Making Care Primary (MCP) Model Welcome Webinar for Accepted Applicants
March 6, 2024

>>Cat Fullerton, Deloitte: Good afternoon everyone, and thank you for joining today's Making Care Primary, or MCP, Model Welcome Webinar for Accepted Applicants. We are excited to share information about upcoming events we have planned for the MCP Model, and next steps for accepted applicants to consider in the coming weeks.

Before we dive into the content, we'd like to briefly review some housekeeping and logistics. To listen to today's presentation, it is recommended that you listen via your computer speakers. If this does not work, there is also a dial-in option for viewers to listen through their phone. The dial-in number and passcode for today's event, are listed on the slide. Closed captioning is 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 you have throughout today's presentation in the Q&A pod displayed on the right side of the meeting window. We have reserved about 15 minutes at the end of the call to answer questions, and we will use the questions you shared during registration and your live feedback to guide the Q&A portion of today's call. We would also like you to know that today's presentation is being recorded. If you have any objections, please hang up at this time. This slide deck and a transcript will be shared via email with registered attendees in the coming days. Let's go to our next slide and review an agenda for today's event.

For today's event, our CMS Innovation Center speakers will walk us through a quick introduction of the cohort of accepted applications. We're excited by the interest in MCP and want to share next steps for accepted applicants to officially participate in the model. The team will share some information on upcoming dates to consider and resources that are available to accepted applicants to support these actions. Next, the team will share some brief content to reorient everyone on the call to key model concepts. After that, the MCP Model team will take questions from the audience. We prepared some answers to questions submitted during registration and through the MCP help desk. We will also take questions from the audience as time allows. Finally, the MCP Model team is excited to share some quick resources and close out the call.

I'd like to introduce our speakers for today's event now. We have Nicholas Minter, who is the Director of the Division of Advanced Primary Care at the CMS Innovation Center. Liz Seeley and Melissa Trible who are co-leading the MCP model, to speak to MCP's goals, structure, and next steps for participating in the model. We are also joined by several CMS Innovation Center colleagues who are supporting the MCP Model and will help us out in the Q&A portion of the event. Now, it is my pleasure to pass the event over to our first speaker for today's webinar, Liz Seeley, who is a Co-Lead of the MCP Model. Liz?

>> Liz Seeley, CMS: Great. Thank you so much for that introduction. Hi everyone, my name is Liz Seeley, and as was just mentioned, I'm one of the Co-Model Leads for the MCP Model. We really appreciate you taking this time this afternoon to spend with us to better understand the MCP Model. I first want to say congratulations to everyone on this call for your acceptance into the model. During today's webinar, we are really excited to share some high-level information with you all about the model that we hope will be helpful to you as you prepare for the model launch. Next slide, please.

MCP is a ten-and-a-half-year model that begins in July of 2024. The model provides a pathway from fee-for-service payment to prospective payment, to support comprehensive primary care that improves care quality and population health outcomes. CMS is eager to partner with other payers to help drive these goals for their beneficiaries. MCP's first goal is comprehensive primary care. MCP aims to ensure that patients receive coordinated, person-centered primary care. We know that many on the call are at different levels of care transformation and data integration. MCP aims to provide tools and resources that help organizations at varying levels of experience in value-based care be able to gradually implement the activities and be able to feel supported in their transition.

That leads into MCP's second goal, which is to create new pathways to value-based care for primary care organizations, including small, independent, rural, and safety net organizations. Accepted applicants have received their acceptance letters by now, which contains information on the track level that the organization is approved to participate in. MCP's track-based approach aims to give organizations flexibility and opportunity to receive payments based on the experience level with accountable care and the ability to report on specified quality metrics.

And third, MCP aims to improve the quality of care and health outcomes for patients. This model supports coordination between patients' primary care clinicians, specialists, social service providers, and behavioral health clinicians to ultimately lead to chronic disease prevention and improved health outcomes. Next slide, please.

This slide shows the regions that will participate in the MCP Model. Colorado, Massachusetts, Minnesota, New Mexico, New Jersey, Upstate New York, North Carolina, and Washington were selected after reviewing criteria related to geographic diversity, health equity opportunity, current CMS Innovation Center footprint, generalizability to the rest of the Medicare population for model evaluation, and the ability to align with state Medicaid agencies. Applications to MCP were accepted based on these participating regions. Next slide, please.

This graph shows how applicants range in size, displaying the average number of physical site locations per MCP applicant. Overall, MCP received 406 applications, representing a total of over 1,800 sites of care. The average number of sites of care per applicant organization is 4.7, with 75% of applicants having less than 5 sites of care. Of these organizations, there are 127 Federally Qualified Health Centers or lookalikes and 279 non-FQHC organizations. Next slide, please.

