KUTAKROCK

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CMMI – Primary Care Initiatives Summary

Introduction

On April 22, 2019, the Centers for Medicare & Medicaid Services (CMS) announced a new set of value-based payment models aimed at primary care delivery: Primary Care First (PCF) and Direct Contracting (DC).[1]

Building on experience from previous initiatives and Center for Medicare & Medicaid Innovation (Innovation Center) payment models, PCF and DC are intended to further expand CMS's value-based transformation initiative, this time with a particular focus on advanced primary care services. As with previous value-based payment models, CMS hopes that PCF and DC will reduce Medicare expenditures while preserving or improving quality of care and patient outcomes.

CMS has provided initial overviews of the PCF and DC models, which are summarized below. However, many of the key structural, economic, and legal details of these models remain forthcoming.

Primary Care First[2]

Overview

PCF will focus on advanced primary care practices ready to assume financial risk in exchange for reduced administrative burdens and performance-based payments. The administrative reductions are designed to improve the doctor-patient relationship by permitting practitioners to spend more time with patients.

On the payment side, performance-based adjustments under PCF offer participating providers an upside of up to 50% of revenue, as well as a small downside (up to 10% of revenue), as an incentive to reduce costs and improve quality, assessed and paid quarterly. CMS has designed these incentives to encourage practices to deliver patient-centered care that reduces acute hospital utilization.

CMS will prioritize patient choice in the assignment of Medicare beneficiaries to primary care PCF practices. More specifically, beneficiaries will be attributed based on voluntary alignment to a practice, with proactive identification and assignment of seriously ill and unmanaged beneficiaries.

In an effort to increase access to primary care and patient engagement, CMS is also exploring beneficiary engagement incentives and payment waivers for PCF. Additional details will be provided in the Request for Application and Participation Agreement.

[1] Press release available at https://www.cms.gov/newsroom/press-releases/hhs-news-hhs-deliver-value-based-transformation-primary-care.
[2] Additional information available at https://innovation.cms.gov/initiatives/primary-care-first-model-options/.

Participation Criteria

Eligible applicants are primary care practices that:

- Are located in one of the 26 selected PCF regions;[3]
- Include primary care practitioners (MDs, DOs, CNSs, NPs, and PAs), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine;
- Provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at a particular location;
- Have primary care services account for at least 70% of the practices' collective billing based on revenue. In the case of a multi-specialty practice, 70% of the practice's eligible primary care practitioners' combined revenue must come from primary care services;
- Have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or fee-for-service payment alternatives, such as full or partial capitation;
- Use 2015 Edition Certified Electronic Health Record Technology (CEHRT), support data exchange with other providers and health systems via Application Programming Interface (API), and connect to their regional health information exchange (HIE);
- Attest via questions in the application to a limited set of advanced primary care delivery capabilities, such as 24/7 access to a practitioner or nurse call line and empanelment of patients to a practitioner or care team; and
- Can meet the requirements of the PCF Participation Agreement (forthcoming).

Model Design

PCF reflects a regionally-based, multi-payor approach to care delivery and payment. PCF fosters practitioner independence by increasing flexibility for primary care, providing participating practitioners with the freedom to innovate their care delivery approach based on their unique patient population and resources. PCF is intended to reward participants with additional revenue for taking on limited risk based on easily understood, actionable outcomes.

In PCF, CMS will use a focused set of clinical quality and patient experience measures to assess quality of care delivered at the practice. A PCF practice must meet standards that reflect quality care in order to be eligible for a positive performance-based adjustment to their primary care revenue. These measures were selected to be actionable, clinically meaningful, and aligned with CMS's broader quality measurement strategy. Measures include a patient experience of care survey, controlling high blood pressure, diabetes hemoglobin A1c poor control, colorectal cancer screening, and advance care planning.

[3] Statewide, unless otherwise indicated: AK, AR, CA, CO, DE, FL, HI, KS (Greater Kansas City region), KY (partial state), LA, ME, MA, MI, MO (Greater Kansas City region), MT, NE, NH, NJ, NY (Greater Buffalo region; North Hudson-Capital region), ND, OH, OK, OR, PA (Greater Philadelphia region), RI, TN, VA.

Model Goals

The intent of PCF is to improve quality, improve patient experience of care, and reduce expenditures. The PCF model will achieve these goals by increasing patient access to advanced primary care services, and has elements specifically designed to support practices caring for patients with complex chronic needs or serious illness. The specific approaches to care delivery will be determined by practice priorities. Practices will be incentivized to deliver patient-centered care that reduces acute hospital utilization. PCF is oriented around comprehensive primary care functions: (1) access and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver engagement; and (5) planned care and population health.

