



U.S. Department of Health & Human Services

Centers for Medicare & Medicaid Services

[Center for Medicare & Medicaid Innovation](#)

[Patient Care Models Group](#)

7500 Security Boulevard

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[Making Care Primary](#)

Request for Applications

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1. Abstract

This Request for Applications (RFA) introduces Making Care Primary (MCP), a new Center for Medicare and Medicaid Innovation (CMS Innovation Center) advanced primary care model that aims to reduce program expenditures and improve key measures of patient outcomes through more coordinated, integrated, whole-person care. MCP provides a pathway for primary care clinicians with varying levels of experience in value-based care (including practices new to value-based care, those supporting underserved communities, and small, independent, and rural practices) to gradually adopt prospective, population-based payments that support the delivery of advanced primary care. MCP's graduated care delivery, quality, and payment structures will provide an on-ramp for organizations looking to begin their transition to value-based care and will support them as they build infrastructure and advance in delivering accountable care.

The goals of MCP are to:

1. Ensure beneficiaries in participating organizations (health systems, group practices, solo primary care practices, and Federally-Qualified Health Centers (FQHCs)¹, Indian Health Programs², receive primary care that is integrated, coordinated, person-centered, and accountable.³
2. Create a pathway for primary care clinicians, especially small and independent, rural, and organizations supporting underserved communities, to adopt prospective, population-based payment to become more accountable for cost and quality of care for their population of patients
3. Improve the quality of care and health outcomes while reducing or maintaining program expenditures.

MCP is a 10.5-year, multi-payer model which will run from July 2024 to December 2034. It will build on lessons learned from previous CMS Innovation Center advanced primary care models and features three progressive upside-only tracks to help participants further their delivery of comprehensive, high-quality advanced primary care. New features of the model include: a track for FQHCs and organizations to transition to value-based care, a stronger focus on health equity and care integration, broad incentives to control cost within the control of primary care, and robust state-based learning and payer partnerships.

Although CMS is implementing MCP with respect to services furnished to beneficiaries who are enrolled in Traditional Medicare (FFS), other payers are encouraged to partner with CMS to realize the goals and

¹ The term "Federally Qualified Health Center" or "FQHC" refers to entities that receive Medicare and Medicaid enhanced payments described at §1834(o) and §1902(bb) of the Social Security Act (the Act), respectively. As defined at §§1861(aa)(4) and 1905(l)(2)(B) of the Act, the term "FQHC" includes certain outpatient clinics associated with tribal/urban Indian organizations in addition to HRSA-designated Health Centers and Look-alikes.

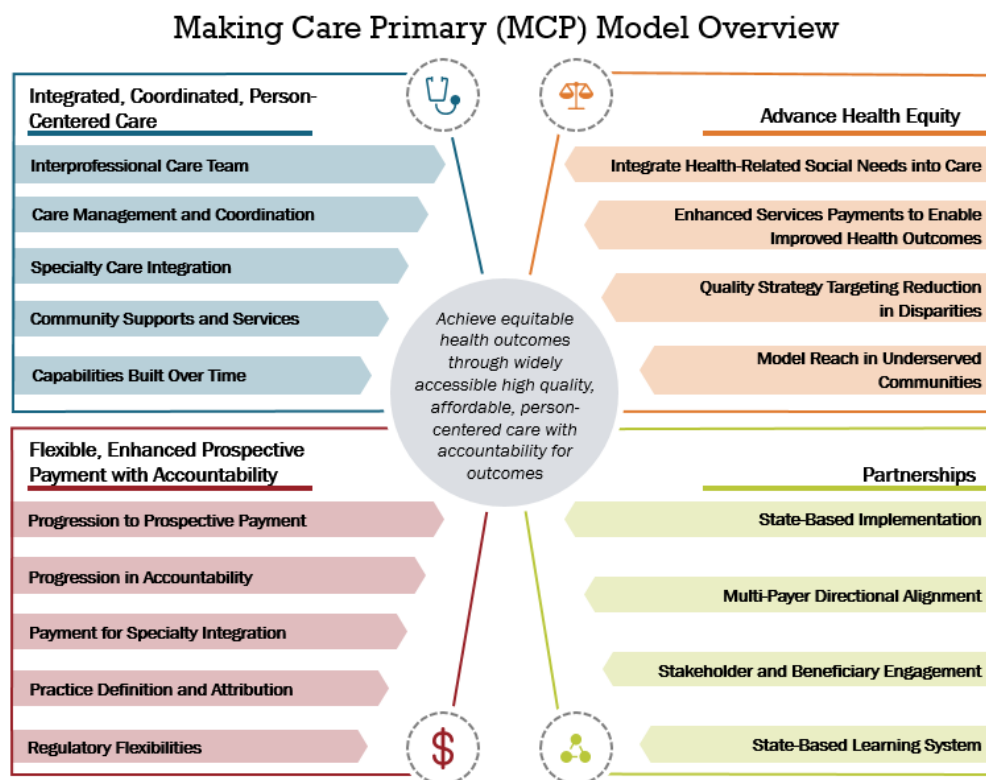
² The term 'Indian Health Program' means any health program administered by the Indian Health Service and any tribal health program as defined by 25 U.S.C. § 1603(25), except that tribal health programs which are Grandfathered Tribal FQHCs are not eligible for MCP.

³ CMS has defined an "Accountable Care Relationship" as the following: "In an accountable care relationship, doctors and other health care providers work with each other and their patients to manage their patients' overall health, all while considering their patients' personal health goals and values." More detail available here: <https://innovation.cms.gov/key-concept/accountable-care-and-accountable-care-organizations>

elements of improved primary care across all patients, including those covered by Medicaid, commercial, and other payers.

1A. Making Care Primary Overview

Figure 1: Making Care Primary Overview



Under the authority of Section 1115A of the Social Security Act, CMS designed MCP, a primary care delivery and payment redesign model test. MCP will be tested for 10.5 years from July 2024 to December 2034 (performance year (PY) 1 is six months and will run from 7/1/24 to 12/31/24 and PY2 through and onwards will align with calendar years). Quality and cost performance assessment will begin in PY2 (beginning 1/1/25). MCP includes a three-track design, which will require participants (primary care organizations that have been accepted to MCP and signed a Participation Agreement) to move through time-limited tracks over the model performance years, with increasing levels of accountability for cost and quality outcomes.

MCP is built upon more than a decade of lessons learned by CMS innovation in models that focus on participants delivering advanced primary care to beneficiaries.⁴ Additionally, it aligns with the National Academies of Science, Engineering and Medicine (NASEM) vision of advanced, high-quality primary care: “whole person, integrated, accessible, and equitable health care by interprofessional teams who are

⁴ The term “Advanced Primary Care” refers to care delivery that reorganizes the way primary care is provided to patients to improve quality of care by focusing on specific patient needs, modeled after the Patient-Centered Medical Home (PCMH). Additional information on Patient-Centered Medical Homes can be found here: <https://www.ahrq.gov/ncepcr/research/care-coordination/pcmh/define.html>

accountable for addressing the majority of an individual’s health and wellness needs across settings and through sustained relationships with patients, families, and communities.”⁵ The Table 1 below outlines how MCP policy responds to lessons learned from previous CMS Innovation Center advanced primary care models such as Comprehensive Primary Care (CPC), Comprehensive Primary Care Plus (CPC+), Primary Care First (PCF), and the Maryland Primary Care Program (MDPCP).

Table 1: CMS Innovation Center Primary Care Model Lessons Learned and their Application in MCP⁶

Lesson Learned	MCP Policy
Primary care organizations new to value-based care need an “on-ramp” to allow them to deliver transformed care in a value-based payment model.	MCP will provide a progressive payment architecture that allows organizations new to value-based care to build up to more accountability and more advanced care delivery over time, while also providing participation options for organizations that have more experience.
Past advanced primary care models have had limited reach into diverse communities.	MCP will be implemented in many regions where the CMS Innovation Center has not yet had an opportunity to implement an advanced primary care model and has been designed to attract organizations serving underserved populations.
Primary care organizations require additional supports and incentives to effectively integrate with high-quality specialists.	For the first time in an advanced primary care model, MCP will directly equip participating primary care organizations with tools to improve care coordination with high-quality specialists through access to data dashboards, collaborative care arrangements, model-specific interprofessional consultation, and time limited co-management billing privileges.
Model-encouraged improvements in quality and efficiency take time to manifest.	CMS will test MCP for 10.5 years, giving participants more time to advance health equity and improve care across populations.
Learning systems and payer engagement approaches should prioritize partnerships at the state level and leverage existing infrastructure to create enduring change.	MCP will integrate into existing state-based capabilities to enable broad and sustainable transformation instead of investing in processes and systems that will end after the model test.

MCP translates these lessons learned into key design features that capture the evolution of advanced primary care and the need to expand access to value-based care programs. It will make advanced primary care available and sustainable for a wider array of practices serving a broader and more diverse

⁵ National Academies of Science, Engineering, and Medicine. 2021. *Implementing high-quality primary care: Rebuilding the foundation of health care*. Washington, DC: The National Academies Press. <https://nap.nationalacademies.org/catalog/25983/implementing-high-quality-primary-care-rebuilding-the-foundation-of-health>.

⁶ Finke B, Davidson K, Rawal P. Addressing Challenges in Primary Care—Lessons to Guide Innovation. *JAMA Health Forum*. 2022;3(8):e222690. doi:10.1001/jamahealthforum.2022.2690. <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2795471>

set of patients. Table 2 summarizes the evolution of CMS Innovation Center’s advanced primary care models, providing a snapshot of key differences (and similarities) between MCP, CPC+, and (PCF).

Table 2: Comparison of CMS Innovation Center’s Advanced Primary Care Models

	CPC+ (2017-2021) 5 years	PCF (2021-2026) 5 years	MCP (2024-2034) 10.5 years
Target participant	Track 1: Primary care practices with certain primary care transformation experience Track 2: Advanced primary care practices	Advanced Primary Care Practices that were ready to accept financial risk in exchange for greater flexibility, increased transparency	Track 1: Organizations (including FQHCs) and practices new to value-based care ⁷ Tracks 2 and 3: Organizations (including FQHCs) with experience in value-based care and providing progressively advanced primary care
Tracks	Two tracks, with no opportunity to progress up tracks	One track	Three progressive tracks that increase in accountability and care delivery requirements
Locations	18 regions	26 regions	8 states
Payment Framework	Care Management fees; prospective, population-based payment opportunities; performance-based bonus payments that reward improvements in quality and reductions in cost and utilization	Prospective-population-based payments; upside and downside performance-based payments that reward participants for cost and utilization outcomes	Upfront Infrastructure Payment – eligible participants in Track 1 only Clinical and social-risk adjusted Enhanced Services payments (historical care management fees) – All Tracks Progressive prospective population-based payments – Tracks 2 and 3 only

⁷ The criteria for organizations being classified as “new to value-based care” is described in the [Track Selection](#) section of this RFA.

	CPC+ (2017-2021) <i>5 years</i>	PCF (2021-2026) <i>5 years</i>	MCP (2024-2034) <i>10.5 years</i>
			Upside-only performance-based payments – All Tracks New specialty-integration incentives - Tracks 2 and 3 only
Multi-payer alignment approach	Alignment focused on ten comprehensive milestones, including institution of non-Fee-for-Service (FFS) payment.	PCF required close alignment on all model design features.	CMS working with state Medicaid agencies to align on quality measurement, data provision to participants, learning priorities, and moving payment away from FFS to a value-based payment framework over time.

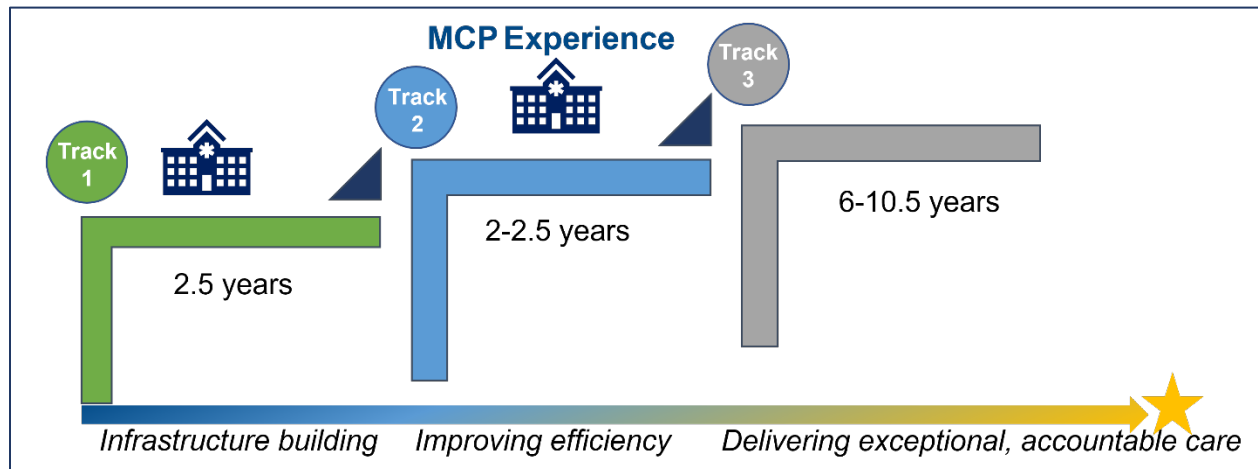
MCP’s progressive [care delivery](#), [performance assessment](#), and [payment structures](#) will support organizations new to value-based care (entering in Track 1) as they build infrastructure and become proficient at delivering accountable care. Tracks 2 and 3 offer additional entry points for participants with intermediate to advanced experience in value-based care, ready to take on more accountability, and currently provide advanced primary care services. In turn, Track 2 and Track 3 participants will have access to receive increased bonus potential through performance-based payments.

1B. Three Track Approach Overview

MCP has three Tracks (Figure 2), providing opportunities for participants with varying experience in value-based care—from participants new to advanced care delivery to participants with more robust capabilities. Tracks 1 and 2 are progressive, meaning that participants will spend 2 years in Tracks 1 and 2 each before progressing to the next track, with an extra six-month period in their entry Track. Participants who start in Track 1 or 2 will spend the remainder of the model in Track 3 once they finish Track 2, and participants who enter in Track 3 will stay in Track 3.

Figure 2: MCP Progressive Three-Track Approach

This graphic illustrates MCP's three-track approach, and the time participants will spend in each track. Organizations with no experience in value-based care may start MCP in Track 1 for 2.5 years. Organizations that are experienced in value-based care may start in Track 2 or 3. Organizations will have an additional 6 months (0.5 years) in their starting Track. An organization entering the model in Track 1 or 2 must remain in that track for the assigned time-period (they cannot move up prior to the end of their Track). Once an organization reaches Track 3, they will stay in that track for the remainder of their participation in the model. Organizations that start in Track 2 or 3 may not "move down" to Track 1 or 2, respectively.



1C. Scope

MCP will be tested over 10.5 years, from July 2024 through December 2034. Performance Year (PY) 1 lasts six months, beginning 7/1/24 when MCP payments, participation, and model requirements begin. Quality and cost [performance assessment](#) begins in Performance Year 2 (PY2- 1/1/25-12/31/25). PY2 and onwards will be assessed in 12-month increments, aligning with calendar years and other annual quality reporting programs.

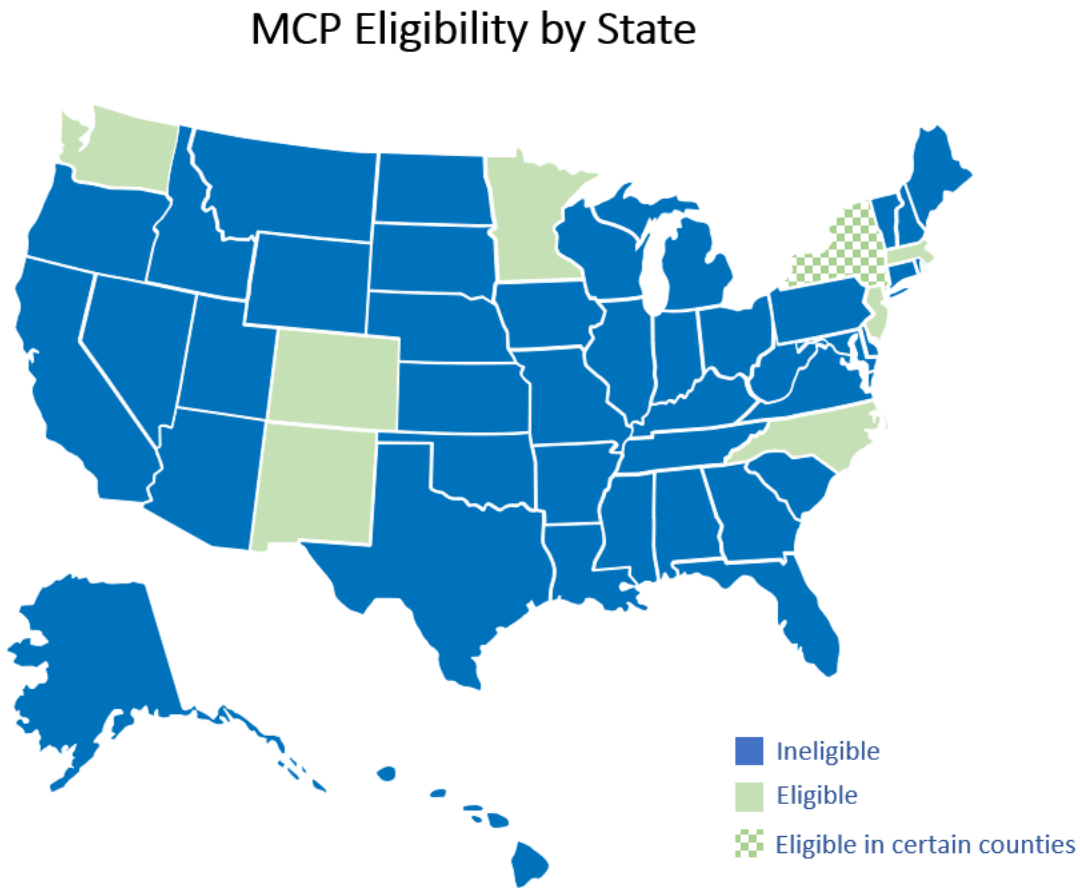
CMS is accepting applications from Medicare-enrolled organizations that provide primary care services to Medicare beneficiaries, including solo primary care practices, group practices, health systems, eligible Indian Health Programs⁸, and FQHCs located in the following states (see Figure 3):

- Colorado,
- Massachusetts,
- Minnesota,
- New Mexico,
- New Jersey,
- upstate New York,⁹
- North Carolina, and

⁸ [Grandfathered Tribal FQHCs](#), which are Indian Health Programs, are not eligible for MCP.

⁹ Please see [Appendix D](#) for zip codes in New York that will be eligible for MCP.

Figure 3: MCP-Eligible States



These states were selected after reviewing criteria related to geographic diversity, health equity opportunity, population, current CMS Innovation Center footprint, generalizability to the rest of the Medicare population for model evaluation, and the ability to align with state Medicaid agencies. Although MCP is a Medicare model, other payers are encouraged to partner with CMS to realize the goals and elements of improved primary care for all patients, including those covered by Medicaid, commercial, and other payers. More information regarding payer partnership is covered in the [Payer](#) section below.

1D. Application and Selection Timing

The application period will open on September 5, 2023, and close on November 30, 2023.

Participants will be selected for the model in early 2024. Onboarding for participants will take place from April - July 2024, with the model beginning in July of 2024.

This RFA serves to provide potential MCP applicants with information regarding model focus and design elements. MCP applications are not legally binding contracts; selected applicants will be required to sign a Participation Agreement with CMS before beginning participation in the model. The Participation Agreement will contain greater detail regarding model requirements and some aspects of the model may be modified as CMS continues to consider stakeholder feedback and operational issues.

2. Eligible Applicants

The following organizations are eligible to apply to participate in MCP: Medicare-enrolled organizations that provide primary care services to Medicare beneficiaries, including solo primary care practices, group practices, health systems, FQHCs¹⁰ and eligible Indian Health Programs.¹¹ Critical Access Hospitals (CAHs) that have selected Standard or Method I billing may apply.¹²

Former CPC+ practices and PCF practices that submitted a withdrawal request before 5/31/23 or were terminated from PCF prior to 5/31/23 are eligible to apply for MCP but will not be eligible for Track 1. ACO REACH Participant Providers that were on a REACH ACO's Participant Provider list as of 5/31/23 are not eligible to apply for MCP.

Please see [Program Overlaps and Synergies](#) for further information on participation in MCP while participating in other programs and Innovation Center models, including the Medicare Shared Savings Program, Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH), Primary Care First and Kidney Care Choices.

2A. Application and Applicant Eligibility Criteria

To be eligible to apply to participate in MCP, an organization must:

- Be a legal entity formed under applicable state, federal, or Tribal law, that is authorized to conduct business in each state in which it operates;
- Be Medicare-enrolled;
- Serve as the regular source of primary care for a minimum of 125 attributed Medicare beneficiaries¹³; and
- Have the majority (at least 51%) of their primary care site(s) (physical locations where care is delivered) located in an MCP state described in the [Scope](#) section.

