Abstract

Background: In July 2024, the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) launched the Making Care Primary (MCP) Model, which aimed to:

(1) Expand beneficiary access to primary care that is integrated, coordinated, person-centered, and accountable
(2) Create a pathway for primary care clinicians, especially small and independent, rural, and organizations supporting underserved communities, to enter value-based care
(3) Improve the quality of care and health outcomes while reducing or maintaining Medicare expenditures

To better align with the CMS Innovation Center's statutory obligation and evolving strategic goals, CMS concluded MCP on June 30, 2025, one year into the model.

Objective: This report describes participation and implementation in its 12 months before ending. It also examines MCP's chances for meeting the CMS Innovation Center's statutory criteria for model expansion had the model continued.

Methods: This report employs qualitative and quantitative descriptive methods, utilizing CMS model data, CMS administrative data, a beneficiary survey, interviews with state Medicaid agencies, and other secondary data sources.

Results: CMS launched MCP in eight states, with selection based on state Medicaid agencies' willingness to align with the model. The model enrolled 131 participating primary care organizations. Despite its modest reach within MCP states, the model preferentially enrolled participants with limited prior experience in CMS value-based payment initiatives, those serving less economically advantaged Medicare beneficiaries, and with varied care delivery experience, as CMS intended. CMS provided participants with $37.6 million in MCP-specific payments, as well as non-financial supports. Early in the model, participants met some of the model's care delivery requirements at baseline, while other requirements seemed less feasible to meet or had room for improvement. The model was designed to improve the quality of care, and MCP participants had meaningful room for improvement in a range of quality outcomes. MCP was not projected to achieve cost neutrality for Medicare for several years (2027 or 2028 at the earliest) and the magnitude of the savings, if any, was expected to be small.

Conclusions: Model participants faced substantial barriers to cost reduction and care improvement in the initial year of MCP, and low participation would have limited the MCP evaluation's ability to detect effects. CMS terminated the model on June 30, 2025. In its announcement of the model's early conclusion, CMS said the Innovation Center was updating its model portfolio to align with its statutory obligation and strategic goals.

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I. Introduction to the MCP Model and its evaluation

In July 2024, the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) launched the Making Care Primary (MCP) Model, which aimed to:

(1) Expand beneficiary access to primary care that is integrated, coordinated, person-centered, and accountable
(2) Create a pathway for primary care clinicians, especially small and independent, rural, and organizations supporting underserved communities, to enter value-based care
(3) Improve the quality of care and health outcomes while reducing or maintaining Medicare expenditures.

Designed to span 10.5 years through December 31, 2034, the model was intended to give provider organizations sufficient time to establish durable care transformation processes and to meaningfully improve patient outcomes. To better align with the CMS Innovation Center's statutory obligation and evolving strategic goals, CMS concluded MCP earlier than planned on June 30, 2025, one year into the model.

This report describes model participation and implementation in its 12 months before ending. The report also examines MCP's chances for meeting the CMS Innovation Center's statutory criteria for model expansion, had the model continued. In the remainder of this Introduction, we describe MCP, provide an overview of the MCP evaluation, and present a roadmap for the rest of this report.

A. Overview of the MCP Model

1. MCP Model Context

The MCP Model built on past primary care model tests, including Comprehensive Primary Care Initiative (CPC Classic), Comprehensive Primary Care Plus (CPC+), and Primary Care First (PCF). CPC Classic had some favorable effects but failed to reduce Medicare spending enough to cover care management fees (Peikes et al. 2018). CPC+, CPC Classic's successor, added multiple tracks to meet the diverse needs of practices, as well as stronger incentives, and increased the size of the model test. CPC+ reduced some acute care utilization and expenditures but did not reduce total Medicare expenditures (Singh et. al 2024). PCF emphasized rewarding value and quality for primary care practices that were already advanced. Through its first three years of the five-year test, PCF had not reduced acute hospitalization rates and increased Medicare expenditures (Schurrer et al. 2025). MCP translated lessons learned from these and other model tests to develop several unique features (Table I.1.).

First, MCP was designed as a 10.5-year model, longer than previous CMS Innovation Center models, which typically ran for five years. The extended duration was intended to give participating organizations time to build enduring structures and processes needed to deliver high-quality, person-centered primary care. CMS hypothesized that improvements in quality and efficiency take time to manifest, and the longer time horizon would give more time for the changes participants implemented to demonstrate improved outcomes.

Second, to accommodate varying levels of readiness for value-based care, MCP offered three progressive participation tracks, all launched in 2024.

- Track 1, available only to organizations without prior value-based care experience, provided full fee-for-service (FFS) or Prospective Payment System (PPS) payments and additional support for care management and infrastructure development.
- Track 2 replaced half of participants' FFS revenue for qualifying primary care services with population-based payments.
- Track 3 eliminated FFS reimbursement entirely for these core primary care services.

Participants were expected to progress through these tracks over time, with all expected to be in Track 3 by 2029.

Third, the model aimed to engage organizations historically underrepresented in previous CMS models, including small, independent, and rural providers, and was the first multi-state primary care model in nearly a decade to include federally qualified health centers (FQHCs). CMS expected that many of these primary care organizations would be new to value-based care.

Finally, MCP pursued new approaches in payment and multipayer alignment. Described in depth in section II.B., MCP's payment design added new approaches—such as specialty integration payments—while refining previous approaches—such as performance-based payments. And while past models had focused multipayer alignment on a set of specific design features, MCP aimed to balance alignment on key model priorities while encouraging payers to tailor aspects of MCP to their own population. In addition, CMS only entered states where state Medicaid agencies (SMAs) agreed to partner.

Table I.1. MCP features build on past advanced primary care models

	CPC+ (2017-2021) 5 years	PCF (2021-2026) 5 years	MCP (2024-2034) 10.5 years
Target participant	Track 2: Advanced primary care practices	Advanced primary care practices that were ready to accept financial risk in exchange for greater flexibility, increased transparency	Tracks 2 and 3: Organizations (including FQHCs) with experience in value-based care and providing progressively advanced primary care
Tracks	Two tracks, with no opportunity to progress up tracks	One track	Three progressive tracks that increase in accountability and care delivery requirements
Locations	18 regions	26 regions	8 states
Payment Framework	Care management fees; prospective, population-based payment opportunities; performance-based bonus payments that rewarded improvements in quality and reductions in cost and utilization	Prospective population-based payments; upside and downside performance-based payments that reward participants for cost and utilization outcomes	Upfront infrastructure payment for eligible Track 1 participants only Clinical and social risk-adjusted enhanced services payments

			(historical care management fees) – all tracks Progressive prospective population-based payments – Tracks 2 and 3 only Upside-only performance-based payments – all tracks New specialty-integration incentives - Tracks 2 and 3 only
Multi-payer alignment approach	Alignment focused on 10 comprehensive milestones, including institution of non-FFS payment.	PCF required close alignment on all model design features.	CMS worked with SMAs to align on quality measurement, data provision to participants, learning priorities, and moving payment away from FFS to a value-based payment framework over time.

Source: MCP Request for Application, Version 1.0, August 14, 2023.

FFS = fee for service; FQHC = Federally Qualified Health Center; SMA = state Medicaid agency.

2. MCP participation eligibility

CMS intended MCP to attract a range of participants that served a diverse patient population. In a departure from previous Innovation Center models in primary care that defined participation at the level of the practice site, CMS defined an MCP participant at the level of the Taxpayer Identification Number (TIN). Each TIN-level participant was eligible to join MCP if it met the following criteria:

- Was a legal entity formed under applicable state, federal, or tribal law that was authorized to conduct business in each state in which it operated
- Was enrolled as a Medicare FFS provider
- Served as the regular source of primary care for a minimum of 125 attributed Medicare FFS beneficiaries
- Had most (at least 51 percent) of their primary care sites (physical locations where care is delivered) located in an MCP state
- Did not participate in the PCF Model or ACO REACH Model or, if they did participate in those models (with which MCP did not allow overlapping participation), submitted a request to withdraw or were terminated from the models by May 31, 2023

In addition, MCP participants could not participate in other CMS shared savings initiatives after 2024. Those MCP participants in the Medicare Shared Savings Program (MSSP) had to exit by 2025. Consequently, MCP participants were ineligible for the ACO Primary Care Flex Model, which launched in 2025 and focuses on low-revenue MSSP ACOs.

3. MCP payments

MCP was designed to offer six new types of payments for Medicare FFS beneficiaries to support advanced primary care (Table I.2). MCP offered an alternative to FFS payment for core primary care services, along with five additional payments to further promote advanced primary care.

The Prospective Primary Care Payment (PPCP) was a quarterly capitated payment that replaced Medicare FFS revenue for most primary care services. The PPCP increased across model tracks, with Track 1

participants reimbursed under the Physician Fee Schedule (PFS) or, as appropriate for FQHCs, the Prospective Payment System (PPS). Track 2 participants received a PPCP replacing 50 percent of FFS revenue (with a commensurate reduction in FFS reimbursement), and Track 3 participants had the PPCP cover all primary care service costs. The PPCP aimed to ensure predictable revenue, increase flexibility in care delivery, and discourage volume-driven care. For FQHCs, additional reconciliation was used to adjust for changes in PPS reimbursement or charges.

In addition to the PPCP, the model was designed to include five additional payment types to support a range of services and infrastructure development and reward strong model performance. The upfront infrastructure payment (UIP), expected to be paid in two lump sums during Track 1 participation, was available only to qualifying Track 1 participants with limited e-consult technology or low revenue[1] for infrastructure investment. Qualifying participants were required to use their UIPs to invest in infrastructure needed to support value-based care. All MCP tracks received enhanced services payment (ESPs), quarterly payments for enhanced care management and coordination, adjusted for clinical and social complexity. The payment amount generally declined as participants advanced to higher tracks (with exact amounts depending on measures of the Medicare beneficiaries' medical and social complexity). Participants in all tracks were supposed to be able to earn performance incentive payments (PIPs). PIPs were intended to be upside risk-only performance-based adjustments, which would have rewarded performance on the MCP performance measure set: a set of cost, utilization, and quality measures (Appendix A). Finally, MCP offered two new billable codes to encourage specialist integration: an MCP e-consult code for Track 2 participants to reimburse their time spent consulting with specialists (Track 3 participants could bill the MCP e-consult, too, but the service was covered under the PPCP so Track 3 would not be reimbursed FFS for the MCP e-consults); and a code for ambulatory co-management services, which was available for specialist partners to collaborate with Track 3 MCP participants as they co-manage patients.

Due to the model's early conclusion in 2025, CMS did not pay any PIPs and paid only the first installment of the lump-sum UIP.[2] The other payment types (PPCP, ESP, MCP e-consult, and ambulatory co-management payments) were available as originally planned for the model's one-year duration.

[1] CMS considered an MCP participant as being low revenue if their total Medicare Parts A and B FFS revenue was less than 35 percent of the total Medicare Parts A and B FFS expenditures for their MCP beneficiaries over a 12-month period before model launch. The 12-month period covered October 1, 2023, to September 30, 2024, for standard participants and January 1, 2023, to December 31, 2023, for FQHC participants.

[2] Some UIP-approved participants were due to receive their first UIP installment only in 2025—instead of 2024—and these participants did not receive any UIP before the model's end. These participants included (1) UIP-approved MCP participants that participated in MSSP in 2024, and (2) UIP-approved MCP participants that CMS allowed into the model on a "glide path." Glide path participants had fewer than 125 attributed Medicare FFS beneficiaries at model launch, but CMS allowed their MCP participation conditional on increasing their attributed beneficiary counts to meet the minimum 125 threshold.

Table I.2. MCP was intended to offer six new payment types

Planned payment type	Track 1	Track 2	Track 3	Payments offered as intended during the model
Alternative to FFS				
Prospective Primary Care Payment Quarterly payments to replace FFS revenue from primary care: capitated payments based on historical billing, with proportion capitated increasing across model tracks		✓ 50% FFS	✓ 0% FFS	**Yes**
Enhanced payments				
Upfront Infrastructure Payment Lump-sum $145,000 payment, to be paid in two installments during Track 1	✓ Eligible organizations only			**No** Most (but not all) UIP-approved participants received the first installment[a]
Enhanced Services Payment Quarterly payments to support care delivery requirements, adjusted for clinical and social risk; per-capita payment amount generally decreased across model tracks	✓	✓	✓	**Yes**
Performance Incentive Payment Intended to reward participants based on the model's performance measure set (upside risk only); opportunity for performance-based payments was designed to increase across tracks	✓	✓	✓	**No**

Planned payment type	Track 1	Track 2	Track 3	Payments offered as intended during the model
MCP e-Consult Billable code for MCP clinicians to consult with specialists (not reimbursed FFS in Track 3, as this service was covered under the prospective primary care payment for Track 3)		✓	✓	**Yes**
Ambulatory Co-Management Billable code for specialist partners to collaborate with Track 3 providers			✓	**Yes**

Source: MCP Payment and Attribution Methodologies PY 2025, Version 1.0, December 2024.

[a] Some participants approved for the UIP were scheduled to receive their first installment in 2025 rather than 2024 and ultimately did not receive any UIP before the model ended. These participants included UIP-approved participants that participated in the Medicare Shared Savings Program in 2024, as well as UIP-approved glide path participants. The model ended before any participants received a second UIP installment.

FFS = fee for service; MCP = Making Care Primary; PY = performance year; UIP = Upfront Infrastructure Payment.

4. MCP non-financial supports

CMS also provided MCP participants with a suite of non-financial tools and supports. These included:

- Technical assistance to ensure participants had the information they needed to understand the model and the expectations and requirements of participation; technical assistance could include guidance documents, webinars, and a help desk
- A collaboration platform for participants to share ideas, tools, and resources and learn from each other
- A care delivery reporting (CDR) platform—the MCP portal—for participants to share with CMS their strategies and care delivery methods used to improve health outcomes and advance health equity for their patients
- A data feedback tool containing cost, utilization, and quality data for the Medicare FFS beneficiaries the participant serves; the data feedback tool allowed participants to compare their measures with other organizations in the states and nationally, and CMS expected to incorporate additional measures to help participants identify high-quality specialists with whom to partner
- Claim and claim-line feeds, available on request, to help participants further track care for their Medicare FFS beneficiaries

Further, in each MCP state, CMS joined with SMAs, other payer partners, and community-based organizations to (1) encourage connection between MCP participants and the specialty practices and community-based organizations that acted as partners in care for participants' patients; (2) make time-

bound practice coaching and facilitation resources available to participants; and (3) contribute to data aggregation and health information exchange resources that could provide participants with data feedback on the non-Medicare patients they serve.

5. Care delivery requirements

MCP had progressive care delivery requirements across the model's three tracks, designed to move participants toward more coordinated, integrated, whole-person care. The care delivery requirements were structured across three domains—care management, care integration, and community connection—with expectations becoming more advanced as participants moved from Track 1 to Track 3. This tiered structure was intended to meet practices where they were in their transformation journey while encouraging continuous improvement. Appendix B provides a comprehensive list of all MCP care delivery requirements.

Within the care management domain, MCP emphasized the foundational role of population health management. All participants, regardless of track, were supposed to empanel their patient populations and conduct risk stratification to identify individuals with greater care needs. Building on this foundation, Track 2 participants were expected to implement episodic care management for patients during acute or transitional care periods. By Track 3, participants were required to develop individualized care plans for high-risk patients, reflecting a more proactive and tailored approach to managing complex care needs.

In the domain of care integration, MCP had a strong focus on behavioral health and specialty care coordination. Track 1 participants were expected to establish basic internal workflows to initiate collaboration across disciplines. Track 2 advanced these efforts by requiring universal behavioral health screening and the implementation of e-consults to streamline communication with specialists. In Track 3, participants were required to engage in formal co-management of select patients between primary care and specialty providers and to apply quality improvement methodologies to enhance behavioral health integration across their care teams.

The community connection domain underscored MCP's commitment to addressing the social drivers of health through structured partnerships with community-based organizations. Track 1 participants were expected to initiate screenings for health-related social needs (HRSNs), marking a critical first step in identifying external factors that influence patient outcomes. In Track 2, participants were required to develop formalized referral workflows to connect patients to appropriate community resources. Track 3 went further by strengthening those referral processes—improving tracking, follow-up, and coordination—to ensure that patients' social needs were effectively addressed as part of their overall care plan.

6. Multipayer support

CMS designed MCP as a multi-payer model to transform primary care across the health care system by promoting better alignment among payers and more integrated care delivery. The model sought to engage not only Medicare, but also Medicaid and commercial payers, to create consistency in payment structures, reduce administrative burden, and accelerate the adoption of advanced primary care strategies within participating states. To achieve this, CMS envisioned a collaborative onboarding process in which interested state Medicaid agencies and commercial insurers would establish formal agreements with the CMS Innovation Center, aligning their payment approaches and quality metrics with those of MCP. By

bringing multiple payers to the table, CMS aimed to empower providers to deliver more coordinated, person-centered care without being hindered by conflicting incentives or fragmented reporting requirements.

B. Overview of the MCP evaluation

The initial goals of the MCP evaluation were to assess MCP's effects on quality and cost outcomes for Medicare FFS and Medicaid beneficiaries, and to assess participants' success in implementing the model. These findings would have informed a CMS decision about whether the model met Innovation Center statutory criteria for expanding MCP beyond the model test.

Because the model ended after the first year, the evaluation instead focused on model participation and participants' early implementation experience, drawing on multiple data sources (see text box). This evaluation report also examines MCP's chances for meeting the CMS Innovation Center's statutory criteria for model expansion: that is, improving quality of care without increasing Medicare expenditures, or decreasing Medicare expenditures without reducing quality of care.

Data sources used in the MCP evaluation

- **CMS model data:** MCP participants' application data; MCP roster data (listing the participants, their clinicians, and specialist partners); participants' care delivery reporting via an MCP Portal designed for participant reporting; MCP payment data; data on use (for example, downloads) of MCP non-financial supports; and CMS lists of payer partners and payers' responses to a payer partner information request.
- **CMS administrative data:** Medicare FFS claims data; Medicare enrollment data; data on organizations' participation in CMS initiatives besides MCP (for example, data from the CMS Master Data Management system); and NPPES data.
- **Beneficiary survey**: Survey data collected from MCP beneficiaries between October 2024 and March 2025.
- **Interviews with state Medicaid agencies:** Information from interviews conducted with one individual per state Medicaid agency partnering in MCP (one in each of the eight MCP states).
- **Other secondary data sources**: HRSA UDS data on FQHCs; U.S. Census Bureau ACS data; and HRSA AHRF data.

ACS = American Community Survey; AHRF = Area Health Resources Files; CMS = Centers for Medicare & Medicaid Services; FFS = fee for service; FQHC = Federally Qualified Health Center; HRSA = Health Resources and Services Administration; MCP = Making Care Primary; MDM = Master Data Management System; NPPES = National Plan and Provider Enumeration System; UDS = Uniform Data System.

C. Roadmap of the report

The remainder of this report presents findings from the MCP evaluation.

- Section II discusses how CMS selected the eight MCP states to participate in MCP.
- Section III describes participation in and attrition from MCP among primary care organizations.
- Section IV describes the payer organizations that expressed interest in collaborating in the model.
- Section V describes the payments and non-financial supports CMS provided to participants over the first year of MCP.
- Section VI discusses MCP participants' care delivery at baseline and plans for change.
- Section VII examines MCP's chances for meeting expansion criteria related to cost and quality, based on participant and beneficiary data at the start of MCP.
- Section VIII concludes by summarizing evaluation findings on model participation, the potential for MCP to meet the expansion criteria, and the early conclusion of the model.

II. Selection of the eight MCP states

Key points

- CMS launched MCP in eight states, with selection based on state Medicaid agencies' willingness to align with CMS in the model.
- In interviews, partnering state Medicaid agencies said they joined MCP, at least in part, because aligning with CMS gave "weight" or "authority" to the primary care initiatives they were already pursuing in their states.
- The eight state Medicaid agencies had experience with primary care transformation (e.g., patient-centered medical home models, state-based ACO models, or other state-specific models), which helped position them to partner in MCP.

Data sources for Section II

- CMS documents
- Interviews with eight state Medicaid agencies

CMS launched MCP in eight states: Colorado, North Carolina, New Jersey, New Mexico, New York (select counties only), Minnesota, Massachusetts, and Washington (Figure II.1). CMS selected MCP states based on several factors, including:

- State Medicaid agencies' willingness to align with MCP goals
- Geographic diversity
- Opportunity to improve health equity
- Size of the Medicare population
- Current CMS Innovation Center footprint as of the model's launch
- Generalizability of the MCP states' populations to the rest of the Medicare population for model evaluation[3]

All eight MCP states were Medicaid expansion states.

[3] State selection criteria were included in CMS' Making Care Primary Request for Applications, Version 1. Centers for Medicare & Medicaid Services. "Making Care Primary Request for Applications, Version 1." August 14, 2023. Available at: https://www.cms.gov/files/document/mcp-rfa.pdf

Figure II.1. States selected for MCP

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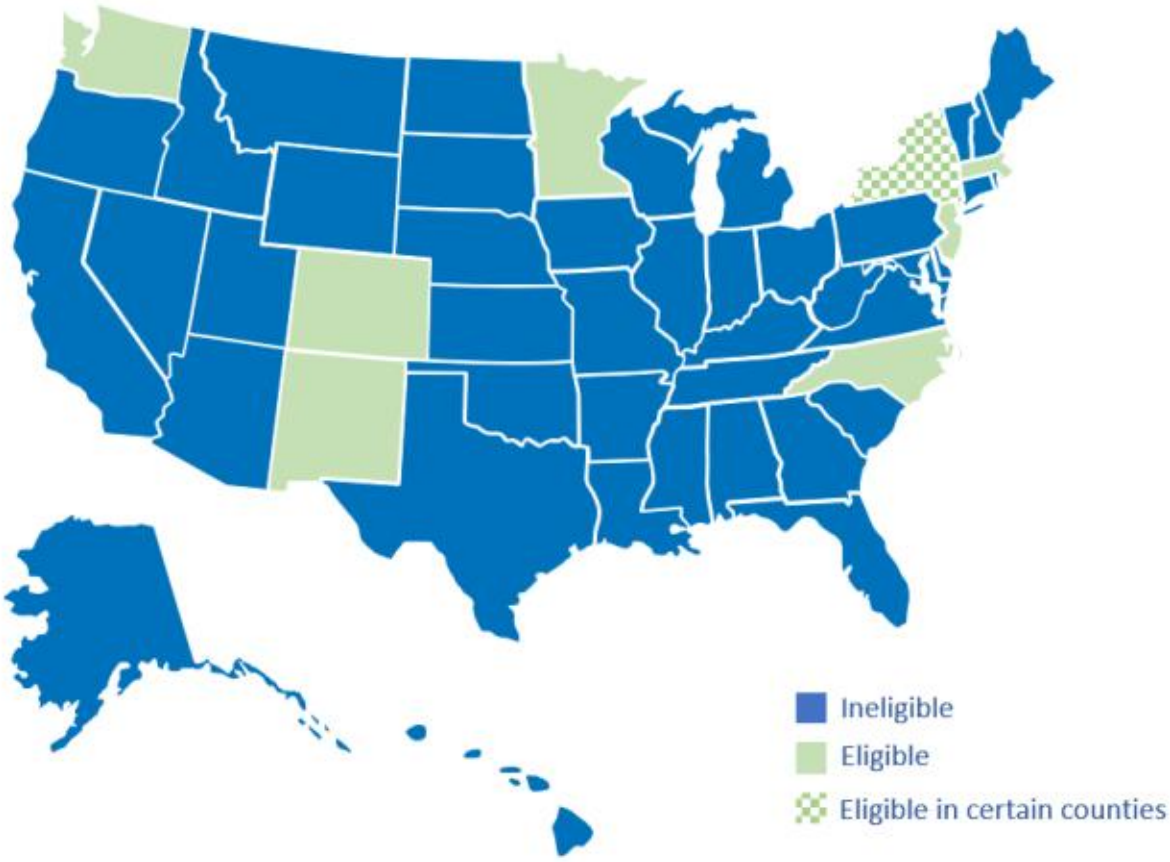


Source: CMS' Making Care Primary Request for Applications, Version 1.

