Making Care Primary (MCP) Office Hour
November 21, 2023

>> TJ Smith, SEA: Hi everyone, and thank you for joining today's Making Care Primary 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. The dial-in number and passcode for today's event are listed on this 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 the 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 interested organizations can continue to use the FAQs to find answers to frequently submitted questioned related to MCP. You can also continue to submit questions to the MCP Help Desk at MCP@cms.hhs.gov.

Today's presentation is also being recorded, if you have any objections do please hang up at this time. This 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 a survey at the end of today's presentation. We ask that you take five minutes to let us know how we did and share any questions that you may have about MCP. Thank you. Next slide, please.

We do have a short agenda today before getting to questions submitted by the audience. We will begin by reviewing the application process and reminding you all of some important dates, and we'll also reference a few resources available to support you. After that we will begin answering questions submitted through the registration form, as well as those submitted live via the platform. And with that, I will now turn it over to Lauren McDevitt to begin today's presentation. Next slide, please.

>>Lauren McDevitt, CMS: Thank you so much TJ. And thanks so much everyone for joining us today for another MCP Office Hours. We are really excited to continue to get to engage with you all ahead of the application window closing next week. So first, we're going to cover again, just some eligibility requirements, because we have been getting a lot of questions on this topic. So next slide, please.

So, just to revisit a few key areas of eligibility for the model. Organizations that are eligible for MCP include independent or solo primary care practices, this can include home-based primary care practices, group practices, FQHCs - and we want to point out that Look-alikes are included in our definition of FQHCs - health systems, Indian Health Programs, and then Standard or Method I CAHs. And then those who are not eligible would be, Rural Health Clinics, concierge practices, Grandfather Tribal FQHCs. So definitely, you know, those are, that's a very specific designation, so definitely want you to check out the link that we have in the slides for that. And then, anyone who is in PCF or ACO REACH as of May 31st, 2023.

Just some reminders that, in general, we will not allow overlap between the MSSP, or Medicare Shared Savings Program and Making Care Primary, except for between July 1st and December 31st 2024. And this is because folks will have already made decisions about participating in MSSP for 2024 before they know whether they are accepted into MCP.

And just a couple of reminders. There's only eight MCP states, for this model that is being launched. And your organization will have to have more than half of your primary care sites located in those eight states to be eligible for the model.

Another, just important piece to highlight here, is that the only track that has specific eligibility criteria is Track 1. And when I mean specific eligibility criteria, I mean track-specific eligibility criteria. In Track 1, we're going to look at your prior experience in value-based care. We get a lot of questions about this. It's really just looking at Medicare experience in value-based care. And so definitely check out the detailed list of models that we're looking at and programs that we're looking at to determine that in the Request for Applications. Next slide, please.

So actually, before we get into application process and timeline, we'd like to walk through a new resource that CMS has just released today. So we're really excited to talk through an MCP Revenue Examples Factsheet. And I'll just give us a moment to pull that up, I think we're hoping to. Awesome.

So, this was this was just released today. CMS received feedback that it would be helpful to further crystallize, kind of, how would an organization's revenue look different under MCP versus fee-for-service. So we have, kind of, a three-page factsheet walking through what the organization's revenue would look like under fee-for-service as well as what their revenue would look like, could look like, under MCP in Track 1, as well as what their revenue could look like in some hypothetical scenarios in Track 3. And so we hope this will be helpful for organizations in trying to understand, kind of, the potential opportunities in some of the different tracks. So thanks so much for showing that. And I think we put the link to that one in the chat.

Alright, picking back up on application process and timeline. Next slide, please.

So we are coming up on the application deadline of November 30th. We really do encourage you to begin your application, even if you're not prepared to submit at this time. Well, hopefully, you'll be prepared to submit by next week. But if you do have any questions at all about your application or about model policies, please just reach out to MCP@cms.hhs.gov.

We also get a lot of questions about our Payer Partner recruitment timeline. And so we do just want to emphasize that in February 2024 we're going to be able to share a list of payers that have signed a Letter of Interest with us to become an MCP Payer Partner. And we're going to be sharing that with accepted applicants so that way they can use that in in understanding kind of what payer participation will look like in their region when deciding to join the model. Next slide, please.

