Making Care Primary (MCP) Payer Office Hours Webinar
8/8/2023

>> TJ Smith, SEA: Hi everyone and thank you for joining today's Making Care Primary Payer Office Hour. We have an exciting presentation for you all today, but first we'd like to start with some housekeeping items. Next slide, please.

To listen to today's presentation, it is recommended that you listen via your computer speakers. If this does not work, there's also a dial-in option for viewers to listen through their phone. Closed captioning is available on the bottom of the screen. During today's presentation, all participants will be in listen-only mode, but 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. We'll also be focusing on answering payer-related questions today throughout the event. Today's presentation is being recorded. If you have any objections, do please hang up at this time. This slide deck, a recording of today's presentation, and a transcript will be made available on the MCP website in the coming days. Finally, we will share a survey at the end of today's presentation, and we ask that you please take five minutes to let us know how we did and share any questions you may have. We have more events coming and would love to know what you all thought as we continue to plan for the events. Next slide, please.

I'd now like to introduce our CMS Innovation Center speakers for today. We have Nicholas Minter, Megan Loucks, Sonja Madera, and Roger Adams. Next slide, please.

We do have a packed agenda today. We will begin by discussing payer partnership within the Making Care Primary Model as well as key features of the model's design. We will then discuss next steps for payer partnership before taking your questions. Lastly, we'll wrap up with a few closing remarks and available resources. And with that, I will now turn it over to Nicholas Minter to begin today's presentation. Next slide, please.

>> Nicholas Minter, CMS: Good afternoon. I'm Nicholas Minter, the Director of the Division of Advanced Primary Care at the CMS Innovation Center. And it's a pleasure to talk to you today about payer partnership and Making Care Primary and to make sure that we have time to answer your questions about how other payers can support the vision for more fulsome, comprehensive, advanced primary care with accountability for patient outcomes through this model. Next slide, please. Thank you so much.

So first off, accordingly, you know, this is a payer office hour and so we're going to focus quite a bit today on sort of payer partnership, how other payers can partner with CMS and us with them in order to help fulfill the vision that you see here. To have primary care that is able to provide more comprehensive sets of services and care delivery capabilities to improve patient outcomes. To provide a pathway by providing more financial, learning, data, resources to primary care practices so that those that simply have been facing a historic barrier to entry, to move to value based payment and away from fee-for-service, have a pathway that was previously closed to them. And, you know, our goal and we think that all payer goals at the end of the day is to improve the outcome, the outcomes, both in terms of quality and, you know, health in general of the patients that we serve.

So, we're not going to talk as much about the parameters of Making Care Primary, but just to give a quick overview. You know, CMS is committed to paying differently for, through fee-for-service to our primary care organizations that voluntarily join the Making Care Primary Model. It's a ten-and-a-half-year primary care model which aims to provide a new pathway for primary care organizations to get additional financial resources, to have additional technical assistance and learning resources at the ready. And also, to provide data where Medicare fee-for-service service was previously unable, in order to equip practices to move away from fee-for-service and treating what comes up and more to a population health value-based payment approach to care. Next slide, please.

One of the things that I think is really important to note is that this isn't CMS's first model. We have a lot of experience in driving change in primary care practices. And in fact, one of the things that we have learned time and time again is that we can't change the way that primary care practices provide care to their patients alone. We are a big payer, however, driving practices to change requires reaching a tipping point where there is enough alignment in movement to value-based payment that practices, it just makes sense for them to, you know, to change the way that they provide care, to start thinking about prospective payment, a population health approach. And because of that, you know, we are very interested in the eight regions that we'll look at in just a moment to partner with payers that are also committed to the view of a more fulsome, comprehensive, and advanced primary care approach to help realize the goals of the Making Care Primary Model.

