CMS Announces the Making Care Primary Model, a Multistate Initiative to Strengthen Primary Care

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On June 8, 2023, the Centers for Medicare & Medicaid Services (CMS), Center for Medicare and Medicaid Innovation (CMMI), announced a new demonstration model under the authority of Section 1115A of the Social Security Act that will test CMS collaboration with state Medicaid agencies to improve primary care services for people with Medicare and/or Medicaid in a payer-agnostic manner.

The Making Care Primary (MCP) Model will be tested in the eight states of Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington.

Goals of the MCP Model

The MCP Model has three stated goals: (1) ensure the primary care that patients receive is integrated, coordinated, patient-centered, and accountable; (2) create a pathway for all primary care organizations and practices to enter into value-based arrangements, with an emphasis on small, independent, rural, and safety-net organizations; and (3) improve health care quality with a focus on patient health outcomes, while reducing both Medicare and Medicaid spending.

With these goals, the MCP Model will work with primary care organizations to take a longer view of the care they provide to their patients. Regardless of their experience with value-based care, the model aims to support participating primary care clinicians to enable them to gradually expand their ability to accept prospective, population-based payments. At the same time, the model will provide additional revenue to assist participating providers in developing the infrastructure they need

People

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Focus Areas

Services

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to improve integration with behavioral health providers and with the many specialists seen by Medicare and Medicaid patients.

With Medicare and Medicaid patients increasingly living with multiple chronic conditions and receiving treatment from an increasing number of specialists—40 percent of Medicare patients now see seven or more specialists each year—CMS hopes that increased investment in primary care will better enable primary care clinicians to provide more seamless, high-quality, and whole-person care. The MCP Model aims to de-fragmentize the health care received by Medicare and Medicaid patients and will give CMS an opportunity, through CMMI, to streamline quality performance measures across programs while simultaneously testing new and innovative measures.

Eligible Participants

The MCP Model seeks to help primary care organizations and practices, especially small, independent, rural, and safety-net organizations, to enter into value-based arrangements for the first time.

To be eligible to participate in the MCP Model, an organization must (1) be a legal entity formed under applicable state, federal, or tribal law, authorized to conduct business in each state in which it operates; (2) be Medicare-enrolled; (3) bill for health services furnished to a minimum of 125 attributed Medicare beneficiaries; and (4) have the majority (at least 51 percent) of their primary care sites (physical locations where care is delivered) located in an MCP state.

Rural Health Clinics, concierge practices (practices that collect a fee from patients for access to their services), current Primary Care First practices, current ACO REACH Participant Providers, and grandfathered tribal Federally Qualified Health Centers (FQHCs) are not eligible for MCP. Organizations may not concurrently participate in the Medicare Shared Savings Program and MCP after the first six months of the model.

Benefits to Participation

The MCP Model will include a three-track progressive approach to funds flow, bonus eligibility, and risk for Medicare reimbursement:

- *Track 1* will be available to organizations that do not have experience in value-based care, in order to allow them time to build capabilities while continuing to bill fee-for-service (FFS) and receiving additional financial support from CMS.
- *Track 2* will be available to organizations that do have experience with value-based care. This track will shift participants' revenue to a 50/50 blend of prospective primary care and FFS

payment, require performance assessment on clinical and utilization/cost metrics, and include larger bonus opportunity.

- *Track 3* will also be available to organizations that have experience with value-based care. Track 3 organizations will receive full prospective primary care payment with larger bonus opportunity.

If a provider enters MCP on Track 1 or 2, the provider must remain on that track for at least 2.5 years before moving up to Track 2 or 3. If a provider enters MCP on Track 3, it must remain on Track 3 for the entirety of the participation period. While the MCP announcement does not explicitly state that the Medicare component of the Model will be limited to FFS Medicare (i.e., Medicare Advantage and PACE will be excluded), that is strongly implied by the description of the design elements and would align with the approach CMMI has taken in other demonstrations.

