Making Care Primary (MCP) Applicant Office Hour
October 24, 2023

>> TJ Smith, SEA: Good afternoon, everyone, and thank you for joining today's Making Care Primary Applicant Office Hour. We do have an exciting event for you all today. But first, we'd like to start with some housekeeping items. Let's go 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, there's also a dial-in option for viewers to listen through their phone. The dial-in number and passcode for today's event are listed on the slide and closed captioning is available on the bottom of the screen. During today's presentation, all participants will be in listen-only mode. Please feel free to submit any questions you have throughout today's presentation in the Q&A pod displayed on the right side of the meeting 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 do hang up at this time.

Please also note that this slide deck, a recording of today's presentation and a transcript will be made available on the MCP website in the coming days. Finally, we will share a survey at the end of today's presentation. We ask that you please take five minutes to let us know how we did, and share any questions that you may have about MCP. We will have more events and other items coming, and would love to know what you all thought as we continue to plan for those. Thank you. Next slide, please.

We have a short agenda today before getting to our Q&A. We will begin by reviewing the application process and reminding you all of some important dates, and we'll also reference a few resources to support you. After that we will begin answering questions, both those submitted through the registration form as well as those that are being submitted live. And with that, I would like to turn it over to Lauren McDevitt to begin today's presentation. Next slide, please.

>>Lauren McDevitt, CMS: Thank you so much TJ. Next slide, please.

So thanks all for taking the time to be with us today. We're really excited to get to take some time and answer any questions that you might have about the Making Care Primary Model. We did just want to start us off with just a reminder that if you're interested in MCP, please do submit an application by November 30th. And so, you can find the application link on the MCP website, which is on the CMMI website, we can drop that link into the chat. So we really do encourage you to submit or even begin your application, even if you're not prepared to submit at this time. So that way we can provide more tailored support to applicants once we have your information in hand. You can submit any and all questions, about the model and application to this email address, MCP@cms.hhs.gov.

We've also gotten a lot of questions about our payer partner recruitment timeline, so we wanted to share a little bit of an update on that before getting into our more targeted questions. So, just so folks know, you may already know that we already really intentionally partnered with state Medicaid agencies in the eight states where we're testing MCP. But we're also beginning to work with other payers to bring, to see where we can align their programs with MCP. And so, in February 2024, that'll be the deadline for payers who are interested in aligning with us to sign a letter of interest to become an MCP Payer partner. And so that should align nicely with the window for signing a Participation

Agreement with us if you, as an MCP applicant, are accepted to MCP. And so, just as a reminder, the model will begin on July 2024. There are some more kind of timelines up here for past July 2024, but I think those are the most key pieces that I wanted to stress right now, and if folks want, we can share more details in the Q&A session. Next slide, please.

So today I'm joined by our amazing MCP model team, and so we're going to be fielding questions and answers across the team. So please do, if you haven't already, just begin to submit questions via the Q&A portion of the webinar. And just to get us started, we're going to start with some of the pre-submitted questions that you all submitted to us in advance of the webinar when you registered. So, thank you. So I'm going to start us off with a few, kind of, eligibility and timeline questions, and so thank you all for taking the time to submit questions to us in advance.

The first one is: After the November 30th deadline, will there be other opportunities during this 10-and-a-half-year model for other practices to apply? So, I'll take this first one. We are not planning any additional cohorts at this time for the model. So, this really is the opportunity to apply, if you're interested. The application is non-binding, so you will have an opportunity to, even after you submit your application, learn more about the model and ultimately determine about whether you'd like to participate. So Participation Agreements will go out to accepted applicants in March, and you'll need to sign those by sometime in April before the model starting in July 2024. So again, this is the opportunity to participate, and so we really encourage you to start working on an application if you're interested.

Moving on to the next question. If multiple primary care clinics bill under a single Tax Identification Number or TIN, do all clinics need to participate, or can one or two participate? This is a great question. So, as opposed to some past models that the Innovation Center has done, this model does require that all physical locations or sites, primary care clinic sites, that are billing or rendering services under the single Tax Identification Number do need to participate. And so we're not going to allow for just partial participation. It really does need to be across the TIN level to encourage more system-level transformation. So thanks for that question and opportunity to clarify that.

