Making Care Primary (MCP) Applicant Office Hours
August 21, 2023

>> TJ Smith, SEA: Good afternoon, everyone, and thank you for joining today's Making Care Primary Applicant Office Hour. We have an exciting event for you all today but first we'd like to start with some housekeeping items. Next slide, please.

To listen to today's presentation, it is recommended that you listen via your computer speakers. If this does not work, there's also a dial in option for viewers to listen through their phone. Close captioning is also available on the bottom of the screen. During today's presentation, all participants will be in listen-only mode. Please feel free to submit any questions that you have throughout today's presentation in the Q&A pod displayed on the right side of the meeting room window. Given time constraints, we may not get to every question, but we will collect those for future events and FAQs. Today's presentation is also being recorded. If you have any objections, please do hang up at this time. The slide deck, a recording of today's presentation and a transcript, will be made available on the MCP website in the coming days. Finally, we will share survey in the coming, we will share a survey at the end of today's presentation. Please take 5 minutes to let us know how we did and share any questions that you may have about MCP. Next slide, please.

We do have a short agenda today. Before getting to the questions, we'll begin by reviewing the application process and reminding you of some important dates. We will then reference a few resources to support you in the process. After that, we will begin answering questions submitted through the registration form, as well as those being submitted live. And with that, I'd like to turn it over to Lauren McDevitt to begin today's presentation. Next slide.

>>Lauren McDevitt, CMS: Thanks, TJ. Good afternoon, everyone. It is great to be with you all today. My name is Lauren McDevitt and I'm the model lead for the Making Care Primary Model at CMMI. Next slide, please.

As TJ mentioned, we're going to focus most of our time today on answering questions from the audience, so please do begin submitting your questions via the Q&A functionality now. For now, I will briefly go through some information on the application process and then we'll begin reviewing those questions in the chat and answering those verbally. Last week, CMS released the Request for Applications, which further details the model's payment, care delivery, and quality policies, as well as much more. We're going to provide the link in the chat in case you haven't seen it. In Appendix A of the RFA, we have listed the questions that will be included in the application portal when that opens on Tuesday, September 5th. If you want to begin to prepare for application, please review the RFA details, submit any questions to our email address, which is MCP@cms.hhs.gov, and review the questions in the RFA Appendix A.

The application portal will close on November 30th, so there will be just under three months to submit an application. We are not currently planning additional application periods, so we do encourage you to submit a non-binding application if you are interested in participating in the model. Additionally, you may submit a Letter of Interest, which is an optional opportunity to share with CMS both what interests you about MCP, as well as any concerns or barriers you may have, or may anticipate having, in applying to or participating in MCP. We will hold additional events and post additional resources to the MCP website leading up to and during the application period, so please do bookmark and visit the

MCP webpage to stay up to date. Additionally, we will send emails out to our listserv when we share new resources, so please sign up for our listserv via the cms.gov email updates page if you have not done so already. The link is in this deck and we will also put it into the chat. Looking ahead, after applications are submitted, CMS will review them, determine eligibility, and communicate decisions to applicants in early 2024. Onboarding to the model will begin around April 2024 ahead of the model start in July 2024. With that, I'm excited to transition us over to the question and answer part of the event. Next slide, please. And next slide, please.

To start us off, I'm going to address a few common questions we've heard from stakeholders so far. First, can Federally Qualified Health Centers, FQHCs, participate? If so, can FQHCs pool resources in this model to build and/or share resources and care coordination? And the answer is, yes, FQHCs are eligible to apply to participate in MCP. A full list of eligibility criteria has been published in the Request for Applications. So FQHCs and other organizations are welcome to work together to meet the model's goals, but each TIN will be considered a separate participant.

Another common question we've gotten is, "Are we able to join the pilot and later go back to a Medicare Shared Savings Program, MSSP ACO?" MCP is a voluntary program and participants may withdraw subject to the terms of the Participation Agreement, which is an agreement that accepted applicants who decide to participate in the model will sign with CMS. So all of the terms will be specified in that Participation Agreement, including withdrawal, voluntary termination terms. After terminating your participant in MCP, a participant may join or rejoin an MSSP ACO, subject to their meeting necessary MSSP deadlines and criteria.

