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MCP

MAKING CARE PRIMARY: PAYMENT AND ATTRIBUTION METHODOLOGIES PY 2025

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List of Acronyms

ACM	Ambulatory Co-Management
ACO	Accountable Care Organization
ACO REACH	Accountable Care Organization Realizing Equity, Access, and Community Health
ADI	Area Deprivation Index
AHEAD	Advancing All-Payer Health Equity Approaches and Development
AHRQ	Agency for Healthcare Research and Quality
BAL	Beneficiary Attestation List
CC	Condition Category
CCA	Collaborative Care Arrangement
CCM	Chronic Care Management
CCN	CMS Certification Number
CG-CAHPS	Clinician and Group Consumer Assessment of Healthcare Providers and Systems®
CI	Continuous Improvement
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CQM	Clinical Quality Measure
DXG	Diagnostic Group
E&M	Evaluation and Management
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
EDU	Emergency Department Utilization
ESP	Enhanced Services Payment
ESRD	End-Stage Renal Disease
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
GAF	Geographic Adjustment Factor
HCC	Hierarchical Condition Category
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
IPC	Interprofessional Consultation
IT	Information Technology
ITU	Indian Health Service, Tribal, and Urban Indian Providers
LIS	Low-Income Subsidy
MCP	Making Care Primary
MEC	MCP e-Consult
MIPS	Merit-based Incentive Payment System
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
PA	Participation Agreement
PBPM	Per-Beneficiary Per-Month
PCF	Primary Care First
PCPCM	Person-Centered Primary Care Measure

PECOS	Provider Enrollment Chain and Ownership System
PFS	Physician Fee Schedule
PIP	Performance Incentive Payment
PPCP	Prospective Primary Care Payment
PPS	Prospective Payment System
PY	Performance Year
Q	Quarter
QRDA	Quality Reporting Document Architecture
SSP	Shared Savings Program
TIN	Taxpayer Identification Number
TPCC	Total Per Capita Cost
UIP	Upfront Infrastructure Payment

Executive Summary

This Executive Summary is an overview of the payment methodologies that the Centers for Medicare & Medicaid Services (CMS) uses for the Making Care Primary (MCP) Model for Performance Year (PY) 2025. The Executive Summary and the detailed technical specifications are organized as follows:

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

ES.1 Introduction

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

MCP creates a variety of pathways to support delivery of high-quality primary care. To implement this flexibility, the model is structured around participant "tracks." There are three tracks, providing opportunities for participants with varying experience in value-based care.

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

Participants will spend the first 2.5 years of the model in the track they began model participation in, and 2 years in any subsequent track until they reach Track 3, where they will remain throughout the model. For each track, MCP Participants are eligible to receive specific payments. Table 1 summarizes the payment types and their applicability to each track.

Table 1. MCP Payment Types by Track

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

[a] For eligible participants only.

MCP includes three types of participants ("participant types"): Standard Participants, Federally Qualified Health Centers (FQHCs), and Indian Health Service, Tribal, and Urban Indian Providers (ITU). Participants of all types can participate in all tracks, though some aspects of the MCP payment methodologies may differ by participant type.

ES.2 Beneficiary Attribution

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

CMS attributes beneficiaries to participants on the basis of either voluntary alignment or claims-based attribution.

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

Attribution is conducted before the start of each quarter because MCP pays participants prospectively (that is, in advance of) each quarter. For each quarter, MCP uses a rolling 24-month "lookback" period for beneficiary claims.

ES.3 Enhanced Services Payment (ESP)

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

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

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

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

ESP Payment Category	Clinical Risk Tier (CMS-HCC Risk Score Percentile)	Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
LIS			$25	$25	$25
Non-LIS Group 1	Tier 1 (≤ 25th)	Not Applicable[a]	$9	$4	$2
Non-LIS Group 2	Tier 2 (> 25th and ≤ 50th)	Not Applicable[a]	$11	$5	$2.50
Non-LIS Group 3	Tier 3 (> 50th and ≤ 75th)	Not Applicable[a]	$14	$7	$3.50
Non-LIS Group 4	Tier 4 (> 75th)	Tier 1, Tier 2, or Tier 3 (≤ 75th)	$18	$8	$4
Non-LIS Group 5	Tier 4 (> 75th)	Tier 4 (> 75th)	$25	$25	$25

ADI = Area Deprivation Index; HCC = Hierarchical Condition Categories; ESP = Enhanced Services Payment; LIS = low-income subsidy.

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

ES.4 Prospective Primary Care Payment (PPCP)

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

- **Track 1: 0% PPCP and 100% FFS.** Track 1 participants continue to bill and receive payment from Medicare FFS as usual (and FQHCs will continue to be paid according to the Medicare FQHC PPS).
- **Track 2: 50% PPCP and 50% FFS.** In Track 2, the PPCP is meant to partially replace FFS revenue from primary care services for a participant's attributed beneficiary population. Track 2 participants receive a hybrid payment consisting of partial PPCP with reduced FFS payments for primary care services.
- **Track 3: 100% PPCP and 0% FFS.** In Track 3, the PPCP is meant to fully replace FFS revenue from primary care services. Participants receive an alternative to FFS payment made up of full PPCP, and FFS payments for primary care services are not paid.

The services affected by these payment policies for Tracks 2 and 3 are referred to as "PPCP Services." The full list of services is in Table 12. The PPCP Services for Track 2 are a subset of the services for Track 3. The applicable list of PPCP Services depends on participant type, as follows:

- For Standard Participants, the PPCP is based on primary care services on the PPCP Services list billed under the Medicare PFS.

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

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

Notably, CMS requires that throughout MCP, participants continue to bill for PPCP Services provided as long as services meet billing requirements.

ES.5 Performance Incentive Payment (PIP)

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

Table 3. MCP Performance Measure Set

Measure	Data Source	Required for Track 1	Required for Track 2	Required for Track 3
Controlling High Blood Pressure NCQA (CMS165)	Participant-reported	Yes	Yes	Yes
Diabetes: Glycemic Status Assessment Greater Than 9% NCQA (CMS122)	Participant-reported	Yes	Yes	Yes
Colorectal Cancer Screening NCQA (CMS130)	Participant-reported	Yes	Yes	Yes
Screening for Depression and Follow-up Plan CMS (CMS2)	Participant-reported	No	Yes	Yes
Depression Remission at 12 Months MN Community Measurement (CMS159)	Participant-reported	No	Yes	Yes
Person-Centered Primary Care Measure (PCPCM) Smart Measures, LLC	Survey measure	Yes	Yes	Yes
Screening for Social Drivers of Health CMS (Quality ID#487)	Participant-reported	No	Yes	Yes
Total Per Capita Cost (TPCC) CMS	Claims-based	No	Yes	Yes

(continued)

Table 3. MCP Performance Measure Set (continued)

Measure	Data Source	Required for Track 1	Required for Track 2	Required for Track 3
Emergency Department Utilization (EDU) NCQA	Claims-based	No	Yes	Yes
Continuous improvement (CI) CMS • For Standard MCP Participants: **Total Per Capita Cost (TPCC) CI** • For Federally Qualified Health Centers (FQHCs) and Indian Health Service, Tribal, and Urban Indian Providers (ITUs): **Emergency Department Utilization (EDU) CI**	Claims-based	No	Yes	Yes

Note: Certain MCP measures are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found at https://innovation.cms.gov/notices-disclaimers.

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

For each participant, starting in 2025, a total PIP will be calculated for each performance year. The first part of the PIP (called the "first lump sum PIP"), based on estimated performance, will be paid up front in the first quarter of each performance year, and the second part (the "second lump sum PIP"), based on actual performance, will be paid in the third quarter of the following year. In 2025 and 2026, MCP performance data will not be available for reported measures; thus, the first lump sum will be estimated using comparable modeled data from available sources. Once MCP performance data are available, the first lump sum PIP for each performance year will be estimated using aggregate performance data from the prior year. It is important to note that the first lump sum PIP may be debited against future payments if the participant earns a lower PIP based on actual participant quality measure performance than was initially estimated and paid in the first lump sum.

ES.6 Specialty Integration Payment Codes

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

- Participants in Tracks 2 and 3 that are composed of MCP Clinicians and MCP Specialists have the option to identify one or more Specialty Care Partners, execute a Collaborative Care Arrangement (CCA), and submit their initial Specialty Care Partner List to CMS. Participants must

review and update their lists annually to ensure that Specialty Care Partners are meeting the requirements and expectations outlined in their CCAs.

- Participants in Tracks 2 and 3 that are not composed of MCP Clinicians and MCP Specialists must identify at least one Specialty Care Partner, execute a CCA, and submit their initial Specialty Care Partner List to CMS. Participants must review and update their lists annually to ensure that Specialty Care Partners are meeting the requirements and expectations outlined in their CCAs.
- Participants in Tracks 2 and 3 will have access to a new MCP e-Consult (MEC) code for all attributed beneficiaries. This code was designed to remove barriers to using current e-consult and FFS Interprofessional Consultation (IPC) codes. The MEC code adjusts the current requesting physician IPC code to capture time spent obtaining and implementing specialist recommendations. As shown in Table 12, the MEC code will not be included in the Track 2 PPCP Service list. This will allow participants in Track 2 to receive the full reimbursement rate for this service on a FFS basis. In Track 3, the MEC code will be included in the PPCP Service list and will therefore be paid prospectively.
- For participants in Track 3, Specialty Care Partners and MCP Specialists will gain access to a new Ambulatory Co-Management (ACM) code for the enhanced collaboration and communication expected (1) between the MCP Clinicians and specialists at Specialty Care Partners or (2) between MCP Clinicians and MCP Specialists.
  - Track 3 participants that are composed of MCP Clinicians and MCP Specialists will be required to define the communication and data-sharing protocols, expectations for coordination of care (such as when a patient should be shifted back to the primary care clinician for decision-making on care), and expectations for co-management of care within their TIN organization.
  - Track 3 participants that are not composed of MCP Clinicians and MCP Specialists will be required to execute CCAs with Specialty Care Partners to define the communication and data-sharing protocols, expectations for coordination of care (such as when a patient should be shifted back to the primary care clinician for decision-making on care), and expectations for co-management of care.

ES.7 Upfront Infrastructure Payment (UIP)

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

To be eligible for the UIP, an MCP Participant must participate in Track 1 and must meet at least one of the following criteria: (1) not have an e-consult technology solution or electronic health record

enhancement that allows two-way communication and the secure sharing of patient records between primary care clinicians and specialists and/or (2) meet the definition of a "low-revenue" participant.[1]

[1] A "low-revenue" Participant is one with a total Medicare Part A and Part B FFS revenue less than 35% of the total Part A and Part B FFS expenditures for the Participant's attributed beneficiaries.

1. Introduction

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

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

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

1.1 MCP Performance Years

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

Table 4. MCP Performance Years

Performance Year	Start Date	End Date
2024	July 1, 2024	December 31, 2024
2025	January 1, 2025	December 31, 2025
2026	January 1, 2026	December 31, 2026
2027	January 1, 2027	December 31, 2027
2028	January 1, 2028	December 31, 2028
2029	January 1, 2029	December 31, 2029
2030	January 1, 2030	December 31, 2030
2031	January 1, 2031	December 31, 2031
2032	January 1, 2032	December 31, 2032
2033	January 1, 2033	December 31, 2033
2034	January 1, 2034	December 31, 2034

1.2 MCP Participant Types and Tracks

MCP offers a variety of pathways to support delivery of high-quality primary care. To implement this flexibility, the model is structured around three participant "tracks," which allow participants with varying experience in value-based care to participate.

- **Track 1** includes organizations that are building capacity to offer advanced services such as risk stratification, data review, identification of staff for chronic disease management, or health-related social needs screening and referral. Track 1 participants also must not have had any value-based care experience in the 5 years before MCP. Participants entering MCP in Track 1 will remain in Track 1 for 2.5 years before progressing to Track 2.
- **Track 2** includes organizations that are building on the Track 1 requirements by partnering with social service providers, implementing care management, screening for behavioral health services, and transitioning between fee-for-service (FFS) and prospective, population-based payment. Participants entering MCP in Track 2 will remain in Track 2 for 2.5 years before progressing to Track 3. Participants moving into Track 2 from Track 1 will spend 2 years in Track 2 before progressing to Track 3.
- **Track 3** includes organizations that are expanding upon the Track 2 requirements by optimizing primary care delivery, integrating specialty care, and deepening connections to community resources, enabled by prospective, population-based payments. Participants entering MCP in Track 3 remain in Track 3 for the entirety of MCP. Participants moving into Track 3 from Track 2 will stay in Track 3 for the remainder of the model.

Care delivery requirements and alternative payment methodologies increase in scope and complexity from Track 1 through Track 3. For each of the MCP tracks, MCP Participants are eligible to receive specific payments.

The three MCP Participant types, Standard, Federally Qualified Health Center (FQHC), and Indian Health Service, Tribal, and Urban Indian Provider (ITU), are based on the reimbursement systems under which they bill Medicare FFS and on the populations the organizations primarily serve. Participants of any type may participate in any track, though some aspects of the MCP payment methodologies may differ by participant type.

1.3 MCP Payment Types

A summary of the payment types available to MCP Participants is below. Table 5 highlights track eligibility for each payment type. As mentioned above, details on each type of payment are in Sections 3 through 7.

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

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

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

There are two additional payments available for **Specialty Integration:**

- **MCP e-Consult (MEC):** Participants in Track 2 are eligible to bill an e-consult code that is unique to MCP. For participants in Track 3, this code is included in the list of PPCP Services. The aim of the MEC code is to address current barriers to e-consult billing, including post-service time to implement the specialist's recommendation.
- **Ambulatory Co-Management (ACM):** In-house MCP Specialists in Track 3 or Specialty Care Partner physicians who have a Collaborative Care Arrangement (CCA) with an MCP Participant in Track 3 are eligible to bill a coordination code unique to MCP that is focused on communication and collaboration. The goal of this payment is to support ongoing communication and

collaboration of shared MCP patients who require both longitudinal primary care and specialized care to stabilize an exacerbated chronic condition.

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

Table 5 summarizes the MCP payment mechanisms available by track.

Table 5. MCP Payment Mechanisms by Track

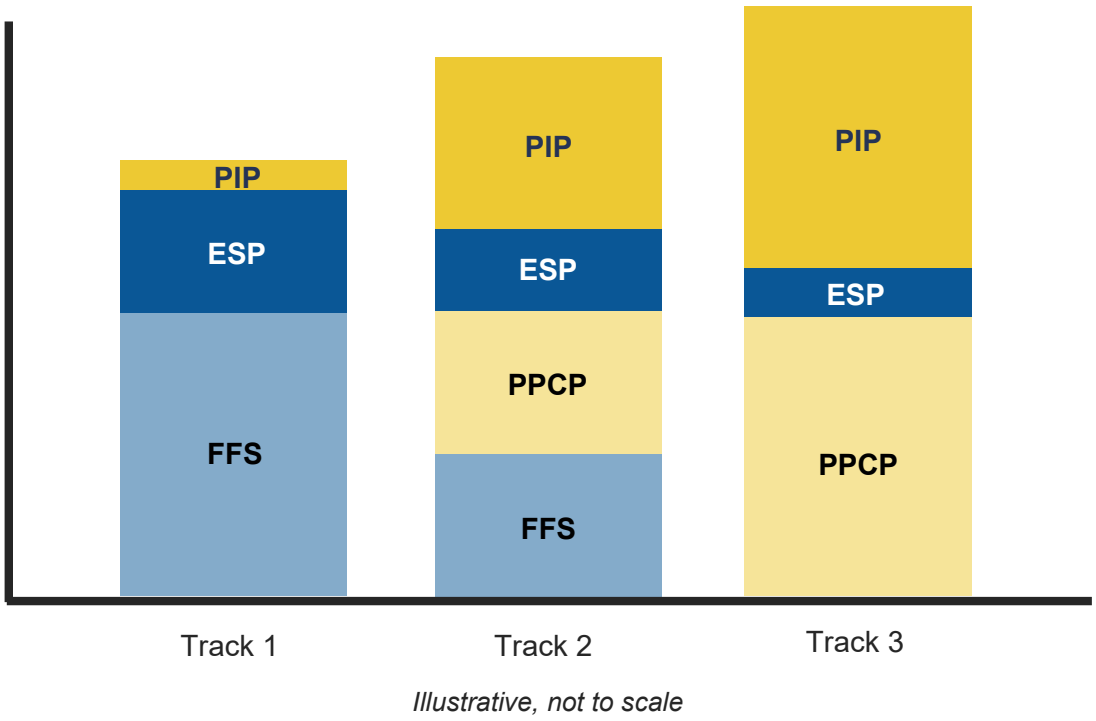
Payment Type	Track 1	Track 2	Track 3
Enhanced Services Payment (ESP)	X	X	X
Prospective Primary Care Payment (PPCP)	N/A	X	X
Performance Incentive Payment (PIP)	X	X	X
MCP e-Consult (MEC)[a]	N/A	X	X
Ambulatory Co-Management (ACM)[b]	N/A	N/A	X
Upfront Infrastructure Payment (UIP)	X	N/A	N/A

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

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

- **PPCP** *increases* from Track 1 to Track 3, while FFS *decreases* accordingly, to support the interprofessional team. Specifically, for primary care services, Track 1 participants are paid 0% PPCP and 100% FFS, Track 2 participants are paid 50% PPCP and 50% FFS, and Track 3 participants are paid 100% PPCP and 0% FFS.
- **ESPs** *decrease* from Track 1 to Track 3 as participants become more advanced.
- **PIP** potential, which is tied to quality performance, greatly *increases* from Track 1 to Track 3 to make up for decreases in guaranteed payments from ESPs and FFS.

Figure 1. Illustration of Relationship Between MCP Payment Types



Note: ESP = Enhanced Services Payment; FFS = Fee-For-Service; PIP = Performance Incentive Payment; PPCP = Prospective Primary Care Payment.

