CMMI's New Making Care Primary Model

Since the passage of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and implementation of the ensuing Medicare Quality Payment Program (QPP), several payment arrangements tied to physician performance have been implemented. Programs such as Comprehensive Primary Care Plus (CPC+), Primary Care First (PCF), and the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model are among the Centers for Medicare & Medicaid Services' (CMS) most well-known Alternative Payment Models (APMs).

A new voluntary primary care model, "Making Care Primary" (MCP), will launch in July 2024 in eight states (CO, NC, NJ, NM, NY, MA, MN, WA). These and other programs have positive elements such as prospective payments, practice transformation, and care coordination. However, ACP has also offered recommendations for improvement, some of which have been considerations in MCP's development.

CMS has released a Request for Applications (RFA) detailing model payment, care delivery, quality, and other policies for the MCP model. Interested applicants may apply to the model through the Application Portal which opens on September 4, 2023, and closes on November 30, 2023.

For a comparison of CPC+ and MCP, see the table at the bottom of the page. For ACP's statement on the model release, including how MCP incorporates some of the key elements the College proposed in the Medical Home Neighborhood model that was submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and approved by HHS, see here. For CMS's FAQs on the MCP model, see here.

MCP boasts an unprecedented extended model length of 10.5 years, which offers participants in the model extended time to become familiar with and adjust to model requirements; this timeframe also provides CMS with a greater opportunity to show overall program savings and model stability. Eligible participants include solo primary care practices, Indian Health Programs, Federally Qualified Health Clinics (FQHCs), group practices, health systems, and certain Critical Access Hospitals (CAHs). Ineligible participants include Rural Health Clinics (RHCs), concierge practices, Grandfathered Tribal FQHCs, and PCF/ ACO REACH Participant Providers active as of 5/31/23.

Payment Design

This three-track, progressive population-based model design offers its first track, *"Building Infrastructure,"* as an onramp for participants who do not have prior experience with value-based care (VBC). Track 1 payment includes traditional fee for service (FFS) payment with three additional payment incentives including an Upfront Infrastructure Payment (UIP), Enhanced Services Payment (ESP), and Performance Incentive Payment (PIP). Track 2, *"Implementing Advanced Primary Care,"* offers a 50/50 blend of prospective, population-based payments and traditional FFS payments. Track 2 and Track 3, *"Optimizing Care and Partnerships,"* participants will be eligible for ESP and PIP as well as a Prospective Primary Care Payment (PPCP). See the CMS infographic[1] below for more track specific information.

UIP (Track 1 only) – Use categories include: Increased Staffing; Social Determinants of Health (SDOH) Strategies; Health Care Clinician Infrastructure. Infrastructure payment is only available to Track 1 participants new to VBC arrangements and that meet a low revenue threshold, or do not have an e-

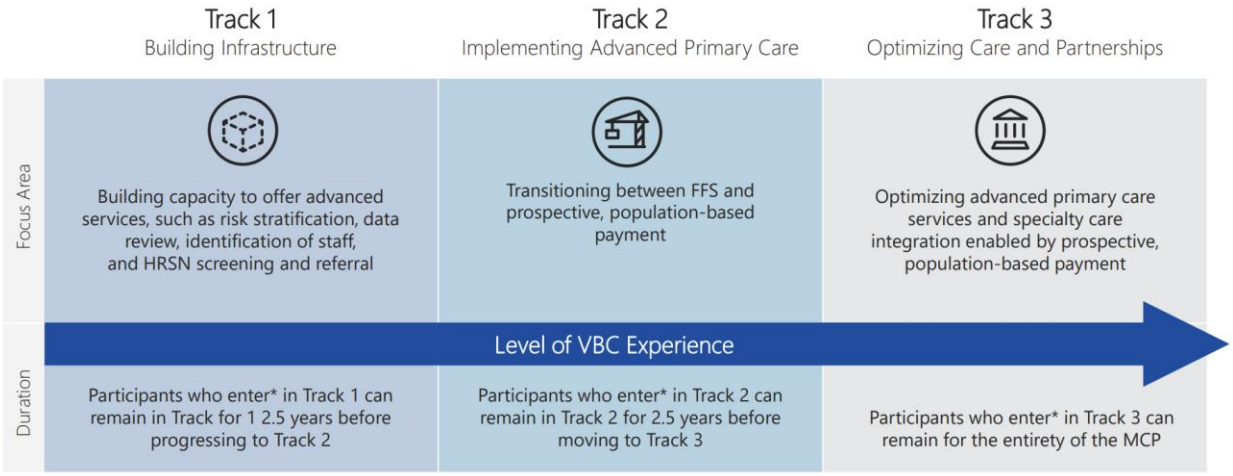
[1] https://innovation.cms.gov/media/document/mcp-ovw-webinar-slides

