Making Care Primary (MCP)
Guide to Alignment for Payer Partners

Background

Primary care forms the foundation of a high-performing health care system. High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.[1] At a time when patients need high-quality primary care to meet their rising needs through fragmented expensive systems, primary care faces increasing challenges to its core functions.

Through **Making Care Primary (MCP)**, CMS aims to provide primary care organizations with enhanced financial, learning, data, and care delivery capabilities while moving payment away from fee-for-service (FFS) to payment for high-quality outcomes. Although CMS is implementing MCP with respect to services furnished to beneficiaries who are enrolled in Traditional Medicare (FFS), other payers are encouraged to partner with CMS to achieve this vision of improved primary care across all patients, including those covered by Medicaid, commercial, and other payers.

Fostering Multi-Payer Alignment

Multi-payer alignment will be critical to achieving success for MCP because primary care organizations transform care most efficiently and effectively when all payers and lines of business are aligned. CMS is seeking to partner with payers to *directionally align* on key design features of payment models such as quality measurement, data, and learning tools. This shared framework of "directional alignment":

- reduces payer fragmentation;
- signals collective movement away from fee-for-service toward population-based payments for primary care; and
- maintains the flexibility needed for CMS, states, and payers to develop payment programs designed with the unique considerations of their providers and beneficiaries in mind.

This document provides an overview of design features for MCP and examples of how payers can design or adapt alternative payment models as MCP Payer Partners. This guide should be viewed as a starting point. MCP is a long-term initiative, and CMS understands that alignment progresses over time. As payers gain experience working together to achieve a shared vision for improving primary care, alignment is expected to evolve. MCP Payer Partners will realize deeper partnership and consensus on the technical specifications of payment approaches (e.g., attribution, benchmarking and risk-adjustment) through goal-oriented, data-driven convening.

Payers interested in partnering with CMS can learn more on the MCP Model webpage and contact the MCP team directly at MCP@cms.hhs.gov.

[1] National Academies of Sciences, Engineering, and Medicine. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. McCauley L, Phillips RL, Mesinere M, Robinson SK, eds. The National Academies Press; 2021.

Priorities for Alignment

To facilitate practice transformation, it is critical that MCP Payer Partners achieve full alignment on a select number of design elements that directly impact provider burden, as described in Table 1. Full alignment does not mean that the payer must mimic CMS's program design, but the aligned program should closely reflect the methodology and goal of the design element to focus providers on the shared goals of improving primary care. For example, use of the same specifications for a quality measure is integral for reducing provider confusion and reporting burden.

Table 1: Core Priorities for Alignment

Design Element	MCP Policy	Standard for Full Alignment for Other Payers	Examples of Implementation for Other Payers
Primary Care Payment	Progressive shift for Medicare FFS with Track 1 using FFS, Track 2 using a hybrid payment and Track 3 using a full prospective population-based payment.	Plan to move to a 50-100% prospective, non-FFS payment structure in primary care.	-Prospective primary care payment based on attributed population. -Prospective benchmark payments based on past spending with reconciliation.
Quality Measures & Incentive	Use of a select set of quality and utilization performance measures to track patient outcomes and inform payment.	Payer uses MCP measure specifications for aligned measures. Payers may decide to include additional measures beyond MCP set or propose a different measure (i.e., patient experience).	-Payer includes all MCP measures, includes additional child-specific measures. -Private insurer includes all MCP measures, adds dementia-specific measures due to payer-specific focus on this special population.
Data Provision	A two-pronged data strategy to develop a Medicare data feedback tool, and participate in Health Information Exchange (HIE), including the provision of Medicare claims data.	Payer agrees to work with other payer partners to aggregate data from multiple payers into one dataset over the duration of the model.	-Data dashboard with advanced analytics software for Medicare claims data. -Actionable spreadsheet that lists quarterly patient and practice outcomes using all payer data and requires limited provider analysis.
Learning Systems & Conveners	Leverage trusted conveners' outcomes and care delivery data. Coach and share best practices with small, independent & safety net providers.	Payer works with convener to provide coaching and facilitation to support a population health approach for participating providers.	Payer participates in regional convening to establish learning priorities and determine supporting entities for each priority.