Now, before we go to the next steps, our team would first love to hear from you all. We have a poll set up, and the poll questions, which you can read on the screen, are to learn more about the makeup of the clinicians in your organization. So "A" is: I belong to an organization that provides primary care as its main function under our TIN. "B" is: I am an FQHC. "C": I belong to a multi-specialty organization that provides specialty and primary care services under the same TIN. And "D" is: I belong to a health system that provides specialty and primary care services, but we do provide primary care services under one TIN and specialty services under a different TIN. Please select the description that best describes your organization. Great. Thank you so much to everybody who has participated. We really appreciate your engagement and learning from you all.

In the next section, our team will review next steps for your organization to take to officially participate in MCP. My Co-Model Lead, Melissa Trible, will share next steps.

>> Melissa Trible, CMS: Awesome. Thanks so much, Liz. My name is Melissa Trible and I'm a Co-Lead of the MCP Model. I will walk us through the next steps to participate in the MCP Model for accepted applicants. Next slide, please.

We have listed here upcoming events for accepted MCP Model applicants to consider as you get ready for model launch. We have several events planned over the next few months to help prepare accepted applicants, including a payment deep dive webinar on March 13, so next week. A quality reporting webinar on March 20, and many more topic-specific webinars throughout March and April. Next slide, please.

As a reminder, signed Participation Agreements, or PAs, are due via web portal submission by April 19, 2024. You will receive a PDF version of your PA in mid-March, via email, and shortly after it will be available in your Practice Portal for signing. You must also notify CMS if you would like to change your track to a higher track by April 19. You may do this by emailing MCP@cms.hhs.gov. Once you sign your PA, you will also receive a HIPAA form and a template to notify beneficiaries of their selection to participate in the MCP Model.

Accepted applicants should have already received their acceptance letter including the approved track option at your organization was approved for it to participate under. In this letter, you should also receive estimated attribution by Enhanced Service Payment tier and the estimated average in the Enhanced Service Payment by-beneficiary-by-quarter. You also should have received an Aligned Payer List for your state. As a reminder, there are some webinars coming up which are noted on the previous slide that will help accepted applicants understand what this information means. Next slide.

This slide is meant to orient you to what to expect in the coming weeks for access to MCP Model systems. Most systems will require the same username and password from your MCP Model application. The MCP portal will house the electronic Participation Agreement, answers to care delivery and health equity questions, and national provider identifier (NPI) or CMS certification number (CCN) rosters.

The MCP Connect site will offer an interactive online community for MCP Model participants to access model specific trainings and webinar recordings, collaborate with peers, and discuss what works in the model. The Innovation Payment Contractor, or IPC, system will offer a way to collect banking information for the purpose of MCP-specific payments. And finally, the Expanded Data Feedback Reporting, or eDFR, tool will offer a system for participants to access and view their beneficiary population data as they work to implement and evaluate care delivery transformations. Next slide.

After PAs have been signed via the Portal, practices will be expected to begin developing their plans to lay the groundwork for future reporting within the MCP Model. We have listed next steps after the PA signing on this slide. First, MCP Model participants will update their Clinician List from the application in May 2024. Eligible Track 1 participants will develop a UIP, Upfront Infrastructure Payment, spend plan using the CMS template that our team will share in summer 2024 via the portal. MCP Model participants will also develop a Health Equity Plan using a CMS template. This plan will be due in October 2024. Participants will then begin to submit baseline care delivery reporting requirements starting in October 2024. Sociodemographic reporting will begin in July 2025 and participants will begin reporting on quality measures starting in January 2026. Next slide, please.

We have shared some introductory information on the Expanded Data Feedback Reporting, or eDFR, Tool that will be available to MCP Model participants. The MCP eDFR Tool will provide participants with insights into their attributed beneficiary population, along with specialists in their region. This data will include quality, cost, and utilization metrics and will allow participants to see how they are doing compared to other aggregate models in their state, along with national trends. CMS will also provide participants with performance, cost, and utilization data on specialists in their region, prioritizing measures related to cardiology, pulmonology, and orthopedics. Next slide, please.

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 environment for practice change. Nationwide support for MCP participants will include technical assistance, or TA, to help MCP participants understand model requirements, rules of participation, payment, attribution, measurement, and waivers available under the model. MCP will also feature a virtual platform for collaboration and coordination within and across regions to support learning and continuous improvement for participants.

MCP will also offer state-based support for participants and will partner with state efforts to create an environment for practice change. Within MCP states, CMS will partner with stakeholders, the state Medicaid programs, and other payer partners to make available supports for practices that builds from what already exists in that state and that will support local implementation and sustainability. This will include, one, connecting MCP participants with each other for a peer-to-peer learning and with the specialty practices and community-based organizations that are partners in providing care. Two, making coaching and facilitation resources available to participants, especially small, independent, and safety net organizations who are new to value-based care and who need help building change management capacity and using data for improvement. And three, contributing to the data aggregation and Health Information Exchange resources so that practices have the data they need to manage patient care for quality improvement.