Next, "If we begin in July of 2024, why do payments not begin until January 2025?" So payments for participants that are not in MSSP for the 2024 performance year will begin July 2024. For payments that, for participants that are both in MSSP and MCP between July 1, 2024 and December 31, 2024, which is really the only six-month period that we expect there will be overlap between MCP and MSSP, no MCP payments will be made to avoid overlap in payments between MCP and MSSP.

Now I'm going to pivot us to answering some of the questions that have been submitted. So I'm just going to take a moment to read through the questions that have been submitted and I will be turning to the model team to help us answer some of those questions. So, next slide, please.

Alright, so I'm seeing a few great questions in the chat. The first one that we'll take up is, "Do the specialty care partners have to be in a separate TIN or can they be in the same TIN as the primary care providers?" Genevieve, I'd like to turn that one over to you.

>>Genevieve Kehoe, CMS: Yes, that's a great question. So yes, the specialty care partners can share the same TIN of an MCP participant and the MCP clinicians that are billing under that TIN. Great question.

>>Lauren McDevitt, CMS: Thank you, Genevieve. Alright, next up. "What services are excluded from the primary care payments under MCP that will still be billed fee-for-service?" Sarah Irie, could you take that one?

>>Sarah Irie, CMS: Sure. This is a great question. So just wanted to clarify a couple, a couple of ways that, where this impacts participant payment. So Track 1 participants, throughout their Track 1 participation, they'll continue to bill and receive payment from fee-for-service as usual. No payments

will be excluded from primary care payments. However, for all three Tracks, CMS is not going to pay participants for services that we consider duplicative of the Enhanced Service Payments, or the ESPs, and those are some services like principal care management, chronic care management, transitional care management. So Medicare won't pay for those to participants when they're furnished to attributed beneficiaries during a performance period of the model. Other services that will continue to be paid fee-for-service, outside of those who are that are eligible for the Prospective Primary Care Payment, are things like, you know, your vaccinations and other services that that we're not capitating under the PPCP methodology.

>>Lauren McDevitt, CMS: Thank you, Sarah. I'm going to stay with you for a couple more questions. "So, how does reimbursement change for an FQHC that participates in MCP?" And I know this one might differ by Track.

>>Sarah Irie, CMS: Yeah, yeah, it gets a little complicated when we're, you know, kind of trying to spell it out by Track and participant type, but for the for the most part MCP model payments for our health center participants will, they'll be based off of Medicare FQHC PPS rates, the Prospective Payment System. And those are the rates that FQHCs, that are FQHC-specific and that they are used to billing and receiving. And then the ESP, the Enhanced Service Payment, for kind of the care management and those types of services, care coordination, that will be provided on a quarterly basis separate from claims-based services. Also, FQHC services, defined as primary care services for purposes of the PPCP, the Prospective Primary Care Payment, will be paid prospectively for Track 2 and Track 3 practices, and those per-bene-per-month amounts are going to also be based off of that individual FQHC's historic spending for the set of services that are PPCP services and eligible.

>>Lauren McDevitt, CMS: Very helpful, thank you. And then we've gotten two questions on attribution that I want to highlight. "So, when will the draft attribution methodology be provided to applicants?" I know there's some information in the RFA, but they might be looking for a little more detail and then, "Are dual-eligible patients going to be included in the attributed population?"

>>Sarah Irie, CMS: Yes, so there is actually a good amount of detail in the RFA, about the attribution methodology. It also is going to look familiar to those who have been interested in our other primary care models in the past, CPC+, PCF, and in some cases, SSP. But it is detailed, you know, what would allow beneficiary to be eligible for attribution is included in there, some exclusions, and dual eligible beneficiaries are eligible for attribution under the model. The key component to, you know, triggering claims-based attribution is that, a Medicare fee-for-service bene or dual bene would have had to receive a qualifying service, and we actually have a code set listed in one of the appendices of the RFA. And so if the bene has one of those qualifying services in the look back period, where we're looking through claims, from a clinician who's associated with an MCP participant, then that begins the claims-based attribution process. And as long as they don't get disqualified for, a couple of the reasons that we list in the RFA, like not having part A and B, not having Medicare as their primary payer, being covered under a Medicare Advantage plan, other similar criteria, they will become attributed.

