Making Care Primary (MCP) for Federally Qualified Health Centers (FQHC) and Indian Health Programs (IHP)

Overview Webinar

July 20, 2023

Welcome & Introductions

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Remarks from HRSA

Remarks from CMCS

Remarks from OMH

Today's Presenters

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Data Lead, Making Care Primary

Agenda

1. Welcome
2. Definitions, Benefits of MCP Participation
3. Partnering with Medicaid
4. Participation Summary
5. MCP Eligibility and Participant Types
6. Care Delivery Requirements
7. Payment Structure and Performance Assessment
8. Application, Next Steps, and Resources
9. Question and Answer Session
10. Closing and Resources

Definitions

Federally-Qualified Health Center (FQHC): 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.

Indian Health Program: 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.

Benefits of Participation in MCP

CMS Innovation Center designed MCP with lessons learned from previous primary care models to build a supportive payment and care delivery structure to advance health equity. The following are national and state level supports for participants to achieve model goals.

On-Ramp to VBC

Resources for organizations new to VBC to build accountability over time

Key features:

- Upfront Infrastructure Payment for eligible Track 1 participants
- Phased in shift from FFS to population-based payment over Tracks 1 and 2
- No downside adjustment based on performance, rewards are focused on key clinical outcomes first

Tools to Improve Care Coordination

Data to improve patient care integration and learning tools to drive care transformation

Key features:

- Specialty care performance data sharing, prioritizing cardiology, orthopedics, and pulmonology
- New specialty integration payments to improve communication and collaboration
- Connection to health information exchange

Health Equity Advancement

Support to deliver coordinated, high-quality health care to diverse populations

Key features:

- Process for identifying and addressing health disparities in the populations that practices serve
- Increased payment for patients that require more intensive services to meet health goals.
- Focus on screening and referrals to address Health Related Social Needs (HRSNs)

Collaboration & Learning

National and state level supports for participants to achieve model goals

Key features:

- Payers partnering to support participants needs for success, including technical assistance, data, and peer-to-peer learning
- Access to independent practice facilitation and coaching, especially for small and safety net organizations who need help building capacity

Resources and Support for MCP Participants

CMS and payer partners will create resources for MCP participants to be successful in the MCP model. This includes partnering in state efforts to create an environment for practice change.

Nationwide Support

Technical assistance to help MCP participants understand model requirements, rules of participation, payment, attribution, measurement, and waivers.
Virtual platform for collaboration and coordination within and across regions to support learning and continuous improvement.
Data feedback with actionable data on cost and utilization for the Medicare beneficiaries served by the participant.
Reporting platform enabling participants to share the tactics, strategies, and care delivery methods they are using to improve health outcomes and advance health equity for their patients with peer comparisons.