So now we're going to move into the question and answer part of the event. So please do submit your questions and answers, sorry, your questions, through the Q&A box and CMS will take a look at them. We're going to start off with a few questions that have been submitted in advance of the webinar. So next slide, please.

So the first question, I'm actually going to turn it, we have a great team of MCP Model team members and experts on the call today, so I'm going to be turning to the team for most of these questions. So on the first one, which is: How does the MCP framework help state Medicaid organizations advance value-based care with their contracted MCOs? And I'm going to turn that over to Nick Minter.

>>Nicholas Minter, CMS: Thank you so much, Lauren. This is a great question. So for context, in each of the eight states in which we are testing the Making Care Primary Model, we originally engaged with the state Medicaid agencies, in those respective states, to ensure that their vision for primary care, in terms of where we're going in terms of payment, aligning our quality strategy as well as our data strategy over time, that those visions were shared. And so in the set, in the several states that have Managed Care Organizations that they work with, the state Medicaid agency has committed, over the course of the model, to driving alignment at the MCO level, and that may look a little bit different in each region.

Each state has different priorities that may also manifest in their Making Care Primary aligned program, however, they have committed toward certain changes, sort of trickling down, if you will, to their managed care program. Things like, moving payment away from fee-for-service, measuring quality in a similar way to, or the same way, if the outcome is the same as Making Care Primary, and over time trying to align data that is provided to providers in a way that it is simpler and more usable. And so that will take some time. It may not all be ready to go when the model launches in July. But it is a commitment that we have that over the course of the ten-year model, Medicaid, either in the managed care space, or the fee-for-service space will align with Medicare fee-for-service, so that we're driving change in a uniform and unified way. Thank you.

>>Lauren McDevitt, CMS: Thank you, Nick. I'll take the next one, which is: What platform will be used to submit data to CMS?

The first thing I'll say is that this is a ten-year model. And so, data submission might look different over time as, kind of, standards for data submission also evolve. I'll mention a few platforms that will be relevant, at least in the beginning of the model. We're going to have a participant portal where you will log in and provide information like on your organization and your name as well as kind of interact with CMS in terms of opting into things like the cost sharing waiver. You'll also use that portal to, or you'll also use CMS systems, to submit care delivery reporting data, health equity plan reporting data. Historically, for quality data, we've used the Quality Payment Program, or QPP, website to submit your QRDA III files. That, again, may evolve with just kind of quality reporting standards moving to FHIR as well. And just want to also mention that CMS is always working to try to reduce the number of different systems that you're using to log in and to submit data. So we're always going to be working towards trying to consolidate, wherever possible.

So for the next question, I'm going to turn to one of our data leads. So the question is: What data will be shared with PCPs, and at what frequency, to strengthen the specialist connection? So, Anna Goldman, I'm going to turn to you for that one.

>>Anna Goldman, CMS: Great thanks, Lauren. So in terms of the data that we intend to share, we will be putting forth a variety of different measures. Initially, those measures will be cost and utilization measures, all for specialty care, so that a primary care practice has the ability to review and identify strong performing partners, and monitor performance. So in order to do that, we're going to share those measures both for attributed beneficiaries within the MCP Model, as well as market level. So, you can do both of those activities. By looking at market level data, you have the ability to identify which providers in your market are the strongest performers, and then have the right data based on the attributed beneficiary population to measure performance and monitor performance over time. We're also considering how we can integrate quality measures that are specialty focused over time. And in terms of frequency that this data will be shared, it will be shared on a quarterly basis.

>>Lauren McDevitt, CMS: Thank you so much, Anna. Alright, the next question is: Can a Specialty Care Partner be under the same TIN as the MCP applicant as long as they are not on the Clinician List? For that one, I'm going to turn over to Mitchell Beers.

>>Mitchell Beers, CMS: Hi, happy to take this one. So yes, a Specialty Care Partner can be under the same TIN as the MCP Participant, as long as they're one of the eligible 32 specialty types, and they also are not on the MCP Clinician List. Additional requirements for the Specialty Care Partner arrangement in this scenario will be detailed in the Participation Agreement. Thanks.

