Making Care Primary (MCP) FQHC and IHP Overview Webinar

7/20/2023

>>TJ Smith, SEA: Good afternoon, everyone, and thank you for joining today's Making Care Primary, Federally Qualified Health Centers and Indian Health Programs Overview Webinar. We have an exciting presentation 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. Closed captioning is also available on the bottom side of your screen. During today's presentation, all participants will be in listen-only mode. Please do feel free to submit any question ns you have though throughout today's presentation in the Q&A pod displayed on the right side of the meeting room window. Given time constraints, we may not get to every question, but we will collect questions for future events and FAQs.

Today's presentation is being recorded. If you have any objections, please hang up at this time. This slide deck, a recording of the 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. Please take five minutes to let us know how we did, and share any questions that you may have about MCP. We do have more events coming, and would love to know what you all thought as we continue to plan.

Now, we will begin with a series of opening remarks to welcome you to today's event. So first, I'm going to turn it over to Jessamy Taylor from the Health Resources and Services Administration, Jessamy.

>>Jessamy Taylor, HRSA: Good afternoon, everyone, and thank you to CMS for inviting the Health Resources and Services Administration to join today's webinar and for being such a great partner. As TJ said, I'm Jessamy Taylor. I'm a Senior Adviser in the Office of Policy and Program Development in the Bureau of Primary Health Care at HRSA.

The Bureau of Primary Health Care oversees HRSA-awarded health centers and HRSA designated look-alikes, and both are Federally Qualified Health Centers eligible to apply to participate in Making Care Primary. HRSA consulted over the last year with CMMI as they developed the model, and they've been great partners working with us, and with many of you, to better understand the health center model of care, and how health centers can be more of a focus of this, and future Innovation Center models.

If you're hearing me right now, you're already doing what we hoped you would. You're attending today's webinar to learn more, so you can determine if the Making Care Primary Model makes sense for your health center or the health centers in your state. In typical health center community fashion, you've already come together and been proactive. We understand that the Primary Care Associations in the eight model states have been talking through and asking questions about the model, and you're leveraging resources like your Health Center Controlled Networks to assess the potential impacts.

You may decide not to apply for Making Care Primary. Perhaps you're participating in a Medicare Shared Savings ACO and your assessment deems that more impactful. Either way, we encourage you and your Primary Care Associations to explore and engage in the value-based opportunities that best assist your health center to improve health outcomes, patient and staff experience, to curtail costs and to achieve health equity. So on behalf of HRSA and the patients and communities that you serve, thank you for

pursuing your health center's value-based care journey. And please reach out to me if you'd like to share your thoughts or concerns, or give me feedback.

Thanks again to the CMMI team for their shared commitment to advancing high-quality, whole-person, primary care. And I'll turn it back to TJ.

>>Smith TJ, SEA: Thank you, Jessamy. Next slide, please.

Now I will turn it over to Ellen Marie Whelan from the Center for Medicaid and CHIP Services to provide her opening remarks, Ellen Marie.

>>Ellen Marie Whelan, CMCS: Thanks, TJ. So, I am Ellen Marie Whelan, and I'm the Chief Population Health Officer at CMCS, or CMS Medicaid, also a primary care provider by training. And I want to first thank you for inviting us to join this webinar, as well as thanking CMMI for all the work that they've done working with us as they move forward with this primary care model.

As you may know, this is the fourth-generation primary care model that the Innovation Center has been working on and introducing. And this is the first one that has such a large Medicaid role in the model. We worked closely with a number of states, trying to identify which ones had a real commitment to transforming primary care, and were willing to come to the table to work closely with the Innovation Center and Medicare to make transformation in their state truly a new and exciting new endeavor.

We knew at Medicaid that we could not move forward in primary care unless we had a strong partnership with both FQHCs and Indian Health Programs. These are really important areas for primary care, for all Medicaid agencies, we hear that over and over again, making sure that we figure out ways to move forward, including that. And this is one of the first models that the Innovation Center has included FQHCs and Indian Health Programs at such a strong level. It's a commitment that the Innovation Center has made over the course of the last number of years to include more providers and patients in their Innovation Center models.

I will also say I have a very close relationship with FQHCs. I was a provider at an FQHC, I was on a governing board, and I also used the Health Center UDS data during my health services research. I also had the opportunity to visit a couple Indian Health Programs when I was working for a senator in South Dakota. And I will say that as we are looking to transform primary care in the nation, in many instances, I think we are trying to move closer to the kind of primary care that has been historically delivered at FQHCs. You were, from the beginning, including the patient voice in your model, which has been something that everyone else now has been looking to catch up with. Patients being on your governing boards is a critical component to having that patient's voice included in your work.

Also, big push now to look at including social determinants of health or health-related social needs. And FQHCs for decades now have been allowing folks to get reimbursed for ancillary services, acknowledging that primary care doesn't just happen in a 15-minute doctor's office visit.

So as we are looking to transform primary care in Making Care Primary and across the nation, there are many instances where we are looking to have the model change to support the kind of thing that's been delivered at FQHCs. What Making Care Primary will do, is develop a payment model that will further support the delivery of those care delivery changes that the model is suggesting, as well as the things that you have been doing for so long.

So I'll close just by saying we're excited that you're all here. We heard there's quite a number of participants here. We hope that all of you will consider applying, once you hear how the Innovation Center is moving forward. We are also committed to working with states to make sure that payments in Medicaid align with the Medicare payments in Making Care Primary. So that's a commitment that we have made and will continue to make. So thank you for the opportunity to say hello, and I will turn it back to TJ for the next CMS speaker.

>>TJ Smith, SEA: Thank you, Ellen Marie. And finally, I'm going to give the floor to Alex Bryden from the CMS Office of Minority Health for our final opening remarks, Alex.

>>Alex Bryden, CMS: Thank you so much, TJ. I am Alex Bryden, my pronouns are she/her, and I'm a Technical Director in the CMS Office of Minority Health, and a lifelong member of the health center family. So I, like my two colleagues, join Jessamy and Ellen Marie in being very proud, it's an honor to have been invited to speak here, and really excited about this work.

Within CMS, as many people from this call I'm sure already know, but I will reiterate, we have a number of strategic pillars, the first of which is to advance equity. So, really embedded in our, the fabric of our agency is to advance health equity by addressing the health disparities that underlie our health care system. We, as an agency, have defined health equity as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health, regardless of their race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language or any other factor that affects access to care and health outcomes. And I think that definition probably resonates with everyone here on the call today. That's been the ethos of FQHCs and look-alikes and tribal health centers perspective to providing care for decades and generations. Within CMS, we sort of started to operationalize that pillar by pulling together a couple of frameworks that have a number of priorities. We have the framework for health equity, we also have a framework for advancing health care in rural, tribal and geographically isolated areas.

