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CMS Launches New Primary Care Payment Models

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On April 22, 2019, the Centers for Medicare and Medicaid Services ("CMS") announced four new voluntary payment models that could allow primary care practitioners like physicians or advanced practice nurses, hospitals or other providers to earn additional Medicare reimbursement for primary care services in exchange for taking on more risk. The models, which will be operated by the Center for Medicare and Medicaid Innovation ("CMMI"), are designed to create opportunities for primary care providers to earn additional payments and manage the costs of care for their patients but also create significant new strategic risks providers should understand. These models provide an important opportunity to gain more resources for primary care services, which have significant impacts on health outcomes but have low reimbursement. CMS anticipates that these voluntary models will begin in January 2020. CMS also requests input on a fifth model that could be of interest to Medicare Advantage plans or other existing payers.

All of the models involve capitated or partially capitated payments made to physicians or other entities, with opportunities for increased payments based on achieving performance-based goals. The Primary Care First ("PCF") model involves:

1. A risk-adjusted population-based payment.

2. A flat primary care visit fee.

3. A performance-based increase to primary care revenue of up to 50% (or a decrease of up to 10% for poor performance).

Additional resources are available to practices that care for "Seriously Ill Populations" (the "PCF-SIP" model). Participants in the PCF models may also receive additional program data sharing. The PCF models are open to practices located in one of 26 "Primary Care First" regions, if these practices meet certain criteria including providing high levels of primary care, having a history of participating in CMS value-based models and implementing "advanced primary care" standards.

The Direct Contracting ("DC") models are formal participation models that involve a "DC Entity" that

would contract with providers to take responsibility for the care delivered to a patient population. Medicare Accountable Care Organizations (“ACOs”) may choose to become DC Entities to supplement their existing care transformation efforts, as could other kinds of health care providers. Beneficiaries will voluntarily align with a DC Entity, and DC participants can offer additional services called “benefit enhancements” above and beyond existing Medicare services. DC Entities can choose to be paid either:

1. A “Professional Performance-based Payment” model featuring risk sharing of 50% savings or losses and capitated primary care payments equal to 7% of the total cost of care; or

2. A “Global Performance-based Payment” model featuring 100% risk sharing and capitated payments covering either primary care only or covering all services provided by the DC Entity and its affiliated providers.

CMS expects the DC models will begin in January 2020, with participation through 2026. Finally, CMS requests information related to a potential future “Geographic DC” model that would allow entities (including health plans) to manage Medicare fee-for-service patients in whole regions. Comments are due on this model by May 23, 2019.

CMS left many unanswered questions in its initial announcement materials. Prospective participants may have additional questions about the models’ eligibility criteria, interactions with ACOs and other value-based models, coordination with private payers, availability of waivers of Medicare fraud and abuse laws and CMS payment rules and other common considerations. We expect many of these questions will be answered in future CMS materials including a more detailed “Request for Application” and Participation Agreements. CMS will also host a number of webinars and informational events regarding these models over the following several weeks (see: https://innovation.cms.gov/Webinars-and-Forums/).

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