>>Lauren McDevitt, CMS: Thank you, Mitchell. Alright, I'm going to take the next few. And thanks so much for submitting your questions in the Q&A. We'll turn to those next.

So the next one is: Is the TPCC, so it's the Total Per Capita Cost, measure benchmarked against all Medicare providers or just MCP participants? So the TPCC measure will be benchmarked against comparable Medicare TINs that are in your region, not just not just MCP participants.

The next one is: Will CMS provide TPCC information with current percentile ranking with the attribution data in February 2024? Just so folks know what they mean by the attribution data is just we're planning to provide some initial high-level information on your likely attributed population with your acceptance letter into the model. So we'll let you know how many beneficiaries you would likely have attributed, as well as where they would fall in the Enhanced Services Payments risk tiers. And so with that context, we will not be able to provide, you know, likely performance information on the TPCC measure, or really on other measures either as early as February, though, we do plan to provide some initial information on utilization measure performance, so EDU and TPCC upon model start, so around the model start, of July 1st.

And the next one is a really good question we've gotten a lot. So, since the application does require you to select just one track that you're planning to apply to, folks have been asking: Can an applicant change their requested track after completing the application? For example, can a practice apply for Track 2, and then decide to participate in Track 1? Would definitely recommend that if you're interested in applying for Track 1 at all, to select Track 1 as the track that you'd like to participate in. But in general, you can select the track that you'd like to apply to, and then before you sign the Participation Agreement you will be able to notify CMS that you'd like to change tracks. We're going to release more guidance about the deadlines for that in in the coming weeks, likely with the acceptance letter. But just know that, you will be able to kind of change tracks between completing the application and then actually deciding to participate.

Alright. With that, we're going to turn to some of the questions that have been submitted. I'm going to take a payer question first, which is: Are the MCP Payer Partners to be announced in February 2024, going to outline both Medicaid and Medicare payers? Sonja, I'm going to turn that one over to you.

>>Sonja Madera, CMS: Thank you, Lauren. As far as the Medicare and Medicaid payers go, Medicare fee-for-service is already in. So that's what the application period is for right now. In addition, the state Medicaid agencies in all eight of our states have already submitted a Letter of Intent to participate in this program. So we know that Medicaid is also in. What we have left are the commercial payers, that we're talking to right now to try to gather support on that side for this program as well. And those are the folks that we have asked to submit their LOIs by February. So the list in February will include

Medicare fee-for-service, which we already have, Medicaid, which we already have, and any of the commercial payers that decide that they want to align with the program as well.

>>Lauren McDevitt, CMS: Thank you, Sonja. Alright. I'll take the next one. Does CMS have a template for the Letter of Support that's required on the MCP application?

Just want to say that the Letter of Support is not required for everyone. It's just required, if you answered yes to certain ownership questions. We do not have a template for the Letter of Support, but it just it does need to be from the organization that's listed in the MCP application. But we just need to see that there's, that there's support. But we don't have a template at this time to share.

Another quick one. But again, just feel free to continue to submit your questions. On the application form, if the entity is a nonprofit or FQHC, for the question asking about ownership. Should we select other and write nonprofit? That's right. And we apologize, that we've gotten that question a lot. If you're a nonprofit, you can just select “Other” and write, you know, “nonprofit” or write “FQHC” or something like that, and especially if you have already selected that you're an FQHC in your application, we'll know what that means, and you'll be good to go.

Alright. I'm not seeing, just going to take a moment here. Okay, I just saw one I think we can answer live. Can a practice opt out of ACO REACH to join MCP? So if you were, if you were part of ACO REACH in 2023, you would not be eligible to join MCP. And that is because we, we're not trying to, we're trying not to pull from active models that have an active evaluation. And so if ACO REACH is working well for you, definitely we wouldn't want to pull anyone away from that.

Okay, I have one other payer question that I see. So when you say commercial payers who want to align with the program are we referring to state Medicaid contracted MCOs or what commercial payers are you referencing? Sonja, I'll turn that one over to you.

