CMMI Announces New Primary Care Payment Models

Part I: Primary Care First

May 1, 2019 – Last week, the Centers for Medicare & Medicaid Services (CMS) announced a series of primary care-focused payment models designed to test various approaches to transforming primary care payments to reward value. Called the CMS Primary Cares Initiative, the Innovation Center (CMMI) will test five new payment model options under two paths – Primary Care First and Direct Contracting – each building on existing CMMI models to advance and expand effective elements of value-based payment programs.

CMS Primary Cares Initiative	
Primary Care First (PCF):	**Direct Contracting (DC):**
1. PCF General	1. Professional
2. High Needs Population or Seriously Ill Population (SIP)	2. Global
	3. Geographic

With its Primary Cares Initiative, CMS intends to provide a menu of voluntary options that address shortcomings of the current FFS payment system that are particularly unfavorable for primary care, such as low rates, non-reimbursable services, and cash flow challenges. While CMMI is testing various approaches to primary care-focused payment and delivery transformation, all five payment model options incorporate the following core aims:

- Allow practices to move away from FFS and eliminate revenue cycle operations
- Reduce administrative burdens by simplifying quality reporting requirements
- Leverage performance transparency to motivate improvement and encourage competition
- Engage multiple payers to align with model principles and strengthen the business case for participation
- Help practices remain independent

At the press conference announcing the new models, Health and Human Services (HHS) Secretary Alex Azar called the Primary Cares Initiative "an historic turning point in American health care," and projects the models will reach 25 percent of all primary care practitioners and over a quarter of all Medicare FFS beneficiaries (an estimated 6.4 million in the PCF payment model options and 5 million in DC).

The five payment model options under Primary Cares are designed to target different participant types and link payments to performance in varying degrees. This brief, the first in a two-part series, summarizes Primary Care First, outlining the model parameters known to date. Part II will cover the DC model options and early implications for ACOs.

Primary Care First Overview

The simpler of the two paths, Primary Care First (PCF), includes two voluntary, five-year payment model options designed for advanced primary care practices who are ready to assume limited financial risk in exchange for a more predictable and flexible payment structure with significant upside potential. The pathway includes two tracks: (1) **PCF General**, and (2) **PCF High-Need Population** (also referred to as the Seriously Ill Population (SIP) option). Additionally, primary care practices may be allowed to participate in **both options**.

The guiding principles and underlying design of PCF's model options are based heavily on Comprehensive Primary Care Plus (CPC+) – a CMMI initiative that began in 2017 and was itself an iteration of an earlier effort, known as "CPC Classic," which ran from 2012 to 2016. Concurrent with PCF's announcement, CMMI released the First Annual Report evaluating CPC+ in its first year. According to the report, 2017 was largely an investment year, as practices began the hard work of transforming care delivery. While CPC+ had minimal effects on cost, service use, and quality for Medicare FFS beneficiaries in its first year, CMMI has applied early lessons and feedback from CPC+ participants to the new PCF model options.

Patient Care First, Medicare's latest advanced primary care installment, follows the same general care delivery model and objectives as CPC+ but focuses on the next phase of practice transformation by moving further away from FFS, prioritizing outcomes over process measures, and by focusing on reducing complications and overutilization of high-cost settings.

PAYMENT MODEL – PCF aims to offer participating primary care practices increased accountability and autonomy through a predicable payment stream comprised of partial capitation with some FFS, adjusted based on ability to reduce acute hospitalizations while meeting quality thresholds. Specifically, PCF's three-part payment model includes:

1. **Flat fee** for primary care visits;
2. Prospective, risk-adjusted **population-based payment** (PBP); and
3. **Performance-based payment adjustment** assessed and paid quarterly.

Together, the professional PBP and the flat primary care visit fee and will replace all Medicare FFS payments to allow practices to more easily predict payments and spend less time processing claims.

Professional Population-Based Payment

Payment for services in or outside of the office, adjusted for practices caring for higher risk populations. This payment is the same for all patients within a practice.

Practice Risk Group	Payment *Per beneficiary per month*
Group 1 (lowest risk)	$24
Group 2	$28
Group 3	$45
Group 4	$100
Group 5 (highest risk)	$175

Flat Primary Care Visit Fee

Flat payment for face-to-face treatment that reduces billing and revenue cycle burden. These payments are the same, regardless of the level of care or practitioner (e.g., MD vs NP).

