Early thoughts on the Primary Care First model

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Introduction

The Center for Medicare and Medicaid Innovation (CMMI) recently unveiled Primary Care First (PCF), a new voluntary payment model focused on primary care, set to start in 2020 across select markets. This model aims to offer additional flexibility in how physicians care for patients while holding them accountable for patient outcomes. Additionally, this model offers a payment model option for accepting accountability for the high-need seriously ill population (SIP). The model also intends to foster multipayer alignment with the Centers for Medicare and Medicaid Services (CMS) by soliciting engagement from other payers. Although many model details remain unshared, the announcement of these new models received praise from both right- and left-leaning pundits.[1] In this issue brief, we explore key model features that are known, as well as key remaining open questions.

Extension of CPC+ initiative

CMS is describing this new payment model as an extension of the Comprehensive Primary Care Plus (CPC+) initiative. Based on the preliminary information shared by CMS, CPC+ works as stepping-stones to risk, with CPC+ Track 1 readying practices to build capabilities and CPC+ Track 2 fostering more comprehensive primary care models.[2] The PCF model is aimed at primary care practices with advanced primary care capabilities that are willing to accept increased financial risk in exchange for potential rewards, based on practice performance in select regions. As compared to CPC+, PCF incorporates an entirely new payment model component in the high-need SIP payment model. The SIP is a model option allowing PCF participants additional support for this subpopulation or the option to partner with a separate organization that focuses on these patients.

FIGURE 1: STATES PARTICIPATING IN PRIMARY CARE FIRST

RI	■
CT	
DE	■
DC	

Source: Centers for Medicare & Medicaid Services
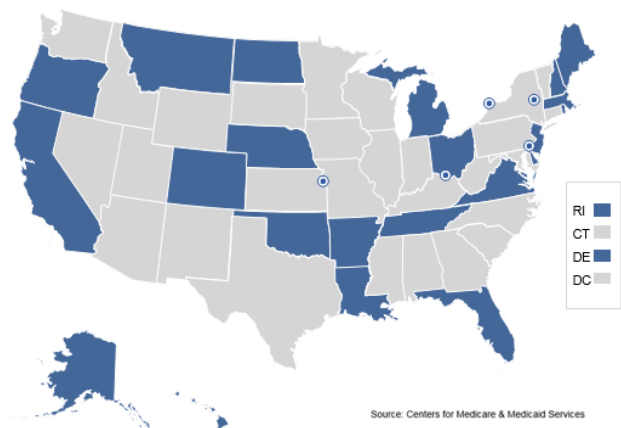
PCF addresses some issues that CPC+ tracks faced, such as insufficient funding to complete the administrative work required by CPC+ and lack of meaningful incentives to drive care transformation. A study by Mathematica for CPC+ practices found that only 41% of Track 1 and 51% of Track 2 practices indicated in the 2018 CPC+ practice survey that CPC+ Medicare funding was adequate for them to complete the work required by CPC+.[3] Some subject matter experts have argued that the size of a motivational incentive should be at least 10% of revenue to support improvement and exceed the cost to implement the desired behaviors.[4]

Like CPC+, PCF is based on the same core principles of care management, 24/7 access to a care management team member, and integrated behavioral health. However, some of the key differences are summarized in Figure 2. More details are provided in Figure 3 below.

[1] Luthi, S. (May 8, 2019). Medicare's Primary Care First model gets bipartisan boost in Senate hearing. Modern Healthcare. Retrieved August 8, 2019, from https://www.modernhealthcare.com/government/medicares-primary-care-first-model-gets-bipartisan-boost-senate-hearing.

[2] CMS (2019). Webinars: Primary Care First Model Options - Informational Webinar Series. Retrieved August 8, 2019, from https://innovation.cms.gov/resources/pcf-model-informational-webinar-series.html.

[3] Mathematica Policy Research (April 2019). Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report. Retrieved May 28, 2019, from https://downloads.cms.gov/files/cmmi/cpcplus-first-ann-rpt.pdf.

