SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

CMMI Primary Cares Initiative

OVERVIEW

On April 22nd, the Centers for Medicare and Medicaid Innovation (CMMI) released a set of five new payment models. The expectation of these models is to transform payment for 25% of Medicare primary care physicians by providing new opportunities to use value-based purchasing in Medicare, and by better aligning the original FFS Medicare program with Medicare Advantage (MA) and Medicaid Managed Care (MMC).

The CMS Primary Cares Initiative will provide two paths: Primary Care First (PCF) and Direct Contracting (DC). PCF will consist of two options that focus on advanced primary care practices with varying levels of risk and employ performance-based payment adjustments. DC will consist of three voluntary, risk-sharing model options aimed at original Medicare enrollees: Global Population-Based Payment (PBP), Professional PBP, and Geographic PBP.

This document summarizes key elements of each payment model offered under the CMMI Primary Cares Initiative. Additional information on Primary Care First is available here. More information on Direct Contracting is available here. Applicants must first submit a letter of intent by August 2nd.

(Note: CMS is also encouraging states to adopt further initiatives to integrate care and financial risk for dual-eligible beneficiaries. A letter to state Medicaid Directors outlining different integrated duals approaches can be found here.)

DIRECT CONTRACTING (DC) MODELS

Under the DC models, CMS will offer both capitated and partially capitated population-based payments. All DC payment models are designed to remove certain pressures to focus on the volume of services and to provide additional financial rewards to organizations that demonstrate efficiency and better quality of care compared to competitors within the delivery system environment. There are three payment model options:

- Professional Population-Based Payment (PBP);
- Global PBP; and
- Geographic PBP.

Participants in any of the payment model options under DC will be referred to as DC entities (DCEs), and may offer benefit enhancements and certain additional services to beneficiaries who choose to participate. Compared to other risk-sharing CMMI initiatives such as the MSSP and NextGen ACO programs, DCEs will be given additional flexibility in reporting and streamlined quality measurements that focus on outcomes rather than processes.

One purpose of DC models is to better integrate care and the reimbursement structure for the dual eligible population. DCEs that contract with, or are themselves, Medicaid MCOs will be able to manage both the Medicare and Medicaid portion of beneficiary costs. Such integration capability is expected to extend to Medicaid Managed Long Term Care (MLTC) plans as well, allowing savings to the Medicare

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program created through improved primary or long term care to be partially or fully captured by the DCE.

Beneficiaries will be aligned to DCEs through one of three methods:

- Voluntary selection of the DC participant as a primary clinician by the beneficiary;
- Claims information using evaluation and management (E&M) services; or
- Enrollment in a Medicaid Managed Care Organization (MCO).

Voluntary and claims-based enrollment will take precedence over Medicaid MCO-based enrollment. Additionally, Prospective Alignment "Plus", a new alignment feature offered by CMMI, will allow DCEs to add beneficiaries on a quarterly basis. DCEs will have the option of adopting either the Prospective Alignment, or the Prospective Alignment "Plus" approach.

Both professional and Global PBP models will use an ACO structure with DCE participants and preferred providers defined at the TIN/NPI level. Similar to ACOs, DCEs generally must have at least 5,000 aligned Medicare FFS beneficiaries. DCEs may contract with Preferred Providers to form referral and care management arrangements, participate in benefit enhancements and rule waivers, and share in responsibility for risk if desired.

DC Risk Sharing

The Professional PBP option offers the lower risk-sharing arrangement at 50% savings/losses on the total cost of care (all Parts A and B services) furnished by DCE participants and optionally Preferred Providers. DCEs in this model will be reimbursed on a prepaid basis through Primary Care Capitation, a monthly risk-adjusted payment for enhanced primary care services equal to 7 percent of the total cost of care.

Global PBP offers a risk sharing arrangement at 100% of savings/losses, with two payment options:

- Primary Care Capitation—as with Professional PBP, a monthly risk-adjusted payment equal to 7 percent of total cost of care for enhanced primary care services furnished by DCE participants and optionally Preferred Providers; or
- Total Care Capitation—a monthly, risk-adjusted payment for all services provided by DCEs and their preferred providers with which they have contracts to participate in the model.