Applicants that are not FQHCs must also:

¹⁰ As defined at §1861(aa)(4) and 1905(l)(2)(B) of the Act, the term "FQHC" includes certain outpatient clinics associated with tribal/urban Indian organizations in addition to HRSA-designated Health Centers and Look-alikes.

¹¹ As noted in section 2A of this RFA, [Grandfathered Tribal FQHCs](#) are not eligible for MCP.

¹² Critical Access Hospital certification criteria may be found on CMS's website [here](#), and information on the Standard Payment Method (Method I) or Optional Payment Method (Method II) are available [here](#).

¹³ CMS Innovation Center will conduct preliminary attribution as part of the application process to see how many attributed beneficiaries the applicant would have if the model were operating during the application period. Please see the [Attribution](#) section for methodology details.

- Bill Medicare for services furnished by primary care clinicians (MD, DO, CNS, NP, PA) who provide primary care services as part of their job. CMS defines primary care clinicians for the purposes of this RFA as a list of National Plan & Provider Enumeration System (NPPES) specialties that represent “primary care,” including internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, nurse practitioner, clinical nurse specialist, and physician assistant. A full list of NPPES specialties considered primary care are listed below.
- Have primary care services account for at least 40% of the applicant’s collective Medicare revenue for the list of primary care clinicians employed by the applicant.
 - Non-FQHC applicants must identify, in the application, each individual primary care National Provider Identifier (NPI) that renders services under the Taxpayer Identification Number (TIN) of the applicant – otherwise known as the MCP Clinician List.

CMS will accept organizations to participate in MCP based on: 1) whether they meet all applicable eligibility requirements for entry to the model as well as any specific requirements for the Track they applied to (see [Track Selection](#) section); and 2) the results of a program integrity screening.

Note: Clinicians with the following [NPPES codes](#) are eligible to be included on an MCP applicant’s MCP Clinician List. Claims for certain primary care services (defined further in the [Payment Design](#) section) furnished by the clinicians on an MCP applicant’s MCP Clinician List to attributed beneficiaries will be adjusted according to the terms in the Participation Agreement and will be used in the attribution methodology. The following specialties are considered primary care clinicians for purposes of MCP:

Internal Medicine, General Medicine, Geriatric Medicine, Family Medicine, Pediatric Medicine, Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and Physician Assistant (PA). Please note that applicants which employ NPs, CNSs, and PAs that primarily practice under a supervising physician and are listed in specialties *other* than Family Medicine, Internal Medicine, General Medicine, Geriatric Medicine, and Pediatric Medicine should not be included on an applicant’s or participant’s MCP Clinician List. NPs that do not bill under supervising physicians must provide primary care as the majority of their services in order to be included on an applicant’s MCP Clinician List.

Given billing and organizational differences, FQHC applicants will not be required to submit a MCP Clinician List with their applications. FQHC applicants must instead submit a list of all physical practice site (physical location) CMS Certification Numbers (CCNs) that are linked to their Medicare-enrolled TIN when applying to MCP.

Sample application questions, including deadlines and contact information, can be found in [Appendix A](#). Applicants must submit all application materials via an online portal that will become available soon. CMS will provide a link to this portal on the MCP website (<https://innovation.cms.gov/innovation-models/making-care-primary>). It is the responsibility of the applicant to ensure that they include all required information in their application.

[Ineligible Applicants](#)

The following organizations are ineligible to participate in MCP:

- PCF practices and ACO REACH Participant Providers that have not withdrawn or been terminated from either model as of 5/31/23.
- [Grandfathered Tribal FQHCs](#)
- Practices that provide concierge care.¹⁴
- Rural Health Clinics.¹⁵

Please see [Program Overlaps and Synergies](#) for further information on participation in MCP while participating in other Innovation Center models.

2B. Track Eligibility

This section discusses eligibility for each Track of the model. Organizations must select the Track they are applying for when applying to MCP. If an organization is found to be ineligible for the Track they applied for but is instead eligible for another Track, then CMS may offer the organization entry to the other Track. If an organization wants to be considered for Track 1 and the up-front infrastructure payment (UIP), they must apply to Track 1 and indicate that they would like to be considered to receive that payment, as CMS will not retroactively offer applicants entry into Track 1 who did not apply to that Track.

When determining which Track to apply for, potential applicants should also familiarize themselves with the expected participation requirements applicable to each Track (which CMS will finalize in the Participation Agreement), including Track-specific care delivery requirements listed in [Appendix C](#), health IT requirements in [Appendix B](#), [Payments](#) and [Performance Assessment](#).

Track 1

To be eligible for Track 1, applicants must have **no** experience in value-based care.

Experience in value-based care is defined as:

The applicant has participated in performance-based Medicare initiatives (including Primary Care First (PCF), Comprehensive Primary Care Plus (CPC+), Next Generation ACO (NGACO), Direct Contracting, Accountable Care Organizations Realizing Equity Access and Community Health (ACO REACH), AND/OR has been part of a Medicare Shared Savings Program (SSP) ACO that has not deferred its entry into a second agreement period under a two-sided model under [§ 425.200\(e\)](#) in the five most recent performance years prior to the start of the agreement. This

¹⁴ Defined as care provided after a doctor or group of doctors charges a membership fee before seeing or accepting a patient into a practice. After payment of this fee, patients may receive some services or amenities that Medicare doesn't cover. (<https://www.medicare.gov/coverage/concierge-care>)

¹⁵ Rural health clinic (RHC) is a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases and meets all other requirements of 42 CFR 405 and 491. Please note, some organizations have multiple different types of providers enrolled in Medicare under the same TIN. For example, it is common for RHCs to share a TIN with a hospital or health system. MCP does not allow RHCs to participate, so organizations with RHCs under their TIN should consider how MCP's full-TIN policy will apply to their situation.

includes scenarios where 60% or more of the TIN's NPIs or CCNs meet the aforementioned criteria.

CMS will monitor applications to identify new TINs with less than one year of historical claims to determine whether those organizations would be eligible to enter into Track 1 and/or receive the UIP.

Track 2 and Track 3

In contrast to Track 1, applicants for Tracks 2 and 3 may, but do not need to, have experience in value-based care. There are no additional eligibility requirements for Tracks 2 or 3 beyond those listed above for all applicants.

2C. Track Selection

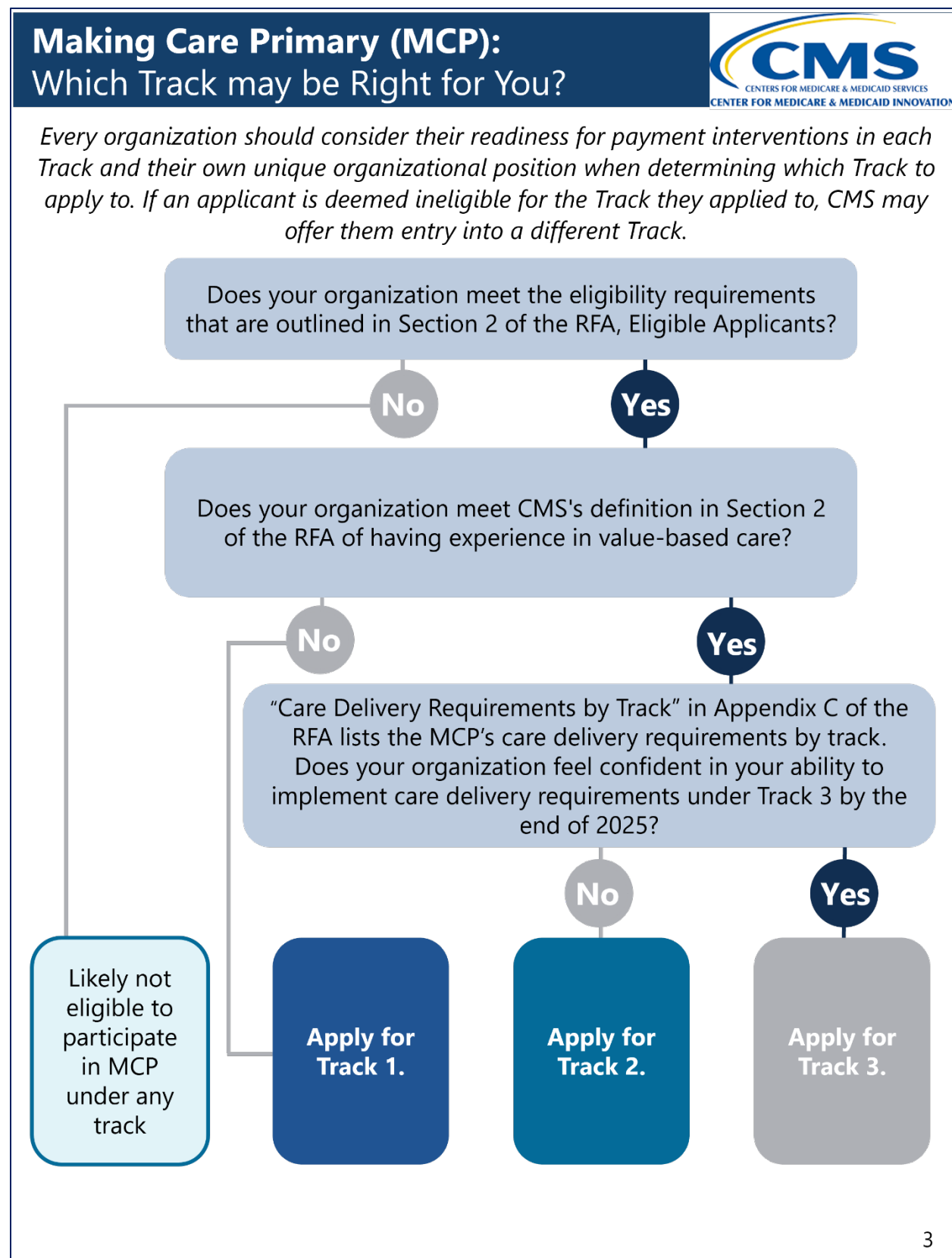
This section discusses what applicants should consider when choosing which Track to apply to. Every organization should consider their own unique organizational position and characteristics when determining which Track to apply to.

Applicants should also consider their readiness to:

- accept payment reforms described in the [Payment Design](#) section, including being assessed on the performance on the measures described in the [Performance Assessment](#) section to drive additional revenue in later Tracks
- meet [Health IT Requirements](#) listed in Appendix B by the date specified for each requirement
- meet the [Care Delivery requirements](#) of the Track you are considering described in Appendix C by the end of 2025

Prior to signing the Participation Agreement, CMS will provide each applicant with information that may support financial modeling for the applicant based on the applicant's attributed population at the time of application. Please note, the projected amounts likely will differ from the amounts in a participant's first quarterly payment as the first quarterly payment will be based on updated attribution prior to the model start.

Figure 4: Track Selection Diagram



3. Model Participants, Specialty Care Partners, and Payers

3A. Model Participants

Upon signing a Participation Agreement (PA) with CMS, an applicant that is selected to participate in MCP will become a “participant.” An individual authorized on behalf of the legal entity participating in MCP will sign the PA.

MCP participation will be defined at the organizational level. For FQHCs, an organization will be defined as a collection of CMS Certification Numbers (CCNs) all enrolled under the same Medicare-enrolled TIN, and non-FQHCs are defined as a single Medicare-enrolled billing TIN. For non-FQHCs, all primary care clinicians under the TIN or CCN (in the case of CAHs) of the participant will be required to participate. For FQHCs, all sites (designated by CCNs) that are part of the same organization will be required to participate.

There will be minor differences in participation requirements for FQHCs and Indian Health Programs (as detailed in “FQHC and Indian Health Program Considerations” subsections throughout this RFA). For the purposes of this RFA, if “participant” is used without any distinction, the policy applies to all participants.

3B. Specialty Care Partners

Beginning in Track 2, participants will be required to work with specialists to improve care coordination processes by identifying Specialty Care Partners; however, Specialty Care Partners are not considered participants. See the [Specialty Care Integration](#) section of MCP’s Care Delivery approach for more information.

Specialty Care Partner Eligibility Criteria

For the purposes of MCP, the term “Specialty Care Partner” is defined as an organization (TIN) that:

- Is Medicare-enrolled and has entered into a Collaborative Care Arrangement (CCA) with a participant;
- Includes clinicians identified via NPI on the participants’ Specialty Care Partner Clinician List;
- Includes clinicians classified as one of the eligible specialty types (included below)

Specialty Care Partner clinicians may not also be listed on an MCP Clinician List.

Specialty care partner clinician specialty types will be identified using the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) classification. This system categorizes specialists using a two-digit identifier. The following is a tentative list of specialties (as described in PECOS) who will be eligible to be added to a Specialty Care Partner List.¹⁶

- | | |
|--|-------------------------|
| • Addiction Medicine | • Medical Oncology |
| • Advanced Heart Failure and Transplant Cardiology | • Nephrology |
| • Allergy/Immunology | • Neurology |
| • Cardiac Electrophysiology | • Neuropsychiatry |
| | • Obstetrics/Gynecology |

¹⁶ This list is considered tentative - CMS is conducting data analysis to refine this list. This list and the Specialty Care Partner criteria may evolve over the course of the model.

- Cardiovascular Disease (Cardiology)
- Dermatology
- Endocrinology
- Gastroenterology
- Geriatric Medicine
- Geriatric Psychiatry
- Hematology
- Hematology/Oncology
- Hospice/Palliative Care
- Infectious Disease
- Internal Medicine
- Interventional Cardiology
- Ophthalmology
- Orthopedic surgery
- Pain Management
- Peripheral Vascular Disease
- Physical Medicine and Rehabilitation
- Psychiatry
- Pulmonary Disease
- Rheumatology
- Sleep Medicine
- Sports Medicine
- Urology

3C. Payers

CMS will partner with payers to align incentives across a participant’s patient population and facilitate effective practice transformation. For example, CMS will partner with state Medicaid agencies in states where MCP will be tested to ensure the model supports access to advanced primary care across their populations and to align on quality measurement, data provision, and learning priorities. CMS also seeks to partner with other payers in MCP states—including Medicare Advantage organizations, commercial health insurers (including their self-insured business), and Medicaid managed care. All payers will be eligible to partner with CMS in MCP regardless of their involvement in other CMS Innovation Center models.

MCP will balance prioritizing alignment on key model principles while encouraging payers to tailor other aspects of MCP to their own covered population. While CMS does not expect payers to build an identical program to MCP, it is critical to closely align with payers on aspects of the model that directly reduce clinician burden, such as:

- quality measurement
- type and format of provided data
- learning priorities, and
- moving away from FFS payment for medical services.

The benefits of payer partnerships with MCP include:

- **Collaboration and alignment with Medicare** to implement an evidence-based transformation model that helps practices provide more comprehensive, integrated, and whole-person care.
- **A unified movement with other payers for value**, to achieve shared goals that increase clinician incentives to improve patient outcomes, while reducing clinical and administrative burden, and ensuring continuity across the coverage and care continuum.
- **Goal-oriented and data-driven convening with other payers** at the state and national level to share lessons learned and work towards consensus on payment approaches.
- **Improved data provision to practices**, with a long-term goal of aggregating data across payers.

Additional information regarding MCP payer partnership is available at the MCP model website, located at <https://innovation.cms.gov/innovation-models/making-care-primary>. Payers interested in partnering with CMS to pursue the goals of MCP will be asked to submit preliminary information on their aligned plan design in late 2023 to facilitate engagement on future alignment. More details will be posted on the MCP model website soon. Please contact CMS at MCP@cms.hhs.gov for more information on partnering in MCP.

4. Care Delivery Design

MCP will focus on building participant capacity to deliver equitable, team-based care and improve outcomes over time on key metrics like hypertension and diabetes control, depression, emergency department (ED) visits, and total cost of care. Care delivery will align to the MCP [Performance Measure Set](#), used to measure progress towards integrated, high-quality primary care.

The MCP care delivery approach focuses on person-centered care delivery transformation through three domains: Care Management, Care Integration, and Community Connection, with specific care delivery requirements organized under each domain.

- **Overall, in Track 1** participants will build the foundation to implement advanced primary care services through activities such as risk-stratifying their population, developing workflows for care management, chronic disease management, and behavioral health and HRSN screenings.
- **Overall, in Track 2** participants continue to meet the requirements of Track 1 while also expanding and integrating the services available to their patients (e.g., once patients are risk stratified and care management workflows established, implementing chronic care management for high-risk patients).
- **Overall, in Track 3** participants will continue to meet and build upon the requirements of Tracks 1 and 2, to further optimize and expand care delivery and specialty care integration (e.g., once patients are risk stratified, chronic care management for high risk patients is established, taking this further and ensuring there are individualized care plans for all high risk patients aligned to their chronic health needs as well as linkages to community-based supports).

All MCP care delivery requirements must be met at the practice-level (or, for participants with multiple sites, at each individual site). Given that MCP participation will be defined at the TIN level, this ensures participants with multiple sites will provide access to MCP-facilitated care delivery services to all patients attributed to an organization. After the first 12-month performance year in each Track, participants will be required to demonstrate that they are meeting the care delivery requirements in their respective Track or must have a comprehensive strategy for implementing those requirements in the following performance year.

Participants must meet the care delivery requirements in their starting Track by the end of PY2 (12/31/25). Participants will be required to report to CMS information on their care delivery capabilities

and progress at least bi-annually for Tracks 1 and 2, and at least annually for Track 3, and will be subject to other documentation requirements. See [Appendix C](#) for a complete description of the MCP care delivery requirements by Track.

4A. Care Management Domain

Participants will be required to build their care management and chronic condition self-management support services, placing an emphasis on preventing and managing chronic diseases such as diabetes and hypertension, and reducing unnecessary emergency department (ED) use and total cost of care. Furthermore, as most Medicare beneficiaries have multiple chronic conditions, frailty, and their risk factors as participants are encouraged to increase their capacity and competencies to deliver integrated, coordinated, whole-person care.

- **Track 1** participants will empanel and risk stratify patients, identify staff and workflows for chronic and episodic care management, identify staff and workflows for chronic condition self-management support services.
- **Track 2** participants will implement chronic and episodic care management, and chronic condition self-management support services
- **Track 3** participants will offer individualized care plans, expand chronic condition self-management support services to include group education and linkages to community-based supports

4B. Care Integration Domain

MCP will require participants to strengthen their connections with specialty care and increase their capacity to manage behavioral health conditions to better support beneficiaries. This domain aligns with the MCP performance assessment strategy of rewarding improved behavioral health outcomes and reduced total cost of care.

Behavioral Health Integration

Behavioral health integration is an essential part of whole-person care that improves health outcomes and patient experience while also reducing costs and treatment delays.¹⁷ Through measurement-based care, utilizing evidence-based screening and evaluation tools and patient data to inform treatment decisions, participants will offer integrated behavioral health services to their patients.¹⁸

- **Track 1** participants will identify staff and develop workflows using measurement-based care¹⁹ to deliver behavioral health services to patients

¹⁷ Agency for Healthcare Research and Quality (n.d.) *What is Integration Behavioral Health?*

<https://integrationacademy.ahrq.gov/about/integrated-behavioral-health>

¹⁸ American Psychological Association (2022) *Measurement-based care*. <https://www.apaservices.org/practice/measurement-based-care>

¹⁹ Measurement-based care is the systematic monitoring of patient outcomes through the use of standardized measurement instruments and the analysis of measurement data to inform clinical decision-making. The Joint Commission (2022). *Outcome Measures Standard*. <https://www.jointcommission.org/what-we-offer/accreditation/health-care-settings/behavioral-health-care/outcome-measures-standard/>

- **Track 2** participants will implement their planned behavioral health integration approach and begin systematically screening patients for behavioral health conditions including depression and substance use disorder (participants must screen for these conditions, but may choose to screen for additional behavioral conditions)
- **Track 3** participants focus on optimizing behavioral integration workflows, using the tools and resources gained throughout MCP

Specialty Care Integration

MCP aims to facilitate coordinated partnerships between MCP primary care clinicians and high-quality specialists to improve consultation, care coordination, and where needed, time-limited co-management processes for shared patients. Beneficiaries are free to receive services from any specialist according to typical coverage requirements, and MCP will not restrict their freedom of choice of providers; however, MCP will provide payments, tools, and resources meant to promote high-quality specialty care integration.

MCP's progressive approach from Track 1 to Track 3 aims to progressively improve the coordination between participants and their Specialty Care Partners through improved data, tools, communication, and payment, eventually facilitating patient co-management between primary and specialty care.

Specialty care integration features by Track:

- **Track 1** participants will use specialist performance data to inform the selection of high-quality Specialty Care Partners in the region
- **Track 2** participants will identify high-quality Specialty Care Partners, establish collaborative care arrangements (CCAs), and access a new primary care e-Consult code
- **Track 3** participants will enhance Specialty Care Partner relationships and introduce a new time-limited ambulatory co-management code for specialists

Track 1

In Track 1, participants will use data to better understand the performance of specialists in their region/ service area. As part of a broader CMS Innovation Center specialty care strategy, CMS will provide participants with measures on utilization, cost, quality, and may in the future provide data on low-value care and appropriateness of care. This data will be based solely on Medicare claims data, with a goal of expanding to include additional payer data through the state-based learning systems. Such information will help participants select high-quality specialists as Specialty Care Partners in Tracks 2 and 3.

