on Medicare.gov can make an attestation, MCP voluntary alignment is limited to eligible beneficiaries ([Section 2.2](#)). For the eligible beneficiaries who have made an attestation via Medicare.gov, CMS applies the voluntary alignment algorithm each quarter according to the steps in the following sections.

Using the beneficiary attestation list (BAL) from Medicare.gov, for a given quarter, CMS identifies each eligible beneficiary’s most recent attested record as of the end of the lookback period (i.e., 3 months before the start of a given quarter). [Table 6](#) lists the BALs and the beneficiary attestation cut-off dates for quarterly attributions for PY 2024 and PY 2025. For example, CMS will use the April 2024 BAL, which will include beneficiary attestations as of March 31, 2024, for voluntary alignment in Q3 2024. Eligible beneficiaries who have made an attestation specifying the health care clinician and practice as their primary clinician are eligible for voluntary alignment.
Table 6: Beneficiary Attestation Lists Used for PY 2024 and PY 2025 Quarterly Attribution

<table>
<thead>
<tr>
<th>Attribution Quarter</th>
<th>BAL Used</th>
<th>Beneficiary Attestation Cut-off Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 2024</td>
<td>April 2024</td>
<td>March 31, 2024</td>
</tr>
<tr>
<td>Q4 2024</td>
<td>July 2024</td>
<td>June 30, 2024</td>
</tr>
<tr>
<td>Q1 2025</td>
<td>October 2024</td>
<td>September 30, 2024</td>
</tr>
<tr>
<td>Q2 2025</td>
<td>January 2025</td>
<td>December 31, 2024</td>
</tr>
<tr>
<td>Q3 2025</td>
<td>April 2025</td>
<td>March 31, 2025</td>
</tr>
<tr>
<td>Q4 2025</td>
<td>July 2025</td>
<td>June 30, 2025</td>
</tr>
</tbody>
</table>

If an eligible beneficiary’s most recent attested record indicates that the beneficiary has removed a previously attested clinician, but has not made a new attestation, the beneficiary is not eligible for voluntary alignment; instead, that beneficiary is attributed via claims-based attribution.

Next, CMS uses this list of eligible beneficiaries and their attested clinicians and locations to check Participant eligibility.4

2.3.1.2 Clinician and Organization Eligibility Check

An MCP Standard Participant is defined by the combinations of TINs and NPIs identified on the MCP Clinician List. For voluntary alignment, an MCP FQHC Participant is defined by the TIN submitted by the Participant; the CCNs associated with the FQHC’s TIN are not used for voluntary alignment. In voluntary alignment for Standard Participants, CMS uses the Participant’s MCP Clinician List to verify whether the attested organization’s TIN and the attested clinician’s NPI match a Standard MCP Participant, and for FQHC Participants CMS uses the TINs collected from FQHC Participants to verify whether the attested TIN matches an FQHC Participant. Non-MCP participants are defined as individual clinicians using single TIN-NPI combinations because of the lack of information regarding how they are grouped as actual practices.

CMS uses the BAL file for a given quarter to determine the eligibility of the clinician and location to which the eligible beneficiary attested. Only eligible clinicians are included in voluntary alignment. If the attested organization (i.e., the attested TIN) is an MCP Standard Participant, the attested clinician must also be listed as active on the Participant’s MCP Clinician List for the given quarter to be eligible. CMS considers a clinician active for a given quarter if the clinician is on the Participant’s MCP Clinician List on the first day of the month before a given quarter. For example, clinicians must

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4 Because the BAL includes the clinician’s and organization’s identification numbers assigned by, and specific to, the Provider Enrollment Chain and Ownership System (PECOS), which are the data used by Care Compare, CMS uses the Provider Master Index file and Center for Program Integrity sole proprietor file (for sole clinicians) to identify the TINs and NPIs for each attested clinician and organization.
be active on June 1, 2024, to be eligible for voluntary alignment in the first quarter of PY 2024 (July 1, 2024–September 30, 2024).

Note that MCP Clinicians must have a primary care specialty code to be included on the Participant’s MCP Clinician List. CMS verifies these specialties using the clinician’s primary and secondary taxonomy codes in the most current National Plan and Provider Enumeration System (NPPES) file, which CMS updates monthly. See Appendix A for the list of specialty codes CMS classifies as a primary care specialty.

If clinician eligibility requirements are met, CMS uses the eligible beneficiary's attestation to attribute the beneficiary via voluntary alignment. If the attested clinician does not meet the eligibility criteria, CMS attributes the eligible beneficiary through claims-based attribution. These requirements are described in greater detail in the section on claims-based attribution below.

Attested clinicians at FQHC Participants will not be required to have a primary care specialty.

See Section 2.4 for more information on voluntary alignment as it pertains to specific Medicare shared savings initiatives.

### 2.3.2 Claims-Based Attribution

CMS attributes remaining eligible beneficiaries, who are not attributed through voluntary alignment, through the claims-based attribution process. CMS first identifies eligible primary care visits for eligible beneficiaries, then attributes eligible beneficiaries to the Participant by recency of Annual Wellness Visits or Welcome to Medicare Visits (Section 2.3.2.2) or, if necessary, plurality of eligible primary care visits (Section 2.3.2.3).

#### 2.3.2.1 Eligible Visits

For claims-based attribution, CMS uses the pool of Medicare claims during the lookback period to identify eligible primary care visits for attribution. The lookback period is the 24-month period ending 3 months before the start of the quarter. For example, CMS uses claims with dates of service from April 2022 through March 2024 to attribute MCP-eligible beneficiaries to practices for Q3 2024. Table 7 lists the lookback periods that will be used for the PY 2024 and PY 2025 quarterly attributions.

<table>
<thead>
<tr>
<th>Attribution Quarter</th>
<th>Lookback Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 2024</td>
<td>April 2022–March 2024</td>
</tr>
<tr>
<td>Q4 2024</td>
<td>July 2022–June 2024</td>
</tr>
<tr>
<td>Q1 2025</td>
<td>October 2022–September 2024</td>
</tr>
</tbody>
</table>

(continued)
CMS waits 1 month after the end of the lookback period to collect claims with service dates during the lookback period. This allows most claims that occurred during the lookback period to count toward attribution, even if they were processed and paid in the month after the lookback period ended.

CMS uses national Medicare FFS physician and outpatient claims with service dates during the lookback period. Most visits are in the physician file, except for claims submitted by FQHCs, which are found in the outpatient file. From all physician and outpatient claims, CMS identifies those that are primary care visits eligible for attribution. Primary care visits eligible for attribution must include one of the Healthcare Common Procedure Coding System (HCPCS) codes in Table 8.

Table 8: Primary Care Services Eligible for Attribution

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/outpatient visit Evaluation and Management (E&amp;M)</td>
<td>99201–99205, 99211–99215</td>
</tr>
<tr>
<td>Complex Chronic Care Management services</td>
<td>99487</td>
</tr>
<tr>
<td>Chronic Care Management (CCM) services</td>
<td>99490, 99491, G0511</td>
</tr>
<tr>
<td>Principal Care Management (PCM) services</td>
<td>99424, 99426, G2064, G2065</td>
</tr>
<tr>
<td>Transitional Care Management (TCM) services</td>
<td>99495, 99496</td>
</tr>
<tr>
<td>Home Care/Domiciliary Care E&amp;M</td>
<td>99324–99328, 99334–99337, 99339–99345, 99347–99350</td>
</tr>
<tr>
<td>Online Digital E&amp;M</td>
<td>99421-99423</td>
</tr>
<tr>
<td>Audio-Only Telephone E&amp;M</td>
<td>99441-99443</td>
</tr>
<tr>
<td>Technology-Based Check-In services</td>
<td>G2010, G2012, G2252</td>
</tr>
<tr>
<td>Remote Physiologic Monitoring (RPM)</td>
<td>99453, 99454, 99457, 99091</td>
</tr>
<tr>
<td>Remote Therapeutic Monitoring (RTM)</td>
<td>98975–98977, 98980</td>
</tr>
</tbody>
</table>

(continued)

5 Please note that all HCPCS codes listed in this table and throughout the document are current as of the CY 2024 Medicare Physician Fee Schedule Final Rule and are subject to change based on future Medicare PFS Final Rules.
Table 8: Primary Care Services Eligible for Attribution\(^5\) (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance care planning</td>
<td>99497</td>
</tr>
<tr>
<td>Depression, substance use disorder, and alcohol misuse screening and counseling services</td>
<td>G0396, G0397, G0442-G0444</td>
</tr>
<tr>
<td>Welcome to Medicare and Annual Wellness Visits</td>
<td>G0402, G0438, G0439</td>
</tr>
<tr>
<td>Assessment/care planning for patients requiring CCM services</td>
<td>G0506</td>
</tr>
<tr>
<td>Care management services for behavioral health conditions</td>
<td>99484</td>
</tr>
<tr>
<td>Cognition and functional assessment for patient with cognitive impairment</td>
<td>99483</td>
</tr>
<tr>
<td>Psychiatric Collaborative Care Model</td>
<td>99492-99494, G0512, G2214</td>
</tr>
<tr>
<td>Outpatient clinic visit for assessment and management (for critical access hospital-based outpatient primary care Participants)</td>
<td>G0463</td>
</tr>
<tr>
<td>Administration of Health Risk Assessment (HRA)/Social Determinants of Health HRA</td>
<td>96160, 96161, G0136</td>
</tr>
<tr>
<td>Interprofessional Consultation (IPC) and MCP e-consult (MEC)</td>
<td>99452, G9037</td>
</tr>
<tr>
<td>FQHC all-inclusive visit</td>
<td>G0466, G0467</td>
</tr>
<tr>
<td>FQHC visit, initial preventive physical examination (IPPE) or annual wellness visit (AWV)</td>
<td>G0468</td>
</tr>
<tr>
<td>Distant site telehealth services Rural Health Clinics or FQHCs</td>
<td>G2025</td>
</tr>
<tr>
<td>FQHC Virtual Communication services</td>
<td>G0071</td>
</tr>
<tr>
<td>Chronic Pain Management and Treatment</td>
<td>G3002</td>
</tr>
<tr>
<td>Principal Illness Navigation (PIN) services</td>
<td>G0023, G0140</td>
</tr>
<tr>
<td>Community Health Integration (CHI) services</td>
<td>G0019</td>
</tr>
</tbody>
</table>

Some HCPCS codes, such as G2064 and 99201, have been removed from the Physician Fee Schedule (PFS). However, CMS will continue to use these codes for attribution purposes when historical claims analysis includes periods when these codes were in use.

Only eligible primary care visits count toward attribution. To be eligible, a primary care visit must meet two criteria:

- The HCPCS code on the claim is among those listed above in Table 8, and
If the claim is for a non-CCM-related service (see Table 9) in the physician file (where claims are found for Standard Participants), it must be provided by a clinician who meets one of the following criteria (called an “eligible clinician”).

- Active in an MCP Participant when the visit occurs, or
- Has one of the primary care specialty codes located in Appendix A

### Table 9: CCM-Related Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex chronic care coordination services</td>
<td>99487</td>
</tr>
<tr>
<td>Chronic care management (CCM) services</td>
<td>99490, 99491, G0511</td>
</tr>
<tr>
<td>Principal care management (PCM) services</td>
<td>99424, 99426, G2064, G2065</td>
</tr>
<tr>
<td>Transitional care management (TCM) services</td>
<td>99495, 99496</td>
</tr>
<tr>
<td>Assessment/care planning for patients requiring CCM services</td>
<td>G0506</td>
</tr>
<tr>
<td>Care management services for behavioral health conditions</td>
<td>99484</td>
</tr>
<tr>
<td>Social Determinants of Health Risk Assessment</td>
<td>G0136</td>
</tr>
<tr>
<td>Chronic Pain Management and Treatment</td>
<td>G3002</td>
</tr>
<tr>
<td>Principal Illness Navigation (PIN) Services</td>
<td>G0023, G0140</td>
</tr>
<tr>
<td>Community Health Integration (CHI) Services</td>
<td>G0019</td>
</tr>
</tbody>
</table>

Each visit in the claims data includes: (1) the TIN (physician) or CCN (outpatient) and (2) the NPI of the clinician who rendered the service. For non-FQHC claims in the physician file, CMS determines whether the TIN and the NPI on the claim match a TIN-NPI combination that is effective on the claim’s service date in the Participant’s MCP Clinician List. For FQHC claims in the outpatient file, the CCN on the claim must match the CCN(s) associated with the FQHC’s TIN. If there is a match, the visit is associated with an MCP Participant organization. Otherwise, the visit is associated with a non-MCP participant organization.

Non-MCP participant organizations that are not FQHCs are defined as individual clinicians’ single TIN-NPI combinations based on the physician claims. Non-MCP participant organizations that are FQHCs are defined as a group of FQHC CCNs billing under the same TIN.

CMS maintains historical TINs, NPIs, and CCNs to associate claims with Participants accurately in the lookback period. When MCP Clinicians leave a Participant organization, their NPIs remain on

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6 There is no specialty code restriction on these services. Therefore, even when CCM-related services are billed by clinicians who do not have one of the primary care specialties listed, they are eligible for attribution.

7 Note that clinicians must have a primary care specialty code to be active in an MCP Participant organization.
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the Participant’s MCP Clinician List but are marked with a termination date. Although no longer “active” MCP Clinicians, past visits to those clinicians during the lookback period continue to be counted toward the Participant’s attribution. Similarly, CCNs for an FQHC MCP Participant that become no longer “active” will continue to be counted during the lookback through the marked termination date.

2.3.2.2 Attribution Based on Annual Wellness Visits or Welcome to Medicare Visits

CMS first checks whether eligible beneficiaries have Annual Wellness Visits (G0438, G0439) or Welcome to Medicare Visits (G0402) in the lookback period. CMS attributes the beneficiary to the Participant (or non-MCP clinician or FQHC) who billed the beneficiary’s most recent claim for an Annual Wellness Visit or a Welcome to Medicare Visit during the lookback period. CMS prioritizes Annual Wellness Visits and Welcome to Medicare Visits because these represent a longitudinal relationship with a Participant.

If there are no eligible Annual Wellness or Welcome to Medicare Visits during the lookback period, CMS proceeds to the plurality step of claims-based attribution.

2.3.2.3 Attribution Based on Plurality

In this step, CMS first counts the number of eligible primary care visits the beneficiary had with each individual clinician or CCN. CMS then, for Standard Participants, combines eligible primary care visits to individual clinicians (i.e., TIN/NPI combinations) into MCP Standard Participant organizations using the Participant’s most current MCP Clinician List. For example, two clinicians working in an MCP Participant’s organization will have their eligible primary care visits aggregated for the purposes of attribution. For FQHC Participants, CMS combines eligible primary care visits to single FQHCs into MCP FQHC Participant organizations using the list of CCNs collected from the FQHC Participant. Finally, CMS attributes the beneficiary to an MCP Participant if it provided the plurality of eligible primary care visits during the lookback period.

If a beneficiary has an equal number of eligible primary care visits to more than one MCP Participant (or non-MCP clinician or FQHC), as measured by a discrete count of services, the beneficiary will be attributed based on the most recent visit. If a tie remains between an MCP Participant and a non-MCP clinician or FQHC, the beneficiary will be attributed to the MCP Participant. If a tie remains between two MCP Participants, the beneficiary is randomly attributed to one of the Participants.

Figure 2 illustrates two examples of claims-based attribution based on plurality of primary care visits. In one scenario, the beneficiary will be attributed to the MCP Participant based on plurality; in the other, the beneficiary will be attributed to the non-MCP clinician after applying the recency criteria to a tiebreaker.
2.4 Interaction with Other Medicare Programs and Models

Beneficiaries may be eligible for more than one CMS coordinated care initiative. This may occur if the beneficiary seeks care from health care clinicians who are participating in multiple initiatives or within a certain geographical region where a model is being tested. In general, CMS prohibits beneficiary overlaps when they would interfere with CMS’s ability to accurately measure the effects of each initiative and account for the effects of the overlap as part of financial reconciliation. CMS does not allow eligible beneficiaries to be attributed to MCP and certain other CMS programs and models at the same time.

2.4.1 Alignment Across Models and Programs

2.4.1.1 The Medicare Shared Savings Program

Eligible MCP Participants currently participating in a Medicare Shared Savings Program ACO (any track) may participate in both initiatives for the first 6 months of MCP (please see section 3.7.D in the Standard Participant and FQHC Participant Participation Agreements (PAs) for more details). In those first 6 months, beneficiaries eligible for MCP who are attributed (either via voluntary alignment or claims-based attribution) to both the MCP Participant and the Shared Savings Program (SSP) Accountable Care Organization (ACO) that the MCP Participant participates in will remain attributed to both. No MCP payments will be made to MCP Participants for the time they
are simultaneously participating in an SSP ACO in PY 2024. Beginning in PY 2025, beneficiaries attributed to both MCP and an MSSP ACO for the same time period will be removed from MCP.

2.4.1.2 Accountable Care Models

To avoid duplicative payment of shared savings or other incentive payments, clinicians participating in certain accountable care models may not simultaneously participate in MCP, and beneficiaries attributed to these initiatives are not eligible for attribution to an MCP Participant. Examples of such models include the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) model, the Kidney Care Choices (KCC) Model, and the Primary Care First (PCF) model. A list of Innovation Center accountable care models operating in 2024 for which beneficiary overlap is prohibited is provided below:

- Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model
- ESRD Treatment Choices (ETC) Model
- Kidney Care Choices (KCC) Model
- Primary Care First (PCF) Model

Voluntary Alignment for MCP, ACO REACH, and the Shared Savings Program

Voluntary alignment to MCP takes precedence over any claims-based attribution to the Shared Savings Program or the ACO REACH model, but only for MCP attributions in the first quarter of each calendar year. For example, beneficiaries who make an eligible attestation to an MCP Clinician or FQHC on or before September 30, 2024, are attributed to their attested MCP Clinician or FQHC for Q1 2025. If MCP-eligible beneficiaries have already been attributed to a Shared Savings Program or REACH ACO during any quarter of 2025, a subsequent attestation to an MCP Clinician or FQHC in 2025 will not lead to their attribution to the MCP Participant until 2026.