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

The approach to region selection intentionally deviated from past primary care models in several ways. CMS substantially reduced the target number of states. While CPC+ included 18 regions, and PCF was offered in 26 regions, CMS only offered MCP in 8 states. This narrower geographic focus was intended to improve CMS's ability to build and sustain multi-payer communities in each state that would amplify the work of MCP and promote long-term sustainability.

CMS also engaged other payers in potential states, particularly SMAs, much earlier in the model design process. Experience from past multipayer alignment efforts suggested that payers wanted to be engaged in the model as early as possible. Securing the buy-in from SMAs was seen as a critical step in encouraging multipayer alignment. MCP launched only in states that had state Medicaid agencies that agreed to partner in the model.

Medicaid partnership within MCP was a key element of the model because it (1) would have expanded the reach of MCP to the Medicaid population and (2) built a stronger foundation for multi-payer collaboration more generally. Specifically, MCP states would have worked with CMS to align on areas such as quality measurement, data sharing and learning supports, and moving away from fee-for-service payment. CMS hoped that payer partnership in MCP would reduce clinician burden, foster comprehensive primary care organization transformation, and deepen impact.

A. Reasons SMAs joined MCP

In interviews, staff at eight state Medicaid agencies who were involved in the decision to partner in MCP described (1) the perceived advantages of partnering in MCP, (2) state Medicaid agencies' goals for MCP partnership, and (3) the Medicaid agencies' prior experience in primary care transformation. Each of the state Medicaid agencies had one individual participate in interviews.

State Medicaid agencies reported that CMS partnership gave "weight" or "authority" to the primary care initiatives that Medicaid agencies were already pursuing in their states. For example, one state Medicaid agency noted CMS could attract more national payers to participate in the agency's existing statewide multi-payer collaboration efforts. Specifically, the state Medicaid agency said that CMS could help the agency engage with people setting value-based payment policy at large national payers and that CMS' presence would have more influence among payers with national presence than the state Medicaid agency on its own.

State Medicaid agencies reported common goals for participating in MCP, such as providing aligned incentives and performance measures and building upon existing primary care transformation initiatives in the states. State Medicaid agencies appreciated the opportunity to provide aligned incentives to a larger set of health care providers in the state to ideally reduce provider burden and improve primary care outcomes. A few state Medicaid agencies said that one of their goals was to increase compensation in primary care—including supporting independent primary care practices with the goal of keeping them independent—and believed that MCP would allow them to channel more resources to struggling independent practices. In addition, state Medicaid agencies reported that having additional resources, such as more payment, data feedback, and learning supports flowing to a larger number of provider organizations, would have helped extend the reach of value-based payment arrangements to Medicaid and CHIP beneficiaries in their state.

Most state Medicaid agencies reported having experience in primary care transformation, which helped position them to partner in MCP. These experiences were either from previous Innovation Center primary care models, such as CPC+ or PCF, or from statewide initiatives. State Medicaid agencies said their participation in patient-centered medical home programs, state-based accountable care organization (ACO) models, and other state-specific models gave them confidence that they had the experience, both from the clinician and the payer perspectives, to be successful in MCP. Yet state Medicaid agencies' direct experiences implementing primary care transformation varied widely. For example, state Medicaid agencies such as those in Massachusetts and Colorado had a long history of primary care transformation and saw MCP as the "minimum guidelines" for care transformation. Other agencies, such as those in New Jersey and North Carolina, were newer to primary care transformation.

III. Participation among primary care provider organizations

Key points

- MCP enrolled 131 primary care organizations across the eight MCP states: 53 FQHC participants and 78 standard participants.
- Overall, model participation was relatively low, with only 4 percent of eligible primary care provider organizations in the MCP states participating. However, model reach was substantially higher among FQHC organizations, with one-third (35 percent) of eligible FQHC organizations joining MCP.
- The most common reason that MCP participants gave for joining the model was to improve their quality of care (43 percent).
- Despite modest participation overall, MCP preferentially enrolled participants without experience in past CMS initiatives and with less economically advantaged Medicare beneficiaries—as CMS intended. For example, MCP participants were less likely than non-participating organizations in MCP states to have past experience in value-based care or to participate in the Medicare Shared Savings Program. MCP beneficiaries were more likely than others in MCP states to qualify for Medicare due to a disability, to be dually eligible for Medicare and Medicaid, or to be eligible for a low-income subsidy for Medicare Part D coverage.
- Between the start of the model and late April 2025, 14 of the 131 MCP participants left the model (10.7 percent). The most common reason for leaving MCP was to participate in another initiative that precluded MCP participation. Attrition rates were higher among Track 2 and 3 organizations, glide path organizations,[4] and organizations not affiliated with a health system.

This section describes MCP participation among primary care provider organizations in the eight MCP states. It covers the reach of MCP, reasons MCP participants joined the model, and characteristics of participants and their patient population, with a focus on Medicare FFS beneficiaries.

[4] Participants with fewer than 125 attributed Medicare FFS beneficiaries at the start of MCP were considered "glide path participants" and were told they would need to increase their Medicare FFS beneficiary count to at least 125 by November 1, 2024, to remain in the model.

Data sources for Section III

- CMS documents
- MCP participant roster data
- MCP application data and clinician rosters provided to CMS by model participants
- Medicare FFS claims and enrollment data
- Participant responses to required reporting in the MCP Participant Portal
- Survey responses from 2,523 Medicare FFS beneficiaries served by MCP participants
- Data on patients' insurance status and other characteristics for 46 FQHC participants from the Uniform Data System
- Other secondary data on organizations' system affiliation, participation in other CMS initiatives, and geographic characteristics of beneficiaries' residence areas

A. Number and reach of organizations participating in MCP

When the model first launched on July 1, 2024, 131 primary care organizations participated in MCP: 53 FQHC organizations and 78 standard organizations (that is, non-FQHC organizations) (Table III.1). All MCP states had at least some participants, ranging from as few as four participants (Minnesota) to as many as 28 (North Carolina). Two thirds of participants joined the model as part of Track 1; less than one third joined in Track 2, and four participants joined in Track 3. About one-fifth of MCP participants joined the model as glide path participants. These glide path participants did not initially meet the model eligibility requirement to have at least 125 attributed Medicare FFS beneficiaries but were allowed to participate on the condition that they accrue at least 125 attributed beneficiaries (see box) by November 1, 2024.

Attributing beneficiaries to primary care organizations

Attribution is the process of linking beneficiaries to the organization that most recently provided their Annual Wellness or Welcome to Medicare visit over a two-year lookback period. If a beneficiary had neither type of visit, they were attributed to the primary care organization providing the largest share of primary care services over that period. The MCP Design & Operations contractor produced a quarterly list of attributed beneficiaries for each MCP participant. The MCP evaluation used a similar algorithm to attribute beneficiaries to MCP and non-participating organizations.

Table III.1. Characteristics of the 131 organizations participating in MCP

Participant characteristic	Count (%) of participants
Participant type	
Standard	78 (59.5%)
FQHC	53 (40.5%)
Region	
Colorado	9 (6.9%)
Massachusetts	15 (11.5%)
Minnesota	4 (3.1%)

Participant characteristic	Count (%) of participants
North Carolina	28 (21.4%)
New Jersey	17 (13.0%)
New Mexico	18 (13.7%)
New York	19 (14.5%)
Washington	21 (16.0%)
MCP track	
Track 1	87 (66.4%)
Track 2	40 (30.5%)
Track 3	4 (3.1%)
Glide path status	
Non-glide path	104 (79.4%)
Glide path	27 (20.6%)

Source: MCP evaluation contractor's analysis of MCP participation rosters
FFS = fee for service; FQHC = Federally Qualified Health Center; MCP = Making Care Primary

Among primary care organizations in MCP states, MCP participation rates were relatively low, particularly among standard organizations (Table III.2). MCP participants accounted for only 1.4 percent of all primary care organizations in MCP states. Participation rates were considerably higher among FQHC organizations: 25.7 percent of all FQHC organizations in MCP states. Model eligibility requirements may have been partially responsible for low model participation, as a large percentage of organizations in MCP states did not meet eligibility criteria (see box). However, **even among eligible organizations, only 4.0 percent of primary care provider organizations in MCP states participated in the model** (35.0 percent among eligible FQHC organizations). Appendix C provides methodological details for the analysis of model participation within MCP states.

Evaluable organizations

Of the 131 model participants, 99 were deemed "evaluable" for the purposes of the evaluation. Evaluable participants met all MCP eligibility requirements at the start of the model (for example, meeting the minimum attributed beneficiary count) and received MCP payments.

Table III.2. Reach of MCP among primary care organizations in MCP states

	All organizations in MCP regions[b] (A)	MCP participants (B)	MCP participants as a percentage of all organizations (B/A)	All eligible organizations in MCP regions[b] (C)	Evaluable MCP participants (D)	Evaluable MCP participants as a percentage of all organizations (D/C)
Total	9,278	126[c]	1.4%	2,500	99	4.0%
Participant type						
Standard	9,072	73	0.8%	2,363	51	2.2%
FQHC	206	53	25.7%	137	48	35.0%
By region[b]						
Colorado	877	9	1.0%	225	6	2.7%
Massachusetts	1,168	15	1.3%	382	11	2.9%
Minnesota	387	4	1.0%	73	4	5.5%
North Carolina	1,694	26	1.5%	476	18	3.8%
New Jersey	2,447	17	0.7%	692	15	2.2%
New Mexico[c]	481	16	3.3%	152	12	7.9%
New York	1,336	18	1.3%	278	15	5.4%
Washington[d]	931	21	2.3%	228	18	7.9%

Source: Participant information is based on MCP evaluation contractor's analysis of MCP rosters provided by CMS. FQHC status and region are based on analyses of Medicare claims data used for attribution. Information about location of attributed Medicare FFS beneficiaries is based on beneficiary addresses from the Medicare Enrollment Database.

[a] Organizations had to meet several criteria to be considered evaluable (see box). MCP participants also needed to receive MCP payments to be counted as evaluable for the evaluation.

[b] Organizations were considered to have a presence in a region if at least 20 percent of the organization's attributed beneficiaries resided in that region. Organizations could have a presence in more than one region, so the sum of organizations across states can be larger than the total number of organizations.

[c] This number is less than the 131 MCP participants included in Table 3.1 because it excludes five organizations with no attributed beneficiaries in the first quarter of 2024.

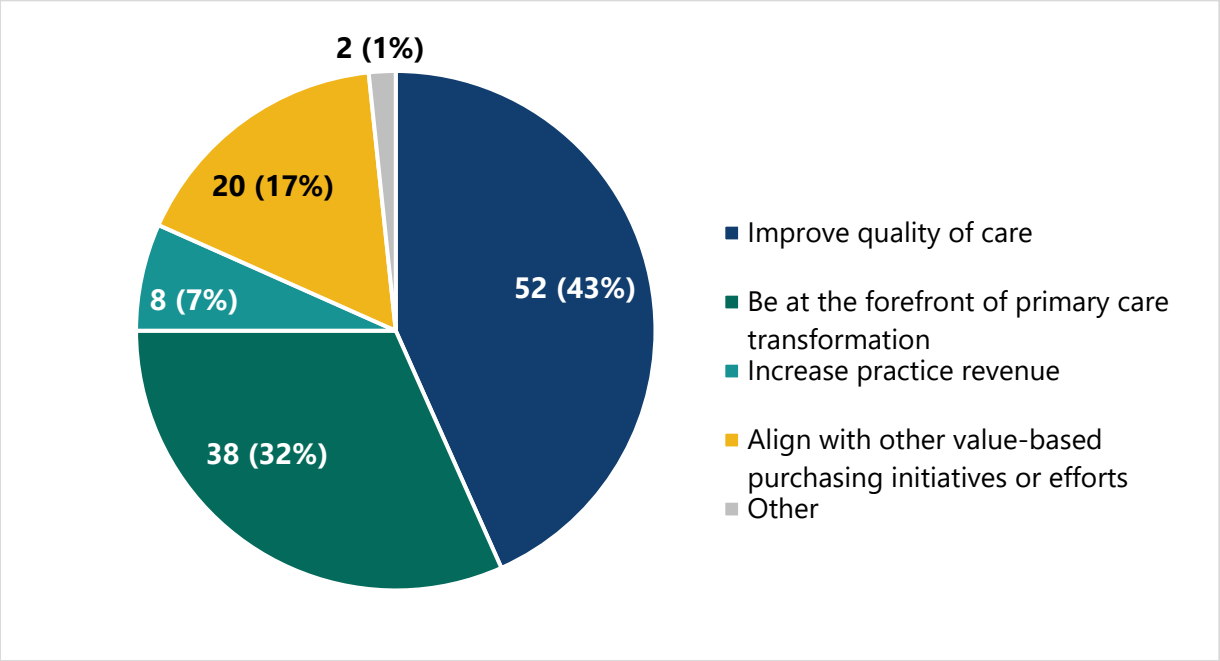
CMS = Centers for Medicare and Medicaid Services; FFS = fee for service; FQHC = Federally Qualified Health Center; MCP = Making Care Primary.

Beneficiary-level participation rates were consistently higher than organization-level rates. This suggests that MCP organizations tended to be larger organizations, accounting for a relatively larger share of Medicare FFS beneficiaries attributed to primary care organizations than the share of organizations in MCP regions.. However, MCP's reach among beneficiaries in MCP states was still relatively low. While MCP participants represented 1.4 percent of primary care organizations in MCP states (4.0 percent of evaluable organizations), these participants accounted for 5.8 percent of all Medicare FFS beneficiaries attributed in MCP states (9.2 percent of beneficiaries attributed to evaluable organizations) as of January 1, 2024 (results not shown).

B. Reasons MCP participants joined the model

MCP participants most commonly reported their primary reason for joining the model was to improve the quality of primary care (43 percent of responding participants; Figure III.1). Participants' other reported reasons for joining MCP included being at the forefront of primary care transformation (32 percent), aligning with the participants' other value-based purchasing initiatives or efforts (17 percent), and increasing practice revenue (7 percent).

Figure III.1. Primary reason participants joined MCP



Source: Analysis conducted by the MCP Design & Operations contractor.

Notes: Data reflect October 2024 responses to required reporting in the MCP Participant Portal. 120 MCP participants completed portal reporting in October 2024. Data labels show the number of participants that reported each reason as their primary reason for joining MCP with percentage of responding participants in parentheses.

C. Characteristics of participant organizations and their beneficiaries

1. Characteristics of MCP participants compared to eligible non-participants in MCP states

As CMS intended, MCP preferentially enrolled participants with less experience than average in past CMS initiatives. Compared to eligible non-participants in MCP states (Table III.3; for methodological details, see Appendix C), MCP participants were:

- **More commonly FQHC organizations**
  Consistent with higher MCP participation rates among FQHC organizations, nearly half of evaluable MCP participants were FQHC organizations, compared to less than 4 percent of non-participants.
- **Less experienced with value-based care and the Medicare Shared Savings Program**
  Just over one-quarter of evaluable participants (26.3 percent) had prior experience in a CMS value-based care initiative that made them ineligible to participate in Track 1 of the model. In comparison, 38.3 percent of eligible non-participants had prior experience with the same value-based care initiatives. Likewise, a greater proportion of evaluable participants had previously participated in the Medicare Shared Savings Program compared to eligible non-participants. (Only Medicare Shared Savings Program tracks with downside financial risk counted as "value-based care" for the MCP Track 1 exclusion.) Among evaluable MCP participants, FQHC organizations had higher rates of prior value-based care experience and Medicare Shared Savings Program participation than standard organizations.

However, MCP had limited success in attracting small independent organizations. Compared to eligible non-participants in MCP states (Table III.3), MCP participants were:

- **Larger in size**
  Evaluable participants tended to have a larger number of PCPs and serve a larger number of beneficiaries than eligible non-participants. This was true among both FQHC and standard organizations participating in MCP, although FQHC participants had fewer Medicare FFS beneficiaries on average than standard participants.
- **More often affiliated with a health system** (including both non-teaching and teaching systems)
  While system affiliation was unknown for over half of eligible non-participants, these organizations are likely independent solo practitioners (system affiliation would be unknown because the AHRQ Compendium does not include TINs when only one clinician is billing).

Table III.3. Characteristics of evaluable MCP participants versus eligible non-participants in MCP states

	Eligible non-participants (N = 2,401)	All evaluable participants (N = 99)	Standard organizations (N = 51)	FQHC organizations (N = 48)
Participant type				
FQHC organization	3.7%	48.5%	--	--
Participation in other CMS initiatives				
Prior participation in CMS value-based care initiatives (MCP Track 1 exclusion)[a]	38.3%	26.3%	17.6%	35.4%
Prior participation in Medicare Shared Savings Program	46.8%	36.4%	25.5%	47.9%
Health system affiliation				
System affiliation is unknown[b]	51.4%	17.2%	29.4%	4.2%
Not in a health system	37.8%	58.6%	33.3%	85.4%
Part of a health system with a hospital: Nonteaching, minor teaching, or of unknown teaching status[c]	6.9%	13.1%	19.6%	6.3%
Part of a health system with a hospital: Major teaching system[c]	4.0%	11.1%	17.6%	4.2%
Organization size				
Number of PCPs[d]				
Very small (1-2 PCPs)	51.4%	12.1%	23.5%	0.0%
Small (3-6 PCPs)	19.4%	14.1%	17.6%	10.4%
Medium (7-26 PCPs)	17.1%	35.4%	17.6%	54.2%
Large (27+ PCPs)	12.0%	38.4%	41.2%	35.4%
Number of attributed Medicare FFS beneficiaries in the first quarter of 2024	794	1,953	2,942	902

Source: MCP evaluation contractor's analysis of Medicare FFS claims and enrollment data, MCP participation rosters, and additional secondary data sources.

[a] Prior value-based care participation was calculated based on the MCP Track 1 eligibility exclusions, which include Medicare Shared Savings Program tracks with downside risk, ACO REACH, NGACO, CPC+, and PCF.

[b] System affiliation is unknown for solo practices and organizations that did not bill Medicare Part B in 2022 because these organizations are excluded from the 2022 AHRQ Compendium, which was used to ascertain system status.

[c] Major teaching systems are defined as those with a resident-to-bed ratio of ≥ 0.25.

[d] Percentages do not sum exactly to 100 percent across PCP size categories because three participants had unknown size. These organizations did not have any primary care practitioners delivering attribution-qualifying services during the first quarter of 2024.

ACO REACH = Accountable Care Organization Realizing Equity, Access, and Community Health Model; AHRQ = Agency for Healthcare Research and Quality; CPC+ = Comprehensive Primary Care Plus; FFS = fee for service; FQHC = Federally Qualified Health Center; MCP = Making Care Primary; N = number of organizations; NGACO = Next Generation Accountable Care Organization; PCF = Primary Care First; PCP = primary care provider.

Table III.4. Characteristics of Medicare FFS beneficiaries attributed to evaluable MCP participants versus eligible non-participants in MCP states

	Beneficiaries attributed to 2,401 eligible non-participants (N = 1,905,732)	Beneficiaries attributed to 99 evaluable MCP participants (N = 193,325)
Age		
Mean age	71.5	70.2
Age categories		
<65	16.0%	19.8%
65 to 74	48.0%	46.7%
75 to 84	27.5%	25.9%
85 or older	8.5%	7.6%
Original reason for Medicare eligibility[a]		
Age	83.6%	79.3%
Disability	16.2%	20.5%
Sex		
Male	43.3%	43.9%
Poverty indicators		
Eligible for Part D low-income subsidy	14.5%	21.5%
Dually eligible for Medicare and Medicaid	13.0%	19.3%
Residence area characteristics		
Median household income	$103,787	$96,655
Mean unemployment rate	4.0%	4.1%
Mean percent in poverty	9.0%	9.7%
Rural	15.7%	19.0%
Mean Social Vulnerability Index	0.4	0.4
Mean HPSA score for primary care	2.7	3.3
Mean HPSA score for mental health	2.1	3.1
Chronic conditions		
Mean Hierarchical Condition Category score	0.9	0.9

Source: MCP evaluation contractor's analysis of Medicare FFS claims and enrollment data, MCP rosters, and secondary data sources.

[a] Percentages do not sum to 100 percent because a very low percentage of attributed beneficiaries in the sample (less than 0.2 percent) have ESRD as their original reason for Medicare entitlement.

ESRD = end-stage renal disease; FFS = fee for service; FQHC = federally qualified health center; HPSA = health professional shortage area; MCP = Making Care Primary; N = number of attributed beneficiaries.

As CMS intended, MCP preferentially enrolled Medicare FFS beneficiaries with greater socioeconomic disadvantage. Compared to beneficiaries attributed to eligible non-participants in MCP states (Table III.4, for methodological details, see Appendix C), beneficiaries attributed to MCP participants were:

- **More frequently eligible for Medicare due to a disability**
  20.5 percent of beneficiaries attributed to evaluable MCP participants originally qualified for

Medicare due to a disability, compared to 16.2 percent of beneficiaries attributed to eligible non-participants.

- **More often dually eligible for Medicare and Medicaid, and more often eligible for a low-income subsidy for Medicare Part D coverage**
  19.3 percent of beneficiaries attributed to evaluable MCP participants were dually eligible, compared to 13.0 percent of beneficiaries attributed to eligible non-participating organizations. Likewise, 21.5 percent of beneficiaries attributed to evaluable MCP participants were eligible for low-income subsidy for Medicare Part D, compared to 14.5 percent of beneficiaries attributed to eligible non-participants.

2. MCP beneficiaries' health-related social needs and barriers to accessing care

Overall, relatively small percentages of MCP beneficiaries reported unmet health-related social needs or barriers to accessing care (Table III.5).

- **Health-related social needs.** 5.3 percent of MCP beneficiaries reported difficulty meeting nonmedical needs, such as food, housing, or transportation. This rate was higher for dually-eligible beneficiaries and beneficiaries attributed to FQHC participants (17.3 and 8.6 percent, respectively).
- **Access to care.** 10.8 percent of MCP beneficiaries reported delaying or not receiving medical care that they thought they needed. Among these beneficiaries, the most common reason for delaying or not receiving needed care was that it took too long to get an appointment (46.8 percent). Less commonly cited barriers to care included concerns about cost or coverage (7.1 percent of the beneficiaries who reported delaying or not receiving needed medical care), being too busy with work or other commitments (6.2 percent), or lack of transportation (5.4 percent). Greater percentages of beneficiaries reported delaying or not receiving needed care among dually-eligible beneficiaries and beneficiaries receiving care from FQHC participants (14.3 percent and 13.5 percent, respectively)

Table III.5. MCP beneficiaries' self-reported health-related social needs and access to care

	All MCP beneficiaries responding (N = 2,523)	MCP beneficiaries dually eligible for Medicare and Medicaid (N = 768)	MCP beneficiaries at FQHC organizations (N = 448)
Barriers to accessing care			
Delayed or did not get medical care that patient thought they needed from their doctor or practice	10.8%	14.3%	13.5%
(Among those who did delay care or not receive care) Reasons that patient delayed or did not get medical care that they thought they needed[a]			
Took too long to get appointment	46.8%	45.5%	49.9%
Could not reach practice via telephone or patient portal	14.8%	21.0%	--
Could not go when practice was open	--	--	--
Takes too long to get to practice or clinic	--	--	--
Could not get transportation to practice	5.4%	12.1%	--
Worried about cost or insurance coverage	7.1%	--	--
Too busy with work or other commitments	6.2%	--	--
Did not think the problem was serious enough	18.7%	17.8%	20.7%
Other	34.5%	39.4%	36.5%
Health-related social needs			
Experienced a period of time when they had difficulty meeting any nonmedical needs, such as food, housing, or transportation	5.3%	17.3%	8.6%

Source: MCP evaluation contractor's analysis of MCP beneficiary survey data, collected October 2024 to March 2025. Details on survey methodology are available in Appendix D, and the survey instrument is in Appendix E.

Note: Respondents were instructed to answer about their experiences in the previous 12 months. Frequencies based on < 11 responses are suppressed ("--") to protect respondent confidentiality.