Track 2

Beginning in Track 2, participants are required to work with specialists to improve care coordination processes. Participants must identify at least one Specialty Care Partner, execute a collaborative care arrangement (CCA), and submit their initial Specialty Care Partner List to CMS by the end of the first 12-month performance year in Track 2 (12/31/25 for participants starting in Track 2). CMS will provide participants with a system for list submission. Lists must be reviewed and updated annually by

participants to ensure Specialty Care Partners are meeting the requirements and expectations outlined in their CCAs.

Non-FQHC and non-Indian Health Program participants (only) will be required to partner with at least one clinician among the following specialties: cardiology, orthopedics, or pulmonology. These identified specialties both represent large shares of traditional Medicare spending and have common clinical conditions for which improved access to specialty care may impact Part A and Part B spending. As noted below, only one total partnership is required. MCP will not specify the specialty area for FQHC and Indian Health Program participants given their different access needs to specialty care.

While only one total partnership is required, participants can establish relationships with as many Specialty Care Partners as they like, as long as there is at least one from one of the identified specialties of cardiology, orthopedics, or pulmonology (for non-FQHCs and non-Indian Health Programs).

See [3B. Specialty Care Partners](#) for more detailed eligibility criteria for Specialty Care Partners.

Collaborative Care Arrangements

Participants will be required to execute their own Collaborative Care Arrangements (CCAs) in Tracks 2 and 3 with Specialty Care Partners, which will formalize the business and clinical relationship parameters between participants and Specialty Care Partners during periods of collaboration and co-management.

Specifically, the CCAs must address the following requirements:

1. Establish communication and data-sharing protocols for shared MCP-attributed beneficiaries;
2. Establish expectations for when a patient should be handed off back to the primary care clinician (if necessary) and what should occur;
3. Establish parameters for coordinating care in order to improve quality of care and prevent unnecessary utilization;
4. Establish general (not condition-specific) expectations for co-management of MCP-attributed beneficiaries between the specialty partner physicians furnishing the MCP-specific [Ambulatory Co-Management \(ACM\) service](#), which will become available in Track 3, and the MCP participant; and
5. In terms of the clinical relationship parameters, every CCA must ensure all parties involved in a beneficiary's care understand their role and expectations. Improving specialty communication and coordination is a specific transformational goal of the MCP model—and, as such, participants will be required to use CCAs to ensure progress toward the desired outcome.

CCAs may be subject to CMS audit and CMS will prescribe certain safeguards to govern CCAs. CMS will set parameters around policy goals that should be addressed in the CCA, such as improved access, coordination, and response time. Details on CCA requirements will be included in the MCP Participation Agreement, to be signed after applicants are accepted into the model and before the model begins. The participant will have the flexibility to determine additional expectations with their partners, which may include additional specificity around communication timeliness, parameters for access, transitions of care, and other care coordination components.

MCP e-Consult (MEC) Code

Beginning in Track 2, participants will have access to a new MCP e-Consult code (MEC) (described in the [Payment](#) section) for all MCP-attributed beneficiaries. This code was designed to address barriers to utilizing current e-consult and fee-for-service (FFS) Interprofessional Consult (IPC) codes, including capturing time spent obtaining and implementing specialist recommendations. These codes will be restricted to participants, and not the Specialty Care Partners, as the barriers to e-consult billing have been experienced principally by the requesting physicians.

Participants are permitted to share a portion of the [Performance Incentive Payment \(PIP\)](#) with their Specialty Care Partners; however, this is not required.

Track 3

In Track 3, participants are expected to review and update their Specialty Care Partner Lists and review their CCAs to ensure expectations are being met while engaging in annual quality improvement (e.g., Plan-Do-Study-Act (PDSA) cycles) to optimize workflows and care coordination processes with specialists. Specialty Care Partners who are on the participant's Specialty Care Partner Lists (and have a CCA in place) will be eligible to furnish a new MCP-specific service—see [Ambulatory Co-Management \(ACM\) section](#)—for time-limited, co-management on shared patients in Track 3. This new service is intended to support ongoing communication and collaboration of a shared patient who requires both longitudinal primary and specialty care but where there may be more intense collaboration needed for a short time to stabilize an exacerbated chronic condition. When Specialty Care Partners furnish the ACM service, they will be establishing themselves as co-managers of the condition.

4C. Community Connection Domain

To help address health disparities and unmet social needs, MCP participants will be required to identify and address health-related social needs (HRSNs) in their patient populations, and also help patients navigate to community supports and services. Additionally, the Community Connection Domain requirements will help participants meet their health equity plan goals and reduce disparities among their patient populations.

Track 1: Implement universal HRSN screening and resources based on screening results; develop workflows for referring beneficiaries with unmet HSRNs to social service providers (i.e., community-based organizations (CBOs) and/or public health organizations); explore partnerships with social service providers; and identify staff to deliver high-impact services to support populations with disparate outcomes in key health conditions and indicators (e.g., hypertension, diabetes, HRSNs).²⁰ These staff members may include community health workers (CHWs) or equivalent professionals with shared lived experience. Staff (a CHW or equivalent professional with shared lived experience) does not need to be employed by the MCP participant. For example, participants may utilize existing navigators in community-based organizations. However, the identified resource must assist all referred beneficiaries.

²⁰ High-impact services refer to evidence-based, cost-effective, and scalable interventions which reduce disparities and/or disease burden. Centers for Disease Control and Prevention (2019). *High-Impact Prevention*.

Track 2: Implement social service referral workflows, establish partnerships with social service providers, and utilize a CHW (or equivalent staff) in supporting high-need beneficiaries.

Track 3: Optimize social service referral workflows, strengthen partnerships with social service providers, and optimize the use of CHWs/equivalent staff.

5. Health Equity Strategy

The CMS Innovation Center believes that equitable care is a key component to achieving high-quality care for Medicare beneficiaries and is therefore critical to MCP's success. CMS defines health equity as: "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."²¹ The term "underserved communities" refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life.²²

MCP includes several model components designed to improve health equity:

- Certain payments are adjusted by clinical indicators and social risk of beneficiaries (see the [Payment](#) section)
- Requirement for participants to develop a strategic plan for how they will identify disparities and reduce them (see the [Health Equity Plan Requirement](#))
- Requirement for participants to implement HRSN screening and referrals (see the Community Connection domain in [Care Delivery](#))
- Opportunity for participants to reduce cost-sharing for beneficiaries in need (see the [Cost Sharing Reduction Program](#))
- Use of the Screening for Social Drivers of Health quality measure for participants to assess the percent of patients screened for HRSNs (see the [Performance Assessment](#) section)
- Collection of data on certain demographic information and HRSNs to evaluate health disparities in MCP communities (see the [Health Equity Data Collection Requirement](#))

5A. Health Equity Plan Requirement

Participants will be required to develop and implement a Health Equity Plan based on the [CMS Disparities Impact Statement](#). The purpose of a Health Equity Plan is for each participant to identify disparities in outcomes in their patient populations and implement initiatives to measure and reduce these disparities over the course of the model.

Participants will develop a Health Equity Plan and report on progress to CMS annually. CMS will provide a template for the Health Equity Plan and the requirements regarding the content and use of the Health Equity Plan will be described in the MCP Participation Agreement. Participants will be required to report

²¹ <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>

²² <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>

their progress in implementing the goals articulated in their Health Equity Plans. Such reporting requirements include but are not limited to certain health metrics and outcomes resulting from a participant's Health Equity Plan.

5B. Health Equity Data Collection Requirement

MCP will require all participants to collect and report certain demographic data and health-related social needs (HRSN) data on their patients to allow CMS and participants to evaluate health disparities and inequities in MCP communities.

- A) Participants will submit annual demographic data (such as race, ethnicity, geography, disability) for MCP-attributed Medicare beneficiaries at the beneficiary-level to CMS via the MCP Participant Portal. Requirements for submission are aligned to the required Health IT capabilities.
- B) Participants will report HRSN data in aggregate for all patients, regardless of payer, to CMS through the following mechanisms:
 - a. Quality Measure Reporting: The Screening for Social Drivers of Health²³ quality measure assesses the percent of patients 18 years and older who were screened for HRSNs, specifically food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. See the [Performance Assessment](#) section for further information on the process for submitting quality measures for MCP.
 - b. Care Delivery Reporting: Additional HRSN data will be collected as part of Care Delivery Reporting and submitted via the Participant Portal. This includes aggregate data (percent screened positive) for specific HRSNs screening domains (corresponding to the Screening for Social Drivers of Health measure). For example, a participant would report the percentage of patients screened as positive for food insecurity.

Please note that beneficiary submission of HRSN data or demographic information is voluntary and participants should not impose on the beneficiaries they serve any requirement to report such information to the MCP organization if the beneficiaries choose not to report it. For more information on health equity data collection, see the [Data Sharing](#) section.

6. Performance Assessment

MCP emphasizes whole-person care by including a diverse set of performance measures that are aligned with the MCP care delivery requirements. The MCP Performance Measure Set provides participants with an opportunity to receive incentive payments via the Performance Incentive Payment (PIP) for demonstrating strong absolute performance in some areas, as well as working to improve in others. This section describes the strategy for selecting the measures, the specifications for each measure, the scoring and benchmarking strategy, and special considerations for individual measures and participants.

Mirroring CMS's broader quality measurement strategy,²⁴ measures were selected to be actionable,

²³ MIPS Quality ID #487.

²⁴ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy>

clinically meaningful, and aligned with measures used in current value-based programs, including the CMS Universal Measure Set²⁵, Quality Payment Program (QPP), MIPS Value Pathways (MVP)²⁶ and MIPS APM Performance Pathway (APP)²⁷ measure sets, and the National Quality Forum (NQF)'s Core Quality Measures Collaborative (CQMC) Primary Care Core Measures²⁸.

6A. Performance Measure Set

MCP has prioritized the following key criteria for selecting performance measures in MCP:

- ***Balance of measures of clinical quality and cost:*** MCP emphasizes whole-person care by including a diverse set of metrics that balance clinical quality, patient-reported outcomes, utilization, and cost.
- ***Quality measure alignment with care delivery:*** MCP's quality measures align with the care delivery requirements (see [Care Delivery](#) section) by track and include measures where even small improvement can yield significant cost and quality improvement over time across common chronic conditions.
- ***Incorporating health equity into performance assessment:*** MCP's measure set includes a measure of health-related social needs and tailors the continuous improvement assessment for FQHCs and Indian Health Programs. In selecting measures, CMS sought to minimize participant burden for reporting and considered feasibility of measure collection for all potential applicants, including alignment with types of health-related social needs collected through HRSA's Uniform Data System (UDS).

See Table 3 below for the proposed MCP Performance Measures by Track. For more information on benchmarking, please see 6B. Scoring and Benchmarking for Performance Measures. Given the length of the model, as new and innovative ways to measure quality and performance become available, CMS may update this measure set in future performance years. Participants in all Tracks will be required to report measures annually.

To support total practice transformation, all non-claims-based measures will be assessed on a participant's total patient population (not just Medicare). Claims-based measures will be assessed on a participant's MCP-attributed Medicare beneficiary population. The measures that are claims-based will be calculated by CMS and do not require practice reporting. Please see the [Health IT requirements](#) for more information on capabilities needed to report quality measures.

²⁵ <https://www.cms.gov/aligning-quality-measures-across-cms-universal-foundation>

²⁶ <https://qpp.cms.gov/mips/explore-mips-value-pathways>

²⁷ <https://qpp.cms.gov/mips/app-quality-requirements?py=2023>

²⁸ https://www.qualityforum.org/CQMC_Core_Sets.aspx

Table 3: Proposed Performance Measures by Track²⁹

The green measures below are assessed on an all-payer patient population and the orange measures represent claims-based measures assessed on MCP-attributed Medicare beneficiaries only.

Focus	Measure ³⁰	Steward (ID, if applicable)	Mode	Track			Unit of Measure	MCP Benchmark
				1	2	3		
Chronic Conditions	Controlling High Blood Pressure+*	NCQA (CMS165)	eCQM	X	X	X	All Payer	MIPS (National)
	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)+*	NCQA (CMS122)	eCQM	X	X	X		MIPS (National)
Wellness and Prevention	Colorectal Cancer Screening+*	NCQA (CMS130)	eCQM	X	X	X		MIPS (National)
Behavioral Health	Screening for Depression and Follow-up Plan+*	CMS (CMS2)	eCQM		X	X		MIPS (National)
	Depression Remission at 12 months*	MN Community Measurement (CMS159)	eCQM		X	X		MIPS (National)
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	American Board of Family Medicine (ABFM) and Larry A. Green Center	CQM, survey vendor, or CMS-fielded	X	X	X		Not applicable (reporting only for first two years)
Health Equity	Screening for Social Drivers of Health ³¹⁺	CMS (Quality ID#487)	TBD		X	X		TBD
Cost	Total Per Capita Cost (TPCC)	CMS	Claims		X	X	MCP-attributed Medicare beneficiaries	Regional
Utilization	Emergency Department Utilization (EDU)	NCQA	Claims		X	X		Regional
Continuous Improvement	TPCC Continuous Improvement (<i>non-FQHCs and non-Indian Health</i>)	CMS	Claims**		X	X		Participant-level TPCC score in previous year

²⁹ CMS will reserve the right to amend the MCP Performance Measure Set as specified in the participation agreements, including scenarios where such amendments facilitate alignment with future CMS-wide quality measure alignment initiatives, such as the Universal Measure Set.

³⁰ Certain measures proposed in the 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://innovation.cms.gov/notices-disclaimers>

³¹ Screening for Social Drivers of Health (Quality ID#487) is a new, evolving measure focused on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure specifications are currently under development and CMS will work with participants to ensure they have the appropriate health IT infrastructure information to successfully report this measure.

	<i>Programs only)</i>							
	EDU Continuous Improvement (FQHCs and Indian Health Programs only)	CMS	Claims**		X	X		Participant-level EDU score in previous year

+ Included in the [CMS Universal Foundation Measure Set](#).

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

** Internal measure of statistically significant improvement.

Individual Measure Considerations

Screening for Social Drivers of Health: The Screening for Social Drivers of Health measure is a new, evolving measure focused on assessing the percent of patients screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. The measure specifications are currently under development and CMS will work with participants to provide technical assistance on best practices for workflow and health IT infrastructure to successfully report this measure.

PCPCM: As required for all measures in the measure set, participants will be assessed on their PCPCM performance beginning in PY2 (1/1/25 – 12/31/25). For Track 1 participants, CMS will fund and manage the administration of the PCPCM Survey for PY2 and PY3. For Tracks 2 and 3, participants will administer the PCPCM survey, beginning in PY2, by contracting directly with an approved third-party intermediary to field the survey. All participants will be asked to submit a patient roster by a date and in a manner specified by CMS. The PCPCM survey will be fielded (i.e., data collected and reported) for all MCP participants, but the PIP will *not* be contingent on a participant's PCPCM results for PY2 and PY3, as CMS intends to assess the survey's implementation feasibility among participants, and its validity and reliability, before determining how the measure will be incorporated into scoring (or considering a new patient-reported survey tool).

TPCC: The TPCC measure is claims-based and does not require participant reporting. The TPCC measure is a payment-standardized, risk-adjusted, and specialty-adjusted cost measure focused on clinicians and clinician groups performing primary care services. Specifically, the measure is an average of 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 quarter. When calculating the TPCC measure, any additional model payments provided to MCP participants will not count toward the MCP participant's TPCC scores. Enhanced Services Payments (ESP), Performance Incentive Payments (PIP), and Upfront Infrastructure Payments (UIPs) will also not count as costs for the purposes of calculating TPCC. The benchmark for TPCC will include MCP-participating and non-participating TINs in the region.

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 1 represents greater-than-expected cost,

and a ratio less than 1 represents lower-than-expected cost. TPCC is an inverse measure; lower performance scores reflect better quality.

FQHC and Indian Health Program Considerations

FQHCs and Indian Health Programs will be assessed on the same clinical quality, cost, and utilization measures as non-FQHC and non-Indian Health Program participants, except for the continuous improvement (CI) measure, which will be measured on EDU CI, rather than TPCC CI.

While FQHCs and Indian Health Programs may have better absolute performance on TPCC at baseline, this may be due to lack of access to care, and TPCC CI may be harder for these participant types to achieve given historical evidence from the Innovation Center's FQHC Advanced Primary Care Practice Demonstration. From the demonstration's evaluation, CMS found that increased access to care resulted in increased primary care spending, making TPCC CI difficult for FQHCs to achieve. This is why EDU CI was selected for these participant types.

6B. Scoring and Benchmarking for Performance Measures

CMS will use benchmarks for each measure to inform scoring and payment for the Performance Incentive Payment (PIP). MCP will use national benchmarks for all electronic Clinical Quality Measures (eQMs) and the Screening for Social Drivers of Health measure and regional benchmarks for utilization and cost measures (EDU and TPCC). This will hold all participants to the same quality standard for clinical care, while recognizing geographic differences and considerations for utilization and cost data. It also incorporates the historical precedent of recognizing the value of including both regional and national standards when assessing performance. As noted above, MCP participants will be required to submit PCPCM data for PY2 and PY3, but their performance incentive will not be contingent on PCPCM results for those first two years.

MCP's scoring and benchmarking structure allows participants to achieve tiered levels of success by providing stepped incentives via lower and upper thresholds for receipt of Performance Incentive Payments. Lower thresholds (to receive partial credit) and upper thresholds (to receive full credit) are set for the clinical quality, cost, and utilization measures. The lower threshold is set at the 50th percentile while the upper threshold begins at the 70th percentile in Tracks 1 and 2, then progresses to an 80th percentile threshold in Track 3 to incentivize performance improvement over time. When measuring continuous improvement for TPCC or EDU, participants will be assessed against their own improvement from the previous year. For more information on scoring and benchmarking, see the [Performance Incentive Payment](#) section.

7. Attribution

Eligible Medicare beneficiaries will be prospectively attributed to a participant, who will receive model-specific payments for that beneficiary and be held accountable for their quality outcomes. Attribution is first determined by CMS based on the beneficiary's chosen alignment to a clinician in Medicare.gov (Voluntary Alignment). Beneficiaries can select a primary care clinician and the location (including FQHC locations) where they receive care on Medicare.gov. Such a choice will supersede the claims-based

alignment methodology described below for any beneficiary that has chosen a clinician on Medicare.gov. For purposes of attribution, eligible clinicians for non-FQHCs are all primary care clinicians (MD, DO, CNS, NP, PA) billing under the TIN of the participant whose NPI is included on the participant's MCP Clinician List submission; for FQHC participants, this includes all clinicians rendering services under the participating list of CCNs linked to their TIN.³²

If the beneficiary has not chosen a clinician on Medicare.gov, CMS will attribute the beneficiary to the participant if one or more of the participant's eligible clinicians furnished the plurality of the beneficiary's primary care visits and/or eligible Chronic Care Management (CCM) services, or if one of the participant's eligible clinicians billed the beneficiary's most recent claim for an Annual Wellness Visit or a Welcome to Medicare Visit during the most recently available 24-month period. CMS will prioritize Annual Wellness Visits and Welcome to Medicare Visits (before looking to the plurality of claims) because these represent a longitudinal relationship with a clinician. If a beneficiary has an equal number of qualifying visits and eligible CCM services billed by more than one participant, as measured by a discrete count of services, the beneficiary will be attributed to the participant with the most recent visit. This means that CMS attributes beneficiaries and pays prospectively for the next quarter based on retrospective data from the last 24 months, with beneficiary lists provided to participants quarterly.³³

To be eligible for attribution to a participant, beneficiaries must:

1. Receive a qualifying service (one of the services listed in Appendix E) from an MCP clinician during the look-back period (the most recent 24 months);
2. Have both Medicare Parts A and B;
3. Have Medicare as their primary payer;
4. Not have end stage renal disease (ESRD) or be enrolled in hospice at the time of initial attribution;
5. Not be covered under a Medicare Advantage or other Medicare health plan;
6. Not be institutionalized;
7. Not be incarcerated;
8. Not be aligned or otherwise attributed to an entity participating in a model that includes an opportunity to share in savings under Medicare FFS or in any other model that CMS has specified in the model overlap policy;
9. Reside in one of the states selected for this model; and

³² As in CPC+ and PCF, we will define a list of National Plan & Provider Enumeration System (NPPES) specialties that represent "primary care," including internal medicine, general medicine, geriatric medicine, family medicine, pediatrics, nurse practitioner, clinical nurse specialist, and physician assistant.

³³ Prospective attribution and payment assume that all attributed beneficiaries continue to be eligible for the entire quarter. However, some beneficiaries become ineligible before or during the quarter, for example, if the beneficiary loses Part A or Part B coverage, joins a Medicare Advantage plan, loses Medicare as the primary payer, becomes incarcerated, becomes long-term institutionalized, or dies before or during the payment quarter. A participant will not be eligible to receive the ESP or PPCP for attributed beneficiaries not meeting MCP eligibility criteria on the first day of a month. To account for this, in each quarterly payment cycle, CMS determines whether a beneficiary lost eligibility during the previous four quarters and computes a deduction from the upcoming quarter's payment to reflect previous overpayments. If a participant leaves the model and CMS determines that it made overpayments to the participant for previously attributed beneficiaries, a demand letter will be sent to the participant notifying them of the model debt they must repay to CMS.