And so, what we're going to talk about in the first few slides, is what that partnership really means. And for us, we want to directionally align, as you see here in the first box, with other payers to achieve these goals for participants, you know, primary care organizations that are in the Making Care Primary Model. And what directional alignment means is that we want to make sure that we're all walking in the same direction, that we are thematically consistent, even if on the details of how we implement certain changes in our model. We are, we differ because we of course, you know, different payers care for different populations and have different priorities. And we think that that's really important to maintain. So, we want to maintain that flexibility while removing barriers to participation for primary care organizations. And so, for us, that means aligning on certain areas of the model such as movement away from fee-for-service for primary care, for primary care payment, for primary care services. Making sure that we are providing, where feasible, one definition of performance success and rewarding primary care organizations for achieving that success. We want to make sure that we are providing data across all payers to our primary care organizations, as well as over time, striving and working to providing one set of data that is consistently formatted and available across an entire patient population, regardless of payer.

And finally, to make sure that we are coordinating and building upon the learning infrastructure in the regions already so that we are aligned in how we support primary care organizations to achieve the goals that we know are possible. And those goals are really, you know, I've talked a little bit about them, but are really summarized in the National Academy's report on implementing high quality care issued in in 2021. We think that that reality of primary care that's at the center of the health care experience is both achievable and, quite frankly, very realistic if we as a payer community and payer partners along with CMS are committed to supporting primary care to do more, to provide help for the whole person so to speak. So, we've begun that process by engaging Medicaid in the eight regions in which we are testing this model. We have been talking to state Medicaid agencies and will continue to work close to them so that payer partners know that there is a firm base of support for movement away from fee-for-service and to patient accountability, or I should say provider accountability, for patient outcomes.

And finally, as we talk about alignment, we really do want to be a partner at a table with other payers in a region to make sure that we're not coming in to reinvent the wheel. We know many payers in the regions in which we are going to be testing this model have made great strides toward transforming primary care already. We want to contribute to those efforts. And we want to make sure that Making Care Primary, as a model, reflects the region of which it's being implemented. And what that means is on areas such as the data that we provide, in the format of that data, it will differ from region to region. The infrastructure that's there, again, we want to build on top of that. So, we want to provide flexibility for payers and for regions to tailor Making Care Primary in so much as is feasible to reflect their region. While there's a core set of features that will span all of the different states in which we're testing the model, we think it's important to remember that care is local and Making Care Primary may look a little bit different, appropriately so, in each region to reflect payer, provider, and patient needs. Next slide.

So, what you see on this slide on the right-hand side is a map that shows the eight states in which we are testing Making Care Primary. And on the left side of the slide, what you see is the answer to a very simple question that we've been asked quite a few times, which is what payers can partner with CMS? You know, our fundamental philosophy is that we want to make it easier for primary care organizations to make the practice transformational changes in order to move to value-based care. And in order to do that, we need to bring payers that are caring for significant portions of a practice's patient population into alignment with our vision for advanced primary care. And our collective vision at the regional level. And so along those lines, we're interested in working with commercial health insurers, state-based health insurers, including Medicaid, managed care organizations both in Medicare and Medicaid for that matter. Really, purchasers in any sort of organization that is committed to this vision of more fulsome, advanced primary care and caring for patients at the whole-person level in an accountable way. We're interested in having conversations about how we can align on certain priority areas to reduce barriers of entry for primary care organizations that are committed to improving the health of their patients. Next slide.

So, what does that mean? What is directional alignment? What does it mean to walk in the same direction? Even if we're all moving at a different pace or, you know, sort of walking in a different way, to speak. Well, this slide provides a few examples of what we mean by aligning on areas that are priority while still retaining flexibility for payers to implement the model in the way, or an aligned model in a way that makes sense to them. So, I'm not going to go through each and every section here, but a good example is the aligned payment approach. We think it's critical that partnering payers implement a non-fee-for-service payment for primary care that ideally is prospective. And to get there over time, you know, some practices will need time to make that adjustment from volume to, you know, to population health, and so we want to make sure there's time there, but we think that movement is imperative to success of the model. So, what we would be looking for in terms of alignment from partnering payers is that that movement away from fee-for-service. However, the methodology, the rate of payment or the actual payment rates themselves, are not areas where we are seeking strict alignment in terms, with what CMS is planning to implement. We understand that resources, needs, and expertise across payers in a given region differ and would expect you know, the exact amount paid and how it is paid in non-fee-for-service way to differ accordingly. We want to acknowledge that, you know, in all of the other areas that you see, we also expect there to be variants across regions and in some respects payers as well, be that learning and technical assistance, the way that health equity is analyzed within payers, even though we know that it's incredible to have, it's incredibly important to have a health equity strategy. We also know that different populations, the