2. Beneficiary Attribution

Navigating this section:

2.1 Overview

Attribution is a tool used to assign beneficiaries to primary care organizations. CMS uses MCP attribution to:

- Calculate the Enhanced Services Payment (ESP).
- Calculate the Prospective Primary Care Payment (PPCP) and apply payment reductions to corresponding fee-for-service (FFS) claims for Track 2 and 3 participants.
- Identify beneficiaries for inclusion in the claims-based quality measures.
- Identify beneficiaries for whom participants and Specialty Care Partners can bill the MCP e-Consult (MEC) code and Ambulatory Co-Management (ACM) code.

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

- **Unit of assignment**. MCP attribution is performed at the MCP Participant level. An MCP Participant organization is composed of a group of National Provider Identifiers (NPIs) billing under the same Taxpayer Identification Number (TIN) (for Standard Participants) or a group of CMS Certification Numbers (CCNs) (for Federally Qualified Health Center [FQHC] Participants) billing under the same TIN.
- **How the beneficiary is attributed**. CMS attributes traditional Medicare beneficiaries to an MCP Participant using either voluntary alignment or claims-based attribution.
  - CMS first determines attribution on the basis of the beneficiary's chosen alignment to a clinician on Medicare.gov (voluntary alignment).
  - If an MCP-eligible beneficiary is not attributed during the voluntary alignment step of attribution, CMS attributes the beneficiary using claims-based attribution.
- **Period of attribution**. To support the MCP Care Delivery model, CMS pays participants prospectively (that is, in advance) so that they may make investments consistent with the aims of MCP. To pay participants prospectively, CMS performs prospective attribution based on historical data before each payment quarter.
- **How often the attribution is made**. Because the intent of attribution is to accurately estimate the number of beneficiaries that receive primary care from an MCP Participant to calculate payments, CMS performs attribution quarterly to facilitate quarterly payments to participants.

Eligible Medicare beneficiaries are prospectively attributed to a participant. Participants receive model-specific payments for these beneficiaries and are held accountable for their quality outcomes.

Prospective attribution and payment assume that all attributed beneficiaries remain eligible for the entire quarter. However, some beneficiaries become ineligible before or during the quarter, after attribution has been completed. In each quarterly payment cycle, CMS determines how many beneficiaries became ineligible in a prior quarter and applies a deduction to the upcoming quarter's payment for their previous overpayments, as described in Section 3.6.2.1.

2.2 Eligible Beneficiaries

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

- Have both Medicare Parts A and B
- Have Medicare as their primary payer
- Do not have end-stage renal disease (ESRD) at the time of initial attribution[2]
- Are not enrolled in hospice
- Are not covered under a Medicare Advantage or other Medicare health plan
- Are not institutionalized
- Are not incarcerated
- Are not aligned or otherwise attributed to an entity participating in certain other CMS programs or models, as listed in Section 2.4
- Have not elected Medicaid Health Home services[3]

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

CMS analyzes eligibility using the most recent month of data available before the quarter begins. Beneficiaries are determined to be eligible as of the first day of that month. For example, beneficiaries must meet all eligibility criteria on December 1, 2024, to be eligible for attribution in the first quarter of Performance Year (PY) 2025 (January 1, 2025–March 31, 2025).

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

[2] Note that this criterion only applies to beneficiaries who have not been attributed to an MCP Participant previously—if the beneficiary has been attributed previously, then developing ESRD does not disqualify a beneficiary from being attributed to an MCP Participant.
[3] Note that the MCP Participant must inform CMS if a patient meets this criterion.

2.3 Attribution Steps

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

CMS performs the beneficiary attribution algorithm and gives each participant a list of attributed Medicare beneficiaries on a quarterly basis throughout the model.

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

2.3.1 Voluntary Alignment

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

CMS assesses voluntary alignment on Medicare.gov quarterly.

2.3.1.1 Beneficiary Attestations on Medicare.gov

To make an attestation, a beneficiary must first create an account on Medicare.gov. They can then visit the Find and Compare Health Care Providers web page on Medicare.gov and follow the directions under "Add your favorite providers." CMS has developed a voluntary alignment factsheet and best practices document for MCP Participants and a voluntary alignment factsheet for beneficiaries.

Although any beneficiary with an account on Medicare.gov can make an attestation, MCP voluntary alignment is limited to eligible beneficiaries (Section 2.2). For the eligible beneficiaries who have made an attestation via Medicare.gov, CMS applies the voluntary alignment algorithm each quarter according to the steps in this section, 2.3.1.1, and the next section, 2.3.1.2.

Using the beneficiary attestation list (BAL) from Medicare.gov, for a given quarter, CMS identifies each eligible beneficiary's most recent attested record as of the end of the lookback period (3 months before the start of a given quarter). Table 6 lists the BALs and the beneficiary attestation cut-off dates for quarterly attributions for PY 2025 and PY 2026. For example, CMS will use the October 2024 BAL, which will include beneficiary attestations as of September 30, 2024, for voluntary alignment in Q1 2025.

Eligible beneficiaries who have made an attestation specifying a health care clinician and location as their primary clinician are eligible for voluntary alignment.

Table 6. Beneficiary Attestation Lists Used for PY 2025 and PY 2026 Quarterly Attribution

Attribution Quarter	Beneficiary Attestation List Used	Beneficiary Attestation Cut-off Date
Q1 2025	October 2024	September 30, 2024
Q2 2025	January 2025	December 31, 2024
Q3 2025	April 2025	March 31, 2025
Q4 2025	July 2025	June 30, 2025
Q1 2026	October 2025	September 30, 2025
Q2 2026	January 2026	December 31, 2025
Q3 2026	April 2026	March 31, 2026
Q4 2026	July 2026	June 30, 2026

PY = Performance Year.

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

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

2.3.1.2 Clinician and Organization Eligibility Check

An MCP Standard Participant is defined by the combinations of TINs and NPIs identified on the MCP Clinician List. In voluntary alignment for Standard Participants, CMS uses the participant's MCP Clinician List to verify whether the attested organization's TIN and the attested clinician's NPI match a Standard MCP Participant. In voluntary alignment for FQHC Participants, the participant is defined by its submitted TIN; the CCNs associated with the FQHC's TIN are not used for voluntary alignment. CMS uses the TINs collected from FQHC Participants to verify whether the attested TIN matches an FQHC Participant.

CMS uses the BAL file for a given quarter to determine the eligibility of the clinician and location to which the eligible beneficiary attested. Only eligible clinicians are included in voluntary alignment. If the attested organization (in other words, the attested TIN) is an MCP Standard Participant, the attested clinician must also be listed as active on the participant's MCP Clinician List for the given quarter to be

[4] Because the BAL includes the clinician's and organization's identification numbers assigned by, and specific to, the Provider Enrollment Chain and Ownership System (PECOS), which are the data used by Care Compare, CMS uses the Provider Master Index file and Center for Program Integrity sole proprietor file (for sole clinicians) to identify the TINs and NPIs for each attested clinician and organization.

eligible. CMS considers a clinician active for a given quarter if the clinician is on the participant's MCP Clinician List on the first day of the month before a given quarter. For example, clinicians must be active on December 1, 2024, to be eligible for voluntary alignment in the first quarter of PY 2025 (January 1, 2025–March 31, 2025).

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

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

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

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

2.3.2 Claims-Based Attribution

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

2.3.2.1 Eligible Visits

For claims-based attribution, CMS uses the pool of Medicare claims during the lookback period to identify eligible primary care visits for attribution. The lookback period is the 24-month period ending 3 months before the start of the quarter. For example, CMS uses claims with dates of service from October 2023 through September 2025 to attribute MCP-eligible beneficiaries to participants for Q1 2025. Table 7 lists the lookback periods that will be used for the PY 2025 and PY 2026 quarterly attributions.

Table 7. Lookback Periods for PY 2025 and PY 2026 Quarterly Beneficiary Attribution

Attribution Quarter	Lookback Period
Q1 2025	October 2022–September 2024
Q2 2025	January 2023–December 2024
Q3 2025	April 2023–March 2025
Q4 2025	July 2023–June 2025
Q1 2026	October 2023—September 2025
Q2 2026	January 2024—December 2025
Q3 2026	April 2024—March 2026
Q4 2026	July 2024—June 2026

PY = Performance Year.

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

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

Table 8. Primary Care Services Eligible for Attribution[5]

Service	HCPCS Codes
Office/outpatient visit evaluation and management (E&M)	99201–99205, 99211–99215
Complex Chronic Care Management (CCM) services[a]	99487
CCM services[a]	99490, 99491, G0511
Principal Care Management services[a]	99424, 99426, G2064, G2065
Transitional care management services[a]	99495, 99496
Home care/domiciliary care E&M	99324–99328, 99334–99337, 99339–99345, 99347–99350
Online digital E&M	99421–99423
Audio-only telephone E&M	99441–99443

(continued)

[5] Please note that all HCPCS codes listed in this table and throughout the document are current as of the CY 2025 Medicare Physician Fee Schedule Final Rule and are subject to change in future Medicare PFS Final Rules.

Table 8. Primary Care Services Eligible for Attribution (continued)

Service	HCPCS Codes
Technology-based check-in services	G2010, G2012, G2252
Remote physiologic monitoring	99453, 99454, 99457, 99091
Remote therapeutic monitoring	98975–98977, 98980
Advance care planning	99497
Depression, substance use disorder, and alcohol misuse screening and counseling services	G0396, G0397, G0442–G0444
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Assessment/care planning for patients requiring CCM services[a]	G0506
Care management services for behavioral health conditions[a]	99484
Cognition and functional assessment for patient with cognitive impairment	99483
Psychiatric Collaborative Care Model	99492–99494, G0512, G2214
Outpatient clinic visit for assessment and management (for critical access hospital-based outpatient primary care participants)	G0463
Administration of Health Risk Assessment (HRA)	96160, 96161
Social Determinants of Health Risk Assessment	G0136
Interprofessional Consultation (IPC) and MCP e-Consult (MEC)	99452, G9037
Federally Qualified Health Center (FQHC) all-inclusive visit	G0466, G0467
FQHC visit, initial preventive physical examination or annual wellness visit	G0468
Distant site telehealth services furnished by RHCs or FQHCs	G2025
FQHC virtual communication services	G0071
Chronic pain management and treatment[a]	G3002
Principal illness navigation services[a]	G0023, G0140
Community health integration services[a]	G0019
Advanced primary care management services[a]	G0556, G0557, G0558

HCPCS = Healthcare Common Procedure Coding System.

[a] These are services related to CCM and are counted toward attribution even if they are provided by a clinician without one of the primary care specialty codes in Appendix A. All other services only count toward attribution if they are provided by a clinician active in an MCP Participant when the visit occurs or has one of the primary care specialty codes in Appendix A.

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

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

- The HCPCS code on the claim is among those listed above in Table 8.

- Claims for a service not related to Chronic Care Management (CCM) in the physician file (where claims are found for Standard Participants) must be provided by a clinician who meets one of the following criteria (called an "eligible clinician"):[6]
  - Active in an MCP Participant when the visit occurs
  - Has one of the primary care specialty codes located in Appendix A[7]

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

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

CMS maintains historical TINs, NPIs, and CCNs to associate claims with participants accurately in the lookback period. When MCP Clinicians leave a participant organization, their NPIs remain on the participant's MCP Clinician List but are marked with a termination date. Although these clinicians are no longer active MCP Clinicians, past visits to them during the lookback period continue to be counted toward the participant's attribution. Similarly, CCNs for an FQHC MCP Participant that become no longer active will continue to be counted during the lookback through the marked termination date.

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

CMS first checks whether eligible beneficiaries have Annual Wellness Visits (G0438, G0439, G0468) or Welcome to Medicare Visits (G0402) in the lookback period. CMS attributes the beneficiary to the participant (or non-MCP clinician or FQHC) who billed the beneficiary's most recent claim for an Annual Wellness Visit or a Welcome to Medicare Visit during the lookback period. CMS prioritizes Annual Wellness Visits and Welcome to Medicare Visits because these typically represent a longitudinal relationship between patient and clinician.

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

2.3.2.3 Attribution Based on Plurality

In this step, CMS first counts the number of eligible primary care visits the beneficiary had with each individual clinician or CCN. CMS then, for Standard Participants, combines eligible primary care visits to individual clinicians (that is, TIN/NPI combinations) into MCP Standard Participant organizations using

[6] There is no specialty code restriction on CCM-related services. Therefore, even clinicians who do not have one of the primary care specialties listed are eligible for attribution when they bill CCM-related services. Table 8 identifies the CCM-related services.

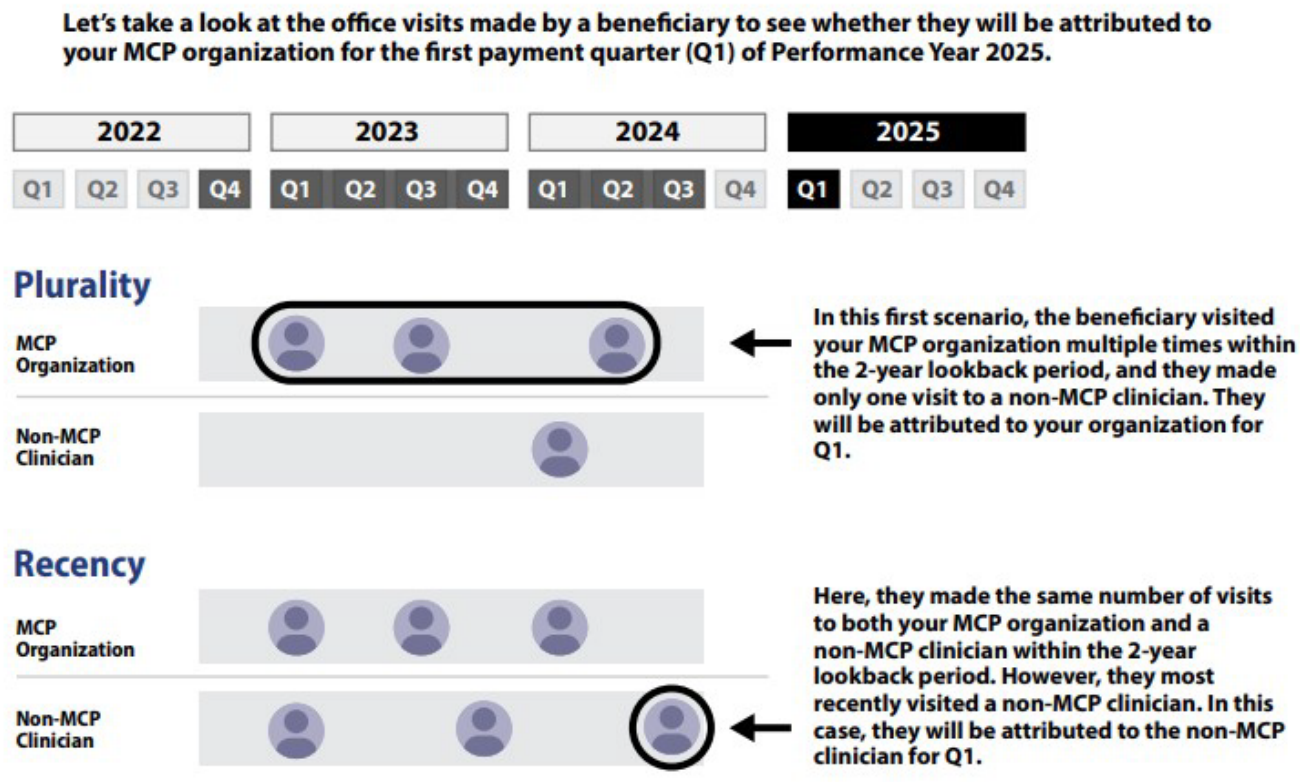
[7] Note that clinicians must have a primary care specialty code to be active in an MCP Standard Participant organization.

the participant's most recent MCP Clinician List. For example, two clinicians working in an MCP Participant's organization will have their eligible primary care visits aggregated for the purposes of attribution. For FQHC Participants, CMS combines eligible primary care visits to single FQHCs into MCP FQHC Participant organizations using the list of CCNs collected from the FQHC Participant. Finally, CMS attributes the beneficiary to an MCP Participant if it provided the plurality of eligible primary care visits during the lookback period.

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

Figure 2 illustrates two examples of claims-based attribution based on the number and timing of primary care visits. In the plurality scenario, the beneficiary will be attributed to the MCP Participant based on plurality; in the recency scenario, the beneficiary will be attributed to the non-MCP clinician after applying the recency criteria to a tiebreaker.

Figure 2. Which Beneficiaries Are Attributed to My Organization Through Claims-Based Attribution?



2.4 Interaction with Other Medicare Programs and Models

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

2.4.1 The Medicare Shared Savings Program

Eligible MCP Participants that participated in a Medicare Shared Savings Program (SSP) Accountable Care Organization (ACO) (any track) were permitted to participate in both initiatives from July 1, 2024, through December 31, 2024 (please see section 3.7.D in the Standard Participant and FQHC Participant Participation Agreements [PAs] for more details). In those first 6 months of MCP, beneficiaries eligible for MCP who were attributed (either via voluntary alignment or claims-based attribution) to both the MCP Participant and the SSP ACO that the MCP Participant participated in remained attributed to both. No MCP payments were made to MCP Participants while they were participating in an SSP ACO.

Beginning on January 1, 2025, to avoid duplicative payment of incentive payments, organizations (TINs) may not simultaneously participate in an SSP ACO and MCP. MCP Participants that are listed as participants in an SSP ACO for PY 2025 will be terminated from MCP. Beneficiaries attributed to both MCP and an SSP ACO for the same time period will also be removed from MCP beginning in 2025.

