

# Primary Care First

*Foster Independence. Reward Outcomes.*

## Payer Solicitation

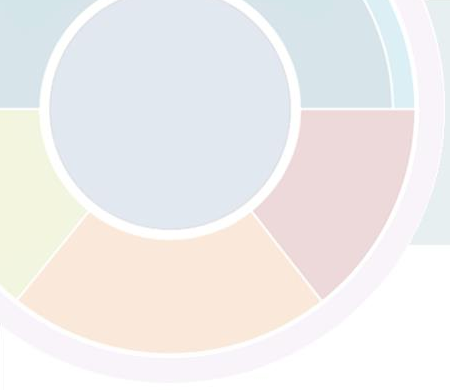
*Center for Medicare & Medicaid Innovation*



# This Presentation Provides an Overview of Payer Partnership and Solicitation

This session will cover content on each of the following topics and will provide an opportunity for live Q&A at the end of the presentation:

- **Primary Care First Model Overview**
- **Overview of PCF Payer Partnership**
- **Payer Solicitation Process**
- **Model Timeline**
- **Live Questions and Answers**



# Primary Care First Model Overview









# Primary Care First (PCF) 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



# Practices May Apply to One of Three Payment Model Options

The three Primary Care First payment model options accommodate for 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 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.

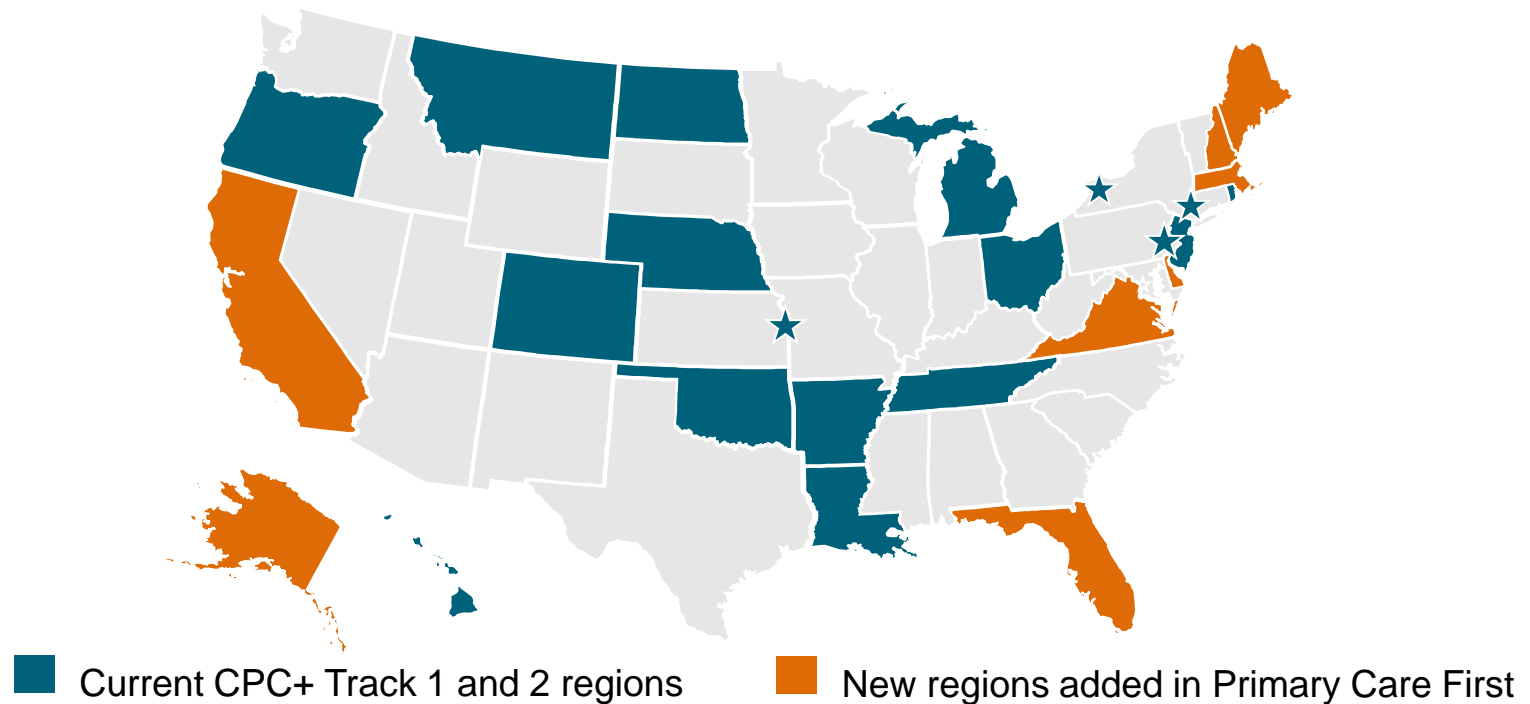
## Option 3

### Both PCF-General and SIP Components

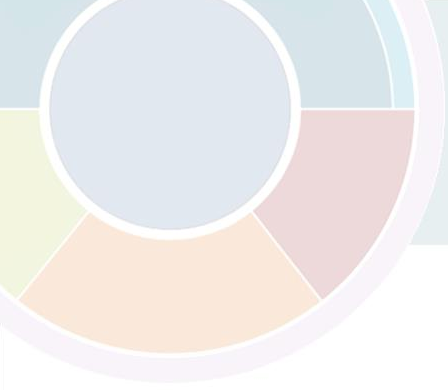
Allows practices to **participate in both** the PCF-General and the SIP components of Primary Care First.

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

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



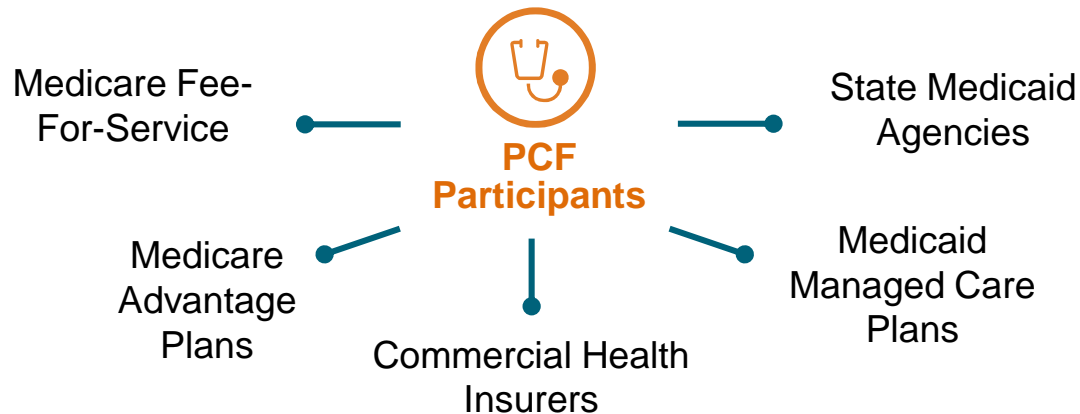
Practices that are **currently not participating in CPC+ but are located in a CPC+ region may be eligible to apply**. Current CPC+ practices may participate in Primary Care First beginning in 2022.



# Overview of PCF Payer Partnership

# 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 winter 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





# PCF Offers Several Benefits to Payers for Promoting the Transition to Value-Based Care



**Potential for greater reductions in avoidable utilization and costs** as compared to individual payer activities, because aligned payment, quality, and data sharing efforts can promote larger improvements in practice performance



**Opportunity to use PCF as a primary care model template**, which may reduce individual payer resources needed to design and develop a new model



**Multi-payer collaboration facilitated by CMS-supported regional convenors**, which may include sharing best practices and working together towards shared goals



**Opportunity to earn Other Payer Advanced Alternative Payment Model (APM) status**



# CMS Will Solicit Payer Partners Based on Their Alignment to Four Core Model Principles

CMMI is seeking to partner with payers who are **aligned to PCF's core model principles**, which include:

- 1 Moving away from a fee-for-service payment mechanism;
- 2 Rewarding value based outcomes over process;
- 3 Using data to drive practice accountability and performance improvement; and
- 4 Leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models.