10. Not have elected Medicaid Health Home services.

For all beneficiaries who meet the criteria above, CMS will assess any selections they have made in Medicare.gov and claims with qualifying CPT and HCPCS codes will be selected for the look-back period (the most recent 24 months) when the physician or clinician specialty is internal medicine, general medicine, geriatric medicine, or family medicine.

CMS will provide each participant with a list of its attributed Medicare beneficiaries prior to the start of the model and on a quarterly basis thereafter. In addition, CMS will run the beneficiary attribution algorithm every three months and will provide reports to the participant within 15 business days of the end of the look-back period (the most recent 24 months). To align with the claims-based processes, CMS will also assess voluntary beneficiary alignment in Medicare.gov every three months.

Attributed beneficiaries will retain their freedom of choice of providers under Medicare and may receive services from providers other than the participant they are attributed to or their Specialty Care Partners. Although CMS will only provide payment for participants' Medicare FFS population, all patients served by participants, including those enrolled in commercial plans, Medicare Advantage, Medicaid, and the uninsured, can benefit from enhanced care delivery as a result of the MCP model. Commercial, Medicare Advantage, and state Medicaid agency payer partners may attribute patients to their MCP-aligned program using their own attribution methodology.

8. Payment Design

MCP will introduce six (6) payment types that will support the model's care delivery and quality improvement goals. Table 4 summarizes the different payment types and purposes, and the following sections describe the different payment types in detail. Table 5 highlights which payments apply in which track.

Table 4: MCP Payment Type and General Purpose

Payment Recipient	Payment Type	General Payment Purpose
Primary Care Participant	Upfront Infrastructure Payment (UIP) for Infrastructure Building	A time-limited, lump sum infrastructure payment for eligible Track 1 participants. This start-up financial support is for health IT investments, such as connecting with health information exchanges (HIE), e-consult technology investments, patient health data systems (i.e., patient portals), event notification systems, or EHR interfaces, which are not otherwise billable under Medicare FFS.

Payment Recipient	Payment Type	General Payment Purpose
	<u>Enhanced Services Payment</u>	A per beneficiary per month (PBPM) payment, adjusted to reflect the attributed population's risk level with a higher payment for beneficiaries at the highest levels of clinical and social risk. These payments, for participants of all Tracks, will be paid prospectively on a quarterly basis, and are intended to fund ongoing care management activities described in the <u>Care Delivery</u> section with respect to MCP beneficiaries.
	<u>Prospective Primary Care Payment</u>	PPCP payments are made quarterly and are based on the historical primary care spending for each participant's attributed beneficiary population. 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 participants receive a hybrid payment consisting of partial Prospective Primary Care Payment (PPCP) with reduced FFS payments. Track 3 participants receive an alternative to FFS payment made up of full PPCP and certain FFS payments are not paid.
	<u>Performance Incentive Payment</u>	Opportunity for a positive adjustment to the sum of FFS amounts and Prospective Primary Care Payments (PPCP) to each participant (all Tracks) for PPCP Services based on performance on the MCP Performance Measure Set.
	<u>MCP e-Consult (MEC)</u>	Participants in Track 2 will be eligible to bill an e-consult code that is unique

Payment Recipient	Payment Type	General Payment Purpose
		to MCP. This code will also be included in the list of PPCP services for Track 3.
Specialty Care Partner	<u>Ambulatory Co-Management (ACM)</u>	Specialty Care Partner physicians that partner with participants in Track 3 will be eligible to bill a short-term coordination code focused on communication and collaboration that is unique to the MCP model.

Table 5: MCP Payments by Track

Payment	Track		
	1	2	3
<u>Upfront Infrastructure Payment (UIP) for Infrastructure Building</u>	X		
<u>Enhanced Services Payment (ESP) for Participant Investment</u>	X	X	X
<u>Prospective Primary Care Payment (PPCP)</u>		X	X
<u>Performance Incentive Payment (PIP)</u>	X	X	X
<u>MCP e-Consult (MEC)</u>		X	
<u>Ambulatory Co-Management (ACM)</u>			X

8A. Payment to Support Advanced Primary Care Delivery

Upfront Infrastructure Payment (UIP)

CMS will provide upfront infrastructure payments (UIPs) to eligible Track 1 participants. Subject to certain limitations, participants will have flexibility to use these funds within three specified categories of allowable uses. Examples of permitted uses within the three categories:

- 1) Increased staffing. Examples include hiring nurse case managers or other relevant support staff to implement screening for SDOH; hiring community health workers, certified peer recovery specialists, other health care professionals with training in delivering culturally and linguistically tailored services; hiring behavioral health clinicians and case managers to integrate behavioral health treatment into the primary care setting; or encouraging partnerships with healthcare systems and local, community-based organizations (such as Area Agencies on Aging, Aging and

Disability Resource Centers, and Centers for Independent Living)³⁴ to increase organizational capacity to identify and address SDOH and connect individuals with culturally and linguistically tailored, accessible health care services, supports, and information at an appropriate literacy level.

- 2) SDOH strategies. Examples include developing or securing transportation services; housing-related services to address housing insecurity or homelessness; home or environmental modifications to support a healthy lifestyle; legal aid services to help patients' address social needs; employment-related services; food-related services; utilities-related supports; services to support personal safety; services to reduce social isolation; services to help patients cope with or address financial strain or poverty; patient caregiver supports; providing remote access technologies, telemonitoring, and meals; ensuring individuals are able to access culturally and linguistically tailored, accessible health care services and supports that meet their needs; partnering with community-based organizations to address SDOH needs; or 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.
- 3) Health care infrastructure. Examples include investment in certified electronic health record technology (CEHRT) (including system enhancements and upgrades, as necessary, to meet Health IT requirements by dates listed in the RFA); expansion of health IT systems to include patient health data systems (e.g., patient portals), e-consult technology investments, event notification systems or EHR interfaces, telehealth systems for video visits, and/or data warehouse capabilities; connections to clinical data registries and networks that support health information exchange across disparate providers and systems involved in patient care (e.g., event notification systems or EHR interfaces);³⁵ integration of participant systems including tools to share and analyze operational and quality data, remote access technologies, telemonitoring, screening tools, case management or practice management systems to improve care coordination operations across the health and social care continuum; develop infrastructure that would enhance sociodemographic data collection; physical accessibility improvements; or tools to further integrate behavioral health into primary care settings.

CMS will pay these funds to participants with a goal of engaging organizations new to value-based care and ensuring that their infrastructure can support the transformational goals of the model.

The goal of the UIP is to help participants with less access to capital participate in and be successful in MCP. CMS recognizes that start-up and ongoing annual operating costs will vary greatly between

³⁴ Any such arrangement must comply with all applicable laws and regulations, including the fraud and abuse laws.

³⁵ CMS encourages applicants to review the recently released Trusted Exchange Framework and Common Agreement (TEFCA) and comments from the request for information in the CY 2023 PFS proposed rule, which included discussion about how connecting to entities exchanging information under TEFCA could help to support health information exchange for a variety of use cases that may be relevant to participants. For more information:

<https://www.healthit.gov/topic/interoperability/policy/trusted-exchange-framework-and-common-agreement-tefca>.

participants for various reasons, including those related to the experience, size, and funding available to the participant.

Eligibility for the UIPs will be based on both a participant's prior experience with value-based payment (the criteria to enter Track 1) and the participant's revenue (as a proxy for assessing the degree to which participants may have access to capital).

To be eligible for UIPs, a Track 1 participant must either:

- Not have an e-consult technology solution (based on self-reported information submitted to CMS); or
- Meet the "low revenue" threshold of 35%: We will assess whether a participant meets the definition of "low revenue" by calculating the participant's within-TIN Part A + Part B revenue and dividing it by the total Part A + Part B spending for the participant's attributed beneficiaries.³⁶ Participants that have a result which is less than 35% will meet the low revenue threshold criteria and will be eligible for the UIP.

An e-consult technology solution is inclusive of phone, video, or a HIPAA-compliant application, platform, or EHR enhancement that allows two-way communication between primary care clinicians and specialists and can securely share patient records.

Eligible Track 1 participants will receive start-up UIP funds in two lump sums—an initial \$72,500 will be partially distributed as a lump sum at the start of the model, after spend plans have been collected and approved, and the remaining \$72,500 will be paid as a lump sum one year later.

CMS will monitor the spending of UIPs to prevent funds from being misdirected or used for activities that are not permitted (to be defined in the Participation Agreement). Eligible participants will be required to submit a spend plan setting forth anticipated spending prior to receiving the UIP and then, during their Track 1 participation, annually report (in a standardized format specified by CMS) an itemization of how any UIPs were actually spent during the year, including expenditure categories, the dollar amounts spent on the various categories, any changes to the spend plan, and such other information as may be specified by CMS. This itemization will include expenditures not identified or anticipated in the submitted spend plan, and any amounts remaining unspent. If an applicant qualified for the UIP based on their lack of an e-consult technology solution, they will be required to include an e-consult technology solution in their spend plan in order to receive the UIP. Any UIPs that are spent for unauthorized purposes or are unspent at the end of the participant's 30-month Track 1 participation period must be repaid to CMS.

Participants will be required to retain adequate records to ensure that CMS has the information necessary to conduct appropriate monitoring and oversight of use of UIPs (for example, invoices, receipts, and other supporting documentation of UIP disbursements). CMS will conduct audits annually to monitor and assess a participant's use of UIPs and participant compliance with other MCP model

³⁶ CMS will assess using the 24-month historical claims period from December 2021 to December 2023. CMS will make UIP eligibility determinations for accepted participants prior to MCP Participation Agreement execution in Spring 2024.

requirements related to such payments. To encourage speedy resolution of noncompliance and provide an added safeguard against abuse, CMS will require the participant to repay all UIPs it received from CMS and may terminate distribution of a participant's UIP and/or take additional remedial actions, if CMS determines that a participant has spent UIP funds on a prohibited use, has unspent funds at the end of the Track 1 participation period, and/or otherwise fails to comply with UIP requirements. If the participant withdraws or CMS terminates its participation prior to entering the Track 3 participation period, the participant may be required to repay all UIPs it received to CMS.

Enhanced Services Payment (ESP)

In order to support participants with resources required to provide the care described in our [Care Delivery](#) section, CMS will pay participants in all Tracks a per beneficiary per month (PBPM) Enhanced Services Payment (ESP) prospectively on a quarterly basis for attributed Medicare FFS beneficiaries. The ESP provides up-front funding to pay for care management, patient navigation, behavioral health, and other enhanced care coordination services. Participants may use the ESP funds to hire dedicated staff (e.g., care managers) to support activities, such as identifying and addressing patients' social needs, and/or to cover costs associated with establishing relationships with external clinicians to facilitate information sharing during care transitions. ESPs are risk-adjusted to ensure participants that serve more high-needs beneficiaries receive proportionally more resources. As participants progress through Tracks, this additional support gradually shifts in form from an ESP to a [Performance Incentive Payment \(PIP\)](#), with increasing opportunity for payment enhancement as well as accountability for beneficiary outcomes.

Monthly ESP payments do not require billing Medicare, are prospective in nature, and are based on each participant's MCP attributed Medicare FFS beneficiary population, as detailed in the [Attribution](#) section. However, ESPs are meant to support enhanced care management and other primary care services which overlap with certain covered services under the Physician Fee Schedule and the Medicare FQHC PPS (see [Appendix F](#)). Medicare payment for these services for the same beneficiaries would be duplicative of the ESP and thus participants will not receive normal Medicare FFS payments for such services when furnished to attributed Medicare beneficiaries.

If participants fail to comply with model requirements or meet 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, care delivery, or financial reporting, CMS may require repayment of ESPs.

The ESP must be used to support augmented services³⁷ and training that align with the transformation aims of the care delivery functions that participants are required to perform, as described in the [Care Delivery](#) section. While participants must use the funds to support covered services (such as care

³⁷ ESP funds will be used to support care transformation, behavioral health, telehealth, remote patient management technology, chronic disease management and prevention services, which may include hiring dedicated staff (e.g., care managers) to support activities such as identifying and addressing patients' social needs, as well as covering costs associated with establishing relationships with external providers to facilitate information sharing during care transitions. They may also be

management and care coordination), participants will have flexibility to invest the dollars according to the needs of their attributed Medicare beneficiaries. CMS will monitor spending of these investments and care delivery changes through regular required care delivery and financial reporting.

As participants progress across Tracks, average base ESP amounts decrease by approximately 50% for each corresponding risk tier (e.g., Track 2 ESPs are 50% lower across the board than Track 1 ESPs, and Track 3 ESPs are 50% lower than Track 2 ESPs). Providing the most ESP support in Track 1 maximizes the funding available to support up-front primary care transformation in order to meet care delivery requirements. As described further in the [Performance Incentive Payment \(PIP\)](#) section, while ESPs progressively decrease from Track 1 to Track 3, participants that achieve full PIP potential can maintain the overall maximum revenue available when progressing across Tracks.

ESP Risk-Adjustment

The ESP PBPM amount will vary for each beneficiary based on three factors: (1) whether the beneficiary is enrolled in the Medicare Part D low-income subsidy (LIS), (2) the Area Deprivation Index (ADI)³⁸ score based on the beneficiary's residence compared to a regional reference population, and (3) the beneficiary's most recent CMS-Hierarchical Condition Categories (HCC) risk score. CMS will also adjust ESPs for geographic price differences.³⁹

CMS' use of ADI and LIS status to assess underserved populations allows CMS to consider both broader neighborhood level characteristics and individual characteristics among CMS beneficiaries, and CMS believes that these variables are good identifiers of beneficiaries with high needs. The ADI measure is intended to capture local socioeconomic factors correlated with medical disparities and underservice, while the beneficiary level measure of LIS is intended to capture socioeconomic challenges that could affect a beneficiary's ability to access care.

CMS will incorporate LIS to identify the highest-needs beneficiaries and then stratify all remaining beneficiaries based on ADI and Hierarchical Condition Categories (HCC) scores and then assign payment amounts accordingly. For attributed beneficiaries who are either (1) enrolled in LIS or (2) have a very high HCC score and who reside in an area with very high ADI, the participant will receive a higher fixed ESP amount. As further described in this section, CMS will keep the ESP amount for high-needs beneficiaries consistent over Tracks, which is intended to support participants' increased provision of high-value services for these beneficiaries. Principal care management (PCM), chronic care management (CCM), and transitional care management (TCM) services are considered duplicative of ESPs, and therefore CMS will not pay participants for PCM, CCM, and TCM services furnished to attributed

³⁸ The ADI was defined by a National Institutes of Health (NIH) team and first published in 2003, with the goal of quantifying and comparing social disadvantage across geographic neighborhoods. It is a validated, area-level composite measure that captures local socioeconomic factors correlated with medical disparities and underservice. ADI is derived through a combination of 17 input variables from census data, which are now estimated annually at the "census block group" level through the US Census Bureau's American Community Survey and reported publicly through the Neighborhood Atlas. ADI is a relative measure, typically reported by percentile (1-100) or decile (1-10), with a higher ADI value representing relatively greater socioeconomic deprivation. While ADI can be reported for an individual, it is important to remember that an "individual's ADI" is the ADI of the census block group of their residence, and each individual faces a unique set and degree of social challenges.

³⁹ To account for regional cost differences, MCP will apply a geographic adjustment factor (GAF) to the ESP PBPM amount, which is tied to the Medicare PFS. See <https://www.cms.gov/files/zip/cy-2023-pfs-final-rule-addenda.zip> Addendum E.

beneficiaries during the performance period of the model. For more information about services considered duplicative of ESPs, see [Appendix F](#).

For each beneficiary enrolled in LIS who is in the participant’s attributed Medicare FFS population, CMS will pay the highest fixed ESP amount of \$25 PBPM. For all remaining attributed beneficiaries, CMS would determine the payment amount that corresponds to the beneficiary’s HCC and ADI tier in accordance with Table 6.

Table 6: ESP Risk Adjusted Payments by LIS Status, CMS HCC Risk Tier, ADI Social Risk Tier, and Participant Track

Enrolled in Low-Income Subsidy (LIS): \$25				
Not Enrolled in LIS: (amounts below)				
CMS-HCC Clinical Risk Tier (Risk Score Percentile)	ADI Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
Tier 1 (< 25 th)	Not Applicable [±]	\$9	\$4	\$2
Tier 2 (25 th – 49 th)	Not Applicable [±]	\$11	\$5	\$2.50
Tier 3 (50 th – 74 th)	Not Applicable [±]	\$14	\$7	\$3.50
Tier 4 (≥75 th)	Tier 1, Tier 2, or Tier 3 (< 75 th)	\$18	\$8	\$4
Tier 4 (≥75 th)	Tier 4 (≥75 th)	\$25	\$25	\$25
Based on CMS’ calculations, the average adjusted ESP payment amount will be \$15 PBPM in Track 1, \$10 in Track 2, and \$8 in Track 3, and paid quarterly on a prospective basis.				

[±] Listed as Not Applicable, because payment for beneficiaries in HCC tiers 1-3 is only based on HCC status.

All Medicare FFS beneficiaries attributed to a participant will be assigned to one of four clinical risk tiers (shown in Table 6), and it is expected that, typically, about one-quarter of each participants’ beneficiaries will meet the clinical risk score criteria to fall into each tier. Higher clinical risk tiers are associated with higher beneficiary clinical risk, as determined by the CMS Hierarchical Condition Categories (CMS-HCC) risk score,⁴⁰ and will result in higher ESPs made to the participant. Risk adjustment will be performed before the beginning of each performance year and will not change mid-year; changes in attributed beneficiary risk scores will impact payment in future performance years.

CMS will introduce a risk score growth cap to safeguard against the potential that participants could be incentivized to capture diagnoses inappropriately (also referred to as “upcoding”) to generate higher ESP revenue through higher HCC scores. CMS will monitor HCC growth in the participants’ beneficiary

⁴⁰ Beneficiary clinical risk score is based on the CMS-HCC risk adjustment model, which is a prospective risk adjustment model that predicts medical expenditures in a given year based on demographics and diagnoses from the prior year. Risk scores will be collected for all beneficiaries attributed to a participant from the most current available risk scores. Risk tier assignment will be based on a regional reference population, such that risk scores for attributed MCP beneficiaries are compared with the risk scores for all Medicare FFS beneficiaries in the same region who meet MCP eligibility requirements. A beneficiary is assigned to a risk tier on the basis of where their risk score falls within the regional distribution, as shown in Table 6. For more information about the risk adjustment model, see <https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf>.

population vs. a comparable Medicare FFS beneficiary population that is not in MCP and place a “cap” on how much risk scores can grow vs. the comparison population.

If the beneficiary is not enrolled in LIS, CMS will use the ADI score based on the census block group in which a beneficiary resides compared to a regional reference population. CMS will then assess which of the participant’s highest clinical risk beneficiaries (i.e., those assigned to HCC tier 4) also live in areas with the highest ADI (i.e., those in ADI tier 4) to determine the share of a participant’s attributed beneficiaries that will receive the higher fixed ESP amount listed in Table 6.⁴¹

While base ESP amounts decrease across tracks, CMS will not decrease the ESP amount, for beneficiaries who are either enrolled in LIS or in the top quartile (>75th) of HCC and ADI (e.g., Tier 4). This will ensure that participants serving high-needs beneficiaries receive the highest ESP amount regardless of Track. Higher risk-adjusted ESP payments 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.

Prior to signing the Participation Agreement (PA), CMS will provide applicants with information that is specific to their organization which may include estimates of their eligible attributed population, average risk scores and the share of their attributed population that are in one of the highest risk categories (i.e., eligible for the highest ESP of \$25 PBPM). Organizations interested in better understanding their potential ESP revenue prior to submitting the RFA could reach out to billing staff to see if they have information on the percentage of their Medicare beneficiaries that are enrolled in LIS or are dual-eligible. ADI data is also publicly available at no cost through the University of Wisconsin’s Neighborhood Atlas website.⁴²

Based on CMS’ calculations, the average adjusted ESP payment amount will be \$15 PBPM in Track 1, \$10 in Track 2, and \$8 in Track 3, and paid quarterly on a prospective basis. However, because the share of each participant’s beneficiary population meeting these high-risk criteria will vary as described above, the distribution of average ESP income across participants will range accordingly.

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 innovative and more precise ways of measuring social risk become available.

⁴¹ ADI scores will be collected for all beneficiaries attributed to a participant based on the address of their residence. Social risk tier assignment will be based on a regional reference population, such that ADI scores for attributed MCP beneficiaries are compared with the ADI scores for all Medicare FFS beneficiaries in the same region who meet MCP eligibility requirements. A beneficiary is assigned to an ADI tier on the basis of where their ADI score falls within the regional distribution, as shown in Table 6.

⁴² ADI data is publicly available at no cost through the University of Wisconsin website at: <https://www.neighborhoodatlas.medicine.wisc.edu/>.