+

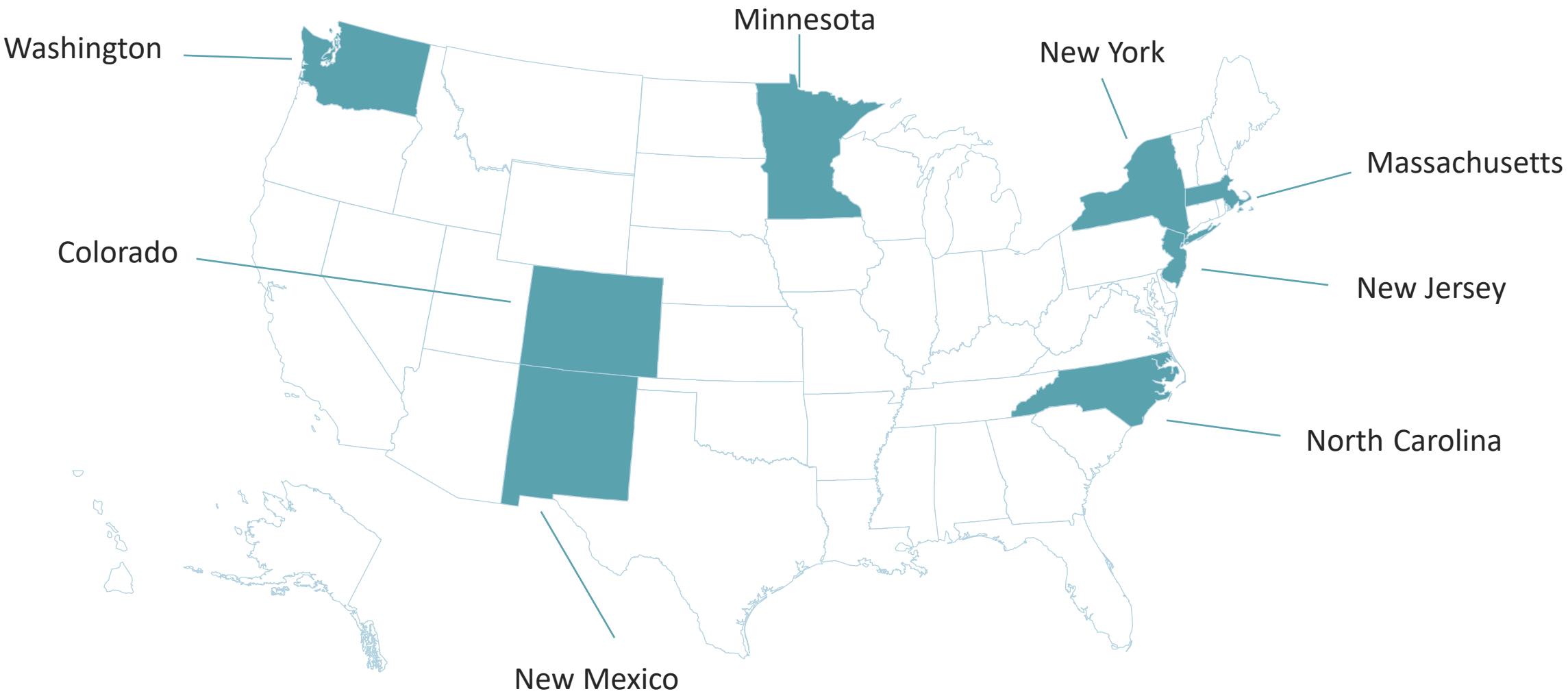
State-Based Support

Collaboration opportunities for MCP participants with the specialty practices and community-based organizations that need to be partners in care for their patients.
Practice facilitation and coaching resources for those 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 to advance health outcomes and health equity.
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.

Partnering with Medicaid

Participating States

MCP selected eight (8) states using several factors, including geographic diversity, health equity opportunity, population, and in partnership with state Medicaid agencies (SMAs) to better align Medicare and Medicaid payers on quality measurement, data requirements, and learning priorities.



Payer Partners

CMS Innovation Center will partner with public and private payers to implement MCP. Through these partnerships, CMS will foster alignment in areas to reduce clinician burden and provide flexibility to encourage increased payer participation.

Directional Alignment

- CMS will work with payers in MCP states to encourage close alignment in areas that directly reduce burden on clinicians, such as the type and format of quality measures
- MCP participants will collect and report required data in the same format and report the same quality measures to MCP payers

Medicaid Engagement

- CMS has partnered with SMAs to streamline primary care payment reform and learning priorities across Medicare and Medicaid
- MCP will continue to work closely with state Medicaid agencies (SMAs) to streamline requirements and learning supports
- **FQHC applicants are encouraged to reach out directly to their state Medicaid office and Medicaid Personal Care Assistants (PCAs) to understand upcoming plans for the MCP model**

Local Implementation

- CMS, SMAs, and payer partners will make practice- and patient-level data available to participants through data sharing efforts within the state
- CMS will provide flexibility for payers to include additional measures that reflect local priorities for their patient population(s)

CMS will partner with aligned payers to establish shared goals, learning priorities, and ensure that participants have the supports they need to be successful, including access to health information exchange and peer-to-peer learning.

Participation Summary

Participation Summary

The following checklist provides the required steps for participation in the MCP Model if accepted.

- **Q2 2024: review and sign Model Participation Agreement and submit onboarding information; July 2024 onward, abide by terms of the Participation Agreement**
- **Up to Quarterly: Complete Care Delivery and Health Equity Plan reporting**
- **Annually: Complete Quality reporting (including surveys)**
- **Quarterly: Update list of sites/CCNs and/or MCP Clinician List* as necessary**
- **Ongoing: Meet Health IT requirements (including connecting to a Health Information Exchange)**
- **Up to Quarterly: Participate in learning events**
- **Ad-Hoc: Participate in any monitoring or auditing activities**

***Non-FQHC participants must identify and maintain with CMS a list of each individual primary care NPI that renders services under the TIN of the participating organization – otherwise known as the MCP Clinician List. FQHCs will maintain a list with CMS of all sites and CCNs that bill under the TIN of the participating organization.*

MCP Eligibility and Participant Types

Overlaps with Other Medicare Programs

In general, CMS will not allow organizations and clinicians to participate in MCP while participating in other Innovation Center Accountable Care Organization (ACO) models and programs. MCP's overlap policy is described below, and more information will be listed in the forthcoming Request for Applications (RFA).

CMMI Models

Not-Eligible

In general, organizations enrolled in CMMI models or will not be allowed to simultaneously participate in MCP, with the exception of bundled payment models.

Bundled Payment Model Participation

Eligible

Organizations and their clinicians that participate in bundled payment models (e.g., BPCI Advanced) can participate simultaneously in MCP.

