Primary Care First

Foster Independence. Reward Outcomes.

Payment Webinar

Center for Medicare & Medicaid Innovation

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 Practices Can Participate In One Of Three Payment Model Options

Option 1

PCF-General Component

Focuses on **advanced primary care practices ready to assume financial risk** in exchange for reduced administrative burden and performance-based payments.

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

This presentation outlines payment under the **Primary Care First-General Payment Model Option** (options 1 & 3)**.** A separate presentation reviews payment for the Seriously Ill Population (SIP) payment model option (option 2). Slides from that presentation can be found on the model website (linked here).

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

Beneficiary Attribution Is Performed Quarterly Through A Two-Step Process

1 Voluntary Alignment

Beneficiaries attest to their **choice of a primary care practitioner on MyMedicare.gov**

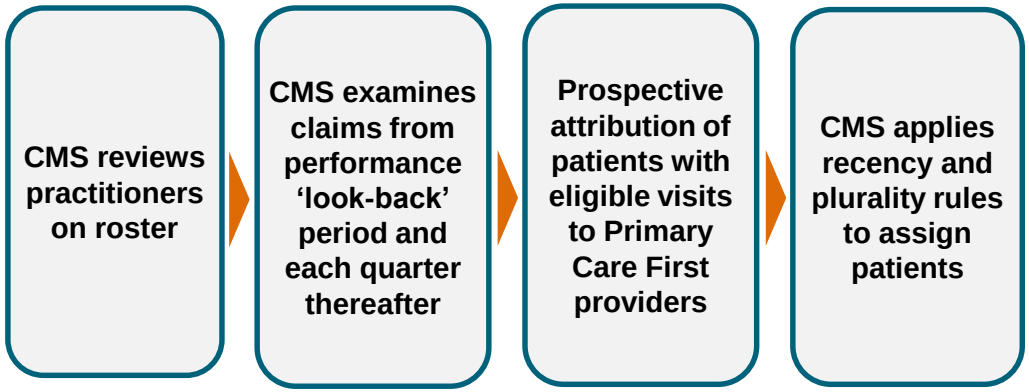
1. Patients accesses MyMedicare.gov
2. Patient selects a practitioner (voluntary alignment)
3. Patient is attributed to selected practitioner

Voluntary alignment will supersede claims-based alignment.

