**Making Care Primary (MCP) Model**

Ten-Year CMS Multi-Payer, Value-Based Demonstration Program for FQHCs and other providers in eight states

Last updated 7/27/23

[Click here for chart showing funding streams](https://docs.google.com/spreadsheets/d/1LB91Xt81DvgVOyyGu9773kVSqvmyUthO2m-7IsjoFgs/edit?usp=sharing)



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# Introduction

On June 8, 2023, the CMS Center for Medicare and Medicaid Innovation (CMMI) [announced a new 10-year program](https://www.cms.gov/newsroom/press-releases/cms-announces-multi-state-initiative-strengthen-primary-care) to support the development and delivery of advanced primary care services by FQHCs and other small, independent, and/or safety net providers in 8 states. The new “Making Care Primary” (MCP) program will support and incentivize participating providers to become “advanced primary care practices”, that incorporate:

* robust care coordination programs;
* strong connections to specialists and behavioral health providers;
* a value-based care approach; and
* a focus on addressing health equity and Health-Related Social Needs (HRSN.)

This set of FAQs and attached charts provide additional information on the new MCP model.

# Provider Participation

## Which FQHCs can participate in MCP?

Eligibility is limited to FQHCs that:

* + Have at least 51% of their physical locations located in one of the following 8 states: Colorado, Massachusetts, Minnesota, New Mexico, New Jersey, New York, North Carolina, and Washington; and
  + Were not participating in either an ACO REACH or Primary Care First (PCF) demonstration models as of May 2023; and
  + If an FQHC is currently participating in a Medicare Shared Savings Program (MSSP) ACO, it must withdraw from that MSSP by 12/31/24 in order to be eligible for MCP.

## Why can FQHCs currently in a MSSP ACO join MCP, while those in an ACO REACH cannot?

CMS staff explained that ACO REACH is a demonstration project that is undergoing a rigorous evaluation, and that “luring” FQHCs or other participants away from REACH would invalidate the results of those evaluations. In contrast, MSSP ACOs are a standard part of Medicare and are not undergoing formal evaluations. (Remember that FQHCs currently in a MSSP ACP must withdraw from it by 12/31/ 2024 in order to participate in MCP.)

FQHCs participating in any of these three programs may be eligible to participate in a MCP-like program with either Medicaid or private payers in their state (but not Medicare). See [here](#_26in1rg) for more information.

## For FQHCs in the eight selected states, is participation voluntary or mandatory?

Participation is voluntary.

## Could FQHCs in other states potentially become eligible?

We do not foresee CMS expanding eligibility to additional states.

## Must an entire CHC organization participate, or can just a subset of its sites participate?

Participation will be at the TIN-level, meaning that all sites registered under the same TIN must take the same approach – i.e., they must all participate jointly in MCP, or none of them can participate in MCP.

## Do FQHCs have to have experience with value-based care or “advanced” primary care to participate in MCP?

No. MCP has a Track specifically designed for providers with no experience in either area.

## Besides FQHCs, what other types of providers can participate in MCP?

The model is designed for “safety net and smaller or independent primary care organizations”, including Indian Health Service facilities, Tribal clinics, and “others”. Notably, Rural Health Clinics are explicitly prohibited from participating in MCP.

# Payer Participation

## Which payers will participate in MCP?

* ***Medicare*** will form the basis of the official MCP model. (It’s the only program that CMS has complete control over.)
* CMS has been “partnering” with state ***Medicaid*** agencies in the eight states, encouraging them to implement initiatives that align with and support MCP. (Initial outreach from PCAs to their state Medicaid agencies suggests that some states are not devoting much attention to MCP.)
* CMS is also encouraging ***commercial payers*** in the eight states to support MCP by offering incentives and payments that align with its goals.

## If an FQHC cannot participate in MCP because it participates in another CMS ACO program, could it engage in MCP-like activities with its state Medicaid agency or commercial payers?

This is definitely a possibility. However, the state Medicaid agency and commercial payers would have to decide if they want to work with these FQHCs in this manner.