Medicare Shared Savings Program (SSP)

Time-limited Eligibility

CMS will make a one-time MCP eligibility exception for organizations and individuals participating in SSP in 2024, but **plan to withdraw from SSP before the drop deadline for the 2025 SSP Performance Year.**

- During the 2024 MCP performance year, these MCP Participants can still participate in SSP, but must abide by the Terms of the MCP Participation Agreement
- For these MCP Participants, MCP payments will begin 1/1/2025

Eligible patients

CMS will follow the attribution methodology specified in the to-be-released MCP Request for Applications (RFA) to attribute beneficiaries with Traditional Medicare to MCP Participants. Attribution will be conducted using a list of CCNs for FQHCs and a list of NPIs for non-FQHCs and will be rolled up to the TIN level for both FQHCs and non-FQHCs. Non-FQHCs must submit a roster of primary care clinicians* in order for CMS to run the attribution methodology. MCP will also test voluntary alignment, where beneficiaries may voluntarily align to their primary care clinician (or usual care delivery site) via MyMedicare.gov.

Beneficiaries with Traditional Medicare (Medicare Fee-for-Service)

Eligible

Beneficiaries with Medicare Fee-for-Service and Medicaid

Eligible

Beneficiaries with Medicaid

This presentation covers policies that will impact payment for beneficiaries with Traditional Medicare. Please contact your state Medicaid agency for plans to include Medicaid beneficiaries in programs aligned with MCP

* List of primary care specialties to be provided in RFA.

Additional Eligibility Requirements

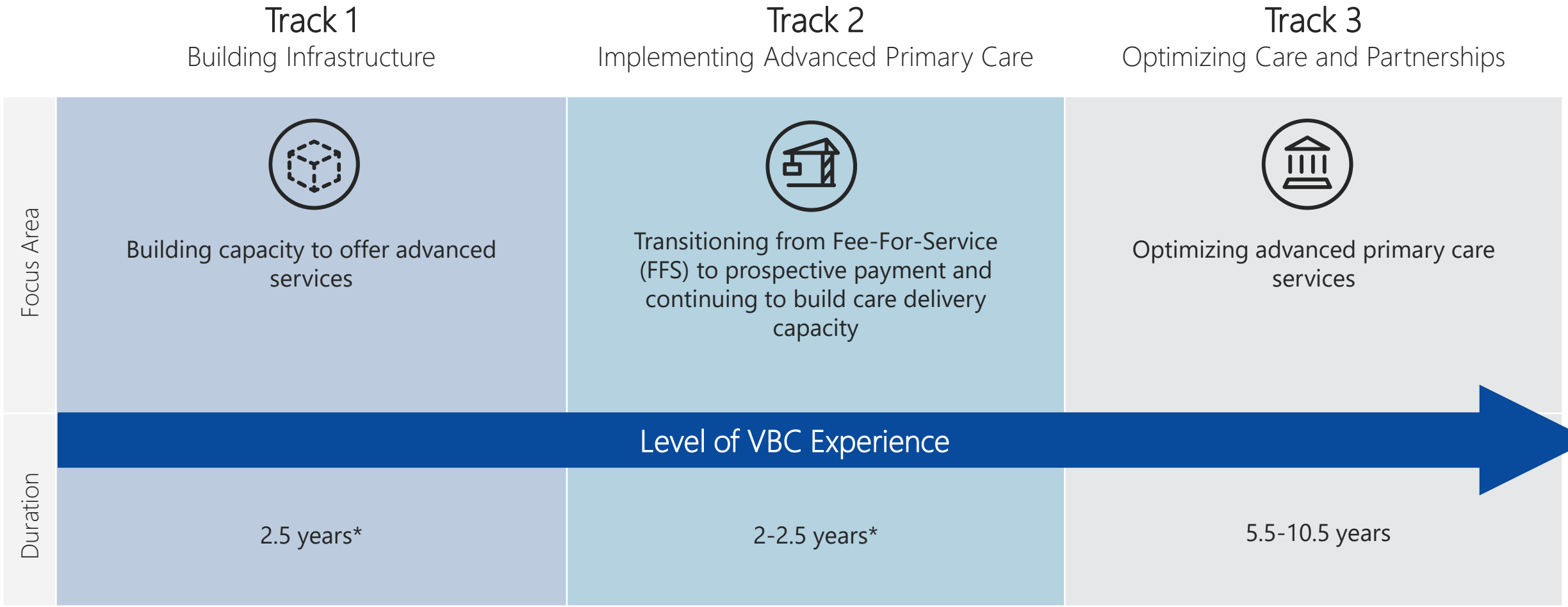
MCP participation will be at the organizational Taxpayer Identification Number (TIN) level. While each TIN must be its own participant and will be evaluated separately, FQHCs and IHPs can continue to work together in the model if desired. Organizations (at the TIN level) must meet the applicant eligibility 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. For applicant FQHCs, all CCNs for all practice sites should be submitted on the application.