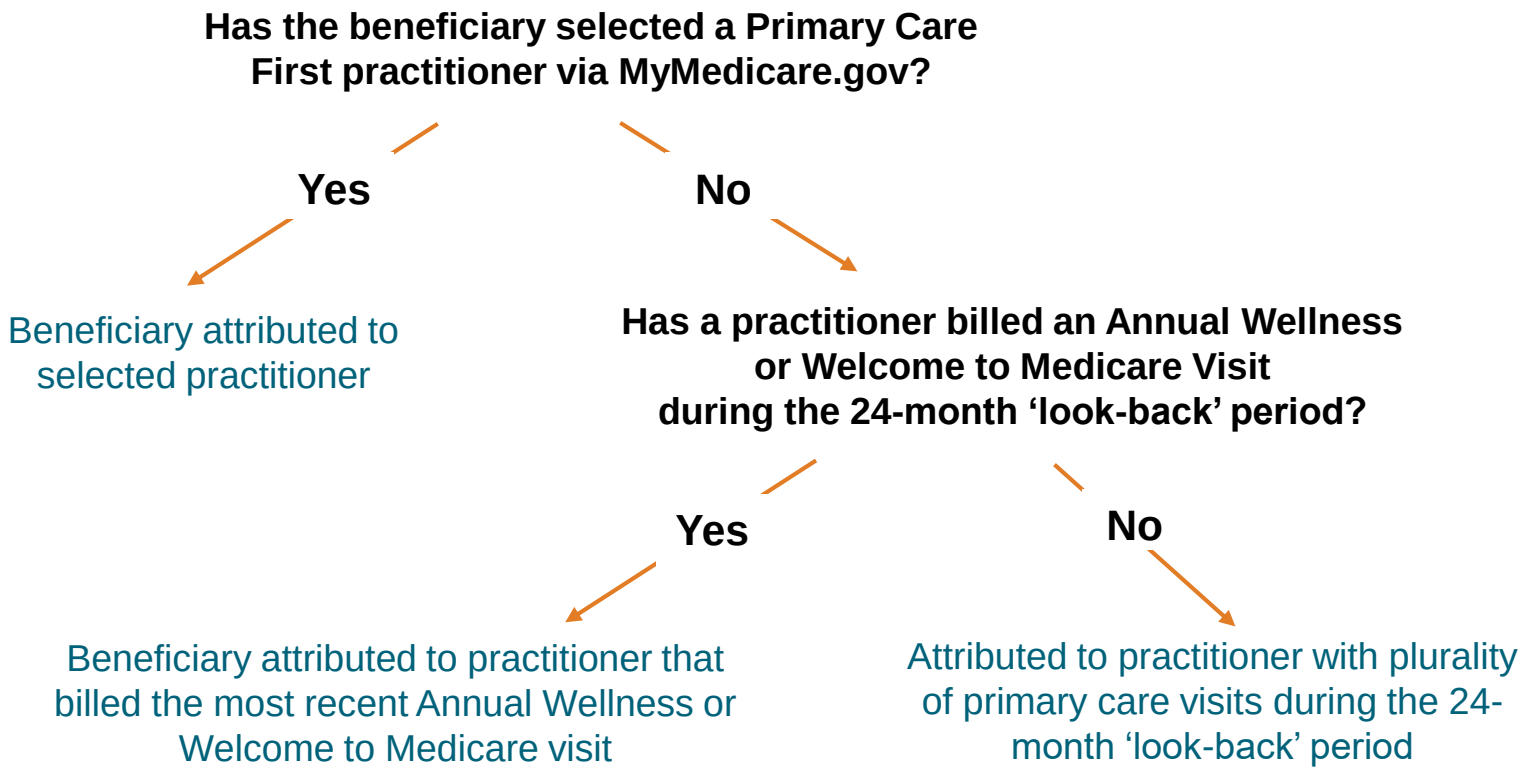
THEN

2 Claims-Based Attribution

If a beneficiary did not select a practitioner on MyMedicare.gov, the beneficiary **can be attributed to the practice** based on an examination of claims from the previous 24 months.



Beneficiary Attribution Prioritizes Beneficiary Choice Over Claims-Based Alignment



Note: This methodology assumes that the practitioners and claims in question meet eligibility requirements.

Frequently Asked Question: Beneficiary Attribution

Q **How is beneficiary attribution determined if a beneficiary sees multiple primary care practitioners within a given quarter?**

A These beneficiaries will be aligned to the practice that **billed the most recent claim** (if that claim was an Annual Wellness Visit or a Welcome to Medicare Visit) during the most recently available 24-month period. If the practice did not bill an Annual Wellness or Welcome to Medicare Visit, the beneficiaries will be aligned to the practice with the plurality of primary care visits during the 24-month look-back period.

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

Frequently Asked Question: Hierarchical Condition Category (HCC) Risk Scores

Q **Is a risk group assigned based on the average Hierarchical Condition Category (HCC) score of the total beneficiary population, or based on an individual beneficiary basis?**

A CMS will assess the average Hierarchical Condition Category (HCC) risk score of **all attributed beneficiaries at a given practice** on an annual basis using a look-back period. **CMS will prospectively assign a practice's risk group** and the practice will receive the same professional population-based payment amounts for each of their attributed beneficiaries.

Flat Primary Care Visit Fee Supports Face-To-Face Care

Primary Care First practices will receive a $40.82 flat visit fee for the following codes provided by a physician or other qualified healthcare professional:

Current Procedural Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) Codes	
Office/Outpatient Visit E/M*	99201-99205 99211-99215
Prolonged E/M*	99354-99355
Transitional Care Management Services	99495-99496
Home Care E/M*	99324-99328, 99334-99337, 99339-99345, 99347-99350
Advance Care Planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439

* E/M = evaluation and management coding

Frequently Asked Question: Payment Amounts

Q How does CMS set the payment amounts and what do they cover?

