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CMS Announces New Primary Care Reimbursement Model

On April 22, 2019, the Secretary of the *U.S. Department of Health and Human Services* (HHS), Alex Azar, and the Administrator for the *Centers of Medicare and Medicaid Services* (CMS), Seema Verma, announced a new system of payment models related to primary care reimbursement.[1] The purpose of this new payment model system is to shift the focus of patient care from *volume*-based to *value*-based care, and to emphasize the importance of primary care's role in the U.S. healthcare system. This new primary care initiative consists of two paths: *Primary Care First* (PCF) and *Direct Contracting* (DC). PCF, which will begin in 2020, consists of two payment models, i.e., PCF and PCF for high need populations.[2] DC, which will begin a year later, in 2021, consists of three payment models, i.e., Global, Professional, and Geographic.[3]

Currently, most primary care providers who provide services to Medicare beneficiaries are paid through the *Medicare Physician Fee Schedule* (MPFS).[4] The MPFS provides payment for more than 10,000 physician services.[5] The fee schedule gives the fee maximums used by Medicare to pay physicians and other enrolled healthcare professionals on a *fee-for-service* (FFS) basis.[6] Medicare bases its payment on the *relative value units* (RVUs) of the specific procedure, which encompasses the work, practice expense, and malpractice RVUs.[7] The pricing amounts for each provider are then modified based on a physician's location, under the *geographic practice cost index* (GPCI).[8] Ultimately, Medicare's payment amount for a given procedure is either the charge for the procedure or the MPFS amount, whichever is less.[9]

While the MPFS is used generally as the primary method of reimbursing primary care physicians, it has been utilized in newer payment models as well, including the *Comprehensive Primary Care Plus* (CPC+) program, which was commenced in January 2017.[10] This model was used as a basis for the new PCF and DC models. [11] The CPC+ program is a national primary care medical home model with the main purpose of bolstering the primary care field through a regionally-based multi-payor payment reform and care delivery transformation.[12] CPC+ includes three payment models: *Care Management Fee* (CMF); *Performance-Based Incentive Payment*; and, payment under the MPFS.[13] The program is comprised of two tracks, both of which are based on a practice's readiness for transformation, a key element of such newer primary care payment models.[14] Track 1 focuses on the shift to value-based care and supports comprehensive care.[15] Track 2 focuses on advanced care and the patients' needs.[16] Between Track 1 and Track 2, the requirements for Track 2 illustrate the goals of CMS to strengthen the primary care field, as it requires a practice to develop and record care plans, follow up with patients after hospital discharge, and implement a process to link patients to community-based resources.[17]

The first annual report regarding the results of CPC+ was released on April 22, 2019.[18] Results indicate that since CPC+ began in 2017, there have been more than 15 million patients served.[19] In the first year, the median practices enrolled in CPC+ received significant financial support.[20] During 2018, Track 1 practices received a total of $88,000 ($32,000 per practitioner on average) in care management fees, and Track 2 practices received a total of $195,000 ($53,000 per practitioner on average) in care management fees.[21] The *care management fee* is a non-visit based fee paid per beneficiary per month.[22] However, CPC+ did not have a profound effect on Medicare FFS beneficiaries.[23] Even with the enhanced CPC+ payments, there were insignificant differences in service use and quality-of-care outcomes between the practices that did not participate in CPC+ and the practices that did participate in CPC+.[24] In fact, there was an actual 2-3% increase in expenditures for Medicare FFS beneficiaries in CPC+ practices that included the enhanced payments.[25]

The PCF Model and DC Model seek to build upon the benefits and drawbacks indicated in the CPC+ first year results. The PCF Model seeks to transform current primary care models and continue to push the system toward a regionally-based, multi-payor approach to care delivery and payment. Specific regions are designated for the PCF Model, which allows it to be considered more regionally-based.[26] This program will reward physicians for higher performance and alleviates administrative burdens that might affect quality of care.[27] The voluntary PCF Model is geared toward advanced primary care practices and seeks to remove from clinicians the financial risks that they face from administrative drains and provide more performance-based payments.[28] As noted above, there will be two PCF payment model options (five years in length), which will be offered in 26 regions for the first performance year.[29] The first model will be for physicians treating general populations, and the second model will be for physicians treating high need populations.[30] With both PCF payment model options, Medicare will pay a risk-

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adjusted professional population-based payment with a flat primary care fee visit.[31] In the first model, those practices that achieve high performance based on relative actionable outcomes such as high blood pressure, maintaining diabetes, and prevention screenings will be rewarded.[32] The second model is more focused on *Seriously Ill Populations* (SIPs) and will encourage clinicians to provide hospice and palliative care to those seriously ill Medicare beneficiaries who do not have a primary care provider; the payments under this model "*will be set to reflect the high need, high risk nature of the population as well as include an increase or decrease in payment based on quality*."[33]

In contrast to PCF, the DC Model has three payment models, with the main aims of reducing expenditures and preserving or enhancing the quality of care for Medicare beneficiaries.[34] The three payment models include: *Global*, *Professional*, and *Geographic*.[35] The *Global Model* offers the highest risk sharing arrangement (100% savings/losses) and offers two payment options:

(1) *Primary Care Capitation* – A capitated, risk-adjusted monthly payment for enhanced primary care services; or,

(2) *Total Care Capitation* – A capitated, risk-adjusted monthly payment for all services provided by the program participants and preferred providers.[36]

The *Professional Model* offers a lower risk-sharing arrangement (50% savings/losses) and provides *Primary Care Capitation*, a capitated, risk-adjusted monthly payment for enhanced primary care services equal to 7% of the total cost of care for enhanced primary care services.[37]

CMS is still seeking input for the *Geographic Model*, which will provide a similar risk level as the *Global Model*, but its potential participants will take responsibility for total cost of care of all Medicare FFS beneficiaries in a defined target region.[38]

These PCF and DC models will seek to transform the current risk-sharing agreements in place and expedite the transition away from the traditional FFS payments and toward *value-based reimbursement*. The main goals for this these models are to help empower beneficiaries and reduce provider burden.[39] This is yet another step in the ongoing transformation of the U.S. healthcare delivery system, from a *volume-based* system to a *value-based* system, and is not likely to be the last. While CMS's payment model initiatives have largely been voluntary for providers to date, CMS Administrator Verma has affirmed that CMS plans to establish mandatory payment models in order to "*help[CMS] understand the impact of our models on a variety of provider types, so the data resulting from the model will be more broadly representative*."[40]

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