Additional eligibility criteria require applicants to:

- 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
- Have a minimum of 125 attributed Medicare beneficiaries
- Have the majority (at least 51%) of their primary care sites (physical locations where care is delivered) located in an MCP state listed in the MCP RFA
- **FQHCs must submit a list of all physical primary care sites (as well as their CMS Certification Numbers (CCNs)) enrolled in Medicare under their organizational TIN when applying to MCP**

Participation Track Options Overview

MCP includes three (3) tracks that FQHCs and Indian Health Programs can select from when applying to the model. The three tracks provide opportunities for organizations with differing levels of value-based payment experience to enter the model at a point that matches their readiness at the beginning of MCP.



**Organizations that start in Track 1, 2, or 3 will have an additional 6 months (or half of a year) in that track, given the mid-year start date for the model. A participant's length of time in a track depends on which track they started in.*

Care Delivery Requirements

Overview of Care Delivery Approach

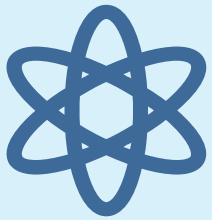
The capabilities participants will need to succeed in MCP are organized under three broad care delivery domains. These domains contain requirements that progress through the Tracks as participants refine their care delivery capacity and quality.

Targeted care management through risk-stratification, empanelment, and timely follow-ups for high-risk patients.

Chronic condition self-management (focusing on diabetes and hypertension), through development of workflows for support and expanded linkages to community supports.

Care Management

Care Integration



Provide behavioral health as part of primary care and strengthen connections with specialty care clinicians to better support patients.

Community Connection

Identify health-related social needs (HRSNs) and collaborate with social service providers to help patients navigate community supports and services.

Care Delivery Requirements

MCP care delivery focuses on building participant capacity to deliver equitable, team-based care and improve outcomes overtime. Requirements align closely with MCP performance measures and the NASEM[1] vision of person-centered, integrated, and high-quality primary care.

	Care Management Targeted Care Management and Chronic Condition Management	Care Integration Behavioral Health and Specialty Integration	Community Connections Health-Related Social Needs (HRSN) Screening/Referral and Community Supports and Service Navigation
Track 1	Empanel and risk stratify patients. Identify staff and develop workflows to (1) provide chronic care management and timely follow-up post ED and hospital visit and (2) deliver individualized self-management support.	Use specialty data tools to inform future partnerships. Identify staff and develop workflows to initiate a behavioral health integration (BHI) approach.	Implement universal HRSN screening with referral resources and develop workflows for referring patients with unmet HRSNs. Explore partnerships with social service providers and identify staff to navigate and coordinate HRSN support services.
Track 2	Implement chronic and episodic care management and individualized self-management support.	Identify high-quality Specialty Care Partners and implement enhanced eConsults. Implement a BHI approach using standardized tools and systematically and universally screen for key BH conditions.	Implement social service referral workflows Establish partnerships with social service providers and utilize Community Health Workers (CHWs) (or equivalent) for patient navigation.
Track 3	Implement individualized care plans and expand self-management services to include group education and linkages to community-based supports.	Establish enhanced relationships with high-quality Specialists. Optimize BHI workflows using a quality improvement framework.	Optimize referral workflows using a quality improvement framework. Strengthen partnerships and optimize the use of CHWs (or equivalent).

[1]National Academies of Science, Engineering, and Medicine (NASEM). Implementing high-quality primary care: Rebuilding the foundation of health care (https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care)

Patient Journey Map

The example below tells the story of a hypothetical organization and patient. For more detail and additional opportunities to promote health equity within MCP, refer to the RFA.

Practice A is a primary care organization with no previous value-based care experience that serves a population with average distribution across social risk tiers and 30% low-income subsidy enrollment.

Dawn is a 68-year-old patient who visits Practice A for her primary care. She has some behavioral health needs and chronic disease risk but has not sought treatment because of cost and transportation barriers.

Begins participation in MCP Track 1 and develops a Health Equity Plan to address patient population needs.

Notifies CMS of plans to **reduce certain cost sharing** for qualifying patients. **Begins collecting disparities-sensitive measures of chronic conditions**. **Implements universal HRSN screening** to begin collecting data on transportation, housing, and food security.

Dawn is able to receive care with **reduced cost sharing**. Her **provider screens her for colorectal cancer** given family history. Dawn's **provider notes barriers she experiences in seeking care**, including transportation.

Uses Upfront Infrastructure Payments to hire a **behavioral health specialist** and **stand up transportation** support and **e-consults.**

Dawn is **able to use transportation services** to attend a follow-up visit and **discuss behavioral health needs.**

Connects with other MCP participants to share promising practices and learns of local resources to **promote care access for low-income patients**.