And with that, I will pass the event over to Nick Minter who will walk us through a refresher to the MCP Model before we go to Q&A.

>> Nicholas Minter, CMS: Yeah, thank you so much, Melissa. It's my pleasure to talk to you today. As Melissa said, I'm the Division Director of the Division of Advanced Primary Care here at the Innovation Center. It is my privilege to again congratulate you as you heard, and also reintroduce some of the concepts of the model. Next slide.

So, want to just briefly touch on the different components of the model that we think come together in a cohesive unit to allow primary care to do more for patients and to be reimbursed for the value that they're providing the health care system and, sort of, in patients' lives directly. Many of these concepts you'll notice actually correspond with other webinars that we have later in our series or the course of the next couple of months. So, we will talk about them in a high-level nature now and then get deeper at a later date.

So, wanted to just first start by acknowledging that we're going to talk a lot, moving forward after the next couple of slides, about sort of the payment details and the quality details of the model from the Medicare fee-for-service side. But I think it's important to acknowledge upfront that Making Care Primary is a multi-payer model, and you received a list in your acceptance letters of payers in each region that have signaled that they are going to partner in support of this initiative by signing a Letter of Intent. And in signing that Letter of Intent, they have agreed to support Making Care Primary by aligning on

areas that will make it easier, administratively, for participants to succeed in the model. Things like moving to align in how primary care is paid, moving away from an encounter basis, and over time. And by signing the Letter of Intent, they signal that by 2027 they seek to move a considerable amount of primary care payment to a sort of non-fee-for-service, prospective basis by measuring quality in a more standardized fashion, with similar definitions, so that it's very clear how you all, how the value that you're producing to the health care spectrum, to your communities, is being measured and you're being rewarded for that.

Things like, over the long term, aggregating data, which Melissa touched on, so that you all are getting data across payers on your patient panel, without having to manage a lot of sophisticated administrative overhead to use that data. So we are working with those payers now and will continue to deepen the alignment that we have with them, in the coming years, and frankly speaking, over the next decade. We have been honest with them as we have with you that this is a ten-year endeavor. So want to sort of note that upfront.

The first payers that we talked to in each region are the state Medicaid agencies, that we know you care for patients, that are being supported of each and every day and so want to note that, you know, we are in the states that we are in. We are so excited about the perspectives for this model because of the partnerships that we've developed with the state Medicaid agencies. And we're very grateful for their support of this model as well.

Wanted to also note that, you know, care delivery is an important part of this model. Unlike, you know, sort of other tests that we have tried or are trying and different regions of the country, in Making Care Primary, we're not only giving you resources to succeed, but also providing a blueprint and guidance and both in learning and in care delivery to help you meet the requirements of the model and to understand what needs to change and what outcomes we expect over time.

And so there are three tracks, we'll talk a little bit more about that later, but again, we will start sort of basic with things like risk stratification, making sure that we are looking at patients and seeing them and meeting their needs based on the risk and setting up workflows to support that. Moving on to integrating care, that isn't always sort of accounted for in primary care, like behavioral health and specialty integration. And then moving on to making community connections so that we're ensuring that we're caring for patients' health-related social needs, as well as those issues that aren't necessarily taken care of always within the four walls of an office.

Want to note upfront, you know, just touching on quality very quickly, we will measure quality in a parsimonious manner. Hopefully you all are familiar with our quality measures. We obviously will dig in deeper there as we sort of talk more about the model elements during the series. But want to flag upfront that one of the advantages of MCP is that, Track 2 and Track 3 in particular, will qualify as Advanced Alternative Payment Models and therefore reporting to this model will take the place of MIPS for those that that qualify.

We plan on working with you, your EHRs, to extract many of the measures directly using electronic clinical quality measures. We have some claims-based measures that of course we will be calculating on our own to look at utilization. And then we are pioneering with a brand new, we think, very light lift patient satisfaction measure in the person-centered primary care measure. So we're really excited about those, and the impact that those will have on patient outcomes, communicating sort of progress to our

participants, and driving down health inequities that we know exist within participants and within communities nationwide.

In addition to those measures, just want to note that we are requiring that there is a Health Equity Plan that is developed by all of our participants over the course of the model. This is something that we will provide significantly more guidance on as we go forward, but it is intended to support participants as they work to identify strategies to address health equities within their community. And one way that we are sort of representing this and supporting payers, especially those that are in areas with historically more health inequity, is by risk-adjusting our Enhanced Service Payments, not only by the clinical risk of the patients being treated, but also by the social risk of the, of where the patients live and what the patients have experienced over time. Things like LIS status and the Area Deprivation Index, we are looking at all of those to make sure that we are building in factors to support practices that care for patients whose risk is not just to found in a clinical nature.