Medicaid population has different levels of concern to stratification than the Medicare population. We certainly want to make sure that payers have the flexibility to focus on what matters most to them. Again, quality measurement is another key example, I think. We think it's really important where outcomes align, to make sure we're measuring those outcomes in an aligned way. However, we want to make sure payers have the ability to add additional measures, or to set benchmarks that are different from the benchmark that CMS is rewarding payers, or rewarding participants, forgive me, for hitting. Populations differ, so do the starting point of different populations and, again, we think it's important to build that in to our idea and concept of partnership. Next slide.

So that alignment level, while you know, granting significant latitude and flexibility to prospective payer partners, it will still take time to achieve. And we understand that. We are proposing, as an example, to implement payment changes in the model in July of 2024. We won't start measuring quality until 2025 and we've been working on this model for some time. Accordingly, and correspondingly, we expect that payers will take some time to align on even the prior, just the priority levels, I should say that I've mentioned so far in this presentation. So, the important takeaway here is we are focused today, and in the coming months, on aligning on the goals of primary care in the regions that we're testing in with partnering payers.

We are really focused over time, on making sure that we are developing aligned model features with payers that are partnering with us to make sure, again, that we're removing payer fragmentation as an obstacle from primary care organizations that want to join and, you know, and realize the resources that this model can offer to them. And then over time, over the course of the 10-year model, we expect the alignment will deepen and will also change to confront different environmental risks or concerns that arise and need to be addressed by a collaborative of payers that we hope to form in each of the regions in which we are testing the model.

So, the takeaway here is, we're not expecting all payers to come in with perfect alignment on the areas that I've mentioned. We plan on providing more information in the near future on what level of alignment we're seeking and what the priorities are. So more to come on that. But I also just want to acknowledge that, if you're interested in the goals and that we are going to talk about today and have started to talk about already, then let's have that conversation in the near future and the timeline should not be a deterrent to that because we expect and will provide allowance for payers to take time to develop alignment. Because we understand that change doesn't happen overnight, especially meaningful change. And with that, let's go to the next slide. I'll hand it over to my colleague, Megan Loucks, now who will walk through some of the specific MCP Model features. Take it away.

>> Megan Loucks, CMS: Thanks, Nick. We can go to the next slide. So, this is a visual summary of the strategies we are using in our MCP Model to achieve this aim. This is an essentially a driver diagram and I'm not going to go through every piece. But I want to highlight a few things for you today. When we are talking about payer partnership and having a shared vision, we do think it's important to walk through the model elements so we can illuminate for you, our approach to achieving that vision.

So, in this upper left-hand corner, this represents our definition of high-quality care and our care delivery requirements mirror that goal. So, we are aiming for a model that supports the interprofessional care team. So, through the payment mechanism, through our care delivery requirements, we are supporting practices, that use a multitude of professionals to support patient care, not just billable clinicians. Our care delivery requirements focus on care management, coordination, and we're talking about coordination internally as well as externally. And something to

flag here is our specialty care integration. We are supporting that through our payment mechanisms as well as our care delivery expectations. When we say integration, we also mean behavioral health integration and that is a key part of our care delivery domains. We want to be clear that we are allowing for capabilities to be built over time. So, we wanted this model to be inclusive to allow primary care organizations that have not had opportunities to enter into value-based payment models. We wanted them to have that opportunity in this model. And so, we have three distinct tracks that build up capabilities over time. So, there are increasingly high expectations in terms of care delivery sophistication, and in accordance to that we have increasing accountability in terms of the payment structure.