Uses **Enhanced Services Payments to hire a care manager** and **establish referral workflows.** Invests in specialty care integration and uses data to identify high-value partners, following advancement to Tracks 2 and 3 later in model.

Dawn **works with the care manager to access additional behavioral and specialty care,** aligning with her providers on a treatment plan.

Uses HRSN and other data to identify remaining gaps in care access and quality. Creates a plan to **address gaps with community partners**.

Receives MCP bonus payments for meeting quality and utilization targets and continues providing advanced primary care with strong community partnerships and data-driven delivery.

Dawn experiences **improved care access and health outcomes**, supported by a connected ecosystem of specialists and community organizations.

Health Equity Strategy

MCP includes several model components designed to work together with the care delivery strategy to improve health equity in alignment with the Innovation Center's Strategy Refresh objective of Advancing Health Equity.[1]

- Requirement for participants to develop a **Health Equity Plan** for how they will identify disparities and reduce them
- Certain **payments** are **adjusted** by clinical indicators and **social risk** of beneficiaries
- Requirement for participants to **implement HRSN screening and referrals**, including the Screening for Social Drivers of Health quality measure for participants to assess the percent of patients screened for HRSNs
- Opportunity for participants to **reduce cost-sharing** for beneficiaries in need
- Collection of data on certain demographic information and HRSNs to **evaluate health disparities** in MCP communities

[1]https://innovation.cms.gov/strategic-direction-whitepaper

Payment Structure

Payment Types Overview

MCP will introduce six (6) payment types to support MCP participants as they work to achieve care delivery and quality improvement goals. Track 1 FQHCs will continue to be paid through Medicare FQHC PPS.

Upfront Infrastructure Payment (UIP)

Optional, and only certain Track 1 participants will be eligible

Track 1 | Track 2 | Track 3

Enhanced Services Payment (ESP)

Track 1 | **Track 2** | **Track 3**

Performance Incentive Payment (PIP)

Track 1 | **Track 2** | **Track 3**

Prospective Primary Care Payment (PPCP)

Track 1 | **Track 2** | **Track 3**

MCP E-Consult (MEC)

Track 1 | **Track 2** | **Track 3**

Ambulatory Co-Management (ACM)

Track 1 | Track 2 | **Track 3**

Upfront Infrastructure Payment (UIP)

Start-up funding to support smaller organizations with fewer resources participate in and be successful in MCP through investments in infrastructure to support MCP's transformational goals as they take on the Model's care delivery and health IT capabilities. Optional payment only available to eligible Track 1 participants.

Eligibility: "Low-revenue" Track 1 participants and Track 1 applicants without an e-consult platform
("Low revenue" criteria will be specified in the Request for Applications)

Timing: Initial $72,500 distributed as a lump sum at the start of model; second payment of $72,500 distributed as a lump sum one year later

Amount: $145,000 per eligible Track 1 participant

MCP participants will submit a spend plan with anticipated spending prior to receiving the UIP, and report on how the UIP funds were spent

Reconciliation: Any unspent or misused UIPs must be repaid to CMS at the end of the participant's 30-month Track 1 participation period and can be recouped if the participant withdraws or CMS terminates its participation in the model prior to entering Track 3

Examples of Permitted Uses

- ***Increased staffing*** such as hiring nurse care managers to implement SDOH screening, behavioral health clinicians to integrate behavioral health treatment into primary care setting; or encouraging partnerships with healthcare systems and local CBOs to connect individuals with culturally and linguistically tailored, accessible health care services and supports
- ***SDOH strategies*** such as partnering with CBOs to address SDOH needs; providing patient caregiver supports; or implementing systems to provide and track patient referrals to community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across communities where beneficiaries reside
- ***Health care clinician infrastructure*** such as investing in CEHRT system enhancements and upgrades; expanding HIT systems to include patient portals, telehealth systems for video visits, and/or e-consult technology; or developing infrastructure that would enhance sociodemographic data collection

Enhanced Services Payment (ESP)

Non-visit-based per-beneficiary-per-month (PBPM) payment that is adjusted to reflect the attributed population's risk level to provide proportionally more resources to organizations that serve high-needs patients, as they develop capabilities and provide enhanced services. Designed to support care management, patient navigation, connection to behavioral health, and other enhanced care coordination services, according to specific needs of patient population.

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Prospective quarterly payment

Potential Amount: Track-based amount based on participant's MCP attributed population and adjusted for social and clinical risk factors, including CMS Hierarchical Condition (HCC), Low Income Subsidy (LIS), and Area Deprivation Index (ADI).

