

The Problems with “Primary Care First” and How to Fix Them

The Need to Improve Payment for Primary Care Services

The most important element of a truly “value-based” healthcare system is strong primary care. The reason is simple – the lowest spending and the best outcomes occur when patients stay healthy, and primary care is the only component of the healthcare system that is specifically designed to help patients prevent health problems from occurring and to identify and treat new problems as early as possible.

Unfortunately, the nation’s primary care system is at risk of collapse. There is a large and growing shortage of primary care physicians in the country¹; many primary care physicians are burning out², and most medical students don’t want to go into primary care³. Although there are multiple causes for this, a major reason is the failure of the current payment system to provide adequate resources to support high-quality primary care services.⁴ The problems are particularly severe for small primary care practices, which deliver most of the care in rural areas of the country.

The CMS “Primary Cares Initiative” and “Primary Care First”

On April 22, 2019, Secretary of Health & Human Services Alex Azar announced the “CMS Primary Cares Initiative,” consisting of five new payment model options intended to “transform primary care to deliver better value for patients throughout the healthcare system.”⁵ Two of the payment model options are titled “Primary Care First,” and the others are called “Direct Contracting.” Following the announcement, many stakeholder groups praised HHS and CMS for creating multiple new primary care payment options, since the only current CMS alternative payment model for primary care is the Comprehensive Primary Care Plus (CPC+) initiative, and it is only available to primary care practices in a small portion of the country.⁶

The full specifications of the new Primary Cares Initiative options have not yet been released, but based on the details CMS has revealed so far,⁷ it appears they may fall far short of what is needed to fully address the problems facing primary care and to successfully sustain a high-value primary care system.

Essential Elements of a Good Primary Care Payment System

What should the payment system for primary care look like? Both the American Academy of Family Physicians (AAFP)⁸ and Jean Antonucci, MD⁹ (a solo primary care physician practicing in rural Maine) have developed proposals for new primary care payment models that the Physician-Focused Payment Model Technical Advisory Committee (PTAC)¹⁰ recommended be implemented by HHS.¹¹ These proposals, as well as proposals developed previously by other primary care physicians and experts on primary care payment,¹² have five key elements in common:

- 1. Flexibility to Deliver Services to Patients Other Than Traditional Face-to-Face Office Visits.** Instead of being paid only for face-to-face office visits with physicians, primary care practices should receive a monthly payment for each patient that provides flexibility for the primary care provider (PCP), a nurse, or other staff to help the patient in person, by phone, or by email. The practice should receive this payment for every patient who agrees to receive primary care from the practice.
- 2. Adequate Resources to Support Essential Services.** In order for primary care practices to have adequate staff and sufficient time to provide high-quality care for patients, the monthly payments need to provide two to three times as much revenue as the practices currently receive from office visit fees. In addition, since patients with more health conditions and other challenges will require more time and services from their primary care practice, a primary care practice will need to receive a higher payment for each higher-need patient.
- 3. Accountability Focused on Patient-Centered Outcomes the Practice Can Control.** A primary care practice that receives adequate, flexible payments can and should be accountable for delivering high-quality care, helping its patients achieve good outcomes, and for reducing avoidable spending. However, primary care practices should not be placed at financial risk for aspects of spending they cannot control or influence.
- 4. Reasonable Administrative Burden.** Primary care practices should be able to spend as much of their time as possible on activities that will improve patient care rather than on burdensome administrative tasks.
- 5. Consistent, Predictable Payments.** Primary care practices should know in advance how much they will be paid if they deliver high-quality care so they will know how much they can afford to spend on staff, equipment, and other costs.

SUMMARY OF PROBLEMS WITH PRIMARY CARE FIRST AND HOW TO FIX THEM

Essential Elements of a Good Primary Care Payment System	Problems with Primary Care First	Changes to Improve Primary Care First
<p>1. Flexibility to deliver services to patients other than traditional face-to-face office visits</p>	<ul style="list-style-type: none"> • Practices would still receive more than one-third of their revenues based on the number of face-to-face office visits • For many patients, payments would still be primarily based on face-to-face office visits • Most primary care practices in the country would not be able to participate 	<ul style="list-style-type: none"> • Pay practices with a monthly per-patient payment in place of all fees for office visits • Begin paying monthly payments immediately for each patient who enrolls for care from the practice • Allow primary care practices in all parts of the country to participate
<p>2. Adequate resources to support essential services for patients (significantly higher than provided by current payments)</p>	<ul style="list-style-type: none"> • Most practices would receive no more revenue than they do today • Practices would no longer receive a higher payment for a patient who has greater needs 	<ul style="list-style-type: none"> • Set monthly payment amounts at levels adequate to support high-quality primary care • Pay a higher monthly amount for a patient who has greater needs • Create a complementary payment model with adequate payments to support home-based palliative care for seriously ill patients
<p>3. Accountability focused on patient-centered outcomes that a primary care practice can control</p>	<ul style="list-style-type: none"> • Most practices would not receive higher payments based on performance • Performance measures used for accountability are not patient-centered and cannot be fully controlled by primary care practices 	<ul style="list-style-type: none"> • Use measures of patient-centered outcomes that can be controlled by the practice in order to evaluate its performance • Set achievable performance targets, adjusting appropriately for the number and characteristics of the patients in the practice
<p>4. A reasonable administrative burden for the primary care practice</p>	<ul style="list-style-type: none"> • Payment complexity would increase and administrative burdens would remain high 	<ul style="list-style-type: none"> • Create new billing codes so that practices can use existing billing systems for both monthly payments and the fees they will continue to receive
<p>5. Consistent, predictable payments</p>	<ul style="list-style-type: none"> • Practice revenues could vary significantly from quarter to quarter based on random variation in hospitalization rates, factors outside the practice's control, and the performance of other practices 	<ul style="list-style-type: none"> • Increase payments annually based on inflation • Allow practices to determine which patients have higher needs that require higher payments • Set performance targets in advance • Prevent practices from being penalized or rewarded for random variation in outcomes • Limit performance-based payment adjustments to 15% of base payments

The Problems with Primary Care First

Although there are five different payment model options in the Primary Care Initiative, the two “Primary Care First” options are the only ones that a small primary care practice will be able to participate in. The “Direct Contracting” options are only available to practices that have at least 5,000 Medicare patients, which is far more patients than solo and small primary care practices will have and more than many practices in rural communities will have. In fact, most of the counties in the United States don’t even have 5,000 Medicare beneficiaries living in them.¹³

Unfortunately, based on the information released so far, Primary Care First doesn’t have the characteristics of a good primary care payment model described above. There are nine important gaps in the current design:

1. Practices Would Still Receive a Significant Portion of Revenues Based on the Number of Face-to-Face Office Visits

As Primary Care First is currently defined, a participating primary care practice will receive a \$24 “Professional Population-Based Payment” (PBPM payment) each month for each attributed patient instead of being paid current Medicare fees for Evaluation & Management (E/M) services and office visits. The monthly payment would give the practice flexibility to deliver services that are not eligible for Medicare payment today, such as phone calls, emails, care management, etc.

However, at the same time that Primary Care First eliminates the current E/M payments for face-to-face office visits for attributed patients, it creates a brand-new \$50 fee for each face-to-face office visit, which is about half as much as the average amount primary care physicians currently receive from Medicare for office visits.¹⁴ Based on the current average frequency with which Medicare beneficiaries make primary care office visits, this means that more than 40% of a typical practice’s payments would still be tied to face-to-face visits.¹⁵ As a result, if the practice is able to care for patients effectively with fewer office visits, it will lose revenue and it could be unable to cover its operating costs.

This hybrid payment model is not what primary care practices have called for, because it does not provide the kind of flexibility that they need to truly redesign care delivery. Under the current design of Primary Care First, a practice that successfully keeps its patients healthy and enables chronic care patients to receive services at home rather than in a hospital or the physician’s office could be financially penalized compared to practices that continue to rely heavily on traditional office visits to deliver services. Moreover, this hybrid payment approach is already being tested in CPC+ Track 2, where the practice receives a quarterly per-patient Comprehensive Primary Care Services Payment in addition to lower E/M payment amounts.

2. Payments for Many Patients Would Not Be More Flexible at All

Although the PBPM payments would provide a practice with some greater flexibility to deliver different services than would be possible with E/M payments alone, the practice would only receive the flexible PBPM payments for patients who are “attributed” to the practice or who “voluntarily align” with the practice. Patients are only attributed to the practice if most of their primary care visits during the previous two years were made to that same practice. For example, a patient will only be attributed to a practice in the first quarter of 2020 if the patient received more primary care visits from that practice than any other practice during the 24-month period between October 2017 and September 2019 or if the patient received their most recent Annual Wellness Visit during that time period from the Primary Care First practice. This means that a patient who switched their care to the Primary Care First practice in 2019 may not be attributed to that practice until 2021, and there would be no change in the payment to the practice for that patient until then.