Want to just acknowledge, and again, we have a webinar on this later as well, that we will have a two-pronged learning strategy that has both a national approach that will disperse sort of best practices nationwide. I think you've already heard a little bit about our Connect platform to make sure we are connecting practices with each other as they sort of address clinical issues or challenges that come up. But we will also have a region-specific strategy that looks to build on existing infrastructure to make sure that practices are getting the sort of one-on-one support where necessary, when they are struggling, to sort of meet requirements or meet performance goals in the model. So, you know, we really are there to walk hand-in-hand with folks as they, sort of, undergo this transformation.

And finally, payment. I left this last, but it certainly is not least. We have several payment types in the model. We will talk about this a little bit more today. We'll talk about this a little bit more in the series. But we have structured these to be supportive of all the changes that we are asking our participants to make to improve care and further increase the reimbursement that's available for primary care within the Medicare system. Next slide, please.

So really quickly, we've received a lot of questions about our overlap policies and how practices can withdraw from the model, if they so choose. So generally speaking, I think we've tried to be upfront about what models we will allow overlap with, what models we will not, generally speaking. If you have questions that are specific, please reach out to us at our Help Desk.

But for, those models that are that are in an ACO, that sort of you know focus on an ACO, things like ACO REACH other primary care specific model, like Primary Care First, we are not allowing overlap because some of those payments would be duplicative of one another. However, if you were in a bundled payment model, let's say that you're part of the health system and are participating in something like BPCI Advanced, we do allow overlaps in those models because they are not primary care-focused or do not otherwise overlap with the primary care intervention.

With SSP, so the Medicare Shared Savings Program, want to highlight, we have, if you are currently in SSP, you can join the model in July and continue to be in both programs through the end of this calendar year. However, you will need to let your SSP ACO know by June is what we are, sort of, tracking toward internally, that you do not wish to stay in the ACO for 2025, in order to continue in MCP and start to receive model payments beginning on January 1st of next year. So please track to that day internally. We are setting up a process to make sure that we are going to be able to circle back around with folks who may be enrolled in both models, but it will be the most streamlined experience for everyone if you all are

tracking that overlap on your end and letting your ACO know that you do want to withdraw from the ACO before they have to enter their 2025 Physician Roster.

And as you see here, if you were in a two-sided risk arrangement under SS, under SSP, forgive me, then you did not qualify for Track 1. I know we've gotten questions from a few folks who said, you know, I was accepted to the model, but asked to join Track 2 instead of Track 1. This is the most common reason for that determination, but if you have specific questions, please send us an email.

And then, very quickly, we've got a lot of questions about withdrawing from, Making Care Primary. It's a ten-year model, things change. And while we think that we are providing additional support that is not present in fee-for-service on the Medicare side, and so hope that folks will continue this journey with us for the entirety of the model, if you do wish to withdraw from Making Care Primary, it's a voluntary model. You will be able to do that throughout the year, there will be a slight lag of a quarter or so while we effectuate that sort of withdrawal.

However, want to note that there is one condition if you qualify for the Upfront Infrastructure Payment and then withdraw before you become a Track 3 participant. That is to say, you graduate to Track 3 from Track 1, then you may be required to repay the Upfront Infrastructure Payment. That payment is intended to help participants develop the infrastructure to succeed in the model and Track 3, and if you leave before, then we do reserve the right to have that money repaid.

Just to note for those that are wondering, can I join another model after I leave MCP? The answer to that question is largely yes. It is a voluntary model. Once you're out of the model, we will not restrict joining another primary care or ACO-based model. So want to be very upfront about that again. We think that this model will be supportive and offer increased compensation for the value that primary care can present, but want folks to know that you do have those options if you join the model. Next slide.

So really quickly, this slide is on, the multi-payer alignment part of the model. As I mentioned a couple of slides ago, we think the multi-payer alignment aspect is really important. We know that all of our participants have many payers and lines of business that they have covering their patients and coordinating how you're getting paid and what's being valued is very difficult. We have learned a lot over the past decade of testing different types of alignment in primary care with our payer partners. And what we found is we need to be very specific on how and where to align, but give payers some flexibility in how they learn. Which is to say that we want payment, for example, to move away from an encounter basis, from a fee-for-service basis, but we don't want to, we can't tell payers how much to pay or exactly how to calculate that payment. So giving them that flexibility is important, and we call that approach directional alignment.

So we're all moving in the same direction, for example, away from fee-for-service, but not necessarily doing it in the exact same way. As I mentioned, we started with Medicaid because we think if both governmental payers, Medicare and Medicaid, are in lockstep and supporting primary care that will create a significant momentum to move the rest of the market in a way that allows you all to care for your population on a needs basis as opposed to a need-to-bill basis.