And also, I think, I saw one more question about attribution and when attribution lists are going to be provided to applicants. So we're going to conduct attribution on a quarterly basis, and it's prospective, so at the start of each payment quarter, participants will receive a beneficiary list with, you know, identifying the beneficiaries that have been attributed to them prospectively for that quarter and that should be available at the end of the first month of each payment quarter. And we do plan to share

some preliminary attribution statistics with participants after Participation Agreements have been signed. I'll hand it back to you, Lauren.

>>Lauren McDevitt, CMS: Thank you so much, Sarah. I know that we'll come back to you, but I'll give you a break for a bit. Just going to scroll through and see a few other questions, okay.

So, I'll take this one. One of the questions is "The RFA was not completely clear regarding how multi-specialty TINs will be evaluated in terms of MIPS responsibility. If a TIN is multi-specialty, will all non-PCP specialties be required to report MIPS? Does this include NPs and PAs who have no specialty? Please advise." So, so the only clinicians that will be considered participating in, you know, a MIPS APM or an AAPM will be the primary care clinicians that are submitted to us on the MCP Clinician List. So I think would ask you to consider kind of your own organization and what those other specialists might be engaged in and whether they would be required to report MIPS. But, but the only the only clinicians that would be eligible for kind of QP determination would be those that are on the MCP Clinician List, which are the primary care clinicians. And we do actually have some, it's possible that NPs and PAs could meet criteria for being included on an MCP Clinician List if they meet criteria listed in the RFA, which are around, you know, providing primary care as the majority of their services. We do understand that there are NPs and PAs that provide primary care and then there are other NPs and PAs that don't and you can't tell which ones are primary care unless, well, by specialty type, you can only tell by kind of the services that they're, that they're using. So, we hope that helps, but, if you have additional questions, please let us know.

Alright, I'm going to take another one that I think I can answer. "Will opportunities to join MCP be open in subsequent years, or is this a one-time opportunity?" So we are not currently planning additional application periods or cohorts for the model, so we do encourage you to submit a non-binding application if you are interested in participating in the model. We will use the lessons learned from, from early years in the model to kind of inform our future work but we're not currently planning to have an additional application period.

Okay. Another kind of specialty care related question. "For the Collaborative Care Arrangement, are applicants only required to have a minimum of one Collaborative Care Arrangement, or is a certain kind of, or is a greater number required?" Genevieve or Mitchell, would you mind taking that one?

>>Mitchell Beers, CMS: Sure, I can take it. Yes, only one Collaborative Care Arrangement in Track 2 is required.

>>Lauren McDevitt, CMS: Thanks, Mitchell. And is there any specific specialty type for that CCA that is required?

>>Mitchell Beers, CMS: Yes, it's prioritized that it's one of three, and that is orthopedics, pulmonology, and one other that's slipping right now from my mind. Okay. If you remember, Genevieve?

>>Genevieve Kehoe, CMS: Yes, cardiology.

>>Mitchell Beers CMS: Thank you.

>>Lauren McDevitt, CMS: Thank you, awesome. Alright, another question, "Can internal medicine providers participate?" Yes, so do encourage you to take a look at the list of specialty types that are

included on, you know, in the MCP RFA, I believe it's section two, which is Eligible Applicants. So, do take a look at that just for your understanding of what our definition of primary care is. And so that does include internal medicine. We just do note that in if looking at the list of clinicians that an applicant might submit, we are going to also run a check to make sure that at least 40% of the applicants collected Medicare revenue for the list of primary care clinicians employed or included on the on the list are by primary care. So, you know, do consider, you know, if you're internal medicine, you can qualify, but, looking at that list of NPIs, the applicant will need to provide at least 40% of their services as primary care.

Alright, we have a good data question. "What kind of data will CMS provide to participants, especially around costs and quality, such as ED use? Are these raw data needing ingestion or ready reports?" I'd like to turn that one over to Melissa Trible, who's our data lead, to answer that one. Melissa?