For each of the above principles, this presentation **will define what would be deemed “preferred alignment”**. Please refer to the [Payer Rubric](#) on the [PCF website](#) for what would qualify as “acceptable alignment” or “not sufficient alignment”.



# CMS Will Evaluate Payer Proposal Alignment Against the Below Framework

CMS will evaluate payer proposals based on prospective partners' alignment in the following domains:

## Payment

Reimburse practices through **an alternative to traditional fee-for-service (FFS)**, such as a population-based payment

## Quality

Implement **performance-based payments** that reward high performance on quality and utilization outcome measures

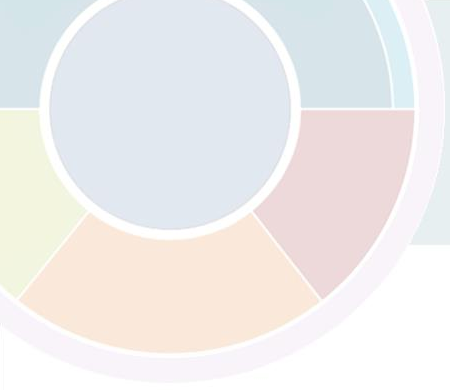
## Data

Share data on **cost, utilization, and quality** to support continuous learning and improvement

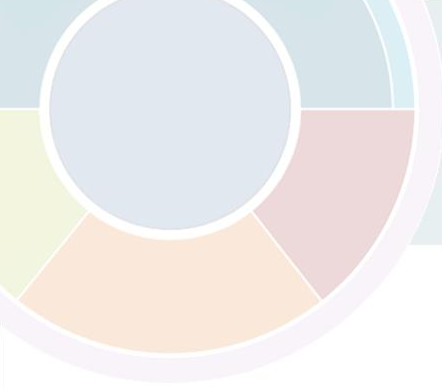
## Collaboration

Participate in multi-payer collaborative activities, including goal setting **for regional multi-payer collaboration and alignment**

This presentation will be **divided into sections by the above domains** and will review important information your organization should consider when determining your alignment to PCF core model principles.



# Payment Alignment



# Alignment to PCF Principle 1 Focuses on Transitioning Towards Value-Based Care

We will first review the PCF payment methodology and alignment criteria associated with the first PCF principle:

- 1 Moving away from a fee-for-service payment mechanism;
- 2 Rewarding value based outcomes over process;
- 3 Using data to drive practice accountability and performance improvement; and
- 4 Leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models.

# 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 that care for higher-risk patients** for the increased level of care these patients typically need.

## 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.



## 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*

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

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

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

\* PBPM = Per Beneficiary Per Month



# Preferred Alignment for Payment Involves Minimizing Volume-Based Incentive and Accounting for Risk Adjustment

CMS encourages payers to design an aligned payment model that meets the following “preferred alignment” criteria:



## Minimize Fee-For-Service

Partial primary care capitation with **more than 50% of revenue reimbursed** through capitated or other non-visit-based payment

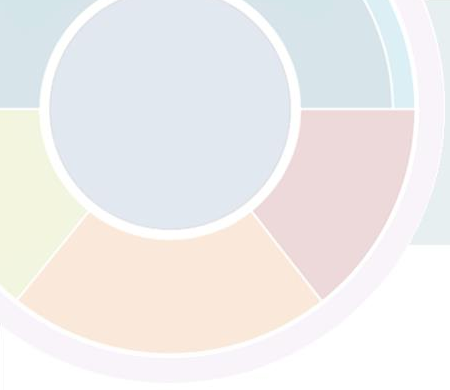
OR

**Full primary care capitation**



## Risk Adjustment

Alternative to fee-for-service payment is risk adjusted to account for factors including but not limited to **health status and patient demographics**



