**Making Care Primary (MCP) Model Overview Webinar**
**June 27, 2023**

**>> TJ Smith, SEA:** Good afternoon everyone, and thank you for joining today's Making Care Primary Overview Webinar. We have an exciting presentation for you all today, but first we would like to start with some housekeeping items. Can we move to the next slide, please?

To listen to today's presentation, it is recommended that you listen via your computer speakers. If this does not work for you, there is also a dial-in option for viewers to listen through their phone. The dial-in number and passcode for today's event are listed on the slide. Closed captioning is also available for today's event on the bottom of the screen. During today's presentation, all participants will be in listen-only mode. Please feel free to submit any questions you have throughout today's presentation in the Q&A pod displayed on the right side of the meeting room window. Given time constraints, we may not get to every question, but we will collect questions for future events and FAQs. You may also submit questions to the MCP mailbox.

Today's presentation is being recorded. If you have any objections, 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. 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 for these events. Thank you. Next slide, please.

Before we jump into content, I'd like to introduce our CMS Innovation Center speakers for today. We have three joining us, including Sarah Fogler, Nicholas Minter, and Lauren McDevitt. Next slide, please.

We have a packed agenda today. We will dive into an overview of the Making Care Primary Model, followed by several sections that describe important areas of MCP, including eligibility, care delivery requirements, performance assessment, and payment structure. We will close the event with some more information on the MCP application, next steps, and things to look for in the coming weeks. First, I will turn it over to Sarah Fogler to share some opening remarks. Sarah?

**>>Dr. Sarah Fogler, CMS:** Hello everyone and welcome. Thank you, TJ. So excited to be here. We have a couple of minutes for opening remarks. Today is our first public-facing webinar post announcement of our new primary care model, the Making Care Primary Model, or MCP for short. We plan to test this model under the CMS Innovation Center authority in eight states, including Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington.

Making Care Primary is an important step in strengthening the primary care infrastructure in the country, especially for safety net and smaller or independent primary care organizations. Ensuring stability, resiliency, and access to primary care will only improve the health care system and the health care outcomes of Medicare and Medicaid beneficiaries. We believe this model represents an unprecedented investment in our nation's primary care network, and anticipate that it will bring us closer to our goal of reaching 100% of traditional Medicare beneficiaries and the vast majority of Medicaid beneficiaries in accountable care relationships or arrangements by 2030.

Throughout today's webinar, our team will expand upon the technical details of this new opportunity. But at a very high level, the MCP Model seeks to improve care for patients by expanding and enhancing care management and care coordination, equipping primary care clinicians with tools to form partnerships with specialists, and leveraging community-based connections to address patients' health needs as well as their health-related social needs. This model promotes strategies recommended by the NASEM 2021, Implementing High-Quality Primary Care report, and also builds upon previous experiences with our primary care model tests at the Innovation Center, such as the Comprehensive Primary Care Model, the Comprehensive Primary Care Model Plus, and Primary Care First, which is still active, as well as the Maryland Primary Care Program. In fact, I just had the privilege of participating in a panel discussion at AcademyHealth this past Saturday, where evaluators highlighted key findings from CPC and CPC+ that directly support and encourage policies being tested in the Making Care Primary Model. Policy, such as the need for the transition to value-based care needs to be tested over a longer time horizon, the need for more direct specialty care engagement to influence rates of hospitalization, and the importance of attribution, and driving the provision of high-value services such as the annual wellness visit.

So, with that brief welcome and introduction, I'll close with noting that we've reserved about 20 minutes for a live Q&A session at the end of this webinar. I want to note and thank you for submitting already over 150 comments or questions, rather, that we'll plan to tackle throughout the presentation today. But definitely make use of the chat function. And if we're not able to get to your question live today or through the presentation materials, we will certainly make sure to get back to you.

So, with no further ado, I'm going to turn it over to Nick Minter, who is the Director of our Primary Care Division at the Innovation Center. He will start us off on the technical overview of the new Making Care Primary Model.

**>>Nicholas Minter, CMS:** Thank you so much, Sarah. As she mentioned, I'm Nicholas Minter, and I am excited to share an overview of Making Care Primary with you all today.

CMS announced MCP on June 8th, 2023, and we have additional materials coming out over the next several days and weeks that will provide more detail on the topics that we cover today. For today, we will share a number of high-level facts, elements, and information, but please don't forget to subscribe to the MCP listserv. And if you are interested in participating in MCP, please submit a Letter of Intent to help you stay updated on new materials as they are released. With that, let's go ahead and dive in. Next slide.

So, it's important to start with where primary care is today. And primary care forms the foundation of a high performing health care system covering a range of services, from prevention to wellness to diagnosis and treatment of conditions, with an emphasis on battling, on building, forgive me, long-term relationships between provider and patient. High quality primary care integrates accessibility, continuity, coordination and comprehensiveness, and person-centered care, and it's delivered by an interprofessional team. Currently, primary care is hampered by misaligned payment systems that disincentivize high-quality primary care and create fragmentation that divides provider efforts. At the same time, Medicare beneficiaries are increasingly seeing both more specialists, and the specialists they see more frequently, while the number of visits that they are devoting to primary care is remaining the same. This is asking primary care to do more with less.

Making Care Primary aims to address the misaligned and fragmented primary care system by increasing financial, learning, and data resources to support clinicians' ability to provide enhanced care delivery and coordination with specialists to improve care, health, and equity for Medicare beneficiaries and all patients. MCP also progressively transitions participants away from fee-for-service by offering performance-based incentives, based on measures assessing health outcomes and quality of care, and moving to prospective payment, so that providers are able to worry about patients and not billing. Next slide, please.

So to design Making Care Primary, it's important to note that CMS built on insights and lessons learned from previous and current primary care models. As Sarah mentioned, we've tested many models, including the Comprehensive Primary Care Model, going forward to Primary Care First, which brings us to where we are today with Making Care Primary. This slide lays out those models by timeline and defining characteristics as a means of showing how we got the, how we got here.

MCP considered lessons learned from previous Innovation Center models as well as stakeholder feedback in its design and development. These lessons include many factors, but notably the need to expand access to value-based programs and organizations to, sorry, access to value-based programs to organizations that have been historically excluded or simply lack the resources to enroll in primary care initiatives in the Innovation Center and beyond in the past. A key lesson that CMS learned over the last decade of primary care models is that CMS must meet practices where they are if we're going to achieve CMS's goal, which Sarah mentioned, of having all beneficiaries in Medicare and the vast majority and Medicaid enter into accountable relationships with their providers. As a result, MCP will offer, for the first time, three entry tracks that are designed to appeal to organizations with differing level of value-based care experience.

CMS learned that practices best transform their care for all patients at once. So CMS is working with state Medicaid agencies, and will be working with commercial and other payers to align our efforts in ways that reduce burdens to clinician participation in MCP. This includes how we measure quality, define success, incentivize care, and provide data on patient care.