A

Payment amounts reflect a **core set of primary care services** commonly billed by primary care practices. The payment amounts do not replace payments for all potential services that a primary care practice might bill.

The Total Primary Care Payment includes both the (1) **Population-Based Payment, calibrated to represent about 60% of the Total Primary Care Payment,** and (2) the **flat primary care visit fee, calibrated to cover 40% of the Total Primary Care Payment**.

Note that practices serving higher risk populations [i.e., Risk Groups 3-4 and Seriously Ill Population (SIP) practices] receive enhanced professional population-based payments relative to comparable Medicare fee-for-service payment amounts.

Performance-Based Adjustments Incentivize Cost Reduction and Quality Improvement

Did the practice meet the annual quality benchmarks (i.e., Quality Gateway)?

*Note: this begins in year 2, based on year 1 performance**

No → **0% or -10%**
Performance Based Adjustment
For year 2, PBA will be 0% or -10%, based on AHU measure performance; years 3-5, PBA is automatically -10%

Yes

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

Yes

No

1 Regional Adjustment

Top 75% of PCF practices on AHU?

No → **-10% Adjustment**

Yes → **0% Adjustment**

AHU Measure Performance	TPCP Adjustment
Top 10% of regional practices	34%
11-20% of regional practices	27%
21-30% of regional practices	20%
31-40% of regional practices	13%
41-50% of regional practices	6.5%
51-75% of regional practices	0%
Bottom 25% of regional practices	-10%

2 Continuous Improvement Adjustment

Does the practice's AHU performance compared to their performance last year achieve the continuous improvement target?

Yes

AHU Measure Performance	TPCP Adjustment
Top 10% of regional practices	16%
11-20% of regional practices	13%
21-30% of regional practices	10%
31-40% of regional practices	7%
41-50% of regional practices	3.5%
51-75% of regional practices	3.5%
Bottom 25% of regional practices	3.5%

No → **0% Adjustment**

* Performance-based adjustments in year 1 are based on performance on the AHU measure only and does not follow the above process.

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 an adjustment 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 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

Payment Is Timed To Be Highly Responsive To Practice Performance

Total Primary Care Payments

Professional Population-Based Payment:

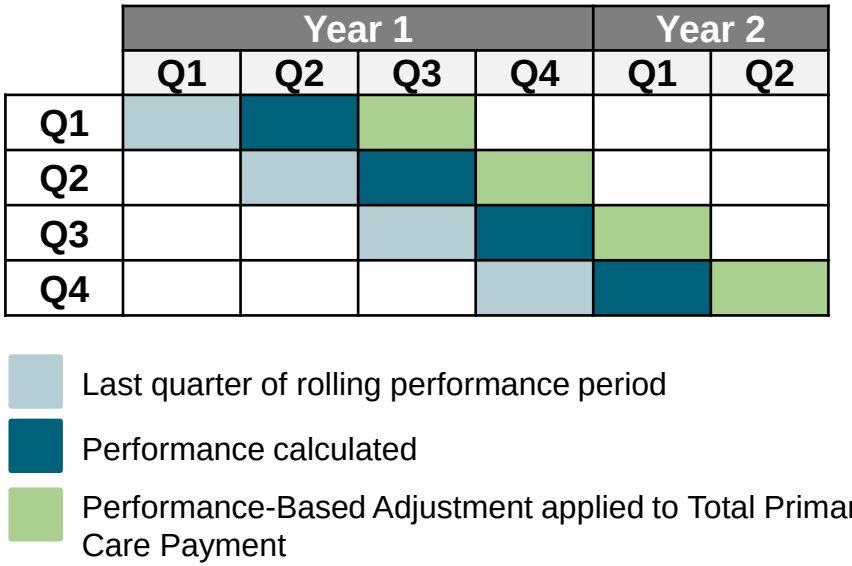
- Prospective, per beneficiary per month (PBPM) payment based on practice risk group
- Paid as a lump sum

Flat Primary Care Visit Fee:

- $40.82 base rate for each face-to-face visit
- Geographically adjusted with copayment applied

Performance-Based Adjustment

Performance-Based Adjustment will use a rolling look-back period that ends two quarters prior to the Performance-Based Adjustment payment quarter.