2.4.2 Accountable Care Models

To avoid duplicative payment of shared savings or other incentive payments, clinicians participating in certain accountable care models may not simultaneously participate in MCP, and beneficiaries attributed to these initiatives are not eligible for attribution to an MCP Participant. The following Innovation Center accountable care models operating in 2025 prohibit beneficiary overlap:

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

2.4.2.1 Voluntary Alignment for MCP, ACO REACH, and SSP

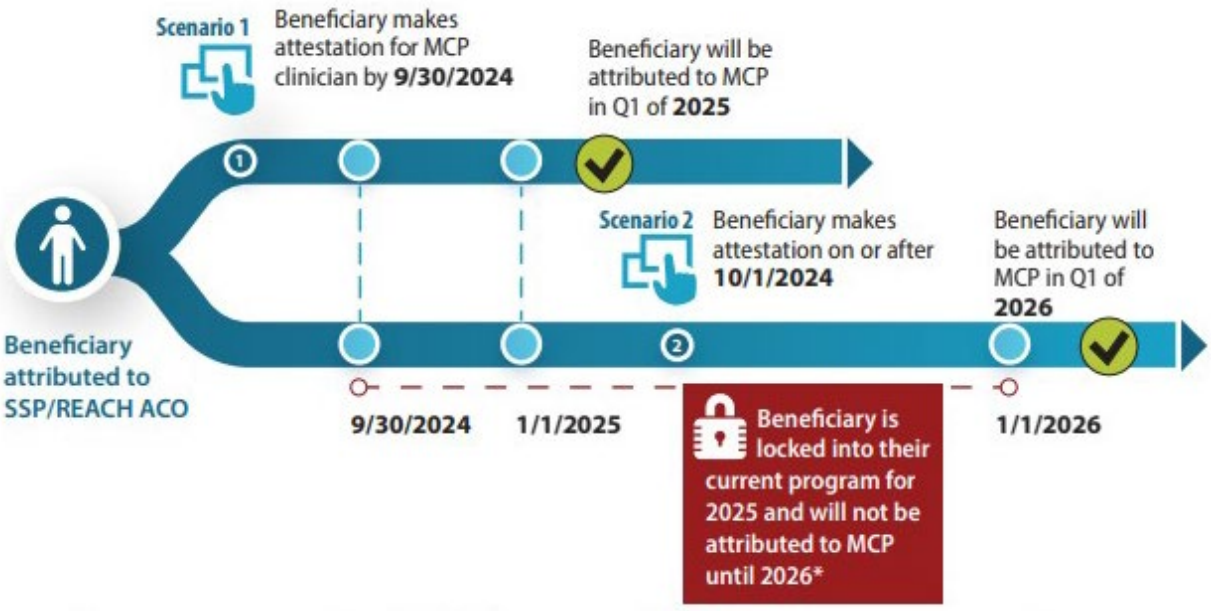
Voluntary alignment to MCP takes precedence over any claims-based attribution to SSP or the ACO REACH model, but only for MCP attributions in the first quarter of each calendar year. For example, beneficiaries who make an eligible attestation to an MCP Clinician or FQHC on or before September 30, 2024, are attributed to their attested MCP Clinician or FQHC for Q1 2025. If MCP-eligible beneficiaries have already been attributed to an SSP or REACH ACO during any quarter of 2025, then make a

subsequent attestation to an MCP Clinician or FQHC in 2025, that subsequent attestation will not take effect until 2026.

> Beneficiaries attributed to an SSP or REACH ACO will remain attributed for the entire calendar year.

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

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



2.4.3 Disease-Specific and Episode-Based Models

MCP Participants and MCP-attributed beneficiaries may overlap with CMS models focused on testing bundled payments for certain episodes of care, where it is possible to account for the financial impact of the overlap. Examples of these models are the Bundled Payments for Care Improvement Advanced

Model, the Enhancing Oncology Model, the Increasing Organ Transplant Access Model, and the Guiding an Improved Dementia Experience model.

2.4.4 State and Community-Based Models

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

2.4.5 Other Models

MCP Participants and their MCP beneficiaries may simultaneously participate in other types of initiatives, such as models that are not Medicare FFS models, including Medicare Advantage Health Plan and Part D models. For example, MCP Participants may simultaneously participate in the Cell and Gene Therapy Access model. CMS may update these overlap policies periodically to include new initiatives as they are finalized.

3. Enhanced Services Payment

Navigating this section:

3.1 Overview

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

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

3.2 Allowable Uses

The ESP provides up-front funding to pay for the services listed in Figure 4, consistent with the specific needs of a participant's MCP beneficiaries.

Figure 4. Allowable Uses for MCP's Enhanced Services Payments

Allowable Uses for MCP's Enhanced Services Payments
• **Care management** • **Patient navigation** • **Behavioral health** • **Enhanced care coordination services** • **Hiring of staff or expanding the roles of current staff (for example, care managers) to support activities such as identifying and addressing patients' social needs** • **Supporting the establishment of relationships with external clinicians and staff to facilitate information-sharing and workflow development**

The ESP is intended to support augmented services and training that align with the transformation aims of MCP Participants' required care delivery functions. Although participants must use the funds to support covered services, they have flexibility to invest the dollars according to their attributed Medicare beneficiaries' needs. The care management personnel should have access to patient data/electronic health records and function as part of the primary care team. CMS will monitor spending on these investments and care delivery changes through regular required care delivery reporting.

3.3 Services Duplicative of the ESP

CMS considers FFS payments for certain care management-related services, identified in Table 9, duplicative with the ESP. Per section 8.3.G in the Standard Participant and FQHC Participant Participation Agreements (PAs), if CMS receives a claim for a duplicative service from an MCP Participant for any of their attributed beneficiaries, CMS will not pay the claim.

Table 9. Services Considered Duplicative of the Enhanced Services Payment

Service	Code
Complex Chronic Care Management (CCM) services	99487, 99489[a]
CCM services	99490, 99491, 99437,[a] 99439,[a] G2058[a]
CCM or General Behavioral Health Integration Services (for Federally Qualified Health Centers [FQHCs])	G0511
Principal Care Management services	99424, 99425,[a] 99426, 99427[a]
Transitional care management services	99495, 99496
Assessment/care planning for patients requiring CCM services	G0506
Social Determinants of Health Risk Assessment	G0136
Chronic pain management and treatment	G3002, G3003[a]
Principal illness navigation services	G0023, G0024,[a] G0140, G0146[a]
Community health integration services	G0019, G0022[a]

[a] CMS also will not pay for these associated add-on codes when billed with other duplicative services.

3.4 Amount of the ESP

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

In addition to varying by track, the ESP is risk-adjusted by certain beneficiary characteristics to ensure participants that serve higher-need beneficiaries receive proportionally more resources. The ESP PBPM amount for each beneficiary is based on three risk factors:

- Whether the beneficiary is enrolled in the Medicare Part D low-income subsidy (LIS)
- The Area Deprivation Index (ADI)[8] ranking based on the beneficiary's residence
- The beneficiary's CMS-Hierarchical Condition Categories (HCC) risk score

Although most ESP PBPM amounts decrease across tracks, CMS does not decrease the ESP PBPM amount for beneficiaries who are either enrolled in LIS or in the top quartile of clinical and social risk (Tier 4). This ensures that participants serving higher-need beneficiaries receive the highest ESP amount regardless of track. Higher risk-adjusted ESPs for the participant's high-risk beneficiaries account for the higher disease burden in these populations, as well as the increased resources required to serve beneficiaries with multiple chronic conditions. The tiered ESP PBPM amounts are in Table 10 below. For an MCP Participant to receive the highest ESP PBPM amount ($25) for a beneficiary, the beneficiary must be enrolled in LIS or have a CMS-HCC risk score in clinical risk tier 4 *and* an ADI score in social risk tier 4.

Table 10. Risk-Adjusted ESPs by LIS Status, Clinical Risk Tier, Social Risk Tier, and Participant Track

ESP Payment Category	Clinical Risk Tier (CMS-HCC Risk Score Percentile)	Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
LIS			$25	$25	$25
Non-LIS Group 1	Tier 1 (≤ 25th)	Not Applicable[a]	$9	$4	$2
Non-LIS Group 2	Tier 2 (> 25th and ≤ 50th)	Not Applicable[a]	$11	$5	$2.50
Non-LIS Group 3	Tier 3 (> 50th and ≤ 75th)	Not Applicable[a]	$14	$7	$3.50
Non-LIS Group 4	Tier 4 (> 75th)	Tier 1, Tier 2, or Tier 3 (≤ 75th)	$18	$8	$4
Non-LIS Group 5	Tier 4 (> 75th)	Tier 4 (> 75th)	$25	$25	$25

ADI = Area Deprivation Index; ESP = Enhanced Services Payment; HCC = Hierarchical Condition Categories; LIS = low-income subsidy.

[a] Payment for beneficiaries in clinical risk tiers 1–3 is based only on risk score.

[8] https://www.neighborhoodatlas.medicine.wisc.edu/

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

3.5 Risk Adjustment

All Medicare FFS beneficiaries attributed to an MCP Participant and not enrolled in LIS are assigned to one of four clinical risk (CMS-HCC) tiers and one of four social risk (ADI) tiers. Thresholds determining the clinical and social risk tiers are defined separately for each MCP region. CMS-HCC risk scores and national ADI rankings for attributed beneficiaries are compared to the distribution of those for all FFS beneficiaries in the same region who meet MCP eligibility requirements and who have had an eligible primary care visit. This group of beneficiaries is called the ESP reference population (see Section 3.5.1). Beneficiaries are assigned to risk tiers on the basis of where their CMS-HCC risk score and national ADI ranking fall within the regional distributions, as shown in Table 10 above. The clinical and social risk tier thresholds, by region, are shown in Appendix B. The methodologies for defining these tiers are described in more detail in Section 3.5.2 (Social Risk Adjustment Methodology) and Section 3.5.3 (Clinical Risk Adjustment Methodology).

3.5.1 ESP Reference Population

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

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

3.5.2 Social Risk Adjustment Methodology

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

By using a blended clinical and social risk adjustment approach that bases the ESP on CMS-HCC risk scores, ADI ranking, and LIS, MCP considers broader neighborhood-level characteristics and individual

beneficiary-level characteristics in its identification of beneficiaries that may be underserved and may require higher levels of primary care funding support. The LIS status (Section 3.5.2.1) is intended to capture socioeconomic challenges that could affect a beneficiary's ability to access care, and the ADI measure (Section 3.5.2.2) is intended to capture local socioeconomic factors that are correlated with medical disparities and underservice.

3.5.2.1 Medicare Part D Low-Income Subsidy

LIS refers to beneficiaries enrolled in the Medicare Part D low-income subsidy program, which uses standardized income criteria across the country. As of 2025, Medicare beneficiaries with annual incomes of up to 150% of the federal poverty level, who also meet resource limits, can qualify for LIS. Dual-eligible beneficiaries automatically qualify for the LIS. LIS statuses are determined using information from CMS' Common Medicare Environment. Medicare LIS status is available for each month. MCP-attributed beneficiaries are designated as enrolled in LIS for the upcoming quarter if they are enrolled in LIS for the most recently available month of data when the quarterly payment is calculated. Beneficiaries who are new to Medicare and not yet included in the Common Medicare Environment LIS data will be considered not qualified for LIS.

For each beneficiary enrolled in LIS who is in the participant's attributed Medicare FFS population, CMS pays the highest fixed ESP amount of $25 PBPM. For all remaining attributed beneficiaries, CMS will determine the payment amount that corresponds to the beneficiary's clinical and social risk tier in accordance with Table 10.

3.5.2.2 Area Deprivation Index

The ADI is a composite measure reflecting a range of socioeconomic characteristics (for example, median family income, percentage of people below the federal poverty line, median home value, median gross rent, and median monthly mortgage) at the Census block group level. It is publicly available (through the University of Wisconsin's Neighborhood Atlas) at no cost and is updated annually.[9] MCP uses the national ADI, where each Census block is ranked relative to the rest of the country using these characteristics and receives a ranking of 1 to 100, with higher numbers reflecting more-deprived areas. Use of the national ADI as a measure relative to the distribution among the *regional* MCP-eligible populations is consistent with the MCP policy of defining clinical risk relative to the regional population and ensures that the percentage of beneficiaries identified as high risk is the same across all regions.

Although ADI can be reported for an individual, an "individual's ADI" is the ADI of the Census block group of their residence, and each individual faces a unique set and degree of social challenges.

Although the rankings are updated annually, CMS data are updated regularly for change in beneficiary residence. Each quarter, CMS uses the currently available beneficiary residence at the time of

[9] ADI data is publicly available at no cost through the University of Wisconsin website at https://www.neighborhoodatlas.medicine.wisc.edu/.

calculation to determine each attributed beneficiary's social risk tier for each quarter. Beneficiaries who are new to Medicare and not yet included in the Chronic Conditions Warehouse ADI dataset will be assigned to social risk tier 1.

3.5.2.3 Setting the Social Risk Tier Thresholds

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

Only values between 1 and 100, inclusive, are considered valid national ADI values. CMS sorts the ADI rankings and identifies the 25th, 50th, and 75th percentiles among the reference population in each region. The regional thresholds are used for payment for all 4 quarters of the year and are shared with participants before each performance year. Social risk tier thresholds by region for Performance Year (PY) 2025 are included in Appendix B.

3.5.3 Clinical Risk Adjustment Methodology

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

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

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

Each quarter, CMS uses currently available risk scores to assign beneficiaries to clinical risk tiers. CMS calculates risk scores for any year at least 12 months after the close of the base year. Final risk scores are generally available 16 to 18 months after the close of the base year. For example, 2023 risk scores (based on 2022 diagnoses) became available in the spring of 2024 and serve as the basis for the PY 2025 clinical risk thresholds and payment. Beneficiaries who are new to Medicare and not yet included in the CMS-HCC data are assigned to clinical risk tier 1.

3.5.3.2 Setting the Clinical Risk Thresholds

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

CMS sorts the ESP reference population's CMS-HCC risk scores and identifies the 25th, 50th, and 75th percentiles among the reference population in each region. The regional thresholds are used for payment for all 4 quarters of the year and are shared with participants before each performance year. PY 2025 clinical risk thresholds by region are in Appendix B.

3.5.3.3 Risk Score Growth

CMS will introduce a risk score growth cap so that participants are not incentivized to capture diagnoses inappropriately (also referred to as "upcoding") to generate higher ESP revenue through higher risk scores. CMS will monitor risk score growth in the participants' beneficiary population compared with a non-MCP reference population and may place a "cap" on the rate by which each participants' risk score is allowed to change.

3.6 Quarterly ESP Calculation

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

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

3.6.1 Geographically Adjusting the ESP

The ESP PBPM amount is adjusted by each participant's applicable geographic adjustment factor (GAF). FQHCs receive the applicable GAF adjustment under the FQHC PPS, whereas Standard Participants receive the applicable GAF adjustment under the PFS. Participants may have sites within a Taxpayer Identification Number (TIN) that are across multiple GAFs. The GAF assigned to each participant is determined by calculating a weighted average GAF based on allowed charges for the primary care services used for attribution (see Table 8). The GAFs are updated annually.

3.6.2 Retrospective Debits

CMS applies retrospective debits to the ESPs paid each quarter to account for prior ESP overpayments. These debits result from beneficiary ineligibility or duplicative service billing.

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

3.6.2.1 Debits for Beneficiary Ineligibility

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

3.6.2.2 Debits for Duplicative Service Billing

If any clinician bills a Chronic Care Management (CCM)–related service identified in Table 8 for a beneficiary attributed to an MCP Participant in the same month *and does not bill the service under the TIN of the beneficiary's attributed MCP organization,* CMS deducts the ESP paid for that month from the MCP Participant's future ESP payment. This prevents CMS from duplicative spending on care management services for attributed beneficiaries.

3.6.3 Example Calculation of the Enhanced Services Payment

In Q1 2025, Main Street Primary Care Associates in Tacoma, Washington, has 500 attributed beneficiaries in their organization. The GAF for Tacoma, Washington, is 1.01 (101%). Main Street Primary Care Associates is a Track 2 MCP Participant.

Of the 500 attributed beneficiaries, 85 are enrolled in LIS. Of the remaining 415 beneficiaries, 120 are in clinical risk tier 1, 100 are in clinical risk tier 2, 100 are in clinical risk tier 3, and 95 are in clinical risk tier 4. Of the 95 beneficiaries in clinical risk tier 4, only 25 are also in social risk tier 4.

The Q1 2025 ESP for Main Street Primary Care Associates is calculated as follows:

- **Step 1:** Multiply the number of attributed beneficiaries in each tier by the applicable ESP PBPM amount. See Table 11 for details about how amounts are determined.

Table 11. Main Street Primary Care Associates ESP PBPM Amounts

ESP Payment Category	Number of Beneficiaries by Group	Track 2 PBPM	Total
LIS	LIS: 85	$25	$2,125
Non-LIS Group 1	Clinical Risk Tier 1: 120	$4	$480
Non-LIS Group 2	Clinical Risk Tier 2: 100	$5	$500
Non-LIS Group 3	Clinical Risk Tier 3: 100	$7	$700
Non-LIS Group 4	Clinical Risk Tier 4, Social Risk Tier 1, 2, or 3: 70	$8	$560
Non-LIS Group 5	Clinical Risk Tier 4, Social Risk Tier 4: 25	$25	$625
	Total: 500	N/A	$4,990

ESP = Enhanced Services Payment; LIS = low-income subsidy; PBPM = per-beneficiary per-month.

- **Step 2:** Apply geographic adjustment.
  $4,990 x 1.01 = $5,039.90
- **Step 3:** Calculate final ESP.
  $5,039.90 x 3 months = $15,119.70

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

4. Prospective Primary Care Payment

Navigating this section:

4.1 Overview

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

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

- **Track 1: 0% PPCP and 100% FFS.** Track 1 participants continue to bill and receive payment from Medicare FFS as usual (and Federally Qualified Health Centers (FQHCs) continue to be paid according to the Medicare FQHC Prospective Payment System [PPS]).
- **Track 2: 50% PPCP and 50% FFS.** In Track 2, the PPCP partially replaces FFS revenue from primary care services for a participant's attributed beneficiary population. Track 2 participants receive a hybrid payment consisting of the PPCP with reduced FFS payments for primary care services.
- **Track 3: 100% PPCP and 0% FFS.** In Track 3, the PPCP fully replaces FFS revenue from primary care services. Participants receive an alternative to FFS payment made up fully of the PPCP and receive no payment for covered primary care services billed to FFS. CMS requires that participants bill for PPCP Services provided, to the extent the services meet billing requirements.