## How will CMS partner with state Medicaid agencies and commercial payers?

* CMS plans to work with aligned payers in MCP states to:
  + “establish shared goals, learning priorities, and ensure that participants have the supports they need.”
  + “encourage close alignment in areas that directly reduce burden on clinicians, such as the type and format of quality measures.”
* CMS is not making additional funding available to state Medicaid agencies explicitly for MCP.

# Tracks

## What participation tracks are available, and how do they differ?

MCP consists of three progressive tracks, meaning that each one builds on the activities undertaken in the previous track. Providers will be permitted to choose which track to join, although the first track – *Building Infrastructure*– is limited to organizations with no prior experience with value-based care. Here is a summary of the activities under each track:

|  |  |  |  |
| --- | --- | --- | --- |
| **Track** | **Title** | **Key Activities** | **Max time a FQHC can stay in this track** |
| **One** | ***Building Infrastructure -*** *Only for providers with no value-based care experience* | Develop the foundation for advanced primary care -- e.g., risk-stratify patients, review data, build out workflows, screen for health-related social needs. | 2.5 years |
| **Two** | ***Implementing Advanced Primary Care*** | Partner with social service providers and specialists; implementing care management services; systematically screen for behavioral health conditions. | 2.5 years for those who start at Track 2; two years for those who start at Track 1. |
| **Three** | ***Optimizing Care and Partnerships*** | Use quality improvement frameworks to optimize and improve workflows; address silos to improve care integration; develop social services & specialty care partnerships. | No limit |

# Payments to FQHCs

## What are the seven payment streams under the MCP?

Payment under MCP is complex, involving seven separate funding streams (six go to FQHCs; the seventh goes to specialty providers.) These funding streams can be groups into the following four categories:

1. **Transitioning per-visit fee-for-service (FFS) payments to value-based payments.**

* Standard Medicare PPS per-visit payments (PPS)
* “Prospective Primary Care Payment” (PPCP)

1. **Additional automatic payments.**

* Enhanced Service Payments (ESP)
* Upfront Infrastructure Payments (UIP). *As discussed below, FQHCs must meet eligibility criteria to qualify for UIPs.*

1. **Performance-based payments** called Performance Incentive Payments (PIP)
2. **Payments to support the integration of specialty care.**

* MCP E-Consult Payments (MEC) – paid to FQHCs
* Ambulatory Co-Management payments (ACM) – paid to specialists

For detailed information on all these funding streams, see [this chart](about:blank), and the FAQs below.

## What payment streams are directly involved in the transition from per-visit FFS to value-based care?

There are two funding streams involved, and CMS’ general idea is to gradually move FQHCs away from the fee-for-service stream (PPS) and towards the value-based stream (PPCP).

* Standard Medicare PPS payments (PPS):
  + Because PPS payments are made on a per-visit basis, they are considered fee-for-service (FFS), and are what CMS is seeking to move away from.
  + PPS payments are capped at $187.19 (subject to regional adjustment) in 2023. Not all FQHCs bill up that amount.
* Prospective Primary Care Payment (PPCP)
* Per-member-per-month (PMPM) payments to FQHCs based on the their FQHC’s historical billing data.
* These payments are designed to support a gradual progression away from basing payment on the number of visits, and to free FQHCs to use the funds in more effective ways. This payment method is considered value-based, and is what CMS is seeking to move towards.

***Which of these two funding streams an FQHC will receive depends on what Track it’s in:***

|  |  |
| --- | --- |
| **Track** | **Funding streams for transitioning from per-visit PPS to value-based pay** |
| One | FQHC will receive Medicare PPS (aka FFS) for all patient visits.  *(There are no PPCP payments.)* |
| Two | FQHC will receive:   * 50% of the Medicare PPS payment for all patient visits   PLUS   * a Prospective Primary Care Payment (PPCP) to cover the remaining 50% |
| Three | FQHC will receive PPCP payments to cover 100% of anticipated PPS/ FFS costs. *(There are no PPS payments.)* |

## What are the two types of “Additional Automatic Payments” under MCP?

1. Enhanced Service Payments (ESPs).
   * In addition to the payment for regular services discussed above, FQHCs will receive an extra payment each month for each Medicare patient (a per-member-per-month payment, or PMPM.)
   * These funds are to support services not generally covered by Medicare, such as CHWs, behavioral health integration, and intensive care management.
   * The amount for each patient will be based on their individual income level, clinical risk, and the “Area Deprivation Index” (ADI) for where they live. Rates will range from $2 to $25 PMPM; most FQHC patients will be at or near the $25 level.