And I'm so excited about this model in particular because, and it's been a pleasure to work with the CMMI team and all of my colleagues across the agency to think about this model, because it really crystallizes and operationalizes, it brings to life so many of the priorities that we put forward as an agency of how to make health equity happen in local communities. Some of the aspects of the Making Care Primary Model that really tease this out are, you know, we've got data-focused priorities that we articulate with health equity, with rural health. And through this model, you know, collecting demographic information, information on health-related social needs, really gets to the heart of that foundational aspect of having data.

The model is also really instrumental in implementing one of our core priorities around understanding the causes of disparity. And then, implementing actions to close those gaps that we see in healthcare access, quality, and outcomes in primary care, in particular in this model. But thinking about a strategic plan, about why disparities exist, what's driving them, screening for health-related social needs and then, thinking about that referral loop and screening and referrals. And also, requirements or allowances around reducing cost sharing for participants that have need, right, that sort of identifying that need, and flexibility in the model to address them.

There's also an aspect of both of our frameworks that thinks about building, that talks about building capacity among healthcare professionals, particularly healthcare professionals serving underserved

areas. And really, that's at the core of this model. And it's so exciting to think about the ways in which this model can help reinforce and drive the strengthening of the capacity of providers and underserved communities, building out those systems and infrastructures. And then, in the rural framework are one of our core priorities is to drive innovation and value-based care in rural, tribal and geographically isolated communities.

So this model really brings to light so many of the priorities that we have articulated as an agency and how to implement our health equity approach. And we really look forward to our partnership in this model as an agency, and as an office, and seeing how MCP participants operationalize our collective vision of health equity. And how we can all move forward to improving access, quality, and outcomes related to primary care for every person we serve, particularly individuals in underserved communities.

And with that, I will turn it back to TJ. Thank you so much.

>>TJ Smith, SEA: Thank you, Alex, and thank you again to Jessamy and Ellen Marie. We really appreciate all three of your insights. I'd now like to introduce our CMS Innovation Center presenters for today. We do have three speakers from the MCP Model team, including Lauren McDevitt, the MCP Model Lead, Liz Seeley, the MCP Payment Co-Lead, and Melissa Trible, the MCP Data Lead. Next slide, please.

We have a packed agenda today. First, we will start with an overview of the Making Care Primary Model for Federally Qualified Health Centers and Indian Health Programs overview, followed by several sections that describe important areas of the model, including eligibility, care delivery requirements, performance assessment, and payment structure. We'll close the event with some more information on the application process, next steps and things to look for in the coming weeks, as well as some resources that are available to support potential MCP participants as they prepare to apply. We will share MCP's projected application timeline, as well as other resources coming soon. And with that, the model team will now give today's presentation. Next slide.

>> Lauren McDevitt, CMS: Hi, everyone. It's great to be here with you today to share more details about the model design and provide a venue for FQHC's and Indian Health Programs to ask questions of CMS.

First, we wanted to start off with a few definitions. First, we are using the statutory definition of an FQHC, which is inclusive of HRSA-designated look-alikes as well as HRSA-designated FQHCs. Similarly, we are also using the statutory definition of an Indian Health Program, although Grandfathered Tribal FQHCs, which are FQHC's that meet the criteria in the link in the chat, and are paid on a different basis than FQHCs, are not eligible for MCP.

Our Model Overview Webinar on June 27th, 2023 covered general model background as well as the model's goals. So we are going to move, move into benefits of participation and dive into more policy details that are specific to FQHCs and Indian Health Programs with this webinar. Next slide, please.

This slide highlights several benefits to participation for organizations considering applying to MCP.

We recognize that engaging in a CMMI model at the TIN, or organizational level, may be new for many organizations, including FQHCs and Indian Health Programs. And MCP is, of course, an entirely new structure. So, we want to stress a few important upsides to participation.

In the broader movement to value-based care, CMS recognizes that some organizations have been left out from past opportunities. That is why with MCP, we have developed a specific track for organizations

without any prior experience in a Medicare performance-based model. This track allows organizations to continue billing the PPS, or Physician Fee Schedule, while receiving additional Enhanced Services Payments, which will be described in later slides, and building capabilities as necessary to meet our care delivery, and other model requirements. There is no downside adjustment based on performance in any of our tracks and Track 1 participants will be focused strictly on key clinical outcomes and patient experience measures at first.

And, eligible Track 1 participants that meet additional criteria listed in the Request for Applications will receive an Upfront Infrastructure Payment to fund non-medical services that will support participants in successfully implementing interventions across their organization. Allowable uses of these funds will be detailed later in the payment portion of this presentation.

MCP includes several tools that we hope will help with collaborating with specialists. We will introduce payments to both our model participants and their specialty care partners to support their coordination, and are looking into the data we can provide our participants on specialists that care for their beneficiaries.

We intend for this model to further support participants in their initiatives to advance health equity, and we include several components to move this forward. Participants will work with community partners and peers to develop Health Equity Plans, which include identifying patient populations experiencing disparities, and developing strategies to address those gaps. We will also adjust our Enhanced Services Payments to provide additional resources for these strategies. As described later in our measure set section, we will also plan to include a measure of HRSN screening in our Performance Incentive Payment to ensure participants are rewarded for this activity.

We will also partner at the state level and with other payers in the states to make technical assistance and learning opportunities available. More on that in the next slide. 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 an environment for practice change.

Nationally, we will provide several supports. We'll provide technical assistance to help MCP participants understand model requirements, rules of participation, payment, attribution, measurement and waiver. We'll also provide a virtual platform for collaboration and coordination within and across regions to support learning and continuous improvement. We'll develop and produce a data feedback tool with actionable data on cost and utilization for the Medicare beneficiaries served by the participant. We will also develop and share a reporting platform, enabling participants to share the tactics, strategies and care delivery methods they're using to improve health outcomes and advance health equity for their patients with peer comparisons.

Additionally within the MCP states, CMS will join the stakeholders, the state Medicaid programs, and other payer partners to connect MCP participants with each other, and with the specialty care practices and community-based organizations that need to be partners in care for these patients. We will make practice coaching and facilitation resources available to participants who need help building capacity, and who desire support in making the changes in workflow and organization of care they need to succeed in the model and advance health outcomes as well as health equity. We will also contribute to the data aggregation and health information exchange resources necessary to give participants a full

view into the care their patients receive, and to enable comprehensive and coordinated care across primary care, acute and subacute care, specialty care, and community-based services. Next slide, please.