# Quality Strategy Alignment





# Alignment to PCF Principle 2 Focuses on Incentivizing Improved Health Outcomes

Next, we will review PCF quality measures and alignment criteria associated with the second PCF principle:

- 1 Moving away from a fee-for-service payment mechanism;
- 2 Rewarding value based outcomes over process;**
- 3 Using data to drive practice accountability and performance improvement; and
- 4 Leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models.



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

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

# Preferred Alignment for Quality Structure Involves Incentivizing Quality Outcomes Similar to Those Used By Other Payers

CMS encourages payers to design an approach that meets the following “preferred alignment” criteria for quality:



## Reimburse Outcomes, Not Process

Performance-based payment tied to **outcomes**:

- Clinical Quality
- Patient Experience
- Health Improvement
- Costs and/or Utilization Measures
- Total-Cost-Of-Care



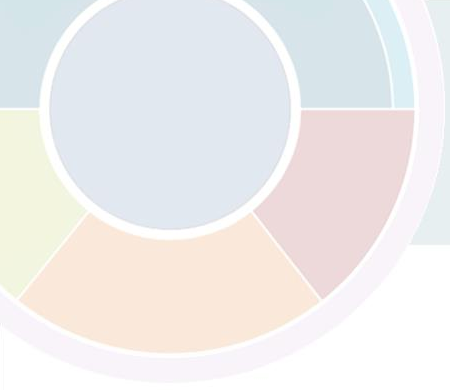
## Substantial Impact on Payment

- Performance-based payment adjustment can increase practices' primary care revenue **by more than 15%**
- Performance can both **increase and decrease payment**



## Align Measures

- Payer uses **the same quality and utilization measures** as PCF to evaluate practice performance
- Payer uses few or **no additional measures** beyond the PCF measure set



# Data Sharing Alignment



# Alignment to PCF Principle 3 Focuses on Using Data-Driven Insights to Improve Care Delivery

We will now review PCF data sharing and alignment criteria associated with the third PCF principle:

- 1 Moving away from a fee-for-service payment mechanism;
- 2 Rewarding value based outcomes over process;
- 3 Using data to drive practice accountability and performance improvement; and**
- 4 Leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models.

# PCF Practices May Request Reports to Gain Data-Driven Insights into the Quality of Care and the Patient Experience

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



## Level of Data

- Beneficiary level
- Practitioner level
- Practice level



## Type of Data

- Expenditure
- Utilization
- Patient demographic
- Diagnoses



## Timing

Delivered quarterly with a one quarter lag



## Format

Interactive data feedback tool with option to request claims line feed data





# Preferred Alignment for Data Sharing Focuses on Delivering Actionable Feedback to Practices

CMS encourages payers to design an approach that meets the following “preferred alignment” criteria:



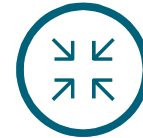
## Attribution

- Receive list of **prospectively attributed members** at least monthly



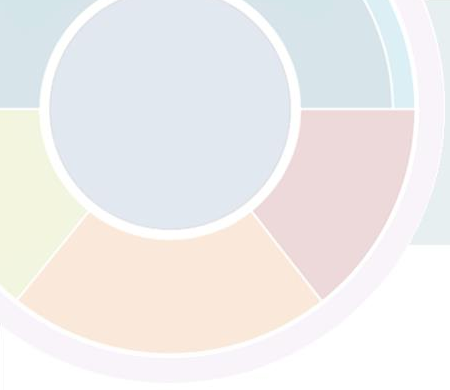
## Data Type and Format

- Provide **beneficiary-level utilization and cost of care data** for attributed members **at least quarterly**
- Data is delivered in **user-friendly formats** and can be exported into electronic formats for analysis
- Data is accompanied by tailored **support and guidance**