And then finally, each region has specific health concerns. And one of the things that we've talked to our partnering payers about is that what we focus on a quarterly, quarter-to-quarter basis, maybe be slightly different in New York than New Mexico, because care is local and some of the burgeoning concerns that

primary care has to deal with are different. So we want you to know that one of the advantages of working with payers in each region like this, is we will be able to customize the types of interventions that we focus on and the support that's available to practices throughout the model based on what we and other payers are seeing as emerging concerns. Next slide.

Yeah, so really quickly, care delivery is a critical part of the model. And as you see, there are really three themes, one, that is sort of the focal point of each track here. We start in care management, where we're really trying, making sure that those practices in Track 1 that have not had much experience in value-based payment are starting to classify or to stratify the risk within their patients, and set up workflows so that there are professionals that are able to track and work with those patients to improve care management and in self-management of chronic care outcomes and symptoms over time.

Once we move to Track 2, we start to think about care integration. Mental health services, behavioral health is a real driver of avoidable health care and less than ideal outcomes. And so focusing on integrating that in a way that makes sense contextually for our participants is a focus of Track 2. As well as working more closely with specialists to ensure that the primary care practitioner, the primary care provider, is in the middle of those discussions and isn't sort of left out and has a say in how that specialist referral process works.

And then finally once we move to Track 3, we focus on making sure that the community is also playing a role in in our patients' health, and that is sort of building connections with existing resources to ensure that health-related social needs are also being addressed. And ensuring that those workflows are there where if need is identified, they have somewhere that they can go.

Well, one note I just want to hit on, based on questions we've gotten already. There's been concern, I'm in Track 2, I don't know if I'm ready to meet those requirements. It's very important to note that we will not assess whether or not a participant is meeting the requirements of a given track until the end of the first year that they are in that track. So for those who are concerned about whether or not Track 2 requirements meet where you are currently, we plan to give you, from the start of the model, a full year and a half before we really look to see where you are in terms of meeting Track 2 requirements and whether or not we can help out in moving that process along. Again, this is meant to sort of build capacity, not to set goals that are unrealistic. And we are taking that sort of approach to the requirements meeting process. Next slide.

Yeah, thank you. And it's at this point I want to turn it over to Liz Seely once again to talk a little bit more in depth about the model structure and some of the elements in a little bit more detail. Thank you.

>>Liz Seeley, CMS: Great. Thank you so much, Nick, for that overview. So as Nick mentioned, we're going to talk a little bit more about payment. As you all know, we also have an entire webinar devoted to payment next week. And we've got a payment methodology paper coming out that will have all of the technical details. And we'll hopefully be able to answer questions as you continue to think and analyze this model for your organization. But for now, we'll, give a high-level overview to help refresh some of the information that you all may be familiar with.

So, participation; there are three tracks in the MCP Model. As Nick mentioned, Track 1 is for organizations that have the least experience in value-based care. And in Track 1, that's really an opportunity for those organizations to be able to invest in the capacities that they will need to succeed in

the model. So that will include e-consult platforms, risk stratification abilities, data reviewing, identifying which staff will perform which functions, determining how to engage in health-related social needs screening and referral. And the participants in Track 1 will have the duration of two-and-a half-years to do these, invest in these capabilities before being required to move to Track 2.

Track 2 then focuses on supporting participants in this shift, where payment begins to shift from fee-for-service to partial prospective population-based payments for primary care services. Participants must meet specified quality and cost thresholds. And we'll have an additional opportunity to earn a Performance Incentive Payment, where the upside opportunity increases from 3% in Track 1, to 45% in Track 2. So that's a substantial increase in the opportunity for additional revenue for participants who are able to perform on the specified metrics. Again, participants who enter into Track 2 remain in Track 2 for the two-and-a-half years and are then required to transition to Track 3.

Track 3 is the track that really is focusing on optimizing care and partnerships for advanced primary care participants. So participants in Track 3 will focus on, they'll have full Prospective Primary Care Payments. And they will have data to be able to assist them in improving behavioral health and specialty care integration. Participants that enter into Track 3 at the start of the model will remain in Track 3 for the duration of the model. So the important thing to understand is that participants are required to shift across tracks from Track 1 to 2 to 3 and that the progression is one direction across the tracks. Next slide, please.

This slide shows an overview of all of the different types of MCP payments. I'll give a high-level overview right now. And as I mentioned earlier, the webinar next week and the payment methodology paper will dive into much more detail on each of these payment methodologies.

So MCP will change the way participants are paid for primary care services through Medicare and will provide additional revenue to support care transformation. We will also introduce two payments to support closer coordination with specialists. The Prospective Primary Care Payments, as we call them, the PPCP, will be provided to organizations in Tracks 2 and 3. These payments will feature quarterly per-beneficiary-per-month payment to support a gradual progression from fee-for-service to population-based payments for primary care. These payments will be specific to each participant and will be calculated using historical billing information. For FQHCs, I know a question has come in, asking if FQHCs will still be reimbursed based on their Prospective Payment System. The answer is yes. PPCP for FQHCs will be based off of their own historical claims under the PPS.

