Transforming Primary Care Through CMS’s Primary Cares Initiative

Jim Daniel
Mark Watson
Hancock, Daniel & Johnson, P.C.

June 18, 2019
James M. Daniel, Jr., JD, MBA
HANCOCK, DANIEL, & JOHNSON, P.C.
(866) 967-9604
jdaniel@hancockdaniel.com
www.hancockdaniel.com

Mark C. Watson, JD
HANCOCK, DANIEL, & JOHNSON, P.C.
(866) 967-9604
mwatson@hancockdaniel.com
www.hancockdaniel.com
Agenda

• The CMS Primary Cares Initiative New Payment Models
• Direct Contracting
• Primary Care First
• Timeline and Next Steps
• Unresolved Questions
• Q&A
The CMS Primary Cares Initiative New Payment Models
Doubling down on primary care

CMS announces new “Primary Cares” models for 2020

1 Direct Contracting (DC)
   - Variable scope of contracted services and downside risk
     - DC Professional
       - Capitation for primary care services; 50% shared risk
     - DC Global
       - Capitation for services across sites; 100% shared risk
     - DC Geographic
       - Capitation for all care within a defined region; 100% shared risk

2 Primary Care First (PCF)
   - Offers simplified payment structure and performance transparency to groups that meet the following criteria:
     - Located in a participating region
     - Primary care services make up 70% of collective billing revenue
     - Minimum of 125 Medicare beneficiaries per location
     - 2015 Certified EHR Technology
     - Network of non-primary care services to meet seriously ill patient needs (e.g. hospice, palliative care)


1) 50% shared savings or shared losses for total cost of all Part A and Part B services.
2) The model will be offered in 25 regions: Statewide: AK, AR, CA, CO, DE, FL, HI, LA, ME, MA, MI, MO, NE, NH, NJ, ND, OK, OR, RI, TN, VA; Regional: Buffalo, NY, North Hudson-Capital region NY, Greater Kansas City, Philadelphia, Northern Kentucky.
3) High need population.
The relationship between the new payment models and existing programs

The Direct Contracting path, together with the Primary Care First payment model options and the updated Medicare Shared Savings Program ENHANCED Track, are part of the CMS strategy to use the redesign of primary care to drive broader delivery system reform to improve health and reduce costs.

Direct Contracting
Direct Contracting Entities

- Generally, must have at least 5,000 aligned Medicare FFS beneficiaries.
- “On ramp” for organizations new to Medicare FFS.
- Added flexibility for organizations serving dually eligible, chronically ill populations.

DC Participants
- Core providers and suppliers.
- Used to align beneficiaries to the Direct Contracting Entity.
- Responsible for reporting quality through the Direct Contracting Entity and improving the quality of care for aligned beneficiaries.

Preferred Providers
- Not used to align beneficiaries to the Direct Contracting Entity.
- Participate in downstream arrangements, certain benefit enhancements or payment rule waivers, and contribute to Direct Contracting Entity goals.

### Direct Contracting Payment Model Options

<table>
<thead>
<tr>
<th>Professional PBP</th>
<th>Global PBP</th>
<th>Geographic PBP (proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- ACO-like structure with Participants and Preferred Providers defined at the TIN/NPI level</td>
<td>- ACO-like structure with Participants and Preferred Providers defined at the TIN/NPI level</td>
<td>- Would be open to entities interested in taking on regional risk and entering into arrangements with clinicians in the region</td>
</tr>
<tr>
<td>- 50% shared savings/shared losses with CMS</td>
<td>- 100% risk</td>
<td>- 100% risk</td>
</tr>
<tr>
<td>- Primary Care Capitation equal to 7% of total cost of care for enhanced primary care services</td>
<td>- Choice between Total Care Capitation or Primary Care Capitation</td>
<td>- Would offer a choice between Full Financial Risk with FFS claims reconciliation and Total Care Capitation</td>
</tr>
</tbody>
</table>

### Direct Contracting Payment Model Options

<table>
<thead>
<tr>
<th>Payment Model Options</th>
<th>Full Financial Risk with FFS claims processing</th>
<th>Primary Care Capitation</th>
<th>Total Care Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional PBP</td>
<td></td>
<td><strong>X</strong></td>
<td></td>
</tr>
<tr>
<td>Global PBP</td>
<td></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Geographic PBP (proposed)</td>
<td></td>
<td><strong>X</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **Total Care Capitation**: Monthly capitation payments for all services furnished by Participants and optionally Preferred Providers.
- **Primary Care Capitation**: Monthly capitation payments for enhanced primary care services furnished by Participants and optionally Preferred Providers.

- All Participants and Preferred Providers must continue to submit claims to CMS.

Direct Contracting Risk-Sharing Arrangement

Depending on the payment option chosen, DCEs will be at risk for either a portion or all of the total cost of care for Parts A and B services for aligned beneficiaries.

