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CMS Announces New Value-Based Primary Care Initiative

Five New Value-Based Payment Models that include Downside Risk

May 2019

PULSE8 is privileged to bring you a summary of a new CMS initiative announced on April 22nd aimed at helping primary care providers transition to value based payments and migrate away from Fee For Service (FFS). The CMS Primary Care Initiative will provide five new payment model options under two paths titled 'Primary Care First' and 'Direct Contracting.' *The new models are anticipated to improve care coordination for more than 25% of all Medicare FFS beneficiaries.*

Model Summaries

CMS Primary Care Initiative		
	Primary Care First (PCF)	**Direct Contracting** (DC)
Description	• Model designed to test whether delivery of advanced primary care can reduce the cost of total care • Designed to reduce administrative burden by focusing quality reporting on a selected set of measures	• The model was built off lessons learned from Medicare NexGen ACO, MSSP, and Medicare Advantage plans • The models offer new capitated population-based payments (PBP) and enhanced payment options • Focused on dually eligible, complex chronic, and seriously ill patients. Designed to reduce administrative burden by focusing quality reporting on a selected set of measures
Payment Structure	• Two voluntary 5-year payment option plans • Flat monthly fee per patient • Performance-based adjustment with an upside of 50% • 10% downside risk	• Fixed monthly payments ranging from a portion of primary care cost to total care costs • **Professional PBP**[1] – *lower risk-sharing* • **Global PBP** – *higher risk-sharing* • **Geographic PBP** – *highest risk-sharing, CMS seeking public input on this option*

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<table>
<tr><td rowspan="1">Participation</td><td>Participants must be in one of the 26 regions offering this program
Primary care practitioners certified in internal medicine (MD, DO, CNS, NP, and PA)
125 attributed Medicare beneficiaries at a particular location
70% of practices' collective billing is for primary care services
Have experience with value-based payment arrangements
Additional requirements can be found by visiting https://innovation.cms.gov</td><td>Voluntary alignment should attract more organizations that were previously ineligible because of the low volume of Medicare FFS beneficiaries
Retains claims-based alignment approaches
Generally requires 5,000 aligned Medicare beneficiaries
Organizations submit a Letter of Intent (LOI) to CMS for review and subsequently a Request for Applications (RFA)
Current Medicare ACOs are eligible to participate in all 3 DC payment models</td></tr>
<tr><td>Ideal Organizations</td><td>Smaller primary care practices.
Provides payment to practices through a simple total monthly payment. This will allow for providers to focus more on patient care rather than revenue cycle
Organizations that already have experience with value-based arrangements such as MSSP</td><td>Designed to target a wider range of organizations that have experience in multiple financial risk-sharing arrangements:
ACOs
Medicare Advantage Plans
Medicaid managed care organizations</td></tr>
<tr><td rowspan="2">Models</td><td>General
Designed for primary care practices prepared to assume large financial risk as well as performance-based payments</td><td>Professional
ACO structure, participating and preferred providers defined at the TIN/NPI level
50% shared savings/losses on total cost of care
Primary Care Capitation[2] equal to 7% of total cost of care for enhanced primary care services</td></tr>
<tr><td>High Needs Populations
Designed to encourage advanced primary care practices including those whose clinicians are enrolled in Medicare and who typically provide hospice or palliative care services
Prepared to take financial responsibility for high need, seriously ill beneficiaries</td><td>Global
ACO structure, participating and preferred providers defined at the TIN/NPI level
100% shared savings/losses on total cost of care
Option of Primary Care Capitation or Total Care Capitation[3]</td></tr>
</table>

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	who lack a PCP and/or effective care coordination	**Geographic** • Open to entities interested in taking on regional risk and entering into arrangements with clinicians in the area • 100% shared savings/losses on total cost of care • Option of Primary Care Capitation or Total Care Capitation
Timeline	• Accepting applications in the Spring of 2019 for the first round • Launch the models beginning in 2020 • Second round of applications in 2020 • Second round launches beginning of 2021 • This model will last for 5 years	• Letter of Intent (LOI) available May 2, 2019 and due August 2, 2019 • Post Request for Applications (RFA) – Fall 2019 • DCEs selected in Winter of 2019 • Launch the models beginning in 2020 • Performance year beginning of 2021 • This model will last for 5 years

PBP[1] *– Population Based Payment*
Primary Care Capitation[2] *– Capitated, risk adjusted monthly payment for enhanced primary care services*
Total Care Capitation[3] *– Capitated, risk adjusted monthly payment for all services provided by Direct Contracting program participants and preferred providers in the agreement*

"Primary Care is a small slice of healthcare spending overall, but it has significant impact on downstream cost and quality," said HHS Secretary Alex Azar. Evidence supports that strengthening primary care has a direct correlation to higher quality, better outcomes, and lower costs within and across major population subgroups.

Even though the new payment models are voluntary, it is anticipated that nearly 11 million beneficiaries will shift from traditional FFS Medicare into value-based payment relationships as a result of this new Primary Care Initiative. Organizations that have found success in other value-based arrangements will benefit from the new models; specifically, the Direct Contracting models, which were heavily designed around the NexGen ACO model. CMS intends on keeping the NexGen ACO model but will reevaluate its success when it terminates at the end of 2019. Organizations need to be mindful of the uncertainty around the future of the NexGen ACO program when deciding whether they should take advantage of the one and only opportunity to apply for a new model.

The transition to value-based care is moving full speed ahead and more options and programs are being presented to encourage adoption and provide opportunities to foster success. The new models were designed to incentivize doctors to stay connected and engaged with patients *before* health problems arise, as opposed to *after*; i.e., quality over quantity and being proactive rather than reactive.

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Pulse8 Insight: *In order to be successful under these agreements, providers need to not only focus on delivering the best outcomes, but also managing resources appropriately. As the saying goes, you can't manage what you can't measure. The introduction of downside risk and capitated payments increases the need for effective tools that will analyze costs related to outcomes and align financial incentives, thereby empowering providers with actionable insight to help them make better patient care decisions.*

Pulse8's Illumin8™ Active Intelligence platform aggregates disparate data and provides advanced analytics that will help at-risk providers monitor their contract and track their clinical performance. Pulse8's Provider Solutions offer insight into cost and utilization both inside and outside of the network. This can help avoid redundancy and waste, as well as shed light on the financial impact of these associated services.

The new models were designed to allow providers to be more proactive in administering care and containing the cost of care, and Pulse8 can help maintain the contract terms as well as identify opportunities for improvement.

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