The Enhanced Service Payment is a non-visit-based, quarterly, per-beneficiary-per-month payment that's adjusted to reflect the attributed population level of clinical and social risk. This will provide proportionally more resources to organizations that serve high-needs patients. And this payment will be available to participants across all three tracks of MCP.

The Performance Incentive Payment is an upside-only payment that's designed to reward MCP participants for improvements in patient outcomes and quality measures. These payments are structured to maximize participants revenue stability by paying half of the estimated PIP in the first quarter of the performance year, and then the other half at the time of assessment in the year following.

To ensure that organizations with less experience in value-based care can actively participate and thrive and MCP, startup funding is available in the form of an Upfront Infrastructure Payment for eligible

organizations in Track 1. And it's important to note that this UIP is only available to eligible participants based on a low revenue calculation threshold calculation that CMS calculates.

Finally, MCP will feature two payment types designed to incentivize specialty care integration for participants. Participants in Tracks 2 and 3 will be eligible to receive MCP e-consult payments, and specialty care partners in Track 3 will be eligible to receive ambulatory co-management payments for coordination of care for MCP-attributed patients. Next slide, please.

So this slide shows how the different payment types are anticipated to work together to gradually support increased payment over time in the model as participants implement care delivery requirements and improve on quality measures. As you can see, the primary care payments that are paid prospectively increase across time in the share that is paid prospectively. So, participants in Track 1 continue to bill on a fee-for-service basis. In Track 2, primary care services, half of what is expected for primary care service spend is paid prospectively. The other half continues to be paid on a fee-for-service basis. In Track 3, it is full prospective payment for primary care services. So, 100% of the expected primary care services are paid upfront. The important thing to understand for participants is that it is very important you continue to bill the claims across the entire model, including in Track 3, as those claims will be used when we re-base the PPCP. So we will want to make sure that we have the record of the claims that you've billed. In addition, that'll be important for updating HCC scores as well.

So, you can see that the Enhanced Service Payment, and these are the guaranteed prospective payments provided, they decrease over time as participants are expected to become more advanced in their capabilities to meet care delivery requirements. But the Performance Incentive Payment increases substantially over time. So there's good opportunity to maintain revenue stability and in fact to increase revenue for participants, depending on how they do according to the cost and quality metrics. Next slide, please.

Mirroring CMS's broader quality management strategy, measures for MCP were selected to be actionable, clinically meaningful, and aligned with other CMS quality programs, including the Universal Foundation Measure Set. MCP's selected performance measures mirror the models care transformation goals and incentivize performance through participation incentive payments. Participants will need to exceed the 30th percentile against the national benchmark on the TPCC threshold measures in order to be eligible for receiving the PIP. However, once an organization has passed the TPCC threshold, they can earn bonuses associated with each of the measures individually. So, if an organization does well on select measures, but is feeling challenged and needs to work to improve in the other measures, there is still the opportunity to receive the prorated bonus amount associated with those measures they perform well on. Next slide, please.

Specialty care integration; This is a feature in MCP that is new for primary care models at CMMI, and we're really excited about. So MCP introduces a gradual approach to the implementation of specialty care coordination to help organizations at different stages of the advanced primary care spectrum succeed in the model. MCP provides participants with data on specialists and peer-to-peer learning opportunities to support the specialty care integration delivery requirements. We will also offer two new payment opportunities. The MCP e-Consult Code, that's the MEC, and the Ambulatory Co-Management Code, that's the ACM. These two new payments work together to provide primary care organizations and their specialty care partners with additional resources to care for patients together in a coordinated fashion. Next slide, please.

Health equity; Health equity is a key feature in MCP. MCP includes several different model components that are 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. These include a Health Equity Plan, the MCP organizations will create to identify health disparities within their patient population and strategies to reduce these disparities. As part of this, MCP participants will implement a health-related needs screening and referral process. This will enable participants to meet the requirements for the PIP measure.

Screening for social drivers of health, where participants are assessed on the percent of patients screened for health-related social needs. The collection of data on certain demographic information and health-related social needs will also support the evaluation of health disparities in MCP communities. To help organizations that serve high-needs beneficiaries we also socially and clinically risk adjust the ESP payment. So, this is an area in which we incorporate health equity into the payments themselves. And then finally, there's an opportunity for the organizations to waive cost sharing for select beneficiaries that are defined as high-needs beneficiaries. Next slide, please.

I will now turn it over to my Co-Model Lead, Melissa Trible, for the Q&A session.

>>Melissa Trible, CMS: Awesome. Thanks so much, Liz and Nick for that great overview. We will now turn to the Q&A section. We have several different individuals who've been working on MCP here to help us answer some questions.