>>Melissa Trible, CMS: Yeah, thanks so much, Lauren, and great question. So to start off with, MCP will provide still the raw data, the CCLF claim line feeds provided during other models, but we will also provide data that's been calculated for cost and utilization. We will provide this in the form of a Data Feedback Tool, which will be an online dashboard that's specific to each practice. It will include all of the different quality measures that are claims-based in Making Care Primary. It will also include information on specialists, both cost, quality, and utilization data, especially for those three specialists that Mitchell mentioned earlier. So we are intending on including quite a bit of different data and will be updated quarterly, and it will look similar to the Primary Care First Data Feedback Tool that was used in Primary Care First, but we're intending to expand it and update it. Lauren, back to you.

>>Lauren McDevitt, CMS: Thanks so much, Melissa. Just going to take a beat here. Alright. Great questions, everyone. Alright, I think we're going to come back to payment for just a little bit. "How does the MCP payment work if the practice expands its number of providers and takes on more Medicare patients or, on the other hand, reduces providers and patients?" Sarah, do you want to take that one?

>>Sarah Irie, CMS: Sure. So the way that our attribution methodology works is we use, we predominantly use, you know, a 24-month look back at historic claims billing, so claims associated with your participant organization. As provider, you know, as a practitioner moves in or out of the practice that practitioner, the services associated with that practitioner will also impact attribution as well as, you know, where beneficiaries are seeking care. So if they're you know, the beneficiary has moved within the last couple of years and is now seeking care in a different state or at a different primary care organization, then attribution does kind of slowly adjust accordingly. So attribution is always going to be kind of an estimate of the Medicare fee-for-service beneficiaries your organization serves but it won't necessarily be an exact, you know, exactly the same as like a patient panel, active panel list that you may have in your practice. But you can work towards increasing attribution in various ways, including utilizing voluntary alignment, which is the process of assisting beneficiaries in identifying a clinician who works with you or your practice through the Medicare.gov website as their primary clinician, if that is the case, and that serves as another way that attribution can be, can be attained through the model. I hope, hopefully that answers that question.

>>Lauren McDevitt, CMS: Yes, thank you, Sarah. And staying with you for a moment, "My organization is an FQHC. We plan to apply for Track 2. With that, the PPCP is 50% and our PPS is, reduced by 50%. Does this mean that we would receive 50% of our PPS rate for each patient seen and a per-bene-per month-payment based on our attribution each quarter?" Could you help clarify kind of what that looks

like for, you know, both what they'll see up front for payment, as well as what, how their claims will be adjusted, Sarah?

>>Sarah Irie, CMS: Yeah, I think, I think the read of this question is for the most part accurate. So, through the model, not through fee-for-service claims, but through our separate claims processing system, we will make quarterly prospective payments. So, in this example, if this is an FQHC who's in Track 2 and they're eligible for the, you know, 50% capitation, the 50% PPCP, then 50% of this practice-specific amount is paid quarterly, prospectively, through the PPCP through the innovation payment contractor. And then as you are continuing to bill fee-for-service claims, those payment amounts will be reduced in half of what the, you know, prevailing rate would have been, the PPS rate or your rate that your billing in your FQHC. But you, yeah, you will continue to receive both the prospective, non-claims-based portion of the PPCP payment and also the claims-based portion, but it will just be reduced by a 50% factor.

>>Lauren McDevitt, CMS: Thank you. Sarah. Going to just take a couple other ones around kind of CCNs and sites. The first is, "Will we be able to add, you know, PTANs or CCNs for new sites over the project period?" Kind of similar to one of the other questions that was asked around like what happens if you expand your practice to include more patients, or maybe you kind of reduce the number of patients you're seeing. You will be able to update, you know, your list of CCNs or your list of NPIs, in terms of the MCP Clinician List with CMS. What we have right now in the RFA is that that would happen, or what we're planning on doing is, that you'd have the opportunity to do that on a quarterly basis. There will be a deadline every quarter by which you cannot make any changes afterwards because we have to run attribution for that upcoming quarter. But yes, there will be, you know, a process for updating those sites with CMS.