<table>
<thead>
<tr>
<th>Option</th>
<th>Risk Arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional PBP</td>
<td>50% Savings/Losses</td>
</tr>
<tr>
<td>Global PBP</td>
<td>100% Savings/Losses</td>
</tr>
<tr>
<td>Geographic PBP (proposed)</td>
<td>100% Savings/Losses</td>
</tr>
</tbody>
</table>

The aggregate amount of shared savings or losses that DCEs will be eligible to receive, if their actual performance year expenditures are lower or higher than their total cost of care benchmark, will be determined through payment reconciliation.

Benchmarking Methodology

- Prospective blend of historical spending and adjusted Medicare Advantage regional expenditures used to develop benchmark (segmented by Aged & Disabled and ESRD).
- Historical baseline expenditures trended forward by US Per Capita Cost growth, with adjustments to account for population risk and geographic price factors.
- Discount applied in Global PBP with potential for quality bonus.
- Considering innovative approaches to risk adjustment, including for complex and chronically ill populations.

Risk Mitigation Mechanisms

Two financial protections will be offered to Global PBP and Professional PBP DCEs:

Risk corridors
- Aggregate amount of shared savings or losses that DCEs will be eligible to receive, if their actual performance year expenditures are lower or higher than the benchmark,
- Calculated as an aggregate expenditure amount, relative to the total cost of care benchmark.

Stop loss
- Intended to reduce financial uncertainty associated with infrequent, but high-cost, expenditures for aligned DCE beneficiaries.
- Calculated at the level of the individual beneficiary.

Reconciliation

Provisional Reconciliation (optional)
Immediately following the performance year, reflecting cost experience through first six months (with seasonality and claims run-out adjustments)

Final Reconciliation
Following full claims run out and data availability, reflecting complete performance year

Source: Informational Webinar, Centers for Medicare & Medicaid Services, Primary Cares Initiative: Overview of Direct Contracting (May 7, 2019),
Primary Care First
Primary Care First Will Be Offered in 26 States and Regions Beginning in 2020

In 2020, Primary Care First will include 26 diverse regions:

Practices Participating in the PCF Payment Model Option Must Meet the Following Eligibility Requirements

- Include **primary care practitioners** (MD, DO, CNS, NP, PA) in good standing with CMS
- Provide health services to a **minimum of 125** attributed Medicare beneficiaries*
- Have primary care services account for the **predominant share** (e.g., 70) of the practices’ collective billing based on revenue*
- Demonstrate **experience with value-based payment arrangements**, such as shared savings, performance-based incentive payments, and alternative to fee-for-service payments
- Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and, if available, connect to their regional health information exchange (HIE)
- Attest via questions in the Practice Application to a limited set of **advanced primary care delivery** capabilities, including 24/7 access to a practitioner or nurse call line, and empanelment of patients to a primary care practitioner or care team

*Note: Practices participating only in the SIP option are not subject to these specific requirements.

Practices Participating in the High Need Population Model Option Must Meet the Following Eligibility Requirements

Practices receiving **SIP-identified patients** (identified based on risk score) must:

- Include **practitioners serving seriously ill populations** (MD, DO, CNS, NP, PA) in good standing with CMS
- Meet **basic competencies to successfully manage complex patients** and demonstrate relevant clinical capabilities (e.g., interdisciplinary teams, comprehensive care, person-centered care, family and caregiver engagement, 24/7 access to a practitioner or nurse call line)
- **Have a network of providers in the community** to meet patients’ long-term care needs for those only participating in the SIP option
- Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and, if available, connect to their regional health information exchange (HIE)

Primary Care Practices Can Participate in One of Three Payment Model Options

The **three Primary Care First (PCF) payment models** accommodate a continuum of providers that specialize in care for different patient populations.

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCF Payment Model</strong></td>
<td><strong>PCF High Need Populations Payment Model</strong></td>
<td><strong>Participation in both options 1 and 2</strong></td>
</tr>
</tbody>
</table>

Focuses on **advanced primary care practices ready to assume financial risk** in exchange for reduced administrative burdens and performance-based payments. Introduces new, higher payments for practices caring for complex, chronically ill patients.

Promotes care for high need, **seriously ill population (SIP)** beneficiaries who lack a primary care practitioner and/or effective care coordination.

Allows practices to **participate in both** the PCF Payment Model and the PCF High Need Populations Payment Model.

Source: Model Briefing, Centers for Medicare & Medicaid Services, Primary Care First (May 16, 2019),
Payments Under the PCF Payment Model Option Are Made Up of Two Major Components

Payments Under the PCF Payment Model Option Are Made Up of Two Major Components

- Total Medicare payments
  - Total primary care payment
    - Professional Population-Based Payment
    - Flat Primary Care Visit Fee
  - Performance-based adjustment
    - Opportunity for practices to increase revenue by up to 50% of their total primary care payment with a 10% downside, based on key performance measures, including acute hospital utilization (AHU).