And if you look in the lower left-hand corner here, this is a summary of our payment approach. So, this is about flexible, enhanced prospective payments with increasing accountability over the course of the three tracks. We have further information on how this payment structure compares to previous models and I will note that in a matter of a week or so, we will be releasing the Request for Applications for potential primary care organizations to review and this goes into a lot of detail on that payment approach.

Regarding health equity, this is flagged so prominently here to reflect how it is integrated throughout the model. Throughout the payment structure, the care delivery requirements, the learning and diffusion strategy, and the basic participation eligibility criteria. FQHCs and Indian Health Programs are eligible to join this model. We have enhanced service payments to practices to account for increasing resources that are needed to care for patients that have a high clinical and social risk. We are integrating health related social needs into care by supporting practices and conducting universal screenings for health-related social needs. And accordingly, working with internal and external resources to address those health-related needs.

And lastly, partnerships. This is one of the reasons we are having this Payer Office Hour is because partnerships is critical to the success of this model. That's partnerships with payers, partnerships with state-based agencies, and other stakeholders. And we are building our learning system based on these conversations with stakeholders about what is existing in these states and regions, and how we can complement that with our approach.

Next slide. Next slide, excuse me. Again, MCP is available in eight states, so that means that primary care organizations within these states are eligible to apply to become participants in the model.

Next slide. Who is eligible to participate? Nick reviewed who is eligible to partner as a payer. In terms of which primary care organizations are eligible to participate, we wanted to make this model inclusive. So, you will see a long list of organizations eligible for MCP. Due to the payment and quality reporting design, certain organizations are not eligible to participate MCP and we have more information in the RFA on those exceptions. Next slide.

Regarding care delivery requirements, I don't want to go through, every detail here, but I just want to highlight a few things. We organized our care delivery requirements along three domains: care management, care integration, and community connections. We also have these three tracks, and you'll see that as you proceed from one track to the second track to the third, there are increasingly high expectations in terms of the sophistication of these care delivery capabilities. For care management, this is focused on targeted care management of chronic conditions. So, it begins within empanelment and risk stratification, and then proceeds from there. For care integration, this is

integration with a highlight of behavioral health integration and specialty care integration. We support this further via payment mechanisms, additional resources for primary care providers and their specialty care partners to accommodate for the time and resources devoted to coordinating care. And lastly, community connections. This, again, circles back to our focus on health equity and reducing disparities in care and outcomes. We want to support practices in conducting health-related social needs screenings and give them resources and support for connecting to social service providers and internal resources to address those needs. Next slide.

This is a summary of the payment types that are introduced in this model. And again, we're speaking to our Medicare for this model, Medicare fee-for-service. There are six payment types. I'll start with the top. So, we have a prospective primary care payment. This is a per-beneficiary-per-month payment that's paid out quarterly. It's based on historical billing, and this is tied with fee-for-service payment. And so, there's progression from fee-for-service payment to increasingly prospective primary care payments over the course of the three tracks. We also have enhanced services payment and this is provided for participants in all tracks, and this is a per-beneficiary-per-month payment as well. But this one is adjusted to reflect the attributed population's level of clinical and social risk. So, this provides additional resources to account for the additional time that organizations need to devote to provide high quality care to patients with complex needs. And lastly, our performance incentive payment. This is an upside-only payment that rewards participants based on improvements in patient outcomes and quality. And we have an MCP performance measure set that is included in the next slide. And at bottom, I'll mention that the upfront infrastructure payment is a one-time payment for certain track one participants to give additional resources to those organizations that have fewer resources to invest in the care delivery capabilities that are needed to engage in this model. And the MCP e-consult code, and the ambulatory co-management payments are supporting the specialty integration strategy I mentioned. Next slide, please.

This is a visual of how these payments interact. And this is an illustration. You will see as one progresses from track one to track three, there is increasing movement from fee-for-service prospective payment. In addition, the potential for that bonus, that performance incentive payment that's tied to outcomes, that potential greatly increases over the course of the three tracks. So, this reflects the increasingly accountable mechanisms as one goes through track one to track two to track three. Next slide.