Now we will move on to share more about our partnerships with state Medicaid. Next slide, please.

We have partnered with those states listed on this slide to agree to implement MCP in these eight regions. We are working with these states to align state programs with MCP in areas that reduce clinician burden, and also bring in payers outside of Medicare and Medicaid to align on key areas. The states participating are Washington, Minnesota, Colorado, New York, Massachusetts, New Jersey, North Carolina, and New Mexico. Please note that only organizations providing care in MCP states are eligible for MCP, and we are not considering expanding MCP to additional states at this time. Next slide, please.

When we talk about aligning with our payer partners, both public and commercial, we think about this as directional alignment. This approach is intended to allow flexible alignment for payer partners to align in areas that directly reduce clinician burden, such as data reporting format and type, but also providing flexibility for pay or partners to develop elements of their own programs that support their own goals and local context. FQHCs and Indian Health Program applicants are encouraged to reach out directly to their state Medicaid office to understand their plans for aligning with MCP. Next slide, please.

Now we will cover a summary of requirements to participate in the model. Next slide, please.

The following checklist provides the required steps for participation in the MCP Model if accepted. I will note that this is from CMS's perspective, and we recognize there is additional work behind the scenes at each organization to meet each of these requirements. If you are accepted into the model, you will be notified, and you will need to submit several pieces of onboarding information to CMS, including banking information, POC information, or point of contact information, and signed documents as needed for CMS to provide you with information on attributed beneficiaries.

We will also share with you the Model Participation Agreement, which is a document that lists the requirements of participation and obligations by both CMS and the participant. Your organization will need to sign and submit that by a deadline prior to the model start so we can make payments on time.

Your organization will also need to complete, once in the model, Care Delivery and Health Equity Plan Reporting. The cadence of these reporting activities will be established in the Participation Agreement. This reporting will be done through a CMS platform. Annually, you will also complete quality reporting, as part of our performance assessment.

As a necessary part of our attribution and payment process, you must ensure that your MCP Clinician, Roster, or Site List, is up to date, at least quarterly. Non-FQHC participants must identify and maintain with CMS full list of each individual primary care NPI that renders services under the TIN of the participating organization, otherwise known as the MCP Clinician List. FQHCs will maintain a list with CMS of all sites and CCNs that bill under the TIN of the participating organization. Up to quarterly, participants will need to participate in learning events and, as requested by CMS, participate in any monitoring or auditing activities. Next slide, please.

Next, I will provide an overview of some of MCP's eligibility requirements and the tracks of the model. For additional detail, please reference our Model Overview Factsheet and the Model Overview. Webinar, posted on the MCP website. Next slide, please.

In general, CMS will not allow organizations and clinicians to participate in MCP while participating in other Innovation Center Accountable Care Organization Models and Programs. Our overlap policy is described in these slides, and will also be listed in the forthcoming RFA.

So, in general, organizations that are enrolled in CMMI models, such as ACO REACH or Primary Care First will not be allowed to simultaneously participate in MCP. FQHCs were not eligible in PCF, the most relevant model to think about for your organization would be ACO REACH, specifically ACO REACH participant providers that were active in ACO REACH as of May 31st, 2023 are not eligible for MCP. And this is because our CMMI models that are currently active are currently undergoing a rigorous evaluation. Organizations and their clinicians that participated in a bundle payment models can participate simultaneously in MCP, and CMS will make a one-time MCP eligibility exception.

Organizations and individuals participating in MSSP in 2024, but plan to withdraw from MSSP before the beginning of the next performance year in MSSP, so during the 2024 MCP performance year, these organizations can still participate in MSSP, but must engage in MCP learning and reporting and onboarding activities. For these organizations and individuals, MCP payments and quality measurement will begin 1/1/2025. Next slide, please.

We also want to spend a moment highlighting the eligible patient for the Medicare proportion of this model. We will follow an attribution methodology that will be specified in the upcoming Request for Applications. Attribution will be conducted at the CCN level for FQHCs, and will be rolled up to the TIN level for non-FQHCs. Non-FQHCs must submit a roster of primary care clinicians in order for CMS to run the attribution, methodology. MCP will also test voluntary alignment where beneficiaries may voluntarily align to the primary care clinician, or usual care delivery site via MyMedicare.gov.

Beneficiaries with traditional Medicare or Medicare fee-for-service are eligible. Beneficiaries who are dually eligible and enrolled in Medicare fee-for-service and Medicaid, are eligible. And for beneficiaries with Medicaid only, please contact your state Medicaid agency for plans to include Medicaid beneficiaries and programs aligned with MCP. Next slide, please.

We do want to run through a few additional eligibility requirements. Again, these will all be listed in the Request for Applications. MCP participation will be at the organizational Tax Identification Number, or TIN level. While each TIN must be its own participant and will be evaluated separately in the model, FQHCs and Indian Health Programs can continue to work together in the model, if desired. Organizations at the TIN level must meet the applicant eligibility requirements listed below, and will be detailed in the RFA for their selected track. An organization must sign a Participation Agreement with CMS in order to participate in MCP. For applicant FQHCs, all CCNs for all practice sites should be submitted on the application. I won't read through all of these individual requirements, but please do take note of them, as you consider applying for MCP. Next slide, please.

We just want to provide a quick overview of the three tracks available. MCP does include three tracks that FQHCs and Indian Health Programs can select from when applying to the model. The three tracks provide opportunities for organizations with differing levels of value-based payment experience to enter the model at a point that matches their readiness at the beginning of MCP. This information is also available in the MCP Overview Webinar, as well as the MCP Overview Factsheet.

With that context, I will now turn it over to Melissa Trible to cover the care delivery approach for this model.

>>Melissa Trible, CMS: Thanks, Lauren. My name is Melissa Trible, and I'm a member of the model team for MCP. I will now cover the care delivery requirements. Next slide, please. One more slide.

The MCP approach to care delivery transformation promotes comprehensive and patient-centered care. Three domains, Care Management, Care Integration, and Community Connection, guide our efforts, with each of the three tracks having progressively more advanced requirements.

Within the Care Management Domain, MCP participants will reduce preventable emergency department use and hospitalization, thereby achieving better outcomes for their patients. Implementing the care delivery requirements within their tracks, along with a commitment to continuous improvement, will enable participants to build effective care management services over time.

Within the Care Integration Domain, MCP participants will strengthen their partnerships with behavioral health teams and specialty care clinicians to enhance patient support and care delivery. FQHCs will be able to select their preferred specialty care partner type, rather than having to prioritize orthopedics, cardiology, or pulmonology, as will be required for other participants.

