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What to Know About the CMS Primary Cares Initiative

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On April 22, 2019, the U.S. Department of Health and Human Services and its Centers for Medicare & Medicaid Services (CMS) announced the "CMS Primary Cares Initiative," a new set of voluntary payment models related to the delivery of advanced primary care.[1] CMS will administer these models through the Center for Medicare & Medicaid Innovation (CMMI).[2]

The five payment model options fall under two paths: ***Primary Care First (PCF)*** and ***Direct Contracting (DC)***.[3] The Primary Care First models focus on individual primary care practice sites with capabilities to deliver advanced primary care. In contrast, the Direct Contracting models engage a wider variety of organizations that have more experience taking on financial risk and serving larger patient populations, such as Accountable Care Organizations (ACOs), Medicare Advantage (MA) plans, and Medicaid managed care organizations (MCOs).[4]

In a press conference announcing the program at the American Medical Association's office in Washington, D.C., U.S. Department of Health and Human Services Secretary Alex Azar described the Primary Cares Initiative as a "pivotal, hockey stick moment in paying for value in American healthcare," and noted the specific design of the initiative to encourage state Medicaid programs and commercial payers to adopt similar approaches.[5] CMS anticipates that these five payment model options administered under the Primary Cares Initiative could potentially include:

- Nearly 11 million Medicare beneficiaries (over 25 percent of all Medicare FFS beneficiaries);
- An estimated 25 percent of primary care practitioners as well as other health care providers; and
- From 11 to 12 million beneficiaries dually eligible for Medicare and Medicaid, specifically those in Medicaid managed care and Medicare FFS.[6]

In addition, these new payment model options are expected to qualify in 2021 as Advanced Alternative Payment Models under Medicare's Quality Payment Program for clinicians.[7] Clinicians participating in Advanced Alternative Payment Models may obtain additional incentive payments depending on their extent of participation (in terms of payment volume or patient count) in the model.[8]

The proposals received support from key industry stakeholders such as the American Hospital Association and the American Medical Association.[9]

Primary Care First

Both models under PCF, as detailed below, incentivize providers to reduce hospital utilization and total cost of care by

[1] Centers for Medicare & Medicaid Services, "HHS News: HHS to Deliver Value-Based Transformation in Primary Care" Press Release, Apr. 22, 2019.
[2] Centers for Medicare & Medicaid Services, "Delivering Value-Based Transformation in Primary Care," Fact Sheet, pg. 1.
[3] *Id.*
[4] *Supra* note 1.
[5] Allison Inserro, "HHS Announces 5 New Primary Care Payment Models to Encourage Value-Based Care," AJMC Managed Markets Network, Apr. 22, 2019.
[6] *Supra* note 1
[7] American Hospital Association, "CMS announces new value-based payment models for primary care," Apr. 22, 2019.
[8] Centers for Medicare & Medicaid Services, Quality Payment Program, Advanced Alternative Payment Models (APMs) Overview.
[9] *Supra* note 7; American Medical Association, "AMA applauds new federal primary care payment models," (Press Releases), Apr. 22, 2019.

potentially rewarding them through performance-based payment adjustments.[10] The two payment model options under PCF include:

1. Primary Care First – General: Under this option, PCF will provide payment to advanced primary care practice sites through a total monthly payment that includes a population-based payment 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), assessed and paid quarterly.[11]

2. Primary Care First – High Need Populations: This option provides higher payment to advanced primary care practices that specialize in care for high-need, seriously ill beneficiaries who currently lack a primary care practitioner and/or effective care coordination.[12] The model refers to these high-need population groups as Seriously Ill Populations (SIP).[13] Payment amounts for SIP patients will be set to reflect the high-need, high-risk nature of the population, and to include an increase or decrease in payment based on performance on quality measures.[14] Participating advanced primary care practices include those practices whose clinicians are enrolled in Medicare and typically provide hospice or palliative care services.