Because CMS performs voluntary alignment quarterly for MCP and annually for the Shared Savings Program and the ACO REACH model, beneficiaries will remain with the ACO until the Shared Savings Program and ACO REACH models perform voluntary alignment again for the following year. When CMS performs voluntary alignment again the following year, if the beneficiary attestation to the MCP Clinician or FQHC remains the most current attestation, the MCP-eligible beneficiary will be attributed to the MCP Participant. For example, if an MCP-eligible beneficiary attributed to an ACO in Q1 2025 makes an attestation in May 2025 to an MCP Clinician, this beneficiary remains assigned to the ACO for the remainder of 2025. If the beneficiary attestation to the MCP Clinician remains the most current attestation when the SSP performs voluntary alignment again for 2026, the beneficiary will become attributed to MCP in Q1 2026. In contrast, MCP-eligible beneficiaries who are not attributed to an
ACO and with May attestations would be captured in Q4 2025 MCP attribution. Figure 3 illustrates the timing of voluntary alignment in MCP and ACO REACH/SSP.

Figure 3: Intersection of Voluntary Alignment for MCP and ACO REACH/SSP

2.4.1.3 Disease-Specific and Episode-Based Models

MCP Participants and MCP-attributed beneficiaries may overlap with CMS models focused on testing bundled payments for certain episodes of care, where it is possible to account for the financial impact of the overlap. Examples of these episode-based payment models are the Bundled Payments for Care Improvement Advanced Model (BPCI-A), the Enhancing Oncology Model (EOM), and the Guiding an Improved Dementia Experience (GUIDE) model.

2.4.1.4 State and Community-Based Models

MCP Participants are prohibited from participating in, and cannot share MCP-attributed beneficiaries with, certain CMS state-based models, including the Maryland Total Cost of Care (TCOC) Model and the Financial Alignment Initiative (FAI). MCP Participants may simultaneously participate in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model.

2.4.1.5 Other Models

MCP Participants and their MCP beneficiaries may simultaneously participate in other types of initiatives, such as models that are not Medicare FFS models, including Health Plan and Part D models. CMS may update these overlap policies periodically to include new initiatives as they are finalized.
3 Enhanced Services Payment

3.1 Overview
The Enhanced Services Payment (ESP) is a per-beneficiary-per-month (PBPM) payment for Participants in all tracks that is paid prospectively on a quarterly basis. ESPs do not require billing Medicare and are based on each Participant’s MCP-attributed Medicare fee-for-service (FFS) beneficiary population, as detailed in Section 2. The payment is adjusted to reflect the attributed population’s risk level, with a higher payment for beneficiaries at the highest levels of clinical and social risk. ESPs are intended to support care management, patient navigation, integration with behavioral health, and other enhanced care coordination services, consistent with the specific needs of the MCP Participant’s beneficiaries and the goals of MCP’s care delivery model. These enhanced care coordination services include activities to improve care coordination, implement data-driven quality improvement, and enhance targeted support to beneficiaries identified as high risk.

ESPs are meant to support enhanced care management and other primary care services that overlap with certain covered services under the Medicare Physician Fee Schedule (PFS) and the Medicare Federally Qualified Health Center (FQHC) prospective payment system (PPS). Because Medicare FFS payment for these enhanced services for the same beneficiaries would be duplicative of the ESP, Participants will not receive normal Medicare FFS payments for such services when furnished to their attributed Medicare beneficiaries. For more information about services considered duplicative of ESPs, see Section 3.3.

Navigating this section:
- Section 3.1 Overview
- Section 3.2 Allowable Uses
- Section 3.3 Services Duplicative of the ESP
- Section 3.4 Amount of the ESP
- Section 3.5 Risk Adjustment
- Section 3.6 Quarterly ESP Calculation

3.2 Allowable Uses
The ESP provides upfront funding to pay for the services listed in Figure 4, consistent with the specific needs of a Participant’s MCP beneficiaries.
Figure 4: Allowable Uses for MCP’s Enhanced Services Payments

<table>
<thead>
<tr>
<th>Allowable Uses for MCP’s Enhanced Services Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care management</td>
</tr>
<tr>
<td>• Patient navigation</td>
</tr>
<tr>
<td>• Behavioral health</td>
</tr>
<tr>
<td>• Enhanced care coordination services</td>
</tr>
<tr>
<td>• Hiring of staff or expanding the roles of current staff (e.g., care managers) to support activities, such as identifying and addressing patients’ social needs</td>
</tr>
<tr>
<td>• Supporting the establishment of relationships with external clinicians and staff to facilitate information-sharing and workflow development</td>
</tr>
</tbody>
</table>

The ESP is intended to be used to support augmented services and training that align with the transformation aims of the care delivery functions that MCP Participants are required to perform. While Participants will use the funds to support covered services, they will have flexibility to invest the dollars according to the needs of their attributed Medicare beneficiaries. The care management personnel should have access to patient data/Electronic Health Records (EHRs), and function as part of the primary care team. CMS will monitor spending of these investments and care delivery changes through regular required care delivery reporting.

3.3 Services Duplicative of the ESP

CMS considers fee-for-service payments for certain care management-related services, identified in Table 10, duplicative with the ESP. Per section 8.3.G in the Standard Participant and FQHC Participant Participation Agreements (PAs), if CMS receives a claim for a duplicative service from an MCP Participant for any of their attributed beneficiaries, CMS will not pay the claim.

Table 10: Services Considered Duplicative of the Enhanced Services Payment

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Chronic Care Management services</td>
<td>99487, 99489*</td>
</tr>
<tr>
<td>Chronic Care Management (CCM) services</td>
<td>99490, 99491, 99437*, 99439*, G2058*</td>
</tr>
<tr>
<td>CCM or General Behavioral Health Integration (BHI) Services (for FQHCs)</td>
<td>G0511</td>
</tr>
<tr>
<td>Principal Care Management (PCM) services</td>
<td>99424, 99425*, 99426, 99427*</td>
</tr>
<tr>
<td>Transitional Care Management (TCM) services</td>
<td>99495, 99496</td>
</tr>
</tbody>
</table>

(continued)
Making Care Primary: Payment and Attribution Methodologies

Table 10: Services Considered Duplicative of the Enhanced Services Payment (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/care planning for patients requiring CCM services</td>
<td>G0506</td>
</tr>
<tr>
<td>Social Determinants of Health Risk Assessment</td>
<td>G0136</td>
</tr>
<tr>
<td>Chronic Pain Management and Treatment</td>
<td>G3002, G3003*</td>
</tr>
<tr>
<td>Principal Illness Navigation (PIN) services</td>
<td>G0023, G0024*, G0140, G0146*</td>
</tr>
<tr>
<td>Community Health Integration (CHI) services</td>
<td>G0019, G0022*</td>
</tr>
</tbody>
</table>

*Add-on codes shall also be excluded when billed with other duplicative services.

3.4 Amount of the ESP

The most ESP support will be provided in Track 1. This maximizes the funding available to support up-front primary care transformation to meet care delivery requirements. As Participants progress through tracks, this additional support gradually shifts in form from an ESP to a performance incentive payment (PIP), with increasing opportunity for payment enhancement as well as accountability for beneficiary outcomes. While ESPs progressively decrease from Track 1 to Track 3, Participants that achieve high performance payments can increase the overall maximum revenue available when progressing across tracks.

In addition to varying by track, the ESP is also risk-adjusted by certain beneficiary characteristics to ensure Participants that serve more high-needs beneficiaries receive proportionally more resources. The ESP PBPM amount will vary for each beneficiary based on three risk factors:

- Whether the beneficiary is enrolled in the Medicare Part D low-income subsidy (LIS),
- The Area Deprivation Index (ADI) ranking based on the beneficiary’s residence, and
- The beneficiary’s CMS-Hierarchical Condition Categories (HCC) risk score.

While most ESP PBPM amounts decrease across tracks, CMS will not decrease the ESP PBPM amount for high-needs beneficiaries, specifically beneficiaries who are either enrolled in LIS or in the top quartile of clinical and social risk (i.e., Tier 4). This will ensure that Participants serving high-needs beneficiaries receive the highest ESP amount regardless of track. Higher risk-adjusted ESPs for the Participant’s high-risk beneficiaries account for the higher disease burden in these populations, as well as the increased resources required to serve beneficiaries with multiple chronic conditions. The tiered ESP PBPM amounts are provided in Table 11 below. For an MCP Participant to receive the highest ESP PBPM amount ($25) for a beneficiary, the beneficiary must be enrolled in LIS or have a CMS-HCC risk score in clinical risk tier 4 and an ADI score in social risk Tier 4.

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8 [https://www.neighborhoodatlas.medicine.wisc.edu/](https://www.neighborhoodatlas.medicine.wisc.edu/)
Table 11: Risk Adjusted ESPs by LIS Status, Clinical Risk Tier, Social Risk Tier, and Participant Track

<table>
<thead>
<tr>
<th>Not Enrolled in LIS:</th>
<th>Clinical Risk Tier (CMS-HCC Risk Score Percentile)</th>
<th>Social Risk Tier (ADI Percentile)</th>
<th>Track 1</th>
<th>Track 2</th>
<th>Track 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 (≤25th)</td>
<td>Not Applicable a</td>
<td>$9</td>
<td>$4</td>
<td>$2</td>
<td></td>
</tr>
<tr>
<td>Tier 2 (&gt;25th and ≤50th)</td>
<td>Not Applicable a</td>
<td>$11</td>
<td>$5</td>
<td>$2.50</td>
<td></td>
</tr>
<tr>
<td>Tier 3 (&gt;50th and ≤75th)</td>
<td>Not Applicable a</td>
<td>$14</td>
<td>$7</td>
<td>$3.50</td>
<td></td>
</tr>
<tr>
<td>Tier 4 (&gt;75th)</td>
<td>Tier 1, Tier 2, or Tier 3 (≤75th)</td>
<td>$18</td>
<td>$8</td>
<td>$4</td>
<td></td>
</tr>
<tr>
<td>Tier 4 (&gt;75th)</td>
<td>Tier 4 (&gt;75th)</td>
<td>$25</td>
<td>$25</td>
<td>$25</td>
<td></td>
</tr>
</tbody>
</table>

a Listed as Not Applicable, because payment for beneficiaries in clinical risk tiers 1-3 is based only on risk score.

More information is provided below on the clinical and social risk adjustment methodologies. Given MCP’s 10.5-year testing period, CMS will consider potential refinements to the ESP risk adjustment methodology and payment amounts in future model years as the science of measuring risk evolves.

3.5 Risk Adjustment

All Medicare FFS beneficiaries attributed to an MCP Participant and not enrolled in LIS are assigned to one of four clinical risk (CMS-HCC) tiers and one of four social risk (ADI) tiers. Thresholds determining the clinical and social risk tiers are defined separately for each MCP region. CMS-HCC risk scores and national ADI rankings for attributed beneficiaries are compared to the distribution of those for all FFS beneficiaries in the same region who meet MCP eligibility requirements and who have had an eligible primary care visit. This group of beneficiaries is called the ESP reference population (see Section 3.5.1). Beneficiaries are assigned to risk tiers based on where their CMS-HCC risk score and national ADI ranking fall within the regional distributions, as shown in Table 11 above. Example data showing the clinical and social risk tier thresholds, by region, are shown in Appendix B. This data will be updated by July 2024, to reflect the actual thresholds across regions, and distributed to model Participants. The methodologies for defining these tiers are described in more detail in Section 3.5.2 (Social Risk Adjustment Methodology) and Section 3.5.3 (Clinical Risk Adjustment Methodology).

3.5.1 ESP Reference Population

Clinical and social risk tiers are determined for each region using the distribution of CMS-HCC risk scores and national ADI rankings in the reference population for that region. The reference population includes all beneficiaries residing in each region who meet the eligibility criteria for attribution (see Section 2.2). In addition, to approximate the utilization patterns of the MCP attributed population, beneficiaries included in the reference population must have had at least
one eligible primary care visit in the prior 24-month period. The required primary care visit must meet all of the same criteria as eligible primary care visits used for attribution (see Section 2.3.2.1).

Prior to each performance year, the reference population is defined for the quarter ending in September of the prior year. For example, beneficiaries included in the reference population used for Q3 2024 must: (1) meet eligibility criteria on June 1, 2024, and (2) have had an eligible primary care visit in the lookback period used for Q3 2024 (April 2022–March 2024). CMS uses Q3 attribution data because it is a midyear capture of the “average” population, and updated annual CMS-HCC risk scores are typically released by this time.

### 3.5.2 Social Risk Adjustment Methodology

CMS uses LIS to first identify the highest-needs beneficiaries and then stratifies all remaining beneficiaries based on ADI ranking and CMS-HCC risk scores. For attributed beneficiaries who either (1) are enrolled in LIS or (2) have a very high CMS-HCC score and who reside in an area with very high ADI ranking, the Participant will receive the highest PBPM ESP amount of $25.

By using a blended clinical and social risk adjustment approach that bases the ESP on CMS-HCC risk scores, ADI ranking, and LIS, MCP considers broader neighborhood-level characteristics and individual beneficiary-level characteristics in its identification of beneficiaries that may be underserved and may require higher levels of primary care funding support. The LIS measure (Section 3.5.2.1) is intended to capture socioeconomic challenges that could affect a beneficiary’s ability to access care, while the ADI measure (Section 3.5.2.2) is intended to capture local socioeconomic factors correlated with medical disparities and underservice.

#### 3.5.2.1 Medicare Part D Low Income Subsidy

LIS refers to beneficiaries enrolled in the Medicare Part D Low-Income Subsidy program, which uses standardized income criteria across the country. As of 2024, Medicare beneficiaries with annual incomes of up to 150% of the federal poverty level (FPL), who also meet resource limits, can qualify for LIS. Dual-eligible beneficiaries automatically qualify for the LIS. LIS statuses are determined using information from CMS’s Common Medicare Environment (CME). Medicare LIS status is available for each month. MCP attributed beneficiaries are designated as enrolled in LIS for the upcoming quarter if they are enrolled in LIS for the most recently available month of data at the time the quarterly payment is calculated. For beneficiaries who are new to Medicare and not yet included in the CME LIS data, Participants will be paid under clinical risk tier 1.

For each beneficiary enrolled in LIS who is in the Participant’s attributed Medicare FFS population, CMS pays the highest fixed ESP amount of $25 PBPM. For all remaining attributed beneficiaries, CMS will determine the payment amount that corresponds to the beneficiary’s clinical and social risk tier in accordance with Table 11.
3.5.2.2 Area Deprivation Index

The ADI is a composite measure reflecting a range of socioeconomic characteristics (e.g., median family income, percentage of people below the federal poverty line, median home value, median gross rent, and median monthly mortgage) at the Census block group level. It is publicly available (through the University of Wisconsin’s Neighborhood Atlas) at no cost and is updated annually. MCP uses the national ADI, where each Census block is ranked based on these characteristics relative to the rest of the country and receives a ranking of 1-100, with higher numbers reflecting more deprived areas. Use of the national ADI as a measure relative to the distribution among the regional MCP-eligible populations is consistent with the MCP policy of defining clinical risk relative to the regional population and ensures that the percentage of beneficiaries identified as high risk is the same across all regions.

While ADI can be reported for an individual, it is important to remember that an “individual’s ADI” is the ADI of the Census block group of their residence, and each individual faces a unique set and degree of social challenges.

While the rankings are updated annually, CMS data are updated regularly for change in beneficiary residence. Each quarter, CMS uses the currently available beneficiary residence at the time of calculation to determine each attributed beneficiary’s social risk tier for each quarter. For beneficiaries who are new to Medicare and not yet included in the CCW ADI dataset, Participants will be paid under clinical risk tier 1.

3.5.2.3 Setting the Social Risk Tier Thresholds

The social risk tier thresholds will be determined prior to each performance year, and will be based on the national ADI rankings for the ESP reference population described above, such that national ADI rankings for attributed MCP beneficiaries are compared with national ADI rankings for all MCP-eligible, Medicare FFS beneficiaries in the same region, for the same year of national ADI rankings.

Only values between 1 and 100, inclusive, are considered valid national ADI values. CMS sorts the ADI rankings and identifies the 25th, 50th, and 75th percentiles among the reference population in each region. The regional thresholds are used for payment for all 4 quarters of the year and are shared with Participants prior to the start of each performance year. Estimated social risk tier thresholds by region for PY 2024 are included in Appendix B.

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9 ADI data is publicly available at no cost through the University of Wisconsin website at: https://www.neighborhoodatlas.medicine.wisc.edu/.
3.5.3 Clinical Risk Adjustment Methodology

3.5.3.1 Centers for Medicare & Medicaid Services–Hierarchical Condition Categories Risk Scores

The CMS-HCC risk adjustment model is a prospective risk adjustment model that predicts medical expenditures using beneficiary demographics and diagnoses, where Medicare FFS medical expenditures in a given year (the risk score year) are predicted using diagnoses from the prior year (the base year). The CMS-HCC model produces a risk score, which measures a person's or a population's health status relative to the average of 1.0, as applied to expected medical expenditures. For example, a population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. Appendix C includes more detail on the CMS-HCC model.

For MCP, CMS uses risk scores based on the CMS-HCC community risk adjustment model. For community-residing beneficiaries new to Medicare, CMS uses the new enrollee risk adjustment model, which is a demographic-only risk adjustment model. Because beneficiaries new to Medicare during the risk score year do not have a complete diagnostic profile in the base year, the diagnosis-based CMS-HCC risk adjustment model cannot be used for these beneficiaries.

Each quarter, CMS uses currently available risk scores to assign beneficiaries to clinical risk tiers. For beneficiaries who are new to Medicare and not yet included in the CMS-HCC data, Participants will be paid under clinical risk tier 1.

CMS calculates risk scores for any year at least 12 months after the close of the base year. Final risk scores are generally available 16-18 months after the close of the base year. For example, 2023 risk scores (based on 2022 diagnoses) will be available in the spring of 2024 and will serve as the basis for the PY 2024 clinical risk thresholds and payment.

3.5.3.2 Setting the Clinical Risk Thresholds

The clinical risk thresholds will be based on the distribution of CMS-HCC risk scores for the ESP reference population described above, such that CMS-HCC risk scores for attributed MCP beneficiaries are compared with CMS-HCC risk scores for all MCP-eligible, Medicare FFS beneficiaries in the same region, for the same risk score year.