>>Sonja Madera, CMS: Thank you, Lauren. We're talking to right now to a number of commercial payers, and those commercial payers hold many lines of business. Some of them hold Medicare Advantage lines of business. Some of them do hold Medicaid lines of business. They hold employer contracts, they have marketplace lines of business, a whole variety there. The decision for a Medicaid MCO, a commercial payer that is a Medicaid MCO, that decision will be made by the state, and that commercial entity together. Those conversations are happening now. And for the other lines of business, that will be up to the commercial payer to decide which ones they would want to include. So we could see a commercial payer that includes all of their lines of business potentially, or they may have some lines of business they include, based on conversations with employers that they hold contracts for, for example. So we're looking at a variety there. Thank you.

>>Lauren McDevitt, CMS: Thank you, Sonja.

Alright. I have one question here that I think we're going to, going to talk a little bit about maybe risk adjustment. So I'm going to kind of, so the question is: As an HCH, we are concerned about risk stratification for our population, as we have many people experiencing homelessness, we have multiple comorbidities and social needs that may supersede medical centered health outcomes. Can you talk about how this will be evaluated, modified over time? I think this is talking about how we're going to adjust and evaluate our risk adjustment methodology. So for that one, I'm going to turn that over to Liz Seeley.

>>Liz Seeley, CMS: Thanks, Lauren. So this this is a great question, and something that we have spent a lot of time working on to make sure that we are sort of at the forefront of incorporating other factors into the support we provide participants besides just clinical risk. The Enhanced Service Payments, which you are all probably familiar with, these are the prospectively given payments that are guaranteed payments, calculated on a per-member-per-month basis, paid out quarterly for each attributed beneficiary in the model for each participant. They, the level of per-member-per-month dollars that's provided to each participant for each attributed beneficiary reflects both social and clinical risk factors. So the clinical risk factor is the HCC score. The social risk factor is a combination of the Area Deprivation Index that the attributed beneficiary resides in, as well as whether they are enrolled in Medicare Part D Low Income Subsidy. The per-member-per-month amount associated with the beneficiaries that fall into the higher social risk tier is $25 per-member-per-month, and that level is maintained across all three tracks in the model. So this higher level of support is intended to do exactly what this question asks, which is to provide additional support to beneficiaries that may have historically had access challenges in the health care system, and which may not be reflected in historical spending data. We will continue also to monitor the best strategies for incorporating social determinant of health measures into our model over time, as they evolve.

>>Lauren McDevitt, CMS: Thank you, Liz. Alright. We did get a question about how will clients, or will patients be determined as paneled to the health center or the participant as part of the payment model? So, for the purpose of the Medicare portion of the model, CMS will deliver a list of attributed beneficiaries to you on a quarterly basis. And so you'll know who's been attributed to you on a quarterly basis. And that attribution will be determined, kind of, based on our attribution methodology, which really just looks at who's providing primary care to a patient. And so that, so we'll do that through our attribution methodology, and we'll also give you a list of your attributed beneficiaries on a quarterly basis as well.

On a bit of a different topic. I'm going to ask a question about, kind of, how do we decide who's primary care on the participation list? So for this one, I'm going to turn it over to Nick. How are family medicine providers under the same TIN handled who are not listed on the Participation List? Example, we have community walk-in clinic that is staffed by separate family medicine MDs and Advanced Practice practitioners who are not strictly primary care who we did not list on the application. Another really common question we're getting. So, I'll turn that one over to Nick.

>>Nicholas Minter, CMS: Yeah, this is a great question, and really appreciate someone putting it forward. So as the application, as the application instructs, we are interested in, and we require all primary care clinicians who primarily treat, who primarily treat primary care, but also are treating Medicare patients to be listed on the clinician roster. If you have clinicians that do not provide Medicare-based primary care, or let's say they even have a primary care specialty, but in the, you know, I should say, in the situation proposed here, they are operating in another theater, or they may be a hospitalist, but have a primary care specialty that they just have listed, you can leave them off of the clinician roster. Our goal is to make sure that we are enrolling all primary care practitioners, which both means that they have to be practicing primary care as their primary form of interaction with patients, but also have one of the designated specialties that the application dictates. So please include those on the roster.