PCF aims to be transparent, simple, and hold practitioners accountable by:

- Providing payment to practices through a simple payment structure, including:
    - A payment mechanism that allows care to be driven by clinicians rather than administrative requirements and revenue cycle management;
    - A risk-adjusted population-based payment (PBP) to provide more flexibility in the provision of patient care along with a flat primary care visit fee; and
    - A performance based adjustment providing an upside of up to 50% of revenue as well as a small downside (10% of revenue) incentive to reduce costs and improve quality, assessed and paid quarterly.
- Providing practice participants with performance transparency, through practitioner-identifiable information on their own and other practice participants' performance to enable and motivate continuous improvement.

Model Types

1. *PCF – General*: The first PCF payment model option tests whether delivery of advanced primary care can reduce total cost of care and focuses on advanced primary care practices. Participants assume financial risk in exchange for reduced administrative burden and performance-based payments. The PCF model option also introduces new, higher payments for practices that care for complex, chronically ill patients.

2. *PCF – High Need Populations*: The second PCF payment model also encourages advanced primary care practices, including practices whose clinicians are enrolled in Medicare and typically provide hospice or palliative care services, to take responsibility for high need, seriously ill beneficiaries who currently lack a primary care practitioner and/or effective care coordination. These population groups are referred to under this payment model option as the Seriously Ill Population or SIP (which are distinct from the complex, chronically ill patients referenced in the PCF – General model above). Relative to PCF – General, payment amounts for SIP patients will be set to reflect the high need, high risk nature of the population as well as include an increase or decrease in payment based on quality.

Timelines

CMS anticipates releasing a Request for Application (RFA) in spring 2019 for the first cohort of PCF payers and practices. Practices and payers will begin participation in the model in January 2020. PCF will have a five (5) year performance period.

CMS anticipates accepting another round of PCF applications during 2020, for participation beginning in January 2021. [4]

The above timeline is expected to apply to both PCF models.

Additional eligibility details will be available in the forthcoming PCF RFA and Solicitation for Payer Partnership.

Direct Contracting[5]

Overview

DC is comprised of three voluntary payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare fee-for-service (FFS). The DC payment model options create opportunities for a broad range of organizations to participate with CMS in testing novel risk-sharing arrangements. Building on lessons learned from initiatives involving Medicare Accountable Care Organizations (ACOs), such as the Medicare Shared Savings Program and the Next Generation ACO Models, the DC payment model options also leverage innovative approaches from Medicare Advantage and private sector risk-sharing arrangements. Relative to existing initiatives, the DC model options also include a reduced set of quality measures that focuses more on outcomes and beneficiary experience than on process.

DC creates three payment model options for participants to take on risk and earn rewards, and provides participants with choices related to cash flow through PBP, beneficiary alignment, and benefit enhancements. Relative to existing CMS initiatives, the DC model options place an emphasis on voluntary alignment, empowering beneficiaries to choose the health care providers with whom they want to have a care relationship. Similar to PCF, the DC model options also aims to improve beneficiaries' experience by reducing administrative burdens on practitioners so that they can focus on spending time with patients.

To ensure that care quality is improved and beneficiary choice and access are protected under DC models, CMS will tie a meaningful percentage of the DC model benchmarks to performance on quality of care, while also monitoring to ensure that beneficiaries' access to care is not adversely affected as a result of the DC models. CMS is considering similar benefit enhancements and payment rule waivers as those offered in the Next Generation ACO program, as well as additional possible offerings, but was not prepared to provide definitive guidance at the time the DC models were announced.

Goals

The payment model options available under DC aim to reduce expenditures while preserving or enhancing quality of care for beneficiaries. By aligning financial incentives, providing a prospectively determined and predictable revenue stream for participants, and putting a greater emphasis on beneficiary choice, the payment model options aim to:

- Transform risk-sharing arrangements in Medicare FFS by offering both capitated and partially capitated population-based payments that move away from traditional FFS.

- Broaden participation in CMS Innovation Center models by allowing model participation by organizations new to Medicare FFS, such as physician managed organizations that currently operate exclusively in the Medicare Advantage program, Medicaid managed care organizations that provide

[4] Practices that are currently participating in the CPC+ Model (Track 1 or 2) may choose to end their participation in CPC+ as of January 2021 in order to participate in PCF.
[5] Additional information available at https://innovation.cms.gov/initiatives/direct-contracting-model-options/.

Medicaid benefits for full-benefit dually eligible beneficiaries, and innovative, new organizations that seek to assume responsibility for Medicare FFS beneficiaries in a geographic target region.

- Empower beneficiaries to engage in their care delivery through voluntary alignment and potential benefit enhancements.

- Reduce provider burden to meet health care needs effectively, through for example, a smaller set of core quality measures and waivers to facilitate care delivery.