And another question that's a good one that we've gotten a few different ways is just, you know, "What happens if you're a newly designated organization and you just enrolled in Medicare, and maybe you don't have, haven't had time, to kind of see enough patients so that way you're, you'll meet the 125 beneficiary requirement?" You can, you can still apply for the model, and we encourage you to do so, you know. If you are in a position where you have had like a historical TIN, that you could provide kind of with your past billing, I think that would help us. But we do encourage you to apply especially if you, you know, anticipate that you would have, that you'd be able to meet that requirement, you know, on an ongoing basis for the model.

Alright, I'm going to take another question. "Will there be an opportunity for HCCN, or Health Care Controlled Networks, to apply?" No, the HCCNs would not be an eligible organization to participate in the model directly. What we do really see HCCNs playing a role in making sure that our model participants are successful and are able to meet the requirements of the model, and so, we do, you know, anticipate working with HCCNs, but just not as formal model participants.

And then, "Is the Participation Agreement renewed on an annual basis or for all 10.5 years? Are there early withdrawal penalties?" So the Participation Agreement is renewed, or revised, when we have major changes to any policies or if there are any terms, that need to be kind of amended or restated, so sometimes that does happen on an annual basis, sometimes it doesn't. Sometimes it might be less than that. So, but there are, you know, in terms of, "Are there early withdrawal penalties?" That'll really just depend. Right now, you know, we understand that organizations, you know, things change. You might have a change in ownership. You might have, you know, staffing changes that make it, you know, not feasible for you to continue in this model. And CMS definitely understands that and will

have a policy for that, you know. For specific, for a specific payment that I do want to just mention is that, for the Upfront Infrastructure Payment (UIP), this is stated in the RFA, but you know, if your organization qualifies for and takes the Upfront Infrastructure Payment, and if you do kind of get that in Track 1 and then withdraw from the model before Track 3, we will, you know, require that you repay that, given that the UIP is intended to support your participation in the model for its entirety. So hope that helps.

Alright. Give me another moment. I'll take one more and then I think we'll do a few more payment questions. “If we currently participate in an ACO, an MSSP ACO, do we need to exit that relationship prior to applying for this program?” You don't need to exit that relationship prior to applying. You can apply while you're currently in an MSSP ACO, and given that we, kind of have, given that the application period, you know, overlaps with the current performance year for MSSP ACO, we would not actually, you know, we wouldn't hold that against you in your eligibility. However, we will require that you are no longer on any MSSP kind of participant provider list or participant lists prior to the beginning of the 2025 performance year, which I know is a ways away but, you know, may require having some conversations now, but you do not, you do not need to exit your relationship with your ACO prior to applying for this program.

Okay, Sarah, who you all have probably figured out is one of our payment leads. So Sarah, I'm going to turn over to you for a couple more questions. “We have providers within one TIN, a medical group that practice in the hospital clinics with a different TIN. Are the facility fees which the hospital clinics would receive for the primary care provider visits impacted by the MCP payment model?”

>>Sarah Irie, CMS: Yeah, this specific question, I think there might be a slightly more nuanced response because we're talking about two different TINs. But in general, if an MCP participant currently bills a facility fee, including for, you know, the set of services we're saying are subject and, you know, considered PPCP services for capitation. If they're building that facility fee within the TIN organization, Medicare will pay the PPCP, and will also pay the fee-for-service reimbursement for any of the applicable facility fees. But the important thing to remember is that, under the model, CMS is only adjusting payments for the professional charges tied to the PPCP services and not the associated facility fees in cases where a participant does bill both.

>>Lauren McDevitt, CMS: Thank you, Sarah. And there was a question about billing for remote patient monitoring. “Will that be still paid fee-for-service or is that included on any of our kind of payment lists for the PPCP or the ESP?”