consult platform. Eligible participants may receive $72,500 in a lump sum payment at the start of Year 1 and an additional $72,500 at the start of Year 2.

ESP (Tracks 1, 2, 3) – Risk-adjusted per beneficiary per month (PBPM) payment to participants in Tracks 1, 2, and 3 in addition to payment for typical primary care services; decreases by track as participants build capacity; supports ongoing care management activities, such as chronic disease management and health-related social needs (HRSN) screenings.

PIP (Tracks 1, 2, 3) – Upside risk only bonus payment (assessed yearly) based on quality utilization, and cost; bonus potential increases by track.

PCCP (Tracks 2, 3) – Replaces FFS revenue for primary care services for beneficiaries attributed to MCP; will reflect participants' historical primary care billing for the first three model years; CMS will introduce a methodology that bases a portion of the PPCP on regional spend trends for Track 3 participants.



For more details on the payment structure, see the CMS MCP factsheet here.

Behavioral and Specialty Care Integration

According to MCP's model design, primary care participants will be required to strengthen their relationships with specialty care clinicians and incorporate evidence-based behavioral health screening and evaluation to improve patient care and coordination. To support increased care coordination with specialists, Track 1 participants will use **data tools to identify "high quality specialists."** Track 2 participants will identify high-quality **Specialty Care Partners through Collaborative Care Arrangements (CCAs)** and implement **enhanced e-consults** with at least one specialist. Track 3 participants will establish enhanced relationships with **Specialty Care Partners through time-limited co-management relationships.** Track 2 and 3 participants will have the opportunity to receive **$40 per service (subject to geographic adjustment) when they send an eligible eConsult to any specialist**. Track 3 Specialty Care Partners in a **Collaborative Care Arrangement (CCA) can additionally bill CMS $50 PBPM.**

Behavioral health integration (BHI), as with specialty care integration, are progressive by track selection within this model. In Track 1, participants are required to identify staff and develop workflows to initiate a BHI approach grounded in measurement-based care (MBC). In Track 2, participants are required to implement a BHI approach using MBC, including measurement tools and data to inform treatment decisions. Additionally, participants are required to screen for key behavioral health conditions

systematically and universally, such as depression and substance use disorder. In Track 3, participants will continue to optimize BHI workflows using a "quality improvement framework."[2]

Payer Alignment

Through multi-payer alignment, CMS aims to move payments away from FFS for primary care services. Participants will report the same core quality measures regardless of payer *(note: MCP payers will have some flexibility to add population-specific measures)*. In collaboration with State Medicaid Agencies (SMAs), CMS will provide MCP participants with state and national resources to streamline Primary Care reform. CMS (alongside SMAs and payer partners) aims to make practice and patient level data available to participants.

Health Equity

MCP participants will be required to identify and work to address health-related social needs (HRSNs) in their patient populations and collaborate with social service providers to help patients navigate community supports and services. Additionally, CMS has created an avenue for incorporating health equity into performance assessment through alignment with HRSA's Uniform Data System (UDS) and an HRSN measure. CMS is **also developing a Screening for Social Drivers of Health quality performance measure for Track 2 and 3 participants**.