A patient can also “voluntarily align” with the practice, which would override the attribution process. However, the patient cannot simply sign a form designating the practice as their primary care provider. The patient has to create an account on the CMS website and go through a multi-step process to designate the PCP as their primary clinician. Even if the patient successfully completes this process, the patient will not be included on the practice’s attribution/alignment list for up to six months after the patient makes the designation.¹⁶

As a result of these complex rules, a significant subset of a primary care practice’s patients may not be formally attributed/assigned to it, and it will not receive the monthly PBPM payments for those patients. Instead, it will only be able to receive traditional E/M fees for these patients, with no flexibility to deliver care differently. This, combined with the office visit fee for the attributed/aligned patients, means that the majority of the practice’s revenues for Medicare beneficiaries will likely still be based on how many face-to-face office visits patients make. Moreover, unless all of the practice’s other payers make changes similar to Primary Care First, the vast majority of the practice’s revenues will still be based on traditional, narrowly-defined fee-for-service payments.¹⁷

3. Practices Would No Longer Receive a Higher Payment for a Patient Who Has Greater Needs

In the current fee-for-service payment system, in the CPC+ demonstration, and in both of the primary care payment models developed by the AAFP and Dr. Antonucci, a primary care practice would receive a higher payment when it provides care to a patient with greater needs:

- Under the current fee for service system, a primary care practice is paid more for a patient with higher needs because (a) the patient will likely need to make more visits to the practice, (b) the visits will likely be

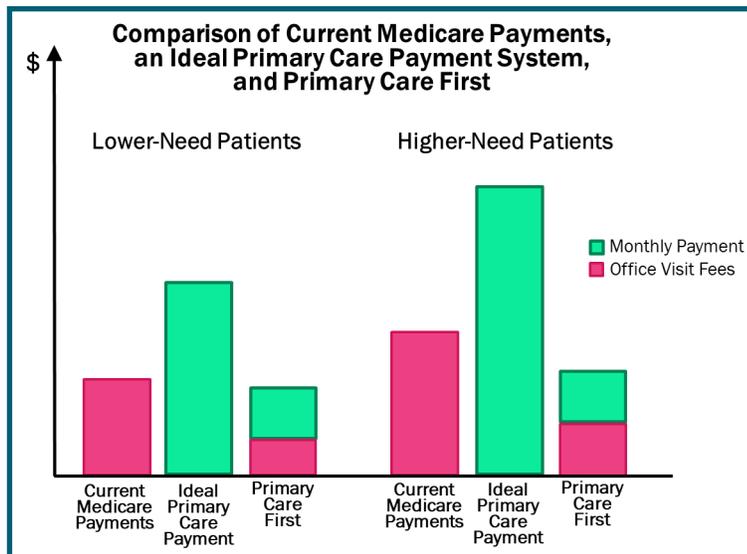
longer and more complex, and thereby eligible for higher Medicare payments, and (c) the practice will also be able to bill for additional Chronic Care Management payments for many of those patients.

- In the current CMS Comprehensive Primary Care Plus (CPC+) initiative, primary care practices receive a Care Management Fee (CMF) for each patient in addition to fee-for-service office visit payments, and the CMF is up to 5-10 times higher for a patient who has multiple health problems than for a patient who is relatively healthy.
- In the primary care payment models developed by both the AAFP and Dr. Antonucci, a practice would receive a higher monthly payment for each patient who has greater needs for care.

Yet under Primary Care First, a primary care practice would receive the exact same monthly payment for a patient regardless of how sick or healthy they are. A practice could receive a higher monthly payment for *all* of its patients if a sufficiently large fraction of its patients are sufficiently sicker than average to bump the practice into a higher payment tier, but it would not receive a higher payment for an *individual* patient who was much sicker than average. Since an individual patient who has higher needs will require more time and resources from the practice than other patients, a practice that is caring for that patient will have to reduce the time and resources it devotes to other patients if the payment is the same.

CMS has not yet defined what average risk score among the patients would trigger a higher monthly payment to the practice in Primary Care First. Even if the average risk score for the practice's patients was high enough to qualify for the next higher level of payment, that would only be \$28 per patient per month instead of \$24. If the average risk score for *all* patients is high enough, the practice could receive payments of \$45 per month, \$100 per month, or even \$175 per month for every patient. However, it seems unlikely that many practices, particularly small practices, would have so many very ill Medicare patients that they could qualify for the payments at these levels. If payment levels of \$45 per month, \$100 per month, or \$175 per month are appropriate when all of the patients in the practice have an average risk score of a certain level, then it would be inappropriate to only pay \$24 or \$28 per month for an individual patient who has high needs simply because the other patients in the practice don't have similar needs.

Moreover, Primary Care First will use the CMS Hierarchical Condition Category (HCC) system to determine a patient's risk score, and HCCs are based only on the number of chronic conditions that a patient had in previous years, not their current chronic conditions, the severity of those conditions, the acute conditions they are currently experiencing, their functional status, or other barriers they face in obtaining care.¹⁸ As a result, a practice could have a very high need group of patients, but still receive no higher payment under Primary Care First because the higher needs of the patients would not be reflected in their HCC scores.



In addition, under Primary Care First, the practice would receive the exact same \$50 office visit fee regardless of how much time is required to address the patient's needs. In contrast, under the current Medicare Physician Fee Schedule, a practice can receive as much as \$148 for a Level 5 visit with an established patient and \$210 for a Level 5 visit with a new patient. In 2018, CMS proposed replacing E/M office visit fees for all physicians with a single flat fee, but it withdrew this change following widespread criticism that this would financially penalize physician practices that have higher-need patients and make it more difficult for such patients to obtain primary care services. These problems would presumably be even greater under Primary Care First, since the practice would receive an even lower amount per visit and the same \$24 per month payment regardless of a patient's needs.

CMS has also created a second option under Primary Care First for "Seriously Ill Patients." In this option, practices would receive \$275 per patient per month in addition to the \$50 visit fees, but this would only apply to seriously ill patients who do not already have a primary care provider. Although this payment amount would be much higher than the default payment of \$24 per patient per month, it is actually far below the amount needed to support the kind of home-based palliative care services these patients need, much less all of their primary care needs, too. Payment models for home-based palliative care developed by both the American Academy of Hospice and Palliative Medicine (AAHPM)¹⁹ and the Coalition to Transform Advanced Care (CTAC)²⁰ included payments of at least \$400 per month to support palliative care services to a patient with advanced illness.

4. Most Practices Would Receive No More Revenue Than They Do Today, and Less Revenue Than Under Other CMS Primary Care Models

While opinions differ about the best methodology for paying for primary care, there is widespread agreement that primary care practices need to be paid more than

they are paid today. Under the CMS Comprehensive Primary Care Plus initiative, primary care practices are paid 30% - 60% more for attributed/aligned patients than they would typically receive under the current fee-for-service system. Both the AAFP and Antonucci primary care proposals call for even higher payment amounts than this.

However, it appears that under Primary Care First, a primary care practice would receive no increase in revenue. Under Primary Care First, a primary care practice would receive less than \$43 per patient per month for each attributed patient, compared to average revenues of \$35 - \$46 per patient per month under the current Medicare Physician Fee Schedule.²¹ In fact, CMS has indicated that the combination of the PBPM payments and office visit fees in Primary Care First is intentionally designed to be equivalent to the current fee-for-service payments that practices receive. Moreover, because the PBPM payment would be the same for all patients, practices whose patients have required more and/or longer visits than average would likely receive less revenue under Primary Care First than they do today.

This also means that primary care practices would receive lower payments under Primary Care First than they do under CMS's existing Comprehensive Primary Care Plus (CPC+) initiative:

- In Track 1 of CPC+, a practice would receive Care Management Fees averaging \$15 per beneficiary per month on top of E/M visit-based payments (which would typically average about \$35 PBPM), for average total payments of about \$50 per patient per month.

- In Track 2 of CPC+, a practice would receive a combination of E/M visit-based payments at a reduced rate and a quarterly Comprehensive Primary Care Payment, plus Care Management Fees averaging \$28 per beneficiary per month, resulting in average total payments of about \$62 per patient per month.
- In contrast, in Primary Care First, the \$24 monthly payment per patient and the \$50 per visit fees would generate average total payments of only about \$43 per patient per month, which would be 14% - 31% less than practices participating in CPC+.

Despite receiving no additional revenue, a Primary Care First practice would be expected to deliver the same kinds of expanded services required under CPC+, including 24/7 access to a care team member, care management services, and integrated behavioral healthcare services.

5. Most Practices Would Receive Little or No Reward Based on Their Performance

Primary Care First also includes a "Performance-Based Adjustment" which could increase the amount the practice is paid by as much as 50%. However, it appears that at most a small fraction of practices would receive an increase that large because of the way the criteria are being defined:

- Two-thirds of the Performance-Based Adjustment would be based on how often a practice's patients are hospitalized relative to other practices participating in the program. Only half of participating practic-

PERFORMANCE-BASED ADJUSTMENTS TO PAYMENTS IN PRIMARY CARE FIRST

		Quality & Cohort Adjustments	Improvement Adjustment	Total Performance-Based Adjustment
Quality Measures	Worse than minimum standard	-10%	0%	-10%
Hospitalization Rate Compared to Primary Care First (PCF) Practices	Worst 25% of practices nationally	-10%		
	Worse than 50% of PCF Practices	0%		
	Better than 50% of PCF Practices	+ 6.5%		
	Better than 60% of PCF Practices	+13%		
	Better than 70% of PCF Practices	+20%		
	Better than 80% of PCF Practices	+27%		
Achievement of Hospitalization Rate Improvement Goals Compared to Other Primary Care First Practices	Bottom 60% of PCF Practices		+ 3.5%	
	Better than 60% of PCF Practices		+ 7%	
	Better than 70% of PCF Practices		+10%	
	Better than 80% of PCF Practices		+13%	
	Better than 90% of PCF Practices		+16%	
MAXIMUM REDUCTION				-10%
MAXIMUM INCREASE				+50%
CHANGE FOR MAJORITY OF PRACTICES				+3.5%

es would even be eligible for this “Cohort Adjustment,” and at most 10% of practices would be able to receive the maximum payment increase of 34%.²² No matter how much the practice reduced the hospitalization rate for its patients, it would only receive an increased payment under the Cohort Adjustment if the hospital admission rate for its patients was lower than the hospitalization rate at other practices. The majority of practices would receive an increase of either 0% or 6.5% for this component.