[a] Only respondents who answered that they had delayed or not received needed medical care were asked about their reasons for delaying or not receiving care: N = 246 overall; 92 dually eligible; and 58 at FQHC participants. Respondents were instructed to mark all answers that apply. As a result, percentages across responses do not sum to 100 percent.

FQHC = Federally Qualified Health Center; MCP = Making Care Primary; N = number of survey respondents.

3. Insurance status of all patients served by MCP FQHC organizations

Although the MCP payments applied to Medicare FFS beneficiaries only, CMS anticipated that MCP would also have effects on non-Medicare patients as participants transformed their primary care broadly in response to the model's incentives and supports (including those offered by non-CMS payer partners in the model). The MCP evaluation does not have data about insurance status of patients served by MCP standard participants. However, FQHC participants reported their patients' insurance status and other characteristics in the Uniform Data System.

Based on these data, evaluable FQHC participants served a large population of patients not covered by Medicare (FFS or Medicare Advantage) (Table III.6, for methodological details, see Appendix C). This likely reflects, in part, FQHC organizations' roles as safety-net providers, providing care for a large proportion of patients covered by Medicaid and patients without insurance.

- **Number of patients.** In 2023 (the most recent year with available data at time of writing), evaluable FQHC participants served an average of 34,519 patients annually (both Medicare and non-Medicare).
- **Payer mix.** 16.5 percent of adult patients (aged 18 and older) at evaluable MCP FQHC participants were insured by Medicare (either FFS or Medicare Advantage), including dually-eligible beneficiaries. Other adult patients served by these participants were insured by Medicaid only (35.7 percent), privately insured (25.5 percent), or uninsured (22.1 percent), with less than 1 percent of adult patients covered by some other public insurance.
- **Income levels and other characteristics.** Nearly half of the patients served by evaluable MCP FQHC participants had an income at or below the federal poverty level, 4 percent were experiencing homelessness, and nearly 30 percent were best served in a language other than English.

Table III.6. Patient characteristics of FQHC participants

	Patients served by 46[a] MCP FQHC participants (N = 1,587,884)
Payer mix [b]	
Medicare only	10.4%
Medicaid only	35.7%
Dually eligible for Medicare and Medicaid	6.1%
Other public insurance	0.1%
Private insurance	25.5%
Uninsured	22.1%
Age distribution	
Less than 18	30.7%
18 to 39	29.1%
40 to 64	28.3%
65 and older	11.9%
Income levels	
At or below the Federal Poverty Level	49.3%
101 to 150% of the Federal Poverty Level	10.5%
151 to 200% of the Federal Poverty Level	6.1%
> 200% of the Federal Poverty Level	7.2%
Unknown	26.9%
Other patient characteristics	
Percentage of patients who are homeless	4.0%
Percentage of patients best served in a language other than English	29.0%

Source: MCP evaluation contractor's analysis of the 2023 HRSA Uniform Data System (UDS), which reports on mandatory annual data collection from all health centers that are funded by HRSA under Section 330 of the Health Centers Consolidation Act of 1996 (Public Law 104-299), as well as health center look-alikes.

Notes: All patient characteristics reported, apart from payer mix, are weighted by the total number of patients served by the FQHC organization during the calendar year. Payer mix variables are weighted by the total number of patients 18 years and older.

[a] Of the 48 evaluable MCP FQHC participants, 47 reported to the Uniform Data System in 2023 (one MCP participant did not report data because it became a FQHC in 2024). Two MCP participants belonged to the same FQHC organization (according to HRSA, which identifies FQHC organizations by BHCMISIDs), so they are reported in aggregate, resulting in a total of 46 FQHC organizations with available data. Of these 46 FQHC organizations, 4 were FQHC Look-Alikes, meaning they met all FQHC requirements but did not receive federal health center grant funding (through Section 330 of the Public Health Service Act).

[b] Among patients 18 years and older, N = 1,101,135.

BHCMISID = Bureau of Primary Health Care Health Center Management Information System ID; FQHC = Federally Qualified Health Center; HRSA = Health Resources and Services Administration; MCP = Making Care Primary; N = number of patients; UDS = Uniform Data System.

D. MCP Participant attrition

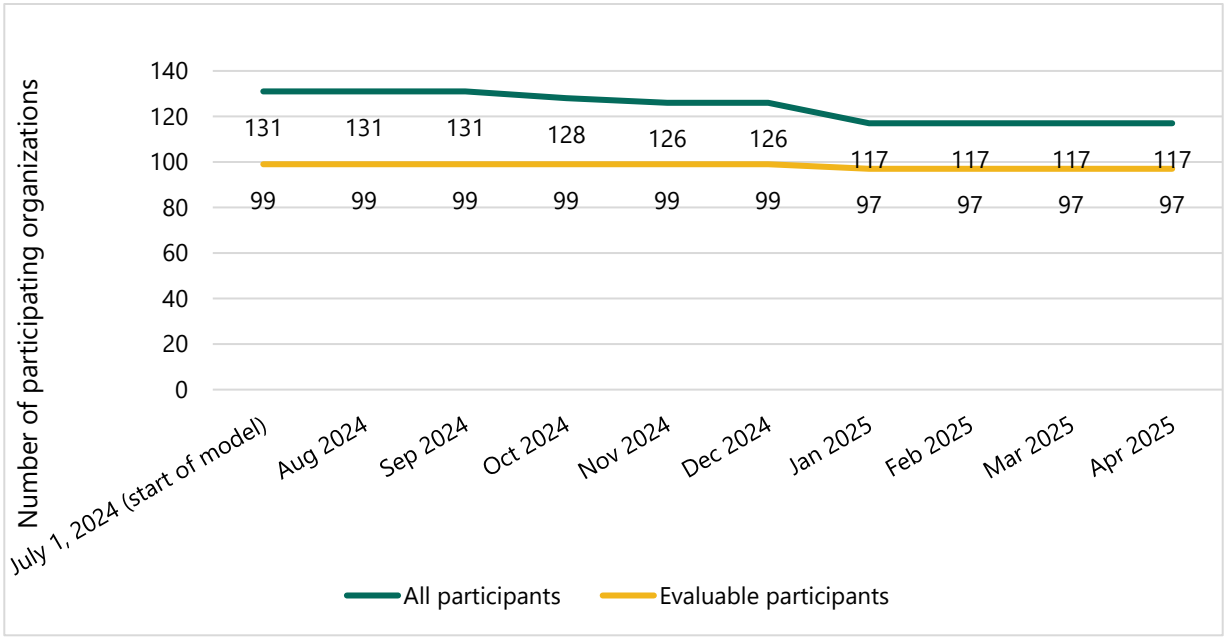
This section discusses how many MCP participants stopped participating before the end of the model, their reasons for ending participation early, and the organizational characteristics of participants that left.

1. Number of MCP participants that exited the model

Between the start of MCP and April 25, 2025 (the last data available for this analysis), 14 of the 131 organizations (10.7 percent) that started the model stopped participating. Most participants that left the model early did so at the end of the calendar year, on December 31, 2024 (Figure III.2).

Attrition was lower among the 99 MCP participants considered evaluable for the evaluation. (Evaluable participants met all eligibility requirements for MCP at the start of the model—for example, meeting the minimum attributed beneficiary count—and received MCP payments.) Only 2 (2.0 percent) of the evaluable participants left MCP early.

Figure III.2. Number of organizations participating in MCP by month



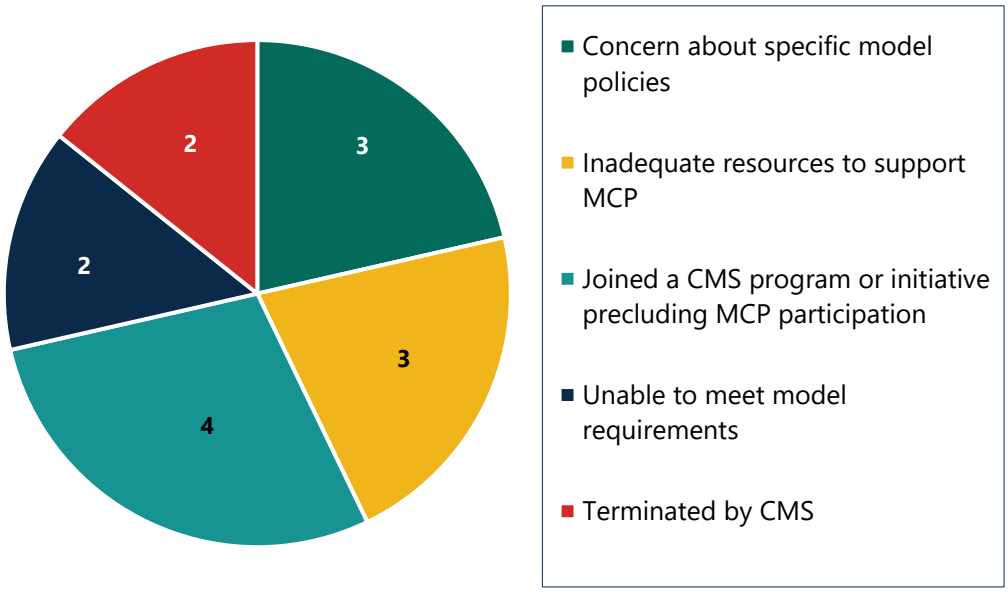
Source: MCP evaluation contractor's analysis of MCP participation rosters provided by CMS.

[a] On March 12, 2025, CMS announced that MCP would end early, by the end of 2025. On April 7, 2025, CMS announced that MCP would end June 30, 2025.

2. Reasons for attrition

MCP participants left the model for a variety of reasons (Figure III.3). Three of the 14 organizations that left MCP did so because they had concerns about specific model policies, such as the attribution criteria or financial structure of the model. An additional three left citing inadequate resources to support the implementation of MCP. Four participants left MCP to join a CMS initiative or other payer program that precluded their MCP participation, such as ACO REACH or the Medicare Shared Savings Program. Two participants left MCP because they were unable to meet model requirements. CMS terminated an additional two participants that failed to sign an Amended and Restated Participation Agreement by the deadline in August 2024.[5]

Figure III.3. Reasons organizations stopped participating in MCP, by number of organizations



Source: MCP evaluation contractor's analysis of MCP participation rosters provided by CMS.

Notes: CMS terminated participation for only two organizations; all other participants leaving the model withdrew voluntarily. CMS terminated the two because they failed to sign an Amended and Restated Participation Agreement.

Of the 14 participants leaving the model, two were *evaluable* participants under the evaluation's definition (see above). Of these, one withdrew from MCP due to inadequate resources and the other withdrew due to concern about the financial structure of the model.

[5] Starting August 12, 2024, all MCP participants were required to sign an Amended and Restated Participation Agreement that clarified some language in the original Participation Agreement and updated some terms for payment. Participants were required to sign by August 30, 2024, to remain in MCP.

3. Characteristics of organizations leaving MCP

The 14 organizations that stopped participating in MCP before the model ended had diverse attributes (Table III.7). These organizations represented both standard and FQHC participants, organizations participating in MSSP in 2024 and those not, a variety of sizes of organizations (from 1 to 114 primary care practitioners), and six of the eight MCP states. However, a higher percentage of organizations that left the model were in Tracks 2 or 3, glide path organizations, or not affiliated with a system.

Table III.7. Characteristics of 14 organizations that stopped participating in MCP

Participant characteristic	Count (%) of participants that left MCP	Count (%) of evaluable participants that left MCP
MCP Track		
Track 1	5 (5.7%)	1 (1.5%)
Track 2	8 (20.0%)	1 (3.2%)
Track 3	1 (25.0%)	0 (0.0%)
Participant type		
Standard	9 (11.5%)	0 (0.0%)
FQHC	5 (9.4%)	2 (4.2%)
Glide path status[a]		
Non-glide path	7 (6.7%)	2 (2.0%)
Glide path	7 (25.9%)	0 (0.0%)
MSSP in 2024		
Non-MSSP participant	9 (8.9%)	2 (2.6%)
MSSP participant	5 (16.7%)	0 (0.0%)
Size of organization		
Very small (1-2 PCPs)	3 (12.0%)	0 (0.0%)
Small (3-6 PCPs)	3 (13.6%)	0 (0.0%)
Medium (7-26 PCPs)	4 (10.3%)	2 (5.7%)
Large (27+ PCPs)	4 (9.5%)	0 (0.0%)
System affiliation		
System affiliated	1 (4.0%)	0 (0.0%)
Not system affiliated	10 (13.9%)	2 (3.4%)
System affiliation unknown[b]	3 (8.8%)	0 (0.0%)
Region		
CO	0 (0.0%)	0 (0.0%)
MA	2 (13.3%)	0 (0.0%)
MN	0 (0.0%)	0 (0.0%)
NC	5 (17.9%)	0 (0.0%)
NJ	3 (17.6%)	2 (13.3%)
NM	1 (5.6%)	0 (0.0%)
NY	2 (10.5%)	0 (0.0%)
WA	1 (4.8%)	0 (0.0%)

Source: Track, participant type, Glide Path status, MSSP participant, and region are based on the MCP evaluation contractor's analysis of MCP rosters provided by CMS. The size of the organization is based on the number of primary care practitioners (primary care physicians, nurse practitioners, and physician assistants) who delivered MCP attribution services under the organization's primary taxpayer identification number (TIN) in the first quarter of 2024, based on Medicare claims data. System affiliation is based on the 2022 AHRQ Compendium, which defines a system-affiliated organization as one that "includes at least one hospital and at least one group of physicians that provides comprehensive care (including primary and specialty care) who are connected with each other and with the hospital through common ownership or joint management."

[a] Organizations with fewer than 125 attributed Medicare beneficiaries at the start of MCP were considered "glide path" participants and were required to increase their Medicare beneficiary count to at least 125 by the end of 2024 to remain in the model.

[b] System affiliation is unknown for solo practices and organizations that did not bill Medicare Part B in 2022, both of which are excluded from the 2022 AHRQ Compendium.

IV. Participation among payer partners

Key points

- 52 distinct payers expressed intent to partner with CMS in MCP.
- The region with the most payer partners was Washington.

Data sources for Section IV

- CMS documents
- Payer partner information request submissions

This section describes payer partner participation across MCP states. As noted in Section II, CMS selected the MCP states based at least in part on the willingness of state Medicaid agencies to align with MCP goals because Medicaid partnership was seen as a key component of the model's reach. CMS recruited additional payer partners to participate as well. These payers could include, for example, Medicare Advantage providers, commercial insurers, and Medicaid managed care organizations.

Payer partners that joined MCP committed to aligning in key areas, including performance measurement and reporting, payment approach to shift away from full FFS, timely and consistent data sharing, and learning supports and technical assistance. Ideally, payer partners would have (1) aligned performance measure specifications with the MCP measure set (Appendix A), (2) chosen non-FFS incentives and payment structures or adopted a payment approach that was directionally consistent with MCP, (3) participated in and contributed resources to multi-payer collaboration on data sharing, and (4) made technical assistance supports available for participants.[6]

Under MCP, CMS allowed flexibility in how payers would adopt the model design elements. This approach was a change from payer partnership in PCF, which required close alignment from payer partners on all of the model design features, and in CPC+, which focused alignment on 10 comprehensive milestones.[7] The shared but flexible framework among payers in MCP was intended to reduce payer fragmentation, signal collective movement away from FFS payment, and maintain the flexibility needed for CMS, states, and payers to develop payment programs designed with the unique considerations of their providers and beneficiaries in mind.[8] In designing MCP, CMS recognized that multi-payer alignment would progress throughout the model as payers gained more experience working together to achieve a shared vision for primary care.

[6] Based on the MCP Payer partner fact sheet. https://www.cms.gov/priorities/innovation/media/document/mcp-payer-partner-fact-sheet

[7] A comparison of the Innovation Center's advanced primary care models can be found here: https://www.cms.gov/files/document/mcp-rfa.pdf

[8] Guidance on alignment for payer partners can be found here: https://www.cms.gov/files/document/mcp-payer-partners-alignment-guide.pdf

In part because of the model's flexible approach to payer partnership, it is unclear how much the MCP payer partners would have changed their approaches to payment, data feedback, or multi-payer collaboration to adopt the model elements and directionally align with MCP. For example, some MCP payer partners already offered alternatives to FFS before MCP began, so they would not have needed to change anything to align with MCP in this area. Other payers might have expected to make changes to directionally align in various areas, but—had the model continued—it is possible some payers might not have executed these changes. Evaluations of previous Innovation Center models, including CPC+ and PCF, found payers in those models rarely changed their approaches under the model.[9]

A. Extent of payer participation

Across the eight MCP states, 52 distinct payer partners expressed interest in MCP participation. This number represents the number of payers that either (1) signed a Letter of Intent (LOI) to partner in winter 2024 or (2) submitted actual plans for payer partnership via the payer partner information request (PPIR) in fall 2024.[10] Payer partners are listed as distinct[11] if they operated in different states, but it is likely that several payers considered distinct, under this definition, have a shared corporate parent. Among MCP states, Washington had the most payer participation with 11 distinct payers while Minnesota had the least, with 3 distinct payers. Table IV.1 details the number of payers by region.

Table IV.1. MCP payer partners by region

Region	Payers that signed an LOI	Payers that submitted PPIR[a]	Distinct payers
CO	4	4	5
MA	8	6	8
MN	3	2	3
NC	7	7	7
NJ	7	5	7
NM	3	4	4
NY	7	5	7
WA	11	9	11
Total	**50**	**42**	**52**

[9] Findings related to limited payer alignment can be found in CPC+ and PCF evaluation reports.

[10] There were 50 payers listed on the CMS payer list and 40 PPIR submissions.

[11] To count distinct payers, we compared the CMS payer list, based on LOIs, to PPIR submissions, and then removed duplicates. In addition to removing obvious duplicates, such as those with the same name appearing in the CMS list and the PPIR data, we doublechecked the payer list against the Internet to make sure differences in payer name truly represented different plans. For example, Medicaid was often duplicated because PPIR submissions included the entity that oversees Medicaid, while CMS listed "[STATE] Medicaid." Finally, we created a crosswalk to match PPIR submission entries to the CMS payer list.

[a] The number of payers that submitted a PPIR in this table does not match the number of submissions because one payer provided information for all the states in which they planned to participate in one submission. In addition, some payers had multiple submissions.

Source: CMS payer list and PPIR submissions.

PPIR = Payer Partner Information Request.

The analysis explored the number of covered lives, as reported by each payer that submitted a PPIR. Using PPIR data, Table IV.2 presents the distribution of total number of covered lives, either current or anticipated as of fall 2024, in an alternative payment model directionally aligned with MCP. Notably, the distribution of lives covered skews toward both extremes; most payers reported that their directionally-aligned programs covered either fewer than 10,000 lives or more than 100,000 lives.

Table IV.2. Distribution of covered lives, as reported by 36[a] MCP payer partners that completed the PPIR

Lives covered	Count of payers reporting	States represented
Fewer than 10,000 covered lives	14	MA, MN, NC, NJ, NM, NY, WA
10,000 – 25,000 covered lives	3	NC, WA
25,001 – 100,000 covered lives	6	CO, NJ, NM, NY, WA
More than 100,000 covered lives	13	CO, MA, NC, NJ, NM, NY, WA

[a] CMS received 40 PPIR submissions. One of the 40 payer partners completing the PPIR listed its number of lives covered across multiple states (>100,000). This is excluded from the table because the number provided is not comparable to the other payers. Two payer partners submitted the PPIR twice. We include each payer only once in this table. One payer did not provide information on lives covered so we excluded them from the table.

Source: PPIR submissions to CMS, Fall 2024.

PPIR = Payer Partner Information Request.

V. CMS payments and non-financial supports to MCP participants

Key points

- Based on analysis of model payment data, CMS paid MCP participants about $37.6 million in MCP-specific payments over the life of the model, although nearly one third of this ($11.7 million) was in population-based payments that replaced FFS or Prospective Payment System (PPS) revenue the organizations would otherwise have received.
- Most of the CMS payments were MCP enhanced services payments (ESPs) because participants in all tracks received this payment type.
- Participants in Tracks 2 and 3 received more of their MCP funding in prospective primary care payments (PPCPs) than in ESPs.
- CMS provided a range of non-financial supports to MCP participants. These included learning supports offered in real time, on-demand learning supports, an online social media platform, and data feedback tools.
- Most MCP participants accessed the data tools CMS provided, indicating at least modest engagement with these tools.

CMS offered six new payment types in MCP that, coupled with a series of non-financial supports and formal care delivery requirements, were intended to encourage care delivery change at MCP participant organizations. This section describes the model payments CMS made and non-financial supports that CMS provided to MCP participants during the one-year model (July 1, 2024 – June 30, 2025).

Data sources for Section V

- CMS data on MCP payments to 124 participants that received payments
- CMS documents, including notes on contractor activities
- Data on participants' downloads of CMS-provided data tools

A. CMS payments

Overall, CMS paid MCP participants about $37.6 million during the model (Table V.1). This number covers MCP prospective primary care payments (PPCPs), enhanced services payments (ESPs), and upfront infrastructure payments (UIPs) to all 131 participants that joined the model on July 1, 2024. The number does not cover the MCP claims-based payments for specialty integration—that is, the MCP e-consult or ambulatory co-management payment—due to insufficient claims runout as of April 2025. The analysis also excludes the performance incentive payment because CMS did not make any relevant payments before terminating the model in 2025.

Most of the MCP payments (62 percent, or $23.7 million) were ESPs because participants in all tracks qualified for this payment type. Track 2 and Track 3 participants received $11.7 million in PPCPs (approximately 31 percent of total outlays), while UIP payments to Track 1 organizations accounted for about 6 percent of total outlays.

Table V.1. Total CMS outlays to MCP participants over the life of the model, by MCP payment type

MCP payment type	All participants	Track 1	Track 2	Track 3
ESP	$23,660,863	$17,267,370	$5,734,915	$658,579
PPCP	$11,748,355	-	$8,374,482	$3,373,872
UIP	$2,175,000	$2,175,000	-	-
Total	$37,584,218	$19,442,370	$14,109,397	$4,032,451

Source: CMS payments (ESP, PPCP, and UIP) are based on MCP evaluation contractor analysis of quarterly payment and recoupment files provided by CMS.

ESP = Enhanced Services Payment; MCP = Making Care Primary; PPCP = Prospective Primary Care Payment; UIP = Upfront Infrastructure Payment.

For Track 1 participants, CMS paid $19.4 million during the model's first year, in addition to reimbursing these organizations at the full FFS (or Prospective Payment System [PPS]) rate for most services provided. The vast majority of these payments ($17.3 million) were quarterly ESPs. In addition, 30 Track 1 organizations received a lump sum UIP installment of $72,500, accounting for 11 percent ($2.2 million) of all CMS payments made to Track 1 participants. Based on the spend plans that participants submitted, 52 participants[12] were approved to receive UIPs. However, only 30 participants received a UIP because the others were due to receive their first UIP installment in 2025, which CMS did not pay due to the model's early conclusion.

CMS paid $18.1 million to Track 2 and 3 participants, although about two-thirds of this ($11.7 million) was in population-based payments that replaced FFS or PPS revenue the organizations would otherwise have received. The remaining $6.4 million were quarterly ESPs, supporting the participants' enhanced care management and care coordination, including some services not previously reimbursed under FFS.

1. Level and variation of ESPs received by MCP participants

As noted previously, most MCP payments were ESPs. Table V.2 shows ESP amounts for the 99 "evaluable" MCP participants that met model eligibility requirements at the start of MCP (for example, meeting the minimum attributed beneficiary count) and received MCP payments in at least one quarter of the model.

[12] Not included among the 30 is one participant that received a UIP payment that was later fully recouped.

The median total ESP that evaluable participants received from CMS over the life of the model was $94,166.

When calculated per beneficiary per month (PBPM) to account for differences in organization size, the median ESP was $14 PBPM. As expected given the ESP design (with progressively lower ESP amounts in higher tracks for a given risk patient risk profile), the Track 1 participants received slightly higher PBPM amounts (a median of $15), with a general decline for higher tracks: $11 and $9 for Track 2 and Track 3, respectively.