If you leave clinicians off the roster appropriately, they will continue to be paid through fee-for-service. Their payment will not be influenced by the model, and so in essence they will continue on as part of

your organization, and be paid the way that they were prior, that they were the year before, and that won't change. So in essence, any provider that you list on the clinician roster will be eligible for their patient panel to receive the additional funding, to receive performance-based payments, and to receive the additional support in MCP. But if you leave a clinician off the roster because they're not primary care, then, of course, their patients will not be attributed to the practice in the model. So I want to make sure that that's very clear. But the instruction is, if you have a primary care specialist that is not practicing primary care, leave them off because they're not really going to affect your attribution one way or another. And we really want this to be focused on those primary care clinicians that are providing those services day in and day out of their sort of medical lives. So hopefully that's helpful.

>>Lauren McDevitt, CMS: Thank you, Nick. Another question is, what would the, what would be the reason for rejecting an application by CMS to participate in this program? So we're really going to look at just whether organizations met the eligibility criteria, and the eligibility criteria are listed in the RFA. But there are things like, do you have 51% of your care sites in the MCP state? Do you meet the 125 beneficiary threshold? Others, like the 40% primary care revenue threshold that applies to non-FQHCs. And we'll also run kind of a program integrity screening on the TIN, just to make sure that folks don't have, you know, that they don't have any active sanctions. And so really, we'll just be looking at eligibility, and whether there are any program integrity concerns.

Taking a moment to scroll through. And if do you have, there's a question about: Do you have to submit a Letter of Support committing to segregate fund if you're a 501(c)(3)? So the Letter of Support is really only required for some applicants, that are owned by you know, a different owner than their organization. It doesn't sound like that would be the case if you're a 501(c)(3), but feel free to reach out to MCP@cms.hhs.gov if you have specific questions about your situation.

I'm going to take one quick one. And feel free to just continue to submit your questions. Apologies for the delay.

Okay, so one question is: So pediatricians in our state have been encouraged to apply, but the eligibility criteria indicates a minimum requirement of 125 Medicare beneficiaries, which definitely makes sense, given the pediatric focus. So I will say that the it sounds like you're really tracking right along, is that the plan for Medicaid in your state would really determine, kind of, how pediatrics is included. We definitely we want to also include pediatrics to the extent possible in the Medicare component. And so in that case, we'll really just be aligning with the Medicaid program that is launched in your state. So yeah apologies for the confusing messaging there. But you would need to meet the 125 Medicare beneficiaries to come to participate in the Medicare fee-for-service. component but we'll definitely be able to participate, I guess eligibility criteria will determine on your on the Medicaid side, but the intent would be that you could participate on the Medicaid side.

Alright. Another question is: What specific information or resources can we expect CMS to distribute between November 30th and July 2024 to help us decide if MCP is the best fit for us? I'm going to turn over to Liz Seeley for that one.

>>Liz Seeley, CMS: Thanks, Lauren. So we will be giving a number of different pieces of information to participants upon learning that you're accepted into the model. So, in the forthcoming months, when you receive notification that you have been accepted into MCP, at the same time we will be, or around the same time, we'll be distributing the Payment Methodology paper. That is a very detailed methodology paper that really gets into how all of the different payment streams are calculated. We

provide examples on all of it to really be able to assist you in understanding the policies in all of their finest details, so that you can understand what that will look like for your organization.

Along with understanding the policies, and seeing the example calculations, we'll provide you with certain preliminary data pieces. So, we will give you preliminary estimates on what your attributed beneficiary population, how many attributed beneficiaries you have in the model. This does not reflect the actual number of attributed beneficiaries that will be used for the payments in July, but is a preliminary estimate for you, to help you in calculating what potential revenue streams could look like. Along with that we will give you a breakdown of what clinical and social risk tiers the attributed beneficiaries will fall into, so that you, you can help determine what your ESP revenue stream specifically can look like.

And then, in addition to all of that, we'll provide information on what track you've been approved to enter into. They, which will also be based on what you've indicated, which track you've indicated you're interested in, as well as whether you've met those eligibility requirements. And, you will receive a preliminary determination on whether you are eligible for the UIP for those participants that are eligible for Track 1. So all of this information should be able to assist you all in in being able to understand implications prior to signing the PA.