Prospective Primary Care Payment

As participants progress across tracks, payment for primary care services will shift from FFS to a quarterly prospective primary care payment (PPCP) based on historic billing. The goals of the PPCP are to:

- Reduce incentives to generate additional revenue by increasing volume;
- Provide participants with increased flexibility in how they provide comprehensive primary care so that resources are invested in the modality that best meets beneficiaries' needs, which is often not a traditional office visit; and
- Provide a predictable source of revenue over time.

MCP will employ a gradual transition to increasing levels of PPCP with the following policies across tracks:

- Track 1 – 0% PPCP / 100% FFS.
- Track 2 – 50% PPCP / 50% FFS.
 - This supports providing team-based care and allows transition time between FFS and full prospective primary care payment.
 - PPCP payments are made quarterly and are based on the historical primary care spending for each participant's attributed beneficiary population. For non-FQHCs, the PPCP is based on primary care services billed under the PFS. For FQHCs, the PPCP is based on the primary care services billed under the Medicare FQHC PPS.
- Track 3 – 100% PPCP / 0% FFS
 - Participants are still required to submit no-pay claims.

The next section covers services subject to the PPCP.

Prospective Primary Care Payment Services

The primary care services that will be included in the PPCP are referred to as “Prospective Primary Care Payment Services,” or PPCP Services. MCP’s PPCP Services were derived from the CPC+ and PCF models and updated to include more services and align with MCP Care Delivery requirements and goals. Track 3 PPCP services are fully inclusive of all Track 2 PPCP Services and will also include behavioral health integration (BHI) services in alignment with our behavioral health integration strategy and MCP e-Consult Codes (MECs). The BHI services and MCP e-Consult 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. [Appendix G](#) shows the Track 2 and Track 3 PPCP Services CPT/HCPCS code lists.

We will also implement a Cost Sharing Reduction Program policy, which will allow participants to offer high-value primary care services to beneficiaries with high disease burden or financial hardship without collecting coinsurance. For more information, see the [Cost Sharing Reduction Program](#) section.

PPCP Calculation

Each participant’s PPCP per beneficiary per month (PBPM) payment, during their Track 2 or Track 3 participation, will be based on the two years of historical claims data for its attributed Medicare FFS

beneficiaries, resulting in a PPCP PBPM for each participant that is based on their own unique claims history. For participants entering directly into Track 2 or Track 3, their PPCP will be based on the claims period April 1, 2022 – March 31, 2024. For participants entering directly into Track 1, their PPCP in Track 2 will be based on the claims period October 1, 2024 – September 30, 2026. The participant-specific payment amount will then be updated annually to reflect PFS rate changes and utilization increases in the PPCP Services. Prior to entering Track 3, or after 5 years in the model for participants that enter directly into Track 3, the PPCP PBPM will also be updated to reflect the two most recent years of historical claims data. This rebasing will ensure that each participant's PPCP PBPM reflects the current health status of their attributed beneficiaries. (See [FQHC and Indian Health Program Considerations](#) for differences in PPCP calculation). CMS will adjust the PPCP calculation using final updates to each calendar year's PFS or Medicare FQHC PPS payment parameters (e.g., CF, RVU, GPCI)⁴³ to express adjusted historical PBPM in current dollars.

CMS plans to eventually move to a PPCP methodology that takes into account regional spending on primary care, to standardize primary care payments among non-FQHC participants. During the first three years of the model, CMS will conduct analyses to understand the factors that drive primary care spending differences. Based on the findings of this analysis, CMS will introduce a revised PPCP methodology. CMS plans for this methodology to be introduced to participants in Track 3 beginning in PY3, but the new methodology may also be phased in for participants in Track 2, beginning in PY3. After PY3, the PPCP PBPMs for non-FQHCs will be partially based on participant-specific historical claims for their attributed beneficiaries and partially based on a regional benchmark for primary care spending. Applicants should anticipate that the revised PPCP methodology may increase or decrease their PPCP PBPM from what they receive prior to the introduction of the methodology, based on whether their primary care spending is above or below regional spending trends. The PPCP regional blend methodology will not apply to FQHCs or Indian Health Programs, which will continue to receive PPCP PBPMs that are based on their historical claims data.

PPCP Partial Reconciliation

CMS will implement a PPCP partial reconciliation under MCP to ensure that participants do not divert care to other settings. CMS will first calculate the proportion of a participant's average attributed beneficiary's total primary care service spend provided by other organizations (outside of the participant's TIN) in a performance year, called the outside-of-participant amount. If the outside-of-participant amount in the performance year exceeds the outside-of-participant amount in the prior year by a value of between \$2-7 PBPM, CMS will make a downward adjustment of \$2 PBPM to the participant's PPCP PBPM. This downward adjustment is made in the form of a recoupment (or debit) that is applied prospectively to the non-claims-based payments made through the Innovation Payment Contractor (IPC). If the outside-of-participant amount exceeds the prior year by a value of more than \$7 PBPM, CMS will make a maximum downward adjustment of \$5 PBPM. No adjustment occurs if the outside-of-participant amount exceeds the year prior by less than \$2 PBPM.

⁴³ The finalized Physician Fee Schedule rates can be found at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched>.

Impact of PPCP on Claims and Documentation

The PPCP allows flexibility in care delivery based on clinical capabilities, rather than administrative requirements. However, CMS will still require that participants bill for PPCP Services provided, to the extent the services meet billing requirements, and submit claims for informational purposes. CMS will annually monitor participant PPCP Services billing patterns as a safeguard against anomalies like changes in care patterns to game the alternative to FFS payments. CMS may audit outlier participants to ensure that participants do not over-bill PPCP Services.

Cost Sharing Reduction Program

Subject to compliance with all applicable laws and regulations, the terms of the MCP Participation Agreement, and CMS approval, MCP participants may have the opportunity to implement a program to provide certain high-value primary care services to a subgroup of Medicare FFS beneficiaries without collecting the beneficiary cost-sharing amount that would usually apply for that service.

CMS will define a broad category of beneficiaries that the policy should be extended to. These may include:

- the beneficiary is experiencing a financial hardship,
- the beneficiary is not dually enrolled in Medicare and Medicaid (CMS to provide a dual status flag on the quarterly participant-facing attribution report), and
- the beneficiary has evidence of a high disease burden.

The services eligible beneficiaries can receive as part of this flexibility will be limited to services impacted by the model, including the PPCP Services and the MCP e-Consult (MEC) code. See Table 7 below for a list of services that this policy can apply to.

Table 7: CPT/HCPCS Codes for Beneficiary Cost-Sharing Reduction

Service	Code
Office/Outpatient Visit E/M	99201-99205, 99211-99215
Complex Chronic Care Coordination Services	99487
Chronic Care Management (CCM) Services	99490-99491
Principal Care Management (PCM)	99424, 99425, 99426, 99427
Transitional Care Management (TCM) Services	99495-99496
Home Care/Domiciliary Care E/M	99324-99328, 99334-99337, 99339-99345, 99347-99350
Advance Care Planning	99497
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	99484
Prolonged E/M	99354, 99355, 99358, 99359, 99415, 99416, G2212
Cognition and functional assessment for patient with cognitive impairment	99483

Service	Code
Psychiatric Collaborative Care Model	99492-99494, G2214
Outpatient clinic visit for assessment and management (for critical access hospital-based outpatient primary care participants)	G0463
Administration of HRA	96160, 96161
Interprofessional Consultation	99452
Online Digital E&M	99421-99423
Telephone E&M services	99441-99443
Technology-based check-in services	G2010, G2012, G2252
Remote Physiologic Monitoring (RPM)	99453, 99454, 99457, 99458, 99091
CCM or General BHI Services (for FQHCs)	G0511
Virtual Communication Services (for FQHCs)	G0071
FQHC Distant Site Telehealth visit	G2025
FQHC All-Inclusive visit	G0466, G0467
FQHC IPPE or AWW visit	G0468
Psychiatric CoCM (for FQHCs)	G0512

Given that this policy will be optional, participants must elect to participate annually in the Cost Sharing Reduction Program and, upon request, share with CMS its written policy detailing how it intends to implement its Cost Sharing Reduction Program, including what type of beneficiaries will be included in the program. CMS has the discretion to reject the participant's request to participate in the Cost Sharing Reduction Program.⁴⁴ Any MCP participant implementing the optional program will be subject to additional monitoring and compliance activities in connection with the Cost Sharing Reduction Program and the use of beneficiary incentives. To minimize potential abuse, CMS may incorporate certain beneficiary protections and other safeguards in the MCP Participant Agreement. If CMS identifies noncompliance, CMS may suspend or prohibit the participant's participation in the Cost Sharing Support Program or in the model or may take other remedial actions, regardless of whether the participant has corrected or otherwise resolved the noncompliance.

8B. Performance Incentive Payment (PIP)

Performance expectations and opportunities to earn a reward through the Performance Incentive Payment (PIP) increase across tracks. The PIP is an upside-only adjustment and will be calculated as a percentage adjustment to the sum of FFS and PPCP amounts to each participant for PPCP Services for their attributed beneficiaries. The performance assessment will be conducted on an annual basis (due to the reporting of eCQM and PCPCM data annually). The PIP will begin in PY2 (1/1/25-12/31-25).

The potential percentage adjustment included in the PIP calculation increases across Tracks, as performance is based on an expanded list of quality, cost, and continuous improvement measures (see the [Performance Assessment](#) section to see the required measures by Track). MCP participants must

⁴⁴ An FQHC that operates a Sliding Fee Discount Program would be considered to have an eligible Cost Sharing Reduction Program for MCP and would be encouraged to inform CMS annually of this program and maintain written policies and information on specific MCP attributed beneficiaries who received cost-sharing support.

report all quality measures for their Track to receive a PIP adjustment. Once in Tracks 2 and 3, they must also meet or exceed the 30th percentile nationally for Total Per Capita Cost (TPCC). As [Enhanced Services Payment \(ESP\)](#) decrease across tracks, PIP opportunity increases to allow participants that perform well to maintain revenue stability.

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

CMS recognizes that a shorter time lag between performance measurement and the PIP can provide participants with earlier resources that they may invest to help increase performance. To mitigate the lag in PIP cash flow that would occur as a result of the time it takes to assess performance, MCP will split the PIP that a participant receives for a performance year into two lump sums:

- The first lump sum will be paid in the first quarter of the performance year. This first lump sum will be calculated in aggregate, reflecting half of what the average participant is expected to earn (based on the expected average PIP, applied to the participant's sum of FFS and PPCP payments for PPCP Services).
- The second lump sum payment will be paid in the third quarter of the year following the performance year and will reflect each participants' actual performance assessment. The second lump sum payment will be calculated as the total PIP a participant has earned in the performance year (each participants' PIP percentage bonus, applied to the participant-specific sum of FFS and PPCP payment for PPCP Services furnished by the participant during the performance year to attributed beneficiaries) minus the first lump sum payment the participant received.

Providing two lump sum PIPs, rather than a percentage adjustment at the time of assessment, pulls the payments forward in time and may afford greater ability to smooth revenue and improve performance over time.

Participants are permitted to share a portion of their PIP with their Specialty Care Partners; however, this is not required. If the participant is sharing in the PIP, this arrangement must be detailed in the Collaborative Care Arrangement (CCA) between the participant and Specialty Care Partner and meet all applicable laws.

Financial Incentive for Performance Improvement

The PIP involves several mechanisms to both measure and reward performance. To be eligible to receive a PIP, a participant must report all required measures from the [MCP Performance Measure Set](#). Further, Track 2 and Track 3 participants must also pass the "gateway threshold" to be eligible to receive a PIP, defined as achieving the national 30th percentile on TPCC.

Each performance measure is assigned a percentage of the overall PIP value. Tables 8-10 show the percentages assigned to each measure by each Track. These percentages or "weights" reflect model

goals, with equal weight given to clinical quality and utilization/cost categories of the absolute performance portion of the PIP.

Except where otherwise noted, participants will receive full credit for a measure (the full measure's percentage of the overall PIP) if they exceed the upper benchmark/threshold which is 70th percentile in Tracks 1 and 2, and 80th percentile in Track 3. Participants will receive half credit (half of the quality measure's percentage of the overall PIP) for a measure if they perform between the 50th percentile and the upper benchmark/threshold. Please see the [Performance Assessment](#) section for more information.

Measures of participant-level continuous improvement (CI) carry significant weight (25%) in the PIP for Tracks 2 and 3. Via the TPCC Continuous Improvement (CI) measure, participants are measured against their own TPCC performance in the previous year and are rewarded if there is a statistically significant improvement of 3% or more. They will receive half credit if their TPCC score improves more than 3% (but less than 5%) and full credit for improvement greater than 5%. CMS Innovation Center will monitor participant performance in CI over time and may adjust the CI weight 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. The PIP strategy for FQHCs and Indian Health Programs includes a small modification for Tracks 2 and 3, where FQHCs are assessed on EDU CI instead of TPCC CI (see [FQHC and Indian Health Program Considerations](#)).

Table 8: Track 1 MCP Performance Incentive Payment Structure

Track 1: Potential PIP is 3%				
The PIP will be calculated as a percentage adjustment to the sum of FFS and PPCP amounts to each participant for PPCP Services for their attributed beneficiaries.				
Strategic Weight		Measure Name	Benchmark	Percentage of overall PIP
Absolute Performance (100%)	Quality (100%)	CMS122: Diabetes: HbA1C Poor Control (>9%)*	≥50 th percentile (half credit) ≥70 th percentile (full credit)	25%
		CMS165: Controlling High Blood Pressure*		25%
		CMS130: Colorectal Cancer Screening		25%
		Person-Centered Primary Care Measure (PCPCM)	N/A (full credit given for reporting in PY2 and PY3)	25%
Total Incentive Potential				100%

Table 9: Track 2 MCP Performance Incentive Payment Structure

Track 2: Potential PIP is 45%				
Gateway threshold to be eligible to receive a PIP: meet or exceed 30% for TPCC (nationally)				
The PIP will be calculated as a percentage adjustment to the sum of FFS and PPCP amounts to each participant for PPCP Services for their attributed beneficiaries.				
Strategic Weight		Measure Name	Benchmark	Percentage of Overall PIP
Absolute Performance (75%)	Quality (50%)	Person-Centered Primary Care Measure (PCPCM)	N/A (full credit given for reporting in PY2 and PY3)	6%
		CMS122: Diabetes: HbA1C Poor Control (>9%)	≥50 th percentile (half credit) ≥70 th percentile (full credit)	6%
		CMS165: Controlling High Blood Pressure		6%
		CMS130: Colorectal Cancer Screening		6%
		Screening for Social Drivers of Health		6%
		CMS2: Screening for Depression and Follow-Up Plan		4%
		CMS159: Depression Remission at 12 months		4%
	Utilization/ Cost (50%)	Emergency Department Utilization (EDU)		18.5%
		Total Per Capita Cost (TPCC)		18.5%

Continuous Improvement (25%)		EDU CI (for FQHCs and Indian Health Programs) OR TPCC CI (non-FQHCs and non-Indian Health Programs only)	≥3% improvement (half credit) and ≥5% improvement (full credit)	25%
Total Incentive Potential				100%

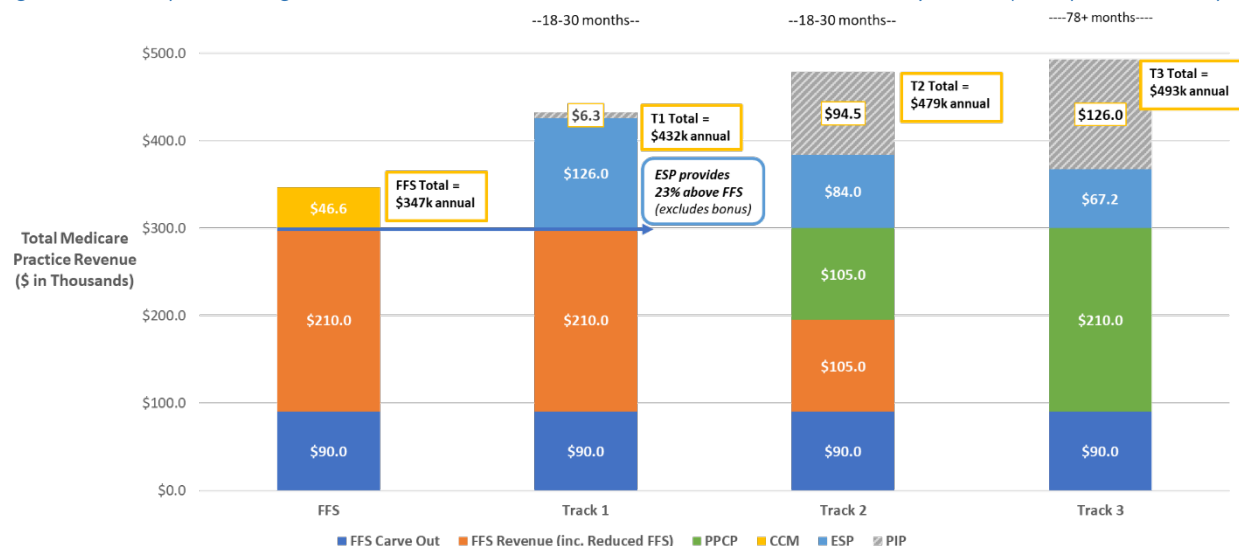
Table 10: Track 3 MCP Performance Incentive Payment Structure

Track 3: Potential PIP is 60%				
Gateway threshold to be eligible to receive a PIP: meet or exceed 30% for TPCC (nationally)				
The PIP will be calculated as a percentage adjustment to the sum of FFS and PPCP amounts to each participant for PPCP Services for their attributed beneficiaries.				
Strategic Weight	Measure Name		Benchmark	Percentage of Overall PIP
Absolute Performance (75%)	Quality (50%)	Person-Centered Primary Care Measure (PCPCM)	N/A (full credit given for reporting in PY2 and PY3)	6%
		CMS122: Diabetes: HbA1C Poor Control (>9%)	≥50 th percentile (half credit) ≥80 th percentile (full credit)	6%
		CMS165: Controlling High Blood Pressure		6%
		CMS130: Colorectal Cancer Screening		6%
		Screening for Social Drivers of Health		6%
		CMS2: Screening for Depression and Follow-Up Plan		4%
		CMS159: Depression Remission at 12 months		4%
	Utilization / Cost (50%)	Emergency Department Utilization (EDU)		18.5%
		Total Per Capita Cost (TPCC)		18.5%
Continuous Improvement (25%)		EDU CI (for FQHCs and Indian Health Programs) OR TPCC CI (non-FQHCs and non-Indian Health Programs only)	≥3% improvement (half credit) ≥5% improvement (full credit)	25%
Total Incentive Potential				100%

8C. Payment to Primary Care Participants: Summary

MCP's payment design will provide more up-front support in Track 1 through Enhanced Service Payments (ESPs) and, for those eligible, a lump sum infrastructure payment (UIP). The ESPs will then decrease over time as participants can achieve increased performance incentive payments (PIPs). Figure 5 below illustrates the proportion of revenue each payment would make up for an average participant. The non-PPCP services that continue to be billed FFS are shown in this Figure in dark blue.

Figure 5: Example Average Annual Medicare Revenue and Source Under MCP by Track (Compared to FFS)



For illustration, an average PBPM of \$15 was used for the quarterly ESP payments in Track 1, \$10 in Track 2, and \$8 in Track 3 (see Table 6), which are summed up for an attributed MCP population of 700 beneficiaries and represented by the light blue shading. Gray striped shading represents the maximum potential PIP earned by the participant, which is calculated as 3%, 45%, and 60% based on total FFS revenue before reduction (\$210,000 per participant—shown in orange and green). Track 1 infrastructure payments are not included.

8D. Payments to Encourage Specialty Integration

MCP will aim to improve consultation, communication, and coordination between participants and their Specialty Care Partners by gradually introducing tools and resources that evolve across tracks. In Track 1, participants will focus on reviewing data and identifying potential Specialty Care Partners. In Track 2, participants will select Specialty Care Partners and execute Collaborative Care Arrangements to facilitate closer coordination. Participants will utilize a new model specific e-consult code (MCP e-Consult or MEC). In Track 3, Specialty Care Partners will gain access to a new time-limited ambulatory co-management (ACM) code for the enhanced collaboration and communication expected during co-management.

MCP e-Consult Code (MEC) for Primary Care Participants

In Track 2, participants will be able to bill the MEC for their MCP-attributed beneficiaries, to incentivize and encourage primary care clinicians to increase use of e-consults. The MEC will be valued at the same

level as the existing requesting physician interprofessional consultation (IPC) code (99452), including geographic adjustments and facility non-facility adjustments. Currently, the code for primary care (requesting) physicians is valued at 0.70 wRVUs (in the CY 2023 Medicare Physician Fee Schedule). However, to address current barriers to utilizing the current IPC codes, CMS intends to include post-service time in the time requirements and propose payment for the MEC code at \$40 per service (subject to geographic adjustments). The MEC will be able to be billed by an MCP primary care clinician for a consultation with any specialist, regardless of whether the consulting specialist is one with whom the primary care clinician has a Collaborative Care Arrangement (CCA). Specialty Care Partners will not be able to bill the MEC.