Median ESP payments were higher for FQHC organizations than standard participants ($16 PBPM versus $14 PBPM). A greater proportion of FQHCs were in Tracks 2 and 3 than were standard participants. Given ESPs progressively decreased from Track 1 to Track 3, on average, the higher median ESP received by FQHCs suggest underlying differences between the two groups in their attributed population's risk level rather than differences in payment amounts by track.

Table V.2.A. Total Enhanced Services Payment amounts per evaluable participant (N=99), by participant characteristic

Participant characteristic	Number of participants with any ESP	Median	Min	Max
Overall	99	$94,166	$15,381	$2,368,451
Track				
1	65	$104,946	$15,381	$2,368,451
2	31	$58,110	$17,269	$1,233,816
3	3	$205,739	$179,457	$273,383
Participant type				
Standard	51	$93,880	$15,381	$2,368,451
Federally Qualified Health Center	48	$106,735	$17,890	$547,018

Source: CMS payments are based on the MCP evaluation contractor's analysis of quarterly payment and recoupment files provided by CMS. Track and participant type are based on evaluation contractor analysis of MCP rosters provided by CMS.

[a] To calculate payments per beneficiary per month (PBPM), we limit to quarters in which a participant had one or more attributed beneficiaries.

ESP = Enhanced Services Payment; FQHC = Federally Qualified Health Center; MCP = Making Care Primary; PBPM = per beneficiary per month

Table V.2.B. Per beneficiary per month enhanced Services Payment amounts per evaluable participant (N=99), by participant characteristic

Participant characteristic	Number of participants with any ESP	Median	Min	Max
Overall	99	$14	$5	$23
Track				
1	65	$15	$10	$23
2	31	$11	$6	$22
3	3	$9	$5	$19
Participant type				
Standard	51	$14	$5	$21
Federally Qualified Health Center	48	$16	$9	$23

Source: CMS payments are based on the MCP evaluation contractor's analysis of quarterly payment and recoupment files provided by CMS. Track and participant type are based on evaluation contractor analysis of MCP rosters provided by CMS.

[a] To calculate payments per beneficiary per month (PBPM), we limit to quarters in which a participant had one or more attributed beneficiaries.

ESP = Enhanced Services Payment; FQHC = Federally Qualified Health Center; MCP = Making Care Primary; PBPM = per beneficiary per month

2. Level and variation of PPCPs received by MCP participants

As noted earlier, about two-thirds of CMS payments received by Track 2 and Track 3 participants were PPCPs. The median PPCP among MCP's 39 evaluable Track 2 and Track 3 participants organizations was $129,371 (Table V.3).

By design, Track 3 participants received larger PPCP amounts from CMS than Track 2 participants (a median of $42 PBPM versus $17 PBPM). This is expected because the PPCP replaced a larger proportion of FFS and PPS revenue in Track 3 than Track 2 (100 percent of qualifying services instead of 50 percent).

As with ESPs, FQHCs received higher PPCPs than standard participants. Median PPCP payments were $20 PBPM for FQHCs and $14 PBPM for standard participants. Although there were more evaluable FQHCs in Track 3 than standard participants (2 versus 1), the differences in PPCP amounts by FQHC status are more likely due to underlying differences in how the two organization types are typically reimbursed for PPCP services. Specifically, each MCP participant's PPCP amount in 2025 was based on the participant's historical billing for relevant services in a two-year period before the model started. For standard participants, historical payments for PPCP services were paid under the Physician Fee Schedule (PFS) and can be isolated in claims. In contrast, payment to FQHCs for PPCP services are often paid at the

per-diem rate under the FQHC Prospective Payment System – a bundled payment for a typical set of services. The FQHC per-diem rate is typically higher than the PFS rate for PPCP services received by standard participants.

Table V.3. Total prospective primary care payment amounts per evaluable participant (Track 2 and Track 3 organizations only, N=34, July 2024 – June 2025), by participant characteristic

Participant characteristic	Number of participants with any PPCP	Median	Min	Max
Overall	34	$129,371	$15,578	$1,873,243
Track				
2	31	$112,611	$15,578	$1,467,656
3	3	$988,242	$512,388	$1,873,243
Participant type				
Standard	15	$112,611	$29,294	$1,873,243
Federally Qualified Health Center	19	$145,203	$15,578	$988,242

Source: CMS payments are based on the MCP evaluation contractor's analysis of quarterly payment and recoupment files provided by CMS. Track and participant type are based on evaluation contractor analysis of MCP rosters provided by CMS.

FQHC = Federally Qualified Health Center; MCP = Making Care Primary; PBPM = per beneficiary per month; PPCP = Prospective Primary Care Payment

Table V.4. Per beneficiary per month prospective primary care payment amounts per evaluable participant (Track 2 and Track 3 organizations only, N=34), by participant characteristic

Participant characteristic	Number of participants with any PPCP	Median	Min	Max
Overall	34	$17	$8	$55
Track				
2	31	$17	$8	$37
3	3	$42	$33	$55
Participant type				
Standard	15	$14	$9	$37
Federally Qualified Health Center	19	$20	$8	$55

Source: CMS payments are based on the MCP evaluation contractor's analysis of quarterly payment and recoupment files provided by CMS. Track and participant type are based on evaluation contractor analysis of MCP rosters provided by CMS.

[a] To calculate payments per beneficiary per month (PBPM), we limit to quarters in which a participant had one or more attributed beneficiaries.

FQHC = Federally Qualified Health Center; MCP = Making Care Primary; PBPM = per beneficiary per month; PPCP = Prospective Primary Care Payment

B. MCP non-financial supports

CMS provided a robust suite of non-financial supports to MCP participants. These supports were designed to facilitate learning, promote collaboration and sharing between participants, and support the use of data to improve quality of care. CMS's efforts were multi-faceted and included real-time and on-demand learning resources, digital collaboration tools, and access to performance data.

1. Real-time learning supports

To address participants' immediate needs and foster engagement in the model, CMS offered several real-time learning opportunities. These included the following:

- Office hours, during which CMS staff and contractors answered participants' questions and conducted live demonstrations of how to use MCP resources, such as MCP Connect (described below).
- Learning communities and small group collaboratives in which MCP participants convene in structured meetings that facilitate peer-to-peer learning and the exchange of best practices.
- One-on-one coaching aimed at supporting independent Track 1 and Track 2 practices in developing and refining model implementation strategies.

2. On-demand learning supports

Recognizing the varying schedules and needs of participants, CMS also offered on-demand resources. These included a help desk, pre-recorded webinars, implementation guides, FAQs, and toolkits covering topics relevant to MCP participation, such as care delivery reporting, quality measure documentation, the model's health IT requirements, and the use of CMS data tools like the data feedback tool described below.

3. Collaborative online platform: MCP Connect

CMS launched MCP Connect, a dedicated online platform to support knowledge sharing and collaboration. This social media-style environment facilitated direct interaction between MCP participants, CMS staff, and MCP contractors on issues related to MCP participation, including questions, insights, and lessons learned. MCP Connect also housed training materials and implementation resources available for download by participants.

4. Data tools to support practice improvement

To help participants monitor their model performance and improve quality, CMS provided a data feedback tool (DFT) and a custom export tool (CET). The DFT and CET gave each participant quarterly reports based on Medicare claims data and other administrative data to describe service utilization and expenditures among the participant's attributed Medicare FFS beneficiaries. The DFT provided data visualizations for summary measures, whereas the CET—as its name suggests—enabled participants to produce custom exports of the underlying data.

Most MCP participants accessed the data reports that CMS provided during the model period. As of April 24, 2025, 98 distinct participants had downloaded at least one file provided. This indicates at least a modest level of engagement with these resources, although we cannot tell from the download number alone how participants used the resources.

5. Regional data aggregation

CMS and its contractors began work to support multi-payer data aggregation and integrated data feedback across payers. However, these data aggregation activities were still being planned when CMS announced it would end MCP early, and the planned activities did not launch before the model concluded.

VI. MCP participants' care delivery at baseline and plans for change

Key points

- Participants met some of MCP's care delivery requirements at baseline, while other requirements seemed less feasible to meet or had room for improvement.
- Participants varied by track in their care delivery experience at baseline, as CMS intended.
- Most participants that qualified for an upfront infrastructure payment (UIP) planned to spend their UIPs on increasing staffing or improving health care infrastructure, with a much lower proportion planning to spend their UIPs on providing accountable care for underserved beneficiaries.
- Participants perceived substantial barriers to changing their care delivery to improve the quality of care and patients' outcomes, and over three-quarters of participants found MCP requirements either very or somewhat burdensome.
- Few participants (7 out of 131 that started the model in July 2024) developed any collaborative care arrangements with MCP specialty care partners before CMS announced the model's end in March 2025.

This section describes MCP participants' care delivery at baseline and their early experiences with model implementation. It covers (1) MCP participants' care delivery as of October 2024, (2) Track 1 participants' plans for using the UIP to invest in staff and infrastructure, (3) MCP participants' perceived barriers to improving care delivery, and (4) progress made on specialist integration in the first year of MCP.

Data sources for Section VI

- Responses from 120 participants (92 percent of all those starting the model) to questions in the MCP participant portal as of October 2024[13]
- Upfront infrastructure payment (UIP) spend plans for 52 participants with "approved" UIP status as of February 2025
- Clinician rosters that MCP participants provided to CMS, including lists of specialists with collaborative care agreements, as of April 2025

[13] Participants' responses to the MCP Participant Portal on Care Delivery Requirements should be interpreted with caution because they are self-reports, and participants are aware that these data could be used by CMS to assess compliance. In addition, some terminology used in the Portal data may not be universally understood across participants which would affect the validity and reliability of their data. For example, during the first 2 years of CPC+ the term "care plan" meant different things to different types of staff at practices, suggesting a lack of understanding about the purpose of care plans.

A. MCP participants' care delivery at baseline

MCP had progressive care delivery requirements across MCP's three tracks, designed to move participants toward more coordinated, integrated, whole-person care.

- Care management requirements included empaneling and risk stratifying patients and implementing chronic and episodic care management.
- Care integration requirements included behavioral health integration, specialty care integration, and entering formal collaborative care arrangements with specialists.
- Community connection requirements included screening for HRSNs and creating partnerships with social service providers and other community-based organizations.

Appendix B lists the progressive requirements across MCP's three model tracks.

Participants reported meeting some of MCP's long-term care delivery requirements at baseline, while other requirements seemed less feasible or had room for improvement. Table VI.1 summarizes participants' reported implementation of care delivery requirements at baseline using data reported by participants to the MCP participant portal in October 2024. Consistent with model recommendations, participants in all three tracks reported that they targeted providing timely follow-up (≤72 hours) after patients' discharge from the hospital (just over 80 percent) or emergency department (65 percent). Approximately 90 percent of organizations across tracks said that they had established a plan for identifying patients with behavioral health needs, relevant for the model's requirements for behavioral health integration. However, participants found some care delivery requirements less clinically relevant. For example, while the model encouraged participants to use data on specialist cost, utilization, and quality to inform referrals to specialists, most did not consider this important. Instead, they made referrals based on other factors such as patients' insurance, convenience, and ability to get an appointment with the specialist.

Participants varied by track in their reported care delivery experience at baseline, as CMS intended. For example, in October 2024, only one-third of Track 1 participants (36 percent) reported meeting the track's requirement for risk stratifying patients, compared with 45 percent and 100 percent of Track 2 and 3 participants, respectively. As another example, 45 percent of Track 1 and 60 percent of Tracks 2 and 3 participants reported having a process to follow up and ensure that a community-based organization responded (that is, confirming the patient was contacted, or service rendered) after a referral was made.

Table VI.1. Summary of select findings about MCP care delivery at baseline

Care delivery requirement	Participants' experience at baseline	Possible implications for future CMS models
	Domain 1: Care management	
Targeted (episodic) care management	• **Most participants (over 90% of organizations in each track) provided episodic care management.** • **Participants did not automatically receive data on unplanned hospital admissions for all local hospitals.** Only 28% of participants systematically identified or got notified in real-time of patients with unplanned hospital admissions for *all* local hospitals.	• Efforts to improve episodic care management could support improved data exchange with all local hospitals. • If CMS feels risk-stratification is important in future models, organizations may need support to implement it. • Future models that promote self-management services could leverage patient interest in this type of support.
Chronic condition management	• **Most MCP participants empaneled patients to a primary care practitioner or primary care team** (69% in Track 1, 82% in Track 2, and 100% in Track 3). • **Less than half of Track 1 and 2 participants risk stratified patients** (36% and 45%, respectively). • **Over two-thirds of organizations used clinician identification of patients for self-management support.** More than half of participants reported that they considered patient or caregiver interest in self-management support as a factor in identifying patients.	
	Domain 2: Care integration	
Specialty care integration	• **Most participants did not consider it important to use data on specialist cost, utilization, and quality to inform referrals to specialists.** About two-thirds of participants reported that these factors were not important or somewhat important. • **Participants prioritized other factors when selecting specialists for referrals**, including how soon the patient could get an appointment (97% reporting this was somewhat or very important), whether the specialist accepts the patients' insurance (95%), patient preference (94%), and location of specialist (93%).	• Primary care organizations need support to improve coordination and communication with behavioral health specialists, in particular.
Behavioral health integration	• **About 90% of participants across tracks had established a plan for identifying patients with behavioral health needs**, an activity relevant to model requirements in all tracks. • **Over two-thirds of participants had either identified or added behavioral health staff.** • **Over half of participants in each track offered evidence-based psychotherapy at their practice sites.** **Nonetheless, participants' ability to coordinate communication between primary care practitioners and behavioral specialists was a challenge.** Two-thirds of participants across tracks reported that this was a minor or major challenge.	
	Domain 3: Community connection	

HRSN screening and referral	• **Just under half of participants across tracks reported screening for HRSNs annually or more frequently.** They screened most for housing, food, and transportation needs. • **Approximately 45% of Track 1, and 60% of Tracks 2 and 3 participants reported having a process to follow-up and ensure that a community-based organization responded**—that is, to report a patient was contacted, or service rendered—after a referral was made.	• Like MCP, future models might consider enhancing support for linkages between primary care and community-based services to improve health care providers' ability to address patients' health related social needs.
Community supports and navigation	• **Over half of participants across tracks reported challenges linking patients to community and social services.** Across tracks, 29% of organizations reported "major" challenges to linking patients to community and social services to address HRSNs, and an additional 33% of organizations reported "minor" challenges.	

Source: MCP evaluation contractor summary of data provided by the MCP Design & Operations contractor.

EHR = electronic health record; HRSNs = health-related social needs; MCP = Making Care Primary.

B. Participants' plans for using the Upfront Infrastructure Payment to improve care delivery

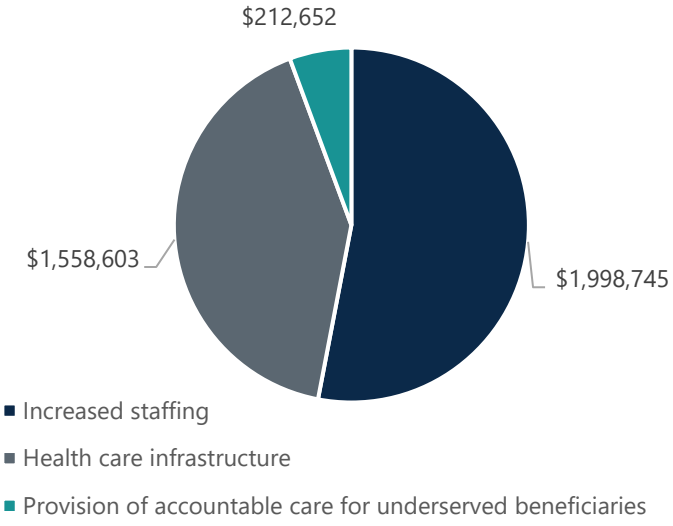
As described in Section V, the upfront infrastructure payment (UIP) was an optional payment for evaluable MCP participants[14] in Track 1. The UIP was intended to help participants (1) offset the financial costs that organizations new to value-based care models face and (2) invest in infrastructure needed to implement the MCP care delivery requirements. Evaluable participants were expected to be paid $145,000 split into two lump-sum payments. However, only the first payment of $72,500 was made before the end of the model, and it was paid only to a subset of the participants approved for a UIP (see Section V). The UIP could be spent on only three allowable categories: increased staffing, health care infrastructure, or the provision of accountable care for patients of underserved communities.[15] CMS provided a final UIP eligibility determination to MCP participants after the start of the model. Following this determination, participants submitted for CMS review and approval a spend plan specifying how they intended to spend the UIP.

Of 52 participants that submitted UIP spend plans, most intended to spend their UIPs on increased staffing or improved health care infrastructure; a much lower proportion planned to spend their UIPs on accountable care for underserved beneficiaries. Of the $3,770,000 in projected UIP spending documented in participants' spend plans, increased staffing represented 53 percent of planned spending ($1,998,745), followed by health care infrastructure investments at 41 percent ($1,558,603), with provision of accountable care for underserved beneficiaries representing only 5 percent of planned spending ($212,652) (Figure VI.1).

[14] To be eligible, Track 1 organizations had to either (1) not have a current e-consult technology solution or (2) meet the definition of "low revenue."

[15] MAKING CARE PRIMARY: PAYMENT AND ATTRIBUTION METHODOLOGIES PY 2025

Figure VI.1. Total projected UIP spending by allowable category



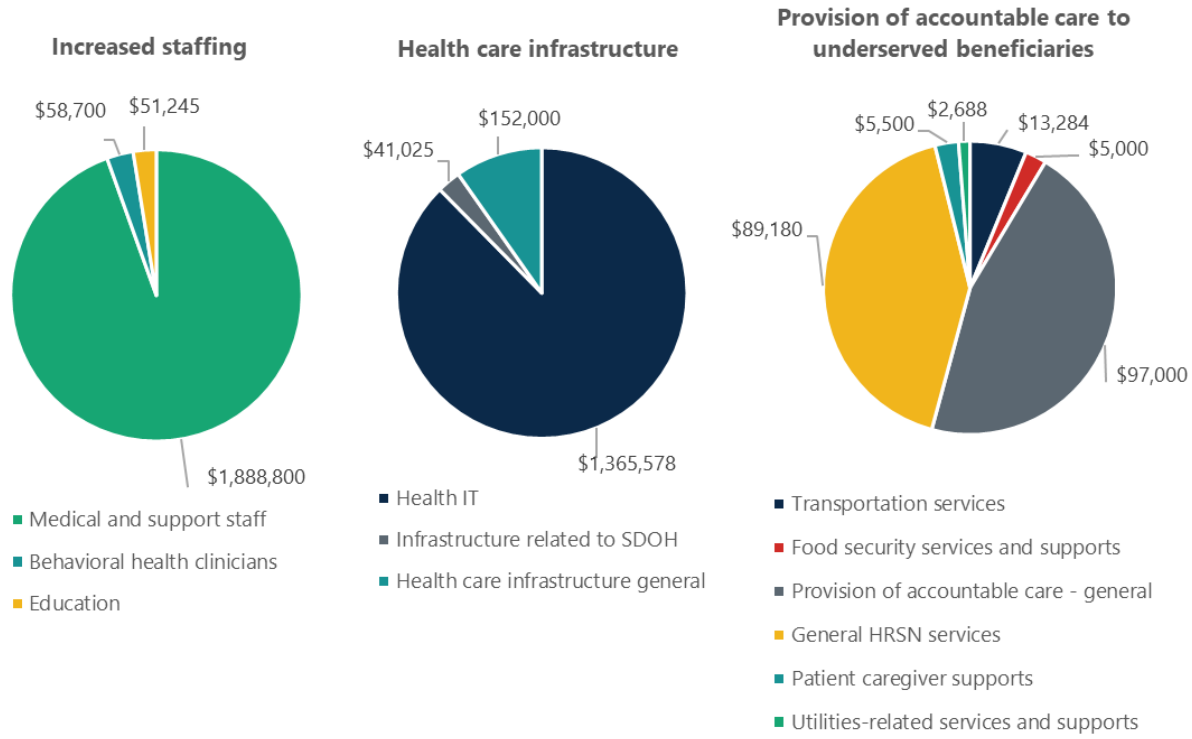
Source: Evaluation contractor's analysis of approved UIP spend plans as of February 2025 (n = 52).

Participants' planned spending aligned with the UIP spending requirements (Figure VI.2). For example:

- *Increased staffing.* Planned spending on additional medical or support staff represented 95 percent of the planned UIP spending on staffing. These additional staff included patient navigators, nurse care managers, or mid-level practitioners (such as a physician assistant or nurse practitioner), and less commonly, community health workers or nutrition professionals. Planned spending on behavioral health clinicians and staff education represented 2.9 and 2.6 percent, respectively, of the planned UIP spending on staffing.
- *Health care infrastructure:* Of the UIP funding that participants planned to spend on infrastructure, participants planned to use 88 percent to improve health information technology (IT), such as e-consult technology investments, investments in certified electronic health record technology, and IT-enabled screening tools, among others. Planned spending on health care infrastructure, more generally, represented 10 percent of planned infrastructure spending. For example, one participant mentioned adding a bariatric exam table to facilitate physical exams for their bariatric patients. Infrastructure to address social needs, such as devices for remote patient monitoring, represented only 2.6 percent of planned UIP spending on healthcare infrastructure.
- *Provision of accountable care for underserved beneficiaries:* Planned spending on provision of accountable care for underserved beneficiaries was limited (only 5 percent of planned UIP spending). This spending was most commonly planned for (1) general provision of accountable care for underserved beneficiaries (46 percent) or (2) general health-related social needs services (42 percent). These categories included the provision of gym memberships for patients needing weight reduction or supporting the integration of social needs assessment into the care model. In addition, a small percentage of spending on accountable care for underserved beneficiaries was planned for transportation, such as vouchers for ride-share services or public transportation; patient caregiver supports, such as in-home assistance or training; food security services and supports, such as medically

tailored meals or food vouchers; and utilities-related services and supports, such as electricity assistance.

Figure VI.2. Planned UIP spending by subcategories

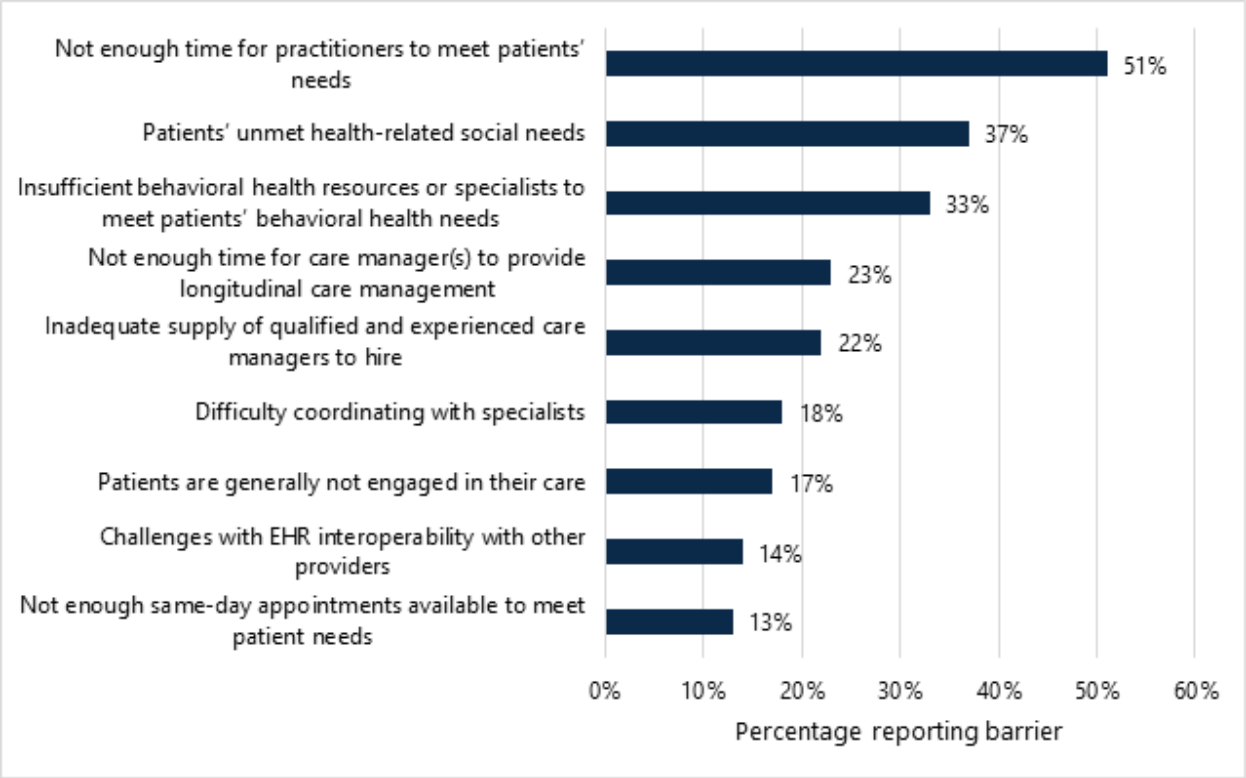


Source: Evaluation contractor's analysis of UIP spend plans as of February 2025 (n = 52).
IT = information technology; HRSN = health-related social needs; SDOH = social determinants of health

C. Perceived barriers to MCP implementation

Participants perceived substantial barriers to improving the quality of care and patients' outcomes under the model, and many participants found MCP requirements burdensome. Across tracks, 51 percent of participants reported that the most significant barrier to improving the quality of care and health outcomes was that there was not enough time for practitioners to meet patients' needs (Figure VI.3). Over three-quarters of participants found MCP requirements, encompassing both care delivery requirements and reporting requirements, to be either very or somewhat burdensome (Figure VI.4).