Stakeholders also shared, in our run up to the design of MCP, that the shorter duration of CPC, PCF, and other past models may limit primary care's potential to show value. So, CMS will test MCP for ten and a half years, starting on July 1st, 2024 to allow primary care the time that it needs to exhibit its transformative potential. MCP will feature new tools like enhanced support for specialty care coordination, not previously tested in our models, that will include financial resources specifically to motivate better specially care integration. Next slide, please.

So MCP is really targeting three goals. The first is to ensure that patients receive primary care that is integrated, coordinated, person-centered, and accountable. Primary care teams provide preventive services, they help manage chronic conditions, they address social determinants of health in the office and beyond, such as food and housing security, and they coordinate care across different settings. As a result, patients experience the best possible outcomes from good primary care. MCP will build upon existing system infrastructure to support participants as they deliver and aspire to deliver this level of care over time.

The second goal is to create a pathway for primary care organizations and practices, especially those that are small, independent, rural, and safety net in nature, to enter value-based care. MCP will include a

track, especially for organizations that have never participated in a value-based model in Medicare, including increased, that will include and feature increased learning, support, and financial resources.

The third goal is to improve the quality of care, health outcomes, and importantly, equity of patients while reducing program expenditures. MCP will accomplish this goal with supportive payment structure, and a track-based approach, that will gradually implement more advanced care delivery requirements. The gradual integration of community supports and additional resources for practices that are new to value-based care also aim to increase equity across all practices and patients over time. Next slide, please.

So, there's a lot on this slide, and so I encourage you to sort of read through it. What you'll see here is a simplified version of MCP's aim, and the four areas of effort that will contribute to our achievement of success. MCP aims to achieve equitable health outcomes through widely, through widely accessible, high-quality, affordable primary care that is person-centered, with accountability for outcomes. CMS hopes to achieve this, this aim through four different pillars, which you see here in the different colors, including integrated person-centered care, flexible, enhanced prospective-based payment with accountability, advancing health equity, and in forming partnerships with both payers and other stakeholders in the community.

To advance primary care delivery, MCP will feature several components, including the requirement and support of an interprofessional care team to manage and coordinate patient needs. It will call upon participants to integrate specialty care and community-based social service partners, based on patient needs and track to build an organization, to build organizational capacity in this realm over time. We know that not everybody is starting out proficient there, that's why we are testing this over ten and a half years.

MCP will also meet organizations where they are to shift payment from fee-for-service for those unfamiliar with prospective value-based payment, our population-based payment. So, we will work with them where they are to shift them to a population-based payment that is fully prospective. We are pulling lessons from previous primary care models, as I mentioned, to make sure that we are also factoring in both social and clinical risk when risk adjusting for the population as we calculate these prospective-based payments. MCP also features several unique payment mechanisms to provide smaller, rural, and safety net organizations with proportionally more resources to support their patient population needs and help them transform in ways that they previously simply didn't have the resources to do.

MCP will focus, as you see in the top, I should say the top right-hand pillar here, on advancing health equity in several key ways. 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 practices as they work to identify strategies to address health disparities within their community. The idea is that practices need to learn from best practices, but also each other. And so we will create a community that facilitates such. Finally, MCP participants will create partnerships with specialists and social service providers in their communities to help address health equity and advance person-centered care delivery requirements within MCP.

These pillars work together to make a framework by which CMS hopes to advance primary care services in the model. Next slide, please.

So here you see a quick summary of additional, key model design features. We will talk more about these in the coming slides, but we thought that these were highlights that were worth calling out, and so I will do so very quickly.

First off, as I've alluded to, there are resources in the model meant to help catalyze transformation for those organizations that do not have considerable experience or any experience with value-based care previously. That is, that will, that takes the of an up-front infrastructure payment at the beginning of the model that we that Lauren will describe a little bit later today. The model focuses on equity for underserved population, populations by including social risk factors in the way that we price out and pay our prospective payment over time. That added focus on equity and serving underserved patient populations is critical for ensuring that regardless of the patient population, that a practice or a primary organization has, they have the same pathway to value-based care open to them.

As I've mentioned before, MCP is a longer model, because we know that primary care investment takes time to yield fruit, to, to sort of show the fruits of its labor, and to return the investment that we intend to put into practices up-front. It also allows practices to fully realize an advanced proficiency in the care delivery requirements that we will require that they take on, things like Behavioral Health Integration, specialty coordination, better care management. We also are going to focus on incorporating high-quality specialty care partnerships, because that coordination is critical to avoiding low-value and avoidable health care costs, and poorer than expected outcomes.

We have been working with state Medicaid agencies over time, and will continue to do so to ensure that at a basic level we are aligned in the region with other major payers in the regions in which we are testing this model. And we are open and eager to continue talking with other payers. We will be doing so over the coming months to build a multi-payer community aligned behind the goals of Making Care Primary, and eager to continue aligning on the areas that really remove barriers to assist patients. And again, we are all defining success the same way so that practices and primary care organizations know what to strive for.

And then finally, community care is a real focus and is one of our care delivery pillars or tenants, if you will. Because we know that care is not restricted to the four walls of the office. And so building those connections to community-based organizations is integral to success, and that is something that is featured in our model, more so than prior primary care transformation efforts. Next slide, please.

So this slide, this slide features several potential benefits to participation for organizations considering applying to MCP. It sort of lays out why, what we think practices and primary care organizations will get out of enrolling in this model. There's a lot here, and I think, taking a minute to read through it is probably just as useful as me sort of explaining it to you. But I'll do what I can to help supplement what's on the slide.

The first is that our goal is to build an on-ramp to value-based care delivery like no model before MCP. As we will discuss in future slides, MCP features a three-track approach that's meant to build an on-ramp to practices regardless of where they are, even if they're starting from a place of relatively little or no experience in advancement, in budgeting and handling a prospective payment.

In addition, we are, we are aimed at removing all barriers for those practices that simply haven't had the resources to get over the initial hump to apply and come into models for the first year. And again, Lauren

will talk a little bit more about those financial resources, but we aim to have a strategy that starts from square one and provides practices the resources that they need to transform their care.

MCP also includes several tools to improve care coordination. We plan on focusing on improving patient experience, and especially in the, in the purview of integration of specialty care. We plan to make sure that our quality measurement strategy rewards not only reduction of cost, but really focuses first on clinical outcomes to make sure that we are incentivizing transformation across both patient quality as well as, as well as reducing unnecessary care.

MCP has a refreshed focus on health equity. As you see here, we have several, you know, several waivers that we will touch on later, that are aimed at making sure that we are removing barriers to access for those patients that don't have as many resources as others to make it into the office. We want to make sure that we are increasing payments to support the additional care that those patients need, and we are incentivizing improvement through the requirement of health equity plans as well as other focuses of the model, to ensure that health equity is something that we act toward and don't just speak towards.