Example For Illustrative Purposes Only: Risk Group 3 Practice Quarterly Payment Calculation

- Total Medicare Fee-For-Service beneficiaries: 800
- # of primary care services attributed beneficiaries received outside the PCF practice last year: 1,888
- # of primary care services attributed beneficiaries received at any practice last year: 4,720

Total Primary Care Payment + **Performance-Based Adjustment** = **Total Medicare Payments**

Professional Population-Based Payment

$100 for Risk Group 3 per beneficiary per month (PBPM)

Leakage adjustment from prior year:
1,888 visits / 4,720 visits = 0.40
$100 x (1-0.40) = $60 PBPM

$60 PBPM x 3 months x 800 beneficiaries = $144,000

Flat Primary Care Visit Fee

$40.82 per in-person visit x 709 visits = $28,941

Total Primary Care Payment

$144,000 professional population-based payment + $28,941 flat primary care visit fee = $172,941

Year 1 Outcome Assumptions

- ✓ Exceeded quality benchmarks
- ✓ Above 50th percentile of a national Acute Hospital Utilization (AHU) benchmark
- ✓ Top 10% of regional Primary Care First practices
- ✓ Met continuous improvement target

Regional adjustment:

34% of the estimated Total Primary Care Payment based on performance tier level
$172,941 x 0.34 = $58,800

Continuous improvement adjustment:

Up to 16% of Total Primary Care Payment based on performance tier level
$172,941 x 0.16 = $27,671

Total Primary Care Payment:
$144,000 professional population-based payment + $28,941 flat primary care visit fee = $172,941

Performance-Based Adjustment:
$58,800 + $27,671 = $86,471

x **Geographic Adjustment Factor**

$259,412 **for Quarter 1**

Note: Further details will be outlined in the Primary Care First Payment Methodology Paper and CMS reserves the right to change the calculations described above.

Overlap Between Models Leverages Incentives and Maintains Program Integrity

Current Model Participation	Potential for Simultaneous Participation with Primary Care First
Comprehensive Primary Care Plus (CPC+ Model) – Tracks 1 and 2	Practices cannot participate in CPC+ and Primary Care First at the same time, and so current CPC+ practices are not eligible to participate in the first performance year of Primary Care First launching in 2021. CPC+ practices will be eligible to participate in the model in the second cohort, beginning in 2022 for a five-year performance period.
Direct Contracting (DC)	Practices cannot participate in DC and Primary Care First at the same time.
Medicare Accountable Care Organizations (ACOs)	• Primary Care First practices may also participate in ACOs in the Medicare Shared Savings Program (Shared Savings Program). • Primary Care First practices may not participate in the Next Generation ACO Model or the Comprehensive End Stage Renal Disease (ESRD) Care Model.
Episode Payment Models	Practices will be permitted to participate in the Primary Care First Model while simultaneously participating in Bundled Payment for Care Improvement (BPCI) Advanced, Comprehensive Care for Joint Replacement (CJR), or Oncology Care Model (OCM).
Emergency Triage, Treat, and Transport Model (ET3)	ET3 and Primary Care First models are complementary and share aligned financial incentives to reduce avoidable emergency department visits and admissions. Payments do not overlap.
Million Hearts™: Cardiovascular Disease Risk Reduction Model	Providers may participate in both the Primary Care First and Million Hearts™ Model. CMS expects this model and Primary Care First interaction to be mutually beneficial.
Accountable Health Communities (AHC)	The payment structures for the AHC Model and Primary Care First differ. Practices may both participate in the Primary Care First Model and be paid by an AHC bridge organization.

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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