Average adjusted ESP PBPM amounts for FQHCs will be $19 in Track 1, $16 in Track 2, and $15 in Track 3. The $25 payment for Tier 4 ADI/HCC and LIS beneficiaries remains fixed across tracks.

Calculation Details

The decision tree below describes the steps CMS will use to determine ESP payment for each MCP patient:

Enrolled in Low-Income Subsidy?	
No	**Yes**
Amount varies based on patient's HCC and ADI-designated risk tier (see table below)	$25

CMS-HCC Clinical Risk Tier (Risk Score Percentile)	ADI Social Risk Tier (ADI Percentile)	Track 1	Track 2	Track 3
Tier 1 (< 25th)	NA±	$9	$4	$2
Tier 2 (25th – 49th)	NA±	$11	$5	$2.50
Tier 3 (50th – 74th)	NA±	$14	$7	$3.50
Tier 4 (≥75th)	Tier 1, Tier 2, or Tier 3 (< 75th)	$18	$8	$4
	Tier 4 (≥75th)	$25		

Notes: 1) MCP payments are for Medicare FFS beneficiaries attributed to the MCP and will be subject to geographic adjustments.
2) ± Listed as NA, or Not Applicable, because payment for patients in HCC tiers 1 to 3 is only based on LIS or HCC.

Prospective Primary Care Payment (PPCP)

Quarterly per-beneficiary-per-month (PBPM) payment that is calculated for each participant's patient population and is designed to support a gradual progression from fee-for-service (FFS) payment for primary care services* to a population-based payment structure. These payments are designed to allow practices to deliver enhanced, comprehensive services without the incentive to increase volume of patients or services to achieve a favorable financial outcome.

Eligibility: Participants in Tracks 2 and 3

Timing: Prospective quarterly payment

Potential Amount: The amount is based on each participant's historical billing data for its attributed Medicare beneficiaries over a two-year period and will be updated annually; The regional blend policy that will be introduced in PY3 will not apply to FQHCs.

Reconciliation: Amount is partially reconciled against actual claims expenditures based on portion of primary care services sought by beneficiaries outside the participant organization.

Calculation Details

The type of payment for primary care services will vary based on an organization's MCP Track.

Payment Type for Primary Care Services	Track 1	Track 2	Track 3
Prospective Primary Care Payment (PPCP)	0%	50%	100%
Fee-for-Service (FFS)	100%	50%	0%

Data sources for billing calculation differs by organization type:

- **FQHCs:** PPCP based on services billed under the Medicare FQHC Prospective Payment System (PPS)
- **Non-FQHCs:** PPCP based on services billed under the Physician Fee Schedule (PFS)

**The primary care services included in or affected by the PPCP will be shared in the MCP Request for Applications (RFA) that will be released in August 2023.*

Performance Assessment

Quality Performance Measures

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, with the exception of the continuous improvement (CI) measure, which will be measured on EDU CI. Asterisk (*) is used to indicate measures included in HRSA UDS measure reporting.

Focus	Measure	Type	Track		
			1	2	3
Chronic Conditions	Controlling High Blood Pressure*	eCQM	X	X	X
	Diabetes Hba1C Poor Control (>9%)*	eCQM	X	X	X
Wellness and Prevention	Colorectal Cancer Screening*	eCQM	X	X	X
Person-Centered Care	Person-Centered Primary Care Measure (PCPCM)	Survey Vendor or CQM	X	X	X
Behavioral Health	Screening for Depression with Follow Up*	eCQM		X	X
	Depression Remission at 12 months	eCQM		X	X
Equity	Screening for Social Drivers of Health*+	To be determined		X	X
Cost/ Utilization	Total Per Capita Cost (TPCC)	Claims		X	X
	Emergency Department Utilization (EDU)	Claims		X	X
	TPCC Continuous Improvement (CI) *(Non-health centers and Non-Indian Health Programs (IHPs))*	Claims		X	X
	EDU CI *(Health Centers and IHPs)*	Claims		X	X

+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.

Performance Assessment for FQHCs/IHPs

TPCC Continuous Improvement will be replaced with the EDU Continuous Improvement for FQHCs and Indian Health Programs as continuous improvement allows for evaluating against own historical performance. CMS, HRSA, and ONC are aligning efforts to modernize quality data reporting processes in the coming years to use FHIR interoperability standards and associated clinical quality reporting architecture.

Balance of Measures of Clinical Quality and Cost

- Includes a diverse set of performance metrics that balance clinical quality, patient-reported outcomes, utilization, and cost.
- Measures of continuous improvement allows for evaluating against own historical performance.

Quality Measure Alignment with Care Delivery

- Small improvement can yield significant cost and quality improvement over time across common chronic conditions.
- Focuses on building participant capacity to deliver equitable, team-based care and improve outcomes over time on key metrics like hypertension and diabetes control.