And finally, we are establishing the learning community that will build upon the efforts existing in the regions in which we are operating this model. But also, seek to have a couple of different layers that are both regionally specific and also national in nature to make sure that learning accommodates the needs of the actual practice, be that coaching or simply a community with which to air out innovative ideas. Next slide.

All right, eligibility and participant type. So, now we're going to talk about who is eligible to participate in the model. And I think we can go to the next slide. Thank you so much.

So first off, where are we testing the model. CMS will test the model, I acknowledge Sarah went over this, but in case it's helpful to look at it on a map, going from west to east here. So, Washington, New Mexico, Colorado, Minnesota, New York, Massachusetts, New Jersey, and North Carolina. We chose these States based on their geographic diversity, the opportunity to, you know, to make a difference in these models, past CMMI footprint, a diversity thereof, as well as the ability to evaluate the model and scale it nationally, if it is proven to be successful. We also have been working, as you have heard, with state Medicaid agencies in these states to ensure that we will be able to achieve multi-payer alignment, because we know that that's absolutely essential to success in any of these regions. Next slide.

So, in general, organizations that provide primary care to services, or primary care services to patients, in these participant states that are Medicare sort of primary care, will be eligible to provide, sorry or to participate. These include independent, or solo primary care practices, group practices, Federally Qualified Health Centers, or those that look are look-alike so to speak by the definition, health systems and Indian Health Programs.

I will note a couple of things really quickly. What I'm talking about now refers to the Medicare part of the program and much, and the payment and other details that we are discussing today also refer to sort of the Medicare payments and requirements thereof. I say that because other payers may have slightly different requirements, and we encourage them to customize their programs to their population. So we want to be very specific about what requirements we're talking about for the purposes of this presentation. I also want to acknowledge that these slides will be posted at a later date. So I know that

there's a lot of text at the bottom of the screen that provides legal definitions for the terms on the slide. You will have access to those at a at a later date.

So, eligibility it's important to note, to participate will be determined at the organization level, which can differ for FQHCs and non-FQHCs. For FQHCs, it will be at the CCN or Health Center level. For non-FQHCs, we will be enrolling participants according to their Tax ID Number, they're TIN, as opposed to the brick and mortar practice definition that we've used previously.

MCP does include some additional eligibility criteria for non-FQHC organizations. Non-FQHCs must bill health services for a minimum of 125 Medicare patients that are attributed. In other words, they must be the primary health care provider for 125 Medicare patients. And the majority of the organization sites for those that are multi-site under a single TIN must be located in an MCP eligible state or region.

Due to MPC's payment and quality reporting design certain organizations will not be eligible to participate in MCP. These includes, these include concierge practices, Rural Health Clinics, Grandfathered Tribal FQHCs, and current or former Primary Care First or ACO REACH participants. Next slide, please.

So to, you know, to elaborate a little bit on this point in general, CMS will not allow organizations or clinicians to participate in MCP while participating in other CMMI models or programs. Organizations that are enrolled in another CMMI model or program will not be allowed to simultaneously participate in MCP. And that includes those that are in the Kidney Care First, or ACO REACH models, as I mentioned. and again also includes those that are currently enrolled in PCF.

Organizations and clinicians participating in bundled payment models if they are part of a health system, for example, including “Bipci-Advanced”, BPCI-Advanced for those that don't use the phonetic acronym, Enhancing Oncology Model or the Comprehensive Care for Joint Replacement Models can participate in Making Care Primary because those bundled service models largely affect payment outside of the primary care realm.

For those practices and organizations that are participating in the Medicare Shared Savings Program, they will not be allowed to simultaneously participate in MSSP and Making Care Primary. We will allow those organizations that wish to remove their participation, or terminate their participation, in MSSP to join MCP to do so. And we will, we will outline this in more detail, but the high-level summary of how this would work is an MSSP participating organization would apply to the model in 2023, learn of their success in early 2024. We'll go over the timeline in more detail later, but then they would terminate their participation in MSSP before the 2025 year, so that in 2025 they would join MCP, six months late, starting January 1st. Again, more detail to come there, but this has been one of our more hotly requested questions to answer. So with that, let's go to the next slide.

So, as mentioned earlier, MCP features three tracks that differentiate practices based on their experience and comfort with value-based payment and care. These tracks are intended to provide opportunities for organizations with differing levels of care delivery as well as existing experience with performance-based payments and allows them to enter MCP at a point that matches their capabilities at the start of the model.

So, as you see here, Track 1 is really about building capacity and infrastructure. This track is available to organizations with no previous experience in value-based care models or programs. They will use the

time that they have in Track 1, which you see to be two and a half years, if they enter the model on that track, to focus on building capacity to deliver advanced services that will be required of them as they progress through tracks later in the model, such as risk stratifying their patient population, developing workflows for chronic disease, management, Behavioral Health Integration and health-related social needs screening. Participants who enter Making Care Primary in Track 1 will stay in that track, as I mentioned, for two and a half years before, they progress, automatically, to Track 2.

Track 2, in turn will focus on improving efficiency as they transition their payment from fee-for-service for the first time to a prospective population-based payment. Participants will use the capabilities that they've built so far in the model, or that they bring into the model, to deliver advanced primary care services to their patients in MCP. They will be able to earn higher bonus payments, significantly higher bonus payments, for the first time, for these services. Participants who enter Track 2 will remain in that model for two and a half years, if they enter in that track before moving to Track 3. If they transition to that track, they will spend 2 years in that track.

Track 3 focuses on optimizing exceptional care that has been learned through the care delivery strategy in the model. Participants will use the capabilities and data that they have gained to date and is made available to them through the model resources, to increase the care, to improve the care that they're providing in an interprofessional manner. The idea is to really optimize the workflows that have been identified and established in the model to date. Participants who enter in Track 3 will remain there for the entirety of the model. And once a participant that, beginning in another track, reaches Track 3, they will complete the model duration in that more advanced track that has finished their transition from fee-for-service to prospective-based payment with accountability for patient outcomes. Next slide.

So one more note on payer partnership. You know, CMS will be partnering with public and private payers to implement Making Care Primary. We think it's incredibly important to foster alignment in areas in particular that reduce clinician burden. And just to note this, our priorities for payer alignment are to make sure that we are moving payment for primary care services away from fee-for-service over time. And that where we are measuring quality measures in the same quality outcomes, we do so in the same way, so that we are defining the same definition of success for those in the model. We want to make sure that over time, and it will take time, we are providing data in the same format to providers in the model, so that they have one place to go, and one set of variables to look at to understand the care their patients are receiving. We want to build upon with our payers the learning infrastructure in each of the regions so that there is a clear set agenda for what success looks like for a primary care practice.