Figure VI.3. MCP participants' perceived barriers to improving the quality of care and health outcomes

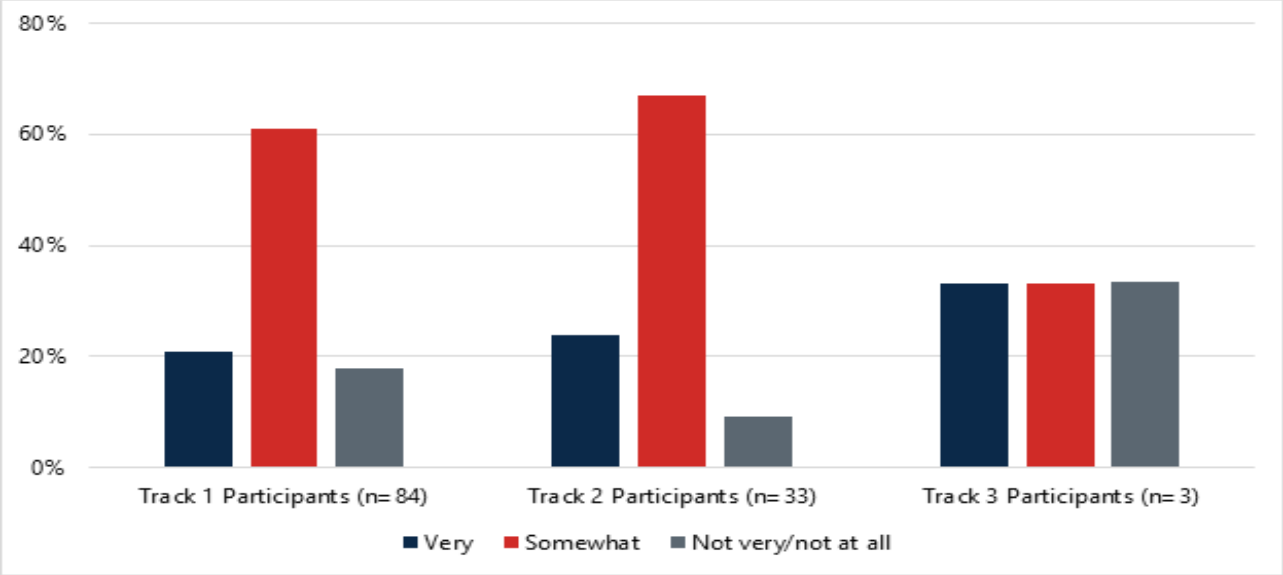


Source: The MCP design & operations contractor's analysis of the MCP participant portal as of October 2024 (n = 120)

Note: Participants were asked to select up to three barriers.

EHR = electronic health record.

Figure VI.4. Proportion of MCP participants reporting that model requirements were "very," "somewhat," or "not very" or "not at all" burdensome, by track



Source: The MCP Design & Operations contractor's analysis of data submitted to the MCP Participant Portal in October 2024 (n = 120)

D. Progress made on specialist integration in the first year of MCP

Although participants did not submit data on early model implementation for most care delivery requirements, participants could provide data to CMS about their changes to specialist integration under the model. MCP participants in Tracks 2 and 3 were required to establish formal, documented relationships with at least one specialist in cardiology, orthopedics, or pulmonary disease during the model (had the model not ended early), and participants in all tracks were allowed to establish these relationships with specialists in 32 approved specialties.[16]

For participants that delivered only primary care (that is, not multispecialty organizations), Track 2 and 3 participants were required to establish their first specialist relationship by December 31, 2025 (had the model not ended early). These formal relationships between the MCP participant and specialists were known as collaborative care arrangements, and the external specialist partners were referred to as specialty care partners.

[16] Approved specialties were as follows: addiction medicine, advanced heart failure and transplant cardiology, allergy/immunology, cardiac electrophysiology, cardiovascular disease (cardiology), dermatology, endocrinology, gastroenterology, geriatric medicine, geriatric psychiatry, hematology, hematology/oncology, hospice/palliative care, infectious disease, internal medicine, interventional cardiology, medical oncology, nephrology, neurology, neuropsychiatry, obstetrics/gynecology, ophthalmology, orthopedic surgery, pain management, peripheral vascular disease, physical medicine and rehabilitation, psychiatry, pulmonary disease, rheumatology, sleep medicine, sports medicine, urology. MCP standard participant amended and restated participation agreement (July 2024 Starters). July 18, 2024.

For multispecialty organizations participating in MCP, Track 2 and 3 participants were required to establish relationships with the specialists within their own organizations (billing to the same TIN) by January 1, 2025. These participants' formal relationships with their specialists were known as written collaborative protocols and the specialist partners were referred to as MCP specialists.

Collaborative care arrangements and written collaborative protocols both outlined key elements of joint care provision, including communication protocols between primary care practitioners and specialists, care transition expectations, care coordination parameters, and billing requirements for ambulatory co-management. MCP primary care clinicians in Tracks 2 or 3 could bill for the model's MCP e-consult payments without the consulting specialist being a specialty care partner or MCP specialist. However, only specialty care partners and MCP specialists with collaborative care arrangements or written protocols with Track 3 participants could bill for ambulatory co-management of patients under MCP.

Few participants identified any MCP specialty care partners before CMS announced the model's end in March 2025. Participants could report their specialty care partners to CMS in the MCP portal. By April 2025, a total of seven participants (six Track 1 organizations, one Track 2 organization, and no Track 3 organizations) had identified at least one specialty care partner, for a total of eight specialty care partners. Data on the number of MCP specialists identified were not available.

Few MCP participants made use of CMS-provided data tools to identify specialist partners. Only 19 participants downloaded the CMS-provided data reports called "Specialist Information" at any point during the model through April 2025. The DFT User Guide from January 25, 2025, said that reports would include highest-expenditure specialists for attributed beneficiaries in each MCP region.

VII. Potential for MCP to meet expansion criteria related to cost and quality

Key points

- CMS intended that, if MCP were to meet the Innovation Center expansion criteria, it would do so by improving quality while remaining cost neutral.
- MCP participants had meaningful room for improvements in quality outcomes in several domains, including clinical quality, delivering person-centered care, and unplanned acute care needs.
- MCP was not projected to achieve cost neutrality for Medicare for several years (2027 or 2028 at the earliest) and the magnitude of the savings, if any, was expected to be small.
- MCP payments to standard participants were higher than typical Medicare reimbursement.
- The MCP evaluation had low statistical power to detect the model's anticipated effects on total Medicare FFS expenditures.

This section assesses MCP's potential to meet the Innovation Center's statutory criteria for model expansion. Under 42 U.S.C. § 1315a, to be eligible for expansion, a model must either:

- Reduce Medicare, Medicaid, or CHIP spending without reducing the quality of care, or
- Improve the quality of patient care without increasing spending

Data sources for Section VII

- CMS model documents
- Clinical quality measure data from the Uniform Data System for 46 FQHCs
- Survey responses from 2,523 Medicare FFS beneficiaries served by MCP participants
- Medicare FFS claims and enrollment data

CMS anticipated that if MCP were to meet these criteria, it would do so by improving quality rather than by generating immediate net cost savings. CMS projected that the model would not achieve Medicare cost neutrality for several years—not before 2027 or 2028, even under optimistic assumptions—and would save no more than 0.5 percent of total Medicare Parts A and B expenditures in its final two years.

The evaluation examined MCP's potential for expansion through two sets of analyses. First, to evaluate MCP's potential to improve quality, we examined participants' quality outcomes at the start of the model across several key domains: clinical quality measures, patient experience, and acute care utilization. Second, to assess the model's potential for cost neutrality, we conducted two activities: (1) we analyzed projected Medicare payments to MCP participants during 2025 and compared them with the payments that MCP participants would have received under typical Medicare reimbursement for the same services, and (2) we calculated the smallest impact that the MCP evaluation would be able to detect reliably, given

MCP participation. For all analyses in this section, we limit the MCP population to evaluable participants (see Section III), as we assume this would be the most relevant population for CMS expansion decisions.

Findings indicate that MCP participants had meaningful room for improvement in quality, which they may have achieved over the course of the model. However, MCP payments reimbursed participants at a higher rate than typical Medicare reimbursement, indicating the model would have needed to attain some reductions in service use to achieve cost neutrality. Pathways to cost neutrality could include, for example: (1) improved population health, leading to fewer acute care needs and fewer resulting acute care services; and (2) better coordination and comprehensiveness of primary care, reducing the number of duplicative services delivered and, as appropriate, reducing the need for specialist services. Yet, with modest participation in the model (see Section III), the MCP evaluation was unlikely to be powered to detect the model's effects on total Medicare FFS expenditures, even in the most promising scenario.

A. Quality of care at MCP organizations

We assessed the quality of care among MCP participants at the start of the model across several key domains. First, we evaluated pre-intervention performance on the five clinical quality measures CMS included in MCP's performance measure set (Appendix A), which CMS planned to use to determine MCP participants' eligibility for the performance incentive payment. We observed pre-intervention (2023) performance only among FQHCs, using data from the HRSA Uniform Data System (UDS) on health center programs and look-alike organizations. Second, we examined patient experience using data from the MCP evaluation's beneficiary survey, fielded from October 2024 to March 2025. Third, we analyzed Medicare FFS claims to assess acute care service use in the first half of 2024, before MCP launched, among beneficiaries attributed to MCP participants. While acute care use is not a direct measure of primary care quality, access to high-quality primary care is associated with reduced use of acute care services by emphasizing prevention, early intervention, and effective management of chronic conditions.[17]

Across each domain, we found that MCP participants had meaningful room for improvements in quality, as described in detail below.

1. Clinical quality measures among FQHC participants

MCP FQHC participants had some room for improvement in the model's clinical quality measures, particularly for colorectal cancer screening and depression remission (Table VII.1). We used UDS data to study the model's five clinical quality measures. For each measure, we calculated the percentage of participants that met the MCP performance benchmarks, which were based on a national population reported under the Merit-based Incentive Payment System (MIPS). MCP participants met the lower MCP benchmark if they met or exceeded the median of the national MIPS population for a given measure. Participants met the upper MCP benchmark if they met or exceeded the 70th (for Tracks 1 and 2) or the 80th (Track 3) percentile.

[17] Bazemore, A., Petterson, S., Peterson, L. E., Bruno, R., Chung, Y., & Phillips, R. L. (2018). *Higher primary care physician continuity is associated with lower costs and hospitalizations.* The Annals of Family Medicine, 16(6), 492–497. https://doi.org/10.1370/afm.2308

Starfield, B., Shi, L., & Macinko, J. (2005). *Contribution of primary care to health systems and health.* Milbank Quarterly, 83(3), 457–502. https://doi.org/10.1111/j.1468-0009.2005.00409.x

- In 2023, less than half of MCP FQHC participants met the lower benchmark for depression remission (41 percent), and less than one-quarter of FQHC participants met the lower benchmark for colorectal cancer screening (22 percent).[18] No MCP FQHC participants met the higher benchmark for colorectal cancer screening. The results suggest MCP participants had substantial room for improvement on these two clinical measures. (If MCP participants had performance similar to the national rates, we would expect around 50 percent of MCP participants to meet the lower benchmark.)
- More than 80 percent of FQHC participants met the lower MCP benchmarks for diabetes control (83 percent) and screening for depression (91 percent). Further, more than 70 percent of FQHC participants met or exceeded the upper MCP benchmark. These findings suggest that MCP participants performed better than other health care providers nationally on these two measures and may have had less room for improvement.
- MCP FQHCs had somewhat better performance than the broader MIPS population on the measure of blood pressure control (61 percent of MCP FQHCs met the lower MIPS benchmark, whereas we would expect about 50 percent of health providers nationally to meet this benchmark). However, there was still room for improvement, as less than a quarter (24 percent) of MCP FQHCs met the higher MIPS benchmark.

[18] Low colorectal cancer screening rates and benchmarks may be partly due to strict documentation requirements, which exclude self-reported screenings unless verified through medical records—making it difficult to count tests performed elsewhere. Further, 2023 was the first year in which individuals ages 46 to 49 were included in the recommended population for screening. (The colorectal cancer screening measure covered only patients aged 50 to 75 in 2022 and before). Therefore, it is possible screening rates (and the corresponding benchmarks) may increase in subsequent years as organizations adapt to the updated guidance. Because FQHCs tend to serve a younger-than-average Medicare population, their scores are likely more affected than average by the expansion of the screened population to include patients ages 46–49.

Table VII.1. Clinical quality measure performance in 2023 among MCP FQHCs (N=46), relative to national benchmarks from MIPS

Electronic Clinical Quality Measure	Average of participant-level performance scores	Lower MCP benchmark (MIPS 50th percentile)	Upper MCP benchmark (Tracks 1 and 2: MIPS 70th percentile; Track 3: 80th percentile)	% of participants meeting or exceeding lower benchmark	% of participants meeting or exceeding upper benchmark
Controlling high blood pressure: Percent of patients with controlled blood pressure among those 18-85 years of age with hypertension	64.5%	64.2%	Tracks 1&2: 71.1%; Track 3: 75.3%	61%	24%
Diabetes HbA1c poor control: Percent of patients with HbA1c >9 percent among those 18-75 years of age with diabetes[a]	27.6%	34.2%	24.3%; 19.8%	83%	35%
Colorectal cancer screening: Percent of adults aged 46-75 years with appropriate screening for colorectal cancer	41.4%	51.9%	67.0%; 75.5%	22%	0%
Screening for depression and follow-up plan: Percent of patients aged 12 years and older screened for depression with a follow-up plan documented as appropriate	67.8%	33.8%	58.9%; 72.8%	91%	70%
Depression remission at 12 months: Percent of patients aged 12 years or older with major depression or dysthymia who reached remission at 12 months [b]	10.0%	9.0%	14.0%; 18.2%	41%	26%

Source: MCP evaluation contractor's analysis of HRSA Uniform Data System (UDS) in 2023.

Note: Benchmarks were set for the model using the national MIPS population in 2023 (for controlling high blood pressure, colorectal cancer screening, and depression screening) or 2024 (for diabetes control and depression remission) (Making Care Primary: Payment and Attribution Methodologies PY 2024, version 1.0, December 2024).

This table is based on UDS data for 46 MCP FQHCs. Of the 48 evaluable MCP FQHC participants, 47 reported to UDS in 2023 (one MCP participant did not become a FQHC until 2024). Two MCP participants belonged to the same FQHC organization (according to HRSA, which identifies FQHC organizations by BHCMISIDs), so they are reported in aggregate, resulting in a total of 46 FQHC organizations with available data. Of these 46 FQHC organizations, 4 were FQHC look-alikes, meaning they met all FQHC requirements but did not receive federal health center grant funding (through Section 330 of the Public Health Service Act).

[a] This measure (CMS122) is an inverse measure, meaning that lower scores reflect higher quality. CMS122 was expanded in 2025 to reflect the percentage of patients with HbA1c or glucose management indicator > 9 percent. Though MCP used the updated measure for the 2025 performance year, the MIPS benchmark is based on data from the HbA1c-specific measure, which aligns with what FQHCs reported in the 2023 UDS data.

[b] The depression remission measure is based on data from 27 MCP FQHC participants (not 46 like the other measures) because data were not available for 19 organizations due to UDS suppressing performance scores based on ≤ 15 patients in the numerator (15 organizations) or denominator (4 organizations).

BHCMISID = Bureau of Primary Health Care Health Center Management Information System ID; CMS = Centers for Medicare & Medicaid Services; FQHC = Federally Qualified Health Center; HbA1c = hemoglobin A1c; HRSA = Health Resources and Services Administration; MCP = Making Care Primary; MIPS = Merit-based Incentive Payment System; UDS = Uniform Data System.

2. Measures of patient experience

MCP beneficiaries rated the care they received from their primary care providers highly (Table VII.2; see Appendix D for survey methodology). At the start of the model, beneficiaries receiving care from standard organizations and beneficiaries who were not dually eligible for Medicare and Medicaid had somewhat more favorable ratings of their primary care providers than beneficiaries in FQHCs and beneficiaries who were dually eligible, but differences were small, and all groups reported positive patient experience with the primary care they received.

- MCP beneficiaries gave an average rating of 8.9 for the care they received from their primary care providers (on a scale of 0 to 10, where 0 is the worst care possible and 10 is the best care). In fact, nearly half of beneficiaries rated their provider a perfect score of 10, and only 14 percent of MCP beneficiaries gave a score of 7 or below.
- Beneficiaries in standard organizations rated their primary care providers higher than beneficiaries receiving care from FQHCs, but both groups rated providers highly (means of 9.0 and 8.6 out of 10 for standard and FQHCs, respectively). More than half of beneficiaries in standard organizations (51 percent) gave their provider a perfect score of 10 compared with 42 percent of beneficiaries in FQHCs.
- Dually eligible beneficiaries and beneficiaries not dually eligible for Medicaid both rated their providers highly, with nearly half of beneficiaries in both groups rating their providers a 10 out of 10. However, a higher percentage of dually eligible beneficiaries gave their providers a score of 7 or less, suggesting there may be more discontent about primary care quality among dually eligible beneficiaries (20.5 percent for dually eligible compared with 12.6 percent for non-dually eligible beneficiaries).

MCP beneficiaries reported their primary care experience was mostly person-centered, though some opportunities remained to enhance engagement and individualized care (Table 8.2). We assessed the extent to which primary care was person-centered using the Person-Centered Primary Care Measure (PCPCM). The PCPCM is an 11-item patient-reported survey that broadly assesses key domains of primary care—such as accessibility, comprehensiveness, coordination, and patient-clinician relationships.[19] The PCPCM uses a 4-point Likert scale (ranging from 4 "definitely" to 1 "not at all") for each of its 11 component items, with higher average scores indicating a greater degree of person-centered care.

- MCP beneficiaries had an overall PCPCM score (averaged across the 11 items) of 3.3 out of 4, indicating that patients mostly experienced person-centered care and key aspects were present but were not consistently strong.
- Patients rated access to care, consideration of health factors, and support for staying healthy highest (with each item scoring an average of 3.5 or higher), highlighting strengths in these areas and less room for improvement.
- The PCPCM item with the lowest average score (2.5) was continuity of the doctor-patient relationship (Item 6, “My doctor and I have been through a lot together”). This may suggest greater room for improvement in building long-term, personal connections.

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- Most domains scored an average between 3.0 and 3.4 out of 4, reflecting person-centered care with some opportunities for enhancements.
- Beneficiaries served by standard participants and FQHCs reported similarly on person-centered care, as did dually eligible beneficiaries and those not dually eligible.

MCP beneficiaries indicated room for improvement in post-acute care follow-up. Less than half of MCP beneficiaries with acute care use in the previous 12 months reported they were contacted by their primary care practice within one week of their ED visit or hospitalization (Table VII.2).

- Among MCP beneficiaries with an ED visit in the last 12 months, 40 percent responded that their primary care provider had followed up with them within a week.
- Follow-up was slightly higher following hospitalizations, with 46 percent of MCP beneficiaries with a hospitalization indicating that their primary care provider had contacted them within a week of their stay.

Table VII.2. MCP beneficiaries' self-reported patient experience

	Mean among MCP survey respondents (N=2,523)	FQHC vs. standard beneficiaries		Dual vs. non-dual beneficiaries	
		Mean among FQHC respondents (N=448)	Mean among standard respondents (N=2,075)	Mean among duals (N=768)	Mean among non-duals (N=1,755)
Overall primary care rating					
Average rating of care received (where 0 is the worst care possible and 10 is the best care possible)	8.9	8.6	9.0	8.6	8.9
Categorical rating of care received					
0 – 7	14.0%	19.1%	12.4%	20.5%	12.6%
8 – 9	37.0%	39.2%	36.3%	32.8%	37.9%
10	49.0%	41.8%	51.3%	46.7%	49.5%
Person-centered primary care					
Overall PCPCM measure score[a]	3.3	3.2	3.3	3.2	3.3
1. My practice makes it easy for me to get care	3.6	3.5	3.6	3.5	3.6
2. My practice is able to provide most of my care	3.4	3.3	3.4	3.3	3.4
3. In caring for me, my doctor considers all factors that affect my health	3.7	3.6	3.7	3.5	3.7
4. My practice coordinates the care I get from multiple places	3.2	3.2	3.2	3.2	3.2
5. My doctor or practice knows me as a person	3.4	3.3	3.5	3.3	3.5
6. My doctor and I have been through a lot together	2.5	2.3	2.5	2.6	2.5
7. My doctor or practice stands up for me	3.4	3.2	3.4	3.2	3.4
8. The care I get takes into account knowledge of my family	3.0	2.9	3.1	2.9	3.0
9. The care I get in this practice is informed by knowledge of my community	2.8	2.7	2.8	2.7	2.8
10. Over time, my practice helps me to stay healthy	3.5	3.4	3.6	3.4	3.6
11. Over time, my practice helps me to meet my goals	3.3	3.2	3.4	3.2	3.3
Follow-up after acute care use					
Contacted by primary care doctor or someone from practice to follow up within one week after most recent emergency department visit[b]	40.2%	41.2%	39.8%	41.5%	39.8%

Contacted by primary care doctor or someone from practice to follow up within one week after most recent hospital stay[c]	46.0%	43.1%	47.1%	47.3%	45.7%

Source: MCP evaluation contractor's analysis of baseline beneficiary survey data.
Note: The sample sizes (N) shown represent the number of MCP Medicare beneficiaries that submitted completed survey questionnaires.
[a] We calculated the PCPCM for beneficiaries who answered at least 8 of the 11 items.
[b] This question was asked to beneficiaries who had an ED visit in the previous 12 months.
[c] This question was asked to beneficiaries who had an overnight hospital stay in the previous 12 months.

FQHC = Federally Qualified Health Center; MCP = Making Care Primary; PCPCM = Person-centered primary care measure.

3. Measures of acute care use

MCP beneficiaries had high rates of outpatient ED visits in the six months before MCP began (first two quarters of 2024), suggesting substantial opportunities for improvement. The rate of ED visits was an outcome included in the MCP performance measure set (Appendix A), which CMS planned to use to determine PIP receipt. The high rate of ED visits among MCP participants was driven by beneficiaries at FQHCs, who had substantially more ED visits than beneficiaries served by standard participants (Table VII.3). The rate of acute hospitalizations for MCP beneficiaries was also higher than those of non-participants, but the differences were less substantial.

