Introduction to Primary Care First and Direct Contracting Models
## Introduction to Primary Care First (PCF)

### Primary Care First Goals

1. **To reduce Medicare spending** by preventing avoidable inpatient hospital admissions

2. **To improve quality of care and access to care** for all beneficiaries, particularly those with complex chronic conditions and serious illness

### Primary Care First Overview

- **5-year** alternative payment model

- Offers greater **flexibility**, increased **transparency**, and **performance-based** payments to participants

- Payment options for practices that specialize in **patients with complex chronic conditions** and high need, **seriously ill populations**

- Fosters **multi-payer alignment** to provide practices with resources and incentives to enhance care for all patients, regardless of insurer
Overview of CMS Innovation Center Primary Care Models

CMS primary care models offer a variety of opportunities to advance care delivery, increase revenue, and reduce burden.

CPC+ Track 1 is a pathway for practices ready to build the capabilities to deliver comprehensive primary care.

CPC+ Track 2 is a pathway for practices poised to increase the comprehensiveness.

Primary Care First rewards outcomes, increases transparency, enhances care for high need populations, and reduces administrative burden.
PCF Payment Model Option
Emphasizes Flexibility & Accountability

PCF Payment Model Option Goals

- **Promote patient access**
  to advanced primary care both in and outside of the office, especially for complex chronic populations

- **Transition primary care**
  from fee-for-service payments to value-driven, population-based payments

- **Reward high-quality, patient-focused care**
  that reduces preventable hospitalizations

PCF Payments

- Professional population-based payments and **flat primary care visit fees** to help practices improve access to care and transition from FFS to population based payments

- Performance-based adjustments up to 50% of revenue and a 10% downside, based on a single outcome measure, with focused quality measures
### PCF – High Need Populations Model Payment Option

#### Seriously Ill Population

- **Engage** newly identified seriously ill population (SIP) patients who lack a primary care practitioner or care coordination.

- **Enhanced payments** to ensure that care is coordinated and SIP patients are clinically stabilized.

#### Participation Options

- **Multiple pathways to participate:** practices may limit participation to exclusively caring for SIP patients.

- **Opportunity for clinicians enrolled in Medicare who typically provide hospice or palliative care services** to participate.
In 2020, Primary Care First will include 26 diverse regions:

- **Current Track 1 and 2 regions**
- **New regions added in Primary Care First**
PCF Will Launch in Early 2020

Spring 2019
Practice applications open

Summer 2019
Practice applications due; Payer solicitation

Fall-Winter 2019
Practices and payers selected

January 2020
Model launch

April 2020
Payment changes begin

Practice application period
Practice and payer selection period
PCF Benefits for Participating Practices

**Simple payment model** so providers can spend more time with patients and deliver care based on patient needs.

Options for practices that specialize in **complex, chronic** and **high need, seriously ill populations**.

**Focus on single outcome measure** that matters most to patients: acute hospital utilization.

**Enhanced access to actionable, timely data** to inform care and assess your performance relative to peers.
Introduction to Direct Contracting
Direct Contracting: Model Goals

- Transform risk-sharing arrangements in Medicare Fee-For-Service (FFS)
- Empower beneficiaries to personally engage in their own care delivery.
- Reduce provider burden to meet health care needs effectively.
Direct Contracting: Design Approach in Brief

• Build off the Next Generation Accountable Care Organization Model to offer new forms of population-based payments (PBPs), enhanced cash flow options, and flexibilities to increase providers’ tools to meet beneficiaries’ medical and non-medical (e.g., social determinants of health) needs

• Expand emphasis on voluntary alignment and beneficiary choice, while retaining claims-based alignment approaches

• Reduce burden by focusing quality reporting on select measures

• Create a more predictable, prospective spending target by capitalizing on Medicare Advantage rate calculations for purposes of the regional component to the benchmark and the trend adjustment

• Focus on dually eligible, complex chronic and seriously ill patients

• Create participation opportunities for organizations new to Medicare FFS, and for Medicaid Managed Care Organizations interested in taking accountability for Medicare cost and quality where already accountable for Medicaid spending
Direct Contracting Model Options

Professional PBP
- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 50% shared savings/shared losses with CMS
- Primary Care Capitation equal to 7% of total cost of care for enhanced primary care services

Global PBP
- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 100% risk
- Choice between Total Care Capitation for all services provided by Participants (and optionally Preferred Providers), or Primary Care Capitation

Geographic PBP (proposed)
- Would be open to entities interested in taking on regional risk and entering into arrangements with providers in the region
- 100% risk
- Would offer a choice between Full Financial Risk with FFS claims reconciliation and Total Care Capitation

 Lowest Risk  

 Highest Risk
Geographic PBP model option would be open to innovative organizations, including health plans, health care technology companies, in addition to providers and supplier organizations.