Ambulatory Co-Management (ACM) Code for Specialists

The Medicare Physician Fee Schedule (MPFS) currently includes a series of care coordination codes that clinicians or other qualified health professionals may bill for time spent on care management activities outside of face-to-face patient visits.⁴⁵ To be billed, these codes require the beneficiary to have one or more conditions that place them at significant risk of hospitalization, acute exacerbation, functional decline, or death. A physician or other professional may bill the Principal Care Management (PCM) code for a beneficiary with a single condition that is expected to last at least 3 months, while the Chronic Care Management (CCM) and Complex Chronic Care Management (CCCM) codes are billed when a beneficiary has at least two conditions that are expected to last 12 months or more. CCCM is only billed when a condition requires a moderate to high complexity of medical decision-making.

The MCP model will test a new care management code that is related to these existing care coordination codes called the Ambulatory Care Management (ACM) code. The ACM code is designed to reflect when care management is shared between primary care and specialist physicians, which is often the clinical reality of care. The ACM code requirements generally align with the PCM requirements, with two exceptions: 1) the ACM code does not require the condition for which the code is being used to place a beneficiary at significant risk of death, acute exacerbation, or functional decline; and 2) the Specialty Care Partner must identify themselves as taking on a co-management role through the CCA with the MCP participant.⁴⁶ The new code is intended to support ongoing communication and collaboration between the MCP participant and the Specialty Care Partner regarding an attributed beneficiary who requires both longitudinal primary care and also short-term specialized care to stabilize an exacerbated chronic condition.

In Track 3, specialists who are on a participant's Specialty Care Partner List will be able to bill the new ACM code for time-limited, ambulatory co-management on shared attributed beneficiaries. As noted above, the Specialty Care Partner List is a list of Specialty Care Partners. CMS will provide participants with a system for submitting the list.

The ACM code will be priced at \$50, before the geographic adjustment is applied. This amount is based on expected physician effort for shared co-management with another clinician versus sole or primary care management responsibilities. CMS expects the level of clinician effort for shared co-management

⁴⁵ Medicare Learning Network (MLN) resource for Chronic Care Management (CCM): <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf>

⁴⁶ Forrest CB. A typology of specialists' clinical roles. *Arch Intern Med.* 2009 Jun 8;169(11):1062-8. doi: 10.1001/archinternmed.2009.114. PMID: 19506176.

to be reduced compared to a typical condition for either chronic care (CCM) or principal care management (PCM). The ACM code will be billable by Specialty Care Partners on a monthly basis for up to three months after the initial co-management code is billed to reflect the increased work required to co-manage an attributed beneficiary's health condition, communicate with the MCP participant, and share care plans for the beneficiary. CMS will require simultaneous documentation in the medical record of beneficiary co-management.

8E. FQHC and Indian Health Program Considerations

Payment to Participating FQHCs and Indian Health Programs

CMS anticipates that the beneficiary populations attributed to participating FQHCs may, on average, have higher social risk and LIS enrollment which would make average ESP payments higher for FQHC participants.

In terms of the underlying primary care payments, FQHCs in Track 1 will continue to be paid according to the Medicare FQHC PPS. FQHCs in Tracks 2 and 3 will have their PPCP PBPMs calculated based on the specified Medicare FQHC PPS services in the PPCP Service list ([Appendix G](#)) and will be based on the historic claims for their attributed beneficiaries, resulting in PBPMs that reflect each participants' unique past primary care provision. Services not listed as part of the PPCP, such as mental health services G0469 and G0470, will continue to be reimbursed at the Medicare FQHC PPS rate. Services that are carved out of the Medicare FQHC PPS, such as immunizations, will continue to be paid regularly.

Indian Health Programs in Track 1 will continue to be paid according to the PFS. Similarly, Indian Health Programs in Tracks 2 and 3 will have their PPCP PBPMs calculated based on the specified Medicare PFS services in the PPCP Service list ([Appendix G](#)) and will be based on the historic claims for their attributed beneficiaries, resulting in PBPMs that reflect each participants' unique past primary care provision.

Performance Incentive Payment

FQHCs and Indian Health Programs will be assessed on the same clinical quality, cost, and utilization measures as non-FQHC participants, except for the continuous improvement measure. MCP recognizes that many beneficiaries that receive services at FQHCs or Indian Health Programs have lower total per capita costs (TPCC) on average at baseline, possibly due to reduced access to care. This could make it more difficult for an FQHC or Indian Health Program to achieve improvement in its historical TPCC performance (TPCC CI). Thus, CMS believes that EDU CI is a more appropriate performance measure for FQHCs and Indian Health Programs instead of TPCC CI in Tracks 2 and 3.

Payment to Specialists

For specialty care integration, to offer services best tailored to the needs of their patients and the community, FQHCs will be able to select their preferred Specialty Care Partner type rather than having to prioritize orthopedics, cardiology, or pulmonology, as will be required for other participants (see [Care Integration](#)).

9. Learning Systems Strategy

MCP will include its partner states and individual participants in multi-stakeholder efforts toward building a health system that achieves equitable outcomes through high-quality, affordable, patient-centered care. Through the support the MCP model provides to participants, CMS will partner with state efforts to create an environment for practice change.

MCP will have both national and state-based supports for participating organizations. At a national level, MCP will provide:

1. **Technical assistance** to ensure that participants have the information they need to understand how the model works and the expectations and requirements of participation. This will likely include guidance documents, webinars, and a Help Desk.
2. A **collaboration platform** to help participants share ideas, tools, and resources and learn from each other.
3. **Data feedback** with actionable data on cost and utilization for the Medicare beneficiaries served by the participant.
4. A **care delivery reporting platform** enabling participants to share the tactics, strategies and care delivery methods that they are using to improve health outcomes and advance health equity for their patients, with peer comparisons.

Within the MCP states, CMS will join with stakeholders, the state Medicaid programs, and other payer partners to:

1. **Connect MCP participants with each other and with the specialty practices and community-based organizations** that need to be partners in care for their patients.
2. **Make time-bound practice coaching and facilitation resources** available to participants who need help building capacity and who desire support in making the changes in workflow and organization of care they need to succeed in the model and advance health outcomes and health equity.
3. **Contribute to the data aggregation and health information exchange** resources necessary to give participants a full view of the care their patients receive and to enable comprehensive and coordinated care across primary care, acute and sub-acute care, specialty care, and community-based services.

CMS will participate in efforts to enhance data aggregation and health information exchange (HIE) in MCP states to ensure that MCP participants have the data they need to guide care for the beneficiaries they serve, including

- Regional health outcomes data that places the care delivery changes and improved outcomes enabled by MCP in the context of a shared agenda for change in the state.
- Real time actionable data through health information exchange that MCP participants will use to manage patient care.⁴⁷

⁴⁷ All participants will be required to participate in an HIE. States are being selected based on criteria that includes the maturity-level of their health IT and data functionality. CMS will work with states as they continue to develop health IT and data.

- Linked cost and quality data for specialists as a tool to inform primary care referral decisions.
- The population-level data (e.g., benchmarked quality results) participants need to guide their transition from care delivery shaped by FFS payment to care delivery enabled by prospective, enhanced, accountable payment.

10. Data Sharing

CMS will provide MCP participants with multiple types of data feedback to inform their care.

- **CMS Innovation Center’s Data Feedback Tool (DFT)**, will give participants information about their quality, utilization and payment metrics relevant to model performance. The DFT also allows participants to compare their metrics with other participants in their region and nationally.
- CMS intends to make several **enhancements to the DFT**, including adding analytics to help clinicians identify high-quality specialists with whom they would like to partner. Metrics are expected to include cost, utilization, and quality measures, and may include measures of low-value care and appropriateness in the future.
- Participants will also be able to request and receive **Claim and Claim Line Feed files (CCLFs)** on a monthly basis, which contain historical claims data from CMS.
- CMS will use the state-based learning infrastructure described in the [Learning Systems](#) section to provide MCP participants with **data from multiple payers**.

10A. Data Reporting Requirements

Under 42 CFR 403.1110(b), any entity participating in the testing of an Innovation Center model is required to collect and report such information, including “protected health information” as defined at 45 CFR 160.103, determined necessary to monitor and evaluate the model. In alignment with the CMS Innovation Center’s 2022 Strategic Refresh, the MCP model is supporting CMS goals to advance health equity by capturing disparities in care. MCP will require participants to collect and submit beneficiary-level information to CMS. Beneficiary-level demographic data will be used to understand and monitor the model impacts on health disparities and to stratify patient outcomes on sociodemographic measures. To submit beneficiary-level information, participants will use the MCP Participant Portal developed by the CMS Innovation Center. The MCP Participant Portal allows participants to submit and aggregate data. The MCP model is cautious of additional reporting burden and will aim to utilize Innovation Center tools such as automated data pulls from electronic health records, as feasible.

For more information on beneficiary-level demographic data collection and HRSN data collection, please see the [Health Equity Data Collection Requirement](#). Please note that MCP participants should not impose on the beneficiaries they serve any requirement to report HRSN data or demographic information if they choose not to report it.

functionality up-to and after the model begins. Please see [Appendix B](#) for more detailed information on MCP’s health IT requirements.

11. Participant Monitoring, Auditing, and Termination Strategy

11A. Monitoring and Screening

CMS will monitor select MCP participant activities to ensure participants are appropriately implementing the model requirements. CMS will use self-reported MCP participants care delivery and financial information, MCP Clinician Lists, Specialty Care Partner Lists, claims, utilization, and quality data in its monitoring strategy. This information will be collected through participant reporting. Identified issues common among participants will guide additional learning activities and monitoring to ensure compliance with the terms of the Participation Agreement (PA) between CMS and MCP participants.

Participants will be required to submit a list of their participating primary care clinicians, and CMS will conduct a cursory analysis of billing under the participant TIN to confirm compliance with the PA (all primary care clinicians billing under the participant TIN must participate in MCP).

CMS will review performance and claims data to identify participants that may be gaming, falsifying data, or engaging in care stinting.

Participants may be subject to CMS remedial action including a Notice of Remedial Action (NRA). An NRA will be imposed when a participant does not meet terms of the Participation Agreement but can reasonably be expected to remediate the deficiency in a timely manner. Examples of scenarios warranting an NRA include failure to meet quality or Care Delivery reporting deadlines. Participants will be required to remedy the situation within a time frame determined by CMS, or potentially face termination (see [Termination](#) section).

CMS will conduct analyses using the data sources described above, and participants with anomalies may be selected for audit (see [Auditing](#) section).

CMS may reject an application or terminate a Participation Agreement on the basis of the results of a Program Integrity (PI) screening of the applicant, the participant, its affiliates, and any other relevant individuals or entities (including when a participant undergoes a change in ownership while in the model). The PI screening may include, without limitation, the following:

- Confirmation of current Medicare enrollment status and history of adverse enrollment actions;
- Identification of delinquent debt;
- Review of performance in, and compliance with the terms of, other CMS models, demonstrations, programs, and initiatives;
- Review of compliance with Medicare program requirements;
- Review of billing history and any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- Review of any civil or criminal actions related to participation in a federal health care program.

11B. Auditing

CMS's monitoring and oversight activities may include, but are not limited to, the following:

- Analysis of specific financial and performance data reported by the participant as well as Medicare claims analyses;

- Analysis of beneficiary and provider/supplier complaints including, but not limited to, those submitted through 1-800-MEDICARE, surveys, and internal processes established and supported by the participant for managing such complaints;
- Audits reviewing the participants' relationships with their Specialty Care Partners and review of billing patterns to ensure MEC and ACM codes are not being used improperly;
- Audits reviewing the participants' cost sharing reduction written program policy and billing records (if the participant is implementing the optional program);
- Audits, including claims data mining, medical chart review, beneficiary survey data, coding audits, and on-site compliance reviews;
- Audit of samples of medical charts;
- Monitoring of beneficiary complaints and surveys;
- Interviews with beneficiaries, providers and suppliers;
- Vetting of model participants and their providers/suppliers on the basis of program integrity issues; and
- Audits of improper payments and care stinting.

Audits may be conducted in-person or virtually and may include a review of clinical and administrative data. Participants will be required to maintain and produce upon request documentation related to their participation in the model. Data that participants will submit annually to CMS, performance on utilization and quality measures, their referral and billing patterns, and other participant information may also trigger an audit of any participant.

11C. Termination

CMS reserves the right to terminate a participant's Participation Agreement at any point during the model for reasons associated with poor performance, program integrity issues, non-compliance with the terms and conditions of the applicable Participation Agreement, or as otherwise specified in the Participation Agreement or required by Section 1115A(b)(3)(B) of the Social Security Act. A participant may voluntarily terminate their Agreement with CMS, subject to terms that will be outlined in the MCP Participation Agreement.

12. Evaluation

All MCP participants will be required to cooperate with CMS efforts to conduct an independent, federally funded evaluation of the model, which may include completion of surveys and participation in interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive evaluation. The evaluation results will be used to inform CMS about the effect of both primary care transformation and aligned payment reform both in MCP and in future primary care payment policy.

13. Statutory Authority to Test the Model

Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a) establishes the Innovation Center to test innovative payment and service delivery models that have the potential to lower Medicare, Medicaid, and Children's Health Insurance Program (CHIP) spending while maintaining or improving the quality of beneficiaries' care.

Under Section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Title XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii) and certain

provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b).

For this model and consistent with the authority under section 1115A(d)(1), the Secretary may consider issuing waivers of certain fraud and abuse provisions in Sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Any such waiver would apply solely to MCP and could differ in scope or design from waivers granted for other programs or models. Thus, notwithstanding any provision of this RFA, participants must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to Section 1115A(d)(1) specifically for MCP.

In addition to or in lieu of a waiver of certain fraud and abuse provisions in sections 1128A and 1128B of the Act, CMS has determined that the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (42 CFR § 1001.952(ii)) will be available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under the MCP participation documentation.

14. Merit-Based Incentive Payment System (MIPS) Alternative Payment Model (APM) and Advanced APM Status (A-APM)

Under the Quality Payment Program, CMS expects that certain components of MCP will qualify as Advanced Alternative Payment Models (A-APMs). The financial risk standards applied in making this determination with respect to MCP are the financial risk and nominal amount standards specific to medical home models.

As noted in Table 11 below, CMS expects that all Tracks in MCP will meet the criteria under 42 C.F.R. § 414.1415 for being a Merit-Based Incentive Payment System (MIPS) APM in performance year 2 and all subsequent performance years, subject to annual APM determinations; however, only Tracks 2 and 3 are expected to be classified as *Advanced APMs* (A-APMs).

Table 11: Tentative MCP QPP Status

	Medical Home Model	MIPS APM	A-APM
Track 1	Yes	Yes	No
Track 2	Yes	Yes	Yes
Track 3	Yes	Yes	Yes

Any MIPS eligible clinicians who are included on the MCP Clinician List be eligible for scoring as part of a MIPS APM Entity, and for reporting through the APM Performance Pathway described at 42 § C.F.R. 414.1367. Participants with MIPS-eligible clinicians who are either Partial QPs that elect to report to MIPS, or who are neither Qualifying APM participants (QPs) nor Partial QPs may be eligible for scoring as part of a MIPS APM Entity.

14A. FQHC Considerations

Physicians and other eligible clinicians who bill exclusively through their FQHC Prospective Payment System (“PPS”) are exempt from MIPS reporting, but they can choose to voluntarily report (without being subject to a MIPS payment adjustment). If they bill under the Medicare Physician Fee Schedule they are subject to participation in MIPS, unless they meet one of the following exemptions: (1) they are a newly-enrolled Medicare eligible clinician who enrolled in Medicare for the first time during the performance year, (2) they are below the low-volume threshold (check the QPP Status Participation Tool at <https://qpp.cms.gov/participation-lookup>), or (3) they are a qualifying APM participant (QP). For more information, please refer to the Quality Payment Program website: <https://qpp.cms.gov/>.

15. Program Overlaps and Synergies

CMS reserves the right to prohibit simultaneous participation in MCP and other CMS or Innovation Center initiatives, potentially include additional requirements and revise initial guidance based on a number of factors, including CMS’s capacity to avoid counting savings twice in overlapping initiatives and to conduct a robust evaluation of each initiative. CMS may also encourage collaboration among participants across models with the goal of enhancing the impact of models on reducing expenditures and improving quality.

15A. Medicare Shared Saving Program (SSP) and CMS Innovation Center Models

In general, CMS will not allow organizations and clinicians to participate in MCP while participating in other Innovation Center models, including Accountable Care Organizations Realizing Equity and Community Health (ACO REACH), Primary Care First and Kidney Care Choices (including Comprehensive Kidney Care Choices and Kidney Care First). As future CMS Innovation Center models are announced, MCP will determine whether overlap should be allowed. Overlap is prohibited at the TIN (participant) level as well as the clinician (NPI) and site (CCN) level.

CMS will allow organizations and individuals participating in SSP to overlap with MCP during the first 6-month performance year (7/1/24-12/31/24), but these organizations must withdraw from SSP by a deadline set by CMS that will be prior to the beginning of the second MCP performance year (1/1/25) if they wish to continue participating in MCP. During the 6-month performance year in 2024, these organizations will be able to participate in MCP and SSP but no MCP model payments will be made to them until 1/1/25 to avoid potential duplicate payments.

Other than the 6-month SSP exception described above, throughout the model, primary care clinicians listed on an MCP participant’s MCP Clinician List cannot participate in a model or program with which MCP has a no-overlaps policy. It will be incumbent on the MCP participant and ACOs to manage their lists of participating providers and inform clinicians of which model or initiative they are in and where their beneficiaries will be attributed.

15B. Episode-Based Payment Models

Organizations and their practitioners that participate in episode-based payment models such as, Bundled Payments for Care Improvement (BPCI) Advanced model, the Enhancing Oncology Model (EOM), and the Comprehensive Care for Joint Replacement (CJR) model will be permitted to participate simultaneously in MCP.

15C. Beneficiary and Clinician Overlaps

Beneficiaries can only be attributed to one MCP participant at a given time and cannot simultaneously be attributed to an MCP participant and a participant in a model or program for which MCP has a no-overlaps policy.

Specialty Care Partners will be free to participate in other CMS Innovation Center models.

Appendices

Appendix A: Participant Application Guidance and Questions

Between September 5, 2023 and November 30, 2023, CMS will accept applications for the Making Care Primary Model.

The following organizations are eligible to apply to participate in MCP: Medicare-enrolled organizations that provide primary care services to Medicare beneficiaries, including solo primary care practices, group practices, health systems, FQHCs⁴⁸ and eligible Indian Health Programs.⁴⁹ CAHs that have selected Standard or Method I billing may apply.

Organizations interested in applying to MCP should also review the Request for Applications (RFA) to learn about the design and requirements of the model. The application must be certified as true, accurate, and completed by an individual authorized to represent the organization (i.e., the legal entity submitting the application).

Applicants that are interested in MCP but aren't ready to apply can also complete the short, online letter of interest (LOI), [linked here](#), to signal their interest to the Center for Medicare & Medicaid Innovation (CMS Innovation Center) and sign up to learn more about the model as information is released.

This document is not the application to be filled out by the applicant; **this is a DRAFT list of the questions that may be found in the online application portal**. This list is for your reference as you assemble your application. CMS reserves the right to seek additional information from applicants to MCP after the application period closes. CMS may also deny individual clinicians or any other relevant entity participation in MCP based on the results of a program integrity review.

The Application will be found online [on the MCP website](#). Questions about the Application for MCP should be directed to mcp@cms.hhs.gov. CMS may publicly share questions or responses or compile them into a Frequently Asked Questions list to ensure that all interested organizations have access to information regarding MCP.

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at <https://www.cms.gov/privacy>.

The following terms are used throughout the application:

- **Organization** – A legal entity, such as an integrated delivery system or group practice, that operates one or more primary care clinics
 - **Organization Headquarters** – This is the primary organization site where MCP information and payments should be directed, if the organization participates in the model.
- **Executive Lead Contact:** An individual who manages or has oversight responsibility for the organization, its finances, personnel, quality improvement, and compliance.

⁴⁸ As defined at §1861(aa)(4) and 1905(l)(2)(B) of the Act, the term "FQHC" includes certain outpatient clinics associated with tribal/urban Indian organizations in addition to HRSA-designated Health Centers and Look-alikes.

⁴⁹ As noted in section 2A of this RFA, [Grandfathered Tribal FQHCs](#) are not eligible for MCP.