CMS sorts the ESP reference population's CMS-HCC risk scores and identifies the 25th, 50th, and 75th percentiles among the reference population in each region. The regional thresholds are used for payment for all 4 quarters of the year and are shared with Participants prior to the start of each performance year. Estimated clinical risk thresholds by region are included in Appendix B.
3.5.3.3 Risk Score Growth

CMS will introduce a risk score growth cap to safeguard against the potential that Participants could be incentivized to capture diagnoses inappropriately (also referred to as “upcoding”) to generate higher ESP revenue through higher risk scores. CMS will monitor risk score growth in the Participants’ beneficiary population compared to a non-MCP reference population and may place a “cap” on the risk score growth rate by which each Participants’ risk score is allowed to change.

3.6 Quarterly ESP Calculation

Each quarter, CMS uses CMS-HCC risk scores, LIS status, and ADI ranking for all beneficiaries attributed to an MCP Participant to determine beneficiaries’ ESP PBPM amounts. Beneficiaries, including those who are eligible for both Medicare and Medicaid (i.e., dual eligible), are first evaluated to determine if they are enrolled in LIS. If so, they are assigned the highest ESP PBPM amount of $25. If they are not enrolled in LIS, beneficiaries are assigned to clinical and social risk tiers based on the thresholds that apply for that quarter and the criteria outlined in the sections above and are assigned the ESP PBPM payment corresponding to their risk tiers.

Beneficiaries who have newly joined Medicare may not have a CMS-HCC risk score or an ADI value to use to determine their risk tiers, because of the inherent lag in the calculation and availability of risk score and ADI data. Such beneficiaries, if they are not enrolled in LIS, are placed into clinical risk tier 1.

3.6.1 Geographically Adjusting the ESP

The ESP PBPM amount is adjusted by each Participant’s applicable geographic adjustment factor (GAF). FQHCs will receive the applicable GAF adjustment under the FQHC PPS, while Standard Participants will receive the applicable GAF adjustment under the PFS. Participants may have sites within a TIN that are across multiple GAFs. The GAF assigned to each Participant will therefore be determined by calculating a weighted average GAF based on allowed charges for the primary care services used for attribution (see Table 8). The GAFs will be updated on an annual basis.

3.6.2 Retrospective Debits

CMS applies retrospective debits to the ESPs paid each quarter to account for prior ESP overpayments, beginning in the second quarter of the model. These debits are either due to beneficiary ineligibility or to duplicative service billing.

If a Participant fails to comply with model requirements or meets the grounds for termination, CMS may take compliance action and may require the Participant to repay ESPs it received. For example, if a Participant does not complete mandatory quality or care delivery reporting or uses the ESP in a prohibited manner, CMS may require repayment of a portion of or the entire ESP.
3.6.2.1 Debits for Beneficiary Ineligibility

CMS determines attribution and calculates quarterly ESPs in advance of each quarter. The prospective quarterly payment assumes that all beneficiaries attributed for the quarter continue to be eligible for the entire 3 months of the quarter. However, some beneficiaries become ineligible before or during the quarter. This happens if the beneficiary loses Part A or Part B coverage, joins a Medicare Advantage plan, loses Medicare as the primary payer, becomes incarcerated, or dies before or during the payment quarter. Beneficiaries not meeting MCP eligibility criteria on the first day of a month are not eligible for the ESP in that month. To account for this, in each quarterly payment cycle, CMS determines whether any beneficiary lost eligibility during any of the previous 4 quarters and computes a deduction from the upcoming quarter’s payment to reflect previous overpayments. This deduction is referred to as an MCP Payment Adjustment.

3.6.2.2 Debits for Duplicative Service Billing

If any clinician bills a CCM-related service identified in Table 9 for a beneficiary attributed to an MCP Participant in the same month, and it is not a clinician at the beneficiary’s attributed MCP organization, CMS deducts the ESP paid for that month from the MCP Participant’s future ESP payment. This prevents CMS from duplicative spending on care management services for attributed beneficiaries.

3.6.3 Example Calculation of the Enhanced Services Payment

In Q3 2024, Main Street Practice in Takoma, Washington has 500 attributed beneficiaries in their practice. The GAF for Takoma, Washington is 1.01 (101%). Main Street Practice is a Track 2 MCP Participant.

Of the 500 attributed beneficiaries, 85 of them are enrolled in LIS. Of the remaining 415, 95 beneficiaries are in clinical risk tier 4, 100 beneficiaries are in clinical risk tier 3, 110 beneficiaries are in clinical risk tier 2, and 110 beneficiaries are in clinical risk tier 1. Of the 95 beneficiaries in clinical risk tier 4, only 25 of them are also in social risk tier 4.

The Q3 2024 Enhanced Services Payment for Main Street Practice is calculated as follows:

- **Step 1**: Multiply the number of attributed beneficiaries in each tier by the applicable ESP PBPM amount.

<table>
<thead>
<tr>
<th>Number of Beneficiaries by Group</th>
<th>Track 2 PBPM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIS: 85</td>
<td>$25</td>
<td>$2,125</td>
</tr>
<tr>
<td>Clinical Risk Tier 1: 120</td>
<td>$4</td>
<td>$480</td>
</tr>
<tr>
<td>Clinical Risk Tier 2: 100</td>
<td>$5</td>
<td>$500</td>
</tr>
</tbody>
</table>

(continued)
### Table 12: Main Street Practice ESP PBPM Amounts (continued)

<table>
<thead>
<tr>
<th>Number of Beneficiaries by Group</th>
<th>Track 2 PBPM</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Risk Tier 3: 100</td>
<td>$7</td>
<td>$700</td>
</tr>
<tr>
<td>Clinical Risk Tier 4, Social Risk Tier 1, 2 or 3: 70</td>
<td>$8</td>
<td>$560</td>
</tr>
<tr>
<td>Clinical Risk Tier 4, Social Risk Tier 4: 25</td>
<td>$25</td>
<td>$625</td>
</tr>
<tr>
<td>Total: 500</td>
<td>N/A</td>
<td>$4,990</td>
</tr>
</tbody>
</table>

- **Step 2:** Apply geographic adjustment.
  
  $4,990 \times 1.01 = $5,039.90

- **Step 3:** Calculate final ESP.

  $5,039.90 \times 3 \text{ months} = $15,119.70

ESPs are subject to the Medicare sequestration and beneficiary cost sharing does not apply. This example reflects ESP amounts prior to application of MCP Payment Adjustments (see Section 3.6.2 above).
4 Prospective Primary Care Payment

4.1 Overview

The Prospective Primary Care Payment (PPCP) is designed to provide MCP Participants with upfront payment for primary care services to allow them to focus on providing in-office care based on need rather than maintaining revenue. Under FFS payment methodologies, organizations have a strong incentive to bring patients into the office to create a billable face-to-face service, even if phone calls or electronic communications would be a better means of meeting the patient’s needs or preferences.

MCP will employ a gradual transition away from fee-for-service (FFS) and to the PPCP by implementing the following payment policies by track:

- **Track 1: 0% PPCP and 100% FFS.** Track 1 Participants continue to bill and receive payment from Medicare FFS as usual (and Federally Qualified Health Centers (FQHCs) will continue to be paid according to the Medicare FQHC prospective payment system (PPS)).

- **Track 2: 50% PPCP and 50% FFS.** In Track 2, the PPCP will partially replace FFS revenue from primary care services for a practice’s attributed beneficiary population. Track 2 Participants receive a hybrid payment consisting of the PPCP with reduced FFS payments for primary care services.

- **Track 3: 100% PPCP and 0% FFS.** In Track 3, the PPCP will fully replace FFS revenue from primary care services. Participants receive an alternative to FFS payment made up fully of the PPCP and will receive zero pay for covered primary care services billed to FFS. CMS requires that Participants bill for PPCP Services provided, to the extent the services meet billing requirements.

The PPCP changes the payment mechanism for primary care from FFS to a prospective payment, promoting flexibility in how Participants deliver care, and allowing them to increase the breadth and depth of the primary care they deliver. It can support services to improve care coordination and enable Participants to serve patients in a way that best meets the needs of the patient, whether by email, phone, or patient portal or in alternative settings, such as the patient’s home.

During the initial implementation of the model, the PPCP will be calculated based on each Participant’s historical claims data for its attributed Medicare beneficiaries, resulting in a Participant-specific per-beneficiary-per-month (PBPM) payment rate. This historical rate will be adjusted each subsequent performance year to reflect updates in Medicare payment policy and utilization changes. In future years, CMS will explore updating this methodology to implement efficiency improvements and regional patterns. The updated methodology will not apply to FQHCs or Indian Health Programs (IHPs), which will continue to receive PBPM PPCPs that are based on
their historical claims data. Additional information on an updated PPCP methodology will be provided in future MCP Payment Methodology Papers.

### Navigating this section:
- Section 4.1 Overview
- Section 4.2 Services Included in or Impacted by PPCP
- Section 4.3 Calculation of the Historical PPCP PBPM Amount
- Section 4.4 Calculation of the Performance Year PPCP PBPM Amount
- Section 4.5 PPCP Partial Reconciliation
- Section 4.6 Reconciliation of FQHC Charges
- Section 4.7 FFS Payment
- Section 4.8 Monitoring PPCP Services and Billing

### 4.2 Services Included in or Impacted by PPCP

The primary care services that will be included in or affected by the PPCP are referred to as “Prospective Primary Care Payment Services,” or PPCP Services. MCP’s PPCP Services lists were derived from past Innovation Center models Comprehensive Primary Care Plus (CPC+) and Primary Care First (PCF), and updated to include more services and align with MCP Care Delivery requirements and goals. For example, Track 3 PPCP Services include behavioral health integration (BHI) services in alignment with the MCP Integration Domain of care delivery. Track 3 PPCP Services also include the MCP e-Consult (MEC), a new model specific e-consult code that MCP Clinicians can use for improved coordination. The BHI services and MEC codes are paid through FFS in Track 2 to allow Participants the opportunity to build a utilization base for these historically underutilized services, before incorporating these payments into the PPCP in Track 3.

Table 13 shows the Track 2 and Track 3 PPCP Services Healthcare Common Procedure Coding System (HCPCS) code lists. Services not included, such as immunizations and screenings, will continue to be paid through FFS.

**Table 13: Services Included in or Impacted by the PPCP**

<table>
<thead>
<tr>
<th>Service</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/outpatient visit E&amp;M</td>
<td>99202-99205, 99211-99215, 99354*, 99355*, 99415*, 99416*, G2212*</td>
</tr>
</tbody>
</table>

(continued)
### Table 13: Services Included in or Impacted by the PPCP (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home care/domiciliary care E&amp;M</td>
<td>99341, 99342, 99344*, 99345*, 99347-99350</td>
</tr>
<tr>
<td>Online digital E&amp;M</td>
<td>99421-99423</td>
</tr>
<tr>
<td>Audio-only telephone E&amp;M</td>
<td>99441-99443</td>
</tr>
<tr>
<td>Technology-based check-in services</td>
<td>G2010, G2012, G2252</td>
</tr>
<tr>
<td>Remote Physiologic Monitoring (RPM)</td>
<td>99091, 99453, 99454, 99457, 99458*</td>
</tr>
<tr>
<td>Remote Therapeutic Monitoring (RTM)</td>
<td>98975-98977, 98980, 98981*</td>
</tr>
<tr>
<td>Advance care planning</td>
<td>99497, 99498*</td>
</tr>
<tr>
<td>Welcome to Medicare and Annual Wellness Visits</td>
<td>G0402, G0438, G0439</td>
</tr>
<tr>
<td>Administration of HRA</td>
<td>96160, 96161</td>
</tr>
<tr>
<td>FQHC All-Inclusive visit</td>
<td>G0466, G0467</td>
</tr>
<tr>
<td>FQHC Initial Preventive Physical Examination (IPPE) visit or Annual Wellness Visit (AWV)</td>
<td>G0468</td>
</tr>
<tr>
<td>Distant site telehealth services (Rural Health Clinic (RHC)/FQHC)</td>
<td>G2025</td>
</tr>
<tr>
<td>FQHC virtual communication services</td>
<td>G0071</td>
</tr>
</tbody>
</table>

**Prospective Primary Care Payment Services Added in Track 3:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression, substance use disorder, and alcohol misuse screening and counseling services</td>
<td>G0396-G0397, G0442-G0444, G2011</td>
</tr>
<tr>
<td>Care management services for behavioral health conditions</td>
<td>99484</td>
</tr>
<tr>
<td>Cognition and functional assessment for patient with cognitive impairment</td>
<td>99483</td>
</tr>
<tr>
<td>Psychiatric Collaborative Care Model</td>
<td>99492, 99493, 99494, G2214, G0512</td>
</tr>
<tr>
<td>Interprofessional Consultation (IPC) and MCP e-Consult (MEC)</td>
<td>99452, G9037</td>
</tr>
</tbody>
</table>

*Add-on codes are included in the PPCP calculation.
†Codes 99344 and 99345 were discontinued as of January 1, 2023. CMS uses historical claims for these codes to calculate the PPCP.

### 4.2.1 Additional Considerations by Participant Type

As described above, for Standard Participants, the PPCP is based on primary care services on the PPCP Services list billed under the Medicare Physician Fee Schedule (PFS).

For FQHCs, the PPCP is based on the primary care services on the PPCP Services list (Table 13) billed under the Medicare FQHC PPS.
• FQHCs in Track 1 will continue to be paid according to the Medicare FQHC PPS.
• FQHCs in Tracks 2 and 3 will have their PPCP PBPM amounts calculated based on the specified Medicare FQHC PPS services in the PPCP Service list (Table 13). Services not listed as part of the PPCP, such as mental health services G0469 and G0470, will continue to be reimbursed outside of the PPCP PBPM at the Medicare FQHC PPS rate at the time of service.

For IHPs, the PPCP is based on the same set of services as for Standard Participants if the IHP bills the PFS. If the IHP bills the Medicare FQHC PPS, the PPCP is based on the same set of services as for FQHCs.

4.3 Calculation of the Historical PPCP PBPM Amount
The historical PBPM amount represents each MCP Participant’s average PBPM payment received from CMS for PPCP Services rendered to a group of attributed beneficiaries over a historical period prior to the initial implementation of the PPCP (called the PPCP Historical Base Period). The historical PBPM amount is used to estimate the amount of primary care that Participants will likely deliver during the performance year. CMS first defines the population of beneficiaries used to calculate the historical PBPM amount, and then calculates the historical payments made for PPCP Services provided to those beneficiaries.

To ensure that each Participant’s PPCP reflects, as much as possible, the current health status of their attributed beneficiaries throughout the model, CMS will rebase the PPCP historical PBPM amount every 3 years. This rebasing will help address the concern that a PPCP could perpetuate historically underfunded primary care and/or unmet primary care needs. The PPCP is a key component of payment reform under MCP, and requiring that Participants move to full PPCP in Track 3 makes them more dependent on PPCP rates than under previous models. These updates are intended to improve accuracy and equity. The rebased historical PPCP PBPM amount will then be adjusted based on the methods described in the sections below.

For PY 2024–PY 2026, the PPCP Historical Base Period is intended to be April 1, 2022–March 31, 2024. However, due to delays and disruptions in Medicare claims submission that occurred in Q1 2024 following a cyberattack, the PPCP Historical Base Period for PY 2024 was modified to be April 1, 2022 – December 31, 2023. For PY 2027–PY 2029, the PPCP Historical Base Period will be updated to October 1, 2024–September 30, 2026. Note that in January 2027, Participants in Track 1 will transition to Track 2 and Participants in Track 2 will transition to Track 3. Participants in Track 3 will remain in Track 3 and will have their PPCP Historical Base Period updated to October 2024–September 2026 along with all other MCP Participants. CMS may make changes to the PPCP Historical Base Period if deemed necessary.

10 The historical base period for PY 2024 was modified to be 21 months to account for claims disruption in Q1 2024 caused by a cyberattack.
4.3.1 Historical Population

The historical population includes all beneficiaries attributed to the MCP Participant in each of the quarters of the PPCP Historical Base Period. To determine the historical population, CMS uses historical claims to attribute beneficiaries to Participants during the PPCP Historical Base Period. The attribution methodology is detailed in Section 2 above. For each of quarter of attribution, the entire Standard Participant Taxpayer Identification Number (TIN) is used for attribution, rather than the subset of clinicians included on the MCP Clinician List, due to potentially incomplete information at the start of the model. Additionally, no other model overlap is removed from the PPCP historical populations. For FQHCs, current and historical CMS Certification Numbers (CCNs) are used, as described in Section 2.

Beneficiaries are included in the PPCP Historical Period only for the applicable portion of the period for which they were attributed and eligible. Beneficiaries are eligible if they meet the criteria listed in Section 2.2.

4.3.2 Historical Payments

To calculate the PPCP historical payments, CMS uses all Medicare payments made for PPCP Services to the MCP Participant for its historical attributed population during the PPCP Historical Base Period. Claims are eligible if:

- The service date on the claim was during a period when the beneficiary was attributed and eligible,
- The claim includes a procedure code for a PPCP Service (see Table 13), and
- The service was billed by a clinician with one of the specialties in Appendix A and the MCP Participant’s TIN or historical TIN (for Standard Participants), or the service was billed by a CCN associated with the MCP Participant’s TIN (for FQHCs).

CMS adjusts historical eligible PPCP Services claims for the following:

- Sequestration: When sequestration was in effect for part of the PPCP Historical Base Period, CMS increases the historical payments based on the historical sequestration reductions.
- Merit-based Incentive Payment System (MIPS) Adjustment: CMS removes the effects of any MIPS quality payment adjustments that were applied to applicable Participants during the PPCP Historical Base Period.
- Geographic Adjustment Factors: CMS will remove the effect of the Geographic Adjustment Factors (GAFs) that were applied to claim payments in the PPCP Historical Base Period.

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11 CMS may modify this approach for the first rebasing of the PPCP, once more complete information on historical clinicians has been collected.

12 The service date for carrier claims is the “line first expense date” and for outpatient claims is the “revenue center date.”
For each MCP Participant, CMS sums the Medicare FFS payment amounts for all eligible claims, as identified above. This does not include amounts paid by third parties.

### 4.3.3 Historical PBPM Calculation

The historical PPCP PBPM amount is calculated as the historical payments divided by the historical eligible beneficiary months, as defined above.