Within the Community Connection Domain, MCP participants will actively identify and strive to resolve health-related social needs among their patient populations. They will collaborate closely with social service providers to assist patients in navigating the various community supports and services available to them. Next slide, please.

This slide gives a breakdown of what our care delivery goals are for each track. Track 1 focuses on infrastructure building, laying the groundwork for effective care management through risk stratification and patient empanelment, participants promote personalized care. By identifying staff and developing workflows for chronic care management and timely follow ups, high-risk patients receive the attention they need.

Additionally, individualized self-management support services empower patients to take charge of their own health. Track 1 also emphasizes the importance of utilizing data tools and implementing a Behavioral Health Integration approach grounded in measurement-based care. By using data tools to identify high-quality specialists, participants enhance the referral process and ensure optimal patient outcomes.

Lastly, Track 1 focuses on addressing health-related social needs by implementing universal screening, establishing referral workflows, and forging partnerships with social service providers. Additionally, identifying staff, such as community health workers, enhances the delivery of services to patients with higher needs.

Track 2 focuses on enhancing efficiency and care management by building upon the foundation laid in Track 1. This includes implementing comprehensive chronic care management for high-risk patients, offering timely follow-ups post emergency department visits and hospitalizations, and expanding individualized self-management support services. Track 2 also focuses on establishing collaborative partnerships with high quality specialty care providers, implementing enhanced E-consults, and systematically screening for behavioral health conditions.

Finally, Track 2 focuses on strengthening referral and partnership to address health-related social needs among our patients. Additionally, utilizing community health workers or professionals with shared-lived experiences, enhances the ability to navigate and coordinate health-related social needs.

Track 3 focuses on optimizing exceptional care by offering individualized care plans for high-risk patients with tailored and impactful interventions. Through the expansion of self-management services, including grouped education sessions, and community connections, we foster patient engagement, empower individuals to take charge of their health, and address the broader social determinants of health. These initiatives elevate our care to new heights, leading to improved patient outcomes, increased patient satisfaction, and a stronger connection to the community.

Track 3 also focuses on strengthening specialty care partnerships and driving quality improvement in Behavioral Health Integration. Through co-management relationships with specialty care partners, participants foster collaboration and shared decision making to improve patient outcomes. By implementing a quality improvement framework, participants continually assess and refine their behavioral health workflows, ensuring efficient and effective delivery of integrated care.

Additionally, Track 3 focuses on streamlining referral processes, establishing robust collaboration, and continuously improving the utilization of these resources. This is done by enhancing social service referral workflows, and optimizing the use of community health workers or professionals with shared lived experiences through a quality improvement framework. Next slide, please.

We will now go over an example that tells the story of a hypothetical organization, Practice A, and a fictional patient, Dawn. It shows the patient experience throughout the different tracks within MCP, describing changes the organization makes over time to meet requirements and use funds generated through the model.

Dawn, a 68-year-old, patient at Practice A, has unaddressed behavioral health needs and chronic disease risk due to cost and transportation barriers. Practice A is new to value-based care and serves a diverse population across social risk tiers with a 30% low-income subsidy enrollment. The practice starts off in Track 1 of MCP to develop a Health Equity Plan to address patient population needs and notifies CMS of cost-sharing reduction plans for eligible patients.

They start collecting disparity-sensitive measures of chronic conditions, and implement universal health-related social need screenings to gather data on transportation, housing and food security. At this step, Dawn is able to receive care with reduced cost sharing, including a colorectal cancer screening due to her family history. Her provider also identifies barriers to care, such as transportation challenges.

Next, Practice A uses Upfront Infrastructure Payments for hiring a behavioral health specialist, and coordinating transportation supports, and E-consults which allows Dawn to use transportation services for her follow up-appointments. Practice A also connects with other MCP participants to share best practices and learn about resources. Now, Practice A can use an Enhanced Service Payment for hiring a case manager and implementing referral workflows.

With the help of the care manager, Dawn can now more easily access additional behavioral and specialty care. After advancing to Tracks 2 and 3 in the model, Practice A can invest in specialty care and leverage data to identify high-value partners. Practice A can use health-related social needs data, and

other data, to identify care access and quality gaps, which they can address by developing a plan in collaboration with community partners.

MCP bonus payments will be given to the practice for achieving quality and utilization targets. At this stage, Practice A should be able to sustain advanced primary care with robust community partnerships and data-driven delivery. On the patient's side, Dawn achieves improved care access and health outcomes through a connected network of specialists and community organizations. Next slide, please.

As previously mentioned, MCP has a refreshed focus on advancing health equity, and includes several components to move this forward. The model includes a requirement that participants create a Health Equity Plan based on their patient population, and features a state and national based learning system to support participants as they work to identify strategies to address health disparities within their community.

Additionally, the model will also feature the implementation of health-related social need screening and referrals to community and social service organizations to address these identified needs. Certain payments will also be adjusted to account for social risk of empaneled patients in order to give practices the financial resources required to promote health equity. I will now pass to my colleague, Liz Seeley to talk through MCP's payment mechanisms.

>>Liz Seeley, CMS: Thanks, Melissa. My name is Liz Seeley, and I'm a member of the model team for MCP. The next group of slides will cover more details about the payment structure. Next slide, please.

MCP will change the way participants are paid for primary care services through Medicare, and provide additional revenue to support care transformation. We will also introduce two payments to support closer coordination with specialists. MCP will introduce a total of six payment types, which we will walk through in more detail in the coming slides.

Some payments, such as the Enhanced Service Payments and Performance Incentive Payments apply to all participants, regardless of their tracks, while the level of payment may differ, based on which track a participant is in. Other payments, such as the Prospective Primary Care Payment and MCP E-Consult code, start to be available in Track 2 in order to reflect where participants are in care delivery transformation. Next slide, please.

First payment type is Upfront Infrastructure Payment, or the UIP. To ensure that smaller organizations with limited resources can actively participate and thrive in MCP, startup funding is available. This funding aims to support these organizations in their journey toward MCP transformational goals. It is important to note that this optional payment is exclusively available to eligible Track 1 participants. To be eligible to receive the UIP, FQHCs and Indian Health Programs in Track 1 must meet the low revenue criteria, which will be outlined in the RFA. With two lump sum payments, totaling $145,000, participants can strategically invest in infrastructure that enables essential care delivery and help IT capabilities. Participants will be required to submit a spending plan, and report on fund utilization to ensure appropriate use of funds, and to provide participants with support in achieving their care delivery and quality improvement goals. By utilizing funds for increased staffing, social determinant of health strategies and health care clinician infrastructure, participants can make tangible and meaningful improvements to their organization. Next slide, please

Enhanced Service Payments, or ESPs, are payments meant to support participants in meeting the care delivery requirements of the model. These payments replace billing for chronic care management, or CCM Services, and are provided up-front on a per-beneficiary-per-month basis. So participants have more flexibility to deliver services across their teams. ESP amounts are the highest in Track 1, and decrease on average over the three tracks as a participant's Performance Incentive Payment potential increases. We will cover the Performance Incentive Payment in the next few slides.