- MCP beneficiaries had an average of 479 ED visits per 1,000 beneficiaries per year compared with 431 visits among beneficiaries at non-participating organizations in the MCP states before the model began. A higher prevalence of ED visits may reflect that some MCP beneficiaries had challenges accessing care at the start of the model, with more than 10 percent of MCP beneficiaries in the MCP beneficiary survey reporting they delayed or did not receive needed medical care, most commonly due to how long it took to obtain care (see Section III).
- MCP participants had a higher average number of acute hospitalizations compared with non-participants before the model began: 260 versus 247 per 1,000 beneficiaries per year. Preventable hospitalizations were similar between the groups.
- FQHC participants in MCP had a substantially higher number of outpatient ED visits than standard participants before the model began: an average of 582 versus 449 ED visits per 1,000 beneficiaries per year. However, beneficiaries at FQHCs had a modestly lower rate of acute hospitalizations. Medicare FFS beneficiaries served at MCP participant FQHCs were younger than those served at standard participants, on average (67 versus 71 years) and had lower mean HCC scores (0.8 versus 0.9), which may have contributed to the lower rates of acute hospitalizations.
- Beneficiaries in FQHCs comprised a larger share of the Medicare FFS patient population at MCP participants (22 percent) than they do for non-participating organizations (4 percent). This fact combined with the higher rates of ED visits at FQHCs appear to drive the high rates of ED visits among MCP participants relative to non-participants.

Table VII.3. Annualized acute care use among MCP beneficiaries, January 1 to June 30, 2024 (per 1,000 beneficiaries per year)

	MCP participants					Non-participants in MCP states[b]
		Track 1 vs. Tracks 2 & 3		FQHC vs. Standard		
	Overall[a] (N=99)	Track 1 (N=65)	Tracks 2 & 3 (N=34)	FQHC (N=48)	Standard (N=51)	
Acute hospitalizations (short-stay acute care and critical access hospitals)	247	260	227	231	252	251
Preventable hospitalizations	47	48	45	47	46	48
Outpatient ED visits	479	505	438	582	449	431

Source: MCP evaluation contractor's analysis of Medicare claims data from January 1, 2024, to June 30, 2024.
Note: This table shows annualized acute care use among beneficiaries attributed to MCP and non-participant organizations in Q1 and Q2 2024. Means are weighted by the number of days each organization's attributed beneficiaries were enrolled in Medicare FFS in the first six months of 2024.
[a] We include only MCP participants that met the MCP evaluation eligibility criteria.
[b] Non-participants comprise organizations that met the MCP eligibility criteria and had at least 20 percent of their beneficiaries residing in MCP states.
FQHC = Federally Qualified Health Center; MCP = Making Care Primary.

B. Assessing the potential for MCP to achieve cost neutrality

As noted earlier, CMS projected MCP would not achieve Medicare cost neutrality for several years—not before 2027 or 2028—and would save at most 0.5 percent in total net Medicare Parts A and B expenditures in the model's final years, even under optimistic assumptions.

To inform whether MCP had the potential to meet cost-neutrality expansion criteria, we conducted two analyses. First, we compared CMS payments under MCP to projected payments under standard Medicare FFS. If MCP payments had been substantially higher than typical Medicare FFS payments, then the model would have needed to generate large savings to achieve cost neutrality. Second, we assessed the minimum magnitude of the impacts that could have been detected through the MCP evaluation, given model participation. If the evaluation had limited sensitivity to detect small effects, it would have increased the risk that the evaluation could fail to detect actual savings or falsely report savings when none were generated.

1. Projected Medicare payments in 2025 under MCP versus typical Medicare reimbursement for standard participants

The evaluation independently assessed how CMS payments under MCP differed from status quo reimbursements under typical Medicare fee-for-service (FFS). The goal was *not* to assess effects of MCP on Medicare expenditures, but rather to judge how much more or less the model's participants would have earned under MCP than under typical Medicare reimbursement if health care service use was

unchanged. This payment calibration analysis thus informs the evaluation's understanding of MCP's potential for cost neutrality. That is, if participants earned much more under MCP than they would have earned under typical Medicare reimbursement for a given set of services, the model would have needed to generate large reductions in other Medicare spending (for example, spending for acute or specialist care) to be cost neutral to the Medicare program. Conversely, if participants earned about the same under the model as status quo for a given set of services, the model could have been cost neutral or even have saved costs with only modest reductions in other spending. We conducted the analysis from the payer's (Medicare's) perspective, that is, we assessed payments made by Medicare to the primary care organization and not the revenue earned by the primary care organization, which would also include beneficiary coinsurance or copays.[20]

We projected the payments that evaluable MCP standard participants would have received under the model in 2025 (based on the participants' 2023 services delivered) and compared projected MCP payments with payments the participants would have received for the same services under typical Medicare reimbursement. We focus on standard participants because results for FQHCs were not available at the time of writing. To calculate typical Medicare reimbursement, we considered traditional FFS payments under the 2025 Physician Fee Schedule (PFS). For MCP payments, we studied two groups of model payments: payments for PPCP services and payments for ESP services. We did not include PIPs because we did not have information to project likely PIP amounts at model end, but these payments would have increased MCP reimbursements relative to our projections. Similarly, we did not include UIPs (because these were designed to be a one-time cost to CMS) or the new billing codes to encourage specialist integration (because these were not billed during 2023, the period in which we assessed MCP participants' service delivery). Appendix F provides more detail on methods used for this analysis.

Projected payments to evaluable standard participants under MCP were higher by $12 per beneficiary per month (PBPM), on average, compared with the PFS—or 36 percent greater than the status quo for covered services (Table 8.4). We calculate standard participants would have received $45 PBPM on average under MCP, compared with $33 PBPM under the PFS in 2025 for the same set of primary care services participants provided to the same beneficiaries in 2023. This $12 PBPM difference was almost entirely driven by the difference in payments for services covered by ESPs ($15 versus $3 PBPM under MCP and PFS, respectively)—in part because most standard participants were in Track 1 and did not earn PPCPs.

Differences in reimbursement varied by track, with Track 1 participants projected to receive the largest increase in payments under MCP, averaging $15 PBPM more than typical Medicare reimbursement. Track 2 participants also saw higher payments under MCP, though more modestly, at $5 PBPM. In contrast, the sole evaluable Track 3 standard participant was projected to receive $5 PBPM *less* under MCP. These differences by track are consistent with the finding that ESPs drove the overall

[20] We expect the difference in an organization's revenue (going from FFS to model payments) to be smaller than the difference in Medicare payments. For example, if model payments were generally higher than FFS reimbursement, we expect the additional cost to Medicare under MCP would exceed the participant's increase in revenue under MCP. This is because higher payments for ESP-covered services under MCP are likely to be offset by the loss of copays on those services that are no longer billable. (Participants were still allowed to bill copays for PPCP-covered services under MCP.)

difference between MCP payment amounts and typical FFS reimbursement. That is, CMS designed the ESP to provide lower rates of funding in Tracks 2 and 3 than in Track 1, as participants in higher tracks of MCP could earn larger PIPs.[21]

Since Tracks 1 and 2 were time-limited, with all participants expected to graduate to Track 3 by 2029, the difference between Track 3 payments and FFS reimbursement is arguably the most relevant for assessing cost-\ neutrality in the long run. Given this, we conducted a separate payment calibration where we assumed all standard participants were in Track 3, rather than their starting track as in Table VII.4.

When we applied MCP payments under Track 3 to *all* evaluable standard participants, projected payments under MCP were still higher than under PFS, but the difference was more modest at $4 PBPM—or 12 percent greater than the status quo for PPCP- and ESP-covered services (Table VII.5). Under this approach, we project PPCPs would be lower by $2 PBPM ($28 versus $30 PBPM), on average, but ESPs would be higher by $6 PBPM ($9 versus $3 PBPM). The relatively small difference in total payments ($4 PBPM) between MCP's capitated rates and typical Medicare reimbursement suggests that CMS set payment levels that were comparable to standard Medicare spending—excluding the additional costs associated with the model's PIPs.

These findings suggest that **MCP standard participants would have needed to reduce Medicare expenditures by at least $4 PBPM—plus whatever the participants earned in PIPs—for MCP to be cost neutral** (for example, through fewer acute care services and/or less duplicative services). Although CMS did not expect that the model would achieve cost neutrality until at least 2027 or 2028, the results from the payment calibration suggest that MCP standard participants would have earned only slightly more in model payments as under the PFS for the participants' PPCP- and ESP-covered services once they transitioned to Track 3, before accounting for PIPs. Because we did not include the PIPs in the payment calibration, participants would have had to reduce Medicare Parts A and B expenditures beyond $4 to cover whatever amount the participants earned in PIPs. CMS designed the MCP PIP as an upside-only adjustment for participants in all tracks, and Track 3 participants could earn up to an additional 60 percent of their revenue for PPCP-covered services. It is not clear how much of this potential bonus the participants would have earned.

[21] CMS MCP Payment and Attribution Methodologies PY 2025

Table VII.4. Projected 2025 Medicare payments to evaluable standard participants under the Physician Fee Schedule vs. MCP

Payment categories	Payments per beneficiary per month ($)		
	Fee-for-service mean	MCP mean	Difference in mean payments (MCP – typical Medicare reimbursement)
Standard evaluable participants[a] in all tracks (N = 51)			
Payments for both PPCP and ESP services	$33	$45	$12
Payments for PPCP services	$30	$30	-$1
Payments for ESP services	$3	$15	$12
Track 1 (N = 36)			
Payments for both PPCP and ESP services	$31	$46	$15
Payments for PPCP services	$29	$29	$0
Payments for ESP services	$2	$17	$15
Track 2 (N = 14)			
Payments for both PPCP and ESP services	$37	$42	$5
Payments for PPCP services	$33	$32	-$1
Payments for ESP services	$4	$10	$6
Track 3 (N = 1)			
Payments for both PPCP and ESP services	$34	$29	-$5
Payments for PPCP services	$33	$23	-$10
Payments for ESP services	$1	$6	$4

Source: MCP evaluation contractor's analysis of Medicare claims data from January 1, 2023, to December 31, 2024.

Notes: To calculate payments, we considered the set of services that participants provided to their attributed beneficiaries during a pre-implementation baseline year (2023) but that reflect payment rates in 2025 for those services under the PFS or under MCP.

[a] We include only MCP participants that met the MCP evaluation eligibility criteria.

ESP = Enhanced Services Payments; MCP = Making Care Primary; PPCP = Prospective Primary Care Payments.

Table VII.5. Projected 2025 Medicare payments to evaluable standard participants under the Physician Fee Schedule vs. MCP, assuming all participants in Track 3

Payment categories	Payments per beneficiary per month ($)		
	Fee-for-service mean	Making Care Primary mean	Difference in mean payments (MCP – typical Medicare reimbursement)
Standard evaluable participants[a] in all tracks (N = 51)			
Payments for both PPCP and ESP services	$33	$37	$4
Payments for PPCP services	$30	$28	-$2
Payments for ESP services	$3	$9	$6
Starting Track 1 (N = 36)			
Payments for both PPCP and ESP services	$31	$37	$6
Payments for PPCP services	$29	$28	-$2
Payments for ESP services	$2	$10	$7
Starting Track 2 (N = 14)			
Payments for both PPCP and ESP services	$37	$38	$1
Payments for PPCP services	$33	$30	-$3
Payments for ESP services	$4	$8	$4
Starting Track 3 (N = 1)			
Payments for both PPCP and ESP services	$34	$29	-$5
Payments for PPCP services	$33	$23	-$10
Payments for ESP services	$1	$6	$4

Source: MCP evaluation contractor's analysis of Medicare claims data from January 1, 2023, to December 31, 2024.

Notes: To calculate payments, we considered the set of services that participants provided to their attributed beneficiaries during a pre-implementation baseline year (2023) but that reflect payment rates in 2025 for those services under the PFS or under MCP. In this table, we assigned all evaluable standard participants to Track 3 (that is, assuming they earn the applicable MCP payments under Track 3).

[a] We include only MCP participants that met the MCP evaluation eligibility criteria.

ESP = Enhanced Services Payments; MCP = Making Care Primary; PPCP = Prospective Primary Care Payments.

2. Minimum detectable effects for testing the average impact of MCP on Medicare FFS expenditures

We calculated the minimum detectable effects (MDEs) for testing the average impact of MCP on Medicare FFS expenditures in the planned MCP impact evaluation, including both MCP standard and FQHC participants. We focused on gross Medicare expenditures across the final four years of the model because this was the evaluation's prespecified test for assessing cost neutrality.[22] Gross Medicare FFS expenditures

[22] We did not consider total Medicare FFS expenditures including all MCP payments (such as ESPs, UIPs, PIPs and payments for MCP e-consults and ambulatory co-management services) as a primary outcome because the

include Parts A and B expenditures, MCP PPCPs, and adjustments from current Medicare payment programs (for example, adjustments under the Merit-based Incentive Payment System and shared savings payments for the Medicare Shared Saving Program). It does not include MCP's ESPs, UIPs, PIPs, and payments for MCP e-consults and ambulatory co-management services. Because CMS intended MCP to be cost neutral in *net* expenditures (that is, including all MCP payments), CMS anticipated savings in *gross* expenditures, which the evaluation sought to detect and ultimately compare to the additional investments to assess cost neutrality.

Given the level of participation, MCP's evaluation was unlikely to detect the level of gross savings projected by CMS, limiting CMS's ability to demonstrate overall cost neutrality to the Medicare program. Based on preliminary participation data from May 2024, the evaluation anticipated having sufficient statistical power to detect a 2.9 percent impact on gross Medicare FFS expenditures across the final four years of the model.[23] However, this threshold exceeded the most optimistic gross savings estimate of 2.1 percent projected by the CMS Office of the Actuary, suggesting that the evaluation would have been underpowered to detect even the most promising savings scenario.

magnitude of projected net savings even in the years with the highest projected savings was relatively low (less than 1 percent, according to CMS Office of the Actuary [OACT] projections in the MCP Innovation Center Investment Plan.

[23] The MDEs were calculated in May 2024 under the assumptions that there would be 114 total participating organizations in the evaluation sample (there were ultimately 99 participants that met the evaluation's eligibility criteria) and that we would match each MCP organization to two comparisons as part of the impact evaluation. MDEs reflect the smallest effect the evaluation could detect with 80 percent power on a two-sided test with alpha=0.1.

VIII. Conclusion

Key points

- MCP enrolled 131 participating primary care organizations in eight states.
- Despite its modest reach within MCP states, MCP preferentially enrolled participants with less experience than average in past CMS value-based payment initiatives and with less economically advantaged Medicare beneficiaries, as CMS intended.
- The model was designed to improve the quality of care, and MCP participants had meaningful room for improvement in a range of quality outcomes.
- Model participants faced substantial barriers to cost reduction and care improvement in the initial year of MCP, and low participation would have limited the MCP evaluation's ability to detect effects.
- CMS terminated the model on June 30, 2025. In its announcement of the model's early conclusion, CMS said the Innovation Center was updating its model portfolio "to align with its statutory obligation and strategic goals."

The Making Care Primary Model launched on July 1, 2024, in eight states and was intended to run for 10.5 years through December 2034. MCP was the CMS Innovation Center's first multi-state primary care model in nearly a decade to include federally qualified health centers (FQHCs), and the model offered three progressive participation tracks. Each track progression (from Track 1 to Track 2, or from Track 2 to Track 3) offered a greater proportion of Medicare revenue for primary care through population-based payments (as opposed to fee-for-service) and greater potential for performance-based incentive payments. The three tracks also featured progressively more advanced care delivery requirements.

MCP was thus designed to accommodate participants that started the model with varying levels of readiness to participate in value-based care. MCP participants that started the model in Tracks 1 and 2 were expected to progress through tracks over time, with all participants in Track 3 by 2029. This progressive track structure, along with MCP's 10.5-year duration and plans to encourage multi-payer alignment with non-CMS payers, was intended to help MCP participants to build enduring structures and processes needed to deliver high-quality, person-centered primary care, and to succeed in value-based care in the long run.

On March 12, 2025, CMS announced it would end MCP early. The model concluded on June 30, 2025, one year after the model launch.

A. Participation in MCP was modest

MCP enrolled 131 participating primary care organizations, with two-thirds (87 participants) starting in Track 1. About one-fifth of all participants (27) were not formally eligible for the model when they joined but were admitted on a glide path—meaning participation was contingent on increasing their attributed Medicare fee-for-service population to a minimum of 125 beneficiaries.

Overall, MCP had relatively low reach within the eight designated MCP states, with only 4 percent of eligible primary care provider organizations in the states participating. However, model reach was substantially higher among FQHCs, with one-third (35 percent) of eligible FQHCs joining MCP.

Despite its modest reach, MCP preferentially enrolled participants with less experience than average in past CMS value-based payment initiatives and less economically advantaged Medicare beneficiaries, as CMS intended. For example, MCP participants were less likely than non-participating organizations in MCP states to have participated in the Medicare Shared Savings Program. MCP beneficiaries were more likely than others in MCP states to qualify for Medicare due to a disability, to be dually eligible for Medicare and Medicaid, or to be eligible for a low-income subsidy for Medicare Part D coverage.

B. CMS designed MCP to meet Innovation Center expansion criteria through improved quality and not to be cost neutral for many years

CMS designed MCP to meet the Innovation Center's statutory criteria for model expansion by improving the quality of care (with cost neutrality to the Medicare program), rather than by cutting costs. MCP aimed to deliver comprehensive, coordinated, patient-centered primary care to improve patients' health and health care experiences. Pathways to cost neutrality could include, for example, (1) improved population health leading to fewer acute care needs and resulting acute care services; and (2) better coordination and comprehensiveness of primary care reducing the number of duplicative services delivered, and, as appropriate, reducing the need for specialist services.

MCP participants started the model with meaningful room for improvement in a range of quality outcomes, indicating the model's potential for quality improvement. Although MCP participants already scored highly on some quality outcomes when the model launched, there was room for improvement in others. For example, among the clinical quality measures included in the MCP performance measure set (intended for use to determine Performance Incentive Payments), FQHC participants in MCP performed well below national benchmarks in 2023 for measures of depression remission and colorectal cancer screening. (Data were not available for standard participants—that is, non-FQHCs.) In addition, the emergency department visit rate was more than 10 percent higher among Medicare FFS beneficiaries at MCP participants (FQHC and standard combined) than among beneficiaries at non-participating organizations before the model began: respectively, 479 versus 431 ED visits per 1,000 beneficiaries per year. These data could potentially indicate insufficient access to primary care for MCP beneficiaries' urgent but low-acuity health concerns before the model began—a finding supported by survey results that showed the most common reason for MCP beneficiaries to forego care was inability to get an appointment.

Although MCP showed potential for quality improvement, model participants faced substantial barriers to cost reduction and care improvement in the initial year of MCP, and low participation would have limited the MCP evaluation's ability to detect effects. In its pre-launch projections for the model, CMS estimated that, even under optimistic assumptions, MCP would not be cost neutral until 2027–2028 and it would save at most 0.5 percent of total Medicare Parts A and B expenditures in the final two years of the model. Given these projections, and given the relatively low number of model participants, the MCP evaluation was underpowered to detect changes in Medicare expenditures (even gross expenditures, ignoring several model payments) sufficient to demonstrate MCP's cost neutrality to the Medicare program.

C. Early conclusion of MCP

CMS terminated MCP on June 30, 2025. In its announcement of the model's early conclusion, dated March 12, CMS said the Innovation Center was updating its model portfolio "to align with its statutory obligation and strategic goals."[24]

The announcement stressed that primary care remains a foundational component of the Innovation Center's strategy. Primary care remains, in most cases, Americans' first point of contact with the health care system for both new and ongoing health concerns, and so primary care models provide CMS with a unique opportunity to shape efficient, high-quality, and patient-centered health care. CMS said that MCP's early conclusion reflects "a need to focus on different approaches [to primary care] that are consistent with the CMS Innovation Center's statutory mandate and produce savings."[25]

[24] "Fact sheets: CMS Innovation Center announces model portfolio changes to better protect taxpayers and help Americans live healthier lives." Posted March 12, 2025. Available online at CMS Innovation Center Announces Model Portfolio Changes to Better Protect Taxpayers and Help Americans Live Healthier Lives | CMS. Last accessed 5/15/2025.

[25] "Fact sheets: CMS Innovation Center announces model portfolio changes to better protect taxpayers and help Americans live healthier lives." Posted March 12, 2025. Available online at CMS Innovation Center Announces Model Portfolio Changes to Better Protect Taxpayers and Help Americans Live Healthier Lives | CMS. Last accessed 5/15/2025.

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Appendices

Appendix A. Performance measure set

Measure[a]	Steward (ID, if applicable)	Mode	Track 1	Track 2	Track 3
Controlling High Blood Pressure	NCQA (CMS165)	eCQM	X	X	X
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)+*	NCQA (CMS122)	eCQM	X	X	X
Colorectal Cancer Screening+*	NCQA (CMS130)	eCQM	X	X	X
Screening for Depression and Follow-up Plan+*	CMS (CMS2)	eCQM		X	X
Depression Remission at 12 months*	MN Community Measurement (CMS159)	eCQM		X	X
Person-Centered Primary Care Measure (PCPCM)	American Board of Family Medicine (ABFM) and Larry A. Green Center	CQM, survey vendor, or CMS-fielded	X	X	X
Screening for Social Drivers of Health[b]+	CMS (Quality ID#487)	TBD		X	X
Total Per Capita Cost (TPCC)	CMS	Claims		X	X
Emergency Department Utilization (EDU)	NCQA	Claims		X	X
TPCC Continuous Improvement (non-FQHCs and non-Indian Health Programs only)	CMS	Claims**		X	X
EDU Continuous Improvement (FQHCs and Indian Health Programs only)	CMS	Claims**		X	X

Source: Adapted from *Table 3: Proposed Performance Measures by Track table* found in the CMS MCP Request for Application, August 2023.

[a] Certain measures proposed in MCP were owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer and use provisions related to the NCQA measures can be found at: Notices and Disclaimers | CMS.

[b] Screening for Social Drivers of Health (Quality ID#487) was a new, evolving measure focused on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure specifications were under development during MCP and CMS planned to work with participants to ensure they had the appropriate health IT infrastructure to successfully report this measure.

+ Included in the CMS Universal Foundation Measure Set.

** Included in Health Center Program Uniform Data System (UDS) Measure Set for 2023.*

*** Internal measure of statistically significant improvement.*

Appendix B. Care delivery requirements

	Track 1	*Track 2* *Same requirements as Track 1, plus…*	Track 3 *Same requirements as Track 2, plus…*
	Care management domain		
Targeted Care Management	**1.** Empanel and risk stratify all patients **2.** Identify staff and develop workflows to provide chronic care management to all high-risk patients, with an emphasis on hypertension and diabetes management **3.** Identify staff and develop workflows to provide timely follow-ups for all high-risk patients post ED visit and hospitalization	**1.** Implement chronic care management for all high-risk patients most likely to benefit, with an emphasis on hypertension and diabetes management **2.** Implement episodic care management to provide timely follow-ups for all high-risk patients post ED visit and hospitalization	**1.** Implement individualized care plans for all high-risk patients most likely to benefit, with an emphasis on hypertension and diabetes management
Chronic Condition Management	**1.** Identify staff and develop workflows to deliver individualized self-management support services for chronic conditions, with an emphasis on hypertension and diabetes management	**1.** Implement individualized self-management support services for chronic conditions, with an emphasis on hypertension and diabetes management	**1.** Expand self-management services to include group education and linkages to community-based supports, as appropriate
	Care integration domain		
Specialty Care Integration	**1.** Use MCP data tools to identify high-quality specialists	**1.** Identify high-quality specialty care partners as required in Article III of the Model Participation Agreement; and **2.** Furnish MCP e-Consult services with at least one specialty care partner.	**1.** Establish enhanced relationships with high-quality specialty care partners through co-management of shared patients.
Behavioral Health Integration	**1.** Identify staff and develop workflows to initiate a behavioral health integration ("BHI") approach grounded in measurement-based care	**1.** Implement a BHI approach utilizing measurement-based care, including using standardized measurement tools and measurement data to inform treatment decisions **2.** For all patients, systematically and universally screen for key behavioral health conditions, including depression and substance use disorder	**1.** Optimize BHI workflows using quality improvement framework
	Community connection domain		

	Track 1	*Track 2* *Same requirements as Track 1, plus…*	Track 3 *Same requirements as Track 2, plus…*
HRSN Screening and Referral	**1.** For all patients, implement universal HRSN screening, and provide referral resources as needed **2.** Develop workflows for referring patients with unmet HRSNs (i.e., positive screens) to social service providers in the community (i.e., community-based organizations or public health organizations)	**1.** Implement social service referral workflows with clear roles and responsibilities for the participants and social service provider partners	**1.** Optimize social service referral workflows, using a quality improvement framework, to improve approaches for assessing and managing socially complex patients through social service partners
Supporting Whole-Person Care Through Community Supports and Service Navigation	**1.** Explore partnerships with social service providers (i.e., community-based organizations or public health organizations) to meet patients' HRSNs **2.** Identify staff (a community health worker [CHW] or equivalent professional with shared lived experience) who will navigate and coordinate health-related and social support services to patients with heightened needs, such as addressing social isolation; supporting stress management; supporting chronic disease management; monitoring for gaps in care; accessing low-income benefits; or other appropriate support services	**1.** Establish partnerships with social service providers **2.** Utilize CHW (or equivalent professional with shared lived experience) in navigating and coordinating health-related and social support services to higher need patients	**1.** Strengthen partnerships with social service providers **2.** Optimize the use of a CHW/professional with shared lived experience, using a quality improvement framework, in navigating and coordinating health-related and social support services to higher need patients

Source: MCP Standard Participant and FQHC Participation Agreements, March 2024.