The next question we've been getting a lot: If my practice has less than 125 Medicare-attributed Medicare fee-for-service beneficiaries, but is above the billing threshold, are we eligible to apply? So when you say billing threshold, I think you mean the primary care services revenue requirement, that is, of 40%, that applies for non-FQHCs, just to determine that the applicants, just to make sure that the applicants we're getting are actually providing primary care, as you know, a large amount of their services. And so, the just to clarify the 125 attributed Medicare fee-for-service beneficiaries is at the TIN level, so across the entire Tax Identification Number. And so we do encourage you to apply. We’re going to look at whether folks meet this requirement by looking at, and if cumulatively over four quarters, whether the 125 threshold is met, and so we hope that most applicants will be able to meet that, and we just do really encourage you to apply so we can evaluate your eligibility that way.

The next question, I'm going to turn to my colleague, Liz Seeley. Liz, I'll just tee it up for us here, is: How will the prospective payment be modified when a new provider is added to a Track 2 or Track 3 organization?

>>Elizabeth Seeley, CMS: Great thanks, Lauren. So this is a great question. MCP payments are set up to account for your changes in staffing. Changes in staffing should be reflected in your MCP Clinician List, which is the list of primary care clinicians that render primary care services under your TIN. The MCP Clinician List is used to determine your number of attributed beneficiaries for each quarter.

In terms of setting the actual PPCP PBPM rate, that's the Prospective Primary Care Payment PBPM rate, for participants that enter directly into Track 2 and 3, the PPCP PBPM will be based on their own unique claims history from a 24-month historical base year period that ends three months before the start of the model. So claims from all MCP clinicians during that base year period will be used to derive a primary care payment amount per attributed beneficiary. This PPCP amount will be adjusted by changes in the Physician Fee Schedule on an annual basis, as well as the geographically adjusted, the GAF, each year, and will be paid out to participants on a quarterly basis for all of their attributed beneficiaries. So, as attribution is updated on a quarterly basis to reflect changes in rosters, the PBPM payments that you will receive will track that. Therefore, as new NPIs gain attribution for the participants, participants will receive the PPCP PBPM for these aligned beneficiaries.

>>Lauren McDevitt, CMS: Thank you, Liz, so much. That’s a really good question we've also been getting a lot of. For the next question, I'm going to turn it over to my colleague, Jade Barberi. So, Jade could you share more about what are the requirements for health equity for model participants?

>>Jade Barberi, CMS: Sure, thank you, Lauren. So under the model CMS will work with participants to develop Health Equity Plans, or HEPs, that will be submitted for initial review in fall 2024. And then within these HEPs participants will outline how they plan to identify disparities and care among their patient populations and the evidence-based strategies they will use to reduce those disparities that they identified. Also, in an effort to reduce administrative burden, participants will report on their HEP progress and patient demographic data as part of their care delivery reporting on an annual basis for the duration of the model.

>>Lauren McDevitt, CMS: Thank you so much, Jade. Alright. I will finish off with the pre-prepared questions, and then, we'll turn over to some of the questions that are being submitted in the chat. So please, just a reminder to submit your questions if you if you haven't already.

So the last one is, you know, group, this is kind of feedback and also questions. So, group national provider identifier-level participation is strongly preferred over TIN-level. Can hospitalists, urgent care doctors, be left off a participant’s Clinician List? So, so I do want to clarify something about TIN-level participation. So I know I mentioned earlier that the participation, you're not allowed to kind of have one primary care clinic in the model, and then one out. But we do want to just clarify is that for all, like non-FQHC participants, you will be submitting a list of clinicians that are primary care clinicians as part of the MCP Clinician List, which is further detailed in the RFA. And so we definitely do want you to leave off hospitalist and urgent care doctors that are not providing primary care from your MCP Clinician List. And so do encourage you to please check out the Request For Applications where we do detail the list of the criteria for including someone on your clinician list, which should include only those that are providing primary care as their main role. And so if someone is providing care mostly as a hospitalist, or in an urgent care setting, they would not be appropriate to include under MCP Clinician List.