[4] Damberg, C.L., Sorbero, M., Mehortra, A., Teleki, S., Lovejoy, S., and Bradley, L. An Environmental Scan for Pay for Performance in the Hospital Setting: Final Report. Santa Monica, CA: RAND Health. Prepared for the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, 2008. https://innovation.cms.gov/Files/x/cpcplus-methodology.pdf

FIGURE 2: SUMMARIZED DIFFERENCES BETWEEN PCF AND CPC+ TRACKS

	PRIMARY CARE FIRST MODELS[5]	CPC+ TRACK 1 AND 2
Underlying payments	Population-based payment PBPM + flat visit fee	Fee-for-service payments + coordinated care fee
Performance Incentives	Up to 50% of primary care revenue	CPC+ Track 1 can get up to $2.50 PBPM and Track 2 can get up to $4.00 PBPM
Risk exposure	Up to 10% of primary care revenue	None
Beneficiary engagement features	Beneficiary incentive waivers may be granted, allowing beneficiary incentives	None
Data sharing/ feedback	National Provider Identifier (NPI) performance data can be provided to beneficiary	No NPI performance data provided to beneficiary
	More detailed claim and claim line feed (CCLF) data provided to participants on a regular basis	No CCLF data provided to participants

Significant departure from traditional primary care FFS

Primary Care First model

In the PCF model, payment for primary care services is through a hybrid of fee-for-service (FFS) and population-based payments. This hybrid payment structure is meant to reduce billing and revenue cycle burden, increase provider's time with patients, and promote team-based coordination of care. Based on the preliminary information shared by CMS, the flat visit fee will be about $50.52 per visit (and geographically adjusted) and the monthly risk-adjusted population-based payments (PBPs) can range from $24 to $175 per beneficiary per month (PBPM).

> *Total primary care payment = Flat visit fees + monthly risk-adjusted population-based payment.*

Note that the PBP will be risk-adjusted based on the overall average risk score for all patients within a practice. Thus, the PBP will be the same for the entire practice's patient panel. Further payment details are provided in Figure 3 below.

Practices also have the opportunity to increase revenue based on their performances. Performance-based payments can range from -10% to 50% of their total primary care payments. Performance benchmarks are based on a national reference population, other PCF participants, and the practices' own historical performances. In the first year all performance-based adjustments are based solely on acute hospital utilization (AHU).

From the second year onward, after meeting annual quality benchmarks (i.e., a Quality Gateway), two-thirds of the performance-based adjustments are based on acute hospital utilization and the remaining one-third is based on whether the practices have achieved their acute hospital utilization continuous improvement targets. More details are provided in Figure 3 below.

> *Total Medicare payments to PCF participants represent the sum of total primary care payments (composed of flat visit fee + monthly risk-adjusted population-based payment) and the performance-based payment.*

Some key questions about PCF are still unanswered or still require further exploration, including:

- Other than performance-based payments, how do the flat fee + PBPs revenues compare to most primary care practice revenues under existing FFS models?
- Into which risk groups will most practices fall for establishing PBP levels?
- Are primary care practices comfortable with a single metric, acute hospital utilization, as the driver of performance-based adjustments?
- How much will the random fluctuation of acute hospitalization impact smaller practice results?
- Will practices have concerns about competing exclusively with other primary care participants to achieve enhanced revenue over current levels?
- Will this program reduce administrative burden or will significant new administrative tasks emerge?
- Will the enhanced revenue opportunity outweigh the potential risk exposure?

Primary Care First: High-need seriously ill population payment model

PCF is also offering an alternative payment model to support care for the high-need seriously ill population (SIP). This model is optional for PCF payment model participants and also available to practices wanting to limit their participation to exclusively caring for SIP patients. Practices seeking participation in this model must demonstrate relevant capabilities and care experience in their applications. These practices will also have the option of having SIP patients with care coordination needs assigned to them. To support care for SIP patients, practices will receive a onetime $325 payment for a patient's first visit, monthly payments of $275 per subsequent visits up to 12 months, and flat visit fees of $50.52 (geographically adjusted). In addition, participants will also be eligible for quality performance payments.

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[5] CMS (April 22, 2019). Primary Care First: Foster Independence, Reward Outcomes. Retrieved May 28, 2019 from https://www.cms.gov/newsroom/fact-sheets/primary-care-first-foster-independence-reward-outcomes.

The quality payment ranges from -$50 PBPM up to $50 PBPM (geographically adjusted), based on performance.[6] Hospice and palliative care providers can participate either as standalone practices or partnering with a PCF participant (by being placed on its practitioner roster).

Some key questions about this model option are still unanswered:

- Will the proposed population-based payments provide sufficient funding to support interdisciplinary teams for SIP patients?

