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 resources while moving payment away from fee-for-service (FFS) to payment for high-quality outcomes. Although CMS is implementing MCP in Traditional Medicare (FFS), CMS is seeking to partner with other payers to improve primary care across all patients, including those covered by Medicaid, commercial, and other payers. Payers eligible to partner with MCP include the full range of plan types, both commercial and federal entities. While CMS seeks the greatest alignment possible for the benefit of participating providers, payers may choose to offer their program to organizations not enrolled with Medicare FFS MCP (e.g., pediatric practices).

Fostering Multi-Payer Alignment

Multi-payer alignment will be critical to achieving success in MCP because primary care organizations transform care most effectively when all payers and lines of business are aligned. CMS is seeking to partner with payers to *directionally align* on key design features 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 guidance for payers interested in becoming MCP Payer Partners on how they can design or adapt alternative payment models that directionally align with MCP. 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. Through multi-payer convening that is goal-oriented and data-driven, MCP Payer Partners will realize deeper partnership and consensus on the technical specifications of payment approaches (e.g., attribution, benchmarking, and risk-adjustment).

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 achieve directional alignment, it is critical that MCP Payer Partners align on a select number of design elements that directly impact provider burden, as described in Table 1. Alignment does not mean that the payer must copy CMS's program design, but the payer should closely reflect the principles of each design element.

Table 1: Core Priorities for Alignment		
Design Element	**MCP Policy**	**Standard for Alignment for Payer Partners**
Primary Care Payment	MCP implements an alternative payment model for Medicare FFS using a 3-Track design that progressively shifts to prospective payment. Participants are required to progress to the next Track after a set period of time. Track 1 uses FFS, Track 2 uses a hybrid payment and Track 3 uses a full prospective population-based payment.	Plan to move to a 50-100% prospective, non-FFS payment structure in primary care. The payment methodology does not need to mirror the payment types used in MCP. Aligned payment models could include prospective primary care payment based on attributed population, prospective benchmark payments based on past spending with reconciliation, and other forms of value-based payment.

Table 1: Core Priorities for Alignment		
Design Element	**MCP Policy**	**Standard for Alignment for Payer Partners**
Quality Measures & Incentive	Use of a select set of quality and cost/utilization measures to track patient outcomes and inform payment. The MCP Performance Measure Set was crafted to consider the following principles: 1) Alignment with Selection Criteria for the Universal Foundation. 2) Alignment with care delivery requirements. 3) Minimization of Participant burden for reporting and considered feasibility of measure collection for all potential applicants.	Payer includes opportunities for Participants to earn payments based on performance on a set of quality measures to include clinical quality and cost/utilization. Payer may decide to include additional measures beyond MCP set to meet the needs of their beneficiaries (such as children). Payer uses the same MCP measure for the same care topic (e.g., Diabetes), with the following exceptions: 1) The alternate measure is different in specifications but aligned in terms of the definition of success. CMS can coordinate with each payer to address this on a measure-by-measure basis; and 2) CMS does not require MCP Payer Partners to use the same MCP measure for patient experience. Payer's quality measure strategy supports stratification of performance data to advance health equity. Over the course of the model, payers may make changes to their measure sets with a priority to align with MCP, the CMS Universal Foundation, and state-level multi-payer efforts to align quality measurement across payers.
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. An aligned plan would have a shared commitment to providing data essential to improving care, reducing costs and burden, and providing accurate payment.

Table 1: Core Priorities for Alignment		
Design Element	**MCP Policy**	**Standard for Alignment for Payer Partners**
Learning Systems & Conveners	A shared strategy with state and payer partners to support local implementation and participant success. This will include how to make available the learning supports needed for model success, such as technical assistance, peer-to-peer learning, and practice facilitation and coaching for small, independent, and safety net organizations.	Payer agrees to work with and contribute in-kind resources to a regional convener to facilitate alignment on shared priority payer topics, including in year one pooling existing resources and developing a plan for how to support model participant success that builds upon existing learning supports within the state.

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. The examples given are illustrative, and not exhaustive.

Table 2: Additional Design Elements for Alignment		
Design Element	**MCP Policy**	**Standard for Alignment for Payer Partners**
Primary Care Payment: Enhanced Services Payment	Per-member per-month (PBPM) payments adjusted for social and clinical risk are provided to Participants. The Enhanced Services Payment (ESP) is in addition to base primary care payment. ESPs can be used to support care management, patient navigation, integration with behavioral health, and other enhanced care coordination services, consistent with the specific needs of the MCP Participant's beneficiaries and the goals of MCP's care delivery model.	Payer supports new Participant capabilities to deliver high-quality primary care through financial support. Examples: -Per-beneficiary prospective payments. -Lump sum payment for specified changes to care delivery services.

Table 2: Additional Design Elements for Alignment		
Design Element	**MCP Policy**	**Standard for Alignment for Payer Partners**
Primary Care Payment: Upfront Infrastructure Payment	Upfront payment for Participants to support initial investments needed for achieving goals of care delivery model, such as Health Infrastructure Technology (HIT). MCP provides an Upfront Infrastructure Payment (UIP) for select Track 1 Participants for use on a range of initial program investments, including HIT.	Payer supports new Participant capabilities to support population health management and care delivery model goals via direct financial, or in-kind financial support. Examples: -Annual bonus for participation. -Lump sum payments for initial 1-2 years. -Practice coaching for new care delivery capabilities.
Care Delivery: Care Management	Participants are required to improve care management services, with expectations increasing from Track 1 through Track 3: Empanel and risk-stratify patients; Implement chronic and episodic care management; and Use chronic condition self-management support services.	Payer places expectations on contracted Participants to improve care management, with customization to reflect payer's patient population.
Care Delivery: Community Connections	Participants are required to identify and address health-related social needs (HRSNs) in their patient populations through the following services, with expectations increasing from Track 1 through Track 3: Implement a health equity plan that describes plans for reducing disparities for patients; Screen patients for HRSNs; and Address HRSNs through referral to social service providers and optimization of Community Health Workers (CHWs), or equivalent personnel.	Payer places expectations on contracted Participants to utilize CHWs (or similar personnel), screen patients for social needs and provide referrals to social service providers.

Table 2: Additional Design Elements for Alignment		
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Care Delivery: Care Integration	Participants are required to strengthen their connections with specialty care, and increase their capacity to manage behavioral health conditions through Behavioral Health Integration (BHI), with expectations increasing from Track 1 through Track 3.	Payer encourages contracted 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	MCP provides financial incentives to specialists to encourage collaboration with PCPs, including 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 and/or non-financial support to contracted Participants to encourage primary-specialty integration. Examples: -Payer establishes standards for collaborative workflows between primary and specialty care, but does not provide direct financial incentive for specialists. -Reduction of billing requirements (given reduced severity of condition) for certain existing codes. -Non-financial guidance on primary-specialty collaboration.
Specialty integration: E-Consults	New code billable by primary care clinicians for support of e-Consult use and management.	Payer provides financial and/or non-financial incentives with contracted Participants to encourage use of e-consults between primary and specialty care. Examples: -New payment code for primary care clinicians for short-term e-consulting collaboration that includes time to implement specialist recommendations. -Support of CMS learning activities encouraging e-consults and provision of technical assistance to providers interested in adopting e-Consult workflows.