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

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

4.2 Services Included in or Affected by PPCP

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

Table 12 shows the Track 2 and Track 3 PPCP Services Healthcare Common Procedure Coding System (HCPCS) code lists. Services not included, such as immunizations and screenings, will continue to be paid through FFS.

Table 12. Services Included in or Affected by the PPCP

Service	Code(s)
Office/outpatient visit evaluation and management (E&M)	99202–99205, 99211–99215, 99354,[a] 99355,[a] 99415,[a] 99416,[a] G2212[a]
Home care/domiciliary care E&M	99341, 99342, 99344,[b] 99345,[b] 99347–99350
Online digital E&M	99421–99423
Audio-only telephone E&M[c]	99441–99443
Technology-based check-in services	G2010, G2012, G2252
Remote physiologic monitoring	99091, 99453, 99454, 99457, 99458[a]
Remote therapeutic monitoring	98975–98977, 98980, 98981[a]
Advance care planning	99497, 99498[a]
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Administration of Health Risk Assessment	96160, 96161

(continued)

Table 12. Services Included in or Affected by the PPCP (continued)

Service	Code(s)
FQHC All-Inclusive visit	G0466, G0467
FQHC initial preventive physical examination visit or annual wellness visit	G0468
Distant site telehealth services (Rural Health Clinic/FQHC)	G2025
FQHC virtual communication services	G0071
Prospective Primary Care Payment (PPCP) Services Added in Track 3	
Depression, substance use disorder, and alcohol misuse screening and counseling services	G0396–G0397, G0442–G0444, G2011
Care management services for behavioral health conditions	99484
Cognition and functional assessment for patient with cognitive impairment	99483
Psychiatric Collaborative Care Model	99492, 99493, 99494, G2214, G0512
Interprofessional Consultation (IPC) and MCP e-Consult (MEC)	99452, G9037

[a] Add-on codes are included in the PPCP calculation.
[b] Codes 99344 and 99345 were discontinued on January 1, 2023. CMS uses historical claims for these codes to calculate the PPCP.
[c] Codes 99441–99443 are discontinued as of January 1, 2025, after which audio-only E&M services are billed using the corresponding office visit E&M code with an appropriate place of service indicator.

4.2.1 Additional Considerations by Participant Type

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

For FQHCs, the PPCP is based on the primary care services on the PPCP Services list (Table 12) billed under the Medicare FQHC PPS.

- FQHCs in Track 1 continue to be paid according to the Medicare FQHC PPS.
- FQHCs in Tracks 2 and 3 have PPCP PBPM amounts based on the specified Medicare FQHC PPS services in the PPCP Services list (Table 12). Services not listed as part of the PPCP, such as mental health services G0469 and G0470, continue to be reimbursed outside of the PPCP PBPM at the Medicare FQHC PPS rate at the time of service.

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

4.3 Calculation of the Historical PPCP PBPM Amount

The historical PBPM amount represents each MCP Participant's average PBPM payment received from CMS for PPCP Services rendered to a group of attributed beneficiaries over a historical period before the PPCP implementation (called the *PPCP Historical Base Period*). The historical PBPM amount is used to estimate the amount of primary care that participants will likely deliver during the performance year.

CMS first defines the population of beneficiaries used to calculate the historical PBPM amount and then calculates the historical payments made for PPCP Services provided to those beneficiaries.

To ensure that each participant's PPCP reflects, as much as possible, the current health status of their attributed beneficiaries throughout the model, CMS will rebase the PPCP historical PBPM amount every 3 years. This rebasing will help address the concern that a PPCP could perpetuate historically underfunded primary care and unmet primary care needs.

Table 13 contains the PPCP historical base period for corresponding performance years.

Table 13. PPCP Historical Base Period by Performance Year

Performance Year	PPCP Historical Base Period
2025–2026	April 1, 2022—March 31, 2024
2027–2029	October 1, 2024—September 30, 2026
2030–2032	October 1, 2027—September 30, 2029
2033–2034	October 1, 2030—September 30, 2032

PPCP = Prospective Primary Care Payment

The PPCP is a key component of payment reform under MCP and requiring that participants move to full PPCP in Track 3 makes them more dependent on PPCP rates than under previous models. These updates are intended to improve accuracy and equity. The rebased historical PPCP PBPM amount will then be adjusted based on the methods described in the sections below.

Note that in January 2027, participants in Track 1 will transition to Track 2, and participants in Track 2 will transition to Track 3. Participants in Track 3 will remain in Track 3 and will have their PPCP Historical Base Period updated to October 2024–September 2026 along with all other MCP Participants. CMS may make changes to the PPCP Historical Base Period if deemed necessary.

4.3.1 Historical Population

The historical population includes all beneficiaries attributed to the MCP Participant in each of the quarters of the PPCP Historical Base Period. To determine the historical population, CMS uses historical claims to attribute beneficiaries to participants during the PPCP Historical Base Period. The attribution methodology is detailed in Section 2 above. For each quarter of attribution in the Historical Base Period used for Performance Year (PY) 2025 and PY 2026, all Standard Participant Taxpayer Identification Numbers (TINs) including both current and historical were used for attribution.[10] Additionally, no other model overlap was removed from this PPCP historical population. For FQHCs, current and historical CMS Certification Numbers (CCNs) are used, as described in Section 2.

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

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

4.3.2 Historical Payments

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

- The service date on the claim was during a period when the beneficiary was attributed to the MCP Participant and eligible.[11]
- The claim includes a procedure code for a PPCP Service (see Table 12).
- The service was billed by a clinician with one of the specialties in Appendix A and the MCP Participant's TIN or historical TIN (for Standard Participants), or the service was billed by a CCN associated with the MCP Participant's TIN (for FQHCs).

CMS adjusts historical eligible PPCP Services claims for the following:

- Sequestration: For PPCP Historical Base Period quarters when sequestration was in effect, CMS will increase the historical payments to reverse historical sequestration reductions.
- Merit-based Incentive Payment System (MIPS) Adjustment: CMS will remove the effects of any MIPS quality payment adjustments that were applied to applicable participants during the PPCP Historical Base Period.
- Geographic Adjustment Factors (GAFs): CMS will remove the effect of the GAFs that were applied to claim payments in the PPCP Historical Base Period.

For each MCP Participant, CMS sums the Medicare FFS payment amounts for all eligible claims, as identified above. This does not include amounts paid by third parties or the beneficiary.

4.3.3 Historical PBPM Calculation

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

Most participants have 2 years of historical data to create PBPM estimates, defined as at least 125 attributed beneficiaries per quarter, on average, over all 8 quarters of the PPCP Historical Base Period. However, if a participant does not have 2 years of data, but has an average of at least 125 attributed beneficiaries per quarter over the most recent 4 quarters of the PPCP Historical Base Period, the most recent year of the PPCP Historical Base Period is used. If a participant meets neither of these criteria, then the participant is assigned a historical PPCP PBPM amount that is calculated as a weighted average of its historical PPCP PBPM amount (over the most recent 4 quarters) using the available data and the median historical PPCP PBPM amount among organizations of the same participant type (Standard or

[11] The service date for carrier claims is the "line first expense date" and for outpatient claims is the "revenue center date."

FQHC) in its region. If there is no historical PPCP data available for a participant, the participant is assigned the median historical PPCP PBPM amount among organizations of the same participant type (Standard or FQHC) in its region.

4.4 Calculation of the Performance Year PPCP PBPM Amount

Once the historical PPCP PBPM amount has been calculated, CMS applies several adjustments to update the historical amount to the upcoming performance year. These adjustments account for varying geography, changes in the PFS and FQHC PPS rates, expected MIPS adjustments, limited claims runout, changes in utilization, and estimated eligibility for the Medicare Shortage Area bonus. Once the PBPM rate has been calculated for the upcoming performance year, it is then reduced by 50% for Track 2 participants.

4.4.1 Geographic Adjustment

Like the Enhanced Services Payment (ESP) PBPM amount, the PPCP PBPM amount is adjusted by each participant's applicable GAF. FQHCs receive the applicable GAF under the PPS, and Standard Participants receive the applicable GAF under the PFS. The GAFs are updated annually.

4.4.2 Changes in the PFS and FQHC PPS

CMS regularly updates the Medicare PFS's national conversion factor and modifies rate scales (for example, relative value units) for existing or new service codes. As such, each year, for Standard MCP Participants, CMS adjusts the PPCP historical PBPM amount to reflect the PFS factors that will be in effect during the performance year. For FQHC Participants, before each performance year, CMS reviews the charges for the most recent quarter to determine whether an FQHC Participant's performance year PPCP PBPM amount should be based on the FQHC PPS rates or the FQHC's recent charge levels (whichever is less).

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

4.4.3 MIPS Payment Factors

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

4.4.4 Claims Completion Adjustment

The claims data in each PPCP historical period include 1 to 4 months of "runout" after the most recent month in the period. In other words, CMS waits 1 to 4 months after the end of the historical period to retrieve claims with dates of service in the historical period to allow time for claims to be submitted and processed. However, some claims with dates of service in the historical period may not be submitted until after claims data are used to calculate the PPCP. To account for this incomplete claims history, CMS applies a completion factor. Completion factors are specific by claim type (carrier versus outpatient). The completion factor applied to the carrier claims (Standard Participants) for the PY 2025 PPCP PBPM amount is 0.9982, and the completion factor applied to the outpatient claims (FQHC Participants) is 0.9987. Claims totals are divided by the completion factor to estimate the total dollars paid allowing for full claims runout (12 months).

4.4.5 Utilization Adjustments

The historical PPCP PBPM amount is also updated annually to reflect increases in the use of PPCP Services. To determine whether a utilization adjustment is warranted, CMS calculates the participant's average number of PPCP Service visits provided to its attributed beneficiaries during a recent 12-month period and compares it to the average number of PPCP Service visits provided to its attributed beneficiaries during the PPCP Historical Base Period. PPCP Service visits are defined in Table 12. If the average number of PPCP Service visits in the performance year is higher than the average number in the PPCP Historical Base Period by an amount that increases the PPCP PBPM by $2 or more, the PPCP PBPM amount is adjusted upward for the next performance year (Figure 5).

Figure 5. Example Calculations of PPCP PBPM Increases to Determine Eligibility for a Utilization Adjustment

For example, consider two MCP Standard Participants, each with a PPCP PBPM amount of $15 in PY 2024. For each participant, CMS calculates the average number of visits per beneficiary from October 1, 2023, through September 30, 2024, and compares that value with the average number of visits per-beneficiary per-year in the historical period. Both participants have 500 continuously attributed beneficiaries per year, or 12,000 attributed beneficiary months in the historical period, and both have an average payment per visit of $60. The first participant sees an average increase of 0.2 visits per attributed beneficiary per year, while the second sees an average increase of 1 visit per attributed beneficiary per year. The increases are calculated as follows:

- Participant 1: **(0.2 * 500 * $60)/(12,000) = $0.50 PBPM**
- Participant 2: **(1.0 * 500 * $60)/(12,000) = $2.50 PBPM**

Participant 1's increase is below the $2 PBPM minimum threshold, so Participant 1 does not receive a utilization adjustment. Participant 2's increase is greater than or equal to $2 PBPM, so its utilization adjustment is $2.50 PBPM. Participant 2's PPCP PBPM therefore increases from $15 to $17.50 PBPM.

The adjusted amount applies for that one performance year and reflects the amount that the PPCP PBPM would have increased had those increased PPCP Services been included in the PPCP Historical Base Period.

4.4.6 Shortage Area Adjustment

CMS applies an adjustment to the PPCP PBPM amount for Standard MCP Participants providing services in Medicare Health Professional Shortage Areas (HPSAs). This Shortage Area Adjustment is designed to ensure that MCP does not diminish existing Medicare HPSA bonus payments that are in place to address disparities in geographic areas without sufficient health care providers to meet the health care needs of the local population.

To determine the Shortage Area Adjustment for each MCP Standard Participant, CMS calculates the ratio of two amounts: A "HPSA-adjusted amount" and an "unadjusted amount." These amounts are based on PPCP Service claims provided to attributed beneficiaries in a recent 12-month period, defined as follows:

- Shortage Area Adjusted amount: Sum of Medicare payments for PPCP Services, had the MCP reduction of 50% or 100% not been applied, provided to MCP beneficiaries where HPSA-indicated claims have had the amounts increased by 10% (some amounts will be increased by 10%, some will not be increased).
- Unadjusted amount: Sum of Medicare payments for PPCP Services, had the MCP reduction of 50% or 100% not been applied, provided to MCP beneficiaries, unadjusted by the 10% HPSA bonus percentage.

If the HPSA-adjusted amount and unadjusted amount are the same, no Shortage Area adjustment will be applied. If they are different, the Shortage Area Adjustment will be greater than 1.0, but will not exceed 1.1.

Shortage Area Adjustments are not applied to the PPCP PBPM amounts for FQHC Participants, consistent with Medicare payment policy. Shortage Area Adjustments are redetermined annually using more recent claims data.

4.4.7 Final PPCP PBPM Amount

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

The resulting value reflects the share of expected Medicare monthly payments for PPCP Services for the participant's average MCP beneficiary that are paid through the PPCP in each track.

4.4.8 Retrospective Debits

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

4.4.9 Example Calculation of Quarterly PPCP

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

*3 * Attributed Beneficiaries * (PPCP PBPM) – PPCP MCP Payment Adjustment Debit*

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

This calculation is made before sequestration (if sequestration is applicable).

4.5 PPCP Partial Reconciliation

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

There are two steps to conducting the Partial Reconciliation for PYs 2024 and 2025:

- **Step 1.** Calculate the PBPM amount for PPCP Services provided to attributed beneficiaries by primary care organizations other than the MCP Participant ("outside-of-participant") during the PPCP Historical Base Period and during the performance year being reconciled. To be included in this amount, the service must meet the following criteria:
  - Be billed by a TIN or FQHC CCN other than that of the MCP Participant.
  - Have a procedure code in the PPCP Services code list (see Table 12).
  - For services paid under the PFS only, be rendered by an eligible primary care clinician, as identified in Appendix A, except for General and Medical physician assistants (taxonomy codes 363A00000X and 363AM0700X) and certain nurse practitioners.[12] This approach safeguards against inadvertently including non-primary care services provided by physician assistants and nurse practitioners in the PPCP Partial Reconciliation.
  - For services paid under the PFS only, be provided in one of the settings listed in Table 14.

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

[12] CMS will specify the applicable nurse practitioner taxonomy codes in future PMPs, before the calculation of the first PPCP Partial Reconciliation in 2026.

Table 14. Eligible Place of Service Codes for PPCP Partial Reconciliation

Place of Service Name	Place of Service Code
Telehealth (provided other than in patient's home)	02
Indian Health Service Freestanding Facility	05
Indian Health Service	06
Tribal 638 Freestanding Facility	07
Tribal 638 Provider-Based Facility	08
Telehealth (provided in patient's home)	10
Office	11
Home	12
Assisted living facility	13
Group home	14
Mobile unit	15
Temporary lodging	16
Walk-in retail health clinic	17
Place of employment–worksite	18
Off campus–outpatient hospital	19
Urgent care facility	20
On campus–outpatient hospital	22
Custodial care facility	33
Independent clinic	49
Federally qualified health center	50
Community mental health center	53
Mass immunization center	60
Public health clinic	71
Rural health clinic	72
Other place of service	99

PPCP = Prospective Primary Care Payment

- **Step 2.** Determine the PPCP Partial Reconciliation amount using the increase in the outside-of-participant amount calculated in Step 1.
  - If the increase in the outside-of-participant amount is less than $2 PBPM, then there is no Partial Reconciliation.
  - If the increase in the outside-of-participant amount is between $2 and $7 PBPM (inclusive), then CMS makes a one-time downward adjustment to the participant's PPCP equal to the increase minus $2 PBPM.

- If the increase in the outside-of-participant amount is greater than $7 PBPM, then CMS makes a one-time downward adjustment of $5 PBPM to the participant's PPCP (in other words, the maximum downward adjustment is $5 PBPM).

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

MCP will not reconcile the PPCP to adjust for decreases in the outside-of-participant amount outlined in Step 1. Instead, MCP will update participants' PPCP to reflect increases in use of PPCP Services, as described in Section 4.4.5.

Please see Figure 6 for an example PPCP Partial Reconciliation calculation for an example participant.

Figure 6. Example PPCP Partial Reconciliation Calculation for Participant "Main Street Practice"

Main Street Practice has 5,500 attributed beneficiary months in the performance year being reconciled.

Step 1: The outside-of-participant Prospective Primary Care Payment (PPCP) per-beneficiary per-month (PBPM) amount in the historical calculation period was $4.

Step 2: The outside-of-participant PPCP PBPM amount in the performance year was $7.

Step 3: Therefore, the difference between the two PBPM amounts is $3 ([Step 2] − [Step 1] = $7 − $4), and Main Street Practice will receive a debit to future payment.

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

The payment debit to Main Street Practice will be $1 * (5,500 beneficiary months from performance year) = $5,500. This example assumes that Main Street Practice did not change tracks between the historical period and the performance year.

4.6 Reconciliation of FQHC Charges

The FQHC PPCP PBPM amounts are participant-specific and depend on the most recently available PPS reimbursement rates and changes to charges observed 2 to 3 months before the start of the performance year. If an FQHC updates their charges or the PPS reimbursement rates are updated, the PPCP PBPM amount calculated for the FQHC Participant will be inaccurate. Thus, 2 quarters after each payment quarter, CMS examines the Medicare payments in that payment quarter to see if they were consistent with the basis for that performance year's PPCP PBPM amount (in other words, if the FQHC has changed its charge levels). If the payment amounts for the PPCP Services differ from what was used to calculate the FQHC's PPCP PBPM amount for the applicable performance year, CMS makes a one-time adjustment, either up or down, in the payment made 2 quarters later such that the PPCP for the reconciled quarter is consistent with the FQHC's actual charges for that quarter. For example, CMS will

make updated payments for Q1 2025 PPCPs in Q3 2025. The first reconciliation of FQHC charges will be in Q1 2025, for the first model quarter, Q3 2024.