Direct Contracting Entities

**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 and/or payment rule waivers, and contribute to Direct Contracting Entity goals

- 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
Benchmarking Methodology

- Professional PBP and Global PBP
  - 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

- Geographic PBP (proposed)
  - Would be based on a one-year historical per capita FFS spend in the target region trended forward (no historical/regional blend) with negotiated discounts
  - Final methodology would be informed by responses to the Request for Information
Quality

Quality strategy reduces clinician burden…

**Professional PBP and Global PBP**
- DCEs report a focused, core set of measures
- DCEs’ quality performance impact discounted benchmark amounts in Global PBP and final shared savings or losses in Professional PBP

**Geographic PBP (proposed)**
- DCEs would propose focused, core set of measures to be reported on their geographically aligned FFS population
- The measures would have to be approved by the CMS Innovation Center prior to participation and be tied to payment

…and focuses on relevant, actionable measures.

Direct Contracting is expected to be an Advanced APM in 2021.
Expanded Voluntary Alignment Approach

In addition to claims-based alignment . . .

• Greater emphasis placed on voluntary alignment, empowering beneficiary choice of providers with whom they want to have a care relationship and further promoting care coordination

• Mid-year alignment opportunities allows beneficiaries to be newly aligned during most of the performance year

• Potentially attractive to innovative providers who have similar arrangements with Medicare Advantage organizations, but have not been eligible for the Medicare Shared Shavings Program or the Next Generation Accountable Care Organization Model due to an insufficient number of alignment-eligible Medicare FFS beneficiaries

• Facilitates prospective benchmarking process
Considerations for High Need Populations

- Complex chronic and seriously ill patients
- Dually eligible for Medicare and Medicaid with complex needs
  - PACE-like populations and PACE-like clinical approach with focus on interdisciplinary team
  - Allowance with minimum alignment thresholds
  - Experience in providing range of Medicaid-covered services and Medicaid coordination
- Dually eligible enrolled in Medicaid managed care and Medicare FFS
  - Direct Contracting Entities convened by or affiliated with Medicaid Managed Care Organizations draw on dually eligible population experience and take accountability for Medicare costs and quality in addition to Medicaid spending under existing arrangements
- For Geographic PBP model option, we would assess, as part of the application process, the level of engagement and support from state Medicaid agencies to address potential for cost-shifting across Medicare and Medicaid, among other considerations
## 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>Post Letter of Intent (LOI)</td>
<td>Spring 2019</td>
<td>TBD</td>
</tr>
<tr>
<td>Release Geographic PBP RFI</td>
<td>NA</td>
<td>Spring 2019</td>
</tr>
<tr>
<td>Post Request for Applications (RFA)</td>
<td>Summer/Fall 2019</td>
<td>Fall 2019</td>
</tr>
<tr>
<td>DCEs selected for participation notified</td>
<td>Fall/Winter 2019</td>
<td>Winter 2019</td>
</tr>
<tr>
<td>DCEs sign Participation Agreements</td>
<td>Winter 2019</td>
<td>April 1, 2020</td>
</tr>
<tr>
<td>Performance Year 0</td>
<td>January 1, 2020</td>
<td>May 1, 2020</td>
</tr>
<tr>
<td>Performance Year 1 (Payments begin)</td>
<td>January 1, 2021</td>
<td>January 1, 2021</td>
</tr>
<tr>
<td>Performance Year 5</td>
<td>January 1, 2025</td>
<td>January 1, 2025</td>
</tr>
</tbody>
</table>
Learn More

• Visit Direct Contracting
  https://innovation.cms.gov/initiatives/direct-contracting-model-options/

• Visit Primary Care First

• Subscribe
  CMS Listserv