BHI = behavioral health integration; CHW = community health worker; ED = emergency department; FQHC = Federally Qualified Health Center; HRSNs = health-related social needs.

Appendix C. Participation study methods

The objectives of the participation study were to (1) assess the extent to which primary care organizations in MCP states participated in MCP, including the reach of the model among Medicare fee-for-service beneficiaries; and (2) examine differences between participating and non-participating primary care organizations. This appendix summarizes the methodology for the reach analysis (addressing the first objective) in Appendix Section C.1 and the methodology for comparing participant and non-participant characteristics (the second objective) in Appendix Section C.2 (for analyses based on Medicare claims and most other secondary data) and Appendix Section C.3 (for analyses of data from the Uniform Data System for FQHCs).

In short, the study population for the reach analysis (covered in Section III.A of the main text) includes all primary care organizations—defined at the Taxpayer Identification Number (TIN) level—within MCP states and with attributed Medicare FFS beneficiaries in the first quarter (Q1) of 2024. We assess the reach of MCP in two ways: (1) among all primary care organizations in MCP states (N = 9,278); and (2) among all primary care organizations eligible to participate in MCP in MCP states (N = 2,500). Conducting the reach analysis both ways allows us to distinguish between scenarios where participation is low because of low uptake among eligible organizations, versus where low participation is driven by fewer organizations being eligible to participate. The reach analysis includes 126 MCP participants; this is fewer than the 131 MCP participants included in other evaluation analyses because this analysis excludes five organizations with no attributed beneficiaries in Q1 2024.

The comparison of MCP participants and non-participants (covered in Section III.C of the main text) is limited to eligible primary care organizations only, that is, the 2,500 organizations that were eligible to participate in MCP. This allows us to examine which organization characteristics, if any, are correlated with the decision to apply for and participate in MCP, among eligible organizations. We did not conduct statistical testing for these comparisons and focused on the magnitude of the differences. This is because the analysis includes the entire population of organizations eligible for the model, and therefore, we did not need to draw statistical inference for a larger theoretical population.

C.1. Methodology for the MCP reach analysis

This appendix section describes the methodology for the MCP reach analysis.

- The **study population** includes primary care organizations within MCP states that were active as of January 1, 2024, and have Medicare FFS beneficiaries who reside in MCP states attributed to them in the first quarter (Q1) of 2024. (As noted below, in one analysis, we further restrict the study population to primary care organizations that are eligible to participate in MCP.) We exclude primary care organizations from the study population if the organization: (1) had greater than 0 percent but less than 75 percent of all primary claims associated with the TIN billed as FQHC claims, because these organizations were not definitively identifiable as FQHCs; and (2) was an Indian Health Center that was not in the FQHC Uniform Data System (meaning they were not health center awardees). Additionally, in identifying Medicare FFS beneficiaries attributed to an organization, we exclude places of service classified as rural health clinics (RHCs) or critical access hospitals (CAHs), and exclude beneficiaries attributed to a TIN based on primary care services provided at RHC and CAH sites.

- We **define organizations at the TIN level** and use the evaluation's claims-based attribution process to attribute beneficiaries to the organizations (TINs) that serve as their usual sources of primary care. We consider organizations with attributed beneficiaries to be primary care organizations. Given this definition, we exclude RHCs and CAHs from our definition of primary care organizations because they do not have attributed beneficiaries.
- We **classify all organizations as either a FQHC organization or a standard (non-FQHC) organization**. Because FQHC claims are found in Medicare outpatient records, we exclude organizations that appear to include FQHCs but are hybrid: that is, organizations for which carrier claims account for more than a quarter of all claims.
- We consider an organization to be **within an MCP region** if the organization has at least 20 percent of its attributed beneficiaries residing in a participating state (or county, in case of the New York region), based on a beneficiary's address in the Medicare Enrollment Database. We limit the beneficiary population to beneficiaries residing in MCP states so that we can – (1) quantify model reach based on proportion of Medicare FFS beneficiaries in the region attributed to an MCP participant; and (2) ensure that the comparison of beneficiary characteristics between participating versus non-participating organizations (as described in Appendix Section C.2) is based on beneficiaries who are within the same MCP states.
- **We assess the reach of MCP in two ways**: **(1) among all primary care organizations** in MCP states (N = 9,278); and **(2) among all primary care organizations eligible to participate in MCP** in MCP states (N = 2,500). Conducting the reach analysis both ways allows us to distinguish between scenarios where participation is low because of low uptake among eligible organizations, versus where low participation is driven by fewer organizations being eligible to participate, or both.
- We **define evaluable organizations as those that met model and the evaluation eligibility criteria** – (1) did not participate in ACO REACH or the Primary Care First Model after May 31, 2023; (2) were not participating in the Maryland Total Cost of Care, Kidney Care Choices, or End-Stage Renal Disease Treatment Choices Models as of July 1, 2024; (3) provided less than 30 percent of all primary care services in rural health centers or critical access hospitals; (4) did not have the majority of their attributed beneficiaries during the full baseline period living in states or counties that participated in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model; and (5) had at least 100 attributed beneficiaries, on average, in the year prior to model start, or—for MCP glide path participants—at least 125 beneficiaries attributed in the third quarter of 2024 (mimicking the model eligibility criteria). For MCP participants, we further required the participant to have received some MCP payments to be deemed an *evaluable* organization for evaluation analyses.
- **Participating organizations** are identified as organizations that were accepted to MCP, signed the initial Participation Agreement (PA), were active as of July 1, 2024, and had Medicare FFS beneficiaries attributed to them for at least one quarter during the baseline period (Q1 2022 – Q2 2024) as well as in Q1 2024 (the point at which the study population for the reach analysis is defined). Participants include organizations that withdrew from the model after July 1, 2024, but exclude organizations that dropped out of MCP prior to receiving any model payments (for example, organizations that did not drop out of MSSP prior to the MCP deadline to do so and were thus terminated by CMS from the model).

- When we assess model reach among all primary care organizations, we look at all MCP participants that meet the criteria above (126 organizations). This is fewer than the 131 MCP participants included in other evaluation analyses because we exclude five organizations with no attributed beneficiaries in Q1 2024.
- In assessing model reach among evaluable primary care organizations, we further restrict to MCP participants that meet these additional criteria – (1) received model payments; (2) had a sufficient number of attributed beneficiaries;[26] (3) did not participate in ACO REACH; and (4) did not have the majority of attributed beneficiaries in an AHEAD region. This reduces the number of participants to 99.

C.2. Methodology for comparing the characteristics of participating and non-participating primary care organizations based on Medicare claims and other secondary data sources

This appendix section describes the methodology for the comparison of characteristics between participating and non-participating primary care organizations, using data from Medicare claims and a variety of other secondary data sources.

- The study sample is limited to the 2,500 primary care organizations eligible to participate in MCP, of which 99 are MCP participants, and the remaining 2,401 are non-participants.
- As with the reach analysis, we classify all organizations as either an FQHC organization or a standard (non-FQHC) organization.
- In comparing organizational characteristics across different groups of organizations (e.g., participants vs non-participants), each organization receives equal weight. However, in comparing beneficiary characteristics that are rolled up to the organization level (including characteristics of the beneficiary's geographic location, such as Census tract or ZIP Code) each organization is weighted by the number of attributed beneficiaries in Q1 2024 so that each beneficiary receives equal weight.
- To describe characteristics and service use of Medicare FFS beneficiaries at the organization level, we use the sample of Medicare FFS beneficiaries attributed in Q1 2024 to a primary care organization, further restricted to those who reside in MCP states. Beneficiary characteristics are defined as of January 1st, 2024, and Medicare service use and expenditures measured over the first 6 months of 2024. Using the Q1 2024 attributed beneficiary population enables us to measure the beneficiaries' baseline characteristics as of a fixed date reasonably close to the start of the intervention, and their service use and expenditures over a duration of time that also precedes the start of MCP.
- In addition to Medicare FFS claims and enrollment data, we draw on several additional data sources for these analyses:
    - The CMS Master Data Management system provides information about organizational participation in other CMS value-based care initiatives in the five years prior to MCP.

[26] We required non-glide path MCP participants to have at least 100 attributed beneficiaries, on average, in the year prior to model start, that is, in quarterly attribution for Q3 2023 – Q2 2024. For MCP glide path participants, which were conditionally accepted into MCP, we only included organizations with 125 or more payment-attributed beneficiaries in the third quarter of 2024.

- The 2022 AHRQ Compendium serves as the source of information on health system affiliation and teaching status.
- We link beneficiary address information to geographic data for the most recent available period, including: (1) the 2022 American Community Survey; (2) 2023 Rural-Urban Continuum Codes from the U.S. Department of Agriculture's Economic Research Service; (3) the 2022 Social Vulnerability Index from the Centers for Disease Control and Prevention's Agency for Toxic Substances and Disease Registry; (4) the 2021 National Walkability Index from the U.S. Environmental Protection Agency; and (5) 2024 Health Professional Shortage Area information from the Health Resources & Services Administration, 2024.

C.3. Methodology for comparing participating and non-participating FQHCs based on the Uniform Data System (UDS)

This appendix section describes the methodology for the comparison of organization and patient characteristics from the UDS between participating vs. non-participating FQHC organizations.

The UDS reports on mandatory annual data collection from all health centers that are funded by HRSA under Section 330 of the Health Centers Consolidation Act of 1996 (Public Law 104-299), as well as health center look-alikes. The data are publicly available and are reported in aggregate for the calendar year at the health center organization level (not the FQHC site level or the patient level). Health center organizations are identified in the data through a unique identifier called the BHCMISID (Bureau of Primary Health Care Health Center Management Information System ID). The evaluation cross-walked BHCMISIDs to TINs for primary care organizations with one or more attributed Medicare FFS beneficiaries in claims using a combination of exact and fuzzy matching on organization name and address (that is, we matched organization names and addresses between the Medicare Provider Enrollment, Chain, and Ownership System [PECOS] and UDS). Over 98 percent of BHCMISIDs were cross-walked to a single TIN, suggesting that the level of UDS data aggregation generally aligns with the level of MCP participation.

The UDS comparison analysis aligns with the Medicare FFS-based comparison analysis (described in Appendix Section C.2), with the following exceptions:

Restricted organization sample

- After limiting the sample to eligible organizations in MCP states (N = 2,500) as described above, we further limit the sample to FQHC organizations (N = 137) that reported to the UDS in calendar year 2023 (N = 132). Only one of the five eligible organizations that did not report to the UDS in 2023 was a participating MCP FQHC. This organization was not yet a health center or look-alike in 2023.
- Furthermore, two eligible MCP participants share a BHCMISID, meaning they have different TINs but belong to the same FQHC organization. In the MCP participation rosters, these organizations had the same name and organization address, but each TIN was associated with different CMS Certification Numbers (CCNs) in the site list. We report these two MCP organizations as a single organization in the UDS comparison analysis.
- This process resulted in a total eligible sample of 131 FQHC organizations (46 participants, 85 non-participants) for the UDS comparison analysis.

All-patient sample

- Whereas the analysis based on Medicare claims, enrollment, and other secondary data sources reported on the characteristics of Medicare FFS beneficiaries attributed in Q1 2024, UDS measures are reported for all patients who visited the FQHC during the calendar year (regardless of insurance status).
- Patient characteristics reported are weighted by the total number of patients served by the FQHC organization during the calendar year such that each patient receives equal weight. The sole exception is characteristics related to payer mix among patients aged 18+, which are weighted by the total number of patients 18 and older served by the FQHC organization during the calendar year.

Appendix D. Beneficiary survey methods

This appendix describes survey methods from the Medicare beneficiary survey, conducted as part of the MCP evaluation.

D.1. Purpose and timing of the MCP evaluation's Medicare beneficiary survey

From October 2024 through March 2025, the MCP evaluation contractor, Mathematica, fielded a survey of beneficiaries for the MCP evaluation. The purpose of the survey, called the Medicare Health Care Experience Survey, was to assess beneficiaries' experiences related to primary care when the model launched, providing the evaluation with baseline data to estimate impacts on patient experience over time.

D.2. Survey content

The Medicare beneficiary survey content was developed by the MCP evaluation team with input from CMS. CMS gave input on the priority topics for the beneficiary survey and on the individual questions themselves.

Prior to finalizing the survey content, the evaluation team conducted think-aloud interviews and full survey debriefings with pre-test respondents to confirm questions were understood as intended. The evaluation recruited participants using Limelight Insights by Shugoll, a research company that specializes in respondent recruiting. There were four rounds of pre-testing, with a total of 18 pre-tests (nine think-aloud interviews and nine full survey debriefs). Survey questions generally pre-tested well. The evaluation team revised the survey during and after each round of pretesting, based on feedback received from the pre-test interviews.

The final survey contained 54 questions (when counting sub-items in a grid as separate questions). The survey was designed to be completed in about 15 minutes and was broadly divided into nine sections:

A. Your primary care doctor's office
B. Getting care from this primary care doctor and practice
C. Medical needs
D. Chronic condition management and care management
E. Care management after emergency room and hospital care
F. Care integration with specialists
G. Additional health needs
H. Overall primary care experience
I. About you

The full text of the Medicare beneficiary survey is available in Appendix E.

D.3. Sampling

The MCP evaluation's Medicare beneficiary survey was intended to reflect experiences among (1) Medicare fee-for-service beneficiaries served by primary care organizations participating in MCP and (2) comparison beneficiaries, whose experiences might be similar to that of MCP beneficiaries before the model started. The comparison group would have enabled the evaluation to estimate effects of MCP on MCP beneficiaries' experience over time. This document does not present findings for the comparison

group, as these findings are not informative for evaluating MCP in its first year. However, the appendix describes survey methodology (for example, sampling) for the comparison group, as these methods for the comparison group are relevant for understanding methods used to survey the MCP beneficiaries.

Sample frame. The full sample frame was made up of 3,771,832 Medicare FFS beneficiaries: 166,045 MCP beneficiaries and 3,605,787 potential comparison beneficiaries. The sample frame was identified using the Medicare Enrollment Database (EDB), Medicare Skilled Nursing Facility Assessment data (known as the Minimum Data Set, or MDS), physician and outpatient Medicare FFS claims, and data from the National Plan and Provider Enumeration System (NPPES).

We designed the sample eligibility criteria (Table D.3.1) to align with the MCP payment attribution methodology to the extent possible within the timeline constraints imposed by fielding the baseline survey starting in Fall 2024. In addition to replicating the model's attribution rules as closely as possible, we limited the sample frame to (1) beneficiaries living in an MCP region as of May 1, 2024, to reduce state-level variation in beneficiary experiences; (2) beneficiaries *not* attributed to glide path MCP participants (because the evaluation did not intend to estimate impacts for these organizations); and (3) beneficiaries with non-missing data for all variables planned for use in comparison selection (excluded only 65 beneficiaries, <0.002%).

Table D.3.1. Sample frame eligibility criteria

Criteria	Data Source	Timing for baseline survey
Medicare Parts A and B coverage	EDB	As of May 1, 2024
Medicare as primary payer	EDB	As of May 1, 2024
Not covered under MA or other Medicare health plan	EDB	As of May 1, 2024
Not incarcerated	EDB	As of May 1, 2024
Not have ESRD or be enrolled in hospice	EDB	As of May 1, 2024
Alive	EDB	As of July 1, 2024
Not institutionalized	MDS	Through Q4 2023
Address in an MCP region	EDB	As of May 1, 2024
Eligible primary care visit from an organization (TIN for standard, CCN for FQHCs[a]) providing primary care to a substantial number (125 for TINs, 50 for CCNs) of Medicare beneficiaries meeting above criteria during lookback period[b]	Physician and outpatient FFS claims, NPPES file	Claims: January 2023 – March 2024[b] (1 month claims runout) NPPES: April 2024

[a] For FQHCs, the CMS Certification Number (CCN)—not the TIN—is populated on Medicare outpatient claims. We were not able to crosswalk CCNs to TINs in time to apply this criterion at the TIN-level for the full survey sample frame. Because CCNs are smaller than TINs, the beneficiary threshold was lower for CCNs compared to TINs.
[b] We limited the lookback period used to assess primary care receipt from 24 months (used for attribution) to 15 months to limit the sample to beneficiaries with a more recent primary care visit.
CCN = CMS Certification Number; EDB = Medicare Enrollment Database; ESRD = end-stage renal disease; FFS = fee-for-service; MA = Medicare Advantage; MCP = Making Care Primary; MDS = Medicare Skilled Nursing Facility Assessment data, known as the Minimum Data Set; NPPES = National Plan and Provider Enumeration System; TIN = Taxpayer Identification Number.

Within the resulting sampling frame, we identified MCP-attributed beneficiaries using the Q3 2024 payment attribution data from the model's design & operations contractor.[27] After dropping beneficiaries attributed to MCP glide path organizations, the MCP (treatment) sample frame included 166,045 MCP-attributed beneficiaries (125,336 [75 percent] attributed to standard organizations; 40,709 [25 percent] attributed to FQHCs).

Of the remaining non-MCP-attributed beneficiaries (that is, the potential comparison beneficiaries), we excluded 158,015 beneficiaries who had one or more primary care visits to an MCP organization during the 15-month lookback period (January 2023 to March 2024), which we used to assess whether each beneficiary received primary care services. This exclusion resulted in a comparison sample frame of 3,605,787 beneficiaries (152,051 of which had one or more visits to a FQHC).

MCP sample selection. We conducted a stratified random sample of MCP beneficiaries in the sample frame, oversampling beneficiaries dually enrolled in Medicare and Medicaid and beneficiaries attributed to FQHCs. We also implicitly stratified the sample by MCP organization (TIN), sex, and age to ensure proportional representation in the sample. Dual enrollment in Medicare and Medicaid was captured as of May 2024 from the Master Beneficiary Summary File (MBSF).

Within strata, defined by the cross classification of dual enrollment and FQHC status, we sampled beneficiaries with equal probabilities of selection (Table D.3.2).

Table D.3.2. Sample allocation

Strata	Sample size
FQHC duals	1,155
FQHC non-duals	825
Non-FQHC duals	2,475
Non-FQHC non-duals	3,795
Total	**8,250**

We originally selected 8,250 MCP beneficiaries but had to remove 127 (1.5 percent) who did not live in an MCP region due to an error in the EDB residency data and 68 (0.8 percent) who were attributed to an MCP participant that withdrew before the model began (based on the August 2024 model participation roster change log). This resulted in a final MCP sample of 8,055 beneficiaries.

Comparison sample selection. For each sampled MCP beneficiary, we employed 2:1 matching to randomly select two comparison beneficiaries, attributed to different organizations (TINs) than the MCP beneficiaries and from each other[28], but with the same values as their matched MCP beneficiary for the following characteristics:

[27] Because our beneficiary survey sampling frame eligibility criteria diverged from the attribution eligibility criteria, the payment-attributed population included some attributed beneficiaries who were not in our sampling frame.

[28] Though we originally proposed 1:1 matching, we conducted 2:1 matching to account for the potential addition of a second MCP cohort. If a second cohort had been enrolled in MCP in the same geographic states, a portion of the comparison beneficiaries sampled for the beneficiary survey likely would have been attributed to cohort 2 MCP

- Zip code
- Sex
- Five-year age group (collapsing all age groups less than 55 into a single category and all age groups 90+ into a single category)
- Original reason for Medicare entitlement (old age v. disability)
- Medicaid dual eligibility status

We first selected comparisons for beneficiaries attributed to MCP FQHCs among a subset of beneficiaries in the comparison sample frame with at least one FQHC visit during the lookback period.

When an exact match within the above strata was not available, we followed the pre-specified decision rules below to broaden the matching specifications:

1. Expand from five-year age group to a version with larger age groups
2. Drop original reason for Medicare entitlement from the exact matching criteria
3. Expand from zip code to county (with original exact matching criteria reinstated)
4. (For FQHC-attributed beneficiaries only) Drop FQHC visit from the exact matching criteria

We found two matches for all but 17 MCP beneficiaries, for whom we could only find a single match within the above decision rules, resulting in a final comparison sample of 16,093 beneficiaries. Of these beneficiaries, 81 percent met all the desired exact-match criteria, without a need to broaden the matching specifications.

D.4. Data collection

Timing. The MCP Medicare beneficiary survey was administered from October 10, 2024, to March 28, 2025.

Respondent. The survey was mailed to 24,148 Medicare beneficiaries, including 8,055 MCP beneficiaries and 16,093 comparison beneficiaries.

Fielding procedures. The MCP evaluation contractor fielded the survey by mail after obtaining mailing addresses from the EDB. The fielding period was initially intended to be 13 weeks but ultimately was extended to 24 weeks given a lower-than-anticipated response rate.

Sample members received an invitation letter during Week 1 of the fielding period, which included instructions for completing the survey online (including a unique username and password and a QR code to access the web survey) and frequently asked questions and answers (FAQ). After the initial invitation letter, sample members received up to three hard copy surveys and two other mailings, including a reminder letter and a reminder postcard. Mailings were sent only to sample members who had not yet

organizations. We conducted 2:1 matching and ensured that comparison beneficiaries in each matched set received care from different organizations, to preserve power if comparison beneficiaries attributed to cohort 2 MCP organizations were to be excluded.

returned the survey at the time that we prepared the mailing. All mailings included information for beneficiaries to contact a help desk with questions or concerns, which was monitored daily.

Though it had not been part of the original data collection plan, some sample members also received up to three email reminders during the second half of the fielding period, when the response rate was lower than expected. As with the physical mailings, only sample members who had not yet returned the survey were sent a reminder email. We obtained email addresses for nonrespondents from AtData, a data solutions provider specializing in email intelligence and verification services. AtData obtained email addresses for roughly 50 percent of the sample members that had not yet completed the survey as of January 17, 2025.

Table D.4.1 provides an overview of fielding procedures by week; all outreach after week 9 was added to try to boost response.

Table D.4.1. MCP baseline beneficiary survey fielding procedures by week

Week	Outreach
1	Invitation letter with log-in information and FAQ document
3	Reminder letter with log-in information and FAQ document
5	Hardcopy survey #1 with CMS cover letter FAQ document
6	Reminder postcard
9	Hardcopy survey #2 with CMS cover letter and FAQ document
15	Email reminder #1 with log-in information and link to FAQ
16	Email reminder #2 with log-in information and link to FAQ
17	Hardcopy survey #3 with CMS cover letter FAQ document
19	Email reminder #3 with log-in information and link to FAQ

Incentive. The survey asked respondents to provide their email address or cell phone number to receive a $15 gift card via email or text message. Gift cards were sent using a digital-incentive vendor. Respondents selected among Amazon, Target, or Walmart gift cards and had 120 days to claim their gift card. For individuals who called or emailed our help desk (or indicated in their completed hard-copy survey) to let us know that they could not receive the gift card via email or text message, the team mailed physical gift cards to their address.