Design elements captured in Table 2 below are important to align on in principle, but payers can employ increased flexibility to reflect payer population needs. These examples are not prescriptive; MCP Payer Partners are encouraged to deploy their own payment model that reflect the principles of MCP, and to adapt design elements to include differences necessary for the payer's beneficiaries.

Table 2: Additional Design Elements for Alignment			
Design Element	**MCP Policy**	**Standard for Full Alignment for Other Payers**	**Examples of Implementation for Other Payers**
Primary Care Payment: Enhanced Services Payment	Per-member per-month (PBPM) payments in addition to base primary care payment to support care delivery activities. The payments are risk-adjusted for clinical and social risk. Payments decrease over time as performance opportunities increase.	Per patient payments adjusted for social and clinical risk.	Support for new care delivery capabilities using financial or in-kind support, such as per-member-per-month payments; and/or lump sum payment to support model-related practice changes.
Primary Care Payment: Upfront Infrastructure Payment	Upfront infrastructure payment for providers with little to no experience in value-based purchasing; support initial program investments, such as Health Infrastructure Technology (HIT).	Upfront payment aimed to support initial investments in some practices, such as those lacking HIT infrastructure	Support for new practice capabilities such as an annual bonus for participation; lump sum payments for initial 1-2 years; and/or practice coaching for new care delivery capabilities.
Quality Measures & Incentive	Upside bonuses for participants that achieve certain quality and utilization goals; the bonus potential increases across Tracks as average Enhanced Services Payments decrease.	Payer includes opportunities for participants to earn bonuses based on performance on MCP quality and utilization measures and, in some cases, additional payer-specified measures.	-Increases to future year population-based/ benchmark payments -flat bonus payments paid at end of year based on retrospective performance -prospective bonuses reconciled based on actual performance

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Design Element	**MCP Policy**	**Standard for Full Alignment for Other Payers**	**Examples of Implementation for Other Payers**
Care Delivery: Care Management	Participants must: -establish workflows for chronic care management; follow-ups for high-risk patients post-ED visit/hospitalization -Improve patient self-management support. -risk stratify and enroll patients based on clinical/social risk.	Payer contracts with participants to implement care delivery requirements, closely reflecting Medicare care management approach.	Payer contracts with practices to improve care management, with customization to reflect payer's patient population.
Care Delivery: Community Connections	Participants must: -Implement a health equity plan that describes how participants aim to reduce disparities. -Screen patients for health-related social needs (HRSNs) -Explore partnerships with social service providers to meet HRSNs. -Refer patients to community resources, including Community Health Workers (CHWs), or equivalent personnel.	Payer contracts with participants to implement care delivery requirements, closely reflecting Medicare community connection approach.	Payer places expectations on participants to utilize CHWs (or similar personnel), screen patients for social needs and provide referrals to social service providers.

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Design Element	**MCP Policy**	**Standard for Full Alignment for Other Payers**	**Examples of Implementation for Other Payers**
Care Delivery: Care Integration	Require participants to optimize Behavioral Health Integration (BHI), and integration with specialists.	Payer contracts with participants to implement care delivery requirements, closely reflecting Medicare care integration approach.	Payer places expectations on participants to integrate and enhance behavioral health and specialty care delivery processes in the way they see best to accomplish quality and utilization goals.
Specialty integration: Payments to Specialists	New payments to specialty clinicians for periods of short-term co-management (for patients with exacerbated conditions) with clinicians participating in MCP.	Payer provides financial incentives to specialists to encourage them to collaborate with PCPs.	Payer establishes standards for collaborative workflows between primary and specialty care, but does not provide direct financial incentive for specialists: -Establishment of new code to incentivize co-management of patients. -Reduction of billing requirements (given reduced severity of condition) for certain existing codes; and/or -Non-financial guidance on primary-specialty collaboration.

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Design Element	**MCP Policy**	**Standard for Full Alignment for Other Payers**	**Examples of Implementation for Other Payers**
Specialty integration: E-Consults	New code billable by primary care clinicians for support of e-Consult use and management.	Payer provides incentives to encourage and/or requires primary care participants to use e-consults.	-New primary care clinician code specifically for short-term e-consulting collaboration that includes time to implement specialist recommendations. -Support of CMS or other payer learning activities encouraging e-consults and provision of technical assistance to providers interested in adopting e-Consult workflows.