And closing out this overview of the model elements. This is the selected performance measure set. We wanted it to be actionable, clinically meaningful, and aligned with other CMS quality programs including the Universal Foundation Measure Set. And this mirrors the model's care transformation goals and is again tied to the performance incentive payment to motivate and incentivize performance. You will also see that the quality measures change slightly from track one to track two and track three. Okay, I will pass it on to my colleague, to go over the next section.

>> Sonja Madera, CMS: Thank you so much, Megan. Good afternoon and good morning everyone. My name is Sonja Madera. I am a member of the Payer Engagement Team who is based in Colorado. And it's a pleasure to be here with you today. Next slide, please.

We wanted to highlight some of the benefits of payer participation with Medicare fee-for-service around this model. So, the first is, we recognize that many payers have been operating in the value-based care space for quite a while. So, we know with those existing efforts going on, we want to bring our Medicare fee-for-service resources to join the work that you're already doing. We hope that by

doing this, we can really accelerate the change, the transformation that practices need in order to achieve these goals of improved outcomes for our beneficiaries. And, ideally, over the course of the model of reduce costs. We've learned from past models that one of the biggest hindrances to practice transformation is the fragmentation that currently exists. So as payers, when we have incentives for great programs that are pulling providers in different directions, that can reduce their ability to really complete, or to achieve the goals that we've set out here. So, we want to work towards alignment to work together there. One thing that we're looking forward to doing is convening with other payers around a shared payer table to talk about the data that we're seeing, what are the lessons learned, what are the strategies that we can implement to support these practices in their transformation, and over time, we do want to work towards aggregating data across payers. We recognize that this is another area where we could achieve greater efficiency for these practices. If they're looking at data that's formatted in a similar way across their different patients, that they don't have to use different insights to try to interpret, to understand how to use that. We want to work together to provide them comprehensive data that's actionable. And again, this is a long-term goal over the life of the model. And finally, we really want to illustrate our commitment to these primary care practices and recognize their role in our health system. Next slide, please.

As far as our timeline, here you can see where we are and looking towards the future, the concurrent timelines that we have for recruiting practice participants as well as developing our partnership with payers. So, this month, as Megan mentioned, we are going to release our Request for Applications for the practice participants that will have a lot more detail about what we are asking of them. How the payments will work, how the measurement will work, lots and lots of detail. Later this fall, we are going to ask potential payer partners to share their Aligned Payer Plans with us, so that we can get a better sense of what payers are already doing, what they propose to do, their timelines of how we can work together, and we would love to have conversations with you one-on-one through the course of the winter about how we can work towards that alignment. Then finally, we do have here in February, our goal is to really start the convening, or perhaps the convening is already happening, and Medicare fee-for-service will be able to join the convening that's already going on. We anticipate around that timeline too, that we would be announcing the participants accepted into MCP. We expect that they're going to be very interested to see which payers in their region are participating with Medicare fee-for-service on the Making Care Primary Model. We know that that may sway some of them as far as whether they want to join the model or not as they're making those final decisions. And we are hoping, we don't have a specific timeline point on this timeline, but we are hoping to sign our non-binding MOUs with payers also in 2024. Next slide, please.

So, our next steps. The first thing that we would ask potential payer partners to do, is to start thinking about the activities that you have going on already, how your plans could put potentially align with MCP goals and some of the design features. Nick mentioned earlier what our priorities for alignment are. He highlighted, I think, four to five areas on an earlier slide. Certainly, we have some flexibility in these areas, but our top four would be, payments moving away from fee-for-service, performance measurement. We know that this is a pain point for practices when all the payers are measuring different things. Thinking about that long-term data aggregation as I mentioned, and then thinking about how we'll collaborate together as payers around learning supports for practices, and learning from each other. If you have questions, there is an email address here. Please feel free to reach out. And again, the Payer Engagement Team would love to be able to meet with you individually if you'd like, with your state Medicaid agency, to talk more about what some of these aligned plans could look like. Then, in October, we will ask payers to kind of give us an idea of what their aligned plans could look like so that we can continue those conversations. You may have seen or heard us talk about the

Payer Partner Solicitation. That's what we're talking about there, learning more about what you're doing. Then, we would work towards signing that non-binding memorandum of understanding in 2024, and that would outline the commitments of both parties to each other and to the participants. Next slide, please.