Most Participants have 2 years of historical data to create PBPM estimates. However, if a Participant does not, the most recent year of the PPCP Historical Base Period is used. If a Participant has fewer than 125 beneficiaries attributed per quarter, on average, for at least the entirety of the most recent year of the PPCP Historical Base Period, then the Participant is assigned a historical PPCP PBPM amount that is calculated as a weighted average of its historical PPCP PBPM amount using the available data and the median historical PPCP PBPM amount among organizations of the same Participant type (Standard or FQHC) in its region.

### 4.4 Calculation of the Performance Year PPCP PBPM Amount

Once the historical PPCP PBPM amount has been calculated, CMS applies several adjustments to update the historical amount to the upcoming performance year. These adjustments account for varying geography, changes in the PFS and FQHC PPS rates, expected MIPS adjustments, and changes in utilization. Once the PBPM rate has been calculated for the upcoming performance year, it is then reduced by 50% if applicable (i.e., for Track 2 Participants).

#### 4.4.1 Geographic Adjustment

Like the Enhanced Services Payment (ESP) PBPM amount, the PPCP PBPM amount will be adjusted by each Participant’s applicable GAF (as represented by the Geographic Practice Cost Index for the payment year). FQHCs will receive the applicable GAF under the PPS, while Standard Participants will receive the applicable GAF under the PFS. The GAFs will be updated on an annual basis.

#### 4.4.2 Changes in the PFS and FQHC PPS

CMS regularly updates the Medicare Physician Fee Schedule to adjust for changes to the national conversion factor (CF) and the GAF for each locality, as well as modify rate scales for existing or new service codes. Each year, for Standard MCP Participants, CMS adjusts the PPCP historical PBPM amount to reflect the PFS factors that will be in effect during the performance year. For FQHC Participants, before the start of each performance year, CMS reviews the charges for the most recent quarter to determine whether an FQHC Participant’s performance year PPCP PBPM amount should be based on the FQHC PPS rates or the FQHC’s recent charge levels (whichever is less).

CMS occasionally introduces new codes into the PFS and the FQHC PPS that may affect calculation of the PPCP PBPM amounts for the performance year. CMS will assess the relevance of these codes as they become finalized and adjust as needed.
4.4.3 MIPS Payment Factors

The PPCP will include any adjustments for which individual MCP Clinicians are eligible under MIPS. For each performance year, CMS will identify individual MCP Clinicians who are subject to MIPS adjustments, and what their adjustments are. MCP Clinicians who are not subject to MIPS in the performance year will be presumed to have no adjustment to their payment rates and will be assigned a MIPS adjustment factor of 1.0. CMS calculates an overall MIPS adjustment to apply to each Participant’s PPCP as the weighted average of the MCP Clinician-level MIPS adjustments, based on the volume of Medicare allowed charges for primary care services eligible for attribution (see Table 8) submitted by each MCP Clinician.

4.4.4 Utilization Adjustments

The historical PPCP PBPM amount is also updated annually to reflect increases in the utilization of PPCP Services. To determine whether a utilization adjustment is warranted, CMS calculates the Participant’s average number of PPCP Service visits provided to its attributed beneficiaries during the performance year and compares it to the average number of PPCP Service visits provided to its attributed beneficiaries during the PPCP Historical Base Period. PPCP Service visits are defined as services included in Table 13. If the average number of PPCP Service visits in the performance year is higher than the average number in the PPCP Historical Base Period by an amount that results in an increased PPCP PBPM amount of more than $2, an upward adjustment is made to the PPCP PBPM amount for the next performance year. The upward adjustment is equal to the increase in the PBPM PPCP between the historical year and performance year, less $2. The adjusted amount will apply for that one performance year and will reflect the amount that the PPCP PBPM would have increased had those increased PPCP Services been included in the PPCP Historical Base Period.

4.4.5 Final PPCP PBPM Amount

The final step in the calculation of a Participant’s performance year PPCP PBPM amount is the application of the share paid prospectively in Tracks 2 and 3. The updated historical PPCP PBPM amount is reduced by 50% in Track 2 to reflect the 50/50 PPCP/FFS revenue split and is not reduced at all in Track 3 to reflect the PPCP service revenue being paid on a fully prospective basis in Track 3.

The resulting value reflects the share of expected Medicare monthly payments for PPCP Services for the Participant’s average MCP beneficiary that will be paid through the PPCP in each track.

4.4.6 Retrospective Debits

CMS determines attribution and calculates quarterly PPCPs in advance of each quarter, assuming that all beneficiaries attributed for the quarter continue to be eligible for the entire 3 months of the quarter. When a beneficiary becomes ineligible before or during the quarter, CMS follows the same process for retrospective debits, called MCP Payment Adjustments, as for the ESP. See Section 3.6.2 for details.
4.4.7 Example Calculation of Quarterly PPCP

The prospective quarterly PPCP for Track 2 and 3 Participants is calculated as:

\[ 3 \times \text{Attributed Beneficiaries} \times (\text{PBPM PPCP}) - \text{PPCP MCP Payment Adjustment Debit} \]

As an example, Main Street Practice is a Standard Participant with 500 attributed beneficiaries in the quarter and is in Track 2. They have $325 in PPCP MCP Payment Adjustments (for overpayments due to beneficiary ineligibility). Their PBPM PPCP is $12.50 (reduced from $25 by 50%). Their quarterly PPCP is \(3\times500\times(12.50) - 325 = 18,425\).

This example calculation is prior to the application of sequestration (if applicable).

4.5 PPCP Partial Reconciliation

An annual reconciliation is conducted after the close of each performance year with the intent of increasing the accuracy of payment for services actually provided during that performance year. This reconciliation is intended to accomplish two aims: (1) protect CMS against paying more than expected amounts for PPCP Services for MCP attributed beneficiaries, and (2) maintain incentive neutrality for MCP Participants, ensuring they are free to deliver enhanced services but are not incentivized to decrease FFS billings to achieve a more favorable financial outcome.

There are two steps to conducting the Partial Reconciliation:

- **Step 1.** Calculate the PBPM amount for PPCP Services provided to attributed beneficiaries by primary care organizations other than the MCP Participant (“outside-of-Participant”) during the historical calculation period and during the performance year being reconciled. To be included in this amount, the service must:
  - Be billed by a TIN or FQHC CCN other than that of the MCP Participant,
  - Have a procedure code in the PPCP Services code list (see Table 13),
  - For services paid under the PFS only, be rendered by an eligible primary care clinician, as identified in Appendix A, except for General and Medical physician assistants (taxonomy codes 363A00000X and 363AM0700X) and certain nurse practitioners.\(^{13}\) This approach safeguards against inadvertently including non-primary care services provided by physician assistants and nurse practitioners in the PPCP Partial Reconciliation.
  - For services paid under the PFS only, be provided in one of the settings listed in Table 14.

\(^{13}\) CMS will specify the applicable nurse practitioner taxonomy codes in future PMPs, prior to the calculation of the first PPCP Partial Reconciliation in 2026.
### Table 14: Eligible Place of Service Codes for PPCP Partial Reconciliation

<table>
<thead>
<tr>
<th>Place of Service Name</th>
<th>Place of Service Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth (provided other than in patient’s home)</td>
<td>02</td>
</tr>
<tr>
<td>Indian Health Service Freestanding Facility</td>
<td>05</td>
</tr>
<tr>
<td>Indian Health Service</td>
<td>06</td>
</tr>
<tr>
<td>Tribal 638 Freestanding Facility</td>
<td>07</td>
</tr>
<tr>
<td>Tribal 638 Provider-Based Facility</td>
<td>08</td>
</tr>
<tr>
<td>Telehealth (provided in patient’s home)</td>
<td>10</td>
</tr>
<tr>
<td>Office</td>
<td>11</td>
</tr>
<tr>
<td>Home</td>
<td>12</td>
</tr>
<tr>
<td>Assisted Living Facility</td>
<td>13</td>
</tr>
<tr>
<td>Group Home</td>
<td>14</td>
</tr>
<tr>
<td>Mobile Unit</td>
<td>15</td>
</tr>
<tr>
<td>Temporary Lodging</td>
<td>16</td>
</tr>
<tr>
<td>Walk-in Retail Health Clinic</td>
<td>17</td>
</tr>
<tr>
<td>Place of Employment–Worksite</td>
<td>18</td>
</tr>
<tr>
<td>Off Campus–Outpatient Hospital</td>
<td>19</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>20</td>
</tr>
<tr>
<td>On Campus–Outpatient Hospital</td>
<td>22</td>
</tr>
<tr>
<td>Custodial Care Facility</td>
<td>33</td>
</tr>
<tr>
<td>Independent Clinic</td>
<td>49</td>
</tr>
<tr>
<td>Federally Qualified Health Center</td>
<td>50</td>
</tr>
<tr>
<td>Community Mental Health Center</td>
<td>53</td>
</tr>
<tr>
<td>Mass Immunization Center</td>
<td>60</td>
</tr>
<tr>
<td>Public Health Clinic</td>
<td>71</td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>72</td>
</tr>
<tr>
<td>Other Place of Service</td>
<td>99</td>
</tr>
</tbody>
</table>

If the Participant changed tracks between the historical calculation period and the performance year, both calculations will be based on the PPCP Services code list for the Participant’s track in the performance year.

- **Step 2.** Determine the PPCP Partial Reconciliation amount based on the increase in the outside-of-Participant amount calculated in Step 1.
Making Care Primary: Payment and Attribution Methodologies

- If the increase in the outside-of-Participant amount is less than $2 PBPM, then there is no Partial Reconciliation.
- If the increase in the outside-of-Participant amount is between $2 and $7 PBPM (inclusive), then CMS makes a one-time downward adjustment to the Participant’s PPCP such that the difference equals $2 PBPM.
- If the increase in the outside-of-Participant amount is greater than $7 PBPM, then CMS makes a one-time downward adjustment of $5 PBPM to the Participant’s PPCP (in other words, the maximum downward adjustment is $5 PBPM).

The PPCP Partial Reconciliation is conducted annually at the Participant level. Amounts calculated from the PPCP Partial Reconciliation are debited against one or more quarterly payments in the subsequent performance year. The first PPCP Partial Reconciliation will take place in PY 2026 and will reconcile PY 2024 and PY 2025 (18 months) together. Subsequent PPCP Partial Reconciliations will reconcile one performance year each (i.e., PY 2026 will be reconciled in PY 2027).

MCP will not reconcile the PPCP to adjust for decreases in the outside-of-Participant amount outlined in Step 1. Instead, MCP will update Participants’ PPCP to reflect increases in use of PPCP Services as outlined in Section 4.4.4.

Please see Figure 5 for an example PPCP Partial Reconciliation calculation for an example Participant.

**Figure 5: Example PPCP Partial Reconciliation Calculation**

<table>
<thead>
<tr>
<th>Example: PPCP Partial Reconciliation Calculation for Participant “Main Street”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Street Practice has 5,500 attributed beneficiary months in the performance year being reconciled.</td>
</tr>
<tr>
<td><strong>Step 1:</strong> The outside-of-Participant PPCP PBPM amount in the historical calculation period was $4.</td>
</tr>
<tr>
<td><strong>Step 2:</strong> The outside-of-Participant PPCP PBPM amount in the performance year was $7.</td>
</tr>
<tr>
<td><strong>Step 3:</strong> Therefore, the difference between the two PBPM amounts is $3 ([Step 2] – [Step 1] = $7 – $4), and Main Street Practice will receive a debit to future payment.</td>
</tr>
</tbody>
</table>

Because the change in the outside-of-Participant amount is more than $2, Main Street Practice will receive a downward adjustment to a future PPCP. The outside-of-Participant amount is allowed to vary by up to $2 PBPM, so the downward adjustment is $3 - $2 = $1 PBPM.

The payment debit to Main Street Practice will be $1 * (5,500 beneficiary months from performance year) = $5,500. This example assumes that Main Street Practice did not change tracks between the historical period and the performance year.
4.6 Reconciliation of FQHC Charges
The FQHC PPCP PBPM amounts are Participant-specific and depend on the most recently available PPS reimbursement rates and changes to charges observed 2-3 months prior to the FQHC starting in Track 2 or 3. If an FQHC updates their charges or the PPS reimbursement rates are updated, the PPCP PBPM amount calculated for the FQHC Participant will be inaccurate. Thus, 2 quarters following each payment quarter, CMS examines the Medicare payments in that payment quarter to see if they were consistent with the basis for that performance year’s PPCP PBPM amount (i.e., if the FQHC has changed its charge levels). If the payments for the PPCP Services differ from what was used to calculate the FQHC’s PPCP PBPM amount for the applicable performance year, CMS makes a one-time adjustment, either up or down, in the payment made 2 quarters later such that the PPCP for the reconciled quarter is consistent with the FQHC’s actual charges for that quarter. For example, CMS will make updated payments for Q1 2025 PPCPs in Q3 2025. The reconciliation of FQHC charges will occur for the first time in Q1 2025, for the first model quarter, Q3 2024.

4.7 FFS Payment
Practices will continue to submit claims at the time of service for the PPCP Services listed in Table 13. Claims will be processed as usual, and all reimbursements will be determined according to standard Medicare PFS and FQHC PPS rules. The net amount remitted is reduced by the proportionate share that the Participant receives through the PPCP. In Track 2, these FFS payments will be reduced by 50% and in Track 3 these FFS payments will be reduced by 100%. The PPCP and reduced FFS payments will only apply to Medicare payments for the applicable PPCP Service claims listed in Table 13 for beneficiaries attributed to Track 2 and 3 Participants. CMS requires that Participants bill for services provided, to the extent the services meet billing requirements.

Beneficiaries are not responsible for coinsurance on the PPCP but continue to be responsible for the usual Part B deductible and coinsurance on FFS claims for PPCP Services. Beneficiary coinsurance amounts are calculated on the original full allowed claim amount, prior to reduction on the claims.

4.8 Monitoring PPCP Services and Billing
For CMS, the potential reduction in claims associated with this Participant-level shift away from traditional FFS payment could have operational implications on attribution, risk adjustment, rebasing of the PPCP, monitoring, and evaluation. CMS will monitor the change in claims volume and billing patterns for Participants over time. This will help safeguard against anomalies that could negatively impact the quality of care provided to MCP Participants or incur unnecessary costs to CMS. CMS also intends to audit any outlier Participants to ensure that Participants do not over-bill PPCP Services.
5 Performance Incentive Payment

5.1 Overview of the PIP

The MCP Performance Incentive Payment (PIP) is an upside-only payment available for Participants in all tracks, to reward Participants for performance on quality and cost/utilization as measured by the MCP Performance Measure Set, which forms the cornerstone of MCP’s quality strategy. In particular, the Performance Measure Set consists of a diverse set of performance measures that are aligned with the MCP Care Delivery requirements, in keeping with an emphasis on whole-person care. In addition to providing the foundation for the PIP, the quality measures in the MCP Performance Measure Set will also be used by CMS for purposes of monitoring and evaluating the overall quality of care in MCP. In 2024, CMS will release the MCP Quality Reporting Guide, which will include additional information on the MCP Performance Measure Set (including details on specifications) and instructions on data collection and reporting procedures.

The specific way in which the performance measures determine the PIP differs by Participant type and track, as described below. In brief, the PIP is calculated as a percentage of the sum of the Participant’s annual fee-for-service (FFS) and Prospective Primary Care Payment (PPCP) revenue for the PPCP Services listed in Table 13 provided to its MCP-attributed beneficiaries. That percentage is determined by the Participant’s performance on the quality measures relative to the criteria for those measures for the Participant’s track.

For each Participant, a total PIP amount will be calculated for each performance year (except PY 2024). The first part of the total PIP will be paid upfront in the first quarter of the performance year, and the second part will be paid in the third quarter of the following year (reconciled based on performance).

Navigating this section:
- Section 5.1 Overview of the PIP
- Section 5.2 MCP Performance Measure Set
- Section 5.3 Measure Scoring and Determination of PIP

5.2 MCP Performance Measure Set

The MCP Performance Measure Set (shown below in Table 15) is a diverse set of measures of clinical quality, patient-reported outcomes, utilization, and cost. Building on CMS’s broader quality measurement strategy, measures were selected to be actionable, clinically meaningful, and aligned with measures used in current value-based programs, including the CMS Universal Measure Set.

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Quality Payment Program (QPP), Merit-based Incentive Payment System (MIPS) Value Pathways (MVP)\(^\text{15}\), and MIPS Alternative Payment Model (APM) Performance Pathway (APP) measure sets\(^\text{16}\), and the Consensus-Based Entity (CBE) Core Quality Measures Collaborative (CQMC)\(^\text{17}\). In selecting measures, CMS sought to minimize Participant burden for reporting and considered feasibility of measure collection for all potential applicants.

### Table 15: MCP Performance Measure Set

<table>
<thead>
<tr>
<th>Measure Title &amp; Steward (ID, if applicable)</th>
<th>Data Source</th>
<th>Patients Included</th>
<th>Required for Track 1</th>
<th>Required for Track 2</th>
<th>Required for Track 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure NCQA (CMS165)</td>
<td>eCQM, Participant-reported</td>
<td>All patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Diabetes: Glycemic Status Assessment Greater than 9% NCQA (CMS122)</td>
<td>eCQM, Participant-reported</td>
<td>All patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Colorectal Cancer Screening NCQA (CMS130)</td>
<td>eCQM, Participant-reported</td>
<td>All patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Screening for Depression and Follow-up Plan CMS (CMS52)</td>
<td>eCQM, Participant-reported</td>
<td>All patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Depression Remission at 12 Months MN Community Measurement (CMS159)</td>
<td>eCQM, Participant-reported</td>
<td>All patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Person-Centered Primary Care Measure (PCPCM) American Board of Family Medicine (ABFM)</td>
<td>Survey measure (^a)</td>
<td>All patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Screening for Social Drivers of Health CMS (Quality ID#487)</td>
<td>CQM, Participant-reported</td>
<td>All patients</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total Per Capita Cost (TPCC) CMS</td>
<td>Claims-based, calculated by CMS</td>
<td>MCP Beneficiaries</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Department Utilization (EDU) NCQA</td>
<td>Claims-based, calculated by CMS</td>
<td>MCP Beneficiaries</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Total Per Capita Cost (TPCC) Continuous Improvement CMS</td>
<td>Claims-based, calculated by CMS</td>
<td>MCP Beneficiaries</td>
<td>X Only MCP Standard Participants</td>
<td>X Only MCP Standard Participants</td>
<td>X Only FQHCs/IHPs</td>
</tr>
<tr>
<td>Emergency Department Utilization (EDU) Continuous Improvement CMS</td>
<td>Claims-based, calculated by CMS</td>
<td>MCP Beneficiaries</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

\(^a\) The survey measure will be reported by a CMS-approved vendor or Qualified Clinical Data Registry (QCDR) in contract with Participant.