ESP amounts are set based on a beneficiary's HCC score, whether they are enrolled in the Medicare Part D low income subsidy program, and the Area Deprivation Index, or ADI, of their zip code. Participants will be paid $25 per-member-per-month for beneficiaries enrolled in LIS, as well as for beneficiaries in the highest ADI, and highest HCC tiers. The $25 amount does not decrease over time, and is fixed across tracks in order to provide sustained support for participants serving beneficiaries at a higher risk.

We anticipate that the beneficiary populations attributed to participating FQHCs and Indian Health Programs may on average have higher clinical and social risk, which would make your ESP payments higher than for non-FQHCs. The estimated average ESP amounts across tracks for FQHCs and IHPs are $19 in Track 1, $16 in Track, 2, and $15 in Track 3. Please note, these average amounts will vary based on each participant's population. It is important to note that these payments are not earmarked for a given beneficiary, and are meant to support care delivery transformation for all Medicare beneficiaries. Next slide, please.

In addition to supporting participants with additional revenue through the ESPs, we recognize the importance of providing core primary care revenue up-front so organizations can implement team-based care. The Prospective Primary Care Payment, or PPCP, will be paid quarterly on a per-member-per-month basis, and will replace fee-for-service payment at different levels, depending on what track a participant is in.

FQHCs in Track 1 will continue to be paid according to the Medicare FQHC PPS. FQHCs in Tracks 2 and 3 will have their PPCP PBPMs based on a primary care service list derived from the Medicare FQHC PPS. The list of services considered primary care will be listed in the Request for Applications. Services not listed as part of the PPCP will continue to be reimbursed at the standard rate at the time of service. For FQHCs that are reimbursed based on their charges, and for Indian Health Programs that are reimbursed at rates specific to their organization, the PPCP amount will be based off of these unique rates.

For Track 2, the PPCP Is intended to replace about half of a participant's fee-for-service revenue that would have been billed for primary care services, and claims will be reduced accordingly. For Track 3, it is intended to replace 100% of our participants' fee-for-service revenue for primary care services.

By Performance Year 3, CMS will introduce a regional component to the payment methodology for non-FQHCs and non-IHPs. But for FQHCs and IHPs, the payment methodology will continue to be calculated, based on each facility's unique claims history for the duration of the model. Next slide, please.

I will now take a deeper dive into the performance assessment and quality performance measures. Next slide, please.

The performance measures selected in MCP are intended to reward participants for providing exceptional care. The measure set balances clinical quality, patient-reported outcomes, utilization and cost. Participants will be assessed on select clinical quality measures in Track 1 while they are building

their capabilities for MCP. Performance assessment will then include additional measures in the areas of equity, utilization, and cost in Tracks 2 and 3. Next slide, please.

All MCP participants will be assessed on the same clinical quality measures as well as EDU and TPCC, the reward for participants that perform well across a range of measures. There will also be an opportunity for organizations to receive additional bonuses for improvement against their own historical performance. For FQHCs and Indian Health Programs, TPCC Continuous Improvement will be replaced with EDU Continuous Improvement. Next slide, please

The Performance Incentive Payment is structured as an upside-only payment that is applied to the fee-for-service payment for primary care services in Track 1, and the sum of the fee-for-service and PPCP payments for primary care services in Tracks 2 and 3. The bonus potential increases from 3% in Track 1, to 45% in Track 2 and 60% in Track 3. Half of the estimated PIP will be paid in Q1 of a performance year, with the second half of the PIP paid in the third quarter of the following performance year. This second half of PIP will reflect the organization's actual performance and we'll reconcile the first half of the PIP based on performance. Next slide, please.

Here is an example payment calculation. The diagram below demonstrates the relative contribution of each payment to the total revenue for an average MCP participant. These calculations are based on a hypothetical FQHC organization with 1,000 MCP attributed patients, and reflects the higher level of ESP payments that result from beneficiaries with above average clinical and social risk. It is also assumed that the organization achieved the fiftieth percentile on three measures, the seventieth or eightieth percentile on three measures, and did not receive credit for EDU Continuous Improvements. The UIP is also not displayed here, as it is assumed that this organization did not qualify for the UIP.

The green bar shows that the Performance Incentive Payment represents a larger proportion of a participant's revenue over time, as ESPs, the purple bar, decreases on average. The orange bar shows the amount of revenue provided up-front as part of the PPCP. The revenue received prospectively increases over time, as does the overall revenue potential for participants.

I will now turn it back to Lauren for more information on the application and next steps for interested organizations. Next slide, please.

>> Lauren McDevitt, CMS: We're so excited to invite FQHCs and Indian Health Programs to apply to MCP. So I'll walk through a few next steps. Next slide, please.

First, please sign up for the MCP listserv and visit the MCP website to stay up to date on the latest information events and resources on MCP. You can sign up for the listserv at the CMS.gov email update subscription page. It's linked here. We'll also put it in the chat.

There are several resources on the MCP website, some of which we've referenced throughout this presentation, including factsheets and one previous model overview recording and slides that we hosted. We will announce additional events over the coming months, including office hours for applicants as well as payers.

Please also submit a Letter of Intent to apply for MCP. The LOI is voluntary and non-binding, but helps us better support and connect with organizations as they decide if MCP is right for them. The MCP RFA will

be released in August 2023. Interested stakeholders can prepare for application by using the resources above to prepare for application.

The MCP RFA Will be released in August 2023. Soon after, the Application Portal will open. The Application Portal will stay open until the end of November, when the Application Portal will close. CMS will then review applications, reach out in case we need information, and ultimately determine organizational eligibility for the model.

In early 2024, we will notify organizations of whether they have been accepted into the model, and then we will begin onboarding accepted participants, and they will sign Participation Agreements as well as submit other onboarding information. And the model will officially begin in July 2024.

With that, that concludes our content for this presentation, and we will turn it over to the question and answer section.

>> Nick Minter, CMS: Thank you so much, Lauren. So, we hope that you all have enjoyed the information that we've shared so far. We've gotten a number of great questions in the chat, and we wanted to spend some additional time, as much as is necessary, to answer some of those great questions.