Despite being paid on a partially or fully capitated basis, all DCEs must continue to submit FFS claims in order to track utilization and performance. Simplified Medicare FFS claims rules are being considered.

DC Benchmarking and Payment Adjustment

Payment and benchmarks will be aligned across organizations through regional payment rates and patient-level adjustment factors. Payments will be based on prospective beneficiary alignment, and will be established prior to the start of each performance year.

Cost benchmarking for the Professional PBP and Global PBP will use a blend of historical spending and adjusted Medicare Advantage regional expenditures, segmented by Aged, Disabled and End-Stage

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Renal Disease (ESRD) status. The consolidated benchmark will be further adjusted to reflect population risk and regional geographic price factors, and payments will be subject to quality performance. CMMI is currently considering new approaches to risk adjustment for complex and chronically ill populations.

DCEs will have two risk mitigation mechanisms: risk corridors and stop loss. Risk corridors will reduce the amount of aggregate shared savings and losses that a DCE may be liable for. Stop loss will limit DCE responsibility for individual high-cost beneficiaries.

In addition to a final reconciliation performed by CMS once full claims run out and data are available, CMS will provide DCEs the option of a provisional reconciliation immediately following the performance year, reflecting cost experience through the first six months.

The quality strategy for both the Global PBP and the Professional PBP options will feature a reduced set of core measures that are compatible with the Merit-based Incentive Payment System (MIPS), and include a minimum of one outcome measure. Quality performance will impact discount benchmark amounts in the Global PBP option, and will affect the final shared savings and losses in the Professional PBP option. CMS expects that both DC models will be treated as an Advanced APM in 2021.

CMS is expected to offer the same benefit enhancements and payment rule waivers as those offered in Next Generation ACO models, such as the 3-Day (Skilled Nursing Facility) SNF Rule Waiver, The Telehealth Expansion Waiver, the Post-Discharge Home Visits Rule Waiver, and the Care Management Home Visits Rule Waiver. CMS is considering additional payment rule waivers, such as allowing Nurse Practitioners to certify that patients are eligible for home health services, and providing home health services to beneficiaries who are not considered “homebound.”

DC Eligibility

Direct Contracting (DC) payment models will focus on organizations that have experience taking on financial risk and serving larger patient populations, such as Accountable Care Organizations (ACOs), physician-managed organizations that currently participate only in Medicare Advantage (MA), and other provider organizations operating under a common governance structure. Medicaid managed care organizations (Medicaid MCOs) that serve dual-eligible individuals who participate in Medicare FFS are also eligible to participate. Current Next Generation ACO and MSSP ACO participants will be eligible to participate as DCEs for their FFS Medicare dual eligible enrollees for all three payment models.

As of May 2nd, CMMI is accepting Letters of Intent (LOI) from organizations interested in participating in either the Global PBP or Professional PBP. The application to submit an LOI is available here. LOIs are required for application but are not binding for participation. LOIs must be received by Friday, August 2nd. Failure to submit an LPI will result in ineligibility to apply during the initial application period. Following LOI submissions, CMS will release an RFA for Global or Professional PBP participation. Additional details, such as eligibility requirements, payment methodology, waiver availability, and selection criteria will be made available at that time.

The two DC payment models will start in January 2020 with an initial “alignment year” for organizations that want to adjust beneficiaries to meet minimum beneficiary requirements. The formal performance period will be five years, beginning in January 2021. CMS may consider additional application rounds for all DC model options following the initial performance year.

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Geographic PBP

CMS also released a Request for Information (RFI) that outlines some criteria for and seeks comments on the design of Geographic PBP, a population-based payment option that would allow organizations to assume responsibility for total cost of care for all original Medicare beneficiaries in a defined target region. The Geographic PBP RFI is available here. Comments are due May 23rd and can be submitted electronically to DPC@cms.hhs.gov.

Geographic PBP is a potential population-based option intended to offer organizations an opportunity to innovate by assuming responsibility for the total cost of care for all Medicare FFS beneficiaries and cater to the unique health needs within a defined target region. For the Geographic PBP, CMMI is considering using a 1-year historical period for parts A and B FFS expenditures within a target region, trended forward and discounted based on negotiations with participants.