\(^\text{15}\) [https://qpp.cms.gov/mips/mips-value-pathways](https://qpp.cms.gov/mips/mips-value-pathways)
\(^\text{17}\) [https://www.qualityforum.org/CQMC_Core_Sets.aspx](https://www.qualityforum.org/CQMC_Core_Sets.aspx)
As shown in Table 15, assessment on quality measures will vary by track. Track 1 Participants will be assessed on three clinical quality measures and patient experience of care. Under Tracks 2 and 3, additional clinical quality measures will be added to the quality assessment to reflect the advanced care delivery expectations for these tracks, to include Screening for Depression and Follow-up Plan, Depression Remission at 12 months, and Screening for Social Drivers of Health. Additionally, for Tracks 2 and 3, claims-based measures of cost and utilization will be added to the quality assessment: Total Per Capita Cost (TPCC) and Emergency Department Utilization (EDU), with Standard Participants also being assessed on TPCC Continuous Improvement (CI), and Federally Qualified Health Center (FQHC) and Indian Health Program (IHP) Participants also being assessed on EDU Continuous Improvement.

CMS will determine what version of each measure’s technical specifications will be included in the MCP Performance Measure Set for the applicable performance year, based on the guidance of the respective measure stewards. CMS will notify MCP Participants of the specifications for each measure that will be included in the MCP Performance Measure Set a minimum of 30 days before the performance year. When applicable, CMS will reference the specifications for electronic Clinical Quality Measures (eCQMs) and Clinical Quality Measures (CQMs) found in the electronic Clinical Quality Improvement (eCQI) Resource Center at https://ecqi.healthit.gov/ep-ec-ecqms.

Certain MCP measures 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 on the CMS Notices and Disclaimers webpage at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.

5.2.1 Data sources
The measures in the MCP Performance Measure Set are calculated using data from a variety of sources, in accordance with the measure types (eCQM, CQM, claims-based, and survey):

- **eCQMs** are submitted by Participants via submission of a Quality Reporting Document Architecture (QRDA) III file to CMS. The use of QRDA III format for eCQM reporting shall be in accordance with Health IT Requirements as listed in the MCP Request for Applications (RFA), and will be mirrored in the forthcoming MCP Quality Reporting Guide.

- **CQMs** are submitted by Participants via submission of a JavaScript Object Notation (JSON) file to CMS.

- **Claims-based measures** are calculated by CMS using administrative data.

- **The survey measure, PCPCM**, is reported by third-party survey vendors or a Qualified Clinical Data Registry (QCDR) in contract with Participants. Please see the Health IT Requirements in the MCP RFA for more information on capabilities needed to report quality measures.
5.2.2 Level of Assessment

To support total practice transformation, all non-claims-based measures will be assessed for a Participant’s total patient population (including all payers and the uninsured). However, claims-based measures will be assessed for a Participant’s MCP-attributed beneficiary population.

- **Requirement for Standard Participants and for IHPs that also bill using the Physician Fee Schedule (PFS):** For eCQMs, the clinicians included in the MCP QRDA III file must align with the clinicians who were active on the MCP Clinician List. Accordingly, the MCP QRDA III file must include all National Provider Identifier (NPI) and Taxpayer Identification Number (TIN) combinations that were active at any time during the performance year, as indicated in the Participant’s MCP Clinician List. Participants must report all measures at the MCP TIN-level. Measures should include patients who were seen one or more times at any of the Participant’s locations during the performance year by one or more clinicians who were active on the Participant’s MCP Clinician List at any point during the performance year and who meet the criteria as specified in each measure. CMS uses MCP Clinician List and TIN rosters to validate the NPIs and TINs reported in Participants’ MCP QRDA III files. Participants are encouraged to work with their health IT vendor to ensure that they have the capability to report all required NPIs in the MCP QRDA III file. Participants are responsible for the completeness of their QRDA files.

- **Requirement for FQHCs and for IHPs that do not bill using the PFS:** FQHCs, and IHPs that do not bill the PFS, are not required to submit an MCP Clinician List. Instead, these Participants submit a list of MCP FQHC sites. Therefore, for eCQMs the MCP QRDA III file is submitted according to the measure specifications, and there will be validation of the TINs only.

5.2.3 Measure Assessment Frequency

MCP Participants shall report on all measures, as applicable, as required by track and Participant type (FQHC, IHP, or Standard Participant). Please reference Table 15.

- **All eCQM and CQM measures** in the MCP Performance Measure Set are reported annually. For the eCQM and CQM measures, the first tentative reporting period is January 2 through February 28, 2026. Measures reported during this period will be used to determine PIPs for PY 2025.

- **All claims-based measures** will be calculated annually by CMS and do not require separate reporting by Participants. Similar to the timing of eCQM and CQM reporting, claims-based measures will be calculated in 2026, to inform PIPs for PY 2025.

- **The PCPCM survey** will be fielded annually beginning March 2025, at the earliest. Participants will contract with a CMS-approved vendor by a date to be determined by CMS, and authorize such vendor to submit information, including the MCP Standard Participant’s
PCPCM results, to CMS on behalf of the MCP Standard Participant by a date and in a manner to be specified by CMS.

- Beginning PY 2025, for Track 1 Participants, CMS will pay for the survey implementation and administer the survey, in partnership with a contracted survey vendor or QCDR.
- Beginning PY 2025, for Track 2 and 3 Participants, the Participant shall pay for the survey fielding and contract with a CMS-approved vendor or QCDR to administer the survey.

MCP Participants must submit all clinical quality measures that are listed in the MCP Performance Measure Set to CMS during the defined reporting period for eCQMs and CQMs as communicated in the MCP Quality Reporting Guide. Participants who do not report as required will not be eligible for a PIP for the performance year.

### 5.2.4 Cost and Utilization Measures

#### 5.2.4.1 Total Per Capita Cost

All Participants in Tracks 2 and 3 will be assessed on cost as part of the PIP. The selected cost measure is TPCC, using the specifications adapted from MIPS for Primary Care First (PCF). The TPCC measure is calculated from claims and does not require Participant reporting. Accounting for 18.5% of the total PIP Percentage Bonus, the TPCC measure evaluates the total costs of care (across Parts A and B, excluding Part D) provided to MCP beneficiaries. The TPCC measure is payment-standardized (as represented by standardized allowed charges) and risk-adjusted; this means that CMS will control for variations in cost due to geographic area and beneficiary risk/comorbidities. When calculating the TPCC measure, ESPs, PIPs, and Upfront Infrastructure Payments (UIPs) will not be counted. Performance on the TPCC measure will be assessed annually based on comparison to regional TPCC benchmarks. Participants retain a pro rata share of the maximum payment for the TPCC component of the PIP based on how their scores compare to the TPCC lower and upper benchmarks.

Beneficiaries attributed to MCP Participants are the eligible population for the calculation of TPCC scores. Total costs of care (as represented by standardized allowed charges) are included in the measure calculations for each attributed beneficiary for each quarter of the performance year in which they were attributed and eligible. Standardized allowed charges are used to account for differences in Medicare payments for the same services across Medicare providers. Payment standardization also accounts for differences in Medicare payment unrelated to the care provided, such as those from payment adjustments supporting larger Medicare program goals (e.g., indirect
TPCC is calculated as an observed-to-expected (O/E) ratio. For each Participant, observed costs are compared with expected costs, risk-adjusted for beneficiary comorbidities. An O/E ratio greater than 1 represents greater-than-expected per capita cost, and a ratio less than 1 represents less-than-expected per capita cost. **TPCC is an inverse measure; lower O/E ratios reflect better performance.**

### 5.2.4.2 Emergency Department Utilization

The EDU component of the PIP, accounting for 18.5% of the total PIP Percentage Bonus, is designed to reward Participants that take sustained actions to improve the overall health of their attributed beneficiaries and reduce potentially avoidable utilization of the emergency department. The EDU measure is calculated using Medicare Part A and Part B claims. The EDU is limited to outpatient visits that do not result in hospital admission. Refer to the NCQA HEDIS® Technical Specifications for this measure. CMS will calculate this measure for MCP Participants using claims data; therefore, it requires no reporting on the part of Participants.

A Participant’s performance on this measure will be calculated using Medicare claims data and will be based on the NCQA Healthcare Effectiveness Data and Information Set® (HEDIS®) specifications. Because the HEDIS® measure is written for health plans, some modifications may be necessary to make the measure applicable to MCP. For example, MCP has its own set of beneficiary eligibility requirements and, in fact, its own specifically defined patient population, thus MCP beneficiaries will be used as the eligible population for the measure. Since MCP beneficiaries vary quarter to quarter, and even month to month as beneficiary eligibility is retroactively examined, a full 12 months of continuous eligibility is not required. Emergency department utilization in any month in which an MCP beneficiary is attributed and eligible will be used for the measure. This means that Participants are responsible only for the months in which a beneficiary is attributed to their organization.

Participant-level EDU scores are calculated as O/E ratios, where expected utilization is the predicted utilization rate that has been risk-adjusted to reflect the attributes of the Participants’ attributed beneficiaries. An O/E ratio greater than 1 represents ED utilization that is higher than the expected average for a comparable beneficiary population, and a ratio less than 1 represents utilization that is less than the expected average. **EDU is an inverse measure; lower O/E ratios reflect better performance.**

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18 For more information, please refer to the “CMS Price (Payment) Standardization—Basics” and “CMS Price (Payment) Standardization—Detailed Methods” documents posted on the Research Data Assistance Center (ResDAC): https://www.resdac.org/articles/cms-price-payment-standardization-overview
5.3 Measure Scoring and Determination of PIP

5.3.1 Overview of the PIP Methodology

The PIP is an upside-only bonus and will be calculated as a percentage (called the PIP Percentage Bonus) of the sum of FFS and PPCP amounts paid to each Participant for PPCP Services for their attributed beneficiaries. A Participant’s MCP performance measures will be scored annually for the purposes of determining their PIP.

To be eligible to receive a PIP for a performance year:

- Participants must report all required measures from the MCP Performance Measure Set, according to their track and Participant type (see Table 15).
- Beginning in PY 2026, Track 2 and Track 3 Participants must also pass the “TPCC Threshold for PIP Eligibility,” defined as performing at or better than the national 30th percentile\(^{19}\) on the TPCC measure. See Section 5.2.4.1 for a description of the TPCC measure and Section 5.3.4 for information on the TPCC Threshold for PIP Eligibility.

Performance expectations, and opportunities to earn additional revenue through the PIP, increase across tracks. The potential PIP Percentage Bonus increases across tracks, as follows:

- Track 1 Participants will be eligible for a maximum PIP Percentage Bonus of 3%.
- Track 2 Participants will be eligible for a maximum PIP Percentage Bonus of 45%.
- Track 3 Participants will be eligible for a maximum PIP Percentage Bonus of 60%.

There are no restrictions or requirements for how Participants may spend their PIP revenue. Participants are permitted to share a portion of the PIP with their rostered Specialty Care Partners; however, this is not required. If the MCP Participant is sharing the PIP, this arrangement must be detailed in the Collaborative Care Arrangement (CCA) between the MCP Participant and the Specialty Care Partner.

5.3.2 Calculation of Quality Scores

A Participant’s quality scores are a key component in calculating the Participant’s PIP Percentage Bonus. CMS will calculate Participants’ scores for each applicable quality measure by comparing the Participant’s measure result to the benchmark (or set of benchmarks) established for the measure. The general benchmark approach is described in Section 5.3.2.1 and the measure scoring approach in Section 5.3.2.2.

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\(^{19}\) The TPCC measure is an inverse measure, where lower measure values mean better performance, Participants “exceed” the national 30th percentile benchmark by having lower TPCC measure values than the benchmark.
5.3.2.1 Benchmark Calculation

CMS will calculate the benchmarks for each measure. As shown in Table 16, MCP will use national benchmarks for all eCQMs and the Screening for Social Drivers of Health measure, and regional benchmarks for utilization and cost measures (EDU and TPCC). This will hold all Participants to the same quality standard for clinical care, while recognizing geographic differences and considerations for utilization and cost data.

Benchmarks for MCP will be derived from the most recently available data that allows release of benchmarks prior to the performance year. The proposed benchmark populations are outlined in Table 16 below. CMS reserves the right to deviate from the benchmark schedule in order to ensure that the benchmarks used are a fair and accurate comparison. Additional measure-specific restrictions may be placed on the benchmark population to eliminate organizations with missing or zero-value measure scores, to ensure that all practices contributing data meet the minimum case counts required by measure specifications, and to otherwise ensure the benchmark population allows for a fair comparison to Participants.

Table 16: Proposed Benchmark Populations by Measure

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Benchmark Reference Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>MIPS (National)</td>
</tr>
<tr>
<td>Diabetes: Glycemic Status Assessment Greater than 9%</td>
<td>MIPS (National)</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>MIPS (National)</td>
</tr>
<tr>
<td>Screening for Depression and Follow-up Plan a</td>
<td>MIPS (National)</td>
</tr>
<tr>
<td>Depression Remission at 12 months a</td>
<td>MIPS (National)</td>
</tr>
<tr>
<td>Person-Centered Primary Care Measure (PCPCM)</td>
<td>Not applicable (full credit given for reporting in PY 2025 and PY 2026)</td>
</tr>
<tr>
<td>Screening for Social Drivers of Health a</td>
<td>MIPS (National)</td>
</tr>
<tr>
<td>Total Per Capita Cost (TPCC) a</td>
<td>Regional (quality scoring)</td>
</tr>
<tr>
<td>Emergency Department Utilization (EDU) a</td>
<td>Regional (National (TPCC Threshold for PIP Eligibility)</td>
</tr>
<tr>
<td>Emergency Department Utilization (EDU) Continuous Improvement a, c</td>
<td>Participant EDU score in prior year</td>
</tr>
</tbody>
</table>

a Tracks 2 and 3 only.
b Standard Participants only, not IHPs or FQHCs.
c Only IHP and FQHC Participants.

TPCC and EDU Benchmark Populations

The benchmark population for the TPCC and EDU measures consists of MCP Participants and non-participating primary care organizations. For purposes of these calculations, a benchmark organization is a virtual construct solely for the purpose of calculating performance benchmarks for
the PIP. Benchmark organizations are defined as all primary care clinicians billing under the same TIN. This list of primary care taxonomy codes is the same as the MCP eligible clinician taxonomies (see Appendix A).

Total per capita costs and emergency department visits are included in the measure calculations for each attributed beneficiary for each quarter of the performance year in which they were attributed and eligible. If a beneficiary is attributed to multiple benchmark organizations within the same year, then their cost/utilization would contribute to only one organization based on attribution.

Note that the benchmark population for the purposes of scoring the TPCC measure will be a *regional* population, and the MCP Participants and non-participating organizations included in that population will be those providing primary care services in each MCP region. For the purposes of determining the TPCC Threshold for PIP Eligibility, described in Section 5.3.4, a *national* benchmark population will be used, comprised of MCP Participants and non-participating organizations providing primary care services across the nation.

Because the TPCC and EDU measures are inverse measures, where lower performance rates indicate better quality, the benchmark percentiles for those measures are calculated by sorting the benchmark populations’ results in descending, rather than ascending, order.

### 5.3.2.2 Measure Scoring and Percentage of Maximum PIP

MCP’s scoring structure allows Participants to achieve tiered levels of success. As shown below in Table 17, Table 18, and Table 19, CMS has set lower and upper benchmarks for each measure. The benchmarks will be set to the specified percentiles of measure performance among the benchmark population specific to each measure. Lower benchmarks for the non-CI measures are set at the 50th percentile of performance among the benchmark population, and upper benchmarks are set at the 70th percentile in Tracks 1 and 2 and the 80th percentile in Track 3. The upper benchmark progresses from the 70th percentile in Tracks 1 and 2 to an 80th percentile in Track 3 to incentivize performance improvement over time. For the CI measures, the lower benchmark is performance improvement over the prior year of at least 3% and the upper benchmark is performance improvement of at least 5%.

Participant measure results are compared to the benchmarks, with credit given individually for exceeding each of the benchmarks. Except where otherwise noted, Participants will receive a score of 0.5 (“half credit”) if they meet or exceed the *lower benchmark* for a measure. Participants will receive a score of 1.0 (“full credit”) if they meet or exceed the *upper benchmark* for a measure. Participants not meeting the lower benchmark for a measure will receive a score of 0 for that measure.

MCP Participants will be required to submit PCPCM data for PYs 2025 and 2026, and all Participants will receive full credit for reporting this measure during that time.
Each performance measure has been assigned a maximum percentage of the overall PIP value. For example, the Controlling High Blood Pressure measure makes up 25% of the PIP for Track 1 Participants and 6% for Track 2 and Track 3 Participants. Evaluation of each measure is independent of performance on the others. Table 17 (Track 1), Table 18 (Track 2), and Table 19 (Track 3) show the percentages assigned to each measure in each track. These percentages reflect model goals, with quality measures weighted approximately equally to the set of utilization and cost measures. The CI measures contribute 25% to the maximum PIP value for Tracks 2 and 3. Please see Section 5.3.3 for more information on how the CI measures are calculated.