We have been answering some, just to give a heads up, of those as they've come in. So if you have asked a question, you know, it might already be answered. But some of those there are common themes, or we thought that they would be best answered live. So, we will go ahead and start that now. Please continue to ask them, because that's what we're here for.

So the first question that we wanted to answer is one that I will go ahead and take myself. It's: “What is the reasoning behind not allowing practices or health centers or otherwise participate, be able to participate in both an ACO or an Accountable Care Organization, as well as this program?” And there's a question about the considerations that an FQHC might have in choosing which opportunity or pathway into value-based care they would like to take.

So first, I wanted to note that the intent of Making Care Primary is really to grow the number of providers that are able to move away from fee-for-service, and into sort of more value-based care, and provide that sort of accountability for patient outcomes. So our goal is to be able to equip providers, to make that transition, and to really reach those that have not felt like they had the opportunity or the resources to make that jump away from sort of billing, and then waiting for payment, and to take on the responsibility for the incredible goals and change that primary care is capable of.

We do understand that there are some areas where there have not been other opportunities beyond current ACO focused models, and we are opening Making Care Primary to those, to those providers and participants that are in ACOs to make a choice, to stay in their current situation or move over. Because we acknowledged that without previously having a choice, the current pathway may not be one that they're thriving in. And so we are allowing our providers to make that determination.

In terms of, in terms of how an FQHC should think about that, I think from our standpoint, every situation, every path, every experience, is going to be unique between the ACO and the primary care organization. And so, from our standpoint, if an MSSP ACO situation is working well, then, we certainly don't want to disrupt that at all. But we leave it to the individual organizations to look at sort of their

experience today, and whether or not that is a choice, that is sort of the pathway that works for them, or they want to be paid individually, as opposed to having funds go through the ACO, etc. There is, those are sort of some notable differences between the two, and why we don't allow overlap between them. But would, you know, would ask sort of, the participants in organizations, or the perspective participants, to analyze their current situations. And also, to review the Request for Applications that comes out in August to determine which pathway best suits the way that they want to move into patient accountability going forward. Thank you.

The next question that we wanted to answer live had to do with whether or not the payments for the MCP program are going to be in addition to prospective payments, or will they be part of the reconciliation at the end of the year. In essence, sort of the payments that we're discussing, how do they interact with the existing payment set FQHCs received through the Medicare Prospective Payment System. And for that, I will ask Liz Seeley to give some guidance. Thank you.

>>Liz Seeley, CMS: Sure, thank you, Nick. So, as we detailed in the presentation, there are six different payment streams in MCP. Each of the payment streams is structured based on the intention of the funding to help support participants in various ways.

Enhanced Service Payments will be paid quarterly, calculated as a per-member-per-month amount. That, those are funding support dollars that are above the, whatever is being billed on a claims basis currently. Those levels depend on the social and clinical risk of beneficiaries and are specific to each track.

The Prospective Primary Care Service Payment will be based on FQHC's attributed beneficiaries, historical spending amounts and updated over time to reflect changes in the PPS rate schedule and to incorporate increases in primary care visits. They will remain specific to the FQHC throughout the course of MCP.

There are other payment streams as well, such as the Performance Incentive Payment. The Performance Incentive Payment will come in the form of two lump sums. The first lump sum of each performance period will be an estimated amount based on the estimated performance. The second lump sum will be based on the actual performance of the participant that will have the reconciliation component. That Nick just mentioned, based on how the FQHC or Indian Health Program actually performed.

>>Nick Minter, CMS: Thank you so much, Liz.

The next question that we wanted to make sure that we answered live has to do with the application process and the amount of information that will be available to perspective participants before they make an ultimate decision. And so the question is: “Will CMS provide data to the applicant about the HCC risk score, LIS numbers, as well as, you know, any ADI information, Area Deprivation Index information that's available? And if so, when in the application process, is it after approval, before or after a contract to participate in the model is signed?”

And I'll turn it over to Lauren to provide some insight into our process there.

>>Lauren McDevitt, CMS: Yes, thank you so much, Nick, and thank you for the question.

So we will plan to provide kind of a projection of the various payments that an applicant, at the time they would still be an applicant, would receive after they have been accepted into the model, but before

you sign your Participation Agreement. So that will be based on kind of the provisional attribution that we do as part of the application process to determine whether you meet our eligibility criteria. So, we will provide that before you sign the Participation Agreement, but after application.

>>Nick Minter, CMS: Thank you so much, Lauren. The next question: "Is this for Medicare patients only, or are Medicaid patients eligible as well?"

And I guess I'll go ahead and take this one really briefly. So, we are hoping that Making Care Primary shifts, the, you know, sort of primary care in all of the states across all payers. The information that we've shared today is focused on the changes that we are making directly to payment for Medicare fee-for-service beneficiaries for our participating organizations.

We are also working and will continue to work both with state Medicaid agencies as well as Managed Care Organizations, and commercial Medicare Advantage, and other payers in all of the regions that we have specified as eligible for the model to ensure that the changes that we are making in Medicare are also, you know, reflected in aligned ways and other plans. Our goal is to make participation in this model and moving to a population-based approach to primary care not only feasible, but easier than the currently fragmented sort of pay, a payer incentive system that may exist today in the regions. So while the details may be different across payers, our goal is to create alignment across Medicare, Medicaid, and also commercial and other lines of business. But again, to be clear, the payment details that we saw today are specific to the Medicare fee-for-service reimbursement changes that we are proposing to make.

So, moving on. So we have a number of questions. I guess one question that I did want to make sure that we cover is, and I'm sorry there's quite a few of them coming in. But, so you know one question that has been asked, and I will sort of, I guess, touch on this as well. ACO involvement obviously, is a hot topic in the Q&As that we're seeing. And one of the questions that came in had to do with whether or not Accountable Care Organization participation across other payers would affect eligibility for Making Care Primary. And I think, this is a point that deserves emphasis.

For the purposes of eligibility for the Medicare Making Care Primary Model, we are only looking at whether or not an entity is in a in a Medicare Shared Savings Program ACO in terms of whether or not there can be an overlap. They also, I will note, ACO REACH participants are not eligible for Making Care Primary. But in terms of needing to choose sort of which model to stay in beyond 2025, or beyond January 1st, 2025, we are looking at Medicare enrollment in an ACO. We understand, and are certainly supportive of ACO involvement in commercial payer situations, in Medicaid. And involvement in a Medicaid ACO or another value-based arrangement with another line of business outside of Medicare fee-for-service will not render a participant in eligible for Making Care Primary participation. So wanted to make sure that I was specific and clear there.