For the first question, we're going to turn it to our payment lead, Meredith. So Meredith, this first question says we currently participate in an ACO. The ACO has no downside penalty. How about MCP? And the participant noted we have very complicated patients with lots of chronic diseases. Meredith?

>>Meredith Yinger, CMS: Thanks, Melissa. Yeah, this is a great, and a common question. MCP is a primary care organization-based model that guarantees additional payments above what participants earn in fee-for-service Medicare. And it's an upside-only model that offers increasing performance-based payments over the ten-year model period. So, there is no direct downside risk.

>>Melissa Trible, CMS: Perfect. Thanks so much, Meredith. Liz, I'm going to turn it back to you for a moment. I know we got a handful of payment questions submitted before the webinar began. Would you like to cover some of those now?

>>Liz Seeley, CMS: Sure. Thanks, Melissa. Some of the payment questions that were submitted were asking questions around how does beneficiary, how is a beneficiary eligible to become an attributed beneficiary? And what determines how those attributed beneficiaries are placed in the different ESP risk tiers?

So we use an attribution process, which many of you may be familiar with. It's very similar to the attribution process that our other primary care models have used, such as PCF and CPC+. We will go into much deeper detail next week on attribution. But the core tenants of attribution and the way it works, is that a beneficiary will be attributed to your organization based on the plurality of where they receive their primary care services, and based on where they receive the annual wellness visit and the welcome to Medicare services, and which organization they've received the annual wellness visit on the most recent basis from.

Once beneficiaries are attributed to organizations, we then assess their clinical risk using their HCC scores, and we assess their social risk. This incorporation of social risk into our placement of beneficiaries in the ESP risk tiers to determine how much Enhanced Service Payment you receive for each beneficiary is something new and innovative that the Center is doing. We understand that identifying beneficiaries on social determinants of health is complicated, and there are many different measures out there and pros and cons to the different measures. So we use two different measures to identify the social risk for a beneficiary. And those measures include the ADI, which stands for the Area Deprivation Index, and LIS, which stands for the Medicare Part D Low-Income Subsidy, enrollment. Beneficiaries that have the highest ADI in their state region, the highest quartile ADI in their state region, and the highest quartile HCC in their state region are considered high-needs. In addition, beneficiaries that are enrolled in LIS are high-needs. These beneficiaries have the highest PBPM amount attached to them for the ESP payments that are provided to your organization. We also tier beneficiaries according to their HCC scores who do not fall into that high-needs category.

Importantly, the high-needs category, the PBPM amount remains the same across all three tracks. So, as you saw from one of the earlier slides, the ESP payment amount on average decreases across tracks for organizations, but the PBPM amount associated with the high-needs beneficiaries remains the same across all three tracks to provide that additional level of support. And you did receive, in your acceptance letters, estimates of how many beneficiaries, how many attributed beneficiaries for your organization may fall into those different ESP tiers. Your actual attributed beneficiary count will be updated in June, prior to the start of the model. But that acceptance letters will give you a sense as you project your budget and think about modeling, it'll give you a sense for what your ESP revenue may look like.

>>Melissa Trible, CMS: Perfect. Thanks so much, Liz. I'll give you a break for just a moment, although I'm sure we're going to be coming back to you. I will turn to you Nick. I'm seeing some questions about ACOs for Medicaid in particular. There's one that says: We have an ACO for Medicaid in Massachusetts. Would we need to change for MCP? Could you answer that, Nick?

>>Nick Minter, CMS: Yes, absolutely. And I think this is a great point. We've gotten questions like this one, which is again, it's a great question, about how participation in Making Care Primary will affect value-based arrangements in other lines of business, or for Medicaid, for example. In the case of this question, and the non-overlap policy in Making Care Primary only applies to arrangements in Medicare fee-for-service. Which is to say the Medicare Shared Savings Program falls into that bucket. However, if you are in an ACO, in Medicaid, or if you have a value-based arrangement with a commercial third-party payer, those do not need to change to participate in Making Care Primary. We, frankly speaking, you know, commend you for taking on that accountability.

We simply can't allow the overlaps, however, in Medicare fee-for-service. So again, if you're in a Medicaid-based, value-based arrangement, if you have other contracts for other commercial payers or otherwise, those are completely fine. It's only in situations where the payment affects revenue for Medicare fee-for-service beneficiaries that we have this rule in place. I hope that's clear, but please reach out to the Help Desk if I can be of more assistance.

>>Melissa Trible, CMS: Awesome. Thanks so much Nick for that answer. Liz, we'll turn back to you now, and we'll call a question that we also got ahead of the webinar. And that one says: Does the program replace or supplement the FQHC Medicare PPS reimbursement? Could you answer that?