With that, I would like to turn it over to my colleague, Roger Adams. Thank you so much.

>> Roger Adams, CMS: Thank you, Sonja, and thank you to everyone joining today. Now it's time for our Q&A session. As mentioned at the top of the webinar, we really would like to focus our questions, receive questions focused on payer alignment as we do not have a team assembled today to address some specific questions that may come up around care delivery and some of the other factors of the model. So, at this time, if you would chat additional questions that have not already been submitted into the chat box, we will read those and get those answered for you at this time.

So, we do have one question in the box that says "LOI says it's now volunteered, what does that mean?" That simply means that you do not have to submit one if you choose not to. However, we would like you to do so.

So, we do have some additional questions that did come in and wanted to just maybe address one or two of those. It says, "Will a practice be able to join MCP after the initial application deadline of November the 23rd? In other words, will there be future options for entry points in the MCP Model after the initial go-live date?" So, I'll defer to our esteemed panelists that you heard speak today to address one or two of those questions. So, I'll volunteer Nick Minter.

>> Nicholas Minter, CMS: Yeah, Roger, can you do me a favor? I apologize. I was having a technical difficulty. Can you restate the question, sir?

>> Roger Adams, CMS: Sure, the question says, "Will the practice be able to join MCP after the initial application deadline of November the 23rd. In other words, will there be future options for entry point in the MCP model after the initial go live date of July 2023?" I believe that might.

>> Nicholas Minter, CMS: Yeah, thank you so much. So great question. And, you know, currently we plan to offer one enrollment period for primary care organizations to indicate their desire to participate in Making Care Primary. That enrollment period will begin in August and will continue until applications close at the end of November. And we believe that's a sufficient amount of time to allow primary care organizations to assess, to work with folks in their community, as well as their internal organizations, to review the Request for Applications and make an informed decision, and we would encourage you, if you have questions, at the organizational level, about participation in CMS's version of MCP, to please email our help desk. We will be turning around questions with answers in rapid format. I also want to use this opportunity to note that we think it's really important for potential payer partners to indicate their enthusiasm and to signal their support for Making Care Primary and partnering with CMS and having CMS partner with them, early on in the application process because we know primary care organizations will ask, and have asked in prior opportunities, whether or not other payers will be supporting CMS model initiatives as well. And so, we want to make sure that we can give an accurate assessment of payer enthusiasm for an expanded, more effective vision for primary care in the future. Before they have to, before primary care organizations make a decision whether or not to participate in the model in late 2023 and going on into early 2024. So, went on a little bit more than the question demanded, but hopefully that was helpful. Thank you.

>> Roger Adams, CMS: Thank you so much, Nick. We have several other questions that are currently being answered, so we will allow those answers to come through. If there are additional questions at this time that you would like to respond to that you do not see in the Q&A, please do so.

So, this is a question that comes in that says, "How can CMMI assist practices to understand the financial modeling for their specific practice? Is there data available to estimate the prospective payment amount? Is there data available to estimate the enhanced payment?" And so, I will defer again to one of the panelists to respond to that question. Don't everybody jump in at once.