>>Lauren McDevitt, CMS: Thank you, Liz. And we of course, encourage folks to not hesitate to reach out to MCP if you do have any questions between, kind of, the model application and also deciding to participate in MCP.

So getting some MIPS questions, I'm going to turn this one over to Nick. Is CMMI interested in having large multi-specialty TINs participate in MCP? The MIPS burden for specialists seems insurmountable. Might there be another forthcoming model with PCP capitation that could be more appropriate for those groups? Nick, I'm going to turn that one over to you.

>>Nicholas Minter, CMS: Yeah, thank you. And I know that there is, both a question and a comment, and appreciate sort of the desire and the need sort of reduce provider burden at all times so that we can focus on patient care. You know, CMMI, CMS, the Innovation Center, is very interested in having multi-specialty TINs that, you know, that really want to focus on primary care and have not necessarily moved into sort of an advanced alternative payment in a sustainable, or a payment model, in a sustainable way. We are interested in having you apply and participate in MCP. The way that that would work is you would apply with just your primary care clinicians using the, you know, through the requirements as a guide that we discussed earlier, that your clinicians meet one of the specialties that are enumerated within the application, and primarily actually provide primary care to all patients, as well as to some Medicare patients.

And in terms of the MIPS burden, for those practitioners, they of course, would be eligible for reporting, using an alternative method as sort of discussed in the QPP rules and regulations. The MIPS burden, the sort of the specialists, of course, depending on sort of your organization's other participation and sort of other requirements, I should say, may still need to report to MIPS. So I can't speak definitively for the Quality Payment Program experts. But do want to note, if there is a desire to sort of have the entire organization be in a model, where a multi-specialty clinic can sort of count everyone as being in an APM, that probably is, is more akin to one of our Accountable Care Organization models. But again, what is right for your organization is going to be a very personal decision. And I think you know the difference between some of those ACO models and this are deeper

than just MIPS participation. Things like, do you want the practice to get paid directly like they are in MCP, or would you prefer that, you know, they participate as a much larger sort of organization with an ACO entity coordinating? So there's a lot that goes into those conversations. But I do want to note that you can participate in MCP if you're a multi-specialty clinic, that is completely fine. But as with anything, it's a personal, it's personal decision, and we'll have considerations that are very particular to your situation. So I hope that's helpful.

>>Lauren McDevitt, CMS: Thank you, Nick. I'm going to just take a quick follow-up on the pediatric question. So, do pediatric practices need to apply now before the November 30th deadline, or will there be another application window if state Medicaid aligns? So, I will say this. This is really the only application window we have for the Medicare component, and of course, always welcome folks to apply, recognizing that the 125 Medicare beneficiary requirement might be a challenge. So, but we always, of course, encourage you to apply and see if you would be eligible. And I do just want to emphasize something that Sonja said earlier, is just that the states that we're launching this model in have already committed to aligning with MCP. So, you know, for further details, you definitely need to contact the state Medicaid agency. But just wanted to point that out.

Okay. One other one about, that I may turn to, let's see, to Nick again, although I can take this one. Actually, I'll take this one. Would CMS accept or consider an application after the deadline? So the application window will close on November 30th. We are, you know, receiving feedback from folks about that. But definitely, please do submit your application by November 30th. So we, you know, the portal will close at the end, at midnight on November 30th. So, if you're not, if you do not submit via the portal on the 30th, we wouldn't have any other way to kind of receive your application.

Okay, I think we're going to keep answering some questions in writing. But we're going to just take a quick moment and pivot. We did get a request to walk people through Figure 5 of the RFA in Section 8. It's a graphic, so it's just going to take us a moment to pull that up. But I do just want to, so just give us a moment, and we'll walk you through it. Just one second, awesome. Thanks, Jenni. Nick, I think you were going to walk through this one. Do you mind going ahead?

>>Nicholas Minter, CMS: Yeah, that would be great. And thank you so much Jenni, this is helpful.