- The remaining one-third of the Performance-Based Adjustment would be based on whether the practice achieved an “improvement target.” CMS has not yet defined how this improvement target would be set, but regardless of the details, CMS has said that at most 10% of practices would be eligible for the maximum payment increase of 16% (and these would not necessarily be the same practices that had qualified for the maximum Cohort Adjustment). By definition, the majority of practices would be eligible for only a 3.5% payment increase on this component.²³

As a result, it appears that the majority of practices would only be able to receive a 3.5% increase in their total payments through the Performance Based Adjustment component of Primary Care First, not a 50% increase. This is less than the Performance Based Payments practices can receive under the Comprehensive Primary Care Plus Initiative, which are equivalent to about 5-7% of the revenue a CPC+ practice would receive from visit-based payments and care management fees. In the first year of the CPC+ program, most practices were not able to achieve the rates of ED visits and hospitalizations necessary to retain the portion of the performance-based payment that is based on utilization.²⁴

Across all practices, it appears the average Performance-Based Adjustment in Primary Care First would be about 17%. This is a bigger percentage increase than the maximum Performance-Based Payment under CPC+; however, because the base payments in Primary Care First would be 14%-31% lower than in CPC+, practices in Primary Care First would still be receiving less revenue in total than practices participating in CPC+. The small percentage of practices that receive the maximum 50% Performance Based Adjustment in Primary Care First would be receiving about the same amount in total payments as a high-performing practice that participates in CPC+ Track 2.

6. Accountability Measures Are Not Patient-Centered

Under Primary Care First, a practice that performs well on quality measures would not automatically receive a higher payment because of that. Delivering high-quality care would merely enable the practice to *avoid a reduction in payment*; the practice would only qualify for an *increase in payment* if its patients were also hospitalized less frequently than the patients in other practices. As noted earlier, the majority of practices would only be eligible for a small increment in payment based on hospitalization rates, so for most practices, delivering care that is better than minimum quality standards would not

result in a significant difference in payment. (In the first year of the Primary Care First program, a practice with a low rate of hospital admissions can qualify for a large increase in payment even if the overall quality of care it delivered was poor.)

Moreover, “quality” would be determined using at most five quality measures (control of hemoglobin A1c for diabetic patients, control of blood pressure, colon cancer screening, existence of an advanced care plan, and patient ratings of their care experience; the diabetes and colon cancer screening measures would be dropped for practices whose patients have high average risk levels, leaving only three quality measures for the highest-risk patients). While this short list would limit the administrative burden of quality measurement, it would also give primary care practices an undesirable incentive to focus more attention on diabetic and hypertensive patients than on patients who have other kinds of health problems or who are at risk of developing problems.

Although Primary Care First has been described as “outcome-based payment,” the Performance-Based Adjustment would be determined based on only one narrowly-defined outcome – whether a patient is hospitalized or not. The hospitalization rate used in determining the amount of the adjustment is a very crude measure that does not distinguish whether a hospitalization could have been avoided by the primary care practice. A hospital admission for injuries in a traffic accident, for planned surgery to treat cancer, or for complications of chemotherapy administered by an oncologist are treated the same as an admission for an exacerbation of a chronic disease due to the PCP’s failure to prescribe appropriate medications. Analyses have shown that the majority of hospital admissions for Medicare beneficiaries are not in the categories considered to be potentially avoidable.²⁵

The heavy weight placed on this one measure appears to be intentionally designed to give primary care practices a large financial incentive to focus their attention on those patients who have a high risk of hospitalization for avoidable reasons. However, since a primary care practice in Primary Care First would not receive higher payments than it does today, this could force the practice to reduce services to other patients in order to fund care management services focused on the high-risk patients.

Moreover, although all patients would like to avoid *unnecessary* hospital admissions, hospital admissions are necessary in many cases to safely treat serious problems, and delaying or discouraging these admissions would negatively affect patients. Recent studies have suggested that financial incentives to reduce hospital readmissions for patients with chronic conditions may have increased the mortality rate for those patients.²⁶

7. Practice Revenues Would Be Unpredictable and Uncontrollable

Most of the costs in a primary care practice are fixed. Personnel, rent, and equipment leases all need to be paid every month, and these costs don't vary depending on the number of office visits patients make or the number of other services they receive. One of the important benefits of paying a practice using monthly payments per patient, rather than traditional fees for individual services, is that monthly payments are better aligned with the way the practice incurs costs.

However, a primary care practice needs to be able to predict how much it will receive each month in order to be sure it will have enough revenues to cover the costs of hiring additional personnel to deliver expanded services to its patients. Several aspects of the current design for Primary Care First will make it impossible for primary care practices to predict or control how much they will be paid from month to month:

- The practice will only receive the monthly Professional Population-Based Payment for patients who are attributed to the practice or who complete the voluntary alignment process. Based on the experience of other programs that use similar attribution methods, including CMS primary care models, a significant proportion of the patients a practice sees will not be attributed to it.²⁷
- Even if a patient is attributed/aligned with the practice, CMS will reduce the practice's monthly payment if the patient receives services from other physician practices, and the practice may not be aware of this until after it occurs.²⁸ A recent study found that adjustments in payments to primary care practices based on whether patients made visits to other practices or an Emergency Department simply penalized those primary care practices that had more high-need patients.²⁹
- A practice could receive a 10% reduction in payments if its performance fell below minimum levels on quality measures that depend on the ability of its patients to afford medications, obtain cancer screening, and adhere to care plans. In the first year of the CPC+ program, 14% of practices did not have quality performance levels sufficient to retain any of the Quality Component of their Performance-Based Payment.
- Any increase in payment would depend not on whether the hospitalization rate for the practice's patients was high or low, but whether it was higher or lower than the hospitalization rates for other participating practices, so even if a practice reduced the rate of hospitalization for its patients, it wouldn't know how much of a payment adjustment it would receive until after the rates were determined for all Primary Care First practices. Moreover, this "tournament" approach to performance-based payment can also discourage collaborative efforts to improve primary care, since practices will only receive bonuses if other practices have poorer performance.
- The hospital admission measure is "risk adjusted" using a variation of the CMS Hierarchical Condition Category (HCC) risk adjustment system. Multiple

studies have shown this type of claims-based risk adjustment methodology inappropriately penalizes providers who serve patients who have low functional status, limited access to community services, and other types of disadvantages.³⁰ As a result, a primary care practice may have a high or low admission rate and experience increases or decreases in the admission rate for reasons that are beyond the control of the practice.

- The practice's payments would increase or decrease by 7% depending on whether the hospitalization rate for the practice's patients fell into a higher or lower performance decile.³¹ Most of the performance deciles would only differ by small amounts. Since the hospital admission rate for the same group of patients can vary significantly from year to year due purely to random factors beyond the control of a practice, a practice's revenues could increase or decrease frequently and unpredictably. In a small practice, unexpected hospitalizations for one or two patients could result in a 7% cut in the practice's revenues.³²
- The Performance-Based Adjustment would be based on patients who are attributed to the practice, and some patients who are no longer receiving services from the practice could still be attributed to the practice for up to two years. The practice would be penalized if these patients are hospitalized even though they are no longer under the care of the practice.

8. Payment Complexity Would Increase and Administrative Burdens Would Remain High

CMS says that Primary Care First will "allow clinicians to focus on caring for patients rather than their revenue cycle." However, the practice's "revenue cycle" will actually become more complex than it is today:

- Participating practices would still need to bill for all current E/M visit codes for the patients they see who are not attributed/aligned with the practice.
- Practices would presumably need to use a new billing code for office visits with attributed/aligned patients in order to receive the \$50 per visit fee. This would require the practice to determine which patients qualify for which codes.
- Practices would have to regularly review attribution/alignment lists in order to determine if they have received the correct number of monthly payments for their patients, and request corrections from CMS if there are errors in the list.
- Practices would still need to bill for all tests and procedures they perform, since the monthly payments and office visit fees are only intended to replace payments for evaluation & management services, not all of the services a practice delivers.
- Practices would still need to submit standard bills for all visits, tests, and procedures they deliver to patients who are insured by health plans that do not participate in Primary Care First or use the same payment methodology as CMS.

As a result, it is unlikely that primary care practices in Primary Care First would experience any reduction in

costs related to billing for services.

9. Most Primary Care Practices in the Country Will Be Unable to Participate

Even if a primary care practice wants to participate in Primary Care First, it will not be able to do so if it is located in Alabama, Arizona, Connecticut, the District of Columbia, Georgia, Iowa, Idaho, Illinois, Indiana, Kansas (other than the Kansas City metro area), Kentucky (other than the Cincinnati metro area), Maryland, Minnesota, Mississippi, Missouri (other than the Kansas City area), Nevada, New Mexico, New York (other than the Buffalo and North Hudson regions), North Carolina, Pennsylvania (other than the Philadelphia Region), South Carolina, South Dakota, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, or Wyoming. This means that more than 40% of the Medicare beneficiaries in the country will not have an opportunity to receive care from a primary care practice participating in either Primary Care First or Comprehensive Primary Care Plus.

In the eighteen states/regions that are part of the CPC+ demonstration, a primary care practice will only be able to participate in Primary Care First in the first year of the program if the practice is not already participating in CPC+. Since CPC+ accepted essentially all practices in those eighteen states/regions that were interested and qualified, and since the payments under CPC+ would be higher and more predictable than those under Primary Care First, it seems unlikely that many practices from these regions would participate in Primary Care First.