We know that this takes time. We have begun in each of the regions by talking to state Medicaid agencies and working with them to make sure that we're aligned in the goals of the model that we covered earlier. And are aligning over time, in how different programs and with the state Medicaid agencies and exploring with them how their programs can align in form and function with the goals that we are, have just outlined.

And again, we think that this is really important, because if both Medicare and Medicaid are working toward the same set of goals, it's much more likely that practices will have enough revenue to be able to transform care for all patients at once. That's the goal that we're trying to achieve. And so we are working with state Medicaid agencies, and we'll be working increasingly in the future to align with other commercial payers. So then, we're all realizing the benefits of enhanced primary care at both the patient and organizational level.

I want to note that, you know, it's important to know I've talked about the priorities for payer alignment, I also want to highlight that we're not asking payers to mirror what we're doing, not to mimic it completely. So you'll see some very specific payment elements as we go through the rest of the presentation. We are going to provide, and have designed our payer alignment strategy to provide, payers with significant flexibility. You know, if there is a particular area that they need to add, additional quality measures to reflect their special populations, be that pediatric population, a younger than 65 population generally, maternal health, etc. they have the ability to add those quality measures and to incentivize those in a way that's consistent with MCP, but certainly may not be the exact carbon copy of what Medicare is doing. Similarly, if their payment approach differs from ours, we think it's most important that we're moving away from fee-for-service and incentivizing better care. Not necessarily that we're doing so in a way that copycats each other. So we think that flexibility is important to make sure that the tent is broad enough to bring everyone under it, and that is our strategy here. So thank you. Let's go to the next slide.

So just wanted to highlight really quickly some of the additional resources and supports for MCP participants before we start talking about the nitty gritty components of the model. So first off, we know that a lot of practices, as they begin this journey into providing high-quality interprofessional primary care, they're going to need support. And so at a national level, we will providing, we will be providing technical assistance to make sure that MCP participants understand what the model requires of them, what the timelines are, you know what payment to expect, and when and where to get additional information about all the things that Medicare isn't doing today, but we'll be doing under the model.

We will be providing templates for some of the more advanced requirements, so that so the practices that simply aren't familiar with, with things like agreements with other providers, to make sure that there's accountability in care have something to work from. We will be providing a virtual platform to entice and incentivize, and frankly speaking, really motivate practices, to share what's working within their walls with other primary care practices and vice versa.

And we want to make sure that we are continuously improving this model. This model lasts 10 years. I am, I am 100% sure, speaking for myself, that what works today will probably still work in some way in the future, but can be improved. And we want to make sure that we are thinking about having the resources and the flexibility to modify our strategy to reflect the care of tomorrow.

And finally, I want to acknowledge I'm not going to read through the bullets on the right-hand side of the slide. We know that, you know, care is local, and we want to make sure that there is, there are learning strategies that also reflect the needs and focuses of the regions and the states in which we are testing this model. So for those practices that needs sort of more one-on-one coaching and peer-to-peer learning, we want to provide those resources and will aim to do that. We plan to be, to hold several convenings throughout the year at, again the state level, both among payers and providers, to make sure that again, while MCP has a national goal and focus, we're not losing the local flavor that's so integral to facilitating primary care transformation. Next slide.

So in the next few slides I'm going to go over the care delivery requirements of the model. And again, starting to get a little bit more into the elements, and then, I'll be passing over to Lauren, who will do a lot more of that. So let's keep it going.

So here, as you see now, the MCP approach to care delivery transformation is really to promote comprehensive and patient-center care. We have three domains that we've organized our care delivery

strategy into: Care Management, Care Integration, and Community Connection. These will guide our efforts. With each track, the Track 1, Track 2, Track 3 approach, progressively building upon the requirements and competency required of practices that are developing skills and capabilities within these domains. Next slide.

So the first domain that we're going to talk about is Care Management. And we think that by prioritizing care management, and in particular chronic disease management, particularly for those in the Medicare population with diabetes and hypertension, and reducing unnecessary ED use and hospitalizations, participants in Making Care Primary can and will achieve better health outcomes for their patients. Implementing the care delivery requirements within their tracks, along with a commitment to continuous improvement over time, will enable participants to build effective care management services within their workflows over the course of the model.

So, as we mentioned, really Track 1 of MCP focuses on infrastructure building, laying the groundwork for effective care management throughout the model's timeline. Through setting, through identifying, approaches and beginning risk stratification and patient empanelment, participants will promote personalized care. By identifying staff and developing workflows for chronic care management and timely follow ups, high-risk patients will receive the care and attention that they need. And finally, additionally, additionally I should say individualized self-management support services will empower patients to increase their own health literacy and to take charge of their own health.

Track 2 of this of this particular domain, will focus on enhancing the efficiency of care management, they'll build, by building upon the foundations of Track 1. By implementing comprehensive chronic care management for high-risk patients, offering again, timely follow-ups, as part of the workflow at this point. And also making sure that there is timely and effective post emergency department visits and follow-ups after ED visits and hospitalizations. We aim to improve the overall effectiveness and the efficiency of care over time.

And as a pattern, Track 3 really focuses on optimizing those, that exceptional care by offering individualized care plans for high-risk patients, with tailored and effective interventions, by utilizing best practices to make sure that care is felt on the individual level, to strengthen that that provider patient bond over time. Through the expansion of self-management services, including group education services and community linkages, we're hoping to foster patient engagement and empower individuals to take charge of their health, and to address the broader social determinants of health within a practice. We think that these initiatives will elevate our care to new heights, and will lead to new patient, to improve patient outcomes as well as increased patient satisfaction, and a stronger connection of the patient and the provider to its surrounding community. Next slide.

So, the next slide has to do with Care Integration, which really focuses on two prongs, the first being Behavioral Health Integration, and the second being specialty integration. So Track 1 really again, building that initial capacity. It focuses on utilizing data tools and implementing, for the first time, sort of identifying how to implement Behavioral Health Integration for those practices at that, at that point of advancement into approach. And to implement an approach that's grounded in measurement-based care by using data tools to identify high-quality specialists, participants will enhance the referral process to ensure optimal patient outcomes. Again, initiating BHI with measurement-based care at its at its heart, enables the systematic monitoring the patient outcomes and the usage of measurement to inform a care plan going forward. And we think that's really important to inform clinical decision making.

So Track 2 focuses on strengthening that approach, but also incorporating more of a specialist integration focus. And in particular, to enhance care through the usage of eConsults with specialists, and also to make sure that measurement-based care is now the norm of how behavioral health is integrated in the practice. By establishing collaborative partnerships with high-quality specialty care providers, implementing enhanced eConsults, and also systematically screening for behavioral health conditions within the practice for all patients, participants will improve access, coordination and patient outcomes.