CMS indicates that the MCP's three progressive tracks are designed to recognize participants' varying experience with value-based care–from under-resourced entities to those with existing advanced primary-care experience in alternative payment modelswhile providing flexible support to eligible participants to expand participation in value-based approaches.

The MCP will include several payment innovations to support participants in delivering advanced primary care. To support team-based care, MCP will include prospective payments for primary care that will reduce organizations' reliance on fee-for-service payments. Risk-adjusted enhanced service payments, which will also be paid prospectively and represent an additional investment in primary care, will allow participants to expand care management, screen for health-related social needs, and integrate with specialty care.

Of particular note, the MCP will allow the inclusion of FQHCs in a multistate advanced primary care model for the first time, as well as other organizations serving Medicare beneficiaries with complex health and social needs. For these participants, the model features upside-only performance incentives that will allow participants to be rewarded for their work to improve quality and outcomes for their patients.

The MCP's three progressive tracks appear to be designed to attract three non-mutually exclusive categories of providers: (1) primary care providers who have heretofore not participated in CMMI models, (2) primary care providers looking for low- or no-risk opportunities to develop value-based care capacity, and (3) those that are especially interested in multi-payer alignment in value-based arrangements.

Open Questions

The MCP Model announcement indicates that the intent is for the payment model to include at least Medicare and Medicaid beneficiaries under aligned quality and value-based payment provisions, with the potential for the inclusion of commercial insurance beneficiaries as well. The announcement also could be read to open the door for Medicare Advantage integration on a state-by-state basis. However, other than signaling that state-specific eligibility criteria will be included in the RFA to be released later this year, the MCP announcement itself does not provide many details about the integration of these other payment sources or the nature of ultimate multi-payer alignment.

This leaves a number of important questions about the model unanswered, including:

- Will Medicare Advantage plans (or PACE plans) be encouraged or allowed to participate in the model (including Dual-Eligible Special-Needs Plans)?
- Will all participating providers need to enroll in the applicable state Medicaid program and accept Medicaid?
- Will financing be integrated between Medicare and Medicaid for dual-eligible beneficiaries, including the potential integration of long-term services and supports?
- Will Medicaid Managed Care Organizations be allowed or required to participate and contract with model providers?

Based on the heterogeneity of the Medicaid delivery systems among the MCP participating states, and the open-ended invitation from CMS for other payers to "partner" with the model, it is likely that the final RFA will include significant program criteria variations by state. To date, none of the participating states' Medicaid agencies have posted information publicly on their MCP alignment plans.

Timeline for Application/Guidance

The MCP announcement indicates that CMS will issue more technical details on the model soon and will issue an initial RFA and commence the federal phase of the application process later this summer. As a component of the announcement, CMS provided an opportunity for interested providers to submit non-binding Letters of Intent here. CMS indicated in the announcement that questions about the alignment efforts by state Medicaid programs should be directed to each respective state Medicaid agency.

Alignment with the CMMI Primary Care Strategy

The MCP announcement was coupled with an overarching CMMI strategy to support the provision of high-quality primary care. The agency sent out a press release and blog post detailing the need for investment and support in primary care, as well as the impact that value-based payment models such as MCP could have on primary care and the health care system in general. CMMI has stated that it is rolling out "a portfolio-wide approach to rebuilding primary care" through a focus on financing, equity, and sustainability. With regard to financing, the agency is focusing on the success of MCP as well as additional state-based ACO models. On advancing equity, CMMI is aiming to increase the participation of FQHCs and other safety net providers in value-based models, as well as increased collection of demographic data in order to identify disparities in the health care system and increase access to community resources. Finally, CMMI wants to ensure the sustainability of primary care transformation through alignment with Medicaid and other payors, as well as scaling up successful models to other payors.

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This Insight *was authored by* **Kevin Malone, Helaine Fingold, Ashley Creech, William Walters,** *and* **Devon Minnick***. For additional information about the issues discussed in this* Insight*, or if you have any other questions or concerns regarding the draft guidance or decentralized clinical trials, please contact one of the authors or the Epstein Becker Green Health Care and Life Sciences attorney who regularly handles your legal matters.*