Consequently, most participants in Primary Care First will likely come from just eight states (Alaska, California, Delaware, Florida, Massachusetts, Maine, New Hampshire, and Virginia), and the majority of eligible Medicare beneficiaries would live in either California or Florida. The program will not even be open to every primary care practice in these eight states; practices will only be able to participate in Primary Care First if they have at least 125 attributed Medicare beneficiaries and if they have “experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternatives to fee-for-service payments such as full or partial capitation.”

The Direct Contracting Options Are Not Options for Most Primary Care Practices

Large primary care practices with at least 5,000 beneficiaries would also be eligible to participate in one of the new “Direct Contracting” options in the CMS Primary Cares Initiative as an alternative to participating in Primary Care First. As noted earlier, most counties in the U.S. do not have 5,000 Medicare beneficiaries living in them, so this option would primarily be applicable to practices located in urban areas.

Under the “Professional Population-Based Payment Direct Contracting” option, a participating primary care practice would receive a monthly payment for “enhanced

primary care services.” The amount of the payment would be set equal to 7% of the total Medicare Part A and Part B spending on the practice’s patients. (CMS has not clearly defined whether “enhanced primary care services” involves just Evaluation & Management (E/M) services such as office visits and chronic care management services, or other services that the primary care practice delivers.) Since Medicare Part A & B spending is projected to be approximately \$12,500 per beneficiary per year in 2020, 7% of that amount would translate into about \$73 per beneficiary per month, which is significantly more than the revenues primary care practices receive today for E/M services and more than what most practices would receive under the basic Primary Care First option.

However, in return for this higher and more flexible payment, a primary care practice participating in the Direct Contracting option would be required to pay CMS for 50% of any increases in total Medicare spending for its attributed patients beyond whatever benchmark spending level CMS establishes. CMS has not defined how it would establish the benchmark spending level in Primary Care First, and while it has said there would be limits on the amount a direct contracting practice would have to repay when total Medicare spending is higher than expected, CMS has not yet defined the specific risk corridors or stop-loss threshold it will use. Since Medicare payments to the primary care practice would only equal 7% of total Medicare spending, if total Medicare spending increased by just 5% more than the expected level, the amount the primary care practice would have to repay could represent more than one-third of the practice’s Medicare revenue. It is unlikely that even medium-sized primary care practices would have the financial reserves needed to manage this level of financial risk.

The Direct Contracting options will likely be of interest primarily to the Accountable Care Organizations (ACOs) participating in the downside risk tracks of the Medicare Shared Savings Program (MSSP), since it would enable the physicians in the ACO to be paid in a more flexible way than is possible today, and to health systems or large multi-specialty groups that are not currently participating in MSSP and have significant financial reserves needed to take on this level of financial risk.

Undesirable Impacts of Implementing Primary Care First as it is Currently Designed

Because the current design of Primary Care First uses non-risk adjusted monthly and visit-based payments and bases the performance-based adjustment primarily on the rate of hospital admissions relative to other practices, it could be a very attractive option for primary care practices whose Medicare patients are relatively healthy. If the practice’s Medicare patients don’t need many office visits and if the visits they do make are for simple issues, a \$24 monthly payment combined with a \$50 visit fee would result in significantly more revenue for the practice than current E/M fees. Moreover, since those healthy patients likely already have a low rate of hospitalization, the practice would also be likely to receive a high

“performance-based” bonus on top of the monthly and visit-based payments.

On the other hand, if a practice has many low-income Medicare patients who experience frequent acute health problems, the \$24 monthly payment and \$50 visit fee could generate less revenue than the practice receives today under the traditional fee-for-service system. Moreover, if the patients’ acute care problems are severe enough to require inpatient treatment, the practice would be unlikely to qualify for a performance bonus, since the risk adjustment in the hospitalization measure would not account for new or acute illnesses or for other patient characteristics that can result in higher rates of hospitalization. The practice would likely even have difficulty reducing the subset of hospitalizations that were avoidable because it would not receive higher payments to support expanded care management services for its patients. Consequently, the practice would be unlikely to receive a bonus payment and it could even be subject to a penalty. It would not be a wise decision for such a practice to participate in Primary Care First, even though that is exactly the kind of practice that most needs additional support.

If only the practices with relatively healthy, infrequently-hospitalized patients participate in Primary Care First, Medicare spending would increase significantly, since those practices could receive much higher payments than they do today even if there is no further reduction in their already-low rates of hospitalization. This might prompt CMS to try and mandate participation by all primary care practices in order to force practices with high rates of hospitalization to participate. However, mandating participation in a poorly-designed program would likely just accelerate the demise of primary care practices rather than result in greater savings for the Medicare program.

The most undesirable impact of all would be if the primary care practices that do enroll in Primary Care First find that they have to avoid accepting sicker and more complex patients in their practices because the payments are inadequate to support the care needed by those patients. While CMS may have designed Primary Care First to provide a strong financial incentive for primary care practices to reduce hospitalization rates, the design also provides a strong financial incentive for primary care practices to avoid serving patients who have a high risk of hospitalization. The non-risk adjusted payments in Primary Care First also could discourage practices from serving patients who require significant amounts of extra time from practice staff in order to prevent the development of new health problems. If these patients have greater difficulty obtaining primary care services, Medicare spending will likely increase.

While CMS may have designed Primary Care First to provide a strong financial incentive for primary care practices to reduce hospitalization rates, the design also provides a strong financial incentive for primary care practices to avoid serving patients who have a high risk of hospitalization.

Changing Primary Care First So It Provides the Support Small Primary Care Practices Need

Fortunately, it would be relatively easy for the Center for Medicare and Medicaid Innovation (CMMI) to modify the Primary Care First initiative to solve the problems described above. The following nine changes would enable CMMI to create the kind of payment model that smaller primary care practices have been seeking:

1. Pay practices with a monthly per-patient payment in place of all fees for office visits.

Instead of a combination of monthly payments and office visit fees, Primary Care First should pay primary care practices a monthly payment for each enrolled patient, with no separate fees for office visits. This is what was requested by both AAFP and Dr. Antonucci in the payment models they submitted to PTAC and that PTAC recommended that HHS implement. CMMI is already testing a payment model with both monthly payments and fees in Track 2 of CPC+, but it is not testing a monthly payment in place of all fees in any of its other demonstration projects.

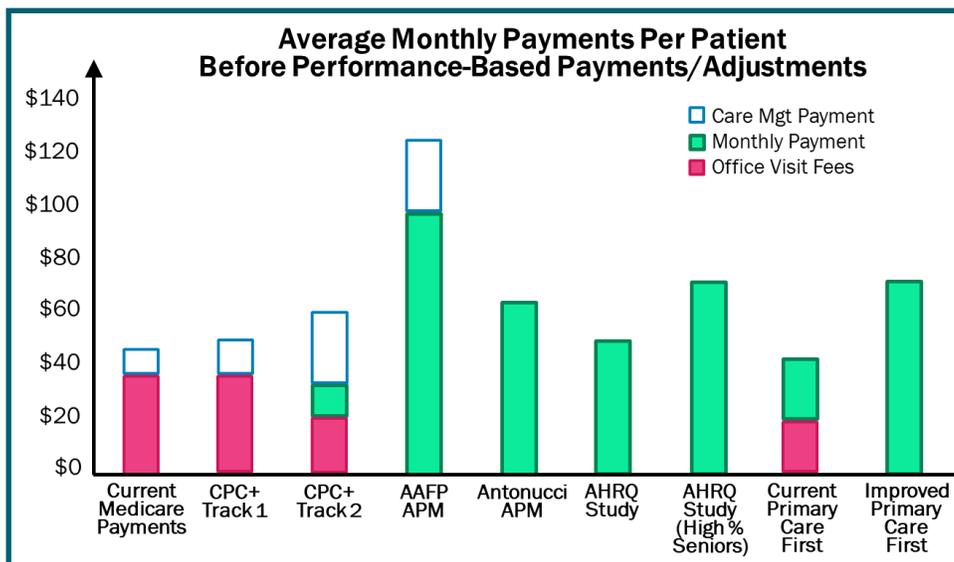
2. Pay a higher monthly amount for a patient who has greater needs.

Under the payment models developed by both the AAFP and Dr. Antonucci, a primary care practice would receive a higher payment for a patient with greater needs. A patient’s needs should not be determined by the patient’s Hierarchical Condition Category (HCC) score. Instead, it should be based on all of the patient’s current health problems and on other factors such as functional limitations that affect the amount of time and types of services the primary care practice will need to deliver in order to properly care for the patient. In CPC+, CMMI requires primary care practices to risk stratify patients, and practices participating in Primary Care First would also be required to do so, so it would be a simple matter to base monthly payment amounts on important clinical characteristics of patients that are not currently captured in Medicare claims data.³³

3. Set monthly payment amounts at levels adequate to support high-quality primary care services.

There is broad consensus that it is not enough to change the *method* by which primary care practices are paid; the *amount* of money they receive must be significantly higher than it is today. The first-year evaluation of CPC+ reported that most primary care practices felt the payment amounts under CPC+ were not adequate to support the kinds of services they needed to perform, so the payments under Primary Care First should be higher than the CPC+ payment amounts, not less.³⁴

HHS funded a detailed study of the staffing required to deliver high-quality primary care services through the Agency for Healthcare Research and Quality (AHRQ).³⁵



The study found that a primary care practice would need to be paid at least \$45 per patient per month for an average patient population, a higher amount (\$46) if the practice were located in a rural area, an even higher amount (\$56) if its patients had high social needs, and \$64 per patient per month if the practice had a higher-than-average population of seniors. These estimates were calculated in 2015 dollars, so the inflation-adjusted amounts in 2020 would be approximately \$50, \$51, \$62, and \$71 respectively. These amounts assume the practice is receiving the same payments from all payers for all patients in the practice, so a practice would need to receive Medicare payments at least as high as these amounts in order for the overall revenues to the practice to cover the costs the studies found would be necessary to deliver high-quality care.