## Regional Aggregation

- Participate in or actively work towards participating in **regional data aggregation**, which provides multi-payer data in a single platform



# Collaboration Alignment





# Alignment to PCF Principle 4 Focuses on Collaborating with Other Payers to Drive Model Success

We will now review alignment criteria associated with the fourth PCF principle:

- 1 Moving away from a fee-for-service payment mechanism;
- 2 Rewarding value based outcomes over process;
- 3 Using data to drive practice accountability and performance improvement; and
- 4 Leveraging multi-payer alignment as a critical tool for driving adoption of value-based care models.**



# Preferred Alignment for Collaboration Involves Goal Setting and Information Sharing with Regional Peers

CMS encourages payers to design an approach that meets the following “preferred alignment” criteria, as possible:



## Collaboration

- Participate in and contribute to PCF-related **regional multi-payer collaborative activities**
- **Set and progress toward annual goals** for regional multi-payer collaboration and alignment



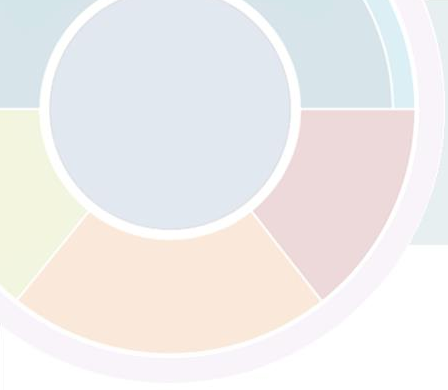
## Transparency

- **Share information about non-payment related topics** with CMS and other payers to inform payer alignment and collaboration activities



## Reasonable Eligibility Criteria

- Set **reasonable eligibility criteria** that enable participating PCF practices in their region to participate in the payer’s PCF-aligned model



# Payer Solicitation Process



# Interested Payers May Respond to This Solicitation By Submitting an Online Proposal

Interested payers were asked to submit an **optional** payer Statement of Interest (SOI) form by December 6, 2019. All interested payers, **regardless of whether you submitted a SOI**, should proceed with the following:



## Complete and submit a payer partnership proposal

- All Interested payers can respond to this solicitation by completing an online proposal, which became available at <https://app1.innovation.cms.gov/PCF> on **December 9, 2019**.
- Payers interested in partnership in multiple regions are asked to **submit separate proposals for each region** if their proposed approach varies significantly between regions.
- Payer proposals are due on **March 13, 2020**.

Not that after the practice application period closes, **payers that submitted a SOI form will receive information from CMS** about how many practices submitted applications to help gauge where there is high practice interest in PCF.





# CMS Follows the Below Solicitation Process to Assess and Select PCF Payer Partners

This solicitation process for payer partnership follows the following steps:

## 1 Assessment of Payers' Alignment with Medicare's Approach

Payer alignment with CMS' payment, quality, and data sharing approaches

## 2 Clarification of Proposals

CMS may contact payers to clarify elements of their proposal or to gain additional context for payer responses

## 3 Final Selection

CMS will use its assessment of payer proposals to inform selection of PCF payer partners






## 4 Memorandum of Understanding (MOU)

CMS expects to enter into an MOU with each selected payer. The MOUs will outline the commitments of payers that sign an MOU with CMS



# CMS Encourages Payers to Design Proposals That Meet ‘Preferred Alignment’ Criteria

Proposals will be evaluated based on the criteria outlined in the [Payer Rubric](#). This proposal evaluation process involves the following:

-  Payers respond to the solicitation **with detailed plans describing their approach and alignment** to PCF
-  Payer alignment to each core model principles is deemed “**not sufficient alignment,**” “**acceptable alignment,**” or “**preferred alignment**”. Designs that meet “preferred alignment” are encouraged
-  CMS may still partner with payers who meet “acceptable alignment” criteria in some areas, with the expectation that these **payers will work towards meeting “preferred alignment” standards**
-  Payers that fall under “**not sufficient alignment**” on 1-2 criteria will still be considered, and CMS will seek **follow-up conversations** with those payers
-  **CMS selects payers** and reserves the right to reject any payer’s proposal