The payment model options available under DC are expected to increase beneficiaries' access to innovative, affordable care while maintaining all Original Medicare benefits. Model participants in DC (referred to as a DC Entity (DCE)) may offer benefit enhancements and certain additional services to beneficiaries with no requirement that beneficiaries accept these benefits or services. Relative to existing CMS initiatives, the payment model options place an emphasis on voluntary alignment, empowering beneficiaries to choose the health care providers with whom they want to have a care relationship. The payment model options also aim to improve beneficiaries' experience of care by reducing administrative burdens on practitioners, so that they can focus on what is most important, spending time with patients.

Models

As mentioned above, there are three payment model options associated with DC:

1. *DC – Professional PBP*: Professional PBP offers DCEs the lower risk-sharing option. DCEs who choose this option will bear risk for fifty percent (50%) of shared savings/shared losses on the total cost of care (i.e. all Parts A and B services) for aligned beneficiaries. Professional PBP DCEs will have a single payment option of "Primary Care Capitation," a capitated, risk-adjusted monthly payment for enhanced primary care services equal to seven percent (7%) of the total cost of care for enhanced primary care services.

2. *DC – Global PBP*: Global PBP offers DCEs a higher risk-sharing option. DCEs who choose this option will bear risk for one hundred percent (100%) of shared savings/shared losses on the total cost of care (i.e. all Parts A and B services) for aligned beneficiaries. Global PBP DCEs will be able to choose between two payment options: Primary Care Capitation, described above, or "Total Care Capitation." Total Care Capitation refers to a capitated, risk-adjusted monthly payment for all services provided by DC Participants and Preferred Providers with whom the DCE has an agreement.

3. *DC – Geographic PBP*: Geographic PBP DCEs will bear risk for 100% of shared savings/shared losses on the total cost of care (i.e. all Parts A and B services) for aligned beneficiaries in a target region. Geographic PBP DCEs will be selected as part of a competitive application process and commit to providing CMS a specified discount amount off of total cost of care for the defined target region. CMS is seeking public input, via a Request for Information (RFI), to further refine the design parameters of the Geographic PBP option.[6]

Timelines

CMS has posted a Letter of Intent (LOI) for organizations interested in the Professional PBP and Global PBP. The LOI may be accessed at the following link: https://app1.innovation.cms.gov/dc. The LOI must be received by Friday, August 2, 2019 at 11:59 p.m. EDT. Submitting an LOI will be required in order to apply for DC models, but an LOI will not bind an interested organization to participate. Failure to submit an LOI

[6] RFI available at https://innovation.cms.gov/Files/x/dc-geographicpbp-rfi.pdf. Responses to the RFI will be accepted from April 22, 2019 through 11:59 p.m. EDT, May 23, 2019, and can be submitted electronically to DPC@cms.hhs.gov.

will result in the organization being ineligible to apply during initial application period. CMS will subsequently release a RFA in Summer/Fall 2019 for organizations interested in the Professional PBP and Global PBP options.[7] Selected participants will be notified in Fall/Winter 2019, and the Participation Agreement will be due in Winter 2019.

The payment model options available under DC will start in January 2020 with an initial alignment year for organizations that want to align beneficiaries to meet the minimum beneficiary requirements. Performance periods will begin January 2021 and will be five years.

Subject to responses received in response to the RFI for the Geographic PBP option, CMS expects to initiate the application process for the Geographic PBP option in Fall 2019 and expects to encourage participation from innovative organizations, including health plans, health care technology companies and other entities interested in entering into contractual relationships with providers and suppliers and taking on risk for a Medicare FFS beneficiary population in a defined geographic target region.

CMS may entertain additional application rounds for future years for all payment model options. Failure to submit an LOI during the allowed timeframe will result in the organization being ineligible to apply during the application period.

Notable Dates

- **April 30, May 16** – CMS hosts PCF informational webinars.[8]
- **May 2** – LOI for DC Global PBP and Profession PBP models available.
- **May 2, May 7** – CMS hosts DC informational webinars.[9]
- **May 23** – Deadline for comments in response to RFI regarding DC – Geographic model option.
- **August 2** – LOI for DC Global PBP and Profession PBP models due.

Additional Information

If you have questions regarding CMS' new set of value-based payment models aimed at primary care delivery, please contact a member of our National Health Care Practice Group. For more information regarding our health care practice, please visit us at www.KutakRock.com.

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[7] The RFA will describe the eligibility requirements, payment methodology, available benefit enhancements, and selection criteria.
[8] All webinars are identical. Registration link available at https://innovation.cms.gov/initiatives/primary-care-first-model-options/ (bottom of page).
[9] All webinars are identical. Slides available at https://innovation.cms.gov/Files/slides/dc-model-options-overview-slides.pdf. Audio available at https://downloads.cms.gov/media/innovations/dc-model-options-overview-audio.mp4.

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