Source: Model Briefing, Centers for Medicare & Medicaid Services, Primary Care First (May 16, 2019),
Total Primary Care Payment Includes Two Payment Types: a Population-Based Payment and a Flat Visit Fee

Hybrid Total Primary Care Payments replace Medicare fee-for-service payments to support delivery of advanced primary care.

**Professional Population-Based Payment**
Payment for service 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.

<table>
<thead>
<tr>
<th>Practice Risk Group</th>
<th>Payment Per beneficiary per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1 (lowest average HCC)</td>
<td>$24</td>
</tr>
<tr>
<td>Group 2</td>
<td>$28</td>
</tr>
<tr>
<td>Group 3</td>
<td>$45</td>
</tr>
<tr>
<td>Group 4</td>
<td>$100</td>
</tr>
<tr>
<td>Group 5 (highest average HCC)</td>
<td>$175</td>
</tr>
</tbody>
</table>

Payment adjusted to account for beneficiaries seeking services outside the practice.

**Flat Primary Care Visit Fee**
Flat payment for face-to-face treatment that reduces billing and revenue cycle burden

$50.52 per face-to-face patient encounter

Adjusted for geography

These payments allow practices to:
- Easily predict payments for face-to-face care
- Spend less time on claims processing and more time with patients

Performance-Based Payment Adjustments Are Determined Based on a Multi-Step Process

In **Year 1**, adjustments are determined based on **acute hospital utilization (AHU)** alone. In **Years 2-5**, adjustments are based on performance as described below.

**Did the practice exceed the Quality Gateway?**

- **No**
  - **-10% Adjustment** to Total Primary Care Payment for next applicable year

- **Yes**
  - Adjustment of up to 50% of total primary care payment determined by comparing performance to three different benchmarks:
    1. National adjustment
    2. Cohort adjustment
    3. Continuous improvement adjustment

In the National Adjustment, Applicable Practices Are Compared to a National Benchmark of Similar Practices

The national minimum benchmark is based on the lowest quartile of Acute Hospital Utilization (AHU) performers in a national reference group.

PCF practice performance

**Above** national minimum benchmark
- Eligible for cohort adjustment

**At or below** national minimum benchmark
- -10% Adjustment (still eligible for continuous improvement bonus)

In the Cohort Adjustment, an Eligible Practice is Compared to Other Practices Enrolled in the Model

Practice performance is next compared against other PCF participants to determine the performance-based adjustment.

<table>
<thead>
<tr>
<th>Performance Level</th>
<th>Adjustment to Total Primary Care Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 20% of eligible practices</td>
<td>34%</td>
</tr>
<tr>
<td>Top 21–40% of eligible practices</td>
<td>27%</td>
</tr>
<tr>
<td>Top 41–60% of eligible practices</td>
<td>20%</td>
</tr>
<tr>
<td>Top 61%–80% of eligible practices</td>
<td>13%</td>
</tr>
<tr>
<td>Top 81–100% of eligible practices</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

A Continuous Improvement Bonus is Based on Whether a Practice Improved Relative to the Prior Year’s Performance

Practices are also eligible for a continuous improvement bonus of up to \( \frac{1}{3} \)rd of total Performance-Based Adjustment amount if they achieve their improvement target. CMS may use statistical approaches to account for random variations over time and promote reliability of improvement data.

<table>
<thead>
<tr>
<th>Performance Level</th>
<th>Potential Improvement Bonus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 20% of PBA-eligible practices</td>
<td>16% of Total Primary Care Payment</td>
</tr>
<tr>
<td>Top 21–40% of PBA-eligible practices</td>
<td>13% of Total Primary Care Payment</td>
</tr>
<tr>
<td>Top 41–60% of PBA-eligible practices</td>
<td>10% of Total Primary Care Payment</td>
</tr>
<tr>
<td>Top 61%–80% of PBA-eligible practices</td>
<td>7% of Total Primary Care Payment</td>
</tr>
<tr>
<td>Top 81–100% of PBA-eligible practices</td>
<td>3.5% of Total Primary Care Payment</td>
</tr>
<tr>
<td>Practices performing above nationwide benchmark, but below top 50% of practices</td>
<td>3.5% of Total Primary Care Payment</td>
</tr>
<tr>
<td>Practices performing at or below nationwide minimum benchmark</td>
<td>3.5% of Total Primary Care Payment</td>
</tr>
</tbody>
</table>