Alright. So we will now transition to answering some of the questions that have been submitted so far. I'm just going to take a moment and scroll through these questions. I think there's, I know the team has been really quick at answering things in the chat, which has been great. Yeah, go ahead, Liz.

>>Elizabeth Seeley, CMS: There's a there was a question on TPCC CI that I'm happy to take live for folks. So I think one of the questions in the chat was around, how the TPCC Continuous Improvement measure will work. For participants that are to bill the Physician Fee Schedule, one of the performance incentive payment measures that will be assessed is the TPCC Continuous Improvement. I'll mention separately that FQHCs in the model will not be assessed on TPCC CI. They'll be assessed on EDU CI instead. But for the participants that are assessed on TPCC CI, they are measured against their own performance in the previous year, and they are rewarded if there's a statistically significant improvement of 3% or more. So you would receive half credit if your score improves by more than 3%, but less than 5% and full credit if your score improves by greater than 5%. When we talk about credit, we're referring to the weight that the TPCC CI measure has toward its contribution of overall PIP bonus.

You can see additional details in the RFA that that lays out the contribution each of the quality metrics has toward the different bonus opportunities. And then, in terms of how the TPCC CI will work over time, it will be measured annually, looking back at each participants' TPCC from the year before. And we, as CMMI, will monitor over time participants' performance in the continuous improvement measures. So, that if we need, so that if we were to need to adjust the CI weight or the thresholds in order to ensure that the threshold remains both challenging and achievable, then we would.

>>Lauren McDevitt, CMS: Thank you, Liz. Alright, taking a look. I think, so there's one I'm seeing about: We are a rural health clinic, and want to know if this could help us. We're losing one provider and are actively seeking another to add. So thanks for that question. I'll just flag that if your organization is designated as a Rural Health Clinic, kind of, meeting the criteria by CMS, Rural Health Clinics that meet those criteria are not eligible for Making Care Primary. However, if your TIN has an RHC and a non-RHC under your TIN, the non-RHC sites may be able to participate. We encourage you to apply. So I just wanted to mention that. Thanks for attending. Let's see**.**

>>Elizabeth Seeley, CMS: I can take another question, Lauren. It goes along with the question that you just answered around the Rural Health Clinics. There's another question that somebody's asking around their Critical Access Hospital ~~has an RHC,~~ has some RHC clinics under the Critical Access Hospital. So, for organizations that are Critical Access Hospitals, those that ~~do not reassign their billing, those that do not reassign their billing rights to the Physician Fee Schedule. Sorry, those that~~ do not reassign their billing rights to the CAH and that continue to bill the Physician Fee Schedule are eligible to participate in MCP as Critical Access Hospitals. Similar to the answer that Lauren just gave, if you meet the eligibility criteria as a Critical Access Hospital, but you have the Rural Health Clinics as part of your organization as well, you would still be eligible to participate in MCP. And the Rural Health Clinic attribution would just not occur to the Rural Health Clinics, but you would still be eligible to participate as a TIN as a whole TIN.

>>Lauren McDevitt, CMS: Thank you, Liz. I'll take one. Okay, so I saw the question about: Can funds be used for subscriptions for access to HIEs? Can funds be used to build interfaces to the HIEs in order to share patient data? So great question. It would depend on the kind of funds you're talking about, and I would encourage you to check out the Request for Applications. Specifically, you might be talking about the Upfront Infrastructure Payment. So, all of those expenses have to be within the categories that CMS has defined as allowable categories of use, and so just encourage you to look at those broad categories and consider whether your request falls in that. I know CMS will be providing kind of proactive guidance on exactly whether something falls into those categories. That will be part of the formal review of the spend plans that any eligible applicants, that have been deemed eligible for the Upfront Infrastructure Payment, will submit spend plans to CMS detailing kind of what the what they will be spending the Upfront Infrastructure Payment on, and so then we will kind of approve those plans or work with participants to revise those plans so that way they can be used. So the RFA lists those categories which are health care infrastructure, social determinants of health strategy, and also health care clinician infrastructure, which I may have already said. But there are three categories. So I think, hopefully, that helps.