In the two proposals recommended by PTAC, the AAFP recommended that primary care practices receive payments equal to 12% of total Medicare spending; this would translate into about \$125 per patient per month. Dr. Antonucci recommended that small and rural practices receive a \$60 per month payment for low-to-medium risk patients and \$90 per month for high risk patients. In the Comprehensive Primary Care Plus program, Track 1 practices with an average risk population receive about \$50 per patient each month and Track 2 practices receive about \$62.

Consequently, the monthly payment under Primary Care First should be no less than \$65 per patient in 2020, and ideally even higher. The monthly payment amounts for patients with more complex needs should be higher than this average amount.³⁶ Payments should be increased annually based on inflation in order to ensure the primary care practice receives adequate revenues to cover increases in costs.

4. *Begin paying monthly payments immediately when a patient enrolls for care in the primary care practice.*

Rather than forcing patients to go to a website to designate the primary care practice as their primary care pro-

vider, and then forcing the practice to wait up to 6 months to receive monthly payments for that patient, a patient should be able to sign a form designating the practice as their primary care provider, and the primary care practice should be able to immediately begin receiving monthly payments for that patient.

CMS already does this for Chronic Care Management (CCM) payments under the Medicare Physician Fee Schedule – as soon as a patient consents to receive CCM services, the physician practice can begin delivering the services and receiving payment for them.³⁷ The practice is required to inform the patient that only one practitioner can furnish and be paid for CCM services during a calendar month and the patient has the right to stop services at any time (with termination effective at the end of the month). Patient consent is only required once before services begin or if the patient wants to begin receiving services from a different provider. A similar approach could be used to trigger the payments under Primary Care First.

5. *Create billing codes so that primary care practices can classify patients appropriately and receive timely monthly payments for each patient.*

The most efficient way to implement all of the above changes would be to allow the primary care practice to submit a newly-created billing code each month for each patient who is receiving Primary Care First services from the practice. By submitting the billing code, the practice would be proactively affirming that the patient is receiving appropriate primary care services from the practice during that month. This would allow immediate changes in payments for new patients who join the practice and for patients who leave the practice, rather than waiting for 6 months to 2 years for adjustments to be made through CMS attribution and alignment processes.

A different billing code should be created for each category of higher-risk patients. In order to submit one of these billing codes, the primary care practice would need to document that the patient had the characteristics associated with the category. This would enable defining

the categories using clinical characteristics of patients, not just the diagnosis codes currently used in claims data.³⁸ Separate billing codes based on a patient's risk category would also allow a practice to receive higher payments immediately when a patient developed a new chronic condition, rather than waiting for a year or more for CMS to calculate a new risk score for the patient.

CMS already uses these types of billing codes for the monthly payments it makes to primary care practices for Chronic Care Management (CCM) services, and there are two different codes to distinguish patients with different levels of complexity: CPT 99490 for regular CCM services and CPT 99487 for "complex" CCM services. CMS also created a new billing code (G9678) to enable oncology practices participating in the CMMI Oncology Care Model to bill for Monthly Enhanced Oncology Services (MEOS) Payments. Similar mechanisms could be used to implement new billing codes for payments to primary care practices under Primary Care First.

6. Evaluate performance using patient-centered outcome measures with achievable performance targets.

Primary care practices clearly agree that in return for receiving larger and more flexible payments, they can and should take greater accountability for delivering high-quality care to their patients and for reducing avoidable services and spending. Although both the AAFP and Antonucci proposals recommended by PTAC include performance-based payment components, neither proposed evaluating performance using only a single measure such as the total hospital admission rate used in the current version of Primary Care First. The AAFP model proposed to use a combination of quality measures and utilization measures similar to the approach currently being used in CPC+, but with a broader range of quality measures that also reflect the needs of patients who have health issues other than diabetes and hypertension. Dr. Antonucci recommended moving away from traditional quality measures altogether and using a patient-reported outcome measure designed to ensure that the primary care practice is addressing what matters most to each individual patient regardless of the specific types of health problems the patient has.

A revised version of Primary Care First would better ensure high-quality care for all patients in a practice while still encouraging savings for Medicare by using patient-centered measures defined as follows:

Accountability for Avoidable Hospitalizations

- Measure the rate of *potentially avoidable* hospitalizations among the practice's patients, rather than the rate of *total* hospitalizations. Definitions of avoidable hospitalizations are available and could easily be incorporated into a performance measure.³⁹ For example, a hospitalization for an exacerbation of COPD is potentially avoidable, whereas a hospitalization for an auto accident or cancer surgery is not.
- Risk-adjust or risk-stratify the avoidable hospitalization measure based on patient characteristics that are known to affect the risk of hospitalization but cannot easily be modified by a primary care practice. Many of

these characteristics will already be identified and documented by the practice in order to bill for the stratified payments. For example, COPD patients who have more severe cases of COPD or who cannot afford the cost-sharing for the bronchodilators needed to control COPD exacerbations would be expected to have more hospitalizations for exacerbations than other patients with COPD, so a primary care practice should not be penalized for a higher rate of hospitalizations if it has more such patients than others.

- Set a target range for the risk-adjusted avoidable hospitalization rate based on what is known to be achievable by adequately-resourced primary care practices, and reward or penalize the practice only if it falls outside of that range. The range should be large enough to avoid rewarding or penalizing a practice based on typical month-to-month and year-to-year random variations in avoidable hospitalization rates. The types of decile-based performance ranges CMS currently plans to use in Primary Care First would be too small to reliably measure the performance of small practices.

Accountability for Quality and Outcomes

- Initially, measure the quality of care using a group of the standard primary care quality measures that are used in the Merit-Based Incentive Payment System (MIPS), similar to the payment model developed by AAFP, and set performance targets based on recent MIPS benchmarks. This would allow participating practices to easily set improvement goals and track their performance, and it would allow CMS to ensure that quality is being maintained or improved.
- In addition, pay practices more if they are willing to begin collecting patient-reported outcome measures, such as the "How's Your Health" measure used in the payment model developed by Dr. Antonucci. Collecting these data will require extra time and effort by primary care practices, and they will need additional resources to enable them to do so. In the Comprehensive Care for Joint Replacement (CJR) payment model, CMMI allows hospitals to retain more savings if they collect and report outcome measures.⁴⁰
- Once a feasible strategy for collecting patient-reported outcomes has been developed and sufficient outcome data are available to establish performance targets, begin transitioning the performance measurement for Primary Care First practices from traditional quality measures to the patient-reported outcome measures.

7. Establish performance-based rewards and penalties that create manageable levels of financial risk for small primary care practices.

Both the AAFP and Antonucci proposals recommended by PTAC proposed to adjust payment amounts based on a practice's performance. However, neither proposal recommended that payments to primary care practices should vary by as much as 60% as in the current version of Primary Care First. In the AAFP payment model, practices could have their payments reduced by up to \$2.50-\$4.00 per patient per month if they failed to meet prede-

defined performance benchmarks for quality and utilization. In the payment model developed by Dr. Antonucci, 15% of the payments would be withheld and the practice would only receive the withheld amount if it achieved predefined quality and utilization benchmarks.

Moreover, both the AAFP and Antonucci models, as well as the existing CMS CPC+ model, provide higher payments to practices so they can improve outcomes for patients, rather than making higher payments completely contingent on performance as in the current design of Primary Care First. Because payments would be higher under both the AAFP and Antonucci payment models than they are today, payment adjustments could create significant financial rewards and penalties for a practice based on its performance without placing the practice at risk of bankruptcy if it fails to perform well. Similarly, in the current CMS CPC+ models, primary care practices receive higher revenues through significant Care Management Fees regardless of their performance; only the Performance-Based Payment, equal to about 5-7% of their revenues, is contingent on performance.

A revised version of Primary Care First should follow a similar approach. As discussed earlier, it should provide significantly higher payments to primary care practices to enable them to deliver high-quality care to their patients. A performance-based component should then be added with the following characteristics:

- the desirable target range for each performance measure (i.e., the avoidable hospitalization rate and/or the quality/outcome measures) should be defined in advance, so primary care practices know what standard they will need to meet in order to receive monthly payments at the expected level. A practice's performance should not be based on what other practices achieve during the same year.
- the monthly payment to a practice should be increased or decreased by a predefined amount if its performance falls outside the predefined target range. If every primary care practice performs better than the target range, every primary care practice should be rewarded for doing so. Primary care practices could still compete with each other and be rewarded for doing better than other practices, rather than making the amount of the reward for each practice depend on how many other practices did better or worse.
- the total adjustment to the monthly payment based on all aspects of performance should be no more than 15% of base payment amounts, assuming that the base payment amounts for the practice have been increased to levels much higher than current Medicare payments.
- the payment adjustments should be phased in over a several year period, to reflect the fact that even if a primary care practice immediately begins changing the way it delivers care to patients, it will take time for the patients' health status to improve and for the patients to learn and successfully implement better approaches to self-management in order to reduce the risk of avoidable hospitalizations.