# Interested Payers Should Account for the Below PCF Partnership Considerations

Some additional considerations for PCF payer partnership include the following:



## Commitment to Ensuring Competitive Markets

- CMS aims to **maintain a competitive environment** while providing an opportunity for payer partnership
- All conversations among payers and primary care practices must **comply with antitrust law**
- Nothing in the solicitation shall be **deemed to suspend any applicable antitrust laws or regulations**

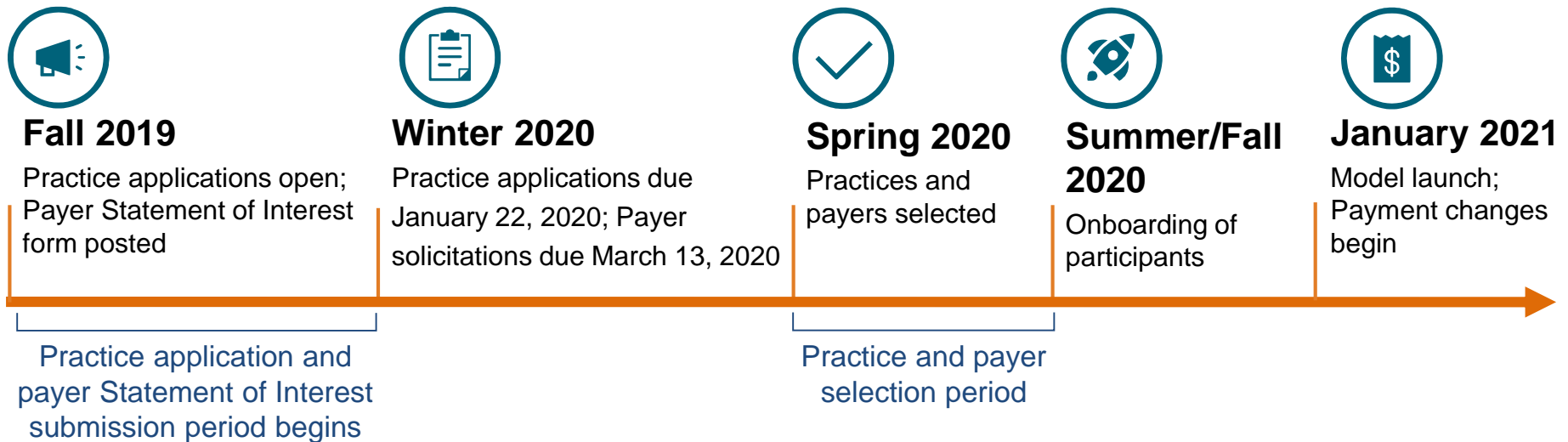


## Partnership with State Medicaid Agencies

- CMS recognizes the importance of states' partnership in multi-payer initiatives and **invites state Medicaid agencies to apply**
- Interested states will need to **fund the non-federal share of Medicaid payments** for their attributed enrollees
- States may need to submit proposals to CMS through **State plan amendments and/or waivers**

# The PCF Payer Solicitation Period Occurs in Winter 2020

The deadline to submit a [PCF Payer Solicitation](#) is March 13, 2020!



Interested payers should review the [Request for Applications \(RFA\)](#) and can access the [PCF Payer Solicitation Portal](#) to complete a solicitation.





# 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/>

## Call

1-833-226-7278

## Follow

@CMSinnovates

## Email

[PrimaryCareApply@telligen.com](mailto:PrimaryCareApply@telligen.com)

## Subscribe

[Join the Primary Care First Listserv](#)

## Apply

[Read the Request for Applications \(RFA\) here](#)

[Read the Payer Rubric here](#)

[Access the Payer Solicitation Portal here](#)