$50

per face-to-face patient encounter

According to CMS, the $50 flat visit fee is said to represent the approximate cost of a Level 2 visit, the average of most primary care visits. The PBP risk group scores are based on practice average HCC score, meaning payments will be made based on the average risk score across the practice's population of patients and practices will receive the same monthly amount for all attributed beneficiaries.

The third element of the PCF payment model is the **performance-based payment adjustments**, which will give practices the opportunity to receive a maximum upside of 50% of revenue with a max downside of only 10%. PCF's asymmetrical bonus/risk structure intends to provide practices with a meaningful incentive that is more aligned with the total cost of care and that utilizes a quality gateway with fewer measures to determine bonus eligibility.

In Year 1, performance-based adjustments will be determined based on acute hospital utilization (AHU) alone. In Years 2-5, adjustments will be based on a practice's ability to first exceed a quality gateway (measures listed below). If a practice does not meet even one of the measures, it will receive an automatic 10% downward adjustment to its primary care payments in the next quarter. Once the quality gateway is met, practices may be eligible to receive an adjustment of up to 50% of total primary care payment based on performance across three different benchmarks:

1. **National Adjustment:** Benchmark based on the lowest quartile of AHU performers in a national reference group.
    a. If above national minimum benchmark → eligible for cohort adjustment
    b. If at or below national minimum benchmark → -10% adjustment *(still eligible for continuous improvement bonus)*
2. **Cohort Adjustment:** Practice performance compared against other PCF participants.
    a. If in bottom 50% of PCF practices based on performance → 0% adjustment
    b. If in top 50% of PCF practices based on performance → (See Table 1)
3. **Continuous Improvement Adjustment:** Practices eligible to receive bonus of up to 1/3rd of total performance-based adjustment amount if they achieve their improvement target. Even practices below the national benchmark can earn a bonus if they demonstrate improvement. (See Table 2)

Table 1: Cohort Adjustment Options

Performance Level (% of eligible practices)	Adjustment to Total Primary Care Payment
Top 20%	**34%**
Top 21-40%	**27%**
Top 41-60%	**20%**
Top 61-80%	**13%**
Top 81-100%	**6.5%**

Table 2: Continuous Improvement Adjustment Options

Performance Level (% of eligible practices)	Potential Improvement Bonus
Top 20%	**16%**
Top 21-40%	**13%**
Top 41-60%	**10%**
Top 61-80%	**7%**
Top 81-100%	**3.5%**
Practices above national benchmark but below top 50% of cohort	**3.5%**
Practices performing at or below national benchmark	**3.5%**

While practices are required to bear downside risk, the potential loss limit of 10% of primary care revenue is "about equivalent to current revenue cycle costs," according to CMMI Director Adam Boehler's remarks at the model announcement press conference.

The SIP model option will have modified payments to account for the population's needs. For the first year, practices serving seriously ill populations will receive:

- $325 one-time payment for the first visit with every SIP patient, which accounts for outreach efforts,
- Monthly SIP payments of $275 PBPM for up to 12 months,
- Flat visit fees of $50, and
- Quality payment of up to $50.

QUALITY MEASUREMENT – As with both Primary Cares pathways, PCF includes fewer quality measures to minimize reporting burden and to focus on incentivizing outcomes over processes. Notably, all but one of the quality measures will be used as a gateway for determining the minimum threshold for performance-based eligibility.

Measure Type	Measure Title	Benchmark
Utilization Measure for Performance-Based Adjustment Calculation (Year 1-5)	Acute Hospital Utilization (AHU) *(HEDIS)*	Non-CPC+ reference population
Quality Gateway (Year 2-5)	CPC+ Patient Experience of Care Survey *(CAHPS)*	MIPS
	Diabetes: HbA1c Poor Control *(eCQM)*	MIPS
	Controlling High Blood Pressure *(eCQM)*	MIPS
	Care Plan (registry measure)	MIPS
	Colorectal Cancer Screening *(eCQM)*	MIPS

The quality gateway for SIP practices will be developed during the model and will be designed to reflect population needs.

TARGET PARTICIPANTS – To be eligible to participate in PCF, primary care practices must have previous experience with value-based contracting, must demonstrate certain advanced primary care delivery capabilities (e.g., 24/7 access to nurse call line, empanelment of patients to a practitioner, etc.), use 2015 edition CEHRT and support data exchange, and must furnish enough primary care services to account for 70% of the practice's collective billing based on revenue. Notably, CMMI expects that existing Medicare ACO participants will be eligible to participate, though details regarding shared savings/performance-adjustment reconciliation are not yet known.