8. Create a complementary payment model to support home-based palliative care for seriously ill patients.

Multiple studies and demonstration projects have shown that providing home-based palliative care services to patients with serious, potentially life-limiting illnesses can both improve their quality of life and reduce Medicare spending by significantly reducing the frequency with which they visit an emergency department, are admitted to the hospital, and receive other expensive services. However, Medicare does not currently pay for home-based palliative care services other than for patients on hospice, so patients who are still being treated for their illnesses cannot receive these desirable and cost-effective complementary services.

Both the American Academy of Hospice and Palliative Medicine (AAHPM)⁴¹ and the Coalition to Transform Advanced Care (CTAC)⁴² developed payment models designed to solve this problem, and PTAC recommended that HHS implement both models.⁴³ AAHPM recommended payments of \$400 per month for advanced illness patients of moderate complexity and \$650 per month for high complexity patients, and CTAC recommended payments of between \$400 per month and \$650 per month based on the palliative care provider's performance in reducing total spending while the patient is receiving services. Based on the proposals from AAHPM and CTAC, it seems clear that monthly payments for palliative care services will need to be at least \$400 for most patients and even higher for more complex patients in order to cover the costs of delivering high-quality services and to ensure that patients with the most complex needs can receive the services they need.

These payments should be provided to palliative care providers separately from the payments used to support primary care services. Although a large primary care practice may have enough advanced illness patients to enable the practice to deliver home-based palliative care services cost-effectively, a small primary care practice will not. A palliative care provider will also need to have a sufficient number of advanced illness patients in order to deliver palliative care services cost-effectively. In rural areas and other communities served by small primary care practices, a palliative care provider will need to deliver services to patients from multiple primary care practices, potentially across a large geographic area, in order to have enough patients to allow home-based services to be delivered cost-effectively. Creating a separate monthly payment for palliative care services would support both scenarios, enabling a small practice to request services for an advanced illness patient from a separate palliative care provider, and enabling a large practice to deliver the services itself if it wished to do so.

Patients with advanced illness who need home-based palliative care services in addition to traditional primary care services can be identified using the criteria developed by AAHPM and CTAC in the payment models they developed. This would be preferable to the claims-based methodology CMS has proposed to use in the Serious Illness option for Primary Care First, since claims data do not contain information on some of the most important clinical criteria needed to identify appropriate patients.

9. Allow primary care practices in all parts of the country to participate in the revised Primary Care First program.

Every Medicare beneficiary deserves to receive high quality primary care services, and every beneficiary with a serious illness deserves to receive palliative care services. While there are differences of opinion about the best way to structure payments for these services, there is broad consensus that the current payments are inadequate and need to be increased significantly. It would be inappropriate to prevent more than 40% of the Medicare beneficiaries from receiving better primary care services for another five years while CMMI tests additional payment model options in only eight states. Consequently, Primary Care First should be expanded so that every primary care practice in every state has the opportunity to participate, and so that palliative care services can be delivered in every community.

The Goal of Primary Care is to Improve Patients' Health, Not Just to Save Money for Medicare

Higher and more flexible payments for primary care will enable delivery of better primary care services. This will likely result in fewer avoidable hospitalizations, unnecessary tests, and inappropriate referrals to specialists, which in turn will produce significant savings for Medicare. However, it may be unrealistic to expect these savings to fully offset the cost of the higher payments needed to adequately support primary care, much less to achieve net savings overall, during the 5-year time period typically used in CMMI evaluations.

Net savings in the early years of an improved Primary Care First model will likely be low, not because of a lack of adequate “risk” for the practices, but because most of the benefits of good primary care will not appear immediately. Efforts to place more financial risk on primary care practices are more likely to accelerate the loss of primary care providers than to achieve greater savings for Medicare. In fact, measuring savings based on changes from *current* levels of Medicare spending presumes that primary care practices will be able to continue to deliver current levels of services if payments are not increased to adequate levels. The correct “benchmark” for savings should not be the current level of total spending, but the higher level of Medicare spending that would likely result if access to high-quality primary care services continues to decline. Paying more to preserve primary care practices will be more likely to show that net savings for Medicare have been achieved if the “counterfactual” is defined properly.

Because of the need to take a longer-term view of the value of primary care, the Center for Medicare and Medicaid Innovation (CMMI) may not be the appropriate mechanism

for successfully addressing the problems facing primary care. By statute, its authority is limited to “testing models” that address deficits in care, not fundamentally restructuring Medicare payment systems for all primary care physicians or even improving the health of Medicare beneficiaries. The need to conduct formal evaluations of payment models has limited the number of states and regions where CMMI can implement changes and has led it to threaten the use of narrowly-defined “mandatory” demonstrations instead of encouraging innovation through multiple, voluntary approaches. Moreover, although CMMI is explicitly authorized to undertake demonstrations that are not initially budget neutral, Congress required it to focus on projects that would reduce Medicare spending, and CMMI is prohibited from continuing a demonstration unless there is reason to believe that spending will not increase. The experience to date suggests that the reforms needed in primary care payment may not meet those criteria.⁴⁴

CMMI is not the only vehicle for changing the way Medicare pays primary care practices. CMS has the authority to create new types of payments for every primary care practice in the country, and over the past several years, it has created several new fees to support additional services by primary care practices. Moreover, CMS can make sweeping changes quickly when it chooses to do so – for example, the physician fee schedule regulation that CMS proposed in 2018 would have completely restructured payments for office visits to all types of physicians in less than a year. However, CMS is also constrained by budget neutrality rules that are even more narrowly defined than those facing CMMI, since CMS cannot consider savings in hospital spending as offsets for higher payments to primary care physicians.

Because of these constraints, it seems increasingly likely that Congressional action will be needed to create a truly effective primary care payment system. The biggest benefits of primary care will be seen beyond the five-year time horizon used in CMMI demonstration projects, through slowing the progression of chronic disease and

Because of the need to take a longer-term view of the value of primary care, the Center for Medicare and Medicaid Innovation (CMMI) may not be the appropriate mechanism for successfully addressing the problems facing primary care. Congressional action will likely be needed to create a truly effective primary care payment system.

even preventing some diseases from occurring at all, not just trying to avoid hospitalizations for those who already have such conditions. Moreover, Medicare will save even more money if individuals are healthier when they first become eligible for Medicare, and that will only occur if more people receive good primary care long before they are 65. Since most primary care practices serve both Medicare beneficiaries and younger individuals, better payments for primary care from Medicare will also

enable primary care practices to deliver more and better services to younger patients, increasing the long-run return on investment for the Medicare program. However, only Congress can authorize making investments designed to achieve these longer-run benefits. Consequently, in addition to revising Primary Care First to make it as successful as possible within current statutory constraints, CMS should ask Congress for the authority to create the kind of primary care payment system that the country truly needs.

APPENDIX

COMPARISON OF CURRENT AND PROPOSED CMS PRIMARY CARE MODELS TO PRIMARY CARE PAYMENT MODELS RECOMMENDED BY PTAC

Dimension	CPC+	AAFP APM	Antonucci APM	Primary Care First
Payments for Office Visits	<p>Payments for office visits are unchanged in Track 1.</p> <p>Payments for office visits continue at reduced amounts in Track 2.</p> <p>Standard office visit payments continue for all unattributed patients.</p>	<p>No separate payments for office visits for enrolled patients.</p> <p>Standard office visit payments continue for patients who are not enrolled or attributed.</p>	<p>No separate payments for office visits for enrolled patients.</p> <p>Standard office visit payments continue for patients who are not enrolled or attributed.</p>	<p>\$50 payment for each office visit, regardless of length, in place of current office visit fees for attributed patients.</p> <p>Standard office visit payments continue for all unattributed patients.</p>
New Payments for Evaluation & Management (E/M) Services	<p>Track 2 practices receive a quarterly payment for each attributed patient based on a fraction of past average office visit revenues in the practice.</p> <p>There is no difference in the quarterly payment based on individual patient needs.</p>	<p>Monthly payment in place of office visit fees for enrolled patients.</p> <p>Higher monthly payment for each patient with higher needs.</p>	<p>Monthly payment in place of office visit fees and most other services for enrolled patients.</p> <p>Higher monthly payment for each patient with higher needs.</p>	<p>Monthly payment for each attributed patient.</p> <p>No difference in payment based on individual patient needs.</p> <p>Monthly payment for all patients is higher if the average risk score for all patients in the practice is high.</p>
Payments for Care Management Services	<p>Monthly payment for each attributed patient.</p> <p>Higher payment for each patient with higher needs.</p>	<p>Monthly payment for each enrolled patient.</p> <p>Higher payment for each patient with higher needs.</p>	<p>No separate payment for care management services.</p>	<p>No separate payment for care management services.</p>
Performance-Based Payments	<p>Additional monthly payment of \$2.50 (in Track 1) or \$4.00 (in Track 2) per attributed patient is paid in advance, but is recouped if performance on quality and utilization measures is poor.</p>	<p>Additional monthly payment per enrolled patient is paid in advance, but is recouped based on performance on quality and utilization measures.</p>	<p>15% of standard monthly payments is withheld and then paid if the performance standard on the outcome measure is met.</p>	<p>Payments are increased up to 50% based on the rate of hospitalizations relative to other practices and based on improvements in hospitalization rates if performance standards on quality measures are also achieved.</p> <p>Payments are reduced by 10% if quality performance is low or if the hospitalization rate is high.</p>

(CONTINUED)

COMPARISON OF CURRENT AND PROPOSED CMS PRIMARY CARE MODELS TO PRIMARY CARE PAYMENT MODELS RECOMMENDED BY PTAC (Continued)