* MCP will be the first time that CMMI will adjust any payment rates based on a patient’s social complexity. They recognize that ADI is far from a perfect measure, but are happy to at least take this first step.

1. Upfront Infrastructure Payments (UIP)

* CHCs who meet the eligibility requirements below will receive an additional $145,000 to invest in infrastructure, such as IT systems.
  + $72,500 will be provided at the start of the MCP, and the remaining $72,500 one year later.
* To be eligible, an FQHC must:
  + Start in Track One
  + Be “low revenue” (CMS will define this in the Request for Applications to be published in August)
  + Not have an e-consult platform.

## If our FQHC leaves the MCP program prior to the end of its 10.5 year project period, will they have to repay the Upfront Infrastructure Payment to Medicare? According to the 7/19 slides, UIPayments “can be recouped if the participant withdraws or CMS terminates its participation in the model prior to entering Track 3.”

## What is the Performance-Based Payment stream?

* There is only one type of performance-based payment under MCP, called the Performance Incentive Payment (PIP).
* To be eligible for a PIP, a the total per-patient cost of care (TPCC) for the FQHC’s patients must be better (aka lower) than at least 30% of a national comparison group.
  + Note that the TPCC includes all Medicare costs incurred by the FQHC’s patients, including hospitals, specialists, therapies, etc.
* CMS rank orders the TPCC for the comparison group, with the 1st percentile being those providers with the highest TPCC, and the 99th percentile being those with the lowest. To be eligible for a PIP, an FQHC’s TPCC must be at or above the 30th percentile from the comparison group.
* PIP payments are capped at a percentage of the FQHC’s PPS/ PPCP payments, as follows:

|  |  |
| --- | --- |
| **Track** | **Cap on PIP Payments** |
| One | 3% of all PPS payments |
| Two | 45% of total of PPS and PPCP payments |
| Three | 60% of PPCP payments |

*We do not yet know what TPCC percentile an FQHC must reach in order to be eligible for the highest PIP payments (45%/ 60% of total PPS/ PPCP). - Needs updating.*

* PIP payments will be made to FQHCs as follows:
  + Half in the 1st quarter of the year in which the FQHC is expected to earn it.
  + Half during the 3rd quarter of the **following** year.

## What are the two payment streams to support integration of specialty care?

In Tracks 2 and 3, all participating providers are expected to implement e-consults with specialists. MCP offers two additional funding streams to support both MCP providers and specialists with this task:

* MCP E-Consult Payments (MEC)
  + FQHCs will receive a $40 payment for each time that one of their providers initiates a e-consult with a participating specialist.
    - For the payment to occur, the specialist’s organization must have a “Collaborative Care Arrangement” (CCA) in place with the FQHC.
* Ambulatory Co-Management (ACM) payment
  + ***This payment will be made to specialists, not FQHCs.***
  + Eligible specialists will receive $50 per month for each FQHC patient for whom they engage in regular collaboration with the FQHC.
    - As with MEC payment, for this payment to occur, the specialist’s organization must have a “Collaborative Care Arrangement” (CCA) in place with the FQHC.

Reminder: For detailed information on all these funding streams, see [this chart](about:blank). (It was too big to paste in this document 😊

# No Direct Downside Risk under Medicare or Medicaid

## Is there any downside financial risk to FQHCs from participating in MCP?

* Medicare: There is no downside financial risk to FQHCs under the Medicare MCP model. For example, while there are incentive payments (PIP) for good performance, there are no penalties for poor performance.
* Medicaid: Each state Medicaid agency will decide for itself how to adapt MCP for implementation in their state. CMS staff have made it clear that they do not expect state agencies to impose downside risk on FQHCs under MCP, as it:
  + Is not part of the model, and
  + More importantly, is not consistent with the FQHC PPS statute. (A state would need a Section 1115 waiver to allow FQHCs to take downside risk.)
* Commercial payers: As commercial payers are not required to adhere to the MCP model or the Medicaid PPS statute, they can choose to require FQHCs to take downside risk. However, FQHCs who participate in MCP are not required to accept the commercial payer’s terms.