Just going to take a moment to scroll. If others want to jump in, please do. So I guess I see another one: Is there a plan for if not enough applications are submitted? Will those who submit an application receive a list of those who in their community who are participating in MCP? So those who are, who submit an application will have opportunities, and who are approved for the model, will have an opportunity to connect with peers in their, both in their region, but also nationally through kind of our peer learning strategy to better connect those who are participating in the model.

And Sonja, thank you so much for jumping in. I think there's a question you want to answer.

>>Sonja Madera, CMS: Yes, thank you. We have a question about pediatric practices. If a pediatric practice, which doesn't have Medicare fee-for-service beneficiaries, is interested in MCP, can they apply?

So for Medicare fee-for-service, MCP, that practice would not be eligible, because without those beneficiaries we would not be able to generate payments or measure quality. But, as Lauren mentioned earlier, we are working with a number of commercial payers and also state Medicaid agencies to develop partnerships for them to participate in MCP as well. So those commercial payers and state Medicaid agencies may be offering MCP, their own MCP programs, to practices that were not able to enroll with Medicare fee-for-service. So, if you're curious as to whether your payers, your Medicaid agency, is planning to offer a program to pediatric practices, you should reach out to them directly. We unfortunately do not have that information at this time, but we have been encouraging those partners to think broadly, as far as practice eligibility goes.

>>Lauren McDevitt, CMS: Thanks, Sonja. One more: Can you say again how often we'll be able to update our MCP Clinician List? So right now, we're planning for that to be able to be updated kind of throughout the quarter, but there will be a cut off for that updating, after which your updates would not be included in the attribution run for payment in the upcoming quarter. That's something that, you know, CMS has discretion to update if, as we go on, we see that there aren't that many changes that are happening. But you know our goal is to make that available to you so it can reflect the latest in your organizational changes. I'm going to turn, oh, go ahead, sorry.

>>Elizabeth Seeley, CMS: I see a question in here, and I just want to make sure folks can hear me okay, because I did see a comment that it was difficult to hear me. Can people hear me okay?

>>Lauren McDevitt, CMS: Liz you're a little faint but I can hear you. Maybe you could just speak a little bit louder, that might help.

>>Elizabeth Seeley, CMS: Okay, great. Hopefully this helps. I'll speak more loudly. So I see a question in here about whether or not participants, interested applicants, will know whether they're eligible for the UIP before applying to MCP. You will not know whether you're eligible for UIP before applying, but if you apply to MCP, you submit the application and you indicate interest in the UIP, you will know whether you are eligible for the UIP before signing the PA. So before you make the decision of whether to join MCP, we will provide that information with you based on the different eligibility criteria that we have outlined in the RFA, which includes whether you have an e-Consult platform, and/or whether you meet the low revenue threshold criteria, and whether you are in Track 1. Only select participants in Track 1 will be eligible for the UIP.

>>Lauren McDevitt, CMS: Thank you, Liz. Going to turn to my colleague, Rhandi Morgan, for the next one. The question is: Are Track 2 care delivery requirements expected to be in place at the start of the program? Do any of the care delivery requirements have implementation period over the first or second performance year? So basically, when do people have to have met the requirements for care delivery in that track? Rhandi, I'll let you take it away.

>>Rhandi Morgan, CMS: Thanks, Lauren. That's a good question. So care delivery requirements are expected to be met in the first 12 months of their track, after their track, so the participants will be required to demonstrate that they are meeting those care delivery requirements at that point. There is an, the question was also about an implementation period, so it's just that the participant is expected to implement those requirements in that following year.

>>Lauren McDevitt, CMS: Thank you so much, Rhandi. I see one about: What is the look-back period for beneficiary alignment - which 24 months are we talking about? For a newly opened TIN that has experienced NPIs transitioning into it this quarter, can the historic patients count toward attribution, so the NPIs can still participate in MCP under their new TIN?