So, understand that there's a lot going on in this particular figure. It's also a really important figure, I think, and it builds on what Lauren showed at the very beginning in terms of our handout. It's a different example of the financial differences between the different tracks of Making Care Primary, as well as what a similar organization should be receiving now, as part of fee-for-service. So we'll just sort of walk through this really quickly, to help hopefully provide a little bit more clarity in what this figure is meant to represent.

So, what we have here is a hypothetical practice that has 700 Medicare fee-for-service patients. And in the far-left hand side, you see, you know, the first the first sort of bar or histogram and the bar chart, thank you for zooming in there, and at the bottom that blue is, to be very clear, there's a bottom blue sort of 90 that represents $90,000 that is meant to represent primary care services that are procedural, things like vaccines. You know, sort of one-off procedures that happen in the office that are not covered by the model, because we want those to be paid separately, because they need, frankly speaking, some of those we pay for separately and Medicare to incentivize their provision. And so therefore, we want to make sure we don't roll those into a capitated payment. So, there are some primary care services outside the model, and that is consistent across the fee-for-service and MCP.

Now, where the model starts to create a difference, is when you look at the next, the next sort of level, up that $210,000 or 210.0 figure represents fee-for-service revenue that is covered in the model. And these are things like care management services, additionally E&M services, a lot of the care coordination that is going on currently and then, of course, E&M across several different modalities. And then on top of fee-for-service, this yellowish orange version, this section that you see here, these are chronic care management services. We know that not all practices are billing these. We know some practices are really focused on these. And so, this particular practice has done a reasonably good job billing chronic care management services for their population. And so, there's around $46,000 or $47,000 in this hypothetical example of 700 Medicare patients. So overall, they're making $347,000 annually over this part of their, across this part of their population. So that's fee-for-service.

Now, would this, you know, let's say, this organization decided to join MCP. For the sake of this analogy, we're going to assume that they join Track 1. They're going to keep their carve out revenue that will continue to be paid through fee-for-service. In Track 1, they'll continue to receive fee-for-service revenue for their primary care services covered in the model. That will change as we go forward. But then, in addition to that, they're going to receive an average of $15 per member, for each of those 700 Medicare members, per month, and that equates to around $126,000. And then, there's a small, very small, around a 3% additional potential performance-based payment.

So, when you total all that up, just by joining the model in Track 1, and meeting those much lighter, more minimal care delivery requirements, a practice will earn up to $432,000, and all but 6.3, or $6,300 of that is guaranteed. So, doing a little bit better than fee-for-service.

When you look at Track 2, the revenue goes up, but how you get there changes, and want to just roll, you know, through that really quickly. The carve out's the same. However, the 210,000. Now, half of that is paid upfront on a quarterly basis. That's what you see in green. That $105,000 is paid quarterly upfront on a per-member-per-month basis. The other $105,000 is continued to be paid through claims. Claims are reduced by 50% because you're getting 50% of that revenue upfront to help make sure that you're thinking about your population on a population basis. Who's sick, who do I need to see? As opposed to, just who do I need to bill for?

The guaranteed payment up-front, that sort of per-member-per-month, care management fee, or what we call the Enhanced Service Payment, goes down slightly to $10 per, around $10 per-member-per-month at $84,000 for this sample population. However, the potential performance-based payment goes up considerably to around $95,000. So, the potential revenue that this practice could earn is now sitting at around 479 or $480,000. So, it's gone up almost $50,000 from the prior track.

Now, let's say, this practice spends two more years in Track 2, they then go to Track 3. And as you can see, their payment changes again, the potential goes up. But again we're trying to make sure that we change how they look at their population as well. So, the carve out is the same. They're now getting all of that money that they used to get through fee-for-service upfront, on a quarterly basis. This allows them to really focus on seeing those that they need to see, as opposed to bringing folks in the office again, to make sure that they're filling out a claim. You don't need to send a claim in to receive credit for caring for these primary care beneficiaries. The amount that they receive on top of that, that's guaranteed, that sort of per-member-per-month payment above goes down a little bit more. As you see, it's now around $67,000 that's guaranteed. Do want to point out that that additional revenue is still above the chronic care management revenue that was assumed in Track 1.