4.7 FFS Payment

Participants continue to submit claims at the time of service for the PPCP Services listed in Table 12. Claims are processed as usual, and all reimbursements are determined according to standard Medicare PFS and FQHC PPS rules. The net amount remitted is reduced by the proportionate share that the participant receives through the PPCP. In Track 2, FFS payments are reduced by 50%, and in Track 3, FFS payments are reduced by 100%. The PPCP and reduced FFS payments only apply to Medicare payments for the applicable PPCP Service claims listed in Table 12 for beneficiaries attributed to Track 2 and 3 participants. CMS requires that participants bill for PPCP Services provided that meet billing requirements.

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

4.8 Monitoring PPCP Services and Billing

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

5. Performance Incentive Payment

Navigating this section:

5.1 Overview of the PIP

The MCP Performance Incentive Payment (PIP) is an upside-only payment available for participants in all tracks. The PIP rewards participants for performance on quality and cost/utilization as measured by the MCP Performance Measure Set, which forms the cornerstone of MCP's quality strategy. The Performance Measure Set consists of a diverse set of performance measures that are aligned with the MCP care delivery requirements, in keeping with an emphasis on whole-person care.

For complete information on the MCP Performance Measure Set, including specifications and instructions on data collection and reporting procedures, please reference the PY 2025 MCP Quality Measure Reporting Guide.

The specific way the performance measures determine the PIP differs by participant type and track, as described below. In brief, the PIP is calculated as a percentage of the sum of the participant's annual fee-for-service (FFS) and Prospective Primary Care Payment (PPCP) revenue for the PPCP Services listed in Table 12 provided to its MCP-attributed beneficiaries. That percentage is determined by the participant's performance on the quality measures relative to the criteria for those measures for the participant's track.

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

5.2 MCP Performance Measure Set

The MCP Performance Measure Set (shown below in Table 15) is a diverse set of measures of clinical quality, patient-reported outcomes, utilization, and cost. Building on CMS' broader quality measurement strategy, measures were selected to be actionable, clinically meaningful, and aligned with measures used in current value-based programs, including the CMS Universal Measure Set,[13] Quality Payment

[13] https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation

Program (QPP), Merit-based Incentive Payment System (MIPS) Value Pathways,[14] MIPS Alternative Payment Model Performance Pathway measure sets,[15] and the Consensus-Based Entity Core Quality Measures Collaborative.[16] Further, CMS sought to minimize participant burden for reporting and considered feasibility of measure collection for all potential participants.

Table 15. MCP Performance Measure Set

Measure Title and Steward (ID, if applicable)	Data Source	Patients Included	Required for Track 1	Required for Track 2	Required for Track 3
Controlling High Blood Pressure NCQA[a] (CMS165)	Participant-reported Electronic Clinical Quality Measure (eCQM)	Reported in aggregate across all patients	Yes	Yes	Yes
Diabetes: Glycemic Status Assessment Greater than 9% NCQA[a] (CMS122)	Participant-reported eCQM	Reported in aggregate across all patients	Yes	Yes	Yes
Colorectal Cancer Screening NCQA[a] (CMS130)	Participant-reported eCQM	Reported in aggregate across all patients	Yes	Yes	Yes
Screening for Depression and Follow-up Plan CMS (CMS2)	Participant-reported eCQM	Reported in aggregate across all patients	No	Yes	Yes
Depression Remission at 12 Months MN Community Measurement (CMS159)	Participant-reported eCQM	Reported in aggregate across all patients	No	Yes	Yes
Screening for Social Drivers of Health CMS (Quality ID#487)	Participant-reported Clinical Quality Measure (CQM)	Reported in aggregate across all patients	No	Yes	Yes
Person-Centered Primary Care Measure (PCPCM)[17] Smart Measures, LLC	Survey measure[b]	Reported in aggregate across all patients	Yes	Yes	Yes
Total Per Capita Cost (TPCC) CMS	Claims-based, calculated by CMS	Reported in aggregate for MCP Beneficiaries only	No	Yes	Yes

(continued)

[14] https://qpp.cms.gov/mips/mips-value-pathways
[15] https://qpp.cms.gov/mips/app-quality-requirements?py=2023
[16] https://www.qualityforum.org/CQMC_Core_Sets.aspx.
[17] Note: CMS will be administering the survey for Track 1 Participants for PY 2025. The survey will be administered as part of an experimental design in Track 1 with some Track 1 patients receiving the PCPCM survey and others receiving a survey containing items from the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS®) v. 3.1 and Patient-Centered Medical Home (PCMH) Supplement v. 3.0."

Table 15. MCP Performance Measure Set (continued)

Measure Title and Steward (ID, if applicable)	Data Source	Patients Included	Required for Track 1	Required for Track 2	Required for Track 3
Emergency Department Utilization (EDU) NCQA[a]	Claims-based, calculated by CMS	Reported in aggregate for MCP Beneficiaries only	No	Yes	Yes
Total Per Capita Cost (TPCC) Continuous Improvement CMS	Claims-based, calculated by CMS	Reported in aggregate for MCP Beneficiaries only	No	Only MCP Standard Participants	Only MCP Standard Participants
Emergency Department Utilization (EDU) Continuous Improvement CMS	Claims-based, calculated by CMS	Reported in aggregate for MCP Beneficiaries only	No	Only FQHCs/ITUs	Only FQHCs/ITUs

FQHC = Federally Qualified Health Center; ITU = Indian Health Service, Tribal, and Urban Indian Provider; NCQA = National Committee for Quality Assurance.

[a] Certain measures in the Making Care Primary (MCP) Model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.

[b] The survey measure is reported by a CMS-approved vendor or Qualified Clinical Data Registry in contract with participant.

As shown in Table 15, assessment on quality measures varies by track. Track 1 participants are assessed on three clinical quality measures and patient experience of care. Under Tracks 2 and 3, additional clinical quality measures are added to the quality assessment to reflect the advanced care delivery expectations for these tracks, including Screening for Depression and Follow-up Plan, Depression Remission at 12 Months, and Screening for Social Drivers of Health. Additionally, for Tracks 2 and 3, claims-based measures of cost and utilization are added to the quality assessment: Total Per Capita Cost (TPCC) and Emergency Department Utilization (EDU), with Standard Participants also being assessed on TPCC Continuous Improvement (CI), and Federally Qualified Health Center (FQHC) and Indian Health Service, Tribal, and Urban Indian Provider (ITU) Participants also being assessed on EDU Continuous Improvement.

To support total participant transformation, all non-claims-based measures are assessed for a participant's *total patient population (including all payers and the uninsured)*. The survey for the PCPCM is fielded to a sample of all adult patients for each participant. Claims-based measures are assessed *only* for a participant's MCP-attributed beneficiary population.

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

CMS uses the guidance of the respective measure stewards to determine what version of each measure's technical specifications are included in the MCP Performance Measure Set for the applicable performance year. As delineated in Table 15, certain MCP measures are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer and use provisions related

to the NCQA measures can be found on the CMS Notices and Disclaimers web page at https://www.cms.gov/priorities/innovation/about/notices-disclaimers.

5.2.1 Measure Assessment Frequency

MCP Participants shall report on all measures, as applicable, as required by track and participant type (FQHC, ITU, or Standard Participant) to be eligible for the PIP. Please reference Table 15.

- **All eCQMs and CQMs** in the MCP Performance Measure Set are reported annually. For the eCQMs and CQMs, the PY 2025 reporting period is January 2 through February 28, 2026. Measures reported during this period will be used to determine PIP amounts for PY 2025. MCP Participants must submit all required eCQMs and CQMs during the defined reporting period according to the guidance communicated in the PY 2025 MCP Quality Measure Reporting Guide. Participants that do not report as required will not be eligible for a PIP for the performance year.
- **All claims-based measures** are calculated annually by CMS and do not require separate reporting by participants. Similar to the timing of eCQM and CQM reporting, claims-based measures will be calculated in 2026 to inform PIP amounts for PY 2025.
- **The PCPCM survey** is fielded annually beginning fall 2025. The PCPCM is administered by CMS for Track 1 participants and by CMS-approved survey vendors in contract with Track 2 and 3 participants. All participants are required to provide a patient roster. For more details on participant responsibilities regarding the PCPCM, please reference the PY 2025 MCP Quality Measure Reporting Guide. Details regarding survey vendor fielding protocols will be communicated in the forthcoming MCP PCPCM Survey Protocols and Guidelines Manual.

5.2.2 Cost and Utilization Measures

5.2.2.1 Total Per Capita Cost

All participants in Tracks 2 and 3 are assessed on costs incurred by their attributed beneficiaries via the TPCC measure. Accounting for 18.5% of the total PIP Percentage Bonus, the TPCC measure evaluates the total costs of care (across Parts A and B, excluding Part D) provided to MCP beneficiaries. The TPCC measure specifications, found in Appendix D, are adapted from MIPS. CMS calculates this measure for MCP Participants using claims data; therefore, it requires no reporting by participants.

The TPCC measure is payment-standardized (as represented by standardized allowed charges when available) and risk-adjusted; this means that CMS controls for variations in cost due to geographic area and beneficiary risk/comorbidities.

Total costs of care (as represented by standardized allowed charges when available) are included in the measure calculations for each attributed beneficiary for each quarter of the performance year in which they were attributed and eligible. Beneficiaries are included in the measure if they are attributed to the participant during any quarter of the performance period. Standardized allowed charges are used to account for differences in Medicare payments for the same services across Medicare providers. Payment standardization also accounts for differences in Medicare payment unrelated to the care provided, such as those from payment adjustments supporting larger Medicare program goals (for example, indirect medical education add-on payments) or variation in regional health care expenses as

measured by hospital wage indexes and Geographic Practice Cost Indexes.[18] When calculating the TPCC measure, Enhanced Services Payments (ESPs), PIPs, and Upfront Infrastructure Payments (UIPs) are not counted.

TPCC is calculated as an observed-to-expected (O/E) ratio. For each participant, observed costs are compared with expected costs, risk-adjusted for beneficiary comorbidities. An O/E ratio greater than 1 represents greater-than-expected per capita cost, and a ratio less than 1 represents less-than-expected per capita cost. TPCC is an inverse measure; lower O/E ratios reflect better performance. **See technical specifications in Appendix D for additional details.**

Performance on the TPCC measure is assessed annually through comparison to regional TPCC benchmarks (see Appendix E). Starting in PY 2026, performance on TPCC is also assessed annually through comparison to a national benchmark for the TPCC threshold (see Section 5.3.2). Participants retain a proportional share of the maximum payment of the PIP for the TPCC measure based on how their scores compare to the TPCC lower and upper benchmarks.

5.2.2.2 Emergency Department Utilization

The EDU measure of the PIP, accounting for 18.5% of the total PIP Percentage Bonus, is designed to reward participants that take sustained actions to reduce potentially avoidable utilization of the emergency department for their attributed beneficiaries. Beneficiaries are included in the measure if they are attributed to the participant during any quarter of the performance period. The EDU measure is calculated using Medicare Part A and Part B claims. The EDU measure is limited to outpatient visits that do *not* result in hospital admission. For detailed specifications, refer to the NCQA Healthcare Effectiveness Data and Information Set (HEDIS)® Technical Specifications for this measure.[19] CMS calculates this measure for MCP Participants using claims data; therefore, it requires no reporting by participants.

A participant's performance on this measure is calculated using Medicare claims data and is based on the NCQA HEDIS Measurement Year 2024 specifications. Because the HEDIS measure is written for health plans, some modifications may be necessary to make the measure applicable to MCP. For example, MCP has its own set of beneficiary eligibility requirements and, in fact, its own specifically defined patient population; thus, MCP beneficiaries are used as the eligible population for the measure. To properly adjust for risk, beneficiaries must be at least 18 years of age and enrolled in FFS Medicare for at least 11 months in both the performance period and 4 quarters before to be eligible for the measure.

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[18] For more information, please refer to the "CMS Price (Payment) Standardization—Basics" and "CMS Price (Payment) Standardization—Detailed Methods" documents posted on the Research Data Assistance Center (ResDAC): https://www.resdac.org/articles/cms-price-payment-standardization-overview

[19] Model Participants may access measure specifications for the model here: https://www.ncqa.org/ncqa-measure-specification-hub-to-support-cms-innovation-center-programs-models/

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

Performance on the EDU measure is assessed annually through comparison to regional EDU benchmarks (see Appendix E). Participants retain a proportional share of the maximum payment of the PIP for the EDU measure based on how their scores compare to the EDU lower and upper benchmarks.

5.3 Measure Scoring and Determination of PIP

5.3.1 Overview of the PIP Methodology

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

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

- Participants must report all required measures from the MCP Performance Measure Set, according to their track and participant type (see Table 15).
- Beginning in PY 2026, Track 2 and Track 3 participants must also pass the "TPCC Threshold for PIP Eligibility," defined as performing at or better than the national 30th percentile[20] on the TPCC measure. See Section 5.2.2.1 for a description of the TPCC measure and Section 5.3.4 for information on the TPCC Threshold for PIP Eligibility.

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

- Track 1 participants are eligible for a maximum PIP Percentage Bonus of **3%.**
- Track 2 participants are eligible for a maximum PIP Percentage Bonus of **45%.**
- Track 3 participants are eligible for a maximum PIP Percentage Bonus of **60%.**

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

5.3.2 TPCC Threshold for PIP Eligibility

Beginning in PY 2026, MCP Participants in Tracks 2 and 3 are subject to the TPCC Threshold for PIP Eligibility, which is used in determining whether they are eligible for a PIP. To hold participants

[20] The TPCC measure is an inverse measure, where lower measure values mean better performance, Participants "exceed" the national 30th percentile benchmark by having lower TPCC measure values than the benchmark.

accountable for their beneficiaries' total costs, the threshold assesses participants against a national benchmark that includes MCP Participants and comparable non-participant organizations. This national benchmark differs from the regional benchmarks used to assess the individual TPCC measure as part of the calculation of the PIP (see Section 5.3.3.1).

CMS has set the TPCC Threshold for PIP Eligibility at the 30th percentile of national TPCC performance so that the majority of participants have an opportunity to earn a PIP.[21] Participants that do not meet the criterion have the incentive to reduce their costs to become eligible to earn a PIP in future performance years. They also continue to receive the guaranteed ESP revenue to support their ability to meet MCP care delivery requirements and transform primary care. Please see Appendix E for the PY 2026 threshold.

For PY 2025, the PIP is based on the assumption that every participant passed the TPCC Threshold for PIP Eligibility. Participants are assessed on the TPCC Threshold for PIP Eligibility at the same time as the PY 2026 first lump sum calculation and must satisfy the threshold criterion to be eligible to receive a PIP. If participants do not pass the TPCC Threshold for PIP Eligibility, they do not receive the first or second lump sum PIP associated with the performance year. For PY 2026, CMS will calculate each participant's TPCC scores during Q4 of 2025 using claims data from a 12-month period before PY 2026 and will assess each participant's performance against the national TPCC benchmark. Participants that perform better than the 30th percentile of national TPCC performance will receive the first lump sum PIP for PY 2026 during Q1 of PY 2026 and will be eligible to receive the second lump sum PIP associated with PY 2026 during Q3 of PY 2027. In Q4 of PY 2026, they will be assessed on the TPCC Threshold again to determine PIP eligibility for PY 2027. Please see Table 20 in Section 5.3.5 for further information on specific PIP payment timelines.

5.3.3 Calculation of Quality Scores

A participant's quality scores are a key component in calculating the participant's PIP Percentage Bonus. CMS calculates participants' scores for each applicable quality measure by comparing the participant's measure result to the benchmark (or set of benchmarks) established for the measure. The general benchmark approach is described in Section 5.3.3.1 and the measure scoring approach in Section 5.3.3.2.

5.3.3.1 Benchmark Calculation

As shown in Table 16, CMS uses national benchmarks for all eCQMs and the CQM (Screening for Social Drivers of Health) and calculates regional benchmarks for utilization and cost measures (EDU and TPCC). This holds all participants to the same quality standard for clinical care while recognizing geographic differences and considerations for utilization and cost data.

[21] The 30th percentile is set with the values for the benchmark population sorted in descending order, such that measure values higher than the 30th percentile indicate better performance.

Benchmarks for MCP are derived from the most recently available data that allows release of benchmarks before the performance year. The benchmark populations are outlined in Table 16 below.

For the clinical quality measures, MIPS benchmarks are used. As shown in Table 16, for PY 2025 CMS will use MIPS 2024 benchmarks (released January 2024) representing calendar year 2022 data. The exceptions are CMS 130 Colorectal Cancer Screening, and CMS 165 Controlling High Blood Pressure, and CMS 2 Preventive Care and Screening: Screening for Depression and Follow-Up Plan. For those three measures CMS will use MIPS 2023 benchmarks as MIPS 2024 benchmarks were not created for these measures. With respect to the unavailability of 2024 benchmarks for these measures: In PY 2023, eCQM CMS 130 was removed from traditional MIPS and moved to MIPS Value Pathway (MVP) - Value in Primary Care/MVP 005. Therefore, an updated 2024 benchmark is not available. The eCQMs CMS 2 and CMS 165 were suppressed from the 2024 MIPS benchmarks because of ICD-10 code updates in the 2022 performance period. For more information on MIPS benchmarks, please see https://qpp.cms.gov/benchmarks.

Please note that the following measures are inverse measures with lower results reflecting better performance: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%); Total Per Capita Cost (TPCC) and Emergency Department Utilization (EDU).

CMS reserves the right to deviate from the benchmark schedule to ensure that the benchmarks used are a fair and accurate comparison. Additional measure-specific restrictions may be placed on the benchmark population to eliminate organizations with too few or zero-value measure scores. This will ensure that all organizations contributing data meet the minimum case counts required by measure specifications and that the benchmark population allows for a fair comparison to participants.