>>Liz Seeley, CMS: Sure. So the program builds on the Medicare FQHC PPS reimbursement by basing the PPCP rates off of PPS. So we fully understand that the FQHC organizations bill under a different reimbursement system, which is the PPS, than non-FQHC organizations in MCP, which bill the Physician Fee Schedule. And we understand the coding system is different. And the services under each code are different and are associated with different rates.

We are not disrupting those different reimbursement systems. What we do is with the methodology, for our Prospective Primary Care Payments, for FQHCs, we use your historical claims to derive your Prospective Primary Care Payment, PBPM amount. And we update the PPCP PBPM amount according to changes in the PPS over time. We will ensure that any changes in your charges over time are reflected in the methodology as well as any changes in gaps.

>>Melissa Trible, CMS: Awesome. Thanks so much, Liz. This next question I will direct to our Care Delivery Lead**,** who is Rhandi. Rhandi, I know with the care delivery section of the RFA, we talked a lot about HRSNs, or health-related social needs. We got a question asking us to expand more on what that is. Could you answer that?

>>Rhandi Morgan, CMS: Sure, thanks, Melissa.

So health-related social needs are individual-level adverse social conditions that negatively impact a person's health or health care and can be identified by the health care system and addressed in partnership with community resources. Some examples would be food insecurity, housing instability, or lack of access to affordable health care. MCP participants will be required to identify and address the health-related social needs in their patient populations. However, the organization can select the tool they wish to use. Regardless of the tool that's used, it should specifically screen for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety at a minimum. And that is detailed in RFA. Thank you.

>>Melissa Trible, CMS: Awesome. Thank you so much, Rhandi.

Liz, I think we'll turn it back to you this time for a track question. We have a question that says: How was it determined which track your organization was approved for? So organizations would have received their preliminary track eligibility in their acceptance letter. And for example, if an organization applied for Track 1, but were approved for Track 2 or 3, how would that work, Liz?

>>Liz Seeley, CMS: Sure, thanks, Melissa. So, the criteria for being eligible to participate in Track 1 is based on experience in Medicare value-based care programs. The way that we have defined that is that if your organization has had experience participating in two-sided MSSP, Medicare MSSP, or the Next Gen Model, or PCF, then we deemed that to have had experience in value-based care and the organization would be eligible for Track 2 or Track 3. Organizations that have not had experience in value-based care are eligible to enter into Track 1 if that is your indicated track of interest.

Once in Track 1, you may be eligible for the UIP payment. The UIP payment has its own set of eligibility criteria. So first you have to meet the Track 1 eligibility criteria that was just described. Then the criteria for the UIP eligibility is based on whether or not you have an e-consult platform, and/or whether or not you pass the low revenue threshold. There will be more details on the low revenue threshold next week, and in the payment methodology paper. But essentially, it's an assessment of

your TIN's revenue for Medicare Part A and Part B divided by your attributed beneficiaries' Total Part A and B spending. And if that is below 35%, then you would be eligible for the UIP. You need to have indicated that in your application if you were interested in receiving the UIP. And at this point you've been provided with preliminary information on whether you're eligible to receive the UIP. We will finalize that eligibility information based on an updated calculation of the low revenue threshold in June. We'll share it with you and then we'll work with you on your submission of a spending plan for the UIP and you would receive the UIP payment by the fall of 2024.

>>Melissa Trible, CMS: Perfect. Thanks so much Liz and to everyone for all these answers. That is all of the time that we have for questions for now, so we'll transition to our next few slides with some closing resources for accepted applicants. Next slide, please.

So to wrap up, we'll go over some closing remarks and additional resources. Don't forget to mark the upcoming MCP Model events on your calendar, and share with members of your team who will support requirements under the MCP Model. We've created on this slide a "to do list" for accepted MCP Model applicants to reference in preparation for the model's launch. Next slide, please.

We pulled the webinar schedule and key date slide up as a friendly reminder for organizations on the line. The next event will be on Wednesday, March 13 at 11 am to 12 Eastern Time. We will take a deep dive into MCP Model payment structure and answer even more questions from accepted applicants about payment details.

We have listed several more upcoming events including a deep dive on the quality measures and care delivery approach on this slide. Please share with your organization's team that will support MCP implementation. Next slide.

To stay informed about upcoming MCP events and for more detailed information, please visit our website, sign up for our listserv, email our help desk or follow us on Twitter. As a reminder, the MCP Help Desk is available for accepted applicants to submit their questions about the model. Please reach out to MCP@cms.hhs.gov if you have any questions, we were not able to answer in today's webinar about the MCP Model.

We'll put the link for the MCP Model webpage, which contain lots of helpful information about the model including an FAQ. We encourage you to follow us at CMS Innovates to stay up to date on what's going on with the Innovation Center.

And with that, we are ready to conclude today's MCP Model Welcome Webinar for accepted applicants. We look forward to seeing, to seeing you next Wednesday for a deep dive into MCP's payment structure. Thank you for joining, and I hope you have a good rest of your day.