>>Sarah Irie, CMS: So, the answer is yes to both. So the remote physiological monitoring, or RPM, and also the remote therapeutic monitoring, or RTM services, both of those CMS will continue to pay MCP participants when those are furnished to attributed beneficiaries in all three Tracks of the model. The exact mechanism by which we're paying differ slightly, so participants who are in Track 1 who are still billing all their primary care services under fee-for-service, they'll receive a hundred percent of the fee-for-service payment amount for those, those service buckets. And then in Tracks 2 and 3, RPM and RTM services are accounted for under the Prospective Primary Care Payment that we've been talking about, the PPCP, and that payment type gives our participants more flexibility in how they provide services, so, you know, you can really invest resources in in ways that best meet your bene's needs. So, Track 2 and Track 3 participants will receive a per-bene-per-month amount based on their historic Medicare claims payments for all PPCP services, so that would include RPM and RTM services. And it's important that participants are still continuing to bill as usual for these services, but submitted claims

will be reduced to 50% in Track 2 and then they'll be reduced to 0% in Track 3. But throughout all three Tracks, payment will continue to be made for those services, just in slightly different ways.

>>Lauren McDevitt, CMS: Thank you, Sarah. And definitely encourage folks to take a look at the RFA, to see, you know, for individual codes, and of how they are treated. Great. I'll take one of these.

"So, would an entity that has experience in Medicaid value-based care initiatives, but not in Medicare, be considered ineligible for Track 1?" No, so, we're only going to look at Medicare value-based care experience. So, and those criteria are also listed in the RFA. Definitely encourage you to take a look at it, but we will not be looking at past experience in Medicaid value-based care initiatives to determine eligibility for Track 1.

And another question just about, you know, "How will, when will we find out which Track we are eligible for?" So there are no kind of specific eligibility requirements other than the main, the ones that apply for all Tracks, for Tracks 2 and 3. So really the only kind of Track-specific eligibility requirements are for Track 1. So Track 1 is reserved for those with no prior kind of Medicare value-based care experience, and those criteria are listed in the RFA. Again, I think that's section two under Track Eligibility. So really you would select which Track you think best matches your organization's, you know, eligibility and readiness. So eligibility would really only apply for Track 1, but, you know, if you think you're ready for Track 2 and the care delivery requirements as well as the payment reforms that are introduced in Track 2, we would encourage you to track, to apply to that Track. So we are really only allowing organizations to apply for one Track and their selected Track. We may offer you entry into a different Track, but we are really kind of relying on our applicants to determine which Track they think is best for them, and then we'll evaluate your eligibility and make a determination, as mentioned, kind of by early 2024.

Okay, just thanks everyone for your patience while we look through these.

>>Sarah Irie, CMS: Lauren, I can take a quick one.

>>Lauren McDevitt, CMS: That would be great. Thanks.

>>Sarah Irie, CMS: Yes. So this may have come in before I was describing the overlap and impact to payment for the remote monitoring services, so this question is specifically about RPM, and whether it be considered a duplicative service. The answer is no. It's not considered a duplicative service in terms of, you know, payment is already made under the ESP. This is one of the sets of services that will be included as part of the Prospective Primary Care Payment in Tracks 2 and 3. So payment will still be made, it'll be based on historic billing of that, and then again in Track 1, you'll still receive 100% of the fee-for-service payment amounts for RPM services that you provide to your attributed benes.

>>Lauren McDevitt, CMS: Thanks, Sarah.

>>Sarah Irie, CMS: I can also take.

>>Lauren McDevitt, CMS: Go for it.

>>Sarah Irie, CMS: I can take another one. I've seen maybe four or five questions about the, in the RFA, we specifically stated that before signing the Participation Agreement, CMS will provide each applicant

with various information. It's not specific in the RFA, but, you know, some estimates that might support financial modeling, including, you know, your preliminary attributed population or the number of attributed beneficiaries who may be at least, on a preliminary basis, attributed to you under the model. I think we, we were not very specific in the RFA on when that will be available, but I would say probably late spring, certainly prior to model launch. It's meant to be, it's meant to be a resource that will help, you know, applicants make the final decision about participation in the model. So we do believe that that's important information to share, so more will come out with specific, you know, targeted dates and when that will be available, but it's not, not this year at least.

>>Lauren McDevitt, CMS: Thanks, Sarah. Alright, I've seen a couple of questions about eligibility that I can take. "So, if a provider group is in ACO REACH in 2023, but will not be a participant in the ACO REACH in 2024, can the provider group apply to MCP?" So we do have a policy where if you are current in ACO REACH in 2023, as if May 31, 2023, you would not be eligible for the model. So we do apologize for that. We do understand that that means you cannot apply for MCP. There, you know, may be other opportunities, but we really do not want to pull from kind of existing CMMI models that are going through an existing application period for our models.