Table 16. PY 2025 Benchmarks by Measure

Measure Name	Benchmark Population	50th Percentile Benchmark	70th Percentile Benchmark	80th Percentile Benchmark
Controlling High Blood Pressure	2023 Merit-based Incentive Payment System (MIPS) (National)	64.24	71.10	75.28
Diabetes: Glycemic Status Assessment Greater than 9%[a]	2024 MIPS (National)	34.15	24.25	19.83
Colorectal Cancer Screening	2023 MIPS (National)	51.89	66.98	75.51
Screening for Depression and Follow-up Plan[b]	2023 MIPS (National)	33.79	58.94	72.82
Depression Remission at 12 Months[b]	2024 MIPS (National)	8.95	14.00	18.16
Screening for Social Drivers of Health[b]	MIPS (National)	TBD[e]	TBD[e]	TBD[e]

(continued)

Table 16. PY 2025 Benchmarks by Measure (continued)

Measure Name	Benchmark Population	50th Percentile Benchmark	70th Percentile Benchmark	80th Percentile Benchmark
Person-Centered Primary Care Measure (PCPCM)	Not applicable (full credit given for reporting in Performance Year [PY] 2025 and PY 2026)	N/A	N/A	N/A
Total Per Capita Cost (TPCC)[b]	Regional (quality scoring) National (TPCC Threshold for PIP Eligibility)	See Appendix E for regional benchmarks		
Emergency Department Utilization (EDU)[b]	Regional	See Appendix E for regional benchmarks		

Measure Name	Benchmark Population	Half credit	Full credit
TPCC Continuous Improvement[b, c]	Participant TPCC score in prior year	3%	5%
EDU Continuous Improvement[b, d]	Participant EDU score in prior year	3%	5%

[a] This measure benchmark uses data associated with "Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)" following a recent change to the measure name.
[b] Tracks 2 and 3 only.
[c] Standard Participants only, not Indian Health Service, Tribal, and Urban Indian Providers (ITUs) or Federally Qualified Health Centers (FQHCs).
[d] Only ITU and FQHC Participants.
[e] The benchmark for Social Drivers of Health measure will be updated in a re-release of this paper in early 2025

TPCC and EDU Benchmark Populations

The benchmark population for the TPCC and EDU measures consists of MCP Participants and non-participating primary care organizations. A benchmark organization that is not an MCP Participant is a virtual construct solely for calculating performance benchmarks for the PIP. Benchmark organizations are defined as all primary care clinicians billing under the same TIN. This list of primary care taxonomy codes is the same as the MCP eligible clinician taxonomies (see Appendix A).

Total per capita costs and emergency department visits are included in the measure calculations for each attributed beneficiary that meets measure specification eligibility requirements.

Note that the benchmark population for quality scoring the TPCC measure is a *regional* population, and the MCP Participants and non-participating organizations included in that population are those providing primary care services in states with similar measure performance and geographic proximity to MCP states. When determining the TPCC Threshold for PIP Eligibility, described in Section 5.3.2 a *national* benchmark population is used, composed of MCP Participants and non-participating organizations providing primary care services across the nation.

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

5.3.3.2 Measure Scoring and Percentage of Maximum PIP

MCP's scoring structure allows participants to achieve tiered levels of success. As shown below in Table 17 and Table 18, CMS has set lower and upper benchmarks for each measure. The benchmarks are set to the specified percentiles of measure performance among the benchmark population specific to each measure. Lower benchmarks for the non-CI measures are set at the 50th percentile of performance among the benchmark population, and upper benchmarks are set at the 70th percentile in Tracks 1 and 2 and the 80th percentile in Track 3. The upper benchmark progresses from the 70th percentile in Tracks 1 and 2 to an 80th percentile in Track 3 to incentivize performance improvement over time. For the CI measures, the lower benchmark is performance improvement over the prior year of at least 3%, and the upper benchmark is performance improvement of at least 5%. To be eligible for the PIP, MCP Participants must report on all measures, as applicable, as required by track and participant type (FQHC, ITU, or Standard Participant).

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

PCPCM Scoring: For PY 2025, MCP Participants, with the support of contracted survey vendors, are required to submit PCPCM data. All participants receive full credit (a score of 1.0) for reporting this measure. The PCPCM is administered by CMS for Track 1 participants and by CMS-approved survey vendors contracted by Track 2 and 3 participants. For more details on participant responsibilities regarding the PCPCM, please reference the PY 2025 MCP Quality Measure Reporting Guide. Details regarding survey vendor fielding protocols will be communicated in the forthcoming MCP PCPCM Survey Protocols and Guidelines Manual.

In PY 2025, all participants receive full credit (a score of 1.0) for reporting this measure

Each performance measure has been assigned a maximum percentage of the overall PIP value. For example, the Controlling High Blood Pressure measure makes up 25% of the PIP for Track 1 participants and 6% of the PIP for Track 2 and Track 3 participants. Evaluation of each measure is independent of performance on the others. Table 17 (Track 1) and Table 18 (Track 2 and 3) show the percentages assigned to each measure in each track. These percentages reflect model goals, with quality measures weighted approximately equally to the set of utilization and cost measures. The CI measures contribute 25% to the maximum PIP value for Tracks 2 and 3. Please see Section 5.3.4 for more information on how the Continuous Improvement measures are calculated.

Table 17. Track 1 MCP PIP Structure

Track 1 Performance Incentive Payment (PIP) Structure		
Measure Name	**Benchmarks**	**Percentage of Overall PIP**
Controlling High Blood Pressure	≥ 50th percentile (half credit) ≥ 70th percentile (full credit)	25%
Diabetes: Glycemic Status Assessment Greater than 9%		25%
Colorectal Cancer Screening		25%
Person-Centered Primary Care Measure (PCPCM)	Not applicable (full credit given for reporting in Performance Year [PY] 2025 and PY 2026)	25%
Track 1 participants are eligible for a maximum PIP Percentage Bonus of 3%.		

Table 18. Track 2 and 3 MCP PIP Structure

Track 2 and 3 Performance Incentive Payment (PIP) Structure TPCC Threshold for PIP Eligibility: Meet or Exceed 30th Percentile for TPCC (nationally)[a]		
Measure Name	**Benchmarks**	**Percentage of Overall PIP**
Controlling High Blood Pressure	≥ 50th percentile (half credit) Track 2: ≥70 percentile (full credit) Track 3: ≥ 80th percentile (full credit)	6%
Diabetes: Glycemic Status Assessment Greater than 9%[a]		6%
Colorectal Cancer Screening		6%
Person-Centered Primary Care Measure (PCPCM)	Not applicable (full credit given for reporting in Performance Year [PY] 2025 and PY 2026)	6%
Screening for Social Drivers of Health	≥ 50th percentile (half credit) Track 2: ≥70 percentile (full credit) Track 3: ≥ 80th percentile (full credit)	6%
Screening for Depression and Follow-Up Plan		4%
Depression Remission at 12 Months		4%
Emergency Department Utilization (EDU)[a]		18.5%
Total Per Capita Cost (TPCC)[a]		18.5%
EDU Continuous Improvement (CI) (for Federally Qualified Health Centers [FQHCs] and Indian Health Service, Tribal, and Urban Indian Providers [ITUs]) OR TPCC Continuous Improvement (CI) (for non-FQHCs and non-ITUs only)	≥ 3% improvement (half credit) ≥ 5% improvement (full credit)	25%
Track 2 participants are eligible for a maximum PIP Percentage Bonus of 45% **Track 3 participants are eligible for a maximum PIP Percentage Bonus of 60%.**		

[a] Participants "exceed" the measure benchmark by having lower measure values than the benchmark. These measures are inverse measures with lower values indicating better performance.

5.3.4 Continuous Improvement Criteria

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

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

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

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

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

The standard error associated with the change in measure performance is calculated as follows. First, CMS calculates the correlation of the EDU or TPCC results between the 2 performance years. Next, CMS estimates the covariance between the 2 performance years by multiplying the correlation between the 2 performance years by the standard errors for both performance years. The combination of each participant's covariance and performance rate standard errors for both performance years allows CMS to calculate the standard error for the change in performance at the participant level, which allows CMS to evaluate the statistical significance of any change in performance between performance years within individual participants. Statistical significance is determined using an alpha threshold of 0.05. This

approach has been applied successfully in other CMS models that assess performance improvement on quality measures over time.

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

CMS also realizes that measures that rely on statistically significant improvement at the participant level may encounter reliability challenges because of small numbers or events out of the participants' control (for example, a public health emergency). CMS will therefore monitor the reliability of the CI measures over the course of the model.

5.3.5 Calculating the PIP

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

- The first lump sum is paid in the first quarter of the performance year. This first lump sum is calculated in aggregate, reflecting half of what the average participant is expected to earn annually (based on the expected average PIP Percentage Bonus, applied to the participant's sum of FFS and PPCP payments for PPCP Services) in each track based on their number of attributed beneficiaries. In PY 2025 and PY 2026, when aggregate data from model participants is not available for all measures (for example, eCQMs), CMS will estimate average participant performance using other historical data sources. More information on these estimates for PY 2025 can be found in Table 21 for Track 1 participants and Table 22 for Track 2 and Track 3 participants.
- The second lump sum is paid (or reconciled) in the third quarter of the year after the performance year and reflects each participant's actual performance. The second lump sum is calculated as the total PIP a participant has earned for the performance year minus the first lump sum payment the participant received. A participant's total PIP is equal to the participant's PIP Percentage Bonus multiplied by the sum of FFS and PPCP payment for PPCP Services furnished by the participant during the performance year to its attributed beneficiaries.

Providing two lump sum PIPs, rather than a percentage adjustment at the time of assessment, pulls the payments forward in time and may afford participants a greater ability to predict revenue and invest in their organization to improve performance over time. The purpose of the PIP is to incentivize the participant to increase the quality of the care provided while containing costs. There are no restrictions on how the participant uses the PIP. Table 19 shows the timing of lump sum PIP payments by performance year.

Table 19. Lump Sum PIP Timeline by Performance Year

Model Performance Year	Q1 2025	Q3 2025	Q1 2026	Q3 2026	Q1 2027	Q3 2027
PY 2025	First Lump Sum PIP Paid			Second Lump Sum PIP Paid		
PY 2026			First Lump Sum PIP Paid			Second Lump Sum PIP Paid
PY 2027					First Lump Sum PIP Paid	

PY = Performance Year

5.3.5.1 Timeline for PIP Calculation

As shown in Table 20, there are no PIPs for the first performance year of the model (PY 2024). For each subsequent performance year, the first lump sum is paid during the first quarter of the performance year, and the second lump sum is paid (or reconciled) during the third quarter of the year following the performance year. Participants must submit the eCQM and CQM data for the MCP Performance Measure Set during the first quarter of the year after the performance year and meet survey requirements for the PCPCM for the required data collection period during the performance year (see Section 5.2.1). CMS uses data from reported quality measures in calculating the second lump sum payment. For example, for PY 2025, the first lump sum payment is paid to participants in the first quarter of 2025 (based on aggregate and estimated performance), and the second lump sum payment is paid in the third quarter of 2026 (based on each individual participant's actual performance in 2025). Although the TPCC Threshold for PIP Eligibility is not applied for PY 2025, it is applied in all subsequent years.

Table 20. Overall Timeline for PIP Calculation and Payment

MCP Performance Year	Measurement Period for MCP Performance Measure Set	eCQM and CQM Measure Data Submitted	TPCC Threshold for PIP Eligibility	PIP Percentage Bonus Calculated	First Lump Sum PIP Paid	Second Lump Sum PIP Paid
PY 2024	None	Not submitted	Not calculated	Not calculated	No PIP in 2024	No PIP in 2024
PY 2025	Calendar year 2025	Q1 2026	Not calculated PIP is based on the assumption that every participant passes the TPCC Threshold.	Q2 2026	Q1 2025 Actual performance data not used; modeled data will be used to estimate average participant performance.	Q3 2026 Participant receives the second PY 2025 PIP lump sum based on their *actual* performance in 2025.
PY 2026	Calendar year 2026	Q1 2027	Q1 2026 Calculated based on a prior 12-month period's TPCC performance.	Q2 2027	Q1 2026 Projections based on participants' measure performance in a prior 12-month period for available measures. Actual performance data not used for reported measures; modeled data will be used to estimate average participant performance.	Q3 2027 Participant receives the second PY 2026 lump sum PIP based on their *actual* performance in 2026.

CQM = Clinical Quality Measure; eCQM = electronic Clinical Quality Measure; PIP = Performance Incentive Payment; PY = Performance Year; TPCC = Total Per Capita Cost.

5.3.5.2 First Lump Sum PIP Calculation

CMS pays the first lump sum of the PIP for a performance year during the first quarter of that performance year. The first year that participants may earn a PIP is PY 2025, and participants in all tracks are eligible. Participants are *not* assessed on the TPCC Threshold in PY 2025.

The first lump sum PIP will be calculated as follows:

- **Step 1**: During the first quarter of the 2025 Performance Year, CMS estimates the expected average PIP Percentage Bonus for each measure in the MCP measure set, using historical performance data from external sources as well as performance data for claims measures only from MCP Participants in the previous year. These estimates are not specific to each participant but rather will reflect the *expected average MCP Participant's performance on each measure*.

  Participants will not report PY 2025 clinical quality measures from the MCP Performance Measure Set until early 2026 (based on the measurement period January 1, 2025–December 31, 2025). Therefore, the first lump sum PIP paid out in PY 2025 *is based on modeled data from a*

historical period. For PY 2025 First Lump Sum PIP, CMS uses performance data on relevant measures from the Comprehensive Primary Care Plus (CPC+) model, the Primary Care First (PCF) model, the Uniform Data Set (UDS), and MIPS. Full credit is given to each participant in the first two performance years for reporting the PCPCM measure. Please note that the first lump sum PIP paid out in the first quarter of PY 2026 will also be based on modeled data to estimate average performance for reported measures.

- **Step 2**: The expected earned percentages of overall PIP for each measure are then summed to arrive at an aggregate estimated PIP Percentage Bonus.
- **Step 3**: The aggregated estimated PIP Percentage Bonus is then multiplied by the sum of FFS and PPCP amounts paid to each participant in the previous year for PPCP Services (see Table 12) for their attributed beneficiaries, and that product is divided by 2. For PY 2025, the FFS and PPCP amounts are estimates because CMS does not have a prior performance year of FFS and PPCP payments for PY 2025.

It is important to note that this first lump sum PIP will be reconciled and may be debited against model payments in Q3 of the following performance year if the participant does not perform well enough on the quality measures. This includes participants that do not report on all required quality measures. However, CMS anticipates that for most participants, debit amounts would be small as a result of the first lump sum PIP being half of what the average MCP Participant is *expected* to earn and because participants will be able to earn portions of the PIP Percentage Bonus through strong performance on some measures even if they do not perform well on other measures.

5.3.5.2.a PY 2025 First PIP Lump Sum Calculation Methodology

As noted above, the PY 2025 first lump sum PIP is an estimate of average aggregate participant performance. The following methodology is used to determine the average performance and estimate the PIP percentage for each measure:

- CMS uses PY 2023 PCF performance data, 2023 UDS performance data, and 2023 MIPS benchmark data to estimate average participant performance on each of the reported measures (eCQMs and CQM).
- For TPCC and EDU measures, CMS determines the average MCP Participant performance on these measures for the period July 1, 2023–June 30, 2024, with a 3-month period for claims maturity (i.e., claims runout).
- For the PCPCM, full credit is given to all participants as the measure is "pay-for-reporting" for PY 2025 with participants receiving full credit for fielding the survey and reporting results (payment is not based on performance).
- The Screening for Social Drivers of Health measure was first collected in MIPS for 2024. Therefore, the MCP PY 2025 first lump sum PIP methodology assumes no credit given to participants as a conservative estimate.
- For the TPCC or EDU Continuous Improvement Measure, no historical data is available for MCP Participants and therefore no credit is given to participants.

See Tables 21 and 22 for the PIP Percentages assigned to each measure in the MCP measure set.

The percentages for each of the above measures were then totaled to get the Total PIP Percentage bonus. We estimate participants will earn, on average, a Total PIP Percentage Bonus of:

- Track 1: 87.5%
- Track 2: 34.25%
- Track 3: 28.25%

For each participant, the above Total PIP Percentage bonus is multiplied by the estimated sum of FFS and PPCP amounts paid in the previous year for PPCP Services for their attributed beneficiaries, and that product is divided by 2. For PY 2025, the FFS and PPCP amounts are estimates because CMS does not have a prior performance year of FFS and PPCP payments for PY 2025. *See the PY 2025 First Lump Sum PIP example calculation below.*

As noted previously, the PY 2025 First Lump Sum PIP will be reconciled against actual individual participant performance on the MCP measure set in Q3 2026, when the PY 2025 Second Lump Sum PIP is calculated (see Section 5.3.5.3).

Table 21. PY 2025 First Lump Sum PIP Percentage Amounts for Track 1 Participants

Measure	First Lump Sum Percentage of PIP
Controlling High Blood Pressure	25%—Full credit
Diabetes: Glycemic Status Assessment Greater than 9%	25%—Full credit
Colorectal Cancer Screening	12.5%—Half credit
Person-Centered Primary Care Measure (PCPCM)	25%—Full credit given in Performance Year (PY) 2025 and PY 2026
TOTAL Performance Incentive Payment (PIP) percentage	**87.5%**

Table 22. PY 2025 First Lump Sum PIP Percentage Amounts for Track 2 and 3 Participants

Measure	First Lump Sum Percentage of PIP	
	Track 2	Track 3
Controlling High Blood Pressure	6%—Full credit	3%—Half credit
Diabetes: Glycemic Status Assessment Greater than 9%	6%—Full credit	3%—Half credit
Colorectal Cancer Screening	3%—Half credit	3%—Half credit
Person-Centered Primary Care Measure (PCPCM)	6%—Full credit given in 2025 and 2026	6%—Full credit given in 2025 and 2026
Screening for Social Drivers of Health	0%—Assuming no credit	0%—Assuming no credit
Screening for Depression and Follow-Up Plan	2%—Half credit	2%—Half credit
Depression Remission at 12 months	2%—Half credit	2%—Half credit
Emergency Department Utilization (EDU)	0%—No credit	0%—No credit
Total Per Capita Cost (TPCC)	9.25%—Half credit	9.25%—Half credit

(continued)

Table 22. PY 2025 First Lump Sum PIP Percentage Amounts for Track 2 and 3 Participants (continued)

Measure	First Lump Sum Percentage of PIP	
	Track 2	Track 3
EDU or TPCC CI	0%—assuming no credit	0%—assuming no credit
TOTAL Performance Incentive Payment (PIP) Percentage	**34.25%**	**28.25%**

5.3.5.3 Second Lump Sum and Total PIP Calculation

CMS pays (or reconciles) the second lump sum of the PIP for a performance year during the third quarter of the following calendar year. This allows time for participants to submit required data for the MCP Performance Measure Set and for CMS to assess each participant's performance to make final PIP determinations.