And I guess you know, we'll sort of look for a second to see what other questions that we have that are sort of thematically relevant. You know, I guess there's, there are a number of questions about what services are included in the Primary Care Payment, so, which services are we talking about. But I guess I don't know. Melissa or Lauren, would either of you all like to speak to that question about what services are they, CPT codes, is there a general description? And where can where can applicants and interested parties find out more information about which services were actually included in the prospective payments that we're discussing?

>>Lauren McDevitt, CMS: Sure, thank you, I can take that one.

So, we will include a full list of the PPCP services in the Request for Applications. And these are typically, you know, cognitive services that are delivered by primary care providers. But in in Track 3, we do add additional kind of behavioral health integration codes into the PPCP services list as well. So we, we'll provide more information in the RFA, including other codes that will be impacted by MCP payments, including specialty care integration codes for both PCPs and specialists, as well as codes that may not be built, given that they are duplicative of the Enhanced Service Payments that we're providing up-front as well.

Back to you, Nick.

>>Nick Minter, CMS: Yeah, thank you so much, Lauren. Another clarifying question: "If someone is currently in an ACO and is, you know, thinking about how to participate in value-based care and enhancing primary care in Medicare specifically, can their ACO leadership send a letter of interest, which is available sort of on our model website, on their behalf?"

Lauren, why don't, why don't you take this question as our, sort of application subject matter expert.

>>Lauren McDevitt, CMS: Yeah, we are requesting the LOIs be filled out by potential applicants themselves. We're really interested in understanding our applicant pool who would be potentially participating in the model. And so participation is at the TIN level. And so each TIN that is kind of enrolled in Medicare and has sites enrolled underneath it in Medicare does need to apply on its own. You can work together. We understand organizations have their own shared resources, but at the end of the day, we are interested in knowing kind of the information about yourself as the applicant.

Thank you for the question.

>>Nick Minter, CMS: Another question that has come up, and I'm going to interpret it a little bit. I think there is a question about what is the main difference between, I believe, its MSSP and ACO REACH.

And I guess I would just note that one of those models is administered, ACO REACH is administered by the Center for Medicare and Medicaid Innovation and would encourage you to go sort of read up on that on our website. MSSP is and is a, it is a larger programmatic element of Medicare or traditional Medicare fee-for-service. And so just want to know those are not the same thing, and their eligibility for organizations in each of those models does differ. And so, you know, we have made some information available regarding eligibility of each.

Again, if you're in the ACO REACH, then for the reasons that Lauren explained, because it's an existing CMMI model that we are currently evaluating, we are not allowing crossover from ACO REACH to MCP. However, MSSP, which is a permanent program within Medicare, we are allowing, we are allowing participants to make a choice as to sort of how they want to participate in value-based care. And again, encourage folks to sort of look at the details of each program and make the decision that makes the most sense for them.

I'm looking through the other questions. and I guess at this point, you know, we're having a few come in. But would encourage others on the team, if there's something that they would like to jump in and answer. I think you know many of these we've seen already. So I want to just give it a few more minutes

to let folks send in any questions they have, or would like us to answer, either in the chat or live, and you know we'll try to get to those before we end today.

>>Lauren McDevitt, CMS: Nick, I just see one question about whether MCP will count as an AAPM.

We do anticipate that Tracks 2 and 3 will qualify as AAPMs by January 1st, 2025, with the quality reporting, or sorry quality performance starts to be assessed in 2025. Before then it is likely that they would not qualify. Track 1 likely will not qualify. But we do anticipate that Tracks 2 and 3 should qualify as AAPMs.

>>Nick Minter, CMS: Yeah, thank you very much. And, Lauren, this next question might be for you as well: "Can perspective participants enroll or apply at any time if they don't apply during the application period from August to November?"

>>Lauren McDevitt, CMS: Yes, thank you for that question.

So this is the one application period for the model. So if you are interested in applying, we really do encourage you to fill out the application which will be available on a portal, an online portal. The Request for Applications will be also a document that is published with much more detail about the model policies before the Application Portal is available. So, if you are interested in the model, we really do encourage you to participate, I'm sorry, to apply to participate given that we are not planning to offer additional application windows at this time.

>>Nick Minter, CMS: Melissa, there is a question up in the chat about sort of investment in data infrastructure. And I you know, I think that there is probably both a sort of multi-payer component to that. But I was curious if you could speak to you know, sort of the type of data and the different formats that CMS is going to make available on the Medicare fee-for-service beneficiaries. Just to make sure that that is clear, because I think that's a really important new resource in the model that does not exist currently, for especially this Medicare fee-for-service patients that providers have. Can you say a little bit more about that?

>> Melissa Trible, CMS: Yeah, of course. Thanks, Nick.

So we will have a data dashboard for Making Care Primary. We've had them in previous models, but we're looking to really expand both how fast the data gets in there and the overall quantity of data for Making Care Primary for the Medicare fee-for-service side. So this includes things like specialty care data, including not just cost and utilization, but quality metrics for rostered specialty care partners, as well as quality metrics and other metrics that payment is based on for Making Care Primary participants.

So we'll also have, in addition to that, the claims line feeds that we've had in previous models. Those will be integrated into the data feedback tool as well, making them a little bit easier to download and work with. And, as we go we intend to both expand our data effort in terms of the data given and really work at the state level, and kind of that down to the community level, to ensure that we're continuing to work to expand data available that reacts to the needs of participants in their communities.

>>Nick Minter, CMS: Thank you so much, Melissa.

Another question, I guess on eligibility over time was just asked: “Once an FQHC has been selected to participate in MCP, is there an option to exit the model and return to the fee-for-service, in this case, FQHC Prospective Payment System for Medicare, if they, if they choose to do so?”

And I'll take this one. The answer is “yes.” Making Care Primary is a voluntary model, so that so participants that enter the model and determine that they would like to leave sometime within the ten-and-a-half-year period will be eligible to do so. We will put out the exact process for doing that to make sure that we can make the payment changes, so that you're able to get back on the Prospective Payment System if desired.

You know, just to note, doing so would forfeit any future Enhance Service Payments, and the ability to earn Performance Incentive Payments going forward, and so would want to make sure that, you know, we would ask that all participants sort of weigh those upside payments before doing so. But certainly, if participants want to leave for any reason, they have that option. They'll just need to give us a little bit of heads up so that we can make the changes on our side to make that a smooth process. Okay.