# Direct Contracting Timeline and Next Steps

<table>
<thead>
<tr>
<th>Activity</th>
<th>Professional PBP &amp; Global PBP</th>
<th>Geographic PBP (anticipated)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Letter of Intent (LOI)</strong></td>
<td>Due on August 2, 2019</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Release Geographic PBP RFI</strong></td>
<td>NA</td>
<td>Spring 2019</td>
</tr>
<tr>
<td><strong>Request for Applications (RFA)</strong></td>
<td>Summer/Fall 2019</td>
<td>Fall 2019</td>
</tr>
<tr>
<td><strong>DCEs selected for participation notified</strong></td>
<td>Fall/Winter 2019</td>
<td>Winter 2019</td>
</tr>
<tr>
<td><strong>DCEs sign Participation Agreements</strong></td>
<td>Winter 2019</td>
<td>April 1, 2020</td>
</tr>
<tr>
<td><strong>Performance Year 0</strong></td>
<td>January 1, 2020</td>
<td>May 1, 2020</td>
</tr>
<tr>
<td><strong>Performance Year 1 (Payments begin)</strong></td>
<td>January 1, 2021</td>
<td>January 1, 2021</td>
</tr>
<tr>
<td><strong>Performance Year 5</strong></td>
<td>January 1, 2025</td>
<td>January 1, 2025</td>
</tr>
</tbody>
</table>

Primary Care First Timeline

- **Late Spring 2019**: Practice applications will open
- **Summer 2019**: Practice applications due; Payer solicitation
- **Fall-Winter 2019**: Practices and payers selected
- **January 2020**: Model launch
- **April 2020**: Payment changes begin

Unresolved Questions
Direct Contracting Geographic Payment Model – Insights from the RFI

- **Who can participate?** Any organization that has formal partnerships or other contractual relationships with Medicare-enrolled providers in a target region.

- **What is a target region?** A target region is a CMS-approved geographic area where a minimum of 75,000 Medicare beneficiaries reside. The target region must also be arranged in terms of administrative (i.e. city or county) and/or statistical (e.g. MSA) geographic units and factor in the healthcare seeking patterns of the Medicare population in that region.

- **Who benefits from this model?** This model is open to innovative organizations such as health plans and healthcare technology companies, as well as providers and supplier organizations.

- **2 Payment Options:**
  1. Receive population based payments taking on full risk of shared savings and losses
  2. Make fee for service claim payments with expenditures at the end of the year reconciled against the geographic population based on the payment benchmark for the target region.

- **How is the benchmark calculated?** The geographic PBP benchmark will likely be determined by calculating historical expenditures for geographically aligned beneficiaries during a baseline period, trending these historical expenditures forward, applying a geographic adjustment factor, and discounting the benchmark.

New players?

- **Hospice**
  - Can participate in Primary Care First High Need Populations if practitioners are caring exclusively for seriously ill patients.
  - Can participate as part of a Direct Contracting Entity, but since beneficiary alignment is done on the basis of primary care services, primary care providers must be part of the Direct Contracting Entity.

- **Federally Qualified Health Centers**
  - Can participate as part of a Direct Contracting Entity, but since beneficiary alignment is done on the basis of primary care services, primary care providers must be part of the Direct Contracting Entity.
  - Cannot participate in Primary Care First.

- **Small Primary Care Practices.**
  - Can participate in Primary Care First.

- **Health Plans, Health Care Tech Companies, and other Innovative Organizations**
  - Direct contracting geographic (subject to RFI)
Overlapping with Medicare Shared Savings and Next Generation ACO programs

• Direct Contracting
  – CMS has not commented on whether a Direct Contracting Entity can also participate in Medicare Shared Savings and Next Generation ACO programs.

• Primary Care First
  – A practice can participate in Primary Care First while being part of a Next Generation ACO or Shared Savings Program.
    – Any payments made by CMS on account of overlapping beneficiaries will be included in the aggregate payments CMS made to the ACO when calculating shared savings/losses.
Waivers?

Direct Contracting

• CMS is considering the same benefit enhancements and payment rule waivers offered in NGACO, such as
  – 3-Day SNF Rule Waiver;
  – Telehealth Expansion Waiver;
  – Post-Discharge Home Visits Rule Waiver; and
  – Care Management Home Visits Rule Waiver.

• CMS also intends to build upon those offerings and explore additional enhancements and payment rule waivers such as:
  – Allowing Nurse Practitioners to certify that a patient is eligible for home health services; and
  – Allowing the provision of home health services to beneficiaries who are not “homebound.”

Primary Care First

• In an effort to increase access to primary care and patient engagement, CMS intends to explore benefit enhancements and payment rule waivers. No further details have yet been released.

CMS has not released any information on Fraud and Abuse waivers for either program. But Stark Law reform may remove regulatory barriers to program adoption.

Are Participating Organizations Subject to State Insurance Regulations?

- CMS and NAIC have not yet provided guidance on this issue.

- Requires review of state law, publications, and bulletins of applicable state insurance authorities.
Questions?