**Table 17: Track 1 MCP Performance Incentive Payment (PIP) Structure**

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Benchmarks</th>
<th>Percentage of overall PIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>≥50th percentile (half credit)</td>
<td>25%</td>
</tr>
<tr>
<td>Diabetes: Glycemic Status Assessment Greater than 9%</td>
<td>≥70th percentile (full credit)</td>
<td>25%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td></td>
<td>25%</td>
</tr>
<tr>
<td>Person-Centered Primary Care Measure (PCPCM)</td>
<td>Not applicable (full credit given for reporting in PY 2025 and PY 2026)</td>
<td>25%</td>
</tr>
</tbody>
</table>

*Track 1 Participants will be eligible for a maximum PIP Percentage Bonus of 3%.*

**Table 18: Track 2 MCP Performance Incentive Payment (PIP) Structure**

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Benchmarks</th>
<th>Percentage of overall PIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>≥50th percentile (half credit)</td>
<td>6%</td>
</tr>
<tr>
<td>Diabetes: Glycemic Status Assessment Greater than 9%</td>
<td>≥70th percentile (full credit)</td>
<td>6%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Person-Centered Primary Care Measure (PCPCM)</td>
<td>Not applicable (full credit given for reporting in PY 2025 and PY 2026)</td>
<td>6%</td>
</tr>
</tbody>
</table>

*TPCC Threshold for PIP Eligibility: Meet or exceed 30th percentile for TPCC (nationally)*

(continued)
### Track 2 PIP Structure

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Benchmarks</th>
<th>Percentage of overall PIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for Social Drivers of Health</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Screening for Depression and Follow-Up Plan</td>
<td>≥50th percentile (half credit)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥70th percentile (full credit)</td>
<td></td>
</tr>
<tr>
<td>Depression Remission at 12 months</td>
<td></td>
<td>4%</td>
</tr>
<tr>
<td>Emergency Department Utilization (EDU) a</td>
<td></td>
<td>4%</td>
</tr>
<tr>
<td>Total Per Capita Cost (TPCC)*</td>
<td></td>
<td>18.5%</td>
</tr>
</tbody>
</table>

**Emergency Department Utilization (EDU) CI** (for FQHCs and IHPs)

≥3% improvement (half credit)  25%

≥5% improvement (full credit)

**Track 2 Participants will be eligible for a maximum PIP Percentage Bonus of 45%.**

* Participants “exceed” TPCC and EDU benchmarks by having lower measure values than the benchmark.

### Track 3 PIP Structure

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Benchmarks</th>
<th>Percentage of overall PIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Diabetes: Glycemic Status Assessment Greater than 9%</td>
<td>≥50th percentile (half credit)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥80th percentile (full credit)</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Person-Centered Primary Care Measure (PCPCM)</td>
<td>Not applicable (full credit given for reporting in PY 2025 and PY 2026)</td>
<td>6%</td>
</tr>
<tr>
<td>Screening for Social Drivers of Health</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>Screening for Depression and Follow-Up Plan</td>
<td></td>
<td>4%</td>
</tr>
<tr>
<td>Depression Remission at 12 months</td>
<td>≥50th percentile (half credit)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>≥80th percentile (full credit)</td>
<td></td>
</tr>
<tr>
<td>Emergency Department Utilization (EDU) a</td>
<td></td>
<td>18.5%</td>
</tr>
<tr>
<td>Total Per Capita Cost (TPCC)*</td>
<td></td>
<td>18.5%</td>
</tr>
</tbody>
</table>

(continued)
Table 19: Track 3 MCP Performance Incentive Payment (PIP) Structure (continued)

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Benchmarks</th>
<th>Percentage of overall PIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Utilization (EDU) CI (for FQHCs and IHPs) OR Total Per</td>
<td>≥3% improvement (half credit) ≥5% improvement</td>
<td>25%</td>
</tr>
<tr>
<td>Capita Cost (TPCC) CI (for non-FQHCs and non-IHPs only)</td>
<td>(full credit)</td>
<td></td>
</tr>
</tbody>
</table>

Track 3 Participants will be eligible for a maximum PIP Percentage Bonus of 60%.

*Participants “exceed” the TPCC and EDU benchmarks by having lower measure values than the benchmark.

5.3.3 Continuous Improvement Criteria

Measures of Participant-level CI carry significant weight (25%) in the MCP Performance Measure Set in Tracks 2 and 3. Participants are measured against their own performance in the previous year and are rewarded if there is a statistically significant improvement of 3% or more. They will receive half credit (12.5%) if their score improves by at least 3% (but less than 5%) and full credit (25%) for improvement equal to or greater than 5%.

While some FQHCs and IHPs may have better absolute performance on TPCC at baseline, this may be due to lack of access to care. In addition, higher rates of diseases and comorbidities in patient populations at FQHCs and IHPs may require increased investment in primary care that may make it more difficult for these Participants to decrease TPCC. As a result, FQHCs and IHPs are assessed on EDU CI instead of TPCC CI.

CMS will monitor Participant performance in TPCC CI for Standard MCP Participants and EDU CI for FQHC and IHP Participants over time and may adjust the CI weight of 25% or may adjust the thresholds required for earning TPCC CI or EDU CI credit, if necessary. This will help ensure that Participants face both challenging and achievable CI goals.

To mitigate the chance that changes in the EDU or TPCC measure performance between the prior and current performance years reflect random variation, rather than true improvement, CMS uses statistical bootstrapping approaches (e.g., a reliability adjustment) to improve the reliability of the CI score.

To determine the CI score, CMS calculates the EDU or TPCC performance for each Participant in the prior and current performance years. To compare performance years, CMS generates a performance rate standard error for both the base performance year and the current performance year. Standard errors represent the accuracy of a measure and are needed to calculate statistical
significance. CMS calculates each practice’s change in measure performance between the 2 performance years by subtracting the measure value of the current performance year from the measure value of the base performance year. In addition to calculating the actual change between performance years, CMS applies a bootstrapping approach to generate a standard error for the change in measure performance. The bootstrapped standard error is then used to determine whether the change between the 2 performance years is statistically significant. The bootstrapping approach involves drawing repeated beneficiary samples from an individual Participant until a distribution of the population of samples for the Participant yields a bootstrapped standard error.

The standard error associated with the change in measure performance is calculated as follows. First, CMS calculates the correlation of the EDU or TPCC results between the 2 performance years. Next, CMS estimates the covariance between the 2 performance years by multiplying the correlation between the 2 performance years by the standard errors for both performance years. The combination of each Participant’s covariance and performance rate standard errors for both performance years allows CMS to calculate the standard error for the change in performance at the Participant level, which allows CMS to evaluate the significance of any change in performance between performance years within individual practices. Statistical significance is determined using an alpha threshold of 0.05. This approach has been applied successfully in other CMS models that include assessing improvement in performance on quality measures over time.

To ensure that assessment of the CI measures is based on MCP Participant performance improvements, rather than broader national or regional changes in healthcare utilization, CMS will assess differences between the PIP performance year and CI base performance year and may make additional adjustments based on that assessment. For example, if CMS determines that the ratio of EDU or TPCC performance in the PIP performance year to performance in the CI base performance year is less than 0.95 or greater than 1.05 for non-MCP participants based on a national benchmark, it may indicate a need for additional adjustments to the CI scoring methodology.

CMS also realizes that measures that rely on statistically significant improvement at the Participant level may encounter reliability challenges due to small numbers and events out of the Participants’ control (e.g., a public health emergency). MCP will therefore monitor the reliability of the continuous improvement measures over the course of the model.

### 5.3.4 TPCC Threshold for PIP Eligibility

Beginning in PY 2026, MCP Participants in Tracks 2 and 3 are subject to the TPCC Threshold for PIP Eligibility, which is used in determining whether they are eligible for a PIP. The Threshold assesses Participants against a national benchmark that includes MCP Participants and comparable non-Participants in order to hold Participants accountable for their beneficiaries’ total costs. This national benchmark differs from the regional benchmarks used to assess the individual TPCC measure as part of the calculation of the PIP (see Section 5.3.2.1).
CMS has set the TPCC Threshold for PIP Eligibility at the 30th percentile of national TPCC performance so that the majority of Participants will have an opportunity to earn a PIP. Participants that do not meet the criterion will have the incentive to reduce their costs in order to become eligible to earn a PIP in future performance years. They will also continue to receive the guaranteed ESP revenue to support their ability to meet MCP Care Delivery requirements and transform primary care.

For PY 2025, the PIP is calculated based on the assumption that every Participant passed the TPCC Threshold for PIP Eligibility. Participants will be assessed on the TPCC Threshold for PIP Eligibility at the start of PY 2026 and must satisfy the Threshold criterion to be eligible to receive a PIP. If Participants do not pass the TPCC Threshold for PIP Eligibility, they will not receive the first lump sum PIP or the second lump sum PIP associated with the performance year. For PY 2026, CMS will calculate each Participant’s TPCC scores during Q1 of 2026 using claims data from a 12-month period prior to the PY and will assess each Participant’s performance against the national TPCC benchmark for the same time period. Participants that perform better than the 30th percentile of national TPCC performance will receive the first lump sum PIP for PY 2026 during Q1 of PY 2026 and will be eligible to receive the second lump sum PIP associated with PY 2026 during Q3 of PY 2027. In Q1 of PY 2027, they will be assessed on the TPCC Threshold again to determine PIP eligibility for PY 2027. Please see Figure 6 below and Table 20 for further context.

**Figure 6: Timeline for PIP Lump Sum Distribution**

5.3.5 Calculating the PIP

CMS recognizes that a shorter time lag between performance measurement and payment of the PIP can provide Participants with earlier resources that they may invest to help improve performance. Therefore, MCP will split the PIP for a performance year into two lump sum payments:

---

20 The 30th percentile is set with the values for the benchmark population sorted in descending order, such that measure values higher than the 30th percentile indicate better performance.
• The first lump sum is paid in the first quarter of the performance year. This first lump sum is calculated in aggregate, reflecting half of what the average Participant is expected to earn annually (based on the expected average PIP Percentage Bonus, applied to the Participant’s sum of FFS and PPCP payments for PPCP Services) in each track based on their number of attributed beneficiaries.

• The second lump sum will be paid in the third quarter of the year following the performance year and will reflect each Participant’s actual performance. The second lump sum will be calculated as the total PIP a Participant has earned for the performance year minus the first lump sum payment the Participant received. A Participant’s total PIP is equal to the Participant’s PIP Percentage Bonus multiplied by the sum of FFS and PPCP payment for PPCP Services furnished by the Participant during the performance year to its attributed beneficiaries.

Providing two lump sum PIPs, rather than a percentage adjustment at the time of assessment, pulls the payments forward in time and may afford Participants a greater ability to predict revenue and invest in their practice to improve performance over time. The purpose of the PIP is to provide the Participant with incentives to increase the quality of the care provided while containing costs. There are no restrictions on how the Participant uses the PIP.

5.3.5.1 Timeline for PIP Calculation
As shown in Table 20, there are no PIPs for the first performance year of the model (PY 2024). For each subsequent performance year, the first lump sum is paid during the first quarter of the performance year, and the second lump sum is paid during the third quarter of the year following the performance year. Participants must submit the eCQM and CQM measure data for the MCP Performance Measure Set during the first quarter of the year following the performance year, for use by CMS in calculating the second lump sum payment. For example, for PY 2025, the first lump sum payment is paid to Participants in the first quarter of 2025, and the second lump sum payment is paid in the third quarter of 2026 (based on each individual Participant’s performance in 2025). Although the TPCC Threshold for PIP Eligibility is not applied for PY 2025, it is applied in all subsequent years.
Table 20: Overall Timeline for PIP Calculation and Payment

<table>
<thead>
<tr>
<th>MCP Performance Year</th>
<th>Measurement Period for MCP Performance Measure Set</th>
<th>eCQM/CQM Measure Data Submitted</th>
<th>TPCC Threshold for PIP Eligibility</th>
<th>PIP Percentage Bonus Calculated</th>
<th>First PIP Lump Sum Paid</th>
<th>Second PIP Lump Sum Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>PY 2024</td>
<td>None</td>
<td>Not submitted</td>
<td>Not calculated</td>
<td>Not calculated</td>
<td>No PIP in 2024</td>
<td>No PIP in 2024</td>
</tr>
<tr>
<td>PY 2025</td>
<td>Calendar year 2025</td>
<td>Q1 2026</td>
<td>Not calculated</td>
<td>Q2 2026</td>
<td>Q1 2025</td>
<td>Q3 2026</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PIP is based on the assumption that every Participant passes the TPCC Threshold.</td>
<td></td>
<td>Actual performance data not used; modeled data will be used to estimate average Participant performance.</td>
<td>Participant receives the second PY 2025 PIP lump sum based on their actual performance in 2025.</td>
</tr>
<tr>
<td>PY 2026</td>
<td>Calendar year 2026</td>
<td>Q1 2026</td>
<td>Q2 2026</td>
<td>Q1 2026</td>
<td>Q3 2026</td>
<td>Participant receives the second PY 2026 PIP lump sum based on their actual performance in 2026.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Calculated based on a prior 12-month period’s TPCC performance.</td>
<td></td>
<td>Projections based on Participants’ measure performance in a prior 12-month period for available measures. Actual performance data not used for reported measures; modeled data will be used to estimate average Participant performance.</td>
<td></td>
</tr>
</tbody>
</table>
### 5.3.5.2 First PIP Lump Sum Calculation

CMS will pay the first lump sum of the PIP for a performance year during the first quarter of that performance year. The first year that Participants may earn a PIP is PY 2025, in which Participants in all tracks will be eligible. Participants will not be assessed on the TPCC Threshold in PY 2025.

It is important to note that this first lump sum PIP may be debited against future payments if the Participant does not perform well enough on the quality measures. This includes Participants that do not report on all required quality measures. However, CMS anticipates that for most Participants, debit amounts would be small as a result of the first lump sum PIP being half of what the average MCP Participant is expected to earn and because Participants will be able to earn portions of the PIP Percentage Bonus through good performance on some measures even if they do not perform well on other measures.

The first lump sum PIP for a performance year will be calculated as follows:

- **Step 1:** During the first quarter of the performance year, CMS will estimate the expected average PIP Percentage Bonus for each measure in the MCP measure set, using performance data from MCP Participants in the previous year. These estimates will not be specific to each Participant but rather will reflect the average MCP Participant’s performance on each measure.

The PIP will begin in PY 2025. MCP Performance Measures will not be reported until early 2026, though, based on the measurement period January 1, 2025 – December 31, 2025. Therefore, the first lump sum payment for the PIP paid out in PY 2025 will be based on modeled data to estimate average historical performance. The first lump sum payment for the PIP paid out in PY 2026 will be based on actual performance for measures where that data is available (e.g., claims-based measures) and modeled data to estimate average historical performance for reported measures. Data sources for this modelling may include performance data on relevant measures from the Comprehensive Primary Care Plus (CPC+) model, PCF, the Maryland Primary Care Program (MDPCP), and MIPS. Full credit will be given to each Participant in the first two performance years for the PCPCM measure. More details on how this first lump sum PIP will be calculated will be available in the 2025 MCP Payment and Attribution Methodologies paper.

- **Step 2:** The expected earned percentages of overall PIP for each measure are then summed to arrive at an aggregate estimated PIP Percentage Bonus.

- **Step 3:** The aggregated estimated PIP Percentage Bonus is then multiplied by the sum of FFS and PPCP amounts paid to each Participant in the previous year for PPCP Services (see Table 13) for their attributed beneficiaries, and that product is divided by 2.
5.3.5.3 Second Lump Sum and Total PIP Calculation

CMS will pay the second lump sum of the PIP for a performance year during the third quarter of the following calendar year. This allows time for Participants to submit required data for the MCP Performance Measure Set and for CMS to assess each Participant’s performance in order to make final PIP determinations.

The total PIP and second lump sum PIP for a performance year will be calculated as follows: (Also see the example of total PIP calculation below in Section 5.3.5.4.)

- **Step 1**: During the second quarter of the calendar year following the performance year, CMS calculates Participants’ actual performance on each measure, using the claims data for the utilization and cost measures and reported data for the clinical quality measures. These calculations will be specific to each Participant, reflecting the actual Participant’s performance on each measure.

- **Step 2**: For each Participant, the total PIP Percentage Bonus is calculated by summing the measure-specific percentages that the Participant earned across all the quality measures.

- **Step 3**: The total PIP is then calculated by multiplying the total PIP Percentage Bonus by the sum of FFS and PPCP amounts paid to each Participant in the previous year (i.e., the performance year that corresponds with that second lump sum PIP) for PPCP Services (see Table 13) for their attributed beneficiaries. CMS will not make any adjustments to reflect changes in beneficiary attributions. In other words, beneficiary attribution from the performance year in which the first lump sum PIP is calculated will be used in the calculation of the total PIP.

- **Step 4**: After Participant performance has been assessed, the first lump sum PIP from the applicable performance year is subtracted from the total PIP amount that the Participant actually earned from that performance year. If this difference it positive (i.e., if the Participant earned at least as much as the first lump sum PIP associated with that PY), then the Participant will receive this additional PIP payment amount in the form of the Second Lump Sum PIP during Q3 of the calendar year following the applicable performance year. If this difference is negative (i.e., if the Participant did not earn at least as much as the first lump sum PIP associated with that PY), then the Participant will not receive a Second Lump Sum PIP. The difference between the amount the Participant actually earned and the first lump sum PIP will be debited against Q3 model payments.

\[
\text{Second Lump Sum PIP} = \text{Maximum} \left( \text{Total PIP} - \text{First Lump Sum PIP}, 0 \right)
\]

5.3.5.4 Example of the Calculation of Total PIP

A hypothetical Track 1 Participant’s PIP Percentage Bonus is 1.875%, based on the scenario in Table 21 below. The Participant’s performance on required MCP Performance Measures would
translate into 62.5% of the maximum PIP Percentage Bonus (3% for Track 1 Participants). Multiplying 62.5% by 3% results in 1.875%.

Table 21: Calculation of PIP Percentage Bonus for a Hypothetical Track 1 Participant

<table>
<thead>
<tr>
<th>Participant's Performance</th>
<th>MCP Measure Credit (Score) Received</th>
<th>Maximum Percentage of the PIP Percentage Bonus</th>
<th>Earned Percentage of the PIP Percentage Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling High Blood Pressure</td>
<td>52nd percentile</td>
<td>Half credit (0.5)</td>
<td>25%</td>
</tr>
<tr>
<td>Diabetes: Glycemic Status Assessment Greater than 9%</td>
<td>80th percentile</td>
<td>Full credit (1.0)</td>
<td>25%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>30th percentile</td>
<td>Zero credit (0.0)</td>
<td>25%</td>
</tr>
<tr>
<td>Person-Centered Primary Care Measure (PCPCM)</td>
<td>Reported (survey results submitted to CMS)</td>
<td>Full credit (1.0)</td>
<td>25%</td>
</tr>
</tbody>
</table>

Using the measure-specific results to calculate the PIP Percentage Bonus:

| Total of Earned Percentage of the PIP Percentage Bonus (sum of each measure's actual percentage) | 62.5% |
| PIP Percentage Bonus (earned percentage of PIP Percentage Bonus x maximum PIP Percentage Bonus) | 1.875% |

The Participant’s total PIP is defined as the product of the PIP Percentage Bonus they earned and the sum of FFS and PPCP amounts paid to the Participant for PPCP Services for their attributed beneficiaries. Therefore, the total PIP dollar amount would be calculated by multiplying 1.875% by the Participant’s Medicare FFS payments paid in the performance year for the PPCP Services provided to attributed beneficiaries. Note that for this example, the PIP would be calculated based on FFS amounts alone, as Track 1 Participants do not receive any PPCPs.
6 Specialty Integration Payment Codes

6.1 Overview

MCP will aim to improve consultation, communication, and coordination between MCP Participants and specialists by gradually introducing tools and resources that evolve across tracks.