>> Nicholas Minter, CMS: I will, I'll start off the answer to this. It's a great question. And again, I think this is sort of a provider-, primary care organization-focused question. So, you know, if you're going to apply to the model, how much would you get paid? That requires a sort of an initial sense, a preliminary understanding of how many patients would be attributed to you and generally what their risk you know, HCC status, etcetera, is so because that also affects some of the additional payments that are referenced in the question. And after an application is submitted to CMS, we will do an initial eligibility clearance on it and over the course, you know, after November when the applications close we will assess eligibility to determine if an applicant meets all of the requirements to be in MCP. And one of those requirements is, do they have a 125 minimum beneficiaries. During that point in time we will also gather the actual attribution for that practice as of the period when we run it, which will be different than when the model starts, but we will provide that data to the practice so that they have an idea of how many patients they would be receiving prospective payment for, as well as additional payments for, either at the beginning of the model or in future tracks. So, in terms of other tools, I will note up front the CMS does not plan to issue a modeling tool. However, after the RFA is released and I can, you know, can only speak to what has happened in past models, it is possible that other organizations will provide assistance to practices interested in enrolling in models and if you have, you know, a need for such tools, would encourage you to reach out to, you know, your associations or other practice primary care resources in your area to let them know that that would be helpful. Thank you.

>> Roger Adams, CMS: Thank you so much, Nick, for that answer. So, we have a few other questions that came in. One question is "How would you like to see states encourage commercial payers to engage? How would you like to see states encourage providers to apply?" So, at this time, I'll also defer this question to the panel. I don't know Lauren, if you're on if you'd like to respond to that.

>> Lauren, McDevitt, CMS: Actually, I would love to defer that one. Thank you. Would love to defer that one to, Megan or Sonya.

>> Roger Adams, CMS: Oh, okay. Megan or Sonja?

>> Megan Loucks, CMS: Oh, sure, I can start. So, we are, we have a team here, as you can see, that are already reaching out to state Medicaid agencies payers, directly in each of these states to have these conversations about potential partnership. For those of you on the line who have not yet heard from us, we encourage you to reach out to us directly. We've been having those conversations for, for several months now and we'll continue to have these conversations one-on-one, and in group settings. We are having state-focused meetings of payers, to dive into some of these regional considerations that we've spoken of. And in terms of how would we like to see states encourage providers to apply, we do appreciate any effort to get the word out. We want this application to be seen by as many

providers as possible. Our role is to convey, the model eligibility criteria and components accurately, so if anyone on the line has questions as you, as you have shown us in the chat, please continue to send them our way. We don't want the lack of information or confusion over the criteria to be a barrier to providers applying.

>> Roger Adams, CMS: Thank you so much, Megan.

>> Sonja Madera, CMS: Thank you. And if I can, if I can add and we have a related question here, "Will this model be expanded for participation in additional states?" At this time, we are not planning to expand beyond the eight states and regions that we currently have. So, just want to add to what Megan is saying, where we are encouraging payers and practices to participate is limited at present to those eight regions.

>> Roger Adams, CMS: Thank you, Sonja. So, another question that comes in is "Do you have a list of national payers that are currently involved and expressing interest? I'm looking not to duplicate efforts." We are currently collecting letters of intent from payers that may be interested however we have not made that publicly available.

So, another question that comes across is "What have you learned from other CMS demos that included multi-payer alignment that informs that a payer's decision to participate in the model?" And so, I'll hand this one over to the panel to discuss. Nick, Lauren, or Sonja?

>> Nicholas Minter, CMS: I'm happy to jump in here and it's, it's a great question. You know, I think we have tested over the course of the last ten, eleven years several primary care transformation efforts and also have multi-payer components of other models that aren't specifically restricted to primary care to draw from. And I think what we have found is that it is important to be concrete about where we want to see alignment and to make sure that we are promoting, like what I would, what I would call meaningful alignment, which is to say that we actually have to define clearly for payers what an end state looks like, that is aligned. Because what we have heard in prior models, speaking candidly, is that you know, it's we have to do more than say that we're aligned with other payers. When providers feel like they're not receiving payment the same way, when they feel like quality measures are scattered and not aligned, it becomes an impediment that sort of payer fragmentation can prevent them from being able to move in the direction that CMS or any one payer is asking them to move.

So, based on that, we've also heard, you know, we have made changes to say here are the five areas which we've discussed as part of this call, you know, we'll present more information on in the near future about where we want to see alignment. Again, moving away from fee-for-service payment. On measuring quality where outcomes are similar, making sure we're using the same specifications. To make sure that we're providing data in similar ways as other payers to make it easier to use at the provider-level, and to make sure that our learning systems are encouraging payers to improve in ways that are aligned. We think that's really important. Otherwise, again, payers aren't able to focus on the changes we want them to make.