>>Lauren McDevitt, CMS: Nick, I did see one about: “Does it matter whether an FQHC has participated in MSSP basic or enhanced?” And just will say that it does matter for whether or not you qualify for Track 1. We will look at whether or not an organization had prior experience with two-sided risk. So, if you were in an ACO that was in a two-sided risk agreement in the last five years, you would not be eligible for Track 1.

>>Nick Minter, CMS: Thank you so much, Lauren.

Another question just came in: “Is there a financial support for care coordination platforms, and sort of risk adjustment models?” And I think I would expand this to also just note other you know, tools that are likely necessary for success in the model. And this is sort of in the in the resource/payment realm, but not exclusively. That being said, I'll kick it to Liz to sort of to provide an initial response on how we're supporting that infrastructure investment that that participants may need to succeed.

>>Liz Seeley, CMS: Sure, thank you, Nick.

So, participants that are in Track 1 especially, back up, in order to be eligible for Track 1 participants need to not have that experience in Medicare value-based purchasing models. That is defined as not having had experience in CPC, or PCF, or two-sided risk MSSP Models. Once in Track 1, a participant may be eligible to receive an infrastructure payment, to support their ability to invest in the infrastructure they need to meet the care delivery requirements.

You can find more information about the eligibility criteria, but it will be based on a similar determination that MSSP uses for what's called low revenue. The intention with the low revenue policy is that participants that have less access to resources will be eligible to receive this infrastructure payment, which comes the form of two lump sum payments. One is at the start of the model, and then one is a year later. And we will work with you if you're in Track 1 to, if you express interest in receiving this payment, to ensure that these funds are provided where eligible, and spent appropriately.

>>Nick Minter, CMS: Thank you very much, Liz.

Another question, and I'll take this one. Is there, I think the question is actually phrased: “Do you, CMS, have a modeling tool to help organizations decide if participation makes financial sense?”

And the answer is, “no,” we do not have a sort of CMS endorsed modeling tool to project the financial impact. I would, you know, a couple of things here. Number one, we will be putting out additional information to help participants sort of understand a little bit more of the methodology and make that assessment themselves, that will be in the Request for Applications. But also it, you know, suggest that folks should look at the resources already on our website which have, I think, some significant detail there for folks that are trying to make those calculations and figure out what's necessary to really make this jump into value-based care on their own.

I would also just note that, over time, you know, what we have found in prior models is that other organizations that folks work with may also create helpful tools, not endorsed by CMS, but decision, sort of decision resources that could be helpful. And so that may be something to keep an eye out. But again, the Request for Applications, I think, will be incredibly helpful. So please keep your eyes open for that in mid-August.

I saw there is a call. Please go ahead, Lauren, you got it.

>>Lauren McDevitt, CMS: “Is this an upside only model in terms of financial risk?”

And that is correct. It is upside only. All three tracks have upside only potential adjustments to the primary care payment and those positive adjustments reach the potential of 3%, 45%, and 60% depending on which track you are in.

>>Nick Minter, CMS: Thank you very much, Lauren.

Going back to the questions, for you know, to see if there any others that we can address now. Wanted to see, I know there is a question, and, Melissa, I think I might have an idea of the answer, but you might have a better idea. So other CMMI models, I think, though, in the question it specifies ACO REACH, requires use of sort of one of three social determinants of health screening tools. We've talked about how screening is a requirement of the model over time. Will MCP require use of one of those three models, or does our requirement differ in some way? Do we, do you want to take a stab at that, or should we? Oh, go ahead, Melissa.

>>Melissa Trible, CMS: Yeah, thanks, Nick.

So we do have a requirement to include a social determinants of health screening that's reported. The specific one is to report the results from social determinants of health screening, not at the beneficiary level, but at the overall conglomerate level. So, we do have that. It's at every track. But it is not at the beneficiary level.

>>Nick Minter, CMS: Thank you so much, Melissa.

So there's a question in the chat, that I'm going to see if Liz, you can help us provide a little bit of clarity there. The question is kind of long. I'm not going to read it all but I think it boils down to the PPCP is based on historical spending. I think there's a question about how that payment will be affected over time, if potentially care becomes more efficient and folks, you know do not bill as much because some care goes to a you know, sort of a non-billable rate like, how will that payment change over the course of the ten-year model. Do we have a mechanism for re-basing it to make sure that we're continuing to offset the real cost of providing those services? And obviously more information will be forthcoming in

future documents. But Liz, was curious if you could give us a little bit of insight into sort of our overall methodology there.

>>Liz Seeley, CMS: Sure.

So the PPCP, we have been very careful in the consideration of the policy around how that will be updated over time. Recognizing that the goal of a PPCP in MCP is to provide the participants with increased flexibility and stability in payments. Part of that is to ensure that it reflects a number of different factors that can change over time. So, changes in the prospective payment, the Medicare Prospective Payment System through rate changes or adjustment factors, those will all continue to be incorporated on an annual basis. Increases in primary care visits, which would come through the claims in that case will be incorporated into the PPCP PBPM amounts.

And we will also re-base, to specifically answer that question. We will re-base at the point that participant enters into Track 3, or after they have been in the model for a certain period of time. The goal there is to ensure that the PPCP continues to reflect their current attributed beneficiaries and to keep up with changes in risk levels. So it is really important that participants continue to bill in Track 2 and in Track 3. In Track 2 they will be the continued billing process and the reimbursement for the services will be at a reduced rate in exchange for the prospective payments that are provided up-front. In Track 3, there will be full prospective payment and participants will be required to continue to bill at zeroed-out rates. So the billing the submitting of the claims will be important over time, so that we can incorporate that into the updates in the PPCP amounts.

>>Nick Minter, CMS: Thank you so much, Liz.

I think we're at a good point to continue sort of answering questions in future Q&As. And we'll take a few more of these in the chat, but would love to kick it over to our facilitator TJ and folks to talk about next steps.

Thank you all so much for your time. We've had a really good time talking about the model with you today and look forward to future engagement. Thank you.

>> TJ Smith, SEA: Thank you, Nick. So to wrap up, we'll go over some closing remarks and additional resources. Please do be sure to take a few minutes to provide feedback on today's session through our short post event survey, and that link will also be posted to the chat. Next slide, please.

So, to learn more about MCP and for more detailed information, please visit our website using the link here on the screen. While there, please also sign up for our listserv to receive email updates, including upcoming events and resources. You may also continue to send questions by emailing our help desk listed here. And you can also follow the Innovation Center on Twitter to stay informed of the latest initiatives at CMMI. Next slide, please.

This does conclude today's webinar. Thank you for joining us, and we hope you have a good rest of your day. Thank you.

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