And Track 3 really focuses on strengthening the specialty care partnerships in particular to drive quality improvement in BHI and improve the quality of referrals as well as coordination of care back to the primary care office after a specialty visit. So through time-limited, co-management relationships with Specialty Care Partners, participants will focus, will foster, forgive me, better collaboration and shared decision making to optimize care coordination and improve patient outcomes with specialists when that need arises. We hope to, through our quality measurement strategy, make sure that we have a quality improvement framework in place to allow participants to continually assess and refine their BHI workflows in particular to ensure efficient and effective delivery of integrated care. We think that this will improve the overall quality of care, and again enhance success for practices both in terms of our performance-based measures, which Lauren will cover later, as well as improving both patient retention and strengthening relationships. Next slide.

The final care delivery domain that I'm going to expound upon today is the Community Connection Domain. And it's one that we are, are really excited to incorporate more deliberately in our primary care models. In this domain, MCP participants will actively identify and strive to resolve health-related social needs among their payment, their patient population. They will collaborate closely with social service providers to assist patients in navigating the various community supports and services that are available to them.

Track 1, again, we'll focus on addressing the health-related social needs by beginning to implement universal screening, by establishing referral workflows, identifying resources in the community and forging partnerships with those resources. It's really integral to this particular track to identify staff, such as community health workers, that can enhance the delivery of services to patients with high needs both within and outside of the four walls of the practice.

Track 2 will focus on strengthening referrals and partnerships to community-based organizations and other resources among those patients that are in need and within a practice. Establishing collaborations with those providers expands the resources that are available to patients, and it promotes comprehensive care by the best definition thereof. Additionally, utilizing community health workers or professionals with shared lived experiences enhances the ability of the practice to navigate and coordinate health-related social needs, patient social needs, for patients with those exhibited higher needs.

And Track 3 really builds upon this and optimizes those workflows to make them routine, to ensure that they become automated for all patients that, that are seen by the practice. By streamlining referral processes, establishing robust collaboration and continuously improving the utilization of these resources, we'll ensure better access to such services. And again, make routine that comprehensive support for patients. Next slide.

And now it's my pleasure to pass the metaphorical ball over to Lauren McDevitt, who will walk us through the payment strategy. Thank you.

**>>Lauren McDevitt, CMS:** Thank you so much, Nick. We will now talk more about the payment structure in MCP. 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, which we will walk through in more detail in the coming slides. Some payments, such as the Enhanced Services Payment and Performance Incentive Payment apply to all participants regardless of their track, while levels of payment may differ, based on which track a participant is in. Other payments, such as the MCP eConsult code and the Ambulatory Co-Management code start to be available in Tracks 2 and 3 respectively, in order to reflect where participants are in care delivery transformation. Next slide, please.

The first payment type we will discuss is the Upfront Infrastructure Payment or UIP. This payment is optional and only open to eligible Track 1 applicants who meet criteria listed in the Request for Applications that will be released later this summer, targeting August. Track 1 applicants who want to be evaluated for eligibility for the UIP must indicate their interest in the application. It is considered an optional payment.

This payment must be used by eligible applicants to invest in infrastructure that enables them to meet MCP care delivery and Health IT requirements. Categories of permitted use include increased staffing, social determinants of health strategies, such as partnering with CBOs, or health care clinician infrastructure, such as investing in CEHRT system enhancements and upgrades or developing infrastructure that would enhance sociodemographic data collection. The total amount of the UIP is $145,000 paid in two installments, and will be subject condition subject to conditions listed in the RFA and the Participation Agreement, but will include required reporting on how the participant plans to use the funds as well as how they spent the funds. And these funds will be subject to recoupment if a participant violates conditions of use and may be recouped if a participant exits MCP prior to their entry into Track 3. Next slide, please.

Enhanced Services 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 upfront 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'll cover the performance incentive payment in the next few slides.

The ESP average amounts across tracks are $15 dollars in Track 1, $10 in Track 2, and $8 in Track 3. Please note, these average amounts will vary based on each participant's population. ESP amounts are set based on the beneficiaries Hierarchical Condition Category, or HCC score, whether they are enrolled in the low-income subsidy program, and the Area Deprivation Index, or ADI, of their zip code. Participants will be paid $25 per-beneficiary-per-month for beneficiaries enrolled in LIS as well as for beneficiaries in the highest ADI and highest HCC tiers. That $25 amount does not decrease over time and is fixed across tracks in order to provide sustained support for participants serving beneficiaries with more complex needs. 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, replaces fee-for-service payment at different levels, depending on what track a participant is in. For Track 2, it is intended to replace about half of a participant's fee-for-service revenue that would have been billed for primary care services and all claims will be reduced, and claims will be reduced accordingly. For Track 3, it is intended to replace 100% of a participant's fee-for-service revenue for primary care services. A list of services considered primary care, or part of the PPCP, will be listed in the Request for Applications.

The PPCP will be paid on a per-beneficiary-per-month basis, and will be calculated for the first two performance years for all participants based on each individual participant's past claims billing. For FQHCs, this will be based on services billed under the Medicare FQHC Prospective Payment System, and for non-FQHCs, it will be based on services billed under the Physician Fee Schedule. By the third performance year, CMS will introduce a regional component to the payment methodology for non-FQHCs. But for FQHCs, the payment methodology will continue to be calculated based on each facility's unique claim history. Next slide, please.

Next we'll talk about performance assessment in MCP, which will include a discussion of the Performance Incentive Payment. Next slide, please.

The performance measures selected in MCP are intended to reward participants for providing exceptional care. The measure set is intended to balance clinical quality, patient-reported outcomes, utilization, and cost. We've aligned our quality measures with our Care Delivery Domains and have also aligned many of our measures with the Universal Foundation and HRSA's Uniform Data System, or UDS. Next slide, please

In Track 1, participants will report four measures, three clinical quality measures and one patient experience survey measure, or PCPCM. In Tracks 2 and 3 we add measures that reflect Tracks 2 and 3's more advanced approach to Behavioral Health Integration and connecting patients to resources in their communities. In Tracks 2 and 3, we also add claims-based measures of cost and utilization, including measures of absolute performance as well as continuous improvement measures which reward participants for improving based on their own individual historic performance.

FQHCs and non-FQHCs perform on different continuous improvement measures. FQHCs will perform on EDU continuous improvement, which is emergency department utilization. And non-FQHCs will perform on a measure of total per capita cost, which is a measure of Part A and B cost continuous improvement. Each measure will contribute to a participant's total Performance Incentive Payment. And in Tracks 2 and 3 utilization or cost measures make-up about half of the performance opportunity, while measures of clinical quality and patient experience make up the other half. Participants in Tracks 2 and 3 will need to meet or exceed the 30th percentile nationally on the total per capita cost measure to be eligible to earn a Performance Incentive Payment based on their performance, on the measures listed here. Next slide, please.