Yeah, so CMS understands there may be new, newer TINs that are applying to Making Care Primary. We do encourage you to submit any historic TINs that may have been serving the same patient population that your TIN will be serving. And in terms of which 24 months it'll be, there'll be some kind of gap between the current month and then the 24 months, but it'll be, there won't be a huge gap. So I think we haven't specified that publicly yet, but just know that it will be pretty recent to when we're assessing that. So we'll be assessing eligibility in, starting in December, after the application window closes. So yeah, definitely, we're sensitive to that situation, and we do still encourage you to apply.

>>Sonja Madera, CMS: Hi, Lauren, I have another.

>>Lauren McDevitt, CMS: Thank you.

>>Sonja Madera, CMS: We have a question here about alignment with State Medicaid agencies: It appears that the Medicaid agencies in our eight states do not have aligned programs available. So, we are working with the Medicaid agencies in all eight states. All eight of them have committed to partner with MCP to offer aligned programs. Those are still in development. It did take us quite a while to put together the Medicare fee-for-service model, and our partners are working on that currently. It may be that your state Medicaid agency does not have an aligned program ready to go on July 1st, 2024, but we are working with them, so that over the course of the ten-year model we will have all of our, we're anticipating that all of our Medicaid partners will be offering aligned programs to practices that are enrolled.

>>Lauren McDevitt, CMS: Thank you, Sonja. Just taking another look. There's a lot of good questions, just trying to figure which ones we're going to answer live here.

>>Elizabeth Seeley, CMS: I'm happy to answer the question about how the PPCP will work for FQHCs. So for Federally Qualified Health Centers, their prospective payments will be calculated based on the historical 24-month base year. And it will be based on the FQHC PPS. So the select G-codes that we define as primary care services, which are listed in the RFA, spend historical spending over the 24-month period for that unique FQHC participant's claims, will be calculated on a per-member-per-month basis for their attributed beneficiaries and paid out quarterly. Those that, that PPCP will also be updated over time to reflect increases in primary care utilization for those beneficiaries, as well as any rate changes in the PPS.

>>Lauren McDevitt, CMS: Thank you, thank you, Liz. I'm seeing one that's maybe a bit more technical. So about having difficulty accessing the CMS portal to view and submit an application.

So thanks for letting us know about that. I would definitely encourage folks to reach out to MCP@cms.hhs.gov, sorry MCP@cms.hhs.gov with these kinds of issues. I will flag that we're working on getting a more technical user guide out and published on the website. That should be up there soon. We're just working through that. But definitely, please, we understand there's a lot of CMS help desks, and we apologize for that experience. Please do reach out to us directly, and we can provide support.

Can you please clarify terms for withdrawing prior to the end of the program? Will hospitals need to repay infrastructure money? So, just to clarify, to make sure, we're talking about, you know, primary care organizations that are eligible to apply. But so there are, this is a voluntary model. You will be able to withdraw at least on an annual basis. So we will be able, you can kind of notify CMS if there's a change in your business, and you need to move on. And we, of course, want folks to stay with us for the entire model program, but understand that that things change. And so it is a voluntary model. These terms will all be specified really in detail in the participation agreement. But just know that you'll have an opportunity to withdraw on an annual basis. The only way that you will need to repay the infrastructure payment is if you enter, if you exit the model before Track 3, and if you received the infrastructure payment.

Just need to take a moment, one second. One other thing I just wanted to mention, that I think we forgot to mention earlier, is that the, we will publish a list of participants once we have finalized that.

Are advanced practitioners doing only primary care with physicians in a single group, considered as individual providers with attributed lives? So, great question. I would say that we encourage, you know, advanced practice practitioners working in primary care to, so your TIN, the TIN that you're rendering services under, would need to submit your NPI on a list, on the MCP Clinician List. That way we can include your NPI in attribution. And you're just to be clear, that your NPI would, and your claims and your services, would all count towards attribution.

Then another question is: Will MCP alignment supersede MSSP alignment? So just to clarify, we do not allow overlap between MSSP and MCP in general. There's, the only time we're going to allow overlap would be in the first six months of the program from July 2024 to the end of December 2024. So, there would be no kind of supersession of alignment. For that six months you'd be able to pull simultaneously if your beneficiary be attributed to MSSP ACO and also MCP. But going forward, you know, there will not be allowed any overlap. And provider precedence is something that would be specified, kind of, in our overlap policies.