## Since PPCP payments (that replace Medicare PPS/ FFS payments) are based on historical data, won’t those payment rates get outdated over 10 years?

## CMMI staff recognize that Medicare billing data from 2023 may not adequately represent CHCs’ actual costs in the later years of MCP (e.g., 2032), even if that data is updated annually for inflation. Therefore, they plan to “rebase” CHC’s billing data (assuming it was still billing under PPS) every 3 years during the demo.

Patient Attribution

## *New 7-27-23:* How will CMS attribute patients to our FQHC for purposes of inclusion in MCP?

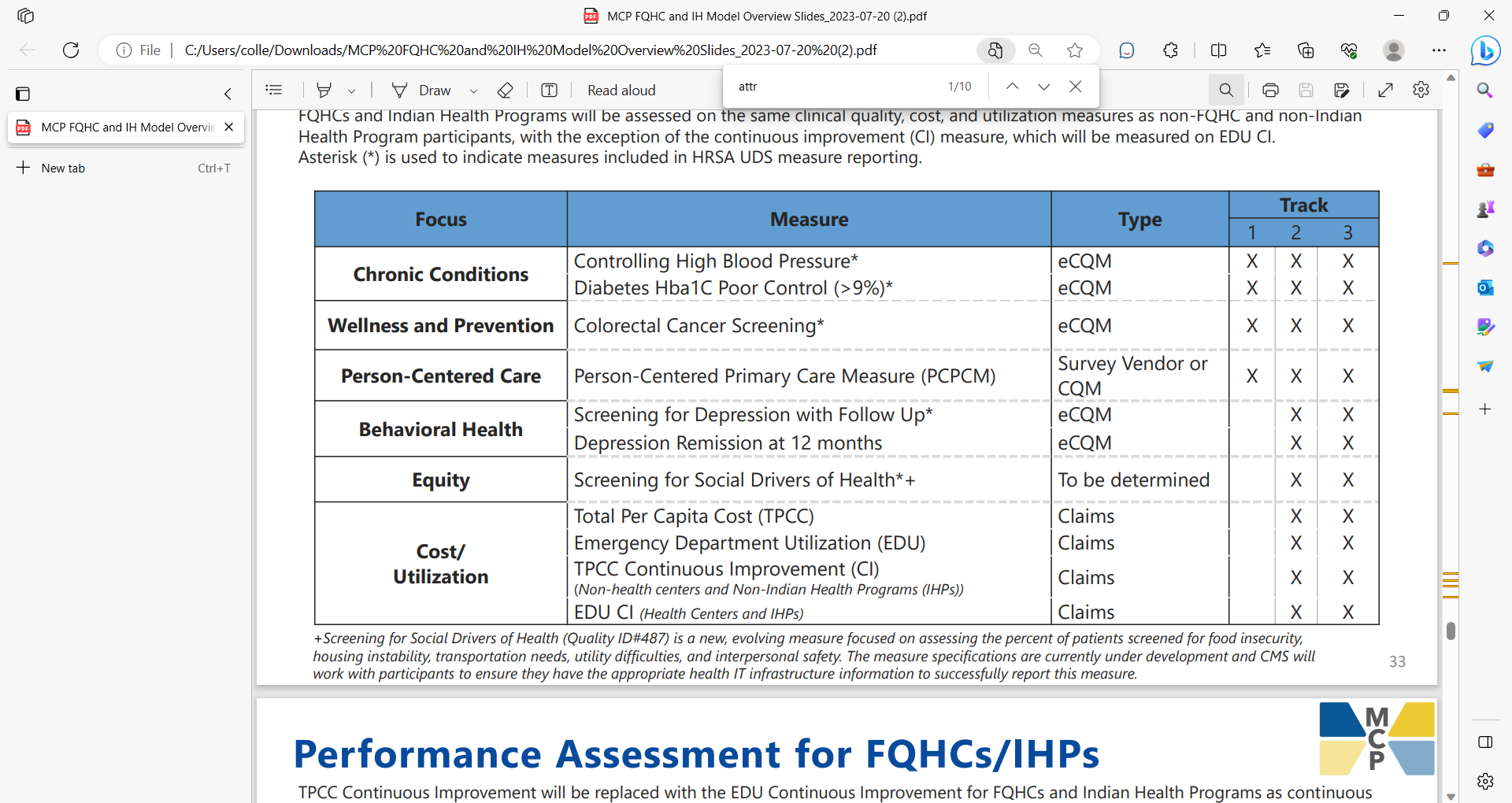
The details of the attribution method will be provided in the Request for Applications (RFA) to be released in August 2023. In the meantime, we know that:

