CMS.gov
Centers for Medicare & Medicaid Services

MCP-RFA-00585 Requested by John Doe on 10/24/2023 09:13

Application Status: In Progress

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)

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 beneficiaries; 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.
- Note: 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 care 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.

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 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 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.

Overlap Policy

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 and MCP participant lists by the PY25 SSP participant list drop deadline. Participant FQHCs may not have CCNs concurrently listed on SSP and MCP participant 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.

Applicants that currently participate in certain other CMS initiatives will be ineligible for concurrent participation in MCP. Applicants enrolled in the Shared Savings Program (SSP) for Performance Year (PY)24 will be eligible to apply to MCP, but must withdraw from SSP by PY25. The SSP and MCP are both 'full-TIN' programs, where the full TIN must participate, therefore, non-FQHC applicants may not have clinicians concurrently listed on SSP and MCP participant lists by the PY25 SSP participant list drop deadline. FQHC applicants may not have CCNs concurrently listed on SSP and MCP participant lists by the PY25 SSP participant list drop deadline.

FQHC Instructions

FQHCs will 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. Given billing and organizational differences, FQHCs will not be required to submit a roster of primary care practitioners.

Track Eligibility

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.

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 main address within the eligible MCP states.

1. Did you or someone from your organization complete a letter of intent (LOI) for MCP?	No
LOI IDs (Optional) Note: Please enter the confirmation number provided after completing your LOI(if you do not remember your confirmation number, you can leave this blank.)	N/A
2. In which MCP region is your organization located?	Colorado

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 and in the Request for Applications.	✓
Our organization has reviewed and understands the MCP Overlap policy listed above and in the Request for Applications.	10/27/2023 9:02 AM

Complete Profile

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 primary organization site where MCP information and funding should be directed.

a. Organization Legal Name	
b. Organization “doing business as” (DBA) Name (if different from site name)	
c. Organization 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 an FQHC?** An FQHC is an entity that meets the criteria listed in 1861 (aa) (4) of the Social Security Act.	

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.

CCN Details

***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.**	
***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?**	
***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?**	

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.

Files

***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 will use to bill primary care in 2024 for MCP services. This is the TIN that your organization will use to bill all services for MCP.

TIN Details

***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?**	
Who is the majority owner of this organization?	
If Other, please specify	
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.	

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 (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.

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 (Section 2) and the Care Delivery design (Section 4) and requirements for each track (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?	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.

Additional UIP details can be found in the RFA. 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 13 months and can be recouped for up to 2 years if the participant withdraws or CMS terminates its participation in the model prior to entering Track 3.

2. Given this information, would your organization like to be considered to receive the track 1 upfront infrastructure payment (UIP)?	

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:	

Non-FQHCs Only: Clinician and Staff Information

If you are a FQHC, you may hit "Save and Continue" to skip this section and move directly to the Health Information Technology (IT) section. We will use the CCN and TIN information you provided previously to conduct program integrity screening.

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 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. CMS may also deny individual clinicians or any other relevant entity participation in MCP based on the results of a program integrity review.

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 (https://www.cms.gov/medicare/provider-enrollment-and-certification/enrollment-applications) 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.	
Please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any.	

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 roster. 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 Clinicians 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:

Primary Care Clinicians

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.

Physical Locations

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 rosters 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.	☐

eConsultations (eConsults)

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 solution54 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?	Yes
1a. If No, do you intend to purchase one using MCP payments?	
Explain:	

Health IT & Data Sharing

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?	No

Certify and Submit

Certification Statement

I certify that the information in this application reflects the most up-to-date information I have about my organization at this time. I understand that CMS will use this information to determine my eligibility to participate in the Making Care Primary model.	
I attest to the above statement.	☐