CMS is requesting comments on general model design as well as specific parameters for the payment model including selection of target regions and beneficiary alignment. Contingent on responses, CMS intends to initiate the application process for Geographic PBP in Fall of 2019 with the earliest potential start date of January 2021.

PRIMARY CARE FIRST (PCF) MODELS

PCF payment models aim to test the ability of advanced primary care to reduce total cost of care, while accommodating participants at varying stages of readiness to take on risk. PCF will align with the underlying principles of the existing Comprehensive Primary Care Plus (CPC+) model design and focus on advanced primary care practices that are ready to assume financial risk in exchange for reduced administrative requirements and performance-based payment. The PCF models will be offered in 26 regions for a January 2020 start date, including the Greater Buffalo and North Hudson-Capital regions of New York.

CMS intends to release a Request for Applications (RFA) in Spring of 2019 for the first cohort of PCF participants. PCF models will be tested for five years and are slated to begin in January 2020. A second application round is set for 2020, to begin participation in January 2021.

Primary Care First (PCF)

PCF general participants will receive a flat primary care visit fee paired with opportunities for performance-based payment adjustments. CMS will use a set of clinical quality and patient experience measures to assess performance and quality of care, including, but not limited to: a patient experience of care survey, managing high blood pressure, controlling diabetes A1c levels, colorectal cancer screening, and advance care planning. Participants that meet standards of quality care will be eligible for positive performance-based adjustments with an upside of up to 50% of revenue and a downside risk of 10% of revenue, paid quarterly.

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PCF Eligibility

Eligible primary care practices must have advanced primary care capabilities and be ready to assume increased financial risk to participate in the general PCF model. Therefore, applicants must be primary care organizations that, among other requirements:

- Are located in any of the selected Primary Care First regions;
- Include primary care practitioners (MD, DO, CNS, NP, and PA) certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine.
- Provide primary care services to at least 125 attributed Medicare beneficiaries at a location;
- Have primary care account for more than 70% of the practices' collective billing based on revenue. For multi-specialty practices, 70% of the practice's eligible primary care providers' combined revenue must come from primary care services;
- Have experience with value-based payment arrangements, such as shared savings, performance-based incentive payments, episode-based payments, and/or alternatives to fee-for-service payments, such as full or partial capitation;
- Use 2015 Edition Certified EHR Technology (CEHRT), support data exchange with other entities via Application Programming Interface (API), and connect to their regional health information exchange (HIE);
- Attest to their advanced primary care delivery capabilities, such as 24/7 access to a provider or nurse call line, through questions in the Practice Application; and
- Can meet the requirements of the PCF Participation Agreement.

Primary Care First (PCF) – Seriously Ill Population (SIP)

A second PCF option will allow advanced primary care practices, including providers whose clinicians are enrolled in Medicare who provide hospice and/or palliative care services, to take responsibility for those with complex, chronic needs and other seriously ill populations (SIPs) that currently lack sufficient primary care and/or care coordination.

Payment amounts for SIP patients will be set to reflect the high-need nature of the population, with quality-based payment increases or decreases. CMS will assess quality of care for these populations through a focused set of measures that are specific to patients with complex, chronic needs and SIPs.

PCF – High Need Populations Eligibility

Practices that demonstrate relevant capabilities and care experience in their application will be eligible to participate in the PCF – SIP and will be able to choose to be attributed and furnish services to the SIP patients that CMS identifies in their respective service areas to those who express interest in the model. Such practices will then initiate care coordination for those designated patients and ensure case coordination and clinical stabilization.

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Practices may limit their participation in PCF to exclusively caring for SIP patients if it is demonstrated in the application that they have a network of relationships with other community care organizations that can offer beneficiaries access to care suited for long-term needs. Practices will also be allowed to accept patients into SIP that are referred to the practice pending CMS approval on a case-by-case basis.

Clinicians enrolled in Medicare that provide hospice and/or palliative care services can provide care for SIP patients by either participating as a practice in the PCF general payment model option, or by partnering with a general PCF participant that includes them as participating practitioners.