The Performance Incentive Payment, or PIP, rewards performance on the measures listed on the previous slide. This is an upside-only bonus opportunity applicable in all three tracks. Participants must report all required quality measures and achieve or exceed the national 30th percentile on total per capita cost to be eligible for the PIP. As mentioned, each measure contributes to the Performance

Incentive Payment and participants can earn either half or full credit for the measure depending on whether they meet or exceed cut points, that will be listed in the RFA.

The actual PIP amount is a percentage adjustment to primary care payments, including fee-for-service and also up-front payments, such as the ESP and PPCP, and will vary for each participant based on their performance and revenue. Participants can earn a positive adjustment of up to 3, 45, and 60% of their primary care payments depending on which track they are in and how well they perform on MCP measures. The adjustment opportunities are higher in Tracks 2 and 3 as average ESP amounts decrease. The PIP will be distributed up-front in two installments and will be reconciled based on performance. Next slide, please.

Now we'll talk through an example payment calculation that will bring the different payment types we've been talking about together. The diagram below demonstrates the relative contribution of each payment type to the total revenue for an example MCP participant. These calculations are based on a hypothetical organization with 1000 MCP attributed beneficiaries, assuming an equal distribution across HCC and ADI tiers. This is also an example that shows annual dollars as well, and the y-axis is in the thousands. It is assumed that the participant achieved the 50th percentile on three measures, the 70th or 80th percentile on three measures, and did not receive credit for the total per capita cost continuous improvement measure. The UIP is also not display here, as we assume that this organization did not qualify for the UIP.

As you can see, the overall revenue potential for participants does increase over time in each track, as does the amount of revenue receive prospectively, or up-front. The green bar shows that the Performance Incentive Payment represents more of the participant's revenue, as well as ESPSs, the purple bar decreases on average. The orange bar shows the amount of revenue that will be provided up-front as part of the PPCP. Next slide, please.

In addition to providing performance data on specialists in their region and peer-to-peer learning opportunities for specialist engagement, MCP will introduce two payment types to support closer coordination with specialists. The first is the MCP eConsult Code, which is designed to address current barriers for primary care in using eConsults codes, and is billable by MCP primary care clinicians. The amount of $40 per service is available for participants in Tracks 2 and 3. The second is the Ambulatory Co-Management Code. As mentioned earlier in this presentation, MCP participants will be required to partner with at least one specialist, which are referred to as Specialty Care Partners. This Ambulatory Co-Management Code can be billed by MCP Specialty Care Partners only, and is designed to support collaboration for shared MCP patients who require both longitudinal primary care and short-term specialized care related to chronic illness. Next slide, please.

Now that we've shared more about the model's design. We would love to cover a few next steps. Next slide, please.

If you're interested in participating in any of the MCP tracks, please submit a voluntary, non-binding, Letter of Intent that you would plan to apply to MCP. This will help us learn more about you and inform our recruitment efforts. You can find the LOI link on the MCP website, and we will also provide it in the chat. Please note that the LOI submission period will remain open until later this year when the MCP application period, which we plan to open later this summer, closes.

As mentioned several times throughout this presentation, the policies talked about today and more details that we did not discuss today, will be in the MCP Requests for Applications, which will be released later this summer, targeting August 2023. The Application Portal, where participants will submit information to CMS, for us to evaluate your eligibility for the model, will open around the same time in August. Throughout the coming weeks, and over the summer, we will also host additional events as more information becomes available. And we'll release guidance over the summer to support applicants in understanding whether MCP could be a good opportunity for them.

To stay informed about important updates and announcements related to MCP, we do encourage you to sign up for the MCP listserv. The MCP listserv will notify you when the MCP Request for Applications becomes available as well as provide information about events and resources. You can sign up for it via the link in the chat or via the MCP website.

I will now turn it over, back to Sarah Fogler, as we will begin the question and answer part of this event.

**>>Dr. Sarah Fogler, CMS:** Well, it took me a minute to find my screen everybody, so forgive me for that hiccup, but I was feverishly responding to the Q&A. We have had a lot of very smart and thoughtful questions come through, and we've been doing our best to feverishly attack those here. It looks like we still have 123 of them open. We've answered 99 of them, so we are doing the best we can over here.

I do think we were going to open up for a live Q&A here. We do have a handful of thematic questions, which always happens on these webinars, because we're all spread over the nation. And so there's a couple that I think have risen to the top as being asked a handful of times that I want to make sure we verbally cover.

Nick, I think I'm going to start with you to ask if you can just put verbal words behind the multi-payer alignment strategy and what that means for Medicaid participation, if you will, in this model, and also the commercial, payer presence.

**>>Nicholas Minter, CMS:** Yeah, it's a great question.

So, we have been working with Medicaid, with state Medicaid agencies, to date to explore how we could align, or how we can align behind MCP's goals, which we believe are universally supported by payers; to improve patient care upstream, improve outcomes, and over time reduce spending. And so we've been working with state Medicaid agencies to figure out how we can align on those priorities for payer alignment, moving payment away from fee-for-service, so that so that providers are able to focus on care for the population. And making sure that we are measuring quality the same way, so that it is less confusing to define success for the, for our, for participants that want to sort of join the primary care transformation. And also to make sure that we're aligning resources both in data and learning going forward.

So we have been talking to state Medicaid agencies, and what that will mean will be particular to each state. The Medicaid environment is different in each of the states. And to be clear, we are, these are ongoing discussions. And I think that, you know, some states have more to say than others, and others are still having conversations internally with stakeholders, a process that we are certainly supportive of.

I want to note the latter half of your question, Sarah, really quickly, and then I'll give it back to you. While we have been talking to state Medicaid agencies, we are eager, and beginning conversations with commercial, Medicare Advantage, purchaser-based, you know, all other payers as well. Our goal is to make sure that we bring sufficient patient revenue and population, all sort of behind the same set of incentives and goals to make primary care transformation, that is the care within a practice, a patient-wide phenomenon, not something that has to be done or contemplated on a payer- by-payer basis.

**>>Dr. Sarah Fogler, CMS:** Thank you so much, Nick. And I did see some questions, too, in the spirit of aligning data, and claims files, and claims feeds. And please know that the alignment that Nick was talking about in the quality measurement space and the payment space, extends to data collection and data transmission as well. So all of that being outlined now.

I'm next going to turn to Lauren, because we have a number of questions about eligibility. I saw a couple on clinically integrated networks, one on PACE, one on OPPS, several on FQHCs. And, under that umbrella, we have some questions about why RHCs in particular, are excluded from this opportunity. Not to say future opportunities at the Innovation Center, but this particular one. So can you run through for us the eligibility requirements and then close with why RHCs are not invited for this opportunity.

**>>Lauren McDevitt, CMS:** Yeah, thank you, Sarah.

So, first I'll say that a full list of the eligibility criteria will be listed in the Request for Applications. But, today we will share that, and we'll note that, applicants and participation will be at the TIN level. So, that you will be assessed kind of at the at the TIN level. We recognize that some groups might, like a clinically integrated network, might support several organizations that are kind of independently owned and have their own TINS. So each TIN would be an applicant, so wanted to mention that.

