CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE & MEDICAID INNOVATION

Primary Care First

Foster Independence. Reward Outcomes.

Model Briefing

Center for Medicare & Medicaid Innovation

Primary Care First Builds on the Underlying Principles of Prior CMS Innovation Models

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

Comprehensive Primary Care Plus (CPC+) Track 1 is a pathway for practices ready to **build the capabilities** to deliver comprehensive primary care.

CPC+ Track 2 is a pathway for practices poised to **increase the comprehensiveness** of primary care.

Primary Care First rewards **outcomes**, increases **transparency**, enhances care for **high need populations**, and reduces **administrative burden**.

Primary Care First Rewards Value and Quality Through an Innovative Payment Structure

Primary Care First Goals

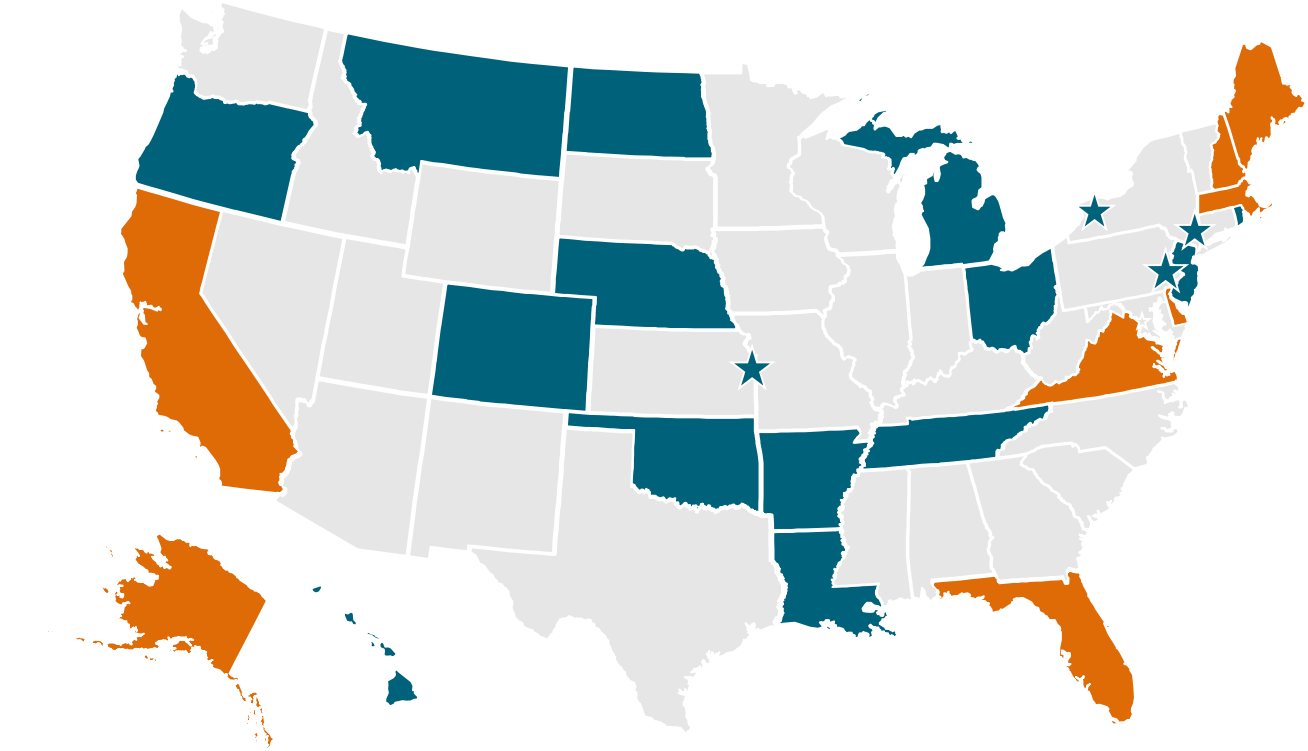
1. To **reduce Medicare spending** by preventing avoidable inpatient hospital admissions
2. To **improve quality of care and access to care** for all beneficiaries, particularly those with complex chronic conditions and serious illness

Primary Care First Overview

- **5-year** alternative payment model
- Offers greater **flexibility**, increased **transparency**, and **performance-based** payments to participants
- Payment options for practices that specialize in **patients with complex chronic conditions** and high need, **seriously ill populations**
- Fosters **multi-payer alignment** to provide practices with resources and incentives to enhance care for all patients, regardless of insurer

Primary Care First Will Be Offered in 26 States and Regions Beginning in 2021

In 2021, Primary Care First will include 26 diverse regions:



Current CPC+ Track 1 and 2 regions

New regions added in Primary Care First

Primary Care Practices Can Participate in One of Three Payment Model Options

The **three Primary Care First (PCF) payment models** accommodate a continuum of providers that specialize in care for different patient populations.