Confidentiality. We informed survey respondents that their survey responses would not be tied to their name or their primary care provider in any report, that we would report responses in aggregate only, and that their responses would not have any consequences for their care.

D.5. Data analysis

Completed questionnaires. We considered a survey "complete" if the respondent completed the following “key” questions: H12 (overall primary care quality rating) and either I1 or I2 (self-rated health). Appendix E presents the full survey instrument.

Eligibility. Before sending emailed reminders (see details on this in Appendix Section D.4. Data Collection), we added a question to verify the survey was completed by the intended recipient. We required web respondents to note their birth year at the end of the survey, which we then compared to the EDB. We reclassified 22 completed cases as ineligible due to the birth year that they entered not matching the EDB.

Analytic sample. To be included in analysis, beneficiaries had to submit an eligible, completed survey between October 10, 2024, and March 28, 2025. Among the 24,148 sampled beneficiaries, 7,044 (29.2 percent) submitted completed questionnaires and were included in the analysis.

Response rate. The unweighted survey response rate target for MCP and comparison beneficiaries was 40 percent. The final response rate among eligible beneficiaries who submitted a completed questionnaire was 31.3 percent among MCP beneficiaries and 28.1 percent among comparisons.

Weighting. The sample weights for MCP (treatment) beneficiaries were calculated as the inverse of the probability of selection (see details on this in Appendix Section D.3. Sampling). The sample weight for each comparison beneficiary was the sampling weight of the matched treatment beneficiary divided by the number of matched beneficiaries for that treatment case, usually two. The nonresponse adjustments were calculated as the inverse of the response rate calculated within weighting classes. Classes were defined by FQHC status, dual enrollment status, race and ethnicity category, age category, and region of the country. We used the same variables to construct weighting classes for both MCP and comparison beneficiaries. The nonresponse-adjusted weights for both MCP and comparison beneficiaries were post-stratified to the total number of MCP beneficiaries in the four sampling strata: the cross classification of dual enrollment and FQHC status.

Methods for analyzing quantitative data. We reviewed weighted means and frequencies for all quantitative, closed-ended items in the survey in aggregate (separately by MCP versus comparison beneficiaries). We also stratified by two key subgroups among MCP beneficiaries: FQHC status and dual enrollment in Medicare and Medicaid. FQHC status for MCP beneficiaries was defined based on the participant type listed in the MCP participation rosters for the organization to which the MCP beneficiary was attributed. Dual enrollment in Medicare and Medicaid was defined using May 2024 MBSF data.

Software. We used SAS version 9.4 to clean and prepare the data for analysis. We constructed data tables using R version 4.4.0.

Appendix E. Beneficiary survey instrument

The Medicare Health Care Experience Survey

Fall 2024

This survey is sponsored by the Centers for Medicare & Medicaid Services (CMS). Mathematica is sending you this survey as part of an important national study. By completing this survey, you will help improve the quality of primary care nationwide. The survey should take you only about 15 minutes to complete.

ES

Si prefiere la encuesta en español, por favor póngase en contacto con Mathematica por teléfono (sin cargo) al 1-833-624-1086 o por correo electrónico a MedicareSurvey@mathematica-mpr.com.

Your Privacy Is Protected. All of your personal information will be kept private and confidential. Mathematica will not share your personal information or individual responses with anyone.

Your Participation Is Voluntary But Important. You may choose to answer this survey or not. Your choice will not affect the health care you get or your insurance coverage.

What To Do When You're Done. Once you finish the survey, please put it in the prepaid envelope that was sent with the survey, seal the envelope, and put the envelope in the mail.

What To Do If You Have Questions. If you have any questions, please review the included Frequently Asked Questions (FAQ) document. If the FAQ document does not answer your questions, please call us toll-free at 1-833-624-1086 or send an email to MedicareSurvey@mathematica-mpr.com.

SURVEY INSTRUCTIONS

- Please use a black or blue ball point pen.
- Answer each question by completely filling in the box to the left of your answer or marking the box with an "X".

■ or ☒

- If you want to change an answer, fill in the box for the correct answer completely or mark the box with an "X" and circle the correct answer as well.

(■) or (☒)

- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☒ Yes → **Go to A1**
☐ No

A. YOUR PRIMARY CARE DOCTOR'S OFFICE

This is a survey about health care you received from your primary care doctor.

- Primary care doctors treat preventive and wellness needs, common illnesses (such as colds, the flu, headaches), and ongoing conditions (such as diabetes, high blood pressure, asthma, and congestive heart failure).
- Primary care doctors do not do surgery and do not limit their treatment to just one part of the body (like the heart).
- In addition to doctors (MD and DO), nurse practitioners (NP) and physician assistants (PA) can serve as primary care providers. For this survey, we use the term "doctor" for simplicity to refer to all types of primary care providers – MD, DO, NP, or PA.

A1. Do you have someone that you consider to be your primary care doctor?

1 ☐ Yes →

0 ☐ No → GO TO A2

If you feel comfortable doing so, please write the name of this doctor: _____

Please think of this doctor or this doctor's practice as you answer this survey. → **Now go to A4.**

A2. Is there a primary care doctor or practice that you usually go to (in-person, by phone, or by video) if you are sick or need advice about your health?

1 ☐ Yes →

0 ☐ No → GO TO A3

If you feel comfortable doing so, please write the name of the primary care doctor you saw most recently:

_____

Please think of this doctor or this doctor's practice as you answer this survey. → **Now go to A4.**

A3. Please think of the last time you had a primary care visit (in-person, by phone, or by video). If you feel comfortable doing so, please write the name of the primary care doctor you saw most recently:

_____

Please think of this doctor or this doctor's practice as you answer this survey.

A4. Is the primary care doctor you listed above a medical doctor, nurse practitioner, or physician assistant?

1 ☐ Medical doctor (MD or DO)

2 ☐ Nurse practitioner (NP)

3 ☐ Physician assistant (PA)

d ☐ Don't know

A5. How long have you been going to this doctor?

1 ☐ Less than 6 months
2 ☐ At least 6 months but less than 1 year
3 ☐ At least 1 year but less than 3 years
4 ☐ At least 3 years but less than 5 years
5 ☐ 5 years or more

A6. Is this the only primary care doctor at the practice, or are there other primary care doctors at the practice?

1 ☐ Only primary care doctor → GO TO SECTION B
2 ☐ There are other primary care doctors at this practice
d ☐ Don't know

A7. When you saw a primary care doctor from this practice in the last 12 months (in-person, by phone, or by video), how often were these visits with the person you consider to be *your* regular doctor?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
5 ☐ I don't have someone I consider to be my regular primary care doctor
6 ☐ I didn't see a primary care doctor from this practice in the last 12 months

B. GETTING CARE FROM THIS PRIMARY CARE DOCTOR AND PRACTICE

Remember, when we say, "this practice," we are referring to the practice of the primary care doctor that you listed at the beginning of the survey.

B1. In the last 12 months, did you contact this practice to get care for an illness, injury, or condition that needed care right away?

1 ☐ Yes
0 ☐ No → GO TO B3

B2. In the last 12 months, when you contacted this practice for care you needed right away, how often did you get care as soon as you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

B3. In the last 12 months, did you make any appointments for a check-up or routine care with this practice?

1 ☐ Yes
0 ☐ No → GO TO B5

B4. In the last 12 months, when you made an appointment for a check-up or routine care with this practice, how often did you get care as soon as you needed?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

B5. In the last 12 months, did you contact this practice with a health question during regular office hours?

1 ☐ Yes
0 ☐ No → GO TO B7

B6. In the last 12 months, when you contacted this practice during regular office hours, how often did you get an answer to your health question that same day?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

B7. In the last 12 months, did you contact this practice with a health question outside of regular office hours, for example, on evenings, weekends, or holidays?

1 ☐ Yes

0 ☐ No → GO TO B9

B8. In the last 12 months, when you contacted this practice outside of regular office hours, how often did you get an answer to your health question as soon as you needed?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

B9. Does this doctor or someone on their staff communicate in the language you prefer, or do they provide interpreter services for you?

MARK ALL THAT APPLY

1 ☐ Yes, someone at this practice communicates in the language I prefer

2 ☐ Yes, this practice provides interpreter services

3 ☐ No, neither

B10. In the last 12 months, how often did this doctor or someone from this practice spend enough time with you?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

B11. In the last 12 months, how often did this doctor or someone from this practice explain things in a way that was easy for you to understand?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

C. MEDICAL NEEDS

C1. Was there any time in the last 12 months when you delayed or did not get the medical care you thought you needed from this doctor or practice?

1 ☐ Yes

0 ☐ No → GO TO SECTION D

C2. In the last 12 months, did you delay or <u>not</u> get the medical care you needed from this doctor or practice for any of the following reasons?

MARK ALL THAT APPLY

1 ☐ It took too long to get an appointment with a primary care doctor

2 ☐ You couldn't get through on the telephone or patient portal

3 ☐ You couldn't go when this practice was open

4 ☐ It takes too long to get to this practice or clinic from your home or work

5 ☐ You couldn't get transportation to this practice

6 ☐ Worry about cost or insurance coverage

7 ☐ You were too busy with work or other commitments to take the time

8 ☐ You didn't think the problem was serious enough

9 ☐ Other *(specify)*

_____

D. CHRONIC CONDITION MANAGEMENT AND CARE MANAGEMENT

D1. Do you have a chronic condition? Chronic conditions are conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic conditions may include diagnoses such as diabetes, high blood pressure, heart disease, congestive heart failure, chronic obstructive pulmonary disease (COPD), acid reflux, and depression.

1 ☐ Yes

0 ☐ No → GO TO SECTION E

D2. In the last 12 months, have you discussed your chronic condition with the primary care doctor that you listed at the beginning of the survey?

1 ☐ Yes

0 ☐ No → GO TO SECTION E

D3. Over the last 12 months, when receiving medical care for your chronic condition …

A.	B. YES	C. NO
a. Did this primary care doctor or someone from their staff tell you how your actions and behaviors could impact your chronic condition?	1 ☐	0 ☐
b. Did this primary care doctor or someone from their staff help you make a treatment plan for your chronic condition that you could do in your daily life?	1 ☐	0 ☐
c. Did this primary care doctor or someone from their staff contact you between visits to check in about your chronic condition?	1 ☐	0 ☐

E. CARE MANAGEMENT AFTER EMERGENCY ROOM AND HOSPITAL CARE

E1. In the last 12 months, have you gone to an emergency room or emergency department for care? Please do not include visits to an urgent care center.

1 ☐ Yes

0 ☐ No → GO TO E3

E2. Did the primary care doctor you listed at the beginning of the survey, or someone from this practice, contact you to follow up within one week after your most recent emergency room or emergency department visit?

1 ☐ Yes, they contacted me within one week

2 ☐ No, because I contacted them within one week

3 ☐ No, there was no contact between us within one week

E3. In the last 12 months, have you been a patient in a hospital overnight or longer?

1 ☐ Yes

0 ☐ No → GO TO SECTION F

E4. Did the primary care doctor you listed at the beginning of the survey, or someone from this practice, contact you to follow up within one week after your most recent hospital stay?

1 ☐ Yes, they contacted me within one week

2 ☐ No, because I contacted them within one week

3 ☐ No, there was no contact between us within one week

F. CARE INTEGRATION WITH SPECIALISTS

F1. Specialists are providers like surgeons, heart doctors, eye doctors, skin doctors, and other doctors who specialize in one area of health care.

In the last 12 months, did you get any health care from a specialist (in-person, by phone, or by video)?

1 ☐ Yes

0 ☐ No → GO TO SECTION G

F2. In the last 12 months, how often did the primary care doctor you listed at the beginning of the survey seem informed and up-to-date about the care you got from specialists?

1 ☐ Never

2 ☐ Sometimes

3 ☐ Usually

4 ☐ Always

G. ADDITIONAL HEALTH NEEDS

Reminder: the questions in this section are about the primary care doctor, and the staff from their practice, that you listed at the beginning of this survey.

G1. In the last 12 months, did someone from this practice ask you if there was a period of time when you felt sad, empty, or depressed?

1 ☐ Yes

0 ☐ No

G2. In the last 12 months, was there a period of time when you felt sad, empty, or depressed?

1 ☐ Yes

0 ☐ No → GO TO G4

G3. In the last 12 months, did someone from this practice help when you felt sad, empty, or depressed?

1 ☐ Yes

0 ☐ No

G4. In the last 12 months, did someone from this practice ask you about alcohol use or drug use?

1 ☐ Yes

0 ☐ No

G5. In the last 12 months, was there a period of time when you had a problem with alcohol use or drug use?

1 ☐ Yes

0 ☐ No → GO TO G7

G6. In the last 12 months, did someone from this practice help with your alcohol use or drug use?

1 ☐ Yes

0 ☐ No

G7. In the last 12 months, did someone from this practice ask you about any nonmedical needs, such as food, housing, or transportation?

1 ☐ Yes

0 ☐ No

G8. In the last 12 months, was there a period of time when you had difficulty meeting any nonmedical needs, such as food, housing, or transportation?

1 ☐ Yes

0 ☐ No → GO TO G10

G9. In the last 12 months, did someone from this practice help you get support for nonmedical needs, such as food, housing, or transportation?

1 ☐ Yes

0 ☐ No

G10. In the last 12 months, did your doctor or someone from this practice ask you if you had any problems with abuse or violence at home or in your neighborhood?

1 ☐ Yes

0 ☐ No

H. OVERALL PRIMARY CARE EXPERIENCE

This section is about your overall experience with the primary care doctor, or their practice, that you listed at the beginning of the survey. Some of the questions in this section may sound similar to questions covered in prior sections.

H1. My practice makes it easy for me to get care.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H2. My practice is able to provide most of my care.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H3. In caring for me, my doctor considers all factors that affect my health.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H4. My practice coordinates the care I get from multiple places.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H5. My doctor or practice knows me as a person.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H6. My doctor and I have been through a lot together.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H7. My doctor or practice stands up for me.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H8. The care I get takes into account knowledge of my family.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H9. The care I get in this practice is informed by knowledge of my community.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H10. Over time, my practice helps me to stay healthy.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H11. Over time, my practice helps me to meet my goals.

1 ☐ Definitely
2 ☐ Mostly
3 ☐ Somewhat
4 ☐ Not at all

H12. Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate the care you have received <u>from this doctor and the staff from this practice</u>?

0 ☐ 0 Worst level of care possible
1 ☐ 1
2 ☐ 2
3 ☐ 3
4 ☐ 4
5 ☐ 5
6 ☐ 6
7 ☐ 7
8 ☐ 8
9 ☐ 9
10 ☐ 10 Best level of care possible

I. ABOUT YOU

I1. In general, how would you rate your <u>overall</u> health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

I2. In general, how would you rate your overall <u>mental or emotional</u> health?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor

I3. What is the <u>highest</u> grade or level of school that you have completed?

MARK ONE ONLY

1 ☐ 8th grade or less
2 ☐ Some high school, but did not graduate
3 ☐ High school graduate or GED
4 ☐ Some college or 2-year degree
5 ☐ 4-year college graduate
6 ☐ Advanced degree (master's, professional, or doctoral degree)

I4. What is your gender?

MARK ALL THAT APPLY

1 ☐ Female
2 ☐ Male
3 ☐ Transgender
4 ☐ Non-binary/Genderqueer
5 ☐ Prefer to self-describe _____
6 ☐ Prefer not to answer

I5. What is your race and/or ethnicity?

MARK ALL THAT APPLY

1 ☐ American Indian or Alaska Native
2 ☐ Asian
3 ☐ Black or African American
4 ☐ Hispanic or Latino
5 ☐ Middle Eastern or North African

6 ☐ Native Hawaiian or Pacific Islander

7 ☐ White

I6. Do you speak a language other than English at home?

1 ☐ Yes

0 ☐ No

I7. Medicare supplemental or Medigap policies are designed to cover the costs of doctor visits or hospital care that are not covered by Medicare. Are you covered by a supplemental Medigap policy you bought on your own or through a previous or current employer?

1 ☐ Yes

0 ☐ No

I8. Were the questions answered by the original addressee for this survey ([First Name] [Last Name]), or did you answer the questions for them because they can't answer for themselves?

1 ☐ Questions answered by the original addressee

2 ☐ Questions answered for the original addressee

Thank you for completing the Medicare Health Care Experience survey. Please provide your email address OR cell phone number to receive a $15 Amazon, Target, or Walmart gift card as a thank you for your time and participation. Please write very clearly so we can process your reward!

Email address:_____

-OR-

Cell phone number:_____

Note that instructions to claim your reward will be sent to this email address or texted to this cell phone number. Please allow up to three weeks after mailing in the survey to receive this email or text message from BHN Rewards.

Thank you!

Please return the completed survey in the prepaid envelope.

If you no longer have the envelope, you can mail your survey to:

Medicare Health Care Experience Survey
PO Box 8007
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Appendix F. Payment calibration methods

To conduct the payment calibration, we calculated how much each standard participant in MCP would have received under the Physician Fee Schedule (PFS) in 2025, for a given set of services provided in 2023 before the model launch. This is an accounting exercise rather than an estimate of spending relative to a comparison group. We calculate hypothetical status quo payments in 2025 for that set of services under PFS as well as hypothetical payments under MCP (including the model's enhanced services payment [ESP], and the prospective primary care payment [PPCP]). Finally, we compare the two sets of payments for each participant in terms of per beneficiary per month (PBPM) dollars to understand MCP's savings potential. We did not include the upfront infrastructure payment (UIP) for qualifying participants in Track 1 as part of the payment calibration analysis since these (1) represent a strict increase in Medicare payments to selected Track 1 participants without any comparable payments under the status quo for infrastructure improvements; and (2) were a one-time payment, so their influence on the model's potential for cost neutrality depends on the time horizon considered. We did not include the MCP performance incentive payment (PIP) in the payment calibration analysis either because we did not have relevant performance data to project likely payment amounts.

F.1. Identification of participants for inclusion in the payment calibration analysis

This analysis covers all standard MCP participants that were *evaluable participants*, as defined previously (see Section III and Appendix Section C.1), and that had Medicare FFS beneficiaries attributed to them for at least one quarter in 2023, the analysis period for this study. Based on these criteria, 51 evaluable standard participants are included in the payment calibration analysis.

F.2. Steps involved in the payment calibration analysis

The payment calibration proceeded in four steps.

1. *Identify a fixed set of primary care services covered by MCP payments.* First, we identified attributed beneficiaries at baseline (2023) for participating practitioners within each participant using the claims-based beneficiary attribution algorithm developed by the MCP evaluation contractor. While attributing beneficiaries and identifying primary care services delivered by participants, we did not limit claims to those delivered by practitioners on submitted MCP rosters for standard participants. Instead, for standard participants, we created practitioner rosters for the evaluation that included all National Provider Identifier (NPI) numbers of practitioners that (1) delivered one or more primary care services used for attribution[29] under the participant Taxpayer Identification Number (TIN) to MCP-eligible beneficiaries within the calendar year, and either (2) had a National Plan and Provider Enumeration System taxonomy code that included a primary care specialty[30] or (3) delivered one or more services for chronic care management to MCP-eligible beneficiaries within the calendar year. We define primary care services to be face-to-face or telehealth evaluation and management (E&M) services, preventive visits, care management services or behavioral health integration services offered in an office or outpatient setting, only including those services that are covered by the ESP and the

[29] See '*Table 8: Primary Care Services Eligible for Attribution*' in Making Care Primary: Payment and Attribution Methodologies, PY 2025 https://www.cms.gov/files/document/mcp-pymt-att-methodologies.pdf

[30] See '*Appendix Table A: Primary Care Specialty Codes*' in Making Care Primary: Payment and Attribution Methodologies, PY 2025

PPCP under MCP.[31] We did not include payments for the MCP e-consult code because MCP e-consults were not billed before the intervention, so they will not be included in the fixed set of services we price for the payment calibration.

2. *Calculate a hypothetical status quo payment for that set of services.* For the fixed set of primary care services identified in Step 1, we calculated how much participants would have been paid in calendar year 2025 if they had not participated in MCP, applying the relevant 2025 payment rates. For standard participants, we used the 2025 PFS, which assigns a payment amount to each service based on the service's Healthcare Common Procedure Coding System (HCPCS) code, the rendering provider's location and whether the service was delivered in a facility or non-facility setting. We further adjusted PFS-derived payments for delivery by a physician versus a nonphysician practitioner, delivery in a health professional shortage area (HPSA), for Medicare FFS sequestration, and by a Merit-based Incentive Payment System (MIPS) adjustment factor calculated from the baseline claim. However, we did not apply adjustments for participation in accountable care organizations or alternative payment models to minimize the complexity in these calculations.
3. *Calculate hypothetical payments under MCP for that set of services.* We calculated, by track, the payments participants would have received for that same set of services while participating in MCP, including ESPs and PPCPs. These numbers represent the payments that would have been expected under MCP absent any behavioral changes caused by MCP. To calculate payments under MCP, we used methods described in the MCP payment and attribution methodologies document for payment year 2025, with some exceptions:[32]
    - When calculating historical PPCP PBPM amounts, we used claims for PPCP services for beneficiaries attributed to participants between April 1, 2022, and March 31, 2024, using the claims-based attribution algorithm developed by the MCP Evaluation contractor.
    - After calculating an unadjusted performance year PPCP PBPM, we then applied adjustments for geographic area, for changes in the PFS rates between 2023 and 2025, and by a participant-level MIPS-adjustment factor for standard participants.
    - We did not apply a utilization adjustment or a PPCP partial reconciliation adjustment; since billable services within the 'payment year' (2023 PPCP services considered as if they had occurred in 2025) were delivered within the historical base period (2022 Q2 through 2024 Q1), it was unlikely that differences in historical and performance year usage would increase PBPM amounts beyond the $2 floor needed to apply these adjustments.
    - We also did not apply retrospective debits for beneficiary ineligibility because we directly used beneficiary eligible months in the calculation of PPCPs. Finally, we did not apply a claims completion adjustment to the PPCP PBPM as we determined that services in the historical base period were completely reflected in the data given the timing of the claims pull used for this analysis (over a year's runout).

[31] See *Table 12: 'Services Included in or Affected by the PPCP'* and *Table 9: 'Services Considered Duplicative of the Enhanced Services Payment'* in Making Care Primary: Payment and Attribution Methodologies, PY 2025, respectively

[32] Making Care Primary: Payment and Attribution Methodologies, PY 2025 https://www.cms.gov/files/document/mcp-pymt-att-methodologies.pdf

We calculated ESP amounts as described in the MCP Payment and Attribution Methodologies document: we first used a reference population of beneficiaries attributed to MCP participants and non-MCP organizations for the second quarter of 2024 and used their Hierarchical Condition Category (HCC) scores and Area Deprivation Index (ADI) scores (based on residence zip code) to determine thresholds for clinical and social risk adjustment within each MCP region. We then calculated base ESP rates for beneficiaries attributed to participants in 2023 using participant track, and clinical and social risk tiers determined by HCC scores, ADI, and Low-Income Subsidy (LIS) eligibility. We adjusted base ESPs by participant-level geographic adjustment factors, and by participant-level MIPS adjustment factors. Finally, we reduced ESPs for beneficiaries with ESP services billed outside of their attributed participant's providers.

4. *Compare payments under the hypothetical status quo and payments for those same services under MCP*. Finally, we compared the payments that participants would have received under the PFS hypothetical status quo (Step 2) with the payments that would be expected under MCP absent any behavioral changes (Step 3) – overall and by track. We weighted all participants equally in the analysis comparing payments under the two scenarios in contrast to weighting participants by their number of attributed Medicare FFS beneficiaries in 2023. Given that a few participants are extremely large and two MCP states (New York and Washington) account for a large share of beneficiaries attributed to MCP participants, beneficiary-level weighting would have resulted in the findings being driven by relatively few organizations. Our approach of weighting each organization equally is intended to make findings more generalizable. Finally, we did not include payments or adjustments that participants receive outside of or incremental to payments for the fixed set of services identified from the baseline period in Step 1, such as shared savings payments from the Medicare Shared Savings Program, because the payment calibration analysis was intended to assess only payments that are strictly tied to the provision of primary care services.