Organizations must be a legal entity, formed under applicable state, federal, or tribal law. They must be Medicare enrolled. They must serve as the regular source of care for a minimum of 125 Medicare fee-for-service attributed beneficiaries, and have the majority, at least 50%, no 51%, of their primary care sites or physical locations where care is delivered located in one of those eight MCP states. And non-FQHCs must also bill for Medicare services, furnished by primary care clinicians. So, we will include a list of primary care clinicians, but MDs, DOs, CNSs, NPs who provide primary care services. And for non-FQHCs, primary care services must account for at least 40% of your collective Medicare revenue for the roster of primary care clinicians that are provided. And just to close the loop, this is a model for participants that bill, or TINs that bill the Medicare Physician Fee Schedule or FQHCs that bill the Medicare Prospective Payment System, or PPS.

And so, coming back to RHCs. We recognize, you know, the challenges that are faced in rural populations. And that when it came to including RHCs in MCP, given that RHCs do not engage in mandatory quality reporting and are exempt from MIPS, we are not able to include them in MCP. Given that, you know, even starting in Track 1, we do start to kind of tie payment to quality reporting. And you know, unlike FQHCs, who do report quality reporting to HRSA every year, RHCs may not have that same infrastructure. And so, there will be other opportunities in the future for RHCs, but at this time MCP will not be including RHCs.

**>>Dr. Sarah Fogler, CMS:** Thank you so much, Lauren very comprehensive response.

Okay, the next, I thought I saw a lot of themes about were questions in terms of, if your organization is already participating in an existing value-based arrangement. And so, a couple of things before I ask Leah Hendrik, who's struggling with some camera issues, but she still has audio and can walk us through the overlap policies here. But before I do, I just want to reiterate that this is an opportunity for any primary care organization with any level of experience to come into this model design. The only distinction is that the more experience you have in value-based care arrangements, the higher the track that you may start your model participation in. And so it's really just Track 1 that is reserved for those organizations that don't yet have experience in value-based care.

And so Leah, if you could maybe take in turn for us, participation, what our overlap rules are again. Nick walked through those on the slide. But we've gotten some questions about what if I'm an organization that's participating in REACH, or PCF, or the Medicare Shared Savings Program. And, can I go back and forth between, or am I just ineligible in-full? So could you walk the group through that?

**>>Leah Hendrick, CMS:** Absolutely. Thanks, Sarah. So yeah, lots of questions about those three particular programs in the chat. So I'll talk about those three in turn.

So the first that I've seen a lot of questions about, is simultaneous participation in the MSSP ACO program and MCP. MSSP, or practices that are currently participating in an MSSP ACO, can apply to participate in MCP. However, they will have to withdraw from their MSSP ACO by, I believe it's December 31st, 2024, to be very specific about it, so that their participation in MCP is not simultaneous with their participation in the ACO. So they are, again, eligible to apply, but must withdraw from MSSP ACO.

Different from that, practices that are part of ACO, or I guess, REACH ACOs cannot withdraw from their REACH ACO at this point, to apply for and participate in MCP. So, any practice that was, as of May 31st of this year, part of a REACH ACO is ineligible to participate in MCP. That same rule stands for PCF practices as well. So, any practice that is participating in PCF as of May 31st of this year, yes, is ineligible to participate in MCP.

And the reason that we've put these restrictions in place is really because ACO REACH and PCF are both CMMI models with robust, independent evaluations. And we have a lot of lessons yet to learn from those programs and those programs do still have opportunities to achieve the statutory goals set forward in CMMI statute. And so we really do find it necessary to protect those evaluations and not allow one new model to pull participants out of our ongoing models that are being evaluated.

One other, just little note that I want to make, Sarah before I hand it back to you. I saw a lot of questions about TIN level organizations who might either have some participant or some practices in PCF, and some not. Or, and this is about taking it a little bit of a different direction, some practices that that provide care within our MCP states, and some outside. So, this is like a situation where a TIN is sort of eligible, but sort of not eligible. And I would just encourage anyone who is in that situation to go ahead and reach out to the MCP inbox, because it will be much easier for us to talk to you about your specific situation than try to cast blanket rules without really knowing all the details. So, really encourage people to reach out with questions so that we can look at your unique situation and give you, give you the most thorough and accurate answer.

I will, I think that's all I've got, so I'll hand it back over to you, Sarah.

**>>Dr. Sarah Fogler, CMS:** Thanks so much, Leah. And encourage everybody, whether it's a question about overlap or other technical questions that we're just not going to be able to get to in the next 15 minutes or so here, please do utilize that MCP mailbox. That helps us to have all these questions, so we can incorporate them into our future public release materials.

So I am going to next take the set of questions around specialty care integration in this model. And it's one of the features that I am most excited about in this new model. And that is because in past model tests, we have encouraged specialty care engagement, and integration, and collaboration, communication. But, we haven't necessarily had incentives for the specialists to partner with their primary care providers in their market.

This particular model has two different payment structures that offer that financial incentive. So, I'm going to tackle the finance, financials, first, that Nick walked through and Lauren walked through at a high level. But just to kind of target in on those specific features of this design, there is a gradual walk, given the progressive nature of this model, from Track 1 to Track 3. That in Track 1 we will be arming primary care practices and information about their population and their markets. So, any given primary care provider could log into a dashboard and better understand the services that their given beneficiaries are receiving, including the specialized care they're receiving from specialists. That information, that a practice would be reviewing in Track 1 would, you know, further expand their understanding about their population and allow them to make some decisions about who might be prime for more formalized specialty care partnerships as they progress into Track 2 and Track 3.

There are three specialty types that we have prioritized interest around. Those include pulmonology, cardiology, and I'm going to forget the third while I'm you know, on this 1,000 person meeting. But there is another one that somebody will stick in chat for me. And what we have done, why, we have prioritized those areas is one, because they're high prevalence areas. Primary care physicians report having problems accessing those specialty types, among many and all specialty types in improving access for their beneficiaries. And also, they can yield more downstream, high-cost procedures.

So there are reasons we selected those three, but they are not limited to those three. So any practice that's moving to Track 2 or advancing into Track 3 is allowed to arm their Specialty Care Partner list, with whichever specialty types they deem most appropriate for their panel. And it would just need to include one of the specialty types that we've prioritized.

The payment structures allow for continuation of the interprofessional consultation code billing, but there is somewhat of a fix on the primary care side. So what we heard from primary care physicians is they're not reimbursed for the time they spend post consultation from a specialist to understand the feedback and work to implement the feedback with the patient. So we have introduced a new code on the primary care side to assist with that e-consultation exchange. And then, on the specialist side, we've introduced, as you heard, the team present a new code that is going to allow for acute care management service or co-care management services on a short-term, limited basis. And that will allow, for, you know, early diagnosis of congestive heart failure with a primary care physician post hospital stay, to engage with the cardiologist on shared care planning exercises back and forth on what the care plan needs to look like for a shared patient.