And additionally, "Are the questions in the RFP all that will be required or will there be more narrative type questions when the portal opens?" So the portal will include the application questions that are in there. We don't have any kind of narrative type questions planned for, for the application.

And "Will all applicants who qualify based on the responses be accepted or is it a competitive process?" I wouldn't use the word competitive to describe the process. We will really just look at eligibility and make decisions based on that. CMS may reach out to you if we have questions based on your application.

Okay, "If a practice is categorized into Track 3 to start, will they remain in that Track for the entirety of the MCP program?" I'd like to turn that one over to, to James. James, would you mind answering that one?

>>James Lee, CMS: Yeah, that's a great question. So in, for Track 1 and Track 2, you are limited to only being in those Tracks for two and a half years. So if, and then you are required to move on to the next Track. So if you start in Track 1, two and a half years later, after you've proven that you can provide the strategy needed to move on to Track 2, you will move on to Track 2. However, I think the question says, if I start in Track 3, am I in Track 3 for the entirety of the model? And that would be yes because there is no track 4. So if you're starting Track 3, you are in Track 3 for 10.5 years.

>>Lauren McDevitt, CMS: Yes, thank you, James. So Track 3 is not limited, it's just limited to the time in the model. And of course, as mentioned, you know, the model is voluntary. So thank you, James.

All right, one other payment question, "In the RFA, it denotes that G0511 is a duplicative service. There are proposed roles in the 2024 Physician Fee Schedule that will expand the services covered under G0511 for FQHCs. Will this remove all reimbursement for G0511 or only those associated with chronic care management?" Great question. Sarah, could you weigh in on that one?

>>Sarah Irie, CMS: Yeah, I think this, this is a really insightful question. You know, we're obviously tracking closely what is happening with the calendar year 2024 Physician Fee Schedule proposed rule. And so I guess with that caveat, like things are potentially going to change, but for now our policy is

that we'll remove reimbursement for the general care management code G0511, and, you know, any service that is allowed to be incorporated or billed under that code for FQHC participants. This is one of those services that is considered duplicative of the Enhanced Service Payment (ESP), so participating organizations won't receive reimbursement through fee-for-service for these duplicative services for their attributed patients, but they will receive the prospective ESP payments and those will be made each quarter and those are on a per-bene-per-month basis for the attributed patients that we are attributing to under the MCP model.

>>Lauren McDevitt, CMS: Thank you so much, appreciate it. So we do have a couple of questions about kind of what happens if you're part of kind of a large TIN, you might have some of your clinics in PCF, you might have some that have never been in PCF and may have never been in value-based care before. So, you know, what, "How would those organizations think about MCP and are they eligible?" So really, a good question. I'm going to turn that one over to Nicholas Minter. Nick, would you be able to take that one and weigh in?

>>Nicholas Minter, CMS: Sure, thank you so much Lauren. So for those organizations, and we realize there are TINs out there that are rather large and have you know sort of participation in some models where we do not have overlapping, where we have a no overlap policy, but many practices where they have not sort of moved into value-based care yet. We are evaluating our overlap policy at the TIN level, which is to say, you know, if there are 30 practices in a TIN, 15 are in PCF, then we would consider that TIN as having PCF experience, and it would not be eligible to apply for the model. Should those other 15 practices apply under a separate TIN, then they would be evaluated as not having overlapping experience. Again, understand that, you know, sort of breaking it down this way to be very clear, that we will look at the TIN and if you know that TIN has PCF providers on it, then that will be considered as violating the overlap policy, but if it is a new or other TIN where there is no such overlap, then that is what we will evaluate, not sort of the historical precedence, or lineage, of those providers to date. So hopefully that's helpful. And back to you, Lauren.

>>Lauren McDevitt, CMS: Thank you, Nick, really appreciate that. Alright. Okay, great. We've got kind of a care delivery as well as, kind of a general model requirements question, so would like to turn it over to James Lee. So James, "Can you describe more about the health equity plan requirement?"