The total PIP and second lump sum PIP for a performance year are calculated as follows:

- **Step 1**: During the second quarter of the calendar year after the performance year, CMS calculates participants' actual performance on each measure, using the claims data for the utilization and cost measures and reported data for the clinical quality measures.[22] These calculations are specific to each participant, reflecting the participant's actual performance on each measure.
- **Step 2**: For each participant, the total PIP Percentage Bonus is calculated by summing the measure-specific percentages that the participant earned across all the quality measures.
- **Step 3**: The total PIP is then calculated by multiplying the total PIP Percentage Bonus by the sum of FFS and PPCP amounts paid to each participant in the previous year for PPCP Services for their attributed beneficiaries (see Table 20; the previous year is the performance year that corresponds with the second lump sum PIP). CMS does not make any adjustments for changes in beneficiary attributions. In other words, beneficiary attribution from the performance year in which the first lump sum PIP is calculated will be used in the calculation of the total PIP.
- **Step 4**: After participant performance has been assessed, the first lump sum PIP from the applicable performance year is subtracted from the total PIP amount that the participant actually earned from that performance year. If this difference is positive (that is, if the participant earned at least as much as the first lump sum PIP associated with that performance year), then the participant receives this additional PIP payment amount in the form of the second lump sum PIP during Q3 of the calendar year after the applicable performance year. If this difference is negative (that is, if the participant did not earn at least as much as the first lump sum PIP associated with that performance year), then the participant does not receive a second lump sum PIP. The difference between the amount the participant actually earned and the first lump sum PIP is debited against Q3 model payments.

[22] Full credit will be given to each Participant in the first 2 performance years for reporting the PCPCM measure.

Second Lump Sum PIP = Maximum (Total PIP – First Lump Sum PIP)[23]

In addition to these steps, see the example of total PIP calculation below in Section 5.3.5.4.

5.3.5.4 Example of the Calculation of Total PIP

For a hypothetical Track 1 participant's PIP Percentage Bonus, see the scenario in Table 23 below. This participant's performance on required MCP Performance Measures sums to 87.5% of the maximum PIP Percentage Bonus. For Track 1 participants, the maximum PIP Percentage Bonus is 3%. Multiplying 87.5% by 3% results in 2.625%.

Table 23. Calculation of PIP Percentage Bonus for a Hypothetical Track 1 Participant

	Participant's Performance	MCP Measure Credit (Score) Received	Maximum Percentage of the PIP Percentage Bonus	Earned Percentage of the PIP Percentage Bonus
Calculating results for each performance measure				
Controlling High Blood Pressure	70th percentile	Full credit (1.0)	25%	25%
Diabetes: Glycemic Status Assessment Greater than 9%	80th percentile	Full credit (1.0)	25%	25%
Colorectal Cancer Screening	50th percentile	Half credit (0.5)	25%	12.5%
Person-Centered Primary Care Measure (PCPCM)	Reported (survey results submitted to CMS)	Full credit (1.0)	25%	25%
Using the measure-specific results to calculate the First Lump Sum PIP Percentage Bonus (Q1 2025)				
Total of Earned Percentage of the PIP Percentage Bonus (sum of each measure's actual percentage)				**87.5%**
PIP Percentage Bonus (earned percentage of PIP Percentage Bonus x maximum PIP Percentage Bonus)				**2.625%** (87.5% x 3%)
PPCP eligible services FFS billing for 2024 (assumed for example)				**$100,000**
Total PIP estimated for PY 2025				**$2,625 ($100,000 x 2.625%)**
First Lump Sum PIP amount				**$1,312.50 ($2,625/2)**

(continued)

[23] If a Participant's actual performance on the MCP Performance Measure Set is worse than the performance estimated for the first lump sum PIP, then the difference between the PIP amount the Participant actually earned and the first lump sum PIP is debited against Q3 model payments.

Table 23. Calculation of PIP Percentage Bonus for a Hypothetical Track 1 Participant (continued)

	Participant's Performance	MCP Measure Credit (Score) Received	Maximum Percentage of the PIP Percentage Bonus	Earned Percentage of the PIP Percentage Bonus
Calculating the Second Lump Sum PIP Percentage Bonus (Q3 2026)				
Earned full credit on all 4 measures (25% each)				**3%** **(100% x 3%)**
Total PIP Earned				**$3,000** **($100,000 x 3%)**
Second Lump Sum PIP amount				**$1,687.50** **($3,000 – $1,312.50)**

The participant's total PIP is the product of the PIP Percentage Bonus they earned and the sum of FFS and PPCP amounts paid to the participant for PPCP Services for their attributed beneficiaries. Therefore, the total PIP dollar amount would be calculated by multiplying 2.625% by the participant's Medicare FFS payments paid in the performance year for the PPCP Services provided to attributed beneficiaries. Note that for this example, the PIP would be calculated with FFS amounts alone, as Track 1 participants do not receive any PPCPs. For this example, we assume the participant billed $100,000 in PPCP eligible services in calendar year 2024. The participant receives $1,312.50 in the first lump sum PIP. This is half of the estimated total PIP earned for PY 2025. In Q3 2026, the total PIP earned is calculated based on the participant's individual performance on the scored measures. In this example, the participant earned full credit for each of the 4 measures (25% each) and earned the maximum 3% PIP for PY 2025. The total PIP earned for PY 2025 is $100,000 multiplied by 3%, or $3,000. The second lump sum PIP is $3,000 minus the amount the participant already received in the first lump sum PIP in Q1 2025, or $1,687.50.

6. Specialty Integration Payment Codes

Navigating this section:

6.1 Overview

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

- In Track 1, participants focus on reviewing data and identifying potential Specialty Care Partners.
- In Track 2, participants select Specialty Care Partners and execute Collaborative Care Arrangements (CCA) to facilitate closer coordination.
  - MCP Standard Participants must have at least one Specialty Care Partner identified as cardiology, orthopedic surgery, or pulmonary disease on their Specialty Care Partner List. Additional eligible specialties (as currently listed in the Provider Enrollment Chain and Ownership System [PECOS]) are in Table 24 below. These identified specialties both represent large shares of traditional Medicare spending and treat common clinical conditions for which improved access to specialty care may affect Part A and Part B spending.
  - Federally Qualified Health Centers (FQHCs) and Indian Health Service, Tribal, and Urban Indian Providers (ITUs) can select their preferred Specialty Care Partner type and are not required to have at least one specialty in cardiology, orthopedic surgery, or pulmonary disease on their Specialty Care Partner List.
  - MCP Standard Participants that are part of multispecialty organizations are not required to execute CCAs with external Specialty Care Partners, but they have the option to do so. They are required to establish coordination and collaboration protocols between MCP Clinicians and MCP Specialists within their organization.
  - Furthermore, participants can use a new model-specific e-consult code (MCP e-Consult, or MEC) in Track 2 and Track 3.
- In Track 3, Specialty Care Partners and MCP Specialists gain access to a new Ambulatory Co-Management (ACM) code for the enhanced collaboration and communication expected during co-management.

Table 24. Specialty Care Partner and MCP Specialist Eligible Specialties

Specialty Care Partner/MCP Specialist Eligible Specialties
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

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

6.2 MCP e-Consult (MEC)

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

In Tracks 2 and 3, MCP Participants may bill the MEC code on a fee-for-service (FFS) basis for all MCP-attributed beneficiaries, as the requesting physicians are the principal practitioners experiencing barriers to e-consult billing. MCP Participants may bill the MEC code for consultation with any specialist. The consultation does not have to be with a specialist on the Specialty Care Partner List. Specialty Care Partners and other non-MCP clinicians may not bill the MEC code. The MEC code is valued at the same level as the existing requesting physician IPC code 99452, including geographic adjustments and facility/non-facility adjustments. Currently, the IPC code for primary care (requesting) physicians is valued at 0.70 work relative value units (in the calendar year 2023 Medicare PFS).

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

The MEC code restrictions align with the IPC code restrictions:

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

As shown in Table 12 (list of PPCP Services), the MEC code is not included in the Track 2 PPCP Service list. This allows participants in Track 2 to receive the full reimbursement rate for this service. In Track 3,

the MEC code is included the PPCP Service list and is therefore paid prospectively. MCP Participants are still required to bill the MEC code at zero-pay rates.

6.3 Ambulatory Co-Management (ACM)

In Track 3, specialty physicians that furnish services under the Taxpayer Identification Number (TIN) of a Specialty Care Partner may bill a new ACM code for time spent co-managing care of an MCP-attributed beneficiary with MCP Clinicians. MCP Specialists at Standard Participant TINs composed of MCP Clinicians and MCP Specialists may also bill the new ACM code for such services. All specialty types listed in Table 24 are eligible to bill the ACM code. The ACM code supports coordination and communication between the MCP Clinicians and specialists in cases where the specialist shares management for a patient's condition with an MCP Clinician. MCP Standard Participants that are not composed of MCP Clinicians and MCP Specialists, as well as FQHC Participants, are required to execute CCAs with the Specialty Care Partners. CCAs define the communication and data-sharing protocols; expectations for coordination of care, such as when a patient should be shifted back to the primary care clinician for decision-making on care; and expectations for co-management of MCP-attributed beneficiaries between the MCP Participant and its Specialty Care Partner. MCP Standard Participants that are composed of MCP Clinicians and MCP Specialists must meet these same requirements within their own TIN organization and may also elect to execute CCAs with Specialty Care Partners outside of their organization.

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

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

- The claim is for a beneficiary attributed to an MCP Participant in Track 3.
- The date of service listed on the claim aligns with the beneficiary's attribution dates.
- The NPI listed on the claim is one of the eligible specialties identified in Table 24.
- Three ACM (G9038) claims have not been submitted by the same specialty type within the current 12-month period for the MCP beneficiary. Note that two specialists who are different specialty types can bill the ACM code concurrently for the same beneficiary.
- No other ACM (G9038) claims have been paid for the same beneficiary by the same specialty type (as the physician submitting the claim for payment) with a date of service less than 30 days from the date of service of the claim being submitted.

CMS reviews all paid ACM codes twice annually and will issue a Technical Direction Letter to reprocess incorrectly billed ACM codes regardless of claims count (in other words, no minimum threshold of claims will need to be met).

7. Upfront Infrastructure Payment

Navigating this section:

7.1 Overview

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

7.2 Eligibility for the UIP

To be eligible to receive the UIP, an MCP Participant must:

- **Participate in MCP under Track 1.** Section 2B of the Request for Applications provides information on Track 1 eligibility requirements. MCP Participants joining MCP in Track 2 or Track 3 are not eligible to receive the UIP.
- **Meet at least one of the following criteria:**
  - Not have a current e-consult technology solution, such as a phone, video, or a Health Insurance Portability and Accountability Act (HIPAA)-compliant application, platform, or

electronic health record enhancement that allows two-way communication and the secure sharing of patient records between primary care clinicians and specialists.[24]

– Meet the definition of "low revenue" where the participant's total Medicare Part A and Part B fee-for-service (FFS) revenue is less than 35% of the total Part A and Part B FFS expenditures for the participant's attributed beneficiaries.

In July 2024, CMS provided final UIP eligibility determinations to certain Track 1 MCP Participants. Determinations were based on low-revenue calculations from calendar year 2023. MCP Track 1 participants that were accepted into the model with fewer than 125 MCP-attributed beneficiaries and those that entered MCP while participating in the SSP had their UIP low-revenue eligibility calculations determined using claims from October 2023 through September 2024, provided that they met other eligibility requirements set forth in the Participation Agreement (PA). Final UIP eligibility will be shared with these participants by December 31, 2024.

7.2.1 Low-Revenue Calculation

The two components of the finalized low-revenue calculation are the participant's total revenue and the total expenditures for the participant's attributed beneficiaries during calendar year 2023.

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

The total Parts A and B FFS expenditures for the participant's attributed beneficiaries are calculated using all Part A and Part B claims billed on behalf of the beneficiary. The participant does not need to be the provider that billed the claim for the amount to be included in the total expenditures. Attributed beneficiaries from 4 quarters of attribution in 2023 are included in the calculation. Claims must have a date of service in calendar year 2023, and only Medicare payments to the provider are included as total expenditures. Low-revenue calculations for MCP Track 1 participants accepted into the model with fewer than 125 MCP-attributed beneficiaries and those participating in both MCP and the SSP in 2024 follow the same methodology, but on a delayed time period for determination (October 2023–September 2024).

[24] An e-consult technology solution is inclusive of HIPAA-compliant applications, platforms, and electronic health record enhancements that support coordinated and clinically appropriate electronic exchanges between clinicians.

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

7.3 Application and Approval Process

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

1. **Participants are in Track 1.** Only MCP Participants in Track 1 can be eligible for the UIP.
2. **CMS provided a final UIP eligibility determination to MCP Participants after the start of the model.** For participants that were accepted into the model with at least 125 MCP-attributed beneficiaries, CMS made a final UIP eligibility determination using 2023 attribution and 2023 Part A and Part B expenditure data for the low-revenue calculation. For participants that were accepted into the model with fewer than 125 MCP-attributed beneficiaries, and for participants that were participating in SSP at the start of the model, CMS made a final UIP eligibility determination using attribution data from Q4 2023 through Q3 2024 and Part A and Part B expenditures data from the same time period (October 2023–September 2024) for the low-revenue calculation.
3. **Participants submit a Spend Plan.** Following the final UIP eligibility determination, the MCP Participant submits supplemental information, including a Spend Plan (detailed in Section 7.6.1) for CMS review and approval, that specifies how the participant intends to spend the UIP during the 2.5-year Track 1 participation period.
4. **CMS notifies participants whether they have been approved to receive the UIP.**

7.4 Payment Process

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

1. Most participants approved to receive a UIP received the first lump sum payment of $72,500 before the end of Q4 2024. MCP Track 1 participants accepted into the model with fewer than 125 MCP-attributed beneficiaries and SSP Participants approved to receive the UIP receive the first lump sum payment in March 2025.
2. By Q4 2025, the participant submits a first Spend Report and a second Spend Plan detailing how the first lump sum UIP was spent and how the second lump sum payment will be spent.
3. Once CMS reviews and deems approved the second Spend Plan and confirms that the participant has remained in compliance with all applicable MCP and UIP requirements, CMS pays the second lump sum payment of $72,500 before the end of Q4 2025.

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

7.5 Allowable Uses

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

CMS tracks expenditure subcategories within the 3 allowable use categories. MCP Participants may spend UIPs on any of the subcategories of allowable uses of UIPs noted in Appendix F.

Where UIPs are used for investments in health IT systems and infrastructure, CMS requires that MCP Participants use health IT that meets standards and implementation specifications adopted in 45 CFR part 170, Subpart B, health IT certified under the Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program, or health IT meeting both criteria.

UIPs cannot be used for anything other than the 3 categories listed above (and the corresponding subcategories listed in Appendix F). For example, prohibited uses include management company or parent company overhead, performance bonuses, other provider salary augmentation, medical services covered by Medicare, and items or activities unrelated to MCP Participant operations.

7.6 Reporting Requirements

7.6.1 Spend Plan

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

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

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

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

7.6.2 Spend Report

During the Track 1 participation period (July 2024–December 2026), the participant is required to submit two reports on the actual spending of the UIP, called the Spend Reports. This itemization includes all

expenditures, including those not identified or anticipated in the Spend Plan. As outlined in the Standard Participant and FQHC Participant PAs, the Spend Reports include the following:

- Total amount of UIP funds received from CMS
- Itemization of how the UIP was spent, including expenditure categories (increased staffing, provision of accountable care for underserved beneficiaries, health care infrastructure), the corresponding subcategories of allowable uses of UIPs, and the dollar amounts spent on these various categories
- Dollar amount remaining unspent
- Any changes to the Spend Plan made in the spending of the UIP
- Other information as specified by CMS

Participants will be required to submit Spend Reports approximately 1 year after receiving each UIP installment. Failure to submit the Spend Reports may result in recoupment of the first UIP lump sum and ineligibility to receive the second lump sum UIP. CMS will provide information to MCP Participants regarding the standardized form, manner, and timelines in which this information must be reported.

7.7 Financial Accounting

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

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

7.8 Monitoring of the UIP

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

Participants are required to retain adequate records to ensure that CMS has the information necessary to conduct appropriate monitoring and oversight of use of UIPs (for example, invoices, receipts, and other supporting documentation of UIP disbursements).

Appendix A: Primary Care Specialty Codes

Specialty Description	Code
Family Medicine	207Q00000X
Adult Medicine	207QA0505X
Geriatric Medicine	207QG0300X
General Practice	208D00000X
Internal Medicine	207R00000X
Internal Medicine Geriatric	207RG0300X
Internal Medicine Hospice and Palliative Medicine	207RH0002X
Clinical Nurse Specialist	364S00000X
Acute Care	364SA2100X
Adult Health	364SA2200X
Chronic Care	364SC2300X
Community Health/Public Health	364SC1501X
Family Health	364SF0001X
Gerontology	364SG0600X
Holistic	364SH1100X
Women's Health	364SW0102X
Nurse Practitioner (NP)	363L00000X
NP Acute Care	363LA2100X
NP Adult Health	363LA2200X
NP Community Health	363LC1500X
NP Family	363LF0000X
NP Gerontology	363LG0600X
NP Primary Care	363LP2300X
NP Women's Health	363LW0102X
Physician Assistant	363A00000X
Medical	363AM0700X

Appendix B: PY 2025 Clinical and Social Risk Tier Thresholds

PY 2025 Clinical and Social Risk Tier Thresholds

MCP Region [a]	25th Percentile Risk Score [b]	50th Percentile Risk Score [b]	75th Percentile Risk Score [b]	75th Percentile ADI Rank
Colorado	0.457	0.582	1.049	41
Massachusetts	0.502	0.684	1.140	35
Minnesota	0.502	0.680	1.182	67
New Jersey	0.516	0.694	1.201	41
New Mexico	0.465	0.629	1.061	78
New York Region	0.502	0.692	1.174	77
North Carolina	0.496	0.630	1.070	76
Washington	0.465	0.584	1.005	42

ADI = Area Deprivation Index; HCC = Hierarchical Condition Categories; PY = Performance Year.