The other change I think that we have made based on lessons learned, is that we can't be too prescriptive of the changes we want payers to make. You know, there's definitely a Goldilocks effect here. If we tell payers to mimic what CMS does, then that eliminates a lot of the tailoring and the customization that patients find to be helpful. And it also removes all latitude for payers to add, you know, their expertise to the way that they provide care. So, all that is to say, we are hoping to provide

ample flexibility to our payer partners as well as be very clear on the alignment that we want to see so that we remove barriers to participation from primary care organizations. Which will help all payers achieve the differences and the positive health outcomes we know, and research has shown, is possible from an effective transformation to value-based care and payment over time. Thank you.

>> Roger Adams, CMS: Thank you so much, Nick. We have another question. It says "Are state Medicaid payers who do participate required to follow the same go-live timeline?" And I'll defer that to Sonja.

>> Sonja Madera, CMS: Thank you so much. Great question. We recognize that any payer partner might need additional time to implement beyond what Medicare fee-for-service is doing with our anticipated start date of July 2024. So, we do have some flexibility there. We know that Medicaid in particular has some additional constraints, I would say, as far as potentially implementing new programs and so, certainly we can be flexible with Medicaid state agencies on the timelines that they need. Appreciate the question.

>> Roger Adams, CMS: Thank you, Sonja. One additional question. "I'm trying to understand which population can apply to. Regarding potential partners, you listed state employee programs. Would that be only for state Medicaid retirees and also for active employees?" I'll pass this one to Nick.

>> Nicholas Minter, CMS: Yeah, thank you very much. And I know this I think you know, refers back to a slide where we talked about the eligible payer partners. You know, we are, and I'm speaking on behalf of CMS and the Medicare fee-for-service program, are looking to partner with any payers that are looking to realize the goals of primary care and the National Academy's report on providing high quality primary care. And, you know, reaching the goals that we've articulated as part of this presentation and will also be further expanded upon in the Request for Applications due out soon. So obviously for state Medicare retirees, either in that if they're in Medicare Advantage plans, we're interested in working with, the payer that provides coverage for them. If they're a Medicare fee-for-service, then we will be, if they're providers, enroll in this model, making those changes directly and supporting them that way and if they are active employees covered by the state then we are interested in currently, in some cases talking to states about making sure that the payment reforms and the additional support that we want to provide primary care, can also be mirrored in those programs. But to be clear, like those are conversations that we are having with those payers and are certainly open to having with other payers that we haven't had a chance to talk to yet. This is just to say, we're not thinking just commercial. We're not thinking just Medicare Advantage. If there is a payer or a purchaser that wants to contribute to achieving the vision for primary care, then please reach out to us. We're here for that conversation.

>> Roger Adams, CMS: Thank you so much, Nick. So also, just remember if there are questions that you may think of later that you or may not have been answered at this time, please also remember that you can submit questions to our help desk at MCP@cms.hhs.gov. Alrighty, seeing no more questions in the chat, this concludes our Q&A session. And I believe we have some additional information about resources for you at this time. Next slide, please.

>> TJ Smith, SEA: Thank you, Roger. To wrap up, we'll go over a couple of additional resources as Roger just mentioned, but first please be sure to take a few minutes to provide feedback on today's session at the survey link that will be posted in the chat. And then with that we can go to the next slide please.

So again, to stay informed about upcoming MCP events and for more detailed information, you can visit the MCP Model website listed here on the screen where you can also sign up for our listserv. And as Roger mentioned, you can also continue to send questions via email to our help desk or access the FAQs on the model website. You can also follow us on Twitter to stay informed of the latest at the CMS Innovation Center. Next slide, please.

And thank you again for joining today. This does conclude today's MCP Payer Office Hour. We hope you have a good rest of your day. Take care.