So, we talk a lot about how this is a an all upside model and a no downside model. And this is what we mean, even for practices not doing anything extra, they should do better in this model. We want to incentivize primary care investing in its services and moving into value-based, patient-driven care.

But let's say this practice is doing well, well then there's an extra $126,000. Now, it's 60% of their covered service revenue, that green bar you see below, that they can earn again for succeeding on the quality measures that that are covered in the RFA. So, this shows both, you know, at a glance, how fee-for-service revenue compares to each individual track. It also does a good job of showing, for a sample practice, but again, a panel of about 700 Medicare fee-for-service members, how their revenue would change over time, and the fact that if you continue to do well and work hard, obviously you're getting paid more for managing your patients, but also moving revenue around in a way that you focus more on those that are sick, where you can make a difference. And the overall revenue potential goes up over time.

So, I hope that's helpful. I realize there's a lot going on here and wanted to make sure that we walked through that in a way that hopefully was plain spoken enough to be to be useful.

>>Lauren McDevitt, CMS: Nick, one quick question on this one. Someone asked: Is the incentive bonus that you highlight the average or the maximum? I think it's just a, yeah, please go ahead.

>>Nicholas Minter, CMS: Yeah, no, that's a great question. So in this particular example, it is the maximum. I want to, one thing I think is really worth pointing out here is, we don't expect every practice to max out on the performance bonus. So what we're showing here is the revenue potential. That being said, unlike past models, there's no, the quality gateway for earning this revenue is only sort of making sure that you're above the 30th percentile on Total Per Capita Cost. So, as long as you hit that one single measure requirement, then you're paid for your success on each individual measure, which is our way of making sure that practices are paid for their success, even if they do struggle on some of the outcomes. So, from that standpoint, we think it is incredibly realistic for a practice to earn well over 50% of the potential, over time. And of course, once you get into Track 2 and Track 3, then you are telling us, or you have shown over time that you can build these workflows and broaden the care that you're receiving.

One thing to note the benchmarks that we're evaluating you against aren't other practices in the model. You're being evaluated against other practices in Medicare in your state and states like yours. Which is to say, that there is room and potential for everyone to succeed and earn more on the performance-based measures that were that we're looking at. So, while everyone may not get $126,000, we think it's very reasonable to earn a significant portion of that, because we're looking measure by measure, and if primary care is doing what it should, then there will be results on, you know, things like blood pressure and colorectal cancer screening, even if let's say, diabetic control is something that folks are struggling with. And the idea is you take the money that you make, and you sort of help close the gaps that that remain, so over time you earn more. That's the concept, that's what we're testing. And so hopefully, that's helpful.

>>Lauren McDevitt, CMS: Thank you, Nick. Alright, I think that we're going to wrap-up the Q&A section. Want to say thank you so much for submitting your questions. If we, you know, didn't get to your question, I think we got to almost all of them, if they came in until just a minute ago. If we didn't

get to your question, please do just submit it to MCP@cms.hhs.gov and we can definitely take a look at it there.

And so, I think I'm going to turn it back over to TJ and team. And again, thanks so much, everyone, for your time and for learning more about the MCP Model. Really hopeful that what you heard today helps you understand, you know, whether this model might be right for you. And we hope to see your application. So I'll turn it back to you, TJ.

>> TJ Smith, SEA: Thank you, Lauren. So just to wrap-up here. And then go to the next slide, please, just to wrap up here. We'll go over some closing remarks and additional resources. But please be sure to take a few minutes to provide feedback on today's session through our short post-event survey that's going to be posted in the chat, and it will also pop up when you close this call. Let's go to the next slide, please.

So to stay informed about upcoming MCP events, and for more detailed information, do please visit our website to see available resources. That does include the Example Revenues Factsheet that Lauren mentioned earlier in the presentation. While you're there, you can also sign up for our listserv to receive the latest announcements. Continue to email the Help Desk with any questions you have. And you can always follow the Innovation Center on Twitter for the latest happenings. Let's go to the next slide, please.

This does conclude today's MCP Office Hour. I really appreciate you joining, and I do hope you have a good rest of your day. Thank you so much.

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