- In Track 1, Participants will focus on reviewing data and identifying potential Specialty Care Partners.
- In Track 2, Participants will select Specialty Care Partners and execute Collaborative Care Arrangements (CCA) to facilitate closer coordination.
  - MCP Standard Participants must have at least one Specialty Care Partner identified as cardiology, orthopedic surgery, or pulmonary disease on their Specialty Care Partner List. Additional specialties (as currently listed in the Provider Enrollment Chain and Ownership System (PECOS)) that are eligible to be added to the Specialty Care Partner List are included in Table 22 below. These identified specialties both represent large shares of traditional Medicare spending and treat common clinical conditions for which improved access to specialty care may impact Part A and Part B spending.
  - Federally Qualified Health Centers (FQHCs) and Indian Health Programs (IHPs) will be able to select their preferred Specialty Care Partner type and will not be required to have at least one specialty in cardiology, orthopedic surgery, or pulmonary disease on their Specialty Care Partner List.
  - MCP Participants that are part of multispecialty organizations are not required to execute CCAs with external Specialty Care Partners, but they have the option to do so. They will be required to establish coordination and collaboration protocols between MCP Clinicians and MCP Specialists within their organization.
  - Further, Participants will utilize a new model-specific e-consult code (MCP e-Consult, or MEC) in Track 2 and Track 3.
- In Track 3, Specialty Care Partners and MCP Specialists will gain access to a new ambulatory co-management (ACM) code for the enhanced collaboration and communication expected during co-management.

Table 22: Specialty Care Partner and MCP Specialist Eligible Specialties

<table>
<thead>
<tr>
<th>Specialty Care Partner/MCP Specialist Eligible Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction Medicine</td>
</tr>
<tr>
<td>Advanced Heart Failure and Transplant Cardiology</td>
</tr>
<tr>
<td>Allergy/Immunology</td>
</tr>
</tbody>
</table>

(continued)
Table 22: Specialty Care Partner and MCP Specialist Eligible Specialties (continued)

<table>
<thead>
<tr>
<th>Specialty Care Partner/MCP Specialist Eligible Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Electrophysiology</td>
</tr>
<tr>
<td>Cardiovascular Disease (Cardiology)</td>
</tr>
<tr>
<td>Dermatology</td>
</tr>
<tr>
<td>Endocrinology</td>
</tr>
<tr>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
</tr>
<tr>
<td>Geriatric Psychiatry</td>
</tr>
<tr>
<td>Hematology</td>
</tr>
<tr>
<td>Hematology/Oncology</td>
</tr>
<tr>
<td>Hospice/Palliative Care</td>
</tr>
<tr>
<td>Infectious Disease</td>
</tr>
<tr>
<td>Internal Medicine</td>
</tr>
<tr>
<td>Interventional Cardiology</td>
</tr>
<tr>
<td>Medical Oncology</td>
</tr>
<tr>
<td>Nephrology</td>
</tr>
<tr>
<td>Neurology</td>
</tr>
<tr>
<td>Neuropsychiatry</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
</tr>
<tr>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
</tr>
<tr>
<td>Pain Management</td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
</tr>
<tr>
<td>Rheumatology</td>
</tr>
<tr>
<td>Sleep Medicine</td>
</tr>
<tr>
<td>Sports Medicine</td>
</tr>
<tr>
<td>Urology</td>
</tr>
</tbody>
</table>


Making Care Primary: Payment and Attribution Methodologies

The following sections describe in detail the payment codes involved in the specialty integration strategy for MCP.

Navigating this section:

- Section 6.1 Overview
- Section 6.2 MCP e-Consult (MEC)
- Section 6.3 Ambulatory Co-Management (ACM)

6.2 MCP e-Consult (MEC)

The MCP e-Consult (MEC) code is a new model-specific code (G9037) for clinicians participating in MCP that expands the scope of existing interprofessional consult codes. The interprofessional consult code (IPC), established in 2019 in the Medicare Physician Fee Schedule (PFS), supports consultation between two physicians or qualified health care personnel. Monitoring data and clinical experts indicate that the current requesting physician IPC code 99452 does not sufficiently support practices in their efforts to improve the comprehensiveness of primary care services. With a few adjustments from the IPC code set, CMS aims to improve primary care communication and collaboration with specialists before referrals in a way that has been shown to reduce specialty care overall cost as well as improving wait times to see specialists. The MEC code adjusts the current requesting physician IPC code to capture time spent obtaining and implementing specialist recommendations.

In Tracks 2 and 3, MCP Participants may bill the MEC code on a fee-for-service (FFS) basis for all MCP-attributed beneficiaries, as the barriers to e-consult billing have been experienced principally by the requesting physicians. MCP Participants may bill the MEC code for consultation with any specialist. The consultation is not required to be with a specialist on the Specialty Care Partner List. Specialty Care Partners and other non-MCP clinicians may not bill the MEC code. The MEC code is valued at the same level as the existing requesting physician IPC code 99452, including geographic adjustments and facility/non-facility adjustments. Currently, the IPC code for primary care (requesting) physicians is valued at 0.70 work Relative Value Units (RVUs) (in the CY 2023 Medicare Physician Fee Schedule).

To address current barriers to utilizing the current IPC codes, CMS includes post-service time in the time requirements. The payment for the MEC code is $40 per service (before geographic adjustments and sequestration). The MEC code may be billed by any clinician on the MCP Clinician List for a consultation with any specialist, regardless of whether the consulting specialist is one with whom the primary care clinician has a CCA. The MEC code is subject to the standard payment reduction for services furnished by non-physician practitioners. Any non-physician practitioner authorized to bill Medicare services will be paid at the appropriate physician fee schedule amount based on the rendering National Provider Identifier (NPI).
Making Care Primary: Payment and Attribution Methodologies

The MEC code restrictions align with the IPC code restrictions such that:

- It may not be billed for an attributed beneficiary within 7 days of the requesting physician IPC code (99452) for the same attributed beneficiary;
- It may not be billed more than once per consult even if more frequent communication is required;
- It may not be billed more than once in a 7-day period; and
- The requesting clinician must document the response of the consultant in the medical record.

As shown in Table 13 (list of Prospective Primary Care Payment (PPCP) Services), the MEC code will not be included in the Track 2 PPCP Service list. This will allow Participants in Track 2 to receive the full reimbursement rate for this service. In Track 3, the MEC code will be included the PPCP Service list and will therefore be paid prospectively. MCP Participants will still be required to bill the MEC code at zero-pay rates.

6.3 Ambulatory Co-Management (ACM)

In Track 3, specialty physicians that furnish services under the TIN of a Specialty Care Partner may bill a new ACM code for time spent co-managing care of an MCP attributed beneficiary with MCP Clinicians. MCP Specialists at Participant TINs composed of MCP Clinicians and MCP Specialists may also bill the new ACM code for such services. All specialty types listed in Table 22 are eligible to bill the ACM code. The ACM code supports coordination and communication between the MCP Clinicians and specialists in cases where the specialist shares management for a patient’s condition with an MCP Clinician. MCP Participants that are not composed of MCP Clinicians and MCP Specialists are required to execute CCAs with the Specialty Care Partners, which defines the communication and data-sharing protocols, expectations for coordination of care, such as when a patient should be shifted back to the primary care clinician for decision-making on care, and expectations for co-management of MCP-attributed beneficiaries between the MCP Participant and its Specialty Care Partner. MCP Participants that are composed of MCP Clinicians and MCP Specialists must meet these same above requirements within their own TIN organization and may also elect to execute CCAs with Specialty Care Partners outside of their organization.

The ACM code is priced at $50 before geographic adjustment and sequestration are applied. This amount is based on expected physician effort for shared co-management with another clinician as opposed to sole or primary care management responsibilities.

When the Specialty Care Partner or in-house MCP Specialist bills for the ACM code (G9038), the claim must meet these conditions to be eligible for payment:

- The claim is for a beneficiary attributed to an MCP Participant in Track 3,
- The date of service (DOS) listed on the claim aligns with the beneficiary’s attribution dates,
• The NPI listed on the claim is one of the eligible specialties identified in Table 22.
• Three ACM (G9038) claims have not been submitted by the same specialty type within the current 12-month period for the MCP Beneficiary. Note that two specialists who are different specialty types can bill the ACM code concurrently for the same beneficiary.
• No other ACM (G9038) claims have been paid for the same beneficiary by the same specialty type (as the physician submitting the claim for payment) with a DOS less than 30 days from the DOS of the claim being submitted.

A Technical Direction Letter (TDL) will be issued to reprocess incorrectly billed ACM codes twice annually regardless of claims count (i.e., no minimum threshold of claims will need to be met).
7 Upfront Infrastructure Payment

7.1 Overview

The Upfront Infrastructure Payment (UIP) is an optional payment for eligible MCP Participants in Track 1. The UIP is a total payment of $145,000 (split into two lump sum payments) that an MCP Participant must use to offset the additional start-up and ongoing costs often required of organizations new to value-based care models. These investments often pose a significant financial burden to organizations, including organizations delivering care in underserved areas and organizations that serve medically complex patients. UIPs will provide an opportunity for eligible organizations to build the infrastructure needed to succeed in MCP. MCP Track 1 Participants that were accepted into the model with fewer than 125 MCP attributed beneficiaries will be eligible to receive the UIP if they reach 125 MCP attributed beneficiaries at a subsequent redetermination point and meet all other UIP eligibility requirements described below. MCP Track 1 Participants that begin MCP model participation while also part of an ACO in MSSP and that remain eligible for MCP model participation in January 2025 will be eligible to receive the UIP if they meet all other UIP eligibility requirements described below.

Navigating this section:

- Section 7.1 Overview
- Section 7.2 Eligibility for the UIP
- Section 7.3 Application and Approval Process
- Section 7.4 Payment Process
- Section 7.5 Allowable Uses
- Section 7.6 Reporting Requirements
- Section 7.7 Financial Accounting
- Section 7.8 Monitoring of the UIP

7.2 Eligibility for the UIP

To be eligible to receive the UIP, at the time of the MCP application cycle an MCP Participant must:

- Have applied to participate in, and been determined by CMS as eligible to participate in, MCP under Track 1. Section 2B of the Request for Applications (RFA) provides information on Track 1 eligibility requirements. MCP Participants joining MCP in Track 2 or Track 3 will not be eligible to receive UIPs, AND
- Meet at least one of the following criteria:
  o Not have a current e-consult technology solution, such as a phone, video, or a Health Insurance Portability and Accountability Act (HIPAA) compliant application, platform, or electronic health record (EHR) enhancement that allows two-way communication and the secure sharing of patient records between primary care clinicians and specialists;\(^{21}\)
  o Meet the definition of “low revenue” where the Participant’s total Medicare Part A and Part B fee-for-service (FFS) revenue is less than 35% of the total Part A and Part B FFS expenditures for the Participant’s attributed beneficiaries.

CMS will provide preliminary UIP eligibility determinations to MCP-accepted applicants that are based on low revenue calculations from claims in calendar year 2022. Applicants may use this information to help inform their decision of whether to join MCP. By August 2024, CMS will provide finalized UIP eligibility determinations to certain Track 1 MCP Participants that are based on low revenue calculations from calendar year 2023. MCP Track 1 Participants that were accepted into the model with fewer than 125 MCP attributed beneficiaries and those entering MCP while also participating in MSSP will have their UIP low revenue eligibility calculations determined using claims from October 2023 through September 2024, provided that they meet other eligibility requirements set forth in the Participation Agreement. Final UIP eligibility will be shared with these participants by December 31, 2024.

### 7.2.1 Low Revenue Calculation
The two components of the finalized low revenue calculation are the Participant’s total revenue and the total expenditures for the Participant’s attributed beneficiaries during calendar year 2023.

The Participant’s total Medicare Parts A and B FFS revenue will be calculated using all claims billed by the Participant’s Taxpayer Identification Number (TIN) and all associated CMS Certification Numbers (CCNs). Beneficiaries do not need to be attributed to the Participant in order for their claims to be included in the total revenue. For non-institutional claims (physician, durable medical equipment (DME)), the claim must be billed by the Participant’s TIN. The non-institutional revenue is calculated as the sum of the line payment amount plus any beneficiary deductible and coinsurance payments. For institutional claims, the claim must be billed by one of the Participant’s CCNs. The institutional revenue is calculated as the sum of the claim payment amount plus any beneficiary deductible and coinsurance payments, as applicable.

The total Parts A and B FFS expenditures for the Participant’s attributed beneficiaries are calculated using all Part A and Part B claims billed on behalf of the beneficiary. The Participant does not need

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\(^{21}\) An e-consult technology solution is inclusive of HIPAA-compliant applications, platforms, and EHR enhancements that support coordinated and clinically appropriate electronic exchanges between clinicians.
to be the provider that billed the claim for the amount to be included in the total expenditures. Attributed beneficiaries from 4 quarters of attribution in 2023 will be included in the calculation. Claims must have a date of service in calendar year 2023 and only Medicare payments to the provider are included as total expenditures. Low revenue calculations for MCP Track 1 Participants accepted into the model with fewer than 125 MCP attributed beneficiaries and those participating in both MCP and MSSP in 2024 follow the same methodology, but on a delayed time period for determination (October 2023 – September 2024).

A Participant is considered a low revenue Participant if the Participant’s total Medicare Part A and Part B FFS revenue is strictly less than 35% of the total Part A and Part B FFS expenditures for the Participant’s attributed beneficiaries.

### 7.3 Application and Approval Process

An MCP Participant interested in the UIP must meet eligibility requirements as described above and must complete and submit UIP Spend Plans to CMS for both UIP lump sum payments. The following list describes the steps involved in application and approval for the UIP:

1. **The Applicant selected Track 1 (and meets eligibility criteria for that track).** As part of the Phase 1 MCP model application, MCP Applicants were required to make a track selection. Only MCP Participants in Track 1 can be eligible for the UIP.

2. **The Applicant indicated interest in receiving the UIP as part of the MCP application.** During Phase 1 of the model application, MCP Applicants were required to indicate whether or not they had an interest in receiving the UIP.

3. **CMS provides a preliminary UIP eligibility determination to MCP Applicants prior to their signing the Participation Agreement (PA).** Once the application is received, CMS makes a preliminary UIP eligibility determination using 2022 attribution and 2022 Part A and Part B expenditure data for the low revenue calculation.

4. **CMS provides a final UIP eligibility determination to MCP Participants after the start of the model.** For Participants that were accepted into the model with at least 125 MCP attributed beneficiaries, CMS makes a final UIP eligibility determination using 2023 attribution and 2023 Part A and Part B expenditure data for the low revenue calculation. For Participants that were accepted into the model with fewer than 125 MCP attributed beneficiaries, and for Participants that are participating in MSSP at the start of the model, CMS will make a final UIP eligibility determination using attribution data from Q4 2023 – Q3 2024 and Part A and Part B expenditures data from the same time period (October 2023 – September 2024) for the low revenue calculation.

5. **The Participant submits a Spend Plan.** Following the final UIP eligibility determination, the MCP Participant submits supplemental information, including a Spend Plan (detailed in
Section 7.6.1) for CMS review and approval, that specifies how the Participant intends to spend the UIPs during the 2.5-year Track 1 participation period.

6. CMS notifies the Participant that it has been approved to receive the UIP.

### 7.4 Payment Process

Once UIP eligibility is finalized and the Spend Plan is deemed approved, the following steps will be executed to distribute the total payment.

1. Each Participant approved to receive a UIP will receive the first lump sum payment of $72,500 before the end of Q4 2024. MCP Track 1 Participants accepted into the model with fewer than 125 MCP attributed beneficiaries and MSSP Participants approved to receive the UIP will receive the first lump sum payment in Q1 2025.

2. The Participant will submit a first Spend Report and a second Spend Plan by Q3 2025, providing details on how the first lump sum UIP was spent and describing plans for how the second lump sum payment will be spent.

3. Once CMS reviews and deems approved the second Spend Plan and confirms that the Participant has remained in compliance with all applicable MCP and UIP requirements, CMS will send the second lump sum payment of $72,500 before the end of Q4 2025.

4. The Participant submits the final Spend Report, identifying whether any funds are left unspent by the conclusion of the Track 1 participation period. The Participant must spend the full UIP (all $145,000) by the conclusion of the Track 1 participation period. If any unspent UIP remains upon the conclusion of the Track 1 participation period, CMS will recoup the unused balance.

### 7.5 Allowable Uses

An MCP Participant must spend the UIP on the following categories: increased staffing, health care clinician infrastructure, and the provision of accountable care for patients of underserved communities, which may include addressing social determinants of health.

CMS will track expenditure subcategories within the three allowable use categories. MCP Participants may spend UIPs on any of the subcategories of allowable uses of UIPs noted in Appendix D.

Where UIPs are used for investments in health IT systems and infrastructure, CMS requires that MCP Participants utilize health IT that meets standards and implementation specifications adopted in 45 CFR part 170, Subpart B, and/or health IT certified under the ONC Health IT Certification Program.
UIPs cannot be used for anything other than the three categories listed above (and the corresponding subcategories listed in Appendix D). For example, prohibited uses include: management company or parent company overhead, performance bonuses, other provider salary augmentation, provision of medical services covered by Medicare, and items or activities unrelated to MCP Participant operations.

7.6 Reporting Requirements

7.6.1 Spend Plan

As outlined in section 8.2.C of the Standard Participant and FQHC Participant PAs, the two Spend Plans will describe how the Participant will spend the UIP to build the infrastructure to develop care coordination capabilities and address specific health disparities. They will identify the categories of goods and services that will be purchased with the UIP, the dollar amounts to be spent on the various categories, the general timing of those purchases, and other information as may be specified by CMS.