	Areas for Opportunity	Positives	Considerations for Model Improvement
Comprehensive Primary Care+	• CPC practices that are in Track 1 MSSP ACOs could not be considered Advanced APMs and therefore could not qualify for the 5% bonus[3] • Requires strong administrative team, which puts smaller practices at a disadvantage[4] • Keeping EHR and related software up to date requires appropriate staff and constant communication with vendors	• Prospective care management fees allowed the rapid deployment of innovative care delivery methods[6] • Assumed a 10% inflation rate for delivering advanced primary care services[7] • Satisfies medical home model criteria[8] • Only medical home model considered to be an Advanced APM • Broader range than CPC • Care coordination staff enables better tracking of patients after discharged from the hospital	• Incorporate social drivers of health into risk adjustment[9] • Allow primary care practices and internal medicine subspecialties the option to elect payment under the Track 2 portion of the program for the remainder of 2020 for ambulatory, office-based, face-to-face, and telehealth evaluation and management (E/M) services • Simplify reporting requirements by streamlining metrics across both CMS and private payers[10] • National expansion

[2] https://innovation.cms.gov/innovation-models/making-care-primary

[3] https://assets.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf

[4] https://assets.acponline.org/acp_policy/testimony/statement_house_energy_commerce_health_subcommittee_hearing_on_macra_and_apms_2017.pdf

[6] https://assets.acponline.org/acp_policy/letters/joint_letter_to_center_for_medicare_and_medicaid_innovation_asking_for_a_transition_after_the_sunset_of_cpc_plus_may_2021.pdf

[7] https://assets.acponline.org/acp_policy/letters/letter_to_cmmi_on_primary_care_first_model_2019.pdf

[8] https://assets.acponline.org/acp_policy/letters/cms_comment_letter_re_cy_2018_macra_qpp_proposed_rule_2017.pdf

[9] https://assets.acponline.org/acp_policy/letters/acp_letter_to_president-elect_biden_regarding_policy_recommendations_for_the_new_administration_dec_2020.pdf

[10] https://assets.acponline.org/acp_policy/letters/acp_letter_to_secretary_azar_in_prioritizing_relief_funds_to_primary_care_and_other_frontline_physician_practices_april_2020.pdf

	• Arbitrary 50-clinician limit[5]	• Financial incentives for self-management programs like nutrition classes and dietitian visits • Feedback data from CMS helps better educate patients when to seek emergency care • Reimbursement for managing patients with dementia helps with better targeting and early detection • Reduced emergency department utilization and reduced acute hospitalizations from 2019 data	
	Areas for Opportunity	**Positives**	**Considerations for Model Improvement**

Making Care Primary	• Scalability: States chosen already have strong pre-established state Medicaid infrastructure/ relationships[11]
	• FFS payment in Track 1
		• 10.5-year model length
		• Onramp for no VBC experience participants via Track 1
		• Health Equity/Community connection
		• Prospective payment
		  ○ Infrastructure
		  ○ Risk-adjusted services
		• Chronic care management
		• Care Coordination/Behavioral Health Integration
			• Pay parity with Medicare
			• National expansion
			• Improved transparency in health equity data collection
			• PC/SC attribution: How will total cost of care will work in collaboration with specialties?[12]

[5] https://assets.acponline.org/acp_policy/letters/acp_response_to_health_innovation_caucus_rfi_on_value_based_payment_and_health_it_2018.pdf

[11] https://innovation.cms.gov/innovation-models/making-care-primary

[12] https://assets.acponline.org/acp_policy/letters/acp_letter_to_cms_on_making_primary_care_model_2023.pdf?_gl=1*11dxbic*_ga*NDMzNjA4NjgyLjE2ODQyNjQ5MTU.*_ga_PM4F5HBGFQ*MTY5MzIzMTU1My4xNzYuMC4xNjkzMjMxNTUzLjYwLjAuMA..&_ga=2.211861012.1875702203.1693231553-433608682.1684264915