Incorporating Health Equity into Performance Assessment

- Includes a measure of health-related social needs and tailors the continuous improvement assessment for FQHCs and Indian Health Programs.
- Seeks to minimize participant burden for reporting and consider feasibility of measure collection, including alignment with HRSA's Uniform Data System (UDS).

Performance Incentive Payment (PIP)

Upside-only performance incentive payment designed to reward MCP participants for improvements in patient outcomes and quality measures. FQHCs and Indian Health Programs are assessed on EDU CI instead of TPCC CI.

Eligibility: Participants in Tracks 1, 2, and 3

Timing: Half of estimated PIP will be paid in the first quarter of each performance year and second half will be paid in the third quarter of the following performance year

Potential Amount: Track-based percentage adjustment to the sum of payments for primary care services (FFS and/or PPCP)

Risk: Upside only; paid up-front and reconciled based on performance

See *Calculation Details* for more information on how CMS will determine PIP.

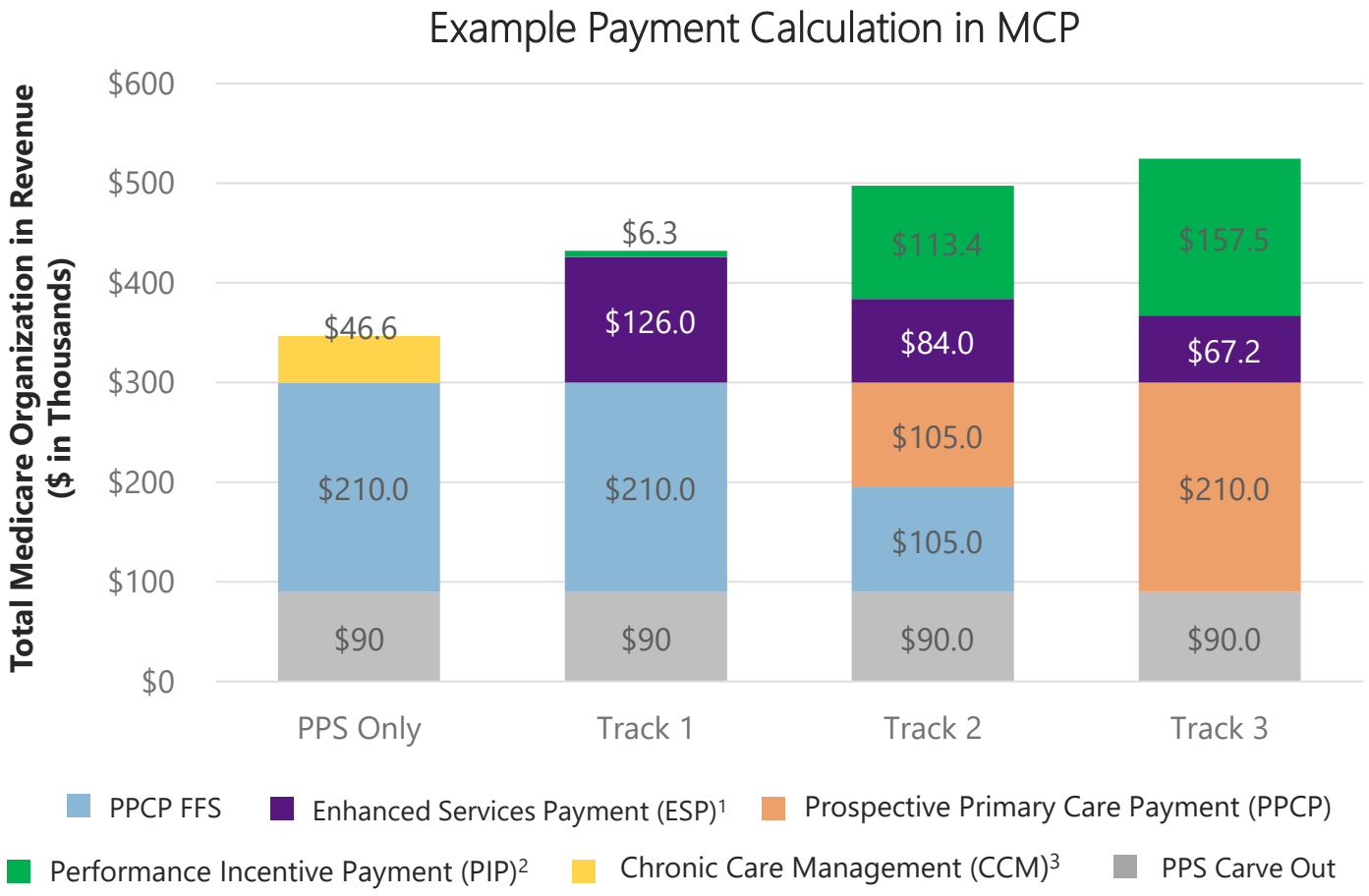
Calculation Details

Track 1	Track 2	Track 3
Potential to receive upside-only PIP of up to **3%** of fee-for-service (FFS)	Potential to receive upside-only PIP of **up to 45%** sum of FFS and prospective primary care payments (PPCP)	Potential to receive upside-only PIP of **up to 60%** of prospective primary care payments (PPCP)