Option 1

PCF-General Component

Focuses on **advanced primary care practices ready to assume financial risk** in exchange for reduced administrative burdens and performance-based payments. Introduces new, higher payments for practices caring for complex, chronically ill patients.

Option 2

SIP Component

Promotes care for high need, **seriously ill population (SIP)** beneficiaries who lack a primary care practitioner and/or effective care coordination.

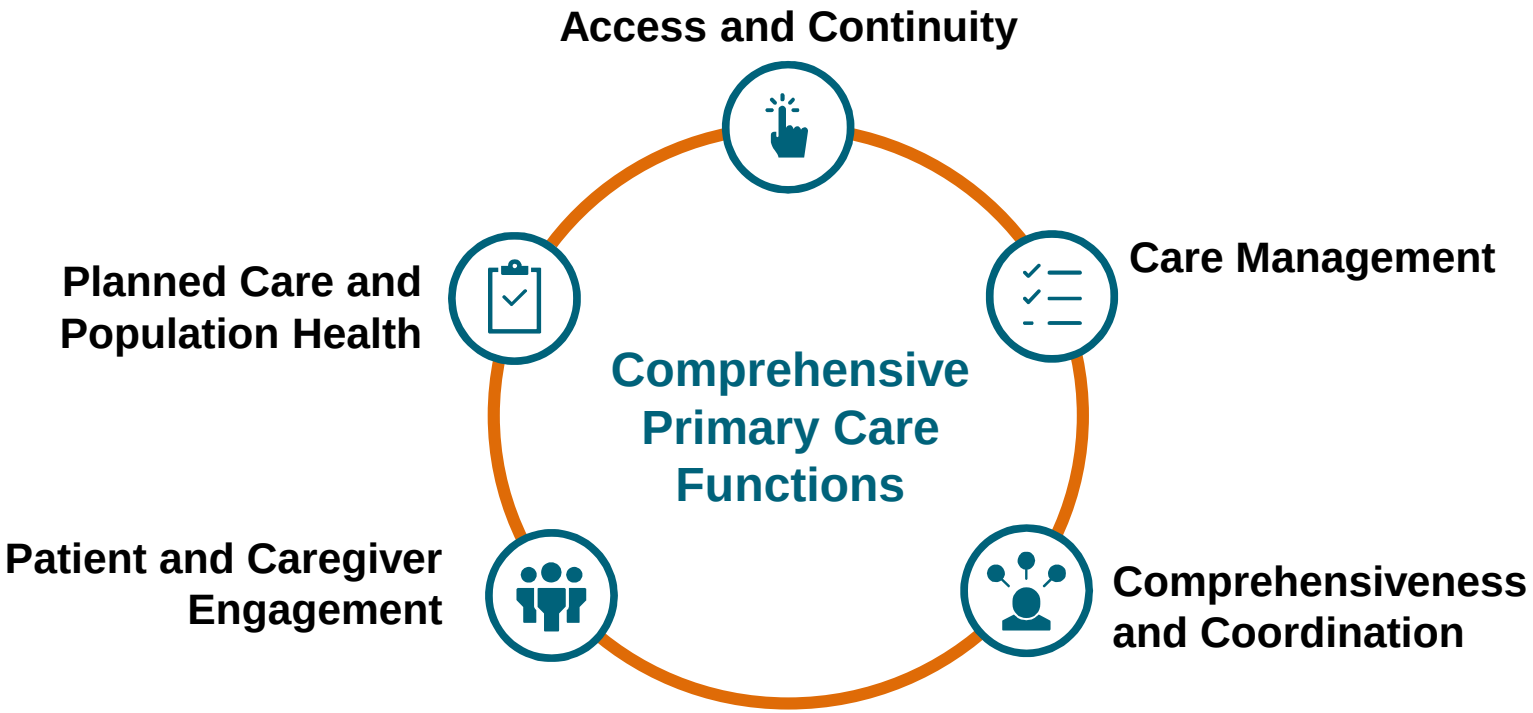
Option 3

Both PCF-General and SIP Components

Allows practices to **participate in both** the PCF-General and the SIP components of Primary Care First