If an applicant qualified for the UIP based on their lack of an e-Consult platform, they will be required to include an e-Consult platform in their first Spend Plan to receive the UIP.

CMS may require the MCP Participant to make changes to the Spend Plans to comply with relevant requirements, such as the obligation to spend UIPs only on allowable uses.

Before receiving the second UIP installment in 2025, Participants will be required to submit a second Spend Plan that describes how they will spend that portion of the UIP.

7.6.2 Spend Report

During the Track 1 participation period (July 2024–December 2026), the Participant will be required to submit two reports on the actual spending of the UIP, called the Spend Reports. This itemization will include all expenditures, including those not identified or anticipated in the Spend Plan. As outlined in the PA, the Spend Reports will include the following:

- Total amount of UIP received from CMS;
- Itemization of how the UIP was spent, including expenditure categories (increased staffing, provision of accountable care for underserved beneficiaries, health care infrastructure), the corresponding subcategories of allowable uses of UIPs, and the dollar amounts spent on these various categories;
- Dollar amount remaining unspent;
- Any changes to the Spend Plan made in the spending of the UIP; and
- Other information as specified by CMS.
Participants will be required to submit Spend Reports approximately one year after receiving each UIP installment. Failure to submit the Spend Reports may result in recoupment of the first UIP lump sum and ineligibility to receive the second lump sum UIP. CMS will provide information to MCP Participants regarding the standardized form, manner, and timelines in which this information must be reported.

### 7.7 Financial Accounting

An MCP Participant that receives UIPs must comply with all applicable UIP requirements including, but not limited to, reporting UIP spending and creation of a separate account for the deposit of UIPs. Failure to comply with these requirements may result in the termination of an MCP Participant’s UIPs or of the MCP Participant from MCP as required by section 8.2 in the Standard Participant and FQHC Participant PAs.

An MCP Participant must segregate UIPs from all other revenues by establishing and maintaining a separate account into which all UIPs will be deposited immediately and from which all disbursements of such funds are made only for allowable uses, as required by section 8.2.C.5 in the Standard Participant and FQHC Participant PAs.

### 7.8 Monitoring of the UIP

In accordance with section 8.2 in the Standard Participant and FQHC Participant PAs, CMS monitors the spending of UIPs to prevent funds from being misdirected or used for activities that are not permitted. CMS will conduct audits annually to monitor and assess a Participant’s use of UIPs and compliance with MCP model requirements related to such payments. CMS may review a Participant’s Spend Plan and/or Spend Report at any time and require the Participant to modify its Spend Plan and/or Spend Report to comply with UIP requirements.

Participants will be required to retain adequate records to ensure that CMS has the information necessary to conduct appropriate monitoring and oversight of use of UIPs (for example, invoices, receipts, and other supporting documentation of UIP disbursements).
### Appendix A: Primary Care Specialty Codes

<table>
<thead>
<tr>
<th>Specialty Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>207Q00000X</td>
</tr>
<tr>
<td>Adult Medicine</td>
<td>207QA0505X</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>207QG0300X</td>
</tr>
<tr>
<td>Hospice and Palliative Medicine</td>
<td>207QH0002X</td>
</tr>
<tr>
<td>General Practice</td>
<td>208D00000X</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>207R00000X</td>
</tr>
<tr>
<td>Internal Medicine Geriatric</td>
<td>207RG0300X</td>
</tr>
<tr>
<td>Internal Medicine Hospice and Palliative Medicine</td>
<td>207RH0002X</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>364S00000X</td>
</tr>
<tr>
<td>Acute Care</td>
<td>364SA2100X</td>
</tr>
<tr>
<td>Adult Health</td>
<td>364SA2200X</td>
</tr>
<tr>
<td>Chronic Care</td>
<td>364SC2300X</td>
</tr>
<tr>
<td>Community Health/Public Health</td>
<td>364SC1501X</td>
</tr>
<tr>
<td>Family Health</td>
<td>364SF0001X</td>
</tr>
<tr>
<td>Gerontology</td>
<td>364SG0600X</td>
</tr>
<tr>
<td>Holistic</td>
<td>364SH1100X</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>364SW0102X</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>363L00000X</td>
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<tr>
<td>NP Acute Care</td>
<td>363LA2100X</td>
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<tr>
<td>NP Adult Health</td>
<td>363LA2200X</td>
</tr>
<tr>
<td>NP Community Health</td>
<td>363LC1500X</td>
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<tr>
<td>NP Family</td>
<td>363LF0000X</td>
</tr>
<tr>
<td>NP Gerontology</td>
<td>363LG0600X</td>
</tr>
<tr>
<td>NP Primary Care</td>
<td>363LP2300X</td>
</tr>
<tr>
<td>NP Women’s Health</td>
<td>363LW0102X</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>363A00000X</td>
</tr>
<tr>
<td>Medical</td>
<td>363AM0700X</td>
</tr>
</tbody>
</table>
## Appendix B: Estimated Clinical and Social Risk Tier Thresholds

### Estimated Clinical and Social Risk Tier Thresholds

<table>
<thead>
<tr>
<th>MCP Region</th>
<th>25th Percentile Risk Score</th>
<th>50th Percentile Risk Score</th>
<th>75th Percentile Risk Score</th>
<th>75th Percentile ADI Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>0.473</td>
<td>0.688</td>
<td>1.168</td>
<td>42</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>0.520</td>
<td>0.807</td>
<td>1.330</td>
<td>33</td>
</tr>
<tr>
<td>Minnesota</td>
<td>0.518</td>
<td>0.804</td>
<td>1.358</td>
<td>66</td>
</tr>
<tr>
<td>New Jersey</td>
<td>0.518</td>
<td>0.796</td>
<td>1.336</td>
<td>40</td>
</tr>
<tr>
<td>New Mexico</td>
<td>0.473</td>
<td>0.686</td>
<td>1.143</td>
<td>77</td>
</tr>
<tr>
<td>New York Region</td>
<td>0.518</td>
<td>0.775</td>
<td>1.265</td>
<td>78</td>
</tr>
<tr>
<td>North Carolina</td>
<td>0.518</td>
<td>0.753</td>
<td>1.257</td>
<td>74</td>
</tr>
<tr>
<td>Washington</td>
<td>0.473</td>
<td>0.730</td>
<td>1.231</td>
<td>40</td>
</tr>
</tbody>
</table>

* MCP regions include the full state, except for the New York region, which includes the New York counties of 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; and Chemung.

* These estimated thresholds are based on 2022 CMS-HCC risk scores, which are based on 2021 diagnoses. It is important to note that 2021 diagnoses may be biased by the COVID-19 Public Health Emergency, resulting in updated 2024 thresholds potentially differing from these estimates.
Appendix C: Description of the Centers for Medicare & Medicaid Services Hierarchical Condition Category Risk Adjustment Model

The Centers for Medicare & Medicaid Services (CMS) uses the CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model to adjust capitation payments made to Medicare Advantage (MA) and Medicare Program of All-Inclusive Care for the Elderly (PACE) plans, with the intention of paying health plans appropriately for their expected relative costs. For example, a health plan enrolling a relatively healthy population receives lower payment than one enrolling a relatively sick population, all else being equal. The CMS-HCC model produces a risk score, which measures a person’s or a population’s health status relative to the average, as applied to expected medical expenditures. A population with a risk score of 2.0 is expected to incur medical expenditures twice that of the average, and a population with a risk score of 0.5 is expected to incur medical expenditures half that of the average. It is important to note that the model is most accurate at the group level, and actual expenditures for any individual can be higher or lower (sometimes significantly) than those predicted.

The CMS-HCC model is a prospective model using demographic and diagnosis information from a base year to estimate expenditures in the next year. For example, risk scores for 2023 (risk score year) are calculated using diagnosis information from 2022 (base year). New Medicare enrollees (defined here as beneficiaries with less than 12 months of Medicare Part B enrollment in the base year) receive a risk score from the new enrollee risk adjustment model, which is a demographic-only model. If a beneficiary does not have 12 months of Part B enrollment in the base year, the beneficiary cannot have had a complete diagnosis profile in the base year, and hence the CMS-HCC model cannot be used. In order to ensure that as many diagnoses are captured in the risk score as possible, CMS calculates final risk scores for any year at least 12 months after the base year ends, such that the final risk scores are generally available 16–18 months after the base year.

The demographic characteristics used for both newly enrolled and continuously enrolled beneficiaries are age, sex, Medicaid status, and originally disabled status. The diagnosis information used for continuously enrolled beneficiaries is the set of diagnosis codes reported on Medicare claims in the base year. The current CMS-HCC model also includes a component for the number of conditions a beneficiary has. Not all types of Medicare claims are used—only hospital inpatient, hospital outpatient, physician, and some non-physician claims are considered. The source of a particular diagnosis code has no relevance (i.e., diagnoses from an inpatient hospitalization have equal weight as those from a physician visit), nor does the frequency with which the diagnosis code has been reported.

The CMS-HCC diagnostic classification system begins by classifying all International Classification of Diseases (ICD)-10 diagnosis codes into Diagnostic Groups, or DXGs. Each DXG represents a well-
specified medical condition or set of conditions, such as the DXG for Type II Diabetes with Ketoacidosis or Coma. DXGs are further aggregated into Condition Categories (CCs). CCs describe a broader set of similar diseases. Although they are not as homogeneous as DXGs, diseases within a CC are related clinically and with respect to cost. An example is the CC for Diabetes with Acute Complications, which includes, in addition to the DXG for Type II Diabetes with Ketoacidosis or Coma, the DXGs for Type I Diabetes and Secondary Diabetes (each with ketoacidosis or coma).

Hierarchies are imposed among related CCs so that if a person is coded with more than one CC from a hierarchy, only the most severe manifestation among related diseases will be coded as the HCC for the risk score calculation. After imposing hierarchies, CCs become HCCs. For example, diabetes diagnosis codes are organized in the Diabetes hierarchy, consisting of three CCs arranged in descending order of clinical severity and cost, from (1) Diabetes with Acute Complications to (2) Diabetes with Chronic Complications to (3) Diabetes without Complication. Thus, a person with a diagnosis code of Diabetes with Acute Complications precludes the less severe manifestations of Diabetes with Chronic Complications as well as Diabetes without Complication from being included in the risk score. Similarly, a person with a diagnosis code of Diabetes with Chronic Complications precludes a code of Diabetes without Complication from being included in the risk score. Although HCCs reflect hierarchies among related disease categories, for unrelated diseases, HCCs accumulate (i.e., the model is “additive”). For example, a female with both Rheumatoid Arthritis and Breast Cancer has (at least) two separate HCCs coded, and her predicted cost will reflect increments for both conditions.

Because a single individual may be coded for no HCCs, one HCC, or more than one HCC, the CMS-HCC model can individually price tens of thousands of distinct clinical profiles. The model’s structure thus provides and predicts a detailed comprehensive clinical profile for each individual.

The CMS-HCC model assigns a numeric factor to each HCC and each age/sex, full-benefit Medicaid/partial benefit Medicaid/non-Medicaid, aged/disabled cell. The values are summed to determine the risk score.

An illustrative hypothetical example using the CMS-HCC V24 model follows for a 70-year-old woman with HCCs Metastatic Cancer and Acute Leukemia (HCC 8) and Bone/Joint/Muscle Infections/Necrosis (HCC 39) who is a full-benefit dual Medicare-Medicaid enrollee:

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/Sex, Full-Benefit Dual Enrollee</td>
<td>0.519</td>
</tr>
<tr>
<td>HCC 8—Metastatic Cancer and Acute Leukemia</td>
<td>2.566</td>
</tr>
<tr>
<td>HCC 39—Bone/Joint/Muscle Infections/Necrosis</td>
<td>0.588</td>
</tr>
<tr>
<td>3 Payment HCCs</td>
<td>0</td>
</tr>
<tr>
<td>Total CMS-HCC Risk Score</td>
<td>3.673</td>
</tr>
</tbody>
</table>
For more information on the CMS-HCC risk model, see the following web page: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvvtqSpecRateStats/Announcements-and-Documents.html
# Appendix D: Allowable Uses of Upfront Infrastructure Payments

<table>
<thead>
<tr>
<th>Category of Allowable Use</th>
<th>Specific Allowable Uses</th>
</tr>
</thead>
</table>
| **Provision of Accountable Care for Underserved Beneficiaries** | General health-related social needs services:  
  - Screening for social needs  
  - Comprehensive assessments  
  - Social care coordination  
  - Follow-up to ensure social needs are being addressed  
  - Substance abuse counseling/programs  
  - Implementing systems to provide and track patient referrals to available community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across the community where beneficiaries reside.  

Food security services and supports:  
  - Nutrition education/counseling  
  - Nutrition support  
  - Medically tailored meals after hospital discharge  
  - Medically tailored meals for a chronic condition  
  - Partnership with food bank  
  - Grocery store, farmers market, or other food voucher  
  - Application for food-related benefits  
  - Other food-related services (explain in “Payment Use”)  

Housing-related services and supports:  
  - Home or environmental modifications to support a healthy lifestyle  
  - Community transition costs  
  - Assisting with housing search, training on how to search for available housing  
  - Housing and environmental assessments, to ensure housing and environment are safe  
  - Moving expenses  
  - Securing documentation and fees to apply for housing  
  - Early identification and intervention for behaviors that may jeopardize housing  
  - Education on the role, rights, and responsibilities of the tenant and landlord  
  - Connecting an individual to community resources or benefits to maintain housing stability  
  - Rapid rehousing interventions  
  - Housing payments for persons experiencing homelessness  
  - Setting up support structures for persons experiencing homelessness  
  - Wraparound housing services  
  - Lead remediation services  
  - Application for housing-related benefits  
  - Other housing-related services (explain in “Payment Use”) |
<table>
<thead>
<tr>
<th>Category of Allowable Use</th>
<th>Specific Allowable Uses</th>
</tr>
</thead>
</table>
| Provision of Accountable Care for Underserved Beneficiaries (continued) | **Transportation services:**  
  • Vouchers for ride-share services  
  • Vouchers for public transportation services  
  • Disability-related transport services  
  • Services to help an individual maintain access to an automobile  
  • Transportation to non-medical locations, such as grocery stores  
  • Help with application for transportation benefits  
  • Other transportation-related services (explain in “Payment Use”)  
| | **Utilities-related services and supports:**  
  • Water services  
  • Electricity services  
  • Heating services  
  • Application for utilities-related benefits  
  • Other utilities-related services and supports (explain in “Payment Use”)  
| | **Employment-related services:**  
  • Employment search assistance  
  • Employment coaching  
  • Services for individuals with disabilities to help them succeed at finding and maintaining employment  
  • Other employment-related services and supports (explain in “Payment Use”)  
| | **Patient caregiver supports:**  
  • Caregiver counseling or support groups  
  • Caregiver training and education  
  • Respite care  
  • Child Support Services  
  • Other patient caregiver support services (explain in ”Payment Use”)  
| | **Services to reduce social isolation:**  
  • Improving cultural and linguistic competency  
  • Reintegration from incarceration counseling/program  
  • Other reduction of social isolation services (explain in “Payment Use”)  
| | **General:**  
  Other (explain in “Payment Use”)
<table>
<thead>
<tr>
<th>Category of Allowable Use</th>
<th>Specific Allowable Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Infrastructure</td>
<td>Health IT:</td>
</tr>
<tr>
<td></td>
<td>• Case/practice management systems</td>
</tr>
<tr>
<td></td>
<td>• Clinical data registries</td>
</tr>
<tr>
<td></td>
<td>• Electronic Quality Reporting</td>
</tr>
<tr>
<td></td>
<td>• Health information exchange and health information network participation</td>
</tr>
<tr>
<td></td>
<td>• Health IT to support behavioral health activities</td>
</tr>
<tr>
<td></td>
<td>• Health IT investments to support integration with dental services</td>
</tr>
<tr>
<td></td>
<td>• Investment in certified electronic health record technology (CEHRT), including system enhancements and upgrades, as necessary to meet Health IT Requirements</td>
</tr>
<tr>
<td></td>
<td>• IT-enabled screening tools</td>
</tr>
<tr>
<td></td>
<td>• Remote access technologies</td>
</tr>
<tr>
<td></td>
<td>• Telehealth and telemonitoring</td>
</tr>
<tr>
<td></td>
<td>• Establishing or improving translation services</td>
</tr>
<tr>
<td></td>
<td>• E-Consult technology investments</td>
</tr>
<tr>
<td></td>
<td>• Patient health data system such as patient portal</td>
</tr>
<tr>
<td></td>
<td>• Event notification systems</td>
</tr>
<tr>
<td></td>
<td>• Data warehouse capabilities</td>
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<tr>
<td>Infrastructure related to social determinants of health (SDOH):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Closed-loop referral tools to connect patients to community-based organizations</td>
</tr>
<tr>
<td></td>
<td>• Other infrastructure related to addressing patient social needs (explain in &quot;Payment Use&quot;)</td>
</tr>
<tr>
<td></td>
<td>• Case management or practice management systems to improve care coordination operations across the health and social care continuum</td>
</tr>
<tr>
<td>General:</td>
<td>• Practice physical accessibility improvements</td>
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</tbody>
</table>
### Specific Allowable Uses

<table>
<thead>
<tr>
<th>Category of Allowable Use</th>
<th>Specific Allowable Uses</th>
</tr>
</thead>
</table>
| **Increased Staffing**    | **Medical and support staff:**  
  • Physician  
  • Physician assistant, nurse practitioner, or clinical nurse specialist  
  • Registered dietitian or nutrition professional  
  • Nurse care manager  
  • Case manager  
  • Licensed Clinical Social Worker  
  • Community health worker (CHW)  
  • Patient navigator  
  • Health equity officer  
  • Other Staff (explain in “Payment Use”)  
| **Behavioral health clinicians:** |  
  • Psychiatrist  
  • Clinical Psychologist  
  • Marriage and Family Therapists  
  • Mental health counselors or Licensed Professional Counselors  
  • Substance use counselors  
  • Peer support specialists  
  • Behavioral health case managers  
  • Behavioral health care coordinators  
| **Oral health providers:** |  
  • Public Health Dental Hygiene Practitioner  
  • Dental Hygienist  
  • Dentist  
| **Education:** |  
  • Training staff to provide culturally and linguistically tailored services  
  • Training staff to provide trauma-informed care  
  • Other staff education (explain in "Payment Use")  |