Dimension	CPC+	AAFP APM	Antonucci APM	Primary Care First
Performance Measures	MIPS quality and patient experience measures. Two utilization measures (ED visits and total hospitalization rate).	MIPS quality and patient experience measures similar to CPC+. Utilization measures similar to CPC+.	Patient-reported outcomes.	All-cause hospitalization rate. Five quality and patient experience measures for lower-risk patients; Three measures for higher-risk patients.
Patient Eligibility	Patients are attributed to the practice based on the proportion of visits the patient made to the primary care practice over the prior two years. Patients can voluntarily “align” with the practice by designating the practice on the CMS website.	Patients could explicitly designate the practice as their primary care provider. Patients who do not explicitly designate the practice could still be assigned based on where visits have been made in the past.	Patients could explicitly designate the practice as their primary care provider. Patients who do not explicitly designate the practice could still be assigned based on where visits have been made in the past.	Patients are attributed to the practice based on the proportion of visits the patient made to the primary care practice over the prior two years. Patients can voluntarily “align” with the practice by designating the practice on the CMS website.
Method of Measuring Differences in Patient Needs	CMS Hierarchical Condition Categories (CMS-HCC).	The Minnesota Complexity Assessment Model.	The “What Matters Index” based on the How’s Your Health patient-reported outcomes tool.	CMS Hierarchical Condition Categories.
Practice Eligibility	Only open to practices located in 18 regions.	Open to practices in all states.	Open to practices in all states.	Only open to practices in Alaska, California, Delaware, Florida, Maine, Massachusetts, New Hampshire and Virginia, and to practices located in the 18 CPC+ regions. Practices must have “experience with value-based payment arrangements.” Practices must have at least 125 Medicare beneficiaries.

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6. Information on Comprehensive Primary Care Plus is available at <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/>
7. The details that have been made available about the Primary Care First options are posted on the CMS website at <https://innovation.cms.gov/initiatives/primary-care-first-model-options/> and the details about the Direct Contracting Model options are posted at <https://innovation.cms.gov/initiatives/direct-contracting-model-options/>.
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10. As part of the Medicare and CHIP Reauthorization Act of 2015 (MACRA), Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review proposals for physician-focused payment models submitted by individuals and stakeholder entities and to make recommendations to the Secretary of Health and Human Services as to whether the proposals meet criteria for such payment models that have been established by HHS in regulations. The eleven members of PTAC are appointed by the Comptroller General of the United States. More information about PTAC is available at <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>
11. The PTAC comments and recommendation regarding the AAFP proposal were submitted to the Secretary of Health and Human Services on February 28, 2018 and are available at <https://aspe.hhs.gov/system/files/pdf/255906/PTACRecommendationsCommentsAAFP.pdf>. The PTAC comments and recommendation regarding the Antonucci proposal were submitted on October 20, 2018 and are available at https://aspe.hhs.gov/system/files/pdf/255726/ReportToTheSecretary_Antonucci_10.20.18.pdf
12. Goroll AH, Berenson RA, Schoenbaum SC, Gardner LB. "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," *Journal of General Internal Medicine* 22(3): 410-415 (March 2007).
13. In 2016, there were 1,805 counties in the U.S. that had fewer than 5,000 Medicare Fee for Service beneficiaries living in them; the remaining 1,340 counties in the country had 5,000 or more. 405 counties had fewer than 1,000 Medicare FFS beneficiaries.
14. In 2019, Medicare pays primary care physicians between \$46.49 and \$209.75 for an office visit with a new patient and between \$23.07 and \$147.76 for an office visit with an established patient. (Practices in high cost-of-living areas receive higher payment amounts for the same services.) Most office visits are Level 3 and Level 4 visits with established patients; the national payment amounts for these visits are \$75.32 and \$110.28. Based on the overall frequency of the different types of visits with family physicians, the average payment for an office visit in 2019 will be about \$95.
15. The first-year evaluation of the Comprehensive Primary Care Plus demonstration reported that in 2017, Medicare beneficiaries in CPC+ practices had an average of 4.5-4.6 primary care office visits per year. (Mathematica Policy Research. *Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report* (April 2019), available at <https://downloads.cms.gov/files/cmmi/cpcplus-first-ann-rpt.pdf>.) Assuming a similar average of 4.5 visits per year, a practice participating in Primary Care First would receive an average of \$18.75 per patient per month from the \$50 per office visit fees and an additional \$24 per patient per month from the professional population-based payment, for a total of \$42.75 per patient per month. 44% of the total amount would come from the office visit fees. If patients in Primary Care First only made 3 office visits per year on average, the primary care practice would only receive 34% of its revenues from office visits, but it would also receive 15% less revenue in total with the same number of patients.
16. In the Comprehensive Primary Care Plus demonstration project, a Medicare beneficiary must take the following ten steps in order to voluntarily align with a primary care practice:
 - (1) Create an account on MyMedicare.gov;
 - (2) Log in to the account;
 - (3) Select the "My Health" tab and select "Providers" from the drop-down menu;
 - (4) Select "Physicians & Other Clinicians" and then select the box "Add a Clinician or Group Practice," indicating that pop-ups are allowed if this request is displayed;
 - (5) Under "Find Medicare physicians and other clinicians," type the primary clinician's zip code and last name;
 - (6) Select the clinician from the drop-down menu and click Search;
 - (7) Select "Add to Favorites" in the top right corner of the screen;
 - (8) On the next page, select the correct address for the clinician;
 - (9) At the bottom of the screen, under the header "Add as

Your Primary Clinician,” check the box labeled “Make this my primary clinician” and click “Add to Favorites”;

(10) If a green pop-up box indicates that the physician has been added to the beneficiary’s favorites list, click on MyMedicare.gov on top of the browser and then click the box “Update Provider Data.”

If this is successfully done, the beneficiary will appear on the Beneficiary Attestation List, and CMS will assign the beneficiary to the practice two calendar quarters later. For example, if the beneficiary completes the voluntary alignment process between April 1 and June 30 of 2019, they will be assigned to the practice beginning in October 2019. (Center for Medicare and Medicaid Innovation. *CPC+ Payment and Attribution Methodologies for Program Year 2019, Version 2* (February 21, 2019). Available at <https://innovation.cms.gov/Files/x/cpcplus-methodology-py19.pdf>.)

17. The evaluation of the CMS Comprehensive Primary Care (CPC) demonstration, which preceded the current CPC+ demonstration, found that out of the 3.05 million patients served by CPC practices, only 320,713 were attributed Medicare beneficiaries and thereby eligible for the additional Medicare payments available under CPC, and only 805,980 were patients attributed by other payers and eligible for different payments from those payers. 63% of the total patients served by the practices were not “attributed” to the practices and so the practices received only traditional fee-for-service payments for those patients. Mathematica Policy Research, *Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report* (May 2018). Based on the information reported in the first-year evaluation of the CPC+ demonstration, it appears that an even larger percentage of the patients who are receiving services from CPC+ practices are not being attributed to the practices by Medicare or other payers, and therefore the practices are not receiving different payments for those patients.
18. A patient’s HCC score is based only on how many different chronic condition diagnoses are recorded in claims data for the patient, not how severe the conditions are, and not on any acute conditions the patient is experiencing (for example, a patient with pneumococcal pneumonia does not receive a higher HCC score). Moreover, HCC scores are only based on the chronic conditions diagnosed two years earlier, not on any newly diagnosed conditions that a primary care practice would need to address in the current year. In the CPC+ initiative, CMS asks practices to risk stratify their patients, and most practices assign risk levels to patients using clinical factors other than the information used in HCC scores. Mathematica Policy Research. *Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report* (April 2019), available at <https://downloads.cms.gov/files/cmimi/cpcplus-first-ann-rpt.pdf>.)
19. American Academy of Hospice and Palliative Medicine. *Payment Reforms to Improve Care for Patients With Serious Illness* (August 2017). Available at <https://aspe.hhs.gov/system/files/pdf/255906/ProposalAAHPM.pdf>
20. Coalition to Transform Advanced Care. *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* (October 2017). Available at <https://aspe.hhs.gov/system/files/pdf/253406/ACM.pdf>
21. In 2019, a primary care practice with an average risk group of Medicare patients will likely receive an average of about \$35 per beneficiary per month (PBPM) from Medicare E/M fees for office visits, based on an average of 4.5 visits per beneficiary per year and an average office visit payment of \$93 for established patients and \$128 for new patients at 2019 Medicare Physician Fee Schedule rates. A practice can also bill an additional \$42 per month

for Chronic Care Management (CCM) services to patients who have two or more chronic diseases. Although many practices do not bill for this service for all eligible patients because of administrative burdens in doing so and the requirement for patient cost-sharing, a practice that bills for this payment for 25% of its patients would increase its total average PBPM payment for the two sets of E/M services to \$46. Because patients are required to pay 20% co-insurance for most of these visits, the practice would receive about \$37 PBPM from CMS and the remaining \$9 PBPM from the patient.

Under the Primary Care First model, a practice with an average risk patient population would only receive \$24 PBPM from CMS through the Professional Population-Based Payment, and there would be no patient contribution for these payments. The practice could no longer bill for E/M office visits or CCM payments if it receives the \$24 PBPM. The practice would be eligible for an additional \$50 fee for each office visit made by the patients; if patients continue visiting practices at the rate of 4.5 visits per year, the practice would receive an additional \$18.75 PBPM for office visits. If the practice reduced the average number of office visits to 3 per year by delivering care in different ways, the practice’s office fee revenue would decrease to \$12.50 PBPM.