- Will the performance payments provide a meaningful incentive to transform the delivery of end-of-life care?

Conclusion

While this model appears to take a large step forward in offering physicians a payment model that facilitates care redesign, it seems likely that other payers (private payers and state Medicaid agencies) will need to jump on board for it to be transformative, given the small percentage of revenue tied to Medicare FFS beneficiaries. Furthermore, additional research needs to be conducted as to the range of potential financial scenarios for primary care practices under various performance levels. We plan to explore some of these outstanding questions in future issue briefs as more information emerges. This model is clearly another big bet that CMS is making on primary care and we look forward to seeing the results.

FIGURE 3:   DIFFERENCES BETWEEN PRIMARY CARE FIRST MODEL OPTIONS AND CPC+ TRACK 1 AND TRACK 2

	PCF MODEL & PCF HIGH-NEED POPULATION PAYMENT MODEL[2]	CPC+ TRACK 1	CPC+ TRACK 2
Underlying payments to practice	PCF and PCF SIP have a primary care flat visit fee of $50.52, which will be geographically adjusted, and a monthly risk-adjusted population-based payment.	Standard fee-for service.	Reduced fee-for-service and remaining comprehensive primary care payment (CPCP). Practices will select a hybrid payment ratio.
Population-based payment	PCF model: Each practice has a risk group rated from 1 (the lowest-risk group) to 5 (the highest-risk group), the basis for PBPM payments. PBPM payments will range from $24 to $175, depending on the overall practice risk score. This population-based payment is the same for all patients within a practice. PCF SIP model: The practice will get a onetime payment for a first visit of $325 and monthly SIP payments of $275 PBPM for up to 12 months. The $275 PBPM will have some withholding for quality purposes. More details will be provided by CMS soon.	No population-based payment. Instead practices receive care management fees (CMFs) for each patient, which start from Tier 1 of $6 PBPM to Tier 4 of $30 PBPM. An average CMF for Track 1 is $15 PBPM.	No population-based payment. Instead practices receive care management fees (CMFs) for each patient, which start from Tier 1 of $9 PBPM to Tier 5 of $100 PBPM. An average CMF for Track 2 is $28 PBPM.
Performance-based payment	(see table below)	Eligible to get performance-based incentive payment of no more than $2.50 PBPM (sum of quality / patient experience of $1.25 PBPM and utilization performance of $1.25 PBPM). It does not have any downside risk.	Eligible to get performance-based incentive payment of no more than $4 PBPM (sum of quality / patient experience of $2 PBPM and utilization performance of $2 PBPM). It does not have any downside risk.

Performance-based payment (PCF model):

Year 1	Years 2 to 5					
	If Quality Gateway Met					If Quality Gateway Unmet
	Then first perform National Adjustment Check			Lastly apply Continuous Improvement Adjustment		
Adjustments based on AHU*	If AHU ≤ Minimum benchmark(BM)	If AHU > Minimum BM				
		Then perform Cohort Adjustment Check compared to other PCF practices				
		If bottom 50% performer	If top 50% performer	All practices	If top 50% performer	
0%**	-10%	0%	Up to 34%	3.5%	Up to 16%	-10%

Note: * AHU: Acute Hospital Utilization
** Payment adjustments will occur from second year onwards

Primary Care First High-need SIP model: The Quality payment can be +/- $50 PBPM (geographically adjusted) based on performance.

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[6] CMS (July 24, 2019). Primary Care First: Webinar for Seriously Ill Population.

	PCF MODEL & PCF HIGH-NEED POPULATION PAYMENT MODEL[2]	CPC+ TRACK 1	CPC+ TRACK 2
Beneficiary engagement	Beneficiary engagement incentives and payment wavers are being explored by CMS. CMS mentions that further details will be available in the request for application and participation agreement.	No beneficiary payment or incentives.	
Data sharing	Practices get Medicare FFS expenditure and utilization data, Medicaid data, and National Provider Identifier level with identifiable information on performance of the participating practitioners. Practices can also receive claim and claim line feed (CCLF) data and, therefore, have the capability to drill down to get actionable data.	Both tracks receive Medicare FFS expenditure and utilization data at practice level on a frequent basis, including beneficiary-level data available only to its practices for their attributed beneficiaries. No CCLF data provided, therefore, practices are limited on drilling down to details.	

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