- MCP participants must report all required quality measures and achieve the national 30th percentile on TPCC in T2 and T3 to *qualify* for any PIP
- Quality measures will have varying degree of impact on the PIP calculation based on the participant's track*
- Full credit for a measure for exceeding upper benchmark (70th percentile in Tracks 1 and 2, 80th percentile in Track 3). Half credit for exceeding lower benchmark (50th percentile)
- Participants in Tracks 2 and 3 will have the opportunity to receive additional PIPs for continuous improvement (CI) in utilization/cost

**More information on how MCP's quality measures will impact the PIP calculation, refer to the MCP Request for Applications (RFA) that will be released in August 2023.*

Example FQHC Revenue Payment Calculation



The hypothetical organization has the following characteristics:

- **1000** total Traditional Medicare beneficiaries
- Above minimum 30th percentile threshold for TPCC nationally
- Met 50th percentile on 3 measures and TPCC, above the 70th/80th percentile on 3 measures and EDU
- Average ESPs of **$19, $16,** and **$15** in Tracks 1, 2 and 3 respectively
- Did not get credit for EDU CI
- Did not quality for the UIP

[1]ESPs will be adjusted for social and clinical risk indicators, including the Medicare Part D low-income subsidy and Area Deprivation Index. For more information will be available in the RFA which will be released in August 2023.

[2]The green shading in visual above indicates bonus payments by track for a hypothetical FQHC Participant with high quality scores. MCP bonus potential increases across tracks. .

[3]While FQHC participants in MCP will not be able to bill CCM code G0511, most will receive increased CCM revenue through larger ESP payments.

Application, Next Steps, and Resources

Application Process and Timeline

Sign up for the MCP listserv and visit the MCP Website:

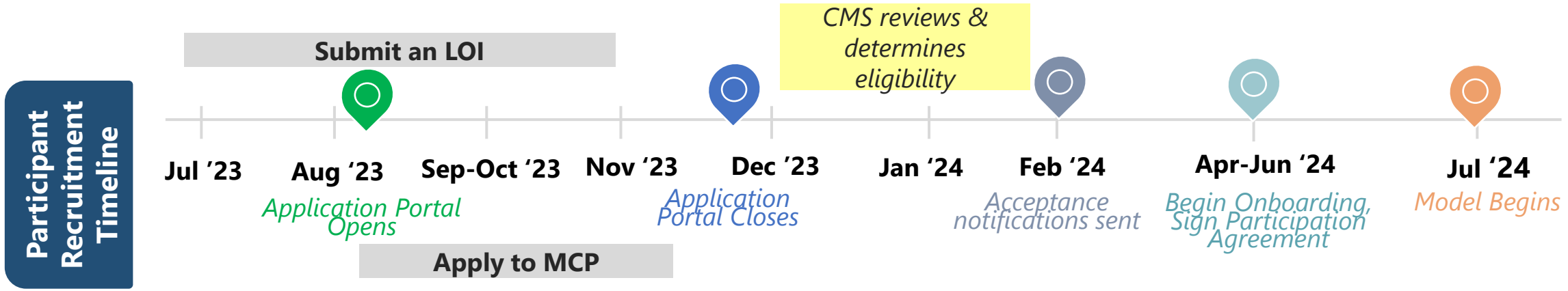
- Visit the MCP Website for more information, including events and resources: https://innovation.cms.gov/innovation-models/making-care-primary
- Sign up for our listserv at the via the CMS.gov Email Updates subscriptions page: https://public.govdelivery.com/accounts/USCMS/subscriber/new

Submit a Letter of Intent (LOI) to Apply for MCP

- For organizations interested in MCP, CMS encourages you to submit a voluntary, non-binding letter of intent (LOI) to apply at this link (https://app1.innovation.cms.gov/MCPLOI/s/). The LOIs help CMS to better support and connect with organizations as they decide if MCP is right for them.

Prepare for Application

- The MCP RFA will be released in August 2023. Interested stakeholders can prepare for application by using the resources above to prepare for application and reach out with questions about MCP.



Questions & Answers

Closing & Resources

Additional Information and Application Support

For more information and to stay up to date on upcoming MCP events:

Visit

https://innovation.cms.gov/innovation-models/making-care-primary

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Thank you

Thank you for attending today's MCP FQHC and Indian Health Programs Overview Webinar!