[a] Making Care Primary (MCP) regions include the full state, except for the New York region, which includes the New York counties of Putnam; Rockland; Orange; Albany; Schenectady; Montgomery; Greene; Columbia; Rensselaer; Saratoga; Fulton; Schoharie; Washington; Otsego; Hamilton; Delaware; Ulster; Dutchess; Sullivan; Warren; Essex; Clinton; Franklin; Saint Lawrence; Onondaga; Cayuga; Oswego; Madison; Cortland; Tompkins; Oneida; Seneca; Chenango; Wayne; Lewis; Herkimer; Jefferson; Tioga; Broome; Erie; Genesee; Niagara; Wyoming; Allegany; Cattaraugus; Chautauqua; Orleans; Monroe; Livingston; Yates; Ontario; Steuben; Schuyler; and Chemung.

[b] These estimated thresholds are based on 2023 CMS-HCC risk scores, which are based on 2022 diagnoses.

Appendix C: Description of the Centers for Medicare & Medicaid Services–Hierarchical Condition Category Risk Adjustment Model

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

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

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

The CMS-HCC diagnostic classification system begins by classifying all International Classification of Diseases, Version 10, diagnosis codes into Diagnostic Groups, or DXGs. Each DXG represents a well-specified medical condition or set of conditions, such as the DXG for Type II Diabetes with Ketoacidosis

or Coma. DXGs are further aggregated into condition categories (CCs). CCs represent a broader set of similar diseases. Although they are not as homogeneous as DXGs, diseases within a CC are related clinically and with respect to cost.

Hierarchies are imposed among related CCs so that if a person is coded with more than one CC from a hierarchy, only the most severe manifestation among related diseases will be coded as the HCC for the risk score calculation. After imposing hierarchies, CCs become HCCs. For example, diabetes diagnosis codes are organized in the Diabetes hierarchy, consisting of three CCs arranged in descending order of clinical severity and cost, from (1) Diabetes with Severe Acute Complications to (2) Diabetes with Chronic Complications to (3) Diabetes with Glycemic, Unspecified, or No Complications. Thus, a person with a diagnosis code of Diabetes with Severe Acute Complications precludes the less severe manifestations of Diabetes with Chronic Complications as well as Diabetes with Glycemic, Unspecified, or No Complications from being included in the risk score. Similarly, a person with a diagnosis code of Diabetes with Chronic Complications precludes a code of Diabetes with Glycemic, Unspecified, or No Complications from being included in the risk score. Although HCCs reflect hierarchies among related disease categories, for unrelated diseases, HCCs accumulate (that is, the model is "additive"). For example, a female with both Rheumatoid Arthritis and Breast Cancer has (at least) two separate HCCs coded, and her predicted cost will reflect increments for both conditions.

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

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

An illustrative hypothetical example using the CMS-HCC V28 model follows for a 70-year-old woman with HCCs Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid (HCC 17) and Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis (HCC 92) who is a full-benefit dual Medicare-Medicaid enrollee:

Risk Factor	Factor
Age/Sex, Full-Benefit Dual Enrollee (Female, Age 70)	0.506
HCC 17—Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic	3.896
HCC 92—Bone/Joint/Muscle/Severe Soft Tissue Infections/Necrosis	0.611
2 Payment HCCs	0
Total CMS-HCC Risk Score	5.013

HCC = Hierarchical Condition Categories

For more information on the CMS-HCC risk model, see the following web page: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html

Appendix D: Technical Specifications of the Total Per Capita Cost Measure for MCP

The Total Per Capita Cost (TPCC) measure, adapted for MCP, is a payment-standardized, risk-adjusted measure of the overall cost of care provided to MCP-attributed beneficiaries for each participant. The TPCC measure is calculated from claims and does not require participant reporting. The measure assesses per capita costs across all attributed beneficiaries and includes all Medicare FFS Parts A and B standardized allowable charges incurred by each attributed beneficiary in the performance period. The TPCC measure is reported as an observed-to-expected (O/E) ratio for each participant, dividing the observed cost by the expected cost. An O/E ratio greater than one represents greater-than-expected cost. TPCC is an inverse measure; lower performance scores reflect better quality.

The measure is based on the Merit-based Incentive Payment System (MIPS) version[25] but differs slightly in the following ways:

- It follows the MCP attribution method for assigning beneficiaries to specific MCP Participants, and
- Because attribution is based on primary care staff (e.g., MCP Clinician List for Standard Participants), the MCP TPCC measure does not standardize costs by provider specialty (the "Specialty Adjustment" as described in the MIPS specifications).

The following paragraphs describe the process for calculating a participant's TPCC measure result. For information regarding how an MCP Participant's performance on TPCC is then scored for calculation of the Performance Incentive Payment (PIP), please see Chapter 5 (Section 5.2.2.1).

Step 1: Beneficiary Attribution

The Centers for Medicare & Medicaid Services (CMS) calculates the TPCC measure using a 1-year performance period for all beneficiaries attributed to the participant over the course of a given year. Attribution follows the same MCP attribution methodology (described in detail in Chapter 2). If, for example, a beneficiary is attributed to a participant in Quarter 1 of a given year, that beneficiary's observed costs from that quarter are included in the measure. The unit of analysis for MCP Participants is the "beneficiary quarter," and the final measure can be interpreted as the ratio of observed costs to expected costs for a given participant across all attributed beneficiary quarters.

Step 2: Calculation of Total Observed Cost

Total cost of care is calculated as the sum of all Medicare fee-for-service (FFS)-standardized allowed charges for a particular beneficiary during a given period. To calculate total observed costs, the most recent available standardized payment files will be used to standardize the costs associated with claims. These costs are standardized to account for differences in Medicare payments for the same services

[25] For MIPS specifications, please see the MIPS Cost Measure Codes Lists at https://qpp.cms.gov/.

across Medicare providers. Payment standardization also accounts for differences in Medicare payment unrelated to the care provided, such as those from payment adjustments supporting larger Medicare program goals (e.g., indirect medical education add-on payments) [26] or variation in regional health care expenses as measured by hospital wage indexes and Geographic Practice Cost Indexes.[27] When standardized costs are not available, non-standardized costs are used.

Inpatient claims are reduced to "stays" before including them in the TPCC calculation. Inpatient stays exclude managed care claims and duplicate claims. Inpatient claims that indicate the same beneficiary ID, provider ID, admission date, and discharge date are consolidated into a single stay. Finally, overlapping claims (in other words, claims with overlapping dates of service) and claims lasting longer than 1 year are removed. Total cost is then calculated by identifying all claims submitted for the beneficiary for inpatient, outpatient, professional, skilled nursing facility, home health, hospice services[28], and durable medical equipment. The payment-standardized costs across all of these claims are first summed and then winsorized at the 1st and 99th percentiles to adjust for outliers.

Please note the following details:

- When calculating the TPCC measure, any additional model payments provided to MCP Participants will not count toward the MCP Participant's TPCC scores. Specifically, Enhanced Services Payments (ESP), Performance Incentive Payments (PIP), and Upfront Infrastructure Payments (UIPs) will not count as costs for the purposes of calculating TPCC.
- Costs associated with Healthcare Common Procedure Coding System (HCPCS) codes A4352 and A4353 for urinary catheters are not included in the TPCC measure for specific performance periods, due to known fraudulent claims (billed during calendar year 2023) associated with these codes.[29] To mitigate potential inequity in measure performance, these codes are excluded from calculations for PY 2025 regional benchmarks, first lump sum calculation, and performance year reconciliation. They are also excluded from the PY 2026 TPCC threshold national benchmark and participant scoring.

Step 3: Risk Adjustment

Each beneficiary is assigned a risk score that is generated by the CMS-Hierarchical Condition Category (HCC) risk adjustment model software. Beneficiary risk scores are assigned based on whether the beneficiary is a continuing or new enrollee in Medicare FFS and their dual eligibility status with

[26] The standardized payment methodology excludes payment adjustments from special Medicare programs that are not directly related to resource use for the service such as: graduate medical education (GME) and indirect medical education (IME) payments; disproportionate share payments (DSH) and uncompensated care payments (for serving a large low-income and uninsured population); value based purchasing (VBP) payment adjustments; and penalties related to the hospital readmission reduction program (HRRP), hospital acquired condition (HAC) reduction program, and quality reporting programs.
[27] For more information, please refer to the "CMS Price (Payment) Standardization—Basics" and "CMS Price (Payment) Standardization—Detailed Methods" documents posted on ResDAC: https://www.resdac.org/articles/cms-price-payment-standardization-overview
[28] Although beneficiaries receiving hospice services are not eligible for MCP, if they leave hospice care and then become attributed to an MCP Participant, their hospice costs will contribute to the TPCC measure during the relevant performance period.
[29] For more information about the fraudulent urinary catheter billing issue, please refer to the bulletin "Urinary Catheter Case Study: CMS' Swift Action Saves Billions": https://www.cms.gov/files/document/cpi-urinary-catheter-case-study.pdf

Medicaid. The CMS-HCC risk score file is updated annually, and TPCC will use the most recent V28 risk score file that is available at the time the measure is calculated for official payment purposes.

Beneficiaries are classified as either continuing or new enrollees on the basis of their enrollment date in Medicare and whether they have a full 12 months of data from which diagnosis information can be drawn. If beneficiaries have both continuing and new enrollee risk scores, CMS uses the higher of the two. These diagnoses are used to assign beneficiaries to the HCCs that are used to calculate the risk score. Risk scores for new enrollees who lack a full year of diagnosis data are calculated using age, sex, Medicare-Medicaid dual enrollment status, and original reason for entitlement to the Medicare benefit.

Expected costs for each beneficiary period are estimated using Ordinary Least Squares regression, controlling for the beneficiary's CMS-HCC risk score. The model is specified as follows:

$$Total\ Cost = \alpha + \beta_1(CEScore) + \beta_2(CEScore)^2 + \delta_1(NEScore) + \delta_2(NEScore)^2 + \varepsilon$$

A beneficiary will have only a Continuing Enrollee risk score (CEScore) or a new enrollee risk score (NEScore) and cannot have both. Therefore, the model estimates the effect of each type of risk score separately. Estimates β and δ can be interpreted as the average effect on total cost of an increase of 1.0 in a beneficiary's CEScore or NEScore, respectively, holding other factors constant. The linear predictions generated by this model are used as the expected cost in the final calculation of TPCC for the MCP Participant.

Step 4: Observed-to-Expected Ratio

The TPCC measure is expressed at the participant level as a ratio of observed-to-expected (O/E) cost of care. This ratio is calculated for a given participant as follows:

$$TPCC = \frac{O}{E}$$

In this equation, the sum of the participant-level observed costs (O) across all attributed beneficiary quarters is divided by the corresponding sum of the participant-level expected costs (E). Operationalizing the measure this way also gives more weight to beneficiaries who are attributed for a longer time within the performance period. For example, an MCP beneficiary attributed for the full year would have 4 quarters in the data, whereas an MCP beneficiary attributed for only 1 quarter would contribute only 1 quarter of data to that participant.

The final ratio can be interpreted as the relative costliness of the beneficiaries attributed to a given MCP Participant compared with organizations with a similar overall level of patient complexity. A lower ratio in this case indicates better performance on the measure, or lower cost relative to model predictions (expected).

Appendix E: Benchmarks for Claims-based Measures, Emergency Department Utilization and Total Per Capita Cost

PY 2026 TPCC Threshold National Benchmark

TPCC 30th Percentile Benchmark	1.08

PY 2025 Regional Benchmarks

MCP State	Additional States in Benchmark Region	TPCC 50th Percentile Benchmark	TPCC 70th Percentile Benchmark	TPCC 80th Percentile Benchmark	EDU 50th Percentile Benchmark	EDU 70th Percentile Benchmark	EDU 80th Percentile Benchmark
Colorado	Arizona, New Mexico, Nevada, Utah, Wyoming	1.02	0.96	0.91	1.06	0.95	0.89
North Carolina	Georgia, South Carolina, Tennessee, Virginia, West Virginia	0.97	0.91	0.87	1.00	0.89	0.81
New Jersey	Delaware, Maryland, Pennsylvania	0.99	0.93	0.89	0.85	0.74	0.68
New Mexico	Arizona, Colorado, Nevada, Utah, Wyoming	1.02	0.96	0.91	1.06	0.95	0.89
New York	Connecticut, Massachusetts, New Hampshire, Rhode Island	0.95	0.89	0.85	0.89	0.77	0.70
Minnesota	Indiana, Iowa, Michigan, North Dakota, Wisconsin	0.98	0.92	0.88	1.04	0.91	0.83
Massachusetts	Connecticut, New Hampshire, New York, Rhode Island	0.95	0.89	0.85	0.89	0.77	0.70
Washington	Alaska, Idaho, Montana, Oregon	0.91	0.86	0.82	1.11	0.99	0.91

Appendix F: Allowable Uses of Upfront Infrastructure Payments

Category of Allowable Use	Specific Allowable Uses
Provision of Accountable Care for Underserved Beneficiaries	<u>General health-related social needs services:</u> • Screening for social needs • Comprehensive assessments • Social care coordination • Follow-up to ensure social needs are being addressed • Substance abuse counseling/programs • Implementing systems to provide and track patient referrals to available community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across the community where beneficiaries reside <u>Food security services and supports:</u> • Nutrition education/counseling • Nutrition support • Medically tailored meals after hospital discharge • Medically tailored meals for a chronic condition • Partnership with food bank • Grocery store, farmers market, or other food voucher • Application for food-related benefits • Other food-related services (explain in “Payment Use”) <u>Housing-related services and supports:</u> • Home or environmental modifications to support a healthy lifestyle • Community transition costs • Assisting with housing search, training on how to search for available housing • Housing and environmental assessments, to ensure housing and environment are safe • Moving expenses • Securing documentation and fees to apply for housing • Early identification and intervention for behaviors that may jeopardize housing • Education on the role, rights, and responsibilities of the tenant and landlord • Connecting an individual to community resources or benefits to maintain housing stability • Rapid rehousing interventions • Housing payments for persons experiencing homelessness • Setting up support structures for persons experiencing homelessness • Wraparound housing services • Lead remediation services • Application for housing-related benefits • Other housing-related services (explain in “Payment Use”)

(continued)

Appendix F: Allowable Uses of Upfront Infrastructure Payments (continued)

Category of Allowable Use	Specific Allowable Uses
Provision of Accountable Care for Underserved Beneficiaries (continued)	Transportation services: • Vouchers for ride-share services • Vouchers for public transportation services • Disability-related transport services • Services to help an individual maintain access to an automobile • Transportation to non-medical locations, such as grocery stores • Help with application for transportation benefits • Other transportation-related services (explain in "Payment Use") Utilities-related services and supports: • Water services • Electricity services • Heating services • Application for utilities-related benefits • Other utilities-related services and supports (explain in "Payment Use") Employment-related services: • Employment search assistance • Employment coaching • Services for individuals with disabilities to help them succeed at finding and maintaining employment • Other employment-related services and supports (explain in "Payment Use") Patient caregiver supports: • Caregiver counseling or support groups • Caregiver training and education • Respite care • Child Support Services • Other patient caregiver support services (explain in "Payment Use") Services to reduce social isolation: • Improving cultural and linguistic competency • Reintegration from incarceration counseling/program • Other reduction of social isolation services (explain in "Payment Use") General: • Other (explain in "Payment Use")

(continued)

Appendix F: Allowable Uses of Upfront Infrastructure Payments (continued)

Category of Allowable Use	Specific Allowable Uses
Health Care Infrastructure	<u>Health IT:</u> • Case/practice management systems • Clinical data registries • Electronic quality reporting • Health information exchange and health information network participation • Health IT to support behavioral health activities • Health IT investments to support integration with dental services • Investment in Certified Electronic Health Record Technology, including system enhancements and upgrades, as necessary to meet Health IT Requirements • IT-enabled screening tools • Remote access technologies • Telehealth and telemonitoring • Establishing or improving translation services • MCP e-Consult technology investments • Patient health data system such as patient portal • Event notification systems • Data warehouse capabilities <u>Infrastructure related to social determinants of health:</u> • Closed-loop referral tools to connect patients to community- based organizations • Other infrastructure related to addressing patient social needs (explain in "Payment Use") • Case management or practice management systems to improve care coordination operations across the health and social care continuum <u>General:</u> • Practice physical accessibility improvements

(continued)

Appendix F: Allowable Uses of Upfront Infrastructure Payments (continued)

Category of Allowable Use	Specific Allowable Uses
Increased Staffing	<u>Medical and support staff:</u> • Physician • Physician assistant, nurse practitioner, or clinical nurse specialist • Registered dietitian or nutrition professional • Nurse care manager • Case manager • Licensed clinical social worker • Community health worker • Patient navigator • Health equity officer • Other staff (explain in "Payment Use") <u>Behavioral health clinicians:</u> • Psychiatrist • Clinical psychologist • Marriage and family therapists • Mental health counselors or licensed professional counselors • Substance use counselors • Peer support specialists • Behavioral health case managers • Behavioral health care coordinators <u>Oral health providers:</u> • Public health dental hygiene practitioner • Dental hygienist • Dentist <u>Education:</u> • Training staff to provide culturally and linguistically tailored services • Training staff to provide trauma-informed care • Other staff education (explain in "Payment Use")