>>Elizabeth Seeley, CMS: I see a question here on how will the PPCP work operationally? So the question is: Will there be a remittance for the claims that are submitted and covered by the PPCP, and will the PPCP be a lump sum, or be paid at the individual provider-level? So the PPCP is calculated as a per member, a PBPM amount. The PBPM amounts will be multiplied by the number of attributed beneficiaries for an MCP participant and multiplied times three, reflecting three months within a quarter and paid out on a quarterly basis. In Track 1, participants will bill fully fee-for-service. The PPCP starts in Track 2, and 50% of the expenditures for the PPCP services will be provided in the form of the PPCP. So, participants will continue to bill for those services as you typically do, and your fee-for-service claims will be reduced by 50%, that 50% that you're receiving prospectively. Then in Track 3, you will receive the full amount prospectively for the PPCP services. But it's really important that you do continue to bill for all the PPCP services. They will be zeroed out, since you will have already received the reimbursement prospectively. But these zeroed out claims are really important, as we rebase the PPCP every three years, for example, in order to be able to have accurate HCC scores. So you will continue operationally to follow the same schedule of billing for these services.

>>Lauren McDevitt, CMS: Thank you guys. Just taking a moment.

Can you please clarify on MSSP withdrawal to move forward with MCP? So yes, so you would need to withdraw from MSSP before the beginning of the 2025 Performance Year. So I just wanted to make sure folks were aware of that.

This is, will there be any patient notification requirements for MCP? Great question. That's something that would be specified more in detail in our Participation Agreement, about the requirements that participants will need to abide by for, kind of, notifying beneficiaries that they have been kind of aligned to the model. I'd say, most likely there will be some sort of requirement for, kind of, informing beneficiaries in Making Care Primary as well.

Just want to mention that beneficiaries that are, kind of, in institutions would not be eligible for MCP. So if you're primarily serving those types of beneficiaries, they would not be included. And I would encourage you to check out in the RFA, we do have a list of, kind of, beneficiary eligibility requirements for attribution, if you're curious to take a look at that.

I see another one: If a practice TIN changes during participation can the practice remain in MCP? So, yes. So, in short, business changes happen, so you may undergo, you know, a purchase, or purchase someone. And so we want to make sure we can be flexible around that. You'll need to notify CMS if any of your billing information changes. There will also be a formal, kind of, novation agreement process, that we specify in the PA around business changes. And CMS, you know, we'll want to make sure we understand what kind of business change you're undergoing, just so that we can update appropriately on our end, but to make sure that the Participation Agreement can be, is still in effect, basically after your change. But we'll specify that again, kind of, in the Participation Agreement, which is that formal agreement between CMS and the organization that ends up participating.

So a question about how will PPCP payment work in a permitted six months overlap period between MSSP and MCP? There will not, just to clarify in that six months overlap period, you will not receive any MCP payments. You'll just continue to be paid fee-for-service to avoid any payments being made in that overlapping of that six months.

Another question is: Do practices need to join individually, or do they need, or can they join as an IPA? So, this, this model is at the at the Medicare-enrolled TIN-level, so our participants should be primarily, should be those who are providing care and doing caregiving in our Medicare-enrolled TINs. So, just want to clarify that.

I see a question, Liz, I'm sorry, I don't know if we answered this one - but about what would the remittance look like for claims that are submitted but covered by the PPCP. Could you share more about kind of how we're paying that upfront? And then how the claims reductions might look?

>>Elizabeth Seeley, CMS: Sure. So, as we were mentioning before, it's important that for Tracks 2 and 3 with the PPCP, that participants continue to bill for these PPCP services in each of the tracks as they provide those services. In Track 2, the fee-for-service component will be reduced by 50% because you'll be receiving reimbursement on a prospective basis for the other 50%. And then Track 3, the claims will be zeroed out as you receive them fully on a prospective basis.

>>Lauren McDevitt, CMS: Thank you, Liz. So I think the what, what the remittance advice looks like, I think it's a little bit “TBD”, but we will reduce the claims accordingly.

