We're Thinking About the New CMS Primary Care First and . . .

Here is the PA Clinical Network's Point of View

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CMS continues to seek payment methodologies that transfer financial risk to primary care physicians. The prospect of additional Medicare revenue may prompt high-performing practices with an appetite for greater accountability to apply for *Primary Care First* (PCF).

As a new program, PCF comes with many important details to catalog, including accuracy/timeliness of attribution and short-term cash flow changes from flat-fee schedule/care management fees vs. higher payments for patients requiring higher-intensity service. Also unclear is the distinction between risks under physician control vs. random risks.

An April 22 CMS announcement describes PCF as a set of value-based payment options that simultaneously (1) help primary care and (2) increase value for patients with chronic conditions:

> *Primary Care First*: This is a five-year pilot designed to regionally determine whether PCPs can reduce the total cost of care with "advanced" primary care practices that are prepared for risk.

According to the HealthExec.com website:

> PCPs will get a flat revenue stream for each patient, for which they are paid a bonus when a patient remains healthy and out of the hospital. Practices will be responsible for added costs—up to a determined share of their revenue—if patients end up sicker than expected. Providers could lose 10 percent of their revenue, though stand to see bonuses as high as 50 percent…

PCF has two models trading financial risk for reduced administrative burden and performance-based payments.

1) ***Primary Care First*, in which the practice accepts monthly payments and a flat visit fee for an attributed population of Medicare beneficiaries.** If hospitalizations and cost of care decline, participating practices earn an additional performance-based payment up to 50% based on total practice income. If costs are

excessive, downside is limited to 10%. This model contrasts with CPC+, which has FFS payments, care management fees and quality bonuses.

2) ***PCF High Needs or Seriously Ill Population (SIP) Option*, requiring practices to demonstrate relevant capabilities and a network of relationships.** Population-based payments will reflect a high-need and high-risk nature. This model includes hospice and palliative care.

To participate, practices must:

- Be in the right region. In Pennsylvania, this is limited to greater Philadelphia.
- “Include” PCPs defined by 70% of primary care income.
- Be “experienced” in alternative payment arrangements.
- Have the right EHR tech connected to a Health Information Exchange (HIE).
- Provide “attestation” such as the statement that 24/7 access is present.
- Work with multiple payers (i.e. “encourage” other payers to “align” measures, payment and data sharing).
- Have a minimum of 125 Medicare beneficiaries at each location.
- NOT be participating in a CPC+ model.

Attribution to a practice is claims-based. There seems to be an option for “proactive identification of assignment of seriously ill and unmanaged beneficiaries.” Data will be provided quarterly at the NPI level and practices can get a data feed from CMS.

To incent beneficiaries to participate, there will be “engagement incentives” and “payment waivers.” CMS expects these incentives to prompt 25% of FFS Medicare beneficiaries to opt into a PCF participating practice.

For information on the PA clinical Network, log onto www.pennsylvaniacin.com.