Participants Achieve Model Aims Through Innovations in Their Care Delivery

PCF participants are incentivized to deliver evidence-based interventions across 5 comprehensive primary care functions:



Practices Have the Freedom to Innovate While Implementing Core Functions of Comprehensive Primary Care

Comprehensive Primary Care Function	PCF Intervention
Access and Continuity	▪ Provide 24/7 access to a care team practitioner with real-time access to the EHR
Care Management	▪ Provide risk-stratified care management
Comprehensiveness and Coordination	▪ Integrate behavioral health care ▪ Assess and support patients' psychosocial needs
Patient and Caregiver Engagement	▪ Implement a regular process for patients and caregivers to advise practice improvement
Planned Care and Population Health	▪ Set goals and continuously improve upon key outcome measures

The PCF Payment Model Option Emphasizes Flexibility and Accountability

PCF Payment Model Option Goals

- **Promote patient access** to advanced primary care both in and outside of the office, especially for complex chronic populations
- **Transition primary care** from fee-for-service payments to value-driven, population-based payments
- **Reward high-quality, patient-focused care** that reduces preventable hospitalizations

PCF Payments

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

Performance-based adjustments of up to 50% of revenue and a 10% downside, based on a single outcome measure, with focused quality measures

Primary Care First Model Payments Include Two Major Components

Total Primary Care First Model payments

Total primary care payment + **Performance-based adjustment**

Professional Population-Based Payment + Flat Primary Care Visit Fee

Opportunity for practices to **increase revenue by up to 50%** of their Total Primary Care Payment based on key performance measures, including acute hospital utilization (AHU).

1. Regional adjustment
2. Continuous improvement adjustment

Total Primary Care Payment Promotes Flexibility in Care Delivery

The Total Primary Care Payment is a hybrid payment that incentivizes advanced primary care while **compensating practices with higher-risk patients**.

Population-Based Payment

Payment for service in or outside the office, adjusted for practices caring for higher risk populations. This base rate is the same for all patients within a practice.

Practice Risk Group	Payment (*per beneficiary per month**)
Group 1: Average Hierarchical Condition Category (HCC) <1.2	**$28**
Group 2: Average HCC 1.2-1.5	**$45**
Group 3: Average HCC 1.5-2.0	**$100**
Group 4: Average HCC >2.0	**$175**

Payment will be reduced through calculating a "leakage adjustment" if beneficiaries seek primary care services outside the practice.

+

Flat Primary Care Visit Fee

Payment for in-person treatment that reduces billing and revenue cycle burden.

$40.82

per face-to-face encounter

Payment amount does not include copayment or geographic adjustment

These payments allow practices to:

- Easily predict payments for face-to-face care
- Spend less time on billing and coding and more time with patients

* PBPM = Per Beneficiary Per Month

Performance-Based Payment Adjustments Are Determined Based on a Multi-Step Process

In **Year 1**, adjustments are determined based on **acute hospital utilization (AHU)** alone.
In **Years 2-5**, adjustments are based on performance as described below.

Did the practice exceed the Quality Gateway?

No

0% or -10%
Adjustment
Depends on year and/or AHU performance;
Note: still eligible for continuous improvement adjustment

Yes

Is practice performance above the 50th percentile of the national Acute Hospital Utilization (AHU) benchmark?

No

0% or -10%
Adjustment
Depends on year and/or AHU performance;
Note: still eligible for continuous improvement adjustment

Yes

Adjustments may be from -10% to 50% of total primary care payment determined by comparing performance to three different benchmarks:

1. Regional adjustment
2. Continuous improvement adjustment

Regional Adjustment Compares Acute Hospital Utilization to a Regional Benchmark

1 Regional adjustment

Practices that exceed the 50th percentile AHU minimum benchmark will earn a PBA based on how they perform relative to regional practices.

Top 75% of the regional reference group?

No

-10%
Adjustment
(*still eligible for continuous improvement bonus*)

Yes

AHU Regional Performance Level	Regional Adjustment
Top 10 percentile of regional practices	**34%** of Total Primary Care Payment
11-20 percentile of regional practices	**27%** of Total Primary Care Payment
21-30 percentile of regional practices	**20%** of Total Primary Care Payment
31-40 percentile of regional practices	**13%** of Total Primary Care Payment
41-50 percentile of regional practices	**6.5%** of Total Primary Care Payment
51-75 percentile of regional practices	**0%** of Total Primary Care Payment

Practices Achieving Improvement Targets are Eligible for a Continuous Improvement Adjustment

2 Continuous improvement adjustment

Practices are also eligible for a **continuous improvement (CI) bonus of up to 16% of the possible 50% PBA amount** if they achieve their improvement target. CMS may use statistical approaches to account for random variations over time and promote reliability of improvement data.