Practices that demonstrate relevant experience and capabilities caring for high-needs populations in their application will have the option to agree to be assigned and furnish services to the SIP patients that CMS identifies within their service area and who express interest in the model. Clinicians enrolled in Medicare who typically provide hospice or palliative care services will be able to provide care for SIP patients either by participating as a practice in the PCF general payment model option or by partnering with a PCF practice.

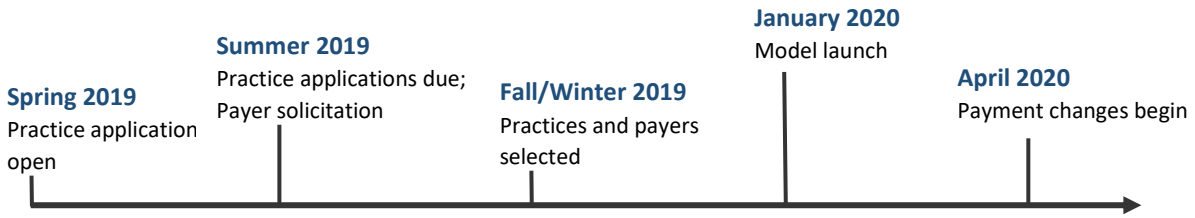
Additionally, as with CPC+, PCF is multi-payer model that limits participation to select geographies based on concentrated payer alignment. In order to participate in 2020, practices and payers must be located in one of 26 approved regions – 18 are existing CPC+ regions[1] and 8 are newly added[2] for PCF. To broaden participation, CMS may add more eligible regions in 2021. While the regions and eligibility requirements overlap, current CPC+ participants will not be allowed to join PCF until 2021.

ATTRIBUTION & BENEFICIARY ENGAGEMENT – To help participants reach the required threshold of 125 attributed beneficiaries per location, PCF will use a combination of voluntary alignment and claims-based attribution to assign Medicare beneficiaries to participating practices. When determining attribution, CMS will prioritize patient choice in the assignment of beneficiaries to PCF practices.

Regarding seriously ill and unmanaged beneficiaries, CMS will proactively identify and attribute SIP patients lacking a PCP or care coordination to PCF practices that specifically opt to participate in the SIP payment model option. Practices will also be allowed on a case-by-case basis to accept patients into SIP who are referred to the practice and deemed eligible by CMS. Practices may limit their participation to exclusively caring for SIP patients if they are able to demonstrate that they have a network of relationships with other care organizations in the community to ensure that beneficiaries can access the care best suited to their longer-term needs.

To increase access and patient engagement, CMS is exploring beneficiary engagement incentives and payment waivers, though details are not yet known.

TIMELINE – PCF's general and SIP model options will follow the same five-year timeline, with two cohorts beginning in 2020 and 2021. CMS expects to release an Request for Applications (RFA) within the coming month for the first cohort of payers and practices.



While not yet confirmed, CMMI believes that PCF is likely to qualify as an Advanced Alternative Payment Model (APM) under MACRA. The model was designed with the intention to qualify, though Advanced APM designation can only be made after the enrollment period is completed in early 2020.

About the ACLC

The Accountable Care Learning Collaborative (ACLC) is a non-profit organization with a mission to accelerate the readiness of healthcare organizations to assume value-based payment models. Founded by former Secretary of Health and Human Services Mike Leavitt, and former Administrator of the Centers for Medicare and Medicaid Services Mark McClellan, the ACLC serves as the foundation for healthcare stakeholders across the industry to collaborate on improving the care delivery system.

To learn more about the ACLC, visit accountablecareLC.org.

[1] Existing CPC+ regions: Arkansas, Colorado, Hawaii, Greater Kansas City Region of Kansas and Missouri, Louisiana, Michigan, Montana, Nebraska, New Jersey, Greater Buffalo Region of New York, North Hudson-Capital Region of New York, North Dakota, Ohio and Northern Kentucky Region, Oklahoma, Oregon, Greater Philadelphia Region of Pennsylvania, Rhode Island, and Tennessee.

[2] Additional regions: Alaska, California, Delaware, Florida, Maine, Massachusetts, New Hampshire, and Virginia.