So that will be the first time we're introducing a formal payment to be available to the specialists to engage in this partnership with the primary care physician. Again, the end goal here is to improve

communication and collaboration between the primary and specialty care partners and reimburse for that time spent. So, excited about that feature.

And next, I'm going oh, and thank you, I don't know how I forgot that orthopedics was that third and final priority area. We did get a question about oncology which we'll make sure that we include in our FAQ set after this call. But, one of the primary reasons for that is that we've, we understand oncology to kind of almost serve in that primary care role for patients that are enduring a cancer diagnosis. And so, we are testing oncology care approaches that have the oncologist sitting as the quarterback. And so we're running that under separate cover, as the short answer.

All right, I am going to turn us, I took a lot of time, because I'm excited about that one. But I'm going to turn us to attribution. We got a lot of questions about "How do you do attribution?", "What if I don't have the 125 minimum?", "What if I'm a new practice and I want to join and I can't meet that minimum?", so I think, Lauren is going to help run through attribution for us.

**>>Lauren McDevitt, CMS:** Sure. Thanks, Sarah.

So for attribution, we do assess that during the application phase, kind of based on a 24-month look back period and based on a roster of clinicians that are submitted to us through the application process. So, we look for eligible Medicare beneficiaries, and those are prospectively attributed to a participant. And it based on an NPI or CCN roster of primary care clinicians, and we go back and look at claims history. Something that that we've done in the past is for new practices, we typically have folks submit kind of a historical TIN if they've been billing under a previous TIN before setting up. So, and we're definitely willing to evaluate that situation as part of the application.

And one other thing to mention attribution is that we do plan to use voluntary alignment in this model, which will allow beneficiaries to select through Medicare.Gov to align to the MCP participant, or to their primary care provider. Was there anything else, Sarah, that we wanted to touch on for attribution?

**>>Dr. Sarah Fogler, CMS:** I think that looks good. I'm just scrolling through as everybody is talking. And forgive me in the audience, if I'm jumping around a little bit. I'm trying to multitask, maybe potentially ineffectively.

But, Nick, I'm going to turn to you next and ask if you can weigh in on: "Will states be, additional states be allowed to come into this opportunity in the future?"

**>>Nicholas Minter, CMS:** Yeah, it's a great question.

So, as I mentioned, we chose the eight states based on geographic diversity to ensure that we had a selection of states that could be nationally, that the model could nationally scale toward, as well as several other factors. To make sure that again, this model was going to be determined, successful or not, based on its own merits as opposed to the, you know, the specific characteristics of one region over another.

You know, one of the reasons that we are testing this model in fewer regions than past models is because we want to be very intentional about building the multi-payer community, making sure that we are supporting primary care transformation, and making the investments in a few enough areas that that

we can really sort of dig deep to build the community necessary to transform primary care in in the vision of the National Academy's report on providing high-quality or implementing high-quality, primary care. So at this point in time, we are not considering enrolling other states in Making Care Primary. However, we will continue to evaluate the success of the model during early implementation and look to expand the model to other states as soon as it's feasibly possible according to, you know, our statutory mandates in terms of how the actual model is performing. Thank you.

**>>Dr. Sarah Fogler, CMS:** Thanks so much, Nick.

I'm actually going to take our next one which is around the care delivery, the opportunities for including new and different partners in the care team. So I think one of the really powerful conclusions, recommendations within the NASEM report. And one of my favorite sayings from that report is that we need to reimburse, or we need to pay teams to care, for patients. We can't continue to pay individual providers for services. And to that end, we've structured this model in a way that really works to pay for the interdisciplinary care team as practices or organizations, you know, how they determine they want to structure it. So, what disciplines they want to include on that care team, we're really deferring to the organization, participant organizations to decide.

So what I would say, is that we've built out these prospective population-based payments. We've considered the cost of primary care services in building those payments. And we've added money to that, as you can see from the model, that we are finding ourselves, above fee-for-service on some of these tracks to do just that. To pay for care teams and an expanded set of services that can include things like community health workers being helping at the practice, Behavioral Health Integration, navigation to social supports, again, working to implement e-consultation platforms and workflows. So, really working to extend beyond the four walls of the practice, pulling in additional partners and using those prospective population-based payments or the Enhanced Service Payments that evolve into the prospective-based payments, and ultimately primary care capitation, to do just that, to have more flexibility with the payments to bring in additional staff to help meet the very needs of the patient panels.

So that I wanted to talk about. And, just give me a minute, while I scroll through and see if there's any other themes that we want to make sure to cover verbally.

**>>Lauren McDevitt, CMS:** Sarah, we thought we could maybe give a quick update on next steps after application.

**>>Dr. Sarah Fogler, CMS:** Yes please, Lauren. Thank you.

**>>Lauren McDevitt, CMS:** I know we touched on a few kind of immediate next steps. Over the next few weeks, we'll release more information and guidance as well as events that folks can register for to learn more about the model. We anticipate the Application Portal will open sometime in August. And then the Application Portal or applications will close sometime later this year. We're hoping to allow for a longer window to really engage with participants, work with potential participants to kind of increase the reach of this model. And then we plan to notify folks of their eligibility determinations for the model by early 2024. That way, we can begin onboarding to the model in April 2024, such as signing Participation Agreements before the model starting on July 2024.

**>>Dr. Sarah Fogler, CMS:** Thanks so much, Lauren. I think we are at a point where I am going to hand it back to our moderator team. And just a huge thank you to everyone. We did not get through all of the questions. I think I had high hopes we would, but likely unrealistic. We will take all of those back. We will be out with more materials. Please utilize that MCP mailbox as you see fit.

And I would just say “yay” for all the questions, because it means there's tons of interest in this new opportunity that we're very proud of. And thank you for listening to our presentation today, and many more months to come. So TJ, I will hand it back to you.

**>> TJ Smith, SEA:** Thank you, Sarah and team. Let's go to the next slide, please.

So to wrap up, we'll go over some closing remarks and additional resources. But first, please do be sure to take a few minutes to provide feedback on today's session through our short post event survey. That link will be posted into the chat now. And we can go to the next slide, please.

So again, as the team mentioned, to stay informed about upcoming MCP events and for more detailed information, do visit our website, sign up for our listserv for announcements, and do continue to email any questions to our help desk. Please also follow us on Twitter to see all the latest initiatives at the CMS Innovation Center. Next slide, please.

This does conclude today's webinar. We really appreciate you all joining and appreciate your time, and we hope you have a good rest of the day. Thank you.

**###**