* CMS will generally attribute a patient to an FQHC if their most recent primary care appointments have been with that FQHC.
* Medicare enrollees will also have the option to proactively indicate to CMS that the FQHC Is their primary care home.

# Performance Measures

## *New 7-27-23:* What measures of clinical and financial performance will FQHCs be required to submit?

CMMI staff provided this list on the July 20 webinar. Measures with an asterisk (\*) are reported under UDS.



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# Timeline for the MCP model

## How long will the MCP model operate?

The MCP will operate for 10.5 years, starting in July 2024. This is the longest duration of any model that the CMS Innovation Office (CMMI) has introduced to date. CMMI staff feel that this length of time is appropriate to truly enable FQHCs to make the necessary transformations and for their impact to become measurable.

## What are key dates for the MCP model?

* June 2023: CMS announces the model publicly, and invites interested providers to [submit a *non-binding* letter of intent (LOI)](https://app1.innovation.cms.gov/MCPLOI/s/).
* July 2023 (date TBD): CMS staff will hold a webinar specifically for FQHCs in the eight eligible states.
* August 2023: CMS will release Request for Applications (RFA) from interested providers (e.g., FQHCs.) This RFA will contain significant new details on how the model will operate.
* Late November 2023: *Anticipated* due date for FQHCs to submit an application to MCP. This will be the only application deadline, and FQHCs that do not apply by this deadline will have no future options to join MCP. (See HERE for information about options to drop out of MCP after applying.)
* Winter/ Spring 2024: FQHCs will sign participation agreements with CMMI.
* July 1, 2024: MPC model launches.
* December 31, 2034: MPC model ends.

# Timeline for FQHCs to decide whether to participate in MPC

## If a FQHC does not apply to MCP by late November 2023, will they have another opportunity to enroll in the program?

No. There is only one opportunity to enroll in the program – during the August-November 2023 application window. FQHCs who do not apply during this window will be unable to participate in the program at any point during its 10.5 year duration.

## If a FQHC does submit an MCP application in fall 2023, are they locked into MCP for the full 10.5 years?

No. FQHCs can decided during January -June 2024 (before the model officially launches) that they do not want to participate. They can also leave MCP after the model is underway. FQHCs should be aware that if they leave the program after it has started:

* There may be only one option to do so each calendar year.
* There may penalties or requirements to repay funds (e.g., the Upfront Infrastructure Payment.)

We are still confirming these last two bullets with CMS.

# Looking Ahead

## What are the next steps?

CMS plans to release a Request for Applications (for participating FQHCs and other providers) in August 2023. They also plan to release more technical details on the model design soon/shortly. For information on your state’s aligned program, CMS recommends contacting your State Medicaid Agency. You can also contact CMS’ MCP team at [MCP@cms.hhs.gov](mailto:MCP@cms.hhs.gov).

## How can PCAs and FQHCs get the latest news on the MCP model?

* Sign up for email updates from CMS [by clicking here](https://public.govdelivery.com/accounts/USCMS/subscriber/new). Enter your email address, and on the next page, scroll down about half-way under you get to “Center for Medicare and Medicaid Innovation.” Making Care Primary is the fourth option under that heading.
* Monitor the CMS MCP website, [here](https://innovation.cms.gov/innovation-models/making-care-primary).
* For information on your state’s aligned program, contact your State Medicaid Agency.
* Contact CMS’ MCP team at [MCP@cms.hhs.gov](mailto:MCP@cms.hhs.gov).