As a result, the combination of PBPM payments and office visit fees under Primary Care First would generate a total of \$36.50 - \$42.75 PBPM for the practice, compared to \$35.00 - \$46.00 PBPM under the current Medicare Physician Fee Schedule.

22. Under the current design of Primary Care First, CMS has indicated that participating practices would only be eligible for the “Cohort Adjustment” if the total rate of hospitalizations for their patients is below the median level for other participating practices, and they would only be eligible for the maximum Cohort Adjustment of 34% if they are among the practices with the lowest 20% of hospitalization rates among those practices with below-median rates, i.e., only practices in the lowest decile of hospitalization rates among the participating practices would receive the maximum increase. Practices with hospitalization rates just below the median would only qualify for a 6.5% adjustment. The maximum 34% adjustment under this component would represent 2/3 of the total maximum 50% performance-based adjustment possible, and it would only be available to 10% of practices.
23. Under the “Continuous Improvement Adjustment,” practices whose improvement performance is below the 60th percentile would receive a 3.5% increase in payments. Only 10% of practices would be eligible for the maximum 16% increase on this component, and they may or may not be the same as the 10% of practices who could receive the maximum 34% increase under the Cohort Adjustment.
24. Data released by CMS indicate that on average, in 2017, CPC+ practices were only able to retain 41.5% of the Utilization Component of their Performance Based Incentive Payment (PBIP) that was based on emergency department visits and hospital admissions. Fewer than 3% retained the full amount of the Utilization Component, and 33% had to return the entire amount to CMS. Centers for Medicare and Medicaid Services, *2017 CPC+ Quality and Utilization Performance Results*. Available at https://innovation.cms.gov/Files/worksheets/CPC_PY2017QualityUtilizationPerformanceResults.xlsx .
25. Joynt KE, Gawande AA, Orav EJ, Jha AK. “Contribution of Preventable Acute Care Spending to Total Spending for High-Cost Medicare Patients,” *JAMA* 309(24):2572-2578 (2013).
26. Wadhwa RK et al. “Association of the Hospital Readmissions Reduction Program With Mortality Among Medicare Beneficiaries Hospitalized for Heart Failure, Acute Myocar-

- dial Infarction, and Pneumonia.” *JAMA* 320(24):2542-2552 (2018)
27. As noted earlier, in both the Comprehensive Primary Care and the Comprehensive Primary Care Plus demonstrations, a majority of primary care practices’ patients were not attributed to them. Studies of Accountable Care Organizations in the Medicare Shared Savings Program, which uses similar attribution methods, have found that many patients are not attributed to the providers who serve them. See, for example, Ouayogodé MH et al. “Forgotten Patients: ACO Attribution Omits Low-Service Users and the Dying.” *American Journal of Managed Care* 24(7): e207-e215 (2018).
 28. Center for Medicare and Medicaid Innovation. *CPC+ Payment and Attribution Methodologies for Program Year 2019, Version 2* (February 21, 2019).
 29. Glazier RH et al. “Do Incentive Payments Reward the Wrong Providers? A Study of Primary Care Reform in Ontario, Canada” *Health Affairs* 38(4):624-632 (2019).
 30. Johnston KJ, Joynt Maddox KE. “The Role of Social, Cognitive, and Functional Risk Factors in Medicare Spending for Dual and Nondual Enrollees.” *Health Affairs* 38(4):569-576 (2019).
 31. In the Cohort Adjustment component of the Performance-Based Payment, practices with hospital admission rates that are above the median for other practices would receive a 0% adjustment. If the practice is in the 41%-50% decile, it would receive a 6.5% increase; if it is in the 31%-40% decile, it would receive a 13% increase; in the 21%-30% decile, a 20% increase; in the 11-20% decile, a 27% increase, and in the lowest decile, a 34% increase. Consequently, if the practice is below the median, its payment will differ by 7% depending on its performance decile. For the Continuous Improvement Adjustment component, payments would differ by 3-3.5% depending on the decile of performance below the median.
 32. The first-year evaluation of the CPC+ demonstration reported that the total hospitalization rate for the Medicare fee-for-service beneficiaries in the CPC+ practices in 2017 was 285.8 admissions per 1,000 beneficiaries, and the rate for comparison practices was 283.6 per thousand. (Mathematica Policy Research. *Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report.*) For a practice with 125 attributed/aligned Medicare beneficiaries (the minimum required to participate in Primary Care First), this would represent about 36 total hospital admissions during the course of the year, or about 9 admissions per calendar quarter. Under Primary Care First, the Performance-Based Adjustment is based on the deciles of admission rates across participating patients. Since the deciles of admission rates near the median differ by about 10-20 admissions per thousand, this would represent fewer than 3 admissions per year for a practice with 125 beneficiaries, or less than 1 admission per calendar quarter. In other words, one more or one fewer hospital admission for the patients in a very small practice could result in the practice being assigned to a different performance decile, and thereby subject to a 7% increase or decrease in its monthly payments. Even for a larger practice with 500 beneficiaries, 2-3 more or fewer admissions during a quarter could result in a change in its payment.
 33. Mathematica Policy Research. *Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report* (April 2019)
 34. Mathematica Policy Research. *Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report* (April 2019)
 35. Meyers DM et al. “Workforce Configurations to Provide High-Quality, Comprehensive Primary Care: A Mixed-Method Exploration of Staffing for Four Types of Primary Care Practices,” *Journal of General Internal Medicine* 33 (1):1774-1779 (July 2018).
 36. Under Primary Care First, practices would be paid \$100 and \$175 per month for each patient if the overall average risk score for all patients in the practice is high, so presumably the payments for individual patients with high risk levels should be at least \$100 per month.
 37. Centers for Medicare and Medicaid Services. *Chronic Care Management Services*. (December 2016) Available at <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf>.
 38. Documenting the patient characteristics for these new billing codes would be analogous to the current requirement for a practice to document why it is billing for a higher-level Evaluation & Management (E/M) code for an office visit, except that the documentation required for the new billing codes would be clinically relevant to the patient’s care, whereas both physicians and CMS agree that the documentation currently required for E/M codes is not clinically relevant and is administratively burdensome.
 39. A decade ago, the Health Care Incentives Improvement Institute developed definitions of “potentially avoidable complications” associated with particular procedures and hospitalizations and with chronic disease management. de Brantes F, D’Andrea G, Rosenthal MB. “Should Healthcare Come With a Warranty?” *Health Affairs* 28(4): w678-w687 (2009). Several measures based on these definitions of potentially avoidable complications have been endorsed by the National Quality Forum (Measures #0704 - Proportion of patients hospitalized with AMI that have a potentially avoidable complication, #0705 - Proportion of patients hospitalized with stroke that have a potentially avoidable complication, #0708 - Proportion of patients hospitalized with pneumonia that have a potentially avoidable complication, and #0709 - Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year. Available at <http://www.qualityforum.org>.) 3M Information Systems has developed software to identify a series of “Potentially Preventable Events,” including “Potentially Preventable (Initial) Hospital Admissions,” that are used by a number of states and health plans. Goldfield N, Kelly WP, Patel K. “Potentially Preventable Events: An Actionable Set of Measures for Linking Quality Improvement and Cost Savings.” *Quality Management in Health Care* 21(4):213-219 (October-December 2012).
 40. In the Comprehensive Care for Joint Replacement (CJR) demonstration, the quality scores for participating hospitals are increased by 10% if they submit data on patient-reported outcomes and patient risk factors that are not included in claims data. The risk factors represent information such as body mass index, pre-operative use of narcotics, and level of pain, and the outcomes measured include pain and functionality. Centers for Medicare and Medicaid Services. *Overview of CJR Quality Measures, Composite Quality Score, and Pay-for-Performance Methodology*. Available at <https://innovation.cms.gov/Files/x/cjr-qualsup.pdf>.
 41. American Academy of Hospice and Palliative Medicine. *Payment Reforms to Improve Care for Patients With Serious Illness* (August 2017). Available at <https://aspe.hhs.gov/system/files/pdf/255906/ProposalAAHPM.pdf>
 42. Coalition to Transform Advanced Care. *Advanced Care Model (ACM) Service Delivery and Advanced Alternative Payment Model* (October 2017). Available at <https://aspe.hhs.gov/system/files/pdf/253406/ACM.pdf>

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43. The PTAC comments and recommendations regarding the AAHPM and CTAC proposals were submitted to the Secretary of Health and Human Services on May 7, 2018 and are available at <https://aspe.hhs.gov/system/files/pdf/255906/PTACCommentsRecommendationAAHPMCTAC.pdf>
 44. The evaluation of the Comprehensive Primary Care demonstration and the first-year evaluation of the CPC+ demonstration both found that the reductions in total Medicare spending for the patients receiving care from participating practices were not sufficient to offset the additional payments made to the participating primary care practices. Mathematica Policy Research, *Evaluation of the Comprehensive Primary Care Initiative: Fourth Annual Report* (May 2018). Available at <https://downloads.cms.gov/files/cmml/CPC-initiative-fourth-annual-report.pdf>. Mathematica Policy Research. *Independent Evaluation of Comprehensive Primary Care Plus (CPC+): First Annual Report* (April 2019), available at <https://downloads.cms.gov/files/cmml/cpcplus-first-annual-report.pdf>.

NOTE: Harold Miller is a member of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), but the comments in this report are not intended to represent the position of the PTAC as a whole or of other individual members. PTAC's statutory charge is limited to reviewing proposals for payment models that are submitted to it by stakeholders, and it has no role in advising HHS or CMS other than submitting comments and recommendations on the proposals it receives.



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