The PCF models are based on the principles of the existing Comprehensive Primary Care (CPC+) model design.[15] Key features and program logistics of the PCF models include:

- Applicant Eligibility: Eligible applicants are primary care practices that are located in one of the selected Primary Care First regions;[16] include primary care practitioners (Medical Doctor, Doctor of Osteopathic Medicine, Clinical Nurse Specialist, Nurse Practitioner, and Physician Assistant), certified in internal medicine, general medicine, geriatric medicine, family medicine, or 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; have experience with value-based reimbursement arrangements; 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); demonstrate via the application 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 meet the requirements of the PCF Participation Agreement.[17]

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[10] *Supra* note 1.
[11] Centers for Medicare & Medicaid Services, "Primary Care First: Foster Independence, Reward Outcomes," Fact Sheet, Apr. 22, 2019.
[12] Centers for Medicare & Medicaid Services, Innovation Center: Primary Care First Model Options (last accessed May 3, 2019), ("Seriously Ill Population Option Participation").
[13] *Id.*
[14] *Supra* note 11 (Question: "Who can participate in the Primary First Care payment model option for the Seriously Ill Population and how does payment differ?").
[15] *Id.* (Question: "Why develop a new model based on the underlying principles of the CPC+ model?") Centers for Medicare & Medicaid Services, Innovation Center: Comprehensive Primary Care Plus Model, Overview.
[16] Primary Care First Model Options will be offered in 26 regions for a 2020 start date: Alaska (statewide), Arkansas (statewide), California (statewide), Colorado (statewide), Delaware (statewide), Florida (statewide), Greater Buffalo region (New York), Greater Kansas City region (Kansas and Missouri), Greater Philadelphia region (Pennsylvania), Hawaii (statewide), Louisiana (statewide), Maine (statewide), Massachusetts (statewide), Michigan (statewide), Montana (statewide), Nebraska (statewide), New Hampshire (statewide), New Jersey (statewide), North Dakota (statewide), North Hudson-Capital region (New York), Ohio and Northern Kentucky region (statewide in Ohio and partial state in Kentucky), Oklahoma (statewide), Oregon (statewide), Rhode Island (statewide), Tennessee (statewide), and Virginia (statewide). *Supra* note 12.
[17] Supra note 12 ("Primary Care First Model Options: Participation").

- Quality Measures: A PCF practice must meet the standards that reflect quality care, as assessed by CMS with a set of clinical quality and patient experience measures, in order to be eligible for a positive performance-based adjustment to its primary care revenue.[18]

- Beneficiary Attribution: The attribution is claims-based with voluntary alignment opportunity.[19] It also includes proactive identification and assignment of seriously ill and unmanaged beneficiaries.[20] CMS indicated that it is also exploring beneficiary engagement incentives and payment waivers.[21]

- Data Sharing: CMS will deliver Medicare FFS expenditure and utilization data as well as Medicaid data (at the practice and the National Provider Identifier (NPI)-level) upon the request of participating practices on a quarterly basis.[22] Data will include identifiable information on the performance of the participating practitioners.[23] Practices can receive claims line feeds and can incorporate claims into their own analytic tools.[24]

- Multi-payer Alignment: CMS will also encourage other payers (such as Medicare Advantage, commercial, Medicaid managed care plans, and state Medicaid agencies) to align payment, quality measurement, and data sharing with CMS in support of PCF practices.[25]

- Request for Application: For both models in the PCF set, CMS anticipates releasing a Request for Application (RFA) in the spring of 2019 and another round of applications during 2020.[26] Additional model details and information, such as application deadlines, will be available in the RFA.[27]

- Place and Time of Implementation: CMS initially anticipates implementing PCF for a five-year performance period with the following start dates and in the following regions.[28]

    - **January 2020**: The model will begin for practices that are not currently participating in the CPC+ Model but are located in the 18 existing CPC+ regions,[29] and for payers and practices in regions in the U.S. where there are limited comparison group practices in the ongoing CPC+ evaluation.[30] Practices in the following additional regions may also submit an application: Alaska, California, Delaware, Florida, Maine, Massachusetts, New Hampshire and Virginia.[31] Payers may also submit proposals for all 26 PCF regions.[32]

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[18] *Id.* ("Primary Care First Model Options: Model Design")
[19] *Supra* note 11 (Question: "How does Primary Care First differ from CPC+ Tracks 1 and 2?").
[20] *Id*
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.* (Question: "Who can participate in the general Primary Care First payment model option?")
[26] *Id.* (Question: "What is the timeline for Primary Care First?")
[27] *Id.* (Question "Where and when will Primary Care First be implemented?")
[28] *Id.*
[29] *Id.* at fn. 1. Existing CPC+ Track 1 and Track 2 regions include 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.
[30] *Id.*
[31] *Id.*
[32] *Id.*

- **January 2021**: Practices currently participating in CPC+ Track 1 or 2 may choose to end their participation in CPC+ early at this time in order to participate in PCF.[33] In addition, new regions may be identified for an additional round of practice applications and payer solicitations at this time as well.[34] CMS indicated additional eligibility details will be available in a forthcoming PCF RFA and Solicitation for Payer Partnership.[35]

