

CMS's New "Primary Cares Initiative" Places Primary Care at the Center of the Shift to Value-Based Care

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by Alissa Smith

On April 22, 2019, the Centers for Medicare and Medicaid Services (CMS) announced two sweeping new payment innovation models under the Primary Cares Initiatives. The models will seek to incentivize primary care and other providers to take on greater responsibility and risk for the lives of covered beneficiaries. Both new models are scheduled to be effective for a first performance year of 2020. Read on for key details of the models, projected impact on the Medicare patient population, and our key takeaways for providers.

Primary Care First Model provides simplified payments with performance-based adjustments

The first model is Primary Care First (PCF), and include two options:

- PCF – General. Participating practices will assume financial risk for aligned beneficiaries and, in exchange, the practices will have reduced administrative burdens and will be eligible for performance-based payments or downside risk.
- PCF - High Needs Populations. Participating practices will assume financial responsibility for high-need, seriously ill beneficiaries who lack a primary care provider or effective care coordination, and, in exchange, the practices will have higher payment amounts as well as eligibility for performance-based payments or downside risk.

PCF – General will provide payment to practices through a simplified payment structure that will provide 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) incentive to reduce costs and improve quality. The performance-based adjustment will be assessed and paid on a quarterly basis. PCF – High Needs Population will set higher payment amounts to reflect the high-need, high-risk nature of the population as well as a yet-to-be-specified increase or decrease in payment based on quality measures.

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PCF is open to a range of eligible applicants, including primary care practitioners certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative care medicine.

Applications for both PCF options will open soon- in Spring 2019, and the model will launch in 26 regions in the U.S. beginning in 2020 and

will continue for five years.

Direct Contracting Model permits providers to take on greater shared savings/shared losses up to full risk

The second model is Direct Contracting (DC), and includes three options:

- DC – Professional. Providers will bear risk for 50% of shared savings/shared losses on the total cost of care (all Part A and B services) for aligned beneficiaries. Participants will 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.
- DC – Global. Participating entities will bear risk for 100% of shared savings/shared losses on the total cost of care (all Part A and B services) for aligned beneficiaries. Participants may receive Primary Care Capitation as described above or may choose to receive Total Care Capitation, a capitated, risk-adjusted monthly payment for all services provided by participants and preferred providers with whom the participant has an agreement.
- DC – Geographic. Participating entities will bear risk for 100% of shared savings/shared losses on the total cost of care (all Part A and B services) for aligned beneficiaries in a target region. Participants will be selected as part of a competitive application process and commit to providing CMS a specified discount amount off of the total cost of care for the defined target region. This option will offer a Total Care Capitation payment as well, where CMS will continue to pay claims for services furnished by providers outside of the participants, including outside the target regions. Alternatively, participants can assume full financial risk while having CMS continue to make fee-for-service claims payments to all providers in the target region.

The DC model is open to a broad range of entities, including health plans, health care technology companies, ACOs, and others operating under a common governance structure.

The DC model 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 in 2021 and continue for five years.

CMS has issued a [request for information \(RFI seeking public comment on the DC-](#)

Geographic model, but nonetheless plans to launch the model in 2021.

CMS anticipates shifting a quarter of beneficiaries out of fee-for-service (FFS) under the new models

CMS anticipates that together, PCF and DC will:

- Shift over 25% of all Medicare FFS beneficiaries out of FFS and into value-based care arrangements;
- Offer new participation and payment options and opportunities for 25% of primary care practitioners and other providers; and
- Create new coordinated care opportunities for a large portion of the 11-12 million dual eligible beneficiaries in the U.S., specifically those in Medicaid managed care and Medicare FFS.

Key Takeaways

As we wait for additional details from CMS about the structure and payment mechanisms under both PCF and DC models, the following are a few key takeaways to keep in mind:



- **CMS is committed to voluntary risk-based payment models.** After experimenting with mandatory risk-based payment under the Comprehensive Care for Joint Replacement (CJR) bundled payment model and the proposed, but ultimately cancelled, Episode Payment Models (EPMs) for cardiac and orthopedic bundles, CMS has moved away (for now) from mandatory risk for providers. However, it appears that voluntary risk-based programs are here to stay. As these voluntary payment models are introduced, participants have opportunities to receive substantial gains (the full risk models of DC – Global and DC-Geographic, for example) if they have the appetite to bear the concurrent substantial downside risk.
- **CMS's pace indicates more reform likely to come.** The Primary Cares Initiative announcement comes on the heels of the Pathways to Success model, an overhaul of the ACO program which was finalized in December 2018, and the BPCI Advanced bundled payment program, which launched in October 2018. In short, CMS is evaluating its existing models, creating new models, and the pace of change is faster than it has been since the slate of mandatory bundled payment programs were announced in 2016 through 2017. Going forward, the industry should expect this pace of new and revised payment models to continue, not lessen. In fact, Adam Boehler, the director of Centers for Medicare and Medicaid Innovation (CMMI), the part of Medicare that develops and administers payment reform programs, [gave a speech in early April 2019](#) that raised the prospect of a new bundled payment program focused on post-acute care providers, which would be a first of its kind and one that those in the post-acute industry are anxiously awaiting.
- **Physicians are increasingly the “owners” of the transition to value.** For many, there's long been a debate about who should “own” the transition away from fee-for-service toward value-based care. While CMS certainly has targeted acute-care

providers for this ownership under ACOs and bundled payment models, physicians have of course been a crucial participant in those programs. Notably, the Primary Care Initiatives place the physician front and center of owning responsibility for the cost and quality of their patients' care – an acknowledgement from CMS that primary care providers and close patient interaction are linchpins for sustained success in transitioning toward better outcomes for the health of a population.

- **The focus on chronic and serious illness highlights a persistent problem for Medicare in controlling spending.** As the population ages, success in controlling spending overall may ultimately come down to targeted efforts to better support and manage the chronically and seriously ill patient populations. While just 17% of Medicare patients live with six or more chronic conditions, they account for half of all spending on Medicare beneficiaries with chronic disease. Moreover, a full quarter of all Medicare spending is spent on Medicare beneficiaries in their last year of life. Including hospice and palliative care physicians in the PCF model, and having an entire model option dedicated to the seriously ill patient population, are clear signs from Medicare that they want to focus on programs and models that may move the dial on this patient population whose health care is notoriously difficult to manage.

To learn more about this model, or to discuss how it may impact your organization, please contact the authors directly at barlow.kristen@dorsey.com or smith.alissa@dorsey.com or your regular attorney at Dorsey & Whitney.