Acute Hospital Utilization (AHU) Regional Performance Level	Potential Improvement Bonus
Top 10 percentile of regional practices	**16%** of Total Primary Care Payment
11-20 percentile of regional practices	**13%** of Total Primary Care Payment
21-30 percentile of regional practices	**10%** of Total Primary Care Payment
31-40 percentile of regional practices	**7%** of Total Primary Care Payment
41-50 percentile of regional practices	**3.5%** of Total Primary Care Payment
51-75 percentile of regional practices	**3.5%** of Total Primary Care Payment
Practices performing in the bottom quartile of their region	**3.5%** of Total Primary Care Payment

The SIP Payment Model Option Increases Seriously Ill Populations' Access to Primary Care

PCF incorporates the following unique aspects for practices electing to serve seriously ill populations to increase access to high-quality, advanced primary care.

Eligibility and Beneficiary Attribution

Practices demonstrating relevant capabilities **can opt in to be assigned SIP patients or beneficiaries** who lack a primary care practitioner or care coordination.

Medicare-enrolled clinicians who provide **hospice or palliative care can partner** with participating practitioners.

Payments

Payments for practices serving seriously ill populations:

First 12 Months
▪ One-time payment for first visit with SIP patient: **$325 PBPM**
▪ Monthly SIP payments for up to 12 months: **$275 PBPM**
▪ Flat visit fees: **$50**
▪ Quality payment adjustment: up to **$50**

The Model's Quality Strategy for Practice Risk Groups 1-2 Includes a Focused Set of Clinically Meaningful Measures

The following measures for **Practice Risk Groups 1-2** will inform performance-based adjustments and assessment of quality of care delivered.

Measure Type	Measure Title	Model Years
Utilization Measure for Performance-Based Adjustment Calculation (Calculated Quarterly)	**Acute Hospital Utilization** (AHU) (HEDIS measure)	Years 1-5
Quality Gateway (Calculated Annually)	**Patient Experience of Care Survey** (CAHPS® with supplemental items)	Year 2-5
	Diabetes: Hemoglobin A1c (HbA1c) **Poor Control** (>9%) (eCQM)	
	Controlling High Blood Pressure (eCQM)	
	Advance Care Plan (MIPS CQM measure)	
	Colorectal Cancer Screening (eCQM)	

Practices in Risk Groups 3-4 and practices accepting SIP patients are evaluated on a different set of quality measures— see the next slide for details.

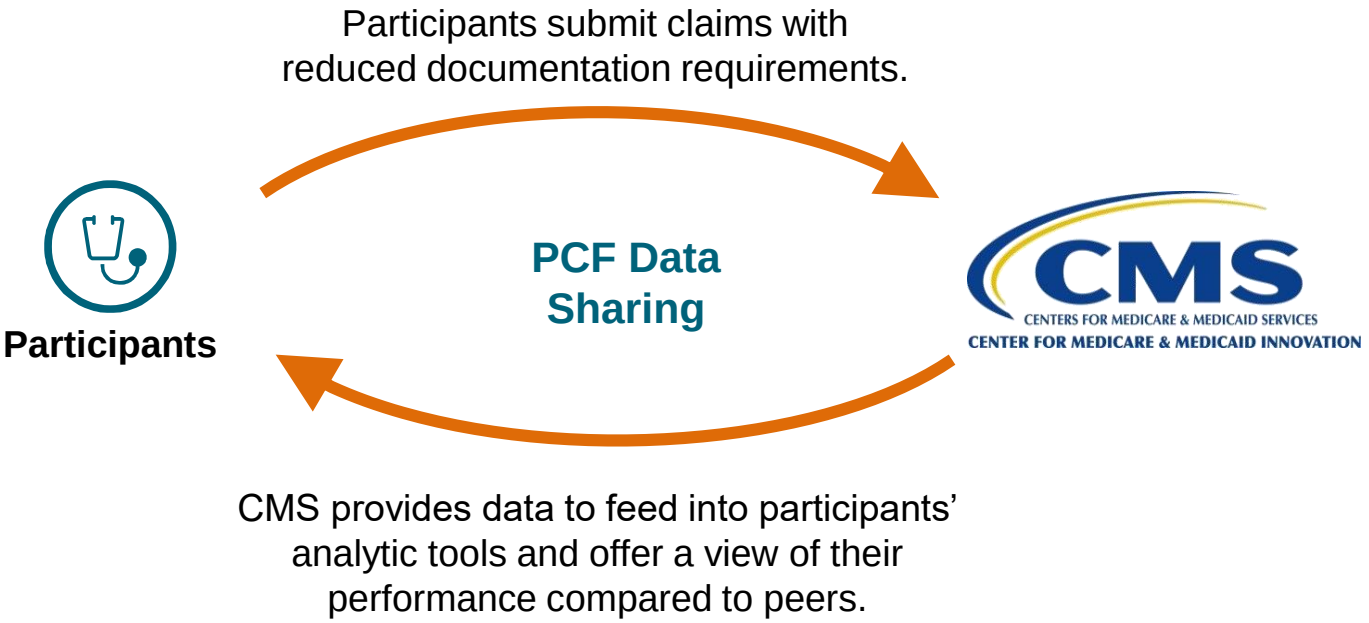
Quality Measures for Practice Risk Groups 3-4 (and SIP) Account for Patients' Clinical and Supportive Needs