Direct Contracting

Direct Contracting creates a set of two voluntary risk-sharing payment model options, as well as a third payment model option for which CMS is seeking public input.[36]

1. Direct Contracting – Professional Population-Based Payment (PBP): Professional PBP Direct Contracting Entities (DCEs) will be eligible for 50% of shared savings and bear risk for 50% of shared losses on the total cost of care (*i.e.*, all Medicare Parts A and B services) for aligned beneficiaries.[37] Professional PBP DCEs will also receive "Primary Care Capitation," a capitated, risk-adjusted monthly payment for enhanced primary care services equal to seven percent of the total cost of care for enhanced primary care services.[38]

2. Direct Contracting – Global PBP: Global PBP DCEs will be eligible for 100% of savings and bear risk for 100% of losses on the total cost of care (*i.e.*, all Medicare Parts A and B services) for aligned beneficiaries.[39] Global PBP DCEs will be able to choose between two payment options: Primary Care Capitation (described above) or "Total Care Capitation."[40] Total Care Capitation refers to a capitated, risk-adjusted monthly payment for all services provided by DC Participants and Preferred Providers with which the DCE has an agreement.[41] CMS has not indicated how the Total Care Capitation payment will be set.

3. Direct Contracting – Geographic PBP: Geographic PBP DCEs would be eligible for 100% of savings and bear risk for 100% of losses on the total cost of care (*i.e.*, all Medicare Parts A and B for services) for aligned beneficiaries in a target region.[42] Geographic PBP DCEs would be selected as part of a competitive application process and commit to providing CMS a specified discount amount off the total cost of care for the defined target region.[43] CMS is seeking additional input from the public on this option through a Request for Information.[44]

All Direct Contracting payment model options include features aimed at encouraging organizations focused on care for patients with complex, chronic conditions and seriously ill populations to participate.[45] Additional key features and program logistics of the models include:

- Eligibility to Participate: The Professional and Global PBP options seek to engage a broader variety of organizations than have previously participated in CMS models and programs, including organizations that are

[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] Centers for Medicare & Medicaid Services, Innovation Center: Direct Contracting, Overview, (Question: **"What participation options are available for organizations interested in being a DCE [Direct Contracting Entity]?").**
[37] *Id.*
[38] *Id.*; *supra* note 2 at 2.
[39] *Supra* note 2 at 2.
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Supra* note 36.

new to Medicare Fee-for-Service (FFS) (such as health care providers and organizations that are currently only in Medicare Advantage) and Medicaid MCOs that can take on risk for Medicare FFS spending for dually eligible members.[46] The Geographic PBP option, if CMS proceeds with it, may also attract participation from organizations such as health plans, health care technology companies and other entities.[47] Current Medicare ACOs will be eligible to participate in all three payment model options.[48]

- Quality Measures: To ensure that care quality is improved and beneficiary choice and access are protected, CMS will tie a meaningful percentage of the benchmark to performance on quality of care, while also monitoring to ensure that the model does not adversely affect beneficiaries' access.[49]

- Beneficiary Alignment: Direct Contracting includes a voluntary alignment option that allows beneficiaries to align with the health care providers of their choice.[50]

- Benefit Enhancements: A DCE may offer benefit enhancements and certain additional services (while maintaining all Original Medicare benefits) to beneficiaries with no requirement that beneficiaries accept these benefits or services.[51]

- Participant Selection: CMMI will request a non-binding Letter of Intent (LOI) from organizations interested in either the Professional PBP or Global PBP options.[52] Submission of LOI is a requirement for an organization to be eligible to apply during the initial application period. CMS will subsequently release an RFA for organizations interested in the Professional PBP and Global PBP options.[53] The RFA will describe the eligibility requirements, payment methodology, available benefit enhancements, and selection criteria.[54] 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 the fall of 2019.[55]

- Model Timeline: 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.[56] Performance periods will begin in January 2021 and will be five years.[57]

[46] Centers for Medicare & Medicaid Services, "Direct Contracting," Fact Sheet (last accessed at May 3, 2019). ("Who can participate in the payment model options available under DC?").
[47] *Id.*
[48] *Id.*
[49] *Supra* note 36 ("Model Details").
[50] *Supra* note 46 (Question: "How are beneficiaries and their families or caregivers expected to benefit from the payment model options available under DC?")
[51] *Supra* note 36 ("Background").
[52] *Id.* ("Participant Selection").
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] Supra note 46 ("What is the model timeline?").
[57] *Id.*