>>James Lee, CMS: Yeah, that's a great question. So in the health equity plan requirement, participants will be required to develop and implement a health equity plan based on the CMS Disparities Impact Statement. And, the participant will have to provide a progress to, kind of like a progress update, to CMS annually, and this, and CMS will provide a template for the health equity plan and the requirement regarding the content and use of the health equity plan.

>>Lauren McDevitt, CMS: Awesome. Thank you so much, James. Alright, and we are getting several questions about the eligibility for Making Care Primary in New York. Nick, could you take that one, please?

>>Nicholas Minter, CMS: Yeah, absolutely, and we're thrilled with all the interest we are getting from the Empire State. So to be clear on the, you know, the final requirements in the RFA. Organizations in New York state and all counties except Westchester, Nassau, Suffolk, New York, Kings, Queens, Bronx, and Richmond are geographically eligible for MCP. More information will be available in the coming months about further possibilities in addition to those already available to engage in other Medicare

value-based payment arrangements in the areas I just mentioned not selected for testing MCP. Thank you.

>>Lauren McDevitt, CMS: Awesome, thank you so much. Just going to take a beat here. Really appreciate all of the great questions here. Just going to look. Okay.

"How long is the duration for each Track and what is the reduced payment rate for Track 3?" I'm just going to, for the sake of time, I'll point you to the RFA. It does have a list of the lengths for each Track. And for Track 3 would also consider, would also point you to the RFA and, listing kind of how the payments, which the list of codes that will be reduced in Track 3 to 0% because of the upfront payment that they will receive.

Alright, and then, Sarah, I would love to turn this one to you. "The UIP provided broad examples for the three buckets of allowable uses. Will CMS provide more detailed examples of how UIPs should be used or written into the application?"

>>Sarah Irie, CMS: Yes, a great question. So not, the application is actually not going to include more detailed examples for this. We included, you know, these broad categories, but also a lot of examples under each of the categories, if you refer to the RFA. But the Upfront Infrastructure Payment is, it's a new payment type that we are, and we're still developing, I think, participant guidance for, for those, so related to, you know, spend plans, and allowed and prohibited uses. I think my best answer at this point in time is that we're still working on developing more specific participant guidance on that, but stay tuned, I guess. Thank you.

>>Lauren McDevitt, CMS: Yes, definitely. Sarah, thank you. But yeah, the broad buckets in the RFA, are meant to be broad and then we will of course collect more information from those that are going to, that are eligible for the UIP on how they're planning to spend it.

Alright, another really quick one. "Will there be an info session to review the details of the model with potential applicants?" You know, we will post and advertise the upcoming events, about the, about the model on the MCP website. We'll also point you to, we've done two model overview webinars, and the slides and recording and transcripts are all on the MCP website. Do encourage you to check those out, in the meantime.

And I think probably the last one before we transition is "What kind of audit or oversight should participants expect to provide evidence around the clinical model?" So what we will do is collect semi regular reporting from applicants, sorry, from participants for kind of how they are implementing the care delivery model and care delivery requirements of MCP. And so, on a cadence that we will specify in the Participation Agreement, your organization will submit a report to CMS describing how you are meeting those care delivery requirements and, also, you might expect to participate, you know, in terms of the model evaluation activities, you might expect to participate in interviews, as well. But those would all kind of depend on, on kind of the approach that we take for the evaluation. Alright, I think with that we will transition to closing, so I'll turn it over to you TJ. Thanks so much everyone for their great questions.

>> TJ Smith, SEA: Thank you, Lauren. I think we can go to the next slide, please.

Great, so to wrap up today's office hours, we're going to go over a few closing items and additional resources. But first, I do want to remind you to please take a few minutes to provide feedback on today's session through our post event survey. Let's go to the next slide, please.

To stay informed about upcoming MCP events and for more detailed information as well as model resources, please visit our website, listed on the screen. There you can also sign up for our listserv to continue to receive updates, and you can also continue to email our help desk with questions as well as follow us on Twitter to hear the latest at the CMS Innovation Center. Next slide.

This does conclude today's MCP Applicant Office Hour. We really appreciate you joining, and we hope you have a good rest of your day. Thank you.