Practices in **Risk Groups 3-4** and practices accepting SIP patients are evaluated on a different set of quality measures than Risk Groups 1-2.

Measure Title	Model Years
Advance Care Plan (MIPS CQM measure) *(also used for Practice Risk Groups 1-2)*	Years 1-5
Total Per Capita Cost (MIPS claims measure)	Years 1-5
CAHPS® (beneficiary survey)	Years 2-5 (but administered in Year 1)
24/7 Access to a Practitioner (beneficiary survey)	Years 3-5
Days at Home (claims measure)	Years 3-5

Primary Care First Innovates Data Sharing to Inform Care Delivery

Participants get access to timely, actionable data to assess performance relative to peers and drive care improvement.



Practices Participating in the PCF-General Payment Model Option Must Meet the Following Eligibility Requirements

Practices participating in the PCF-General Payment Model Option must:

- ✓ Include **primary care practitioners** (MD, DO, CNS, NP, PA) in good standing with CMS
- ✓ Provide health services to a **minimum of 125** attributed Medicare beneficiaries*****
- ✓ Have primary care services account for the **predominant share** (e.g., 70) of the practices' collective billing based on revenue*****
- ✓ Demonstrate **experience with value-based payment arrangements**, such as shared savings, performance-based incentive payments, and alternative to fee-for-service payments
- ✓ Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and, if available, connect to their regional health information exchange (HIE)
- ✓ Attest via questions in the Practice Application to a limited set of **advanced primary care delivery** capabilities, including 24/7 access to a practitioner or nurse call line, and empanelment of patients to a primary care practitioner or care team

***Note:** Practices participating only in the SIP option are not subject to these specific requirements.

Practices Participating in the SIP Payment Model Option Must Meet the Following Eligibility Requirements

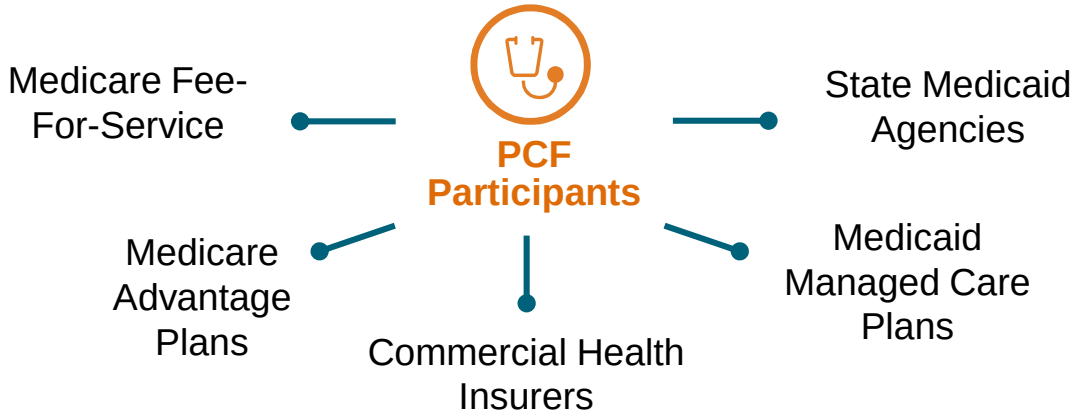
Practices receiving **SIP-identified patients** (identified based on risk score) must:

- ✓ Include **practitioners serving seriously ill populations** (MD, DO, CNS, NP, PA) in good standing with CMS
- ✓ Meet **basic competencies to successfully manage complex patients** and demonstrate relevant clinical capabilities (e.g., interdisciplinary teams, comprehensive care, person-centered care, family and caregiver engagement, 24/7 access to a practitioner or nurse call line)
- ✓ **Have a network of providers in the community** to meet patients' long-term care needs for those only participating in the SIP option
- ✓ Use 2015 Edition **Certified Electronic Health Record Technology** (CEHRT), support **data exchange** with other providers and health systems via Application Programming Interface (API), and, if available, connect to their regional health information exchange (HIE)*

*SIP-only practices can request a one-year implementation delay for the CEHRT requirement

CMS is Committed to Partnering with Aligned Payers in Selected Regions

In PCF, CMS will encourage other payers to engage practices on similar outcomes. **CMS is soliciting interested payers starting in summer 2019.**



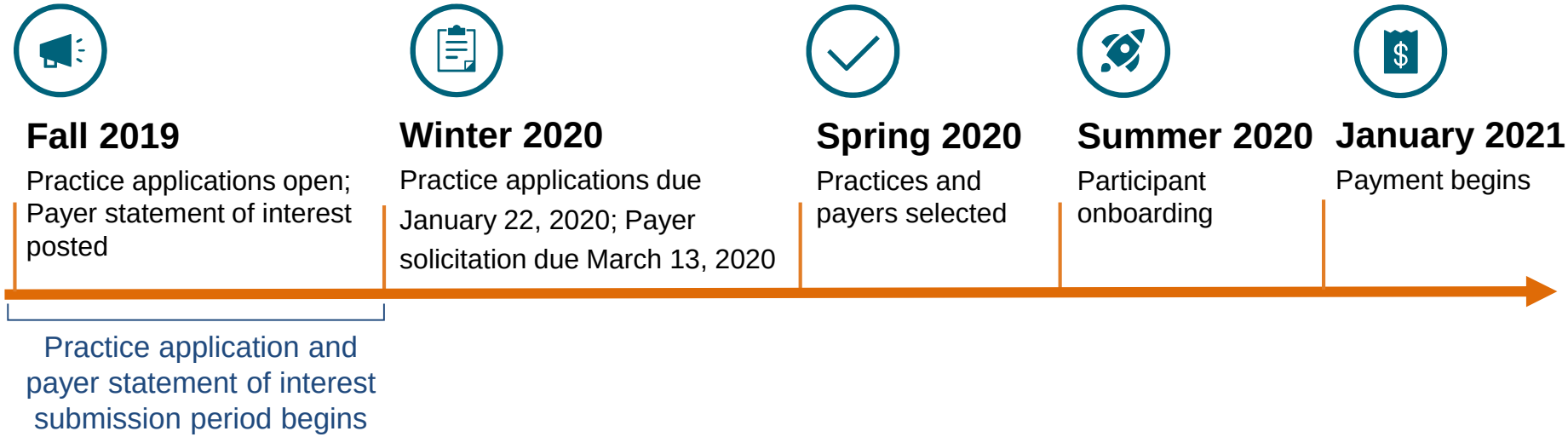
Multi-payer alignment promotes:

- An alternative to fee-for-service payments
- Performance-based incentive opportunity
- Practice- and participant-level data on cost, utilization, and quality
- Alignment on practice quality and performance measures
- Broadened support for seriously ill populations

Your Practice Can Experience Many Benefits By Participating in Primary Care First

- **Less administrative burden and more flexibility** so providers can spend more time with patients and deliver care based on patient needs
- **Ability to increase revenue** with performance-based payments that reward participants for easily understood primary care outcomes
- **Enhanced access to actionable, timely data** to inform your care transformation and assess your performance relative to peers
- **Focus on single outcome measure** that matters most to patients
- **Opportunities** for practices that specialize in complex, chronic patients and high need, seriously ill populations
- **Potential to become a Qualifying APM Participant** by practicing in an Advanced Alternative Payment Model

Primary Care First Will Launch in 2021



Interested practices should review the Request for Applications (RFA) and can access the Application Portal to complete an application.

Use the Following Resources to Learn More About Primary Care First

For more information about Primary Care First and to stay up to date on upcoming model events:

Visit

https://innovation.cms.gov/initiatives/primary-care-first-model-options/

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Read the Request for Applications (RFA) here

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