I saw a question about: Will the MCP team release any kind of participant-specific data prior to submit, signing the PA similar to the BPCI Advanced team? So we will provide accepted MCP applicants with a, with some information about your attributed population, including, kind of, the number of attributed beneficiaries. So that way you can inform any modeling that you may need to do about your revenue prior to signing the PA.

Another question is: The application does not ask for NPI number for the organization, only clinician’s NPI is requested. Yes, so we'll need your organizational TIN, that's the one that's enrolled in Medicare. We don't need the org NPI. We just need your clinician NPIs as well as your organizational TIN. Alright, just give me one moment.

>>Elizabeth Seeley, CMS: Oh, sorry apologies, I was talking on mute.

There's a question here about: When might applicants expect to see some of the metrics, such as historical primary care and average HCC score to help you determine whether this is financially viable? After you apply, if you are accepted into the model, when you receive news of being accepted into the model, we will give you projections that are preliminary projections of what your attributed beneficiary count would be. And that will also include what the attributed beneficiary count would be across the different risk tiers. This would help you be able to calculate your ESP payments so that you can determine what amount of financial support you may receive to help support the care delivery requirements. I should note, though, that the actual ESP PBPM amounts will be based on the updated attribution calculations which are run closer to the start of the model for the actual payments. But we, we will provide you with some preliminary attribution numbers to help you calculate. You can also go to your own records to try to understand what share of your beneficiaries are enrolled in the Medicare Part D Low Income Subsidy, as an example, which has higher associated ESP, yeah, ESP PBPM rates.

>>Lauren McDevitt, CMS: Thank you Liz. Questions are starting to slow down a little bit. So, I’ll just note that we may end up closing a little early. Let’s see, maybe take a couple more.

If we are operating in a non-REACH ACO or operating under this ACO’s TIN, can we rejoin MCP under our own TIN? So we will be, just so you know, we'll be checking, kind of how, whether you've participated in an ACO in the past when we're determining your eligibility for Track 1. Yes, you can definitely apply if you were part of a non-REACH ACO.

And just want to mention again, that we'll provide information on the preliminary attribution, including, so kind of the number of beneficiaries that fall into, kind of, each ESP risk tier, if you're familiar with that table in the RFA.

Yeah, so just to clarify. I'm sorry that, I feel like we've answered this, but maybe not. It's just a question about: What happens for, kind of, specialists that are billing Part B that are not included on the MCP Clinician List? And just to really clearly say that the QPP Program still applies if you've not, if you're not a primary care clinician that is listed on the MCP Clinician List. And so you have additional questions, please reach out to the QPP team who are the experts on that. But you wouldn't be exempt from, the only folks who will be considered AAPM participants will be those that are participating in the primary care portion of the model.

Alright, before we close things out, I think I'll just see if anyone else on the MCP team wants to jump in and add anything before we start to wrap up.

>>Sonja Madera, CMS: Hi, Lauren, I see a question about adding additional states during the model. At this time, we have no plans to add any additional states beyond the eight that we have already announced.

>>Lauren McDevitt, CMS: Thank you, Sonja. Alright, well, we want to say thank you so much for all of these questions.

I think just want to emphasize to just, don't hesitate to reach out to us directly. At the MCP CMS email address that we've been kind of putting in the chat. And also, please do submit an application, or begin an application. If you're having, if you have any questions, we can definitely continue to support you and help answer your questions, not just today. Alright, well, thank you. I'll turn it back over to the SEA team.

>> TJ Smith, SEA: Thanks, Lauren. So just to wrap up, we'll have a few closing remarks and a few additional resources to support you all. We will also ask that you take a few minutes to provide feedback on today's session through our short post event survey. That link will be in the chat, as well as pop up when you close your window.

On this slide, just to stay informed about upcoming MCP events and for more detail, detailed information, please do visit the MCP website. While there, you can sign up for our listserv to continue receiving MCP updates on future events, resources, and news. And you may also continue to email our help desk with questions, as Lauren mentioned. Lastly, you could follow us on Twitter to learn the latest going on at the CMS Innovation Center. Let's go to the next slide.

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

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