- **Federally Qualified Health Center (FQHC):** entity that receives Medicare payments described at §1834(o) of the Social Security Act (the Act) and meets the criteria defined at §§1861(aa)(4) of the Act.
- **Indian Health Programs:** The term ‘Indian Health Program’ means any health program administered by the Indian Health Service and any tribal health program as defined by 25 U.S.C. § 1603(25), except that tribal health programs which are Grandfathered Tribal FQHCs are not eligible for MCP.
- **Model Performance Period:** refers to the time period where the model is proposed to operate. The Model Performance Period begins on July 1, 2024 and ends on December 31, 2034.
- **Performance Year (PY):** Refers to a time period during the entire model performance period specified by CMS when the model is operating. The first performance year is 6 months and lasts from 7/1/24-12/31/24. PY2 and subsequent performance years will occur in calendar years, lasting 12 months (PY2 is from 1/1/25-12/31/25).
- **Practice or practice site:** physical location where care is provided and MCP Care Delivery Requirements (detailed in the Request for Applications- RFA) are met; there may be multiple practices per participant, but they must all bill under the same Medicare-enrolled Taxpayer Identification Number (TIN)
- **Participant:** An organization that has applied, been accepted to participate in MCP, and has executed a Participation Agreement with CMS.
- **Specialty Care Partner:** The specialty organization (defined at the TIN level) that enters into a Collaborative Care Arrangement (CCA) with the MCP participant to improve consultation, treatment, and where needed, time-limited co-management processes for shared patients (see RFA for full CCA and Specialty Care Partner eligibility details)

General Instructions

Making Care Primary (MCP) participation will be at the organizational Taxpayer identification Number (TIN) level. Organizations must meet the applicant eligibility requirements (listed below and detailed in the RFA) for their selected track. An organization must sign a Participation Agreement with CMS in order to participate in MCP.

All Applicants must submit a single application for all of the primary care site(s) operating under its TIN.

For applicant FQHCs, all CCNs for all practice site(s) should be submitted on the application.

If the Applicant is owned by a person, entity, or organization other than a clinical or other leader who practices at a single primary care site, organization, or FQHC location identified in the application, or by a separate entity or healthcare organization, the Applicant also must submit a letter of support from the owner committing to segregate model payments that are paid to the Applicant should they join the model and become a model participant, and assuring that all MCP payments will be used in a manner consistent with the MCP Participation Agreement and related CMS guidance.

Preliminary Questions

MCP Eligibility Criteria

Eligible participants include:

- Health systems, group practices, solo primary care practices (including freestanding Indian Health Service (IHS) and Tribal clinics), and [Standard Payment Method \(Method I\)](#) CAHs
- Facility-based primary care clinics (including IHS and Tribal provider-based clinics)
- Federally Qualified Health Centers (FQHCs)⁵⁰

To be eligible to apply for MCP participation, an organization must:

- Be a legal entity formed under applicable state, federal, or Tribal law, that is authorized to conduct business in each state in which it operates;
- Be Medicare-enrolled;
- Serve as the regular source of primary care for a minimum of 125 attributed Medicare beneficiaries⁵¹; and
- Have the majority (at least 51%) of their primary care sites (physical locations where care is delivered) located in an MCP state (or NY zip code) listed in the MCP RFA

Applicants that are not FQHCs must also:

- Bill Medicare for services furnished by primary care clinicians (MD, DO, CNS, NP, PA) who provide primary care services as part of their job. CMS defines primary care clinicians for the purposes of this RFA as a list of [National Plan & Provider Enumeration System \(NPPES\) specialties](#) including internal medicine, general medicine, geriatric medicine, family medicine, pediatric medicine, nurse practitioner, clinical nurse specialist, and physician assistant. A full list of NPPES specialties considered primary care are listed below.
- Have primary care services account for at least 40% of the applicant's clinicians' collective billing based on Medicare revenue.
 - Non-FQHC applicants must identify, in the application, each individual primary care NPI that renders services under the TIN of the applicant – otherwise known as a MCP Clinician List.

Note: Clinicians with the following [NPPES codes](#) are eligible to be included on an MCP applicant's MCP Clinician List. This means that claims for these clinicians will be adjusted according to the terms in the Participation Agreement and will be used in the attribution methodology. The following specialties are considered primary care clinicians and should be included on the MCP Clinician List:

- Internal Medicine, General Medicine, Geriatric Medicine, Family Medicine, Pediatric Medicine, Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and Physician Assistant (PA). Please note that applicants which employ NPs, CNSs, and PAs that primarily practice under a supervising physician that are applying to participate in MCP listed in specialties *other* than Family Medicine Internal Medicine, General Medicine, Geriatric Medicine, and Pediatric Medicine are not eligible

⁵⁰ Entities that receive Medicare enhanced payments described at §1834(o) of the Social Security Act (the Act) and meet the definition specified at §§1861(aa)(4) of the Act.

⁵¹ CMS Innovation Center will conduct preliminary attribution as part of the application process to see how many attributed beneficiaries the applicant would have if the model were operating during the application period. Please see the [Attribution](#) section for methodology details.

for MCP. NPs that do not bill under supervising physicians must provide primary care as the majority of their services in order to be included on an MCP applicant's MCP Clinician List.

Rural Health Clinics (RHCs), Grandfathered Tribal (GFT) FQHCs, PCF practices and ACO REACH Participant providers that were active in either model as of 5/31/2023 are not eligible to apply to MCP. Practices that provide concierge care⁵² are also ineligible to apply. Former CPC+ practices as well as organizations with experience in Medicare two-sided risk ACO models or programs are eligible to apply to participate in Track 2 or 3 of the model, but not Track 1.

MCP has an overlap policy. Organizations participating in the following programs as of July 1, 2024, are also ineligible to participate in MCP*. If you are accepted to participate in MCP and will, as a result, withdraw from the other initiative(s) in which you currently participate, you will be asked to enter your planned withdrawal date.

- Kidney Care Choices (including Comprehensive Kidney Care Choices and Kidney Care First)
- Financial Alignment Initiative (FAI) for Medicare-Medicaid Enrollees
 - *Note: This includes both the Capitated Model and Managed Fee-for-Service (FFS) Model. Please refer <https://innovation.cms.gov/initiatives/Financial-Alignment/> for more information.*
- Any other CMS Innovation Center ACO or shared savings initiative

CMS will allow organizations and individuals participating in a Shared Savings Program (SSP) to overlap with MCP during the first 6-month performance year between 7/1/24-12/31/24, but these organizations must withdraw from SSP by a deadline set by CMS that will be prior to the beginning of the next MCP performance year (1/1/25) if they wish to continue participating in MCP. During the 6-month performance year in 2024, these organizations will be able to participate in MCP and SSP but no MCP model payments will be made to them until 1/1/25 to avoid potential duplicate payments.

Non-FQHC participants may not have clinicians concurrently listed on SSP participant lists and MCP Participant or Clinician lists by the PY25 SSP participant list drop deadline. Participant FQHCs may not have CCNs concurrently listed on SSP participant lists and MCP Participant or Clinician lists by the PY25 SSP participant list drop deadline.

Other than the 6-month SSP exception described above, throughout the performance years, primary care clinicians on an MCP Clinician List cannot participate in a model or program with which MCP has a no-overlaps policy. It will be incumbent on the participant to manage its list of clinicians and inform clinicians of which model or initiative they are in and where their beneficiaries will be attributed.

FQHC Instructions

FQHCs must submit a list of all physical practice sites (as well as their CMS Certification Numbers (CCNs)) enrolled in Medicare under their organizational TIN when applying to MCP.

⁵² Defined as care provided after a doctor or group of doctors charges a membership fee before seeing or accepting a patient into a practice. After payment of this fee, patients may receive some services or amenities that Medicare doesn't cover. (<https://www.medicare.gov/coverage/concierge-care>)

Track Selection

Applicants should review the MCP RFA for detailed information on track eligibility. Beyond determining eligibility, applicants should review details of payment, care delivery and health IT requirements to determine the most appropriate track for their organization. Organizations with multiple practice sites (physical locations where care is delivered) will need to determine which Track is most appropriate given their organization's care delivery capabilities overall.

Applicants inexperienced in value-based care (see definition in [Track Selection](#)) can choose to enter in Track 1, and applicants with experience will enter in Track 2 or 3 depending on which Track they apply to.

MCP Eligibility Questions

The questions in this section are required to move forward with the application to MCP. The answers to these questions impact your organization's eligibility for MCP and may disqualify you from completing the remainder of the application.

Applicants must have a primary address within the eligible MCP states.

1. Did you or someone from your organization complete a letter of intent (LOI) for MCP?
 - a. Yes
 - i. *If yes, please enter the confirmation number provided after completing your LOI (if you do not remember your confirmation number, you can leave this blank)*
 - b. No
2. In which MCP state is your organization located?

Select response from drop-down options menu in online application

- Colorado
- Massachusetts
- Minnesota
- New Jersey
- New Mexico
- Upstate New York
- North Carolina
- Washington

Please review the MCP eligibility in the RFA and summarized in this application, and attest to the following statement confirming your understanding.

☐ Our organization has reviewed and understands the MCP Overlap policy listed above.

Complete Profile

This section focuses on background information about your organization. Information in this section will be used to determine whether your organization meets the baseline eligibility criteria for participation in MCP.

If an organization is accepted to participate in MCP and CMS later learns that answers to the questions in this section were not or are no longer accurate, CMS reserves the right to terminate the organization's participation in the model immediately.

Organization Information

This section asks questions about the structure and ownership of your organization. If you have a question about organizational structure that is not addressed in the Request for Applications (RFA) or in the Application Instructions, please contact CMS at mcp@cms.hhs.gov.

This section should be filled out by someone within the organization who is familiar with the Taxpayer Identification Number (TIN), CCNs (if applicable) and information about organization ownership.

1. Organization Headquarters Information:

The organization headquarters is the organization's primary site (physical location)

- a. Organization Legal Name:
- b. Organization "doing business as" (DBA) Name (if different from site name):
- c. Organizational Billing TIN:
- d. Street Address 1:
- e. Street Address 2:
- f. City:
- g. State:
- h. County
- i. ZIP Code:
- j. +4 (Optional)
- k. Organization Phone Number:
- l. Organization Fax Number (Optional):
- m. Website (Optional)

2. Is your organization applying as a FQHC?

An FQHC is an entity that meets the criteria listed in 1861 (aa) (4) of the Social Security Act.

- a. Yes
- b. No

Please list your organization's CCN(s). *Note: If you are applying as a FQHC and do not know what a CCN is, more information can be found [here](#).*

Site name	Address	Phone Number	CCN

3. Is your organization an Indian Health Program as defined under 25 USC § 1603(12)? Please note that [Grandfathered Tribal FQHCs](#) are not eligible for MCP.

- a. Yes
- b. No

4. As of January 1, 2024, will your organization be a CAH that has selected Standard or Method I billing, meaning that clinicians bill under their own National Provider Identifier (NPI)s and have not reassigned their billing rights to your CAH?
- a. Yes
 - b. No
5. Is your organization owned by a person, entity, or organization other than a clinical or other leader who practices at a single primary care site, organization or FQHC location identified in the application, or by a separate entity or healthcare organization?
- a. Yes
 - i. *If yes, the Applicant also must submit a letter of support from the owner committing to segregate funds that are paid based on the Applicant's participation in MCP and assuring that all MCP payments will be used in a manner consistent with the Participation Agreement.*
 - b. No

6. *If your organization has multiple TINs, please submit a separate application for each TIN.*

Please provide all the TINs that your organization has used to bill Medicare since January 1, 2021. Select a check box for the ONE billing TIN that your organization would use to bill primary care in 2024 for MCP services. This is the TIN that your organization would use to bill all services for MCP.

- ☐ TIN 1:
- ☐ TIN 2:
- ☐ TIN 3:
- ☐ TIN 4:

7. Is your organization owned and operated by a larger health care organization or parent organization, such as a health system or a group practice?
- a. Yes, Hospital-based health system
 - b. Yes, Non-hospital-based health system
 - c. Yes, Clinician-owned group practice
 - d. No

If "No," who is the majority owner of this organization?

- a. Physicians in the organization
- b. Non-physician practitioners (nurse practitioners or physician assistants) in the organization
- c. Other (Specify)

If "Yes," does your larger health care organization/ Parent Organization bill under a different TIN than your organization? If so, please enter the TIN below. If your parent organization does not use a TIN to bill Medicare for services, you may leave this blank.

TIN: _____

Organization Contacts

This section asks for organization contact information needed for MCP. Please use the explanations provided to identify the most appropriate person for each contact field and enter their most current contact information.

- **Applicant Contact:** The applicant contact is the person who has filled out your MCP application and/or is very familiar with the different sections of the application and understands the answers your organization has provided. If this contact also works in your organization (and you indicate this when filling out their contact information), they will also receive your organization's acceptance/rejection letters and be automatically signed up to get the weekly MCP newsletter.
- **Organization Contact(s) (if applicable):** If your applicant contact does not work in your organization, you will also need to fill out the "Organization Contact" field. This person must work in your organization. They will receive your acceptance/rejection letters and be automatically signed up to get the weekly MCP newsletter.
- **Health IT Contact:** This should be someone, from your organization who administers your organization's EHR and other health IT and is prepared to answer specific questions about the health IT in use in your organization.
- **Executive Lead Contact:** An individual who manages or has oversight responsibility for the organization, its finances, personnel, quality improvement, and compliance.

1. Add Contact Details

- a. E-mail Address:
- b. First Name:
- c. Last Name:
- d. Title/Position:
- e. Contact Type:
 - a. Applicant Contact
 - b. Organization Contact
 - c. Health IT
 - d. Executive Lead Contact
- f. {Symbol} Does this person work in the organization? If you answer no to this question, you will have to fill out the "Organization Site Contact" Section.
- g. Business Phone Number:
- h. Business Phone Number Extension (Optional):
- i. Alternative Phone Number (e.g., cell phone) (Optional):
- j. Street Address 1:
- k. City:
- l. State:
- m. ZIP Code:
- n. +4 (Optional)

Complete Application

Track Eligibility

Applicants will self-select into Track 1, 2, or 3 based their ability to meet the track requirements outlined in the RFA. Please review the RFA in detail, including Track Eligibility (pages 14-16) and the Care Delivery requirements (pages 19-24) and for each track (found in Appendix C).

CMS reserves the right to seek additional information from applicants after the application period closes. MCP Track 1 is designed for participants who have no experience in value-based care (inexperienced with performance-based risk Medicare initiatives).

Experience in value-based care is defined as:

The applicant has participated in performance-based risk Medicare initiatives (including Primary Care First (PCF), Comprehensive Primary Care Plus (CPC+), Next Generation AGO (NGACO), Direct Contracting, Accountable Care Organizations Realizing Equity Access and Community Health (ACO REACH), AND/OR has been part of a Medicare Shared Savings Program (SSP)ACO that has not deferred its entry into a second agreement period under a two-sided model under [§ 425.200\(e\)](#) in the five most recent performance years prior to the start of the agreement. This includes scenarios where 60% or more of the applicant TIN's NPIs or CCNs meet the aforementioned criteria.

Applicants that demonstrate experience with performance-based risk and meet the relevant application eligibility requirements are not eligible for Track 1 and must begin MCP in Tracks 2 or 3.

☐ Our organization has reviewed and understands the information above and in the RFA regarding Track eligibility requirements based on experience with performance-based risk and will apply to the appropriate Track based on historical experience.

1. Has your organization ever participated in CPC+, PCF, or any other Medicare two-sided risk ACO model or performance-based risk program as defined above in the last five years?
 - a. Yes
 - b. No

Upfront Infrastructure Payment (UIP) Eligibility

Track 1 eligible participants may qualify for an up-front infrastructure payment (UIP). Only participants deemed to be “low revenue” (“low revenue” is intended to be a proxy for whether the organization is smaller, physician-owned, or rural) will be eligible. Using the 24-month historical claims period from December 2021 to December 2023, we will assess whether a participant meets the definition of “low revenue” by calculating participant’s within-TIN Part A + Part B revenue and dividing it by the total Part A + Part B spending for the participant’s attributed beneficiaries. Participants that have a result which is less than 35% will meet the low revenue threshold criteria and are eligible for the UIP, which we will communicate to accepted participants in Spring 2024.

2. Of note, recipients of the UIP will be required to provide detailed reporting regarding how funds are spent, return any unspent funds, and sign a Participation Agreement acknowledging that UIP funds will be distributed over the 2.5-year investment period (the 30-month MCP Track 1 period) and can be recouped if the participant withdraws or CMS terminates its participation in the model prior to the participant entering Track 3. Given this information, would your organization like to be considered to receive the Track 1 upfront infrastructure payment (UIP)?
 - a. Yes
 - b. No

Confirmation of RFA Review and Applicant Understanding

Please attest to the following statements after reviewing the RFA in its entirety:

- ☐ Our organization has reviewed and understands the information in the RFA regarding requirements and MCP payment structure differences for each MCP track.
- ☐ Our organization has reviewed the Care Delivery section of the RFA and agrees to comply with the Care Delivery expectations of the track we are applying to, if accepted to participate in the model.
- ☐ Our organization understands that all participants will complete baseline and ongoing Care Delivery reporting (at least bi-annually for Tracks 1 and 2 and annually for Track 3) to ensure we are meeting the requirements, which will be subject to monitoring and audit.
- ☐ Our organization understands that all Track 2 and Track 3 participants will be required to administer the PCPCM survey. Participants in all Tracks will be asked to submit a patient roster by a date and in a manner specified by CMS.
- ☐ A clinical leader from our organization has reviewed the MCP RFA and requirements and is committed to providing leadership support in the organization's participation in the program.

3. After attesting to the above statements, please indicate which track you are applying to:
 - a. Track 1
 - b. Track 2
 - c. Track 3

Non-FQHCs Only: Clinician and Staff Information

If you are a FQHC, you may skip this section and move directly to the Health Information Technology (IT) section.

This section asks questions about the clinicians in your organization and should be filled out by someone familiar with the clinician information, including National Provider Identifiers (NPIs), number of clinicians, and clinician specialty and work within the organization. Unless otherwise indicated, please

answer only for the primary care clinicians that will be participating in MCP. As a reminder, non-FQHC applicants must identify each individual NPI that meets the eligibility criteria and renders services under the TIN of the applicant.

Applications will be screened to determine eligibility for further review using criteria detailed in this solicitation and in applicable law and regulations. In addition, CMS may also deny individual clinicians or any other relevant entity participation in MCP based on the results of a program integrity review of the applicant, its clinicians, or any relevant individuals or entities.

Applicants will be required to disclose any investigations of, or sanctions that have been imposed on the applicant or individuals in leadership positions in the last three years by an accrediting body or state or federal government agency. Individuals in leadership positions include key executives who manage or have oversight responsibility for the organization, its finances, personnel, and quality improvement, including, for example, CEO, CFO, COO, CIO, medical director, compliance officer, or an individual responsible for maintenance and stewardship of clinical data.

1. To the best of your knowledge, has your organization, organization's owners, or anyone employed in your organization had a final adverse legal action (as defined on page 12 of the Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855B or page 16 of CMS-855A (found [here](#)) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative.

☐ Yes

☐ No

If yes, please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any.

Explanation:

The purpose of the next question is to create a list of participating clinicians that bill through the TIN of your organization (i.e., they have reassigned to your organization the right to receive Medicare payments but are listed as the rendering provider on claims). As you add information about each of the clinicians in your organization, please create only one record, even if a clinician works at multiple locations of your larger health care organization.

Note: Clinicians with the following [NPPES codes](#) are eligible to be included on an MCP Clinician List. This means that claims for these clinicians will be adjusted according to the terms in the Participation Agreement and will be used in the attribution methodology. The following specialties are considered primary care clinicians for purposes of MCP:

Internal Medicine, General Medicine, Geriatric Medicine, Family Medicine, Pediatric Medicine, Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and Physician Assistant (PA). Please note

that applicants which employ NPs, CNSs, and PAs that primarily practice under a supervising physician listed in specialties *other* than Family Medicine Internal Medicine, General Medicine, Geriatric Medicine, and Pediatric Medicine should not be included on an applicant's MCP Clinician List. NPs that do not bill under supervising physicians must provide primary care as the majority of their services in order to be included on an MCP applicant's MCP Clinician List.

If your organization is found eligible for participation in the model, CMS will conduct a program integrity screening of all clinicians on the list and confirm their specialty.

2. For each primary care clinician in your organization, please provide the following information.

a. National Practitioner Identifier (NPI):

Note: You can look up NPIs at this link <https://npiregistry.cms.hhs.gov/>

b. Clinician First Name:

c. Clinician Middle Initial (Optional)

d. Clinician Last Name

e. Clinician Type:

- ❖ Physician (MD or DO)
- ❖ Clinical Nurse Specialist
- ❖ Physician Assistant
- ❖ Nurse Practitioner

f. Primary Specialty:

You can confirm each clinician's specialty type using the [NPPES website](#)

- ❖ General Medicine
- ❖ Family Medicine
- ❖ Internal Medicine
- ❖ Pediatric Medicine
- ❖ Geriatric Medicine
- ❖ N/A (e.g., NPs, CNSs, and PAs)

3. *If your organization has multiple physical locations where primary care is delivered to Medicare beneficiaries, please list each location below. Please note, MCP requires that all physical locations that provide primary care to Medicare beneficiaries be included in this list, as all physical locations will be considered part of the model.*

Site name	Address	Phone Number

Specialty Care Partners

Track 2 and 3 applicants: MCP participants are required to enhance communication and collaboration with at least one specialty practice to improve their provision of high-quality primary and specialty care. This requirement will begin in Track 2.

- Non-FQHCs and non-Indian Health Programs will be required to designate at least one Specialty Care Partner who specializes in Pulmonology, Cardiology, or Orthopedics.
- FQHCs and Indian Health Programs will not be required to partner with at least one Specialty Care Partner who specializes in Pulmonology, Cardiology, or Orthopedics.

CMS will collect Specialty Care Partner Lists on at least an annual basis during each calendar year of MCP. Please acknowledge below that you have reviewed the RFA and understand the Specialty Care Partner requirements.

☐ Our organization has reviewed and understands the information in the RFA regarding Specialty Care Partner requirements.

e-Consultations (e-Consults)

An e-consult is a form of interprofessional consultation where the specialist provides clinical guidance without seeing the patient face to face. e-Consults typically occur asynchronously, either integrated into the EMR or through a separate system. MCP requires participants to implement e-consults beginning in Track 2, which may require a separate e-consult technology solution⁵³ to support coordinated, and clinically appropriate electronic exchanges between MCP participants and specialists.

The lump sum Upfront Infrastructure Payment (UIP), available only to Track 1 applicants who meet the eligibility criteria, may be used to invest in an e-consult technology solution. Once MCP participants enter Tracks 2 and 3, they are required to send and receive e-consults as part of their care delivery requirements. This may require use of a separate technology solution beyond current EMR capabilities.

Given the critical role of e-consults in encouraging specialty integration, CMS will consider the lack of e-consult technology as a potential reason for overriding a negative result on the other UIP eligibility checks (e.g., if an Indian Health Program participating in Track 1 fails the “low revenue” eligibility criteria, but does not have an e-consult technology solution, it would be eligible for the UIP).

1. Does your organization currently use an e-consult technology solution?

- a. Yes
- b. No

a. *If no, do you intend to purchase one using MCP payments?*

- i. Yes

⁵³An e-consult technology solution is inclusive of phone, video, or a HIPAA-compliant application, platform, or EHR enhancement that allows two-way communication between primary care clinicians and specialists and can securely share patient records.

- ii. No
- iii. Not sure (please explain):

Health Information Technology (IT)

This section asks questions about the health IT capabilities of your organization. The person filling out this section should be familiar with the health IT in use in your organization today. The health IT requirements are detailed in the RFA.

Please attest to the following statement:

- ☐ Our organization has reviewed the Health IT section of the RFA, and understands the Health IT requirements for the Track we are applying to, including the requirements to:
 - ☐ Connect with a Health Information Exchange (HIE) by the July 1, 2024, for Track 3 and January 1, 2025 for Tracks 1 and 2.
 - ☐ Use certified health IT that has been updated to United States Core Data for Interoperability (USCDI) USCDI Version 3, where applicable for certified functionality required under the CEHRT definition at 42 CFR 414.1305 by the deadline finalized by ONC.
 - ☐ Report annual quality measures (including electronic clinical quality measures [eCQMs] via Quality Reporting Data Architecture [QRDA] III), as applicable by track.

Application Data Sharing

1. Does your organization agree for CMS to share your TIN, with payers applying to support the model within your state?
 - ☐ Yes
 - ☐ No

Appendix B: Certified Health IT Requirements

All Participants

MCP health IT requirements were designed to meet model-specific standards to promote data and health information exchange (HIE), provide patients access to electronic health information, and avoid information blocking. MCP participants will benefit from the use of interoperable health IT systems and will see the value of data sharing, both between clinicians and suppliers and with patients by implementing the requirements listed below.

MCP participants will be required to connect to a regional or national health information exchange (HIE). Applicants will be eligible for the model even if they have not yet connected to an HIE but will be required to do so if selected for participation in MCP. Additional requirements for all participants can be found in the table below.

Health IT Requirements Table

This table describes the proposed health IT requirements for Making Care Primary participants and the tentative date by which each must be accomplished. Participants will also have to comply with certain interoperability requirements under the terms of the MCP Participation Agreements. The proposed requirements below provide the minimum necessary health IT capabilities and participants are encouraged to further evolve capabilities over the course of the model.

Table C-1: Tentative Health IT Requirements for MCP ⁵⁴

Requirement	Date	Notes
Overall CEHRT Definition Adoption		
Adopt and maintain, at a minimum, health IT needed to meet the CEHRT definition required by the QPP at 42 CFR 414.1305.	By July 1, 2024.	
Use certified health IT that has been updated to a required version ⁵⁵ of the United States Core Data for Interoperability (USCDI) Version 3, where applicable for certified functionality required under the CEHRT definition at 42 CFR 414.1305 .	By deadline finalized by ONC.	ONC has proposed to require USCDI Version 3 ⁵⁶ in certified health IT products by January 1, 2025. ⁵⁷
Patient Access to their Health Information		
The MCP participant must provide patients access to their health information via technology incorporating a standards-based Application Programming Interface (API) meeting the certification criterion at 45 CFR 170.315(g)(10).	By July 1, 2024.	ONC, in partnership with CMS, has identified HL7® Fast Healthcare Interoperability Resources (FHIR®) Release 4.0.1 as the foundational standard to support data exchange via secure APIs at 45 CFR 170.215.
Model Reporting		
Maintain Health IT Details Tab in the Participant Portal.	By June 1, 2024 (30 days prior to model start), then ongoing.	Making Care Primary participants must maintain up-to-date health IT information in the Participant Portal. This includes, but is not limited to, changes in primary or quality reporting health IT vendor(s), and product information.

⁵⁴ CMS reserves the right to update Health IT requirements in future model years.

⁵⁵ Participants may also use certified health IT updated to newer versions of the USCDI approved under ONC's Standards Version Advancement Process.

⁵⁶ See <https://www.healthit.gov/isa/sites/isa/files/2022-10/USCDI-Version-3-October-2022-Errata-Final.pdf>.

⁵⁷ See <https://www.federalregister.gov/d/2023-07229/p-283> (88 FR 23762)

Requirement	Date	Notes
Information Blocking		
Information Blocking: Refrain from information blocking as defined at 45 CFR 171.103 .	By July 1, 2024, then ongoing.	
HIE Requirement		
Connect to an HIE that allows participants to send data and receive electronic alerts for patient transitions of care from hospitals	Tracks 1 and 2: By January 1, 2025. Track 3: By July 1, 2024.	The term “HIE” broadly refers to arrangements that facilitate the exchange of health information and may include arrangements commonly denoted as exchange “frameworks,” “networks,” or using other terms. HIEs should be capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs and should not engage in exclusionary behavior when determining exchange partners.
Certified Health IT for Electronic Clinical Quality Reporting Measures (eCQM) Reporting		
Adopt health IT meeting certification criteria found at 45 CFR 170.315(c)(1) – (c)(3) for all of the electronic clinical quality measures in the MCP measure set.	No later than January 1, 2025.	For each performance year, participants must use the eCQM specifications for Reporting listed in the eCQI Resource Center .
eCQM reporting submission in Quality Reporting Document Architecture Category III (QRDA III) format via qpp.cms.gov.	The first expected Reporting Period is tentatively scheduled from January 1 to February 28, 2026 (reflecting performance year 2025). Reporting Period dates will be communicated yearly.	All Making Care Primary participants must report eCQMs electronically in the QRDA III format via the qpp.cms.gov website during the applicable reporting period. While Making Care Primary will require measure reporting in the QRDA III format via the qpp.cms.gov website, we plan to align with approaches under the CMS Digital Quality Measures initiative as they become available. ⁵⁸
Adopt and maintain technology with the capability to filter quality measure data for reporting at the MCP organization level [TIN(s)/NPI(s)].	No later than January 1, 2025.	eCQM and Social Drivers of health measure reporting must be filtered at the Making Care Primary organization level, [TIN(s)/NPI(s)] and may not be filtered at the individual clinician level. ⁵⁹

⁵⁸ For more information about the CMS Digital Quality Measures initiative, see <https://ecqi.healthit.gov/dqm>.

⁵⁹ MCP participants may adopt and maintain health IT certified to the “Clinical quality measures (CQMs) — filter” at 170315(c)(4), but this is not required.

Requirement	Date	Notes

Appendix C: MCP Care Delivery Requirements

This table summarizes the progressive care delivery requirements, across tracks and domains.

Care Delivery Requirements by Track			
	Track 1	Track 2 <i>Same requirements as Track 1</i> +	Track 3 <i>Same requirements as Track 2</i> +
Care Management Domain			
Targeted Care Management	<ul style="list-style-type: none"> Empanel and risk stratify all patients Identify staff and develop workflows to provide chronic care management to high-risk patients, with an emphasis on hypertension and diabetes management Identify staff and develop workflows to provide timely follow-ups for high-risk patients post ED visit and hospitalization 	<ul style="list-style-type: none"> Implement chronic care management for high-risk patients most likely to benefit, with an emphasis on hypertension and diabetes management Implement episodic care management to provide timely follow-ups for high-risk patients post ED visit and hospitalization 	<ul style="list-style-type: none"> Implement individualized care plans for high-risk patients most likely to benefit, with an emphasis on hypertension and diabetes management
Chronic Condition Management	<ul style="list-style-type: none"> Identify staff and develop workflows to deliver individualized self-management support services for chronic conditions, with an emphasis on hypertension and diabetes management 	<ul style="list-style-type: none"> Implement individualized self-management support services for chronic conditions, with an emphasis on hypertension and diabetes management 	<ul style="list-style-type: none"> Expand self-management services to include group education and linkages to community-based supports, as appropriate
Care Integration Domain			
Specialty Care Integration	<ul style="list-style-type: none"> Use MCP data tools to identify high-quality specialists 	<ul style="list-style-type: none"> Participants identify high-quality Specialty Care Partners through Collaborative Care Arrangements and Specialty Care Partner List 	<ul style="list-style-type: none"> Establish enhanced relationships with high-quality specialists through

		<ul style="list-style-type: none"> • Furnish MCP e-Consult services with at least one specialist 	time-limited co-management
Behavioral Health Integration	<ul style="list-style-type: none"> • Identify staff and develop workflows to initiate a behavioral health integration (BHI) approach grounded in measurement-based care (MBC)⁶⁰ 	<ul style="list-style-type: none"> • Implement a BHI approach utilizing measurement-based care, including using standardized measurement tools and measurement data to inform treatment decisions. • Systematically and universally screen for key behavioral health conditions, including depression and substance use disorder 	<ul style="list-style-type: none"> • Optimize BHI workflows using a quality improvement framework
Community Connection Domain			
Health-Related Social Needs (HRSN) Screening and Referral	<ul style="list-style-type: none"> • Implement universal HRSN screening & provide referral resources • Develop workflows for referring beneficiaries with unmet HSRNs (i.e., positive screens) to social service providers in the community (i.e., community-based organizations (CBOs) and/or public health organizations) 	<ul style="list-style-type: none"> • Implement social service referral workflows with clear roles and responsibilities for MCP participant and social service provider partners 	<ul style="list-style-type: none"> • Optimize social service referral workflows, using a quality improvement framework, to improve approaches for assessing and managing socially complex beneficiaries through social service partners.
Supporting Whole-Person Care Through Community Supports and	<ul style="list-style-type: none"> • Explore partnerships with social service providers (i.e., community based (CBOs) and/or public health organizations) to meet beneficiaries HRSNs 	<ul style="list-style-type: none"> • Establish partnerships with social service providers • Utilize CHW (or equivalent professional with shared lived 	<ul style="list-style-type: none"> • Strengthen partnerships with social service providers • Optimize the use of a CHW/professional with shared lived

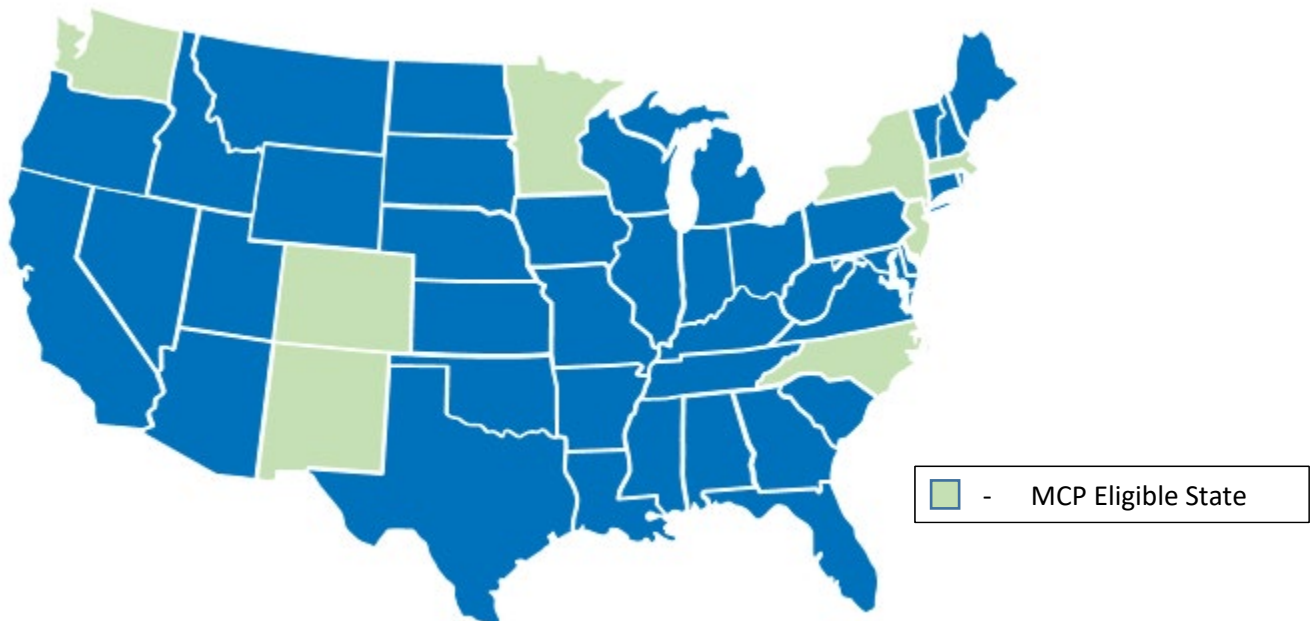
⁶⁰ Measurement-based care is the systematic monitoring of patient outcomes through the use of standardized measurement instruments and the analysis of measurement data to inform clinical decision-making. The Joint Commission (2022). *Outcome Measures Standard*. <https://www.jointcommission.org/what-we-offer/accreditation/health-care-settings/behavioral-health-care/outcome-measures-standard/>

Service Navigation	<ul style="list-style-type: none"> • Identify staff (a community health worker (CHW) or equivalent professional with shared lived experience) who will navigate and coordinate health-related and social support services to higher need beneficiaries, such as addressing social isolation; supporting stress management; supporting chronic disease management; monitoring for gaps in care; accessing low-income benefits; and/or other appropriate support services. 	experience) in navigating and coordinating health-related and social support services to higher need beneficiaries	experience, using a quality improvement framework, in navigating and coordinating health-related and social support services to higher need beneficiaries
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**Note: Staff (a CHW or equivalent professional with shared lived experience) does not need to be employed by the MCP participant. For example, participants may utilize existing navigators in community-based organizations. However, the identified resource must assist all referred beneficiaries.*

Appendix D: Making Care Primary States and Counties

State	County Participation
Colorado	All Counties
Massachusetts	All Counties
Minnesota	All Counties
New Jersey	All Counties
New Mexico	All Counties
New York	Putnam; Rockland; Orange; Albany; Schenectady; Montgomery; Greene; Columbia; Rensselaer; Saratoga; Fulton; Schoharie; Washington; Otsego; Hamilton; Delaware; Ulster; Dutchess; Sullivan; Warren; Essex; Clinton; Franklin; Saint Lawrence; Onondaga; Cayuga; Oswego; Madison; Cortland; Tompkins; Oneida; Seneca; Chenango; Wayne; Lewis; Herkimer; Jefferson; Tioga; Broome; Erie; Genesee; Niagara; Wyoming; Allegany; Cattaraugus; Chautauqua; Orleans; Monroe; Livingston; Yates; Ontario; Steuben; Schuyler; Chemung;
North Carolina	All Counties
Washington	All Counties



Appendix E: Qualifying CPT or HCPCS Codes Eligible for Claims-based Attribution

CMS will attribute Medicare beneficiaries who meet the eligibility criteria in the [Attribution](#) section to an MCP participant, if they have received qualifying services, based on the following CPT and HCPCS codes, from an MCP clinician or MCP site (in the case of FQHCs) during the look-back period (the most recent 24 months).

Please note that all CPT and HCPCS codes listed in this table and throughout the document are current as of the CY 2023 PFS Final Rule and are subject to change based on future Medicare PFS Final Rules. For the performance year beginning on July 1, 2024, and subsequent performance years, we will define primary care services for purposes of assigning beneficiaries to participants as the set of services identified by the Shared Savings Program published in each year's Medicare PFS Final Rule.

Service	Code
Office/Outpatient Visit E/M	99201-99205, 99211-99215
Complex Chronic Care Coordination Services	99487
Chronic Care Management (CCM) Services	99490-99491
Principal Care Management (PCM)	99424-99427
Transitional Care Management Services	99495-99496
Home Care/Domiciliary Care E/M	99339-99345, 99347-99350
Online Digital E/M	99421-99423
Audio-Only Telephone E/M	99441-99443
Technology-based check-in services	G2010, G2012, G2252
Remote Physiologic Monitoring (RPM)	99453-99454, 99457-99458, 99091
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	G0506

Care management services for behavioral health conditions	99484
Cognition and functional assessment for patient with cognitive impairment	99483
Psychiatric Collaborative Care Model	99492-99494, G0511-G0512
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
Interprofessional Consultation (IPC) and MCP e-Consult (MEC)	99452, TBD
Federally qualified Health Center (FQHC) all-inclusive visit	G0466-G0467
Federally qualified Health Center (FQHC) visit, initial preventive physical examination (IPPE) or annual wellness visit (AWV)	G0468
Distant site telehealth services Rural Health Clinics or Federally Qualified Health Centers (RHC/FQHC)	G2025
FQHC Virtual Communication Services	G0071

Appendix F: Services Considered Duplicative of the Enhanced Services Payment

MCP participants will not be paid for the following services billed for attributed Medicare beneficiaries:

Duplicative Enhanced Care Management and Other Primary Care Services ⁶¹	
Service	Code
Prolonged E&M without direct patient contact	99358, 99359*
Prolonged Clinical Staff Services	99415, 99416*
Principal care management (PCM) services	99424, 99425*, 99426, 99427*, G2064a, G2065a
Prolonged CCM services	99437*
Non-complex CCM	99439*, G2058*
Complex chronic care coordination services	99487
Chronic care management (CCM) services	99489*, 99490, 99491
Transitional care management (TCM) services	99495, 99496
Assessment/care planning for patients requiring CCM services	G0506
CCM or General Behavioral Health Integration (BHI) Services (for FQHCs)	G0511

CPT = Current Procedural Terminology; HCPCS = Healthcare Common Procedure Coding System; PCM = principal care management; CCM = Chronic care management; TCM = transitional care management.

Notes: * Add-on codes are also excluded when billed with other duplicative services.

^a Effective January 1, 2022, CMS replaced HCPCS codes G2064 and G2065 with CPT codes 99424, 99425, 99426, and 99427 under the Medicare PFS. However, these codes will continue to be used for attribution or payment purposes, when historical claims analysis includes periods before 2021, during which this code was in use.

⁶¹ Please note that all CPT and HCPCS codes listed in this table and throughout the document are current as of the CY 2023 PFS Final Rule and are subject to change based on future Medicare PFS Final Rules.

Appendix G: CPT/HCPCS Codes Used to Calculate Prospective Primary Care Payments⁶²

Prospective Primary Care Payment Services (PPCP Services) Included In Track 2 and Track 3 Prospective Primary Care Payment (PPCP)	
Service	Code
Administration of health risk assessment (HRA)	96160, 96161
Office/outpatient visit for the evaluation and management (E&M) of a patient	99202-99205, 99211-99215
Home care/domiciliary care E&M	99324-99328, 99334-99337, 99341-99345, 99347-99350
Home care/domiciliary care plan oversight	99339-99340
Prolonged E&M with direct patient contact	99354, 99355, G2212
Remote therapeutic monitoring (RTM) non-face-to-face treatment management services	98975-98977, 98980, 98981
Online digital E&M	99421-99423
Telephone E&M services	99441-99443
Remote physiologic monitoring (RPM) non-face-to-face treatment management services	99453, 99454, 99457, 99458, 99091
Technology-based check-in services	G2010, G2012, G2252
Advance care planning	99497, 99498
Welcome to Medicare and annual wellness visits	G0402, G0438, G0439
FQHC Virtual Communication Services	G0071
FQHC Distant Site Telehealth visit	G2025
FQHC All-Inclusive visit	G0466, G0467
FQHC IPPE or AWW visit	G0468
Services Added to the PPCP in Track 3	

⁶² Please note that all CPT and HCPCS codes listed in this table and throughout the document are current as of the CY 2023 PFS Final Rule and are subject to change based on future Medicare PFS Final Rules.

Prospective Primary Care Payment Services (PPCP Services) Included In Track 2 and Track 3 Prospective Primary Care Payment (PPCP)	
Interprofessional consult (IPC) services [Track 1]	99451, 99446-99449
MCP e-Consult (MEC) codes [Track 2]	TBD
Behavioral health integration (BHI) services	99484, 99492, 99493, 99494, G2214, G0512
Depression, substance use disorder, and alcohol misuse screening and counseling services	G0396-G0397, G0442